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Evaluating the Kaiser Permanente Community Fund's Social Determinants of Health Portfolio

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Key Points

- Research over the past two decades repeatedly demonstrates the relationship between poor health outcomes and socioeconomic factors such as poor housing, poverty, racism, and structural inequity.
- In 2005, the Northwest Health Foundation, supported by the Kaiser Permanente Community Fund, began an initiative to address these social determinants of health (SDOH).
- A variety of projects – short- and long-term, large and small – were supported over the five-year period for a total of $12.4 million. The mean project-implementation grant was $175,350 and 2½ years in length; capacity-building grants averaged $50,000 for 1½ years.
- In all, 323 social-determinant accomplishments were identified. The most-often identified accomplishments were improvements in neighborhood living conditions; health promotion, disease and injury prevention; and civic engagement and social cohesion.
- The broad, inclusive qualities of the SDOH framework allowed the fund to reach multiple sectors and establish new partners and relationships, but the lack of depth may limit opportunities to make a profound and measurable difference within any specific domain.

Introduction

> Health begins where we live, work, learn and play – long before any clinical intervention is required to treat disease or injury.
>
> – Northwest Health Foundation

The concept of the social determinants of health (SDOH) has been widely embraced within the public health community. Research over the past two decades repeatedly demonstrates the relationship between poor health outcomes and socioeconomic factors such as poor housing, unsafe work environments, poor education, social exclusion, poverty, racism, and structural inequity (Krieger, 1994; Marmot & Wilkinson, 1999; Williams, Costa, Odunlami, & Mohammed, 2008; Commission on the Social Determinants of Health, 2008; Centers for Disease Control and Prevention, 2011). Despite this evidence, few community-based health foundations have taken the opportunity to invest in the social determinants of health.

Addressing the social determinants of health is a challenge for two reasons. One is that societal conditions have evolved over generations; as a result, problems such as poverty, racism, and social exclusion cannot be mitigated, much less solved, through short-term investments. The second challenge is the long lag time between changes in social determinants and corresponding health outcomes. This delay means that scalable best practices are still largely theoretical (Bramba et al., 2010).

Background

In late 2004, Kaiser Permanente Northwest established the Kaiser Permanente Community Fund within the Northwest Health Foundation (NWHF) with a $28 million gift. In 2006, the fund advisors took the bold and strategic step of

investing in improvements to the social determinants of health. In order to improve the impact of the fund, key leaders at the NWHF and Kaiser Permanente Northwest made a commitment to continuous learning based on their own experiences and those of community partners. As part of this commitment, NWHF commissioned the Center for Community Health and Evaluation (CCHE), part of Group Health Research Institute in Seattle, Wash., to retrospectively evaluate the first five years of the fund's grantmaking (2005-2009).

In this article we present an overview of the Kaiser Permanente Community Fund's SDOH initiative and its theory of change. We then introduce the frameworks and methods we used to conduct our evaluation. In the findings section we summarize the accomplishments of the initiative and grantee success factors. We conclude the article by imparting the lessons learned during and from the evaluation. We believe these lessons will be helpful to other foundations and funders interested in interventions and initiatives focused on social determinants of health.

Development of the Initiative

The fund is based at the Northwest Health Foundation in Portland, Ore. In 2005, the fund invited and funded proposals to advance health equity and promote cultural competency in health care. Although some of the fund's 2005 grantees were already addressing social determinants, the following year, the fund's advisory board and NWHF staff made a commitment to focus grantmaking on social determinants of health. They believed this refined strategy offered the greatest opportunity to improve community health. A survey of the local philanthropic landscape revealed a significant gap in upstream community health initiatives. The fund focused on determinants as diverse as economic opportunity, public safety, civic engagement, and early education as avenues for long-term health improvements.

The fund is governed by an advisory board comprised of six representatives of different constituencies within the Kaiser Permanente system and five representatives from the broader community. Community representatives have worked in a variety of areas, including housing, economic development, public health, and advocacy for social equity. Advisors and NWHF staff jointly develop requests for proposals, outreach strategies, and criteria for selecting proposals that are most likely to achieve sustained community impact. Each year, the advisors and NWHF made improvements in the fund's operations that allowed the fund to better achieve its mission. These improvements included the addition of capacity-building grants, more intentional outreach to communities of color, and increased visibility of the fund's mission and presence among grantmakers throughout the region.

Addressing the social determinants of health is a challenge for two reasons. One is that societal conditions have evolved over generations; as a result, problems such as poverty, racism, and social exclusion cannot be mitigated, much less solved, through short-term investments. The second challenge is the long lag time between changes in social determinants and corresponding health outcomes.

SDOH Grantmaking Strategy

The advisory board and NWHF staff used an initiative approach (comprised of capacity-building and implementation grants) to address the social determinants of health. NWHF staff also served as partners and technical resources for grantees. Projects were intentionally funded to create a diverse pool of grantees. The request for proposals encouraged cross-sector collaboration and a shift in emphasis from individual health to upstream determinants such as housing, employment, community building, transportation, and poverty

BOX 1 Examples of Funded Projects

Organization	Project Description
Neighborhood Partnerships	To support the statewide advocacy efforts of a broad-based coalition to develop and advocate for policies that address asset poverty
Cambodian-American Community of Oregon	To build community and community capacity and foster community-trauma healing of the Cambodian American community through an oral history project
City of Portland Bureau of Planning	To build the capacity of the Portland Bureau of Planning to integrate health within planning activities
Community Solutions for Clackamas County	To support the integration of individuals with mental illness into a new planned Oregon community
Educational Opportunities for Children and Families	To identify and address the environmental factors affecting physical activity and nutrition in early-childhood-development and day care programs in Clark County
Southwest Washington Tribal Health Alliance	To support the startup costs of a new Community Nursing Center serving American Indian, low-income, and elderly residents of Skamania County and east Clark County
American Lung Association of Oregon	To create smoke-free environments in multiunit rental properties in the Portland metropolitan area

reduction. There was much variation in the scope and purpose of projects. For example, one project targeted institutionalized racism by increasing organizational diversity in order to enhance the environmental organization's capacity to collaborate with multiple communities and populations more effectively. Another project focused on urban development and promoted transportation planning as a community health promotion strategy. Box 1 provides examples of a range of project topics.

Evaluation Methods

The NWHF and CCHE collaboratively developed a logic model (see Figure 1) for the Kaiser Permanente Community Fund. The logic model presents a pathway of inputs and activities into grantee and initiative outcomes that are unique to an SDOH approach. The logic model makes explicit the role of the social, policy, and physical environments that inform and affect the initiative. The logic model also makes explicit the role of the NWHF, which supported the initiative by providing ongoing support to grantees, outreach to target communities, and advocacy for grantees.

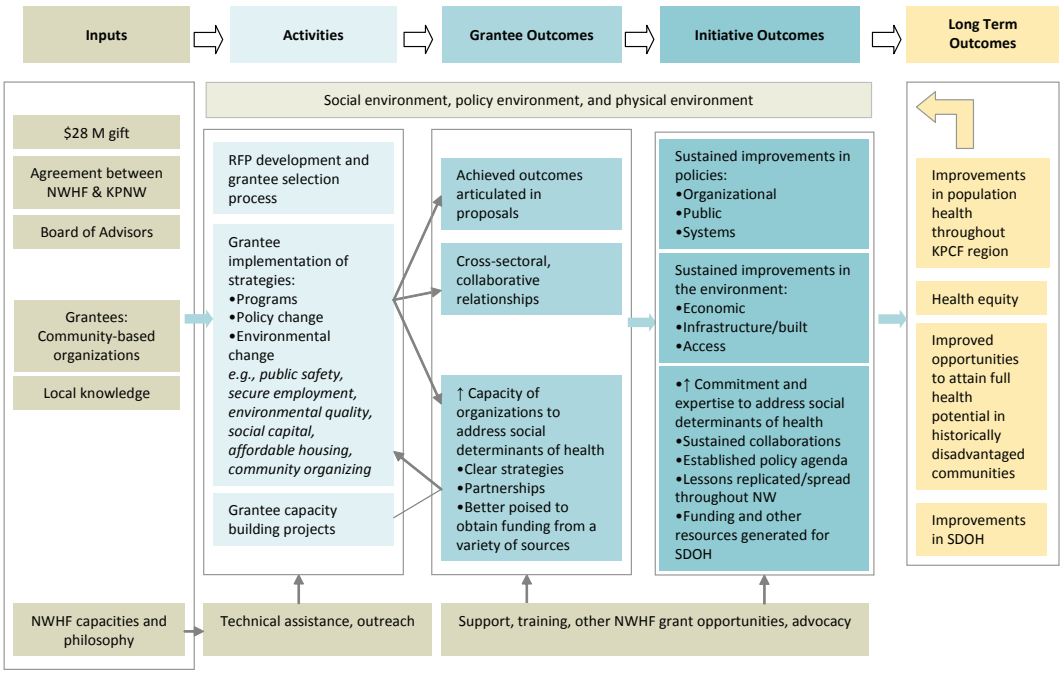
Evaluation questions were developed based on priorities of the advisory board, the NWHF staff, and the logic model. The questions focused on increases in knowledge, awareness, and commitment to the social determinants of health; the impact of collaboration among grantees in achieving success; and identifying and highlighting the social-determinants projects that appeared to have the greatest impact.

CCHE collected data using four methods: review of grantee documents, key informant interviews with grantees, key informant interviews with individuals in position to observe the impact of the fund at the initiative level, and a web-based survey.

A document review was conducted for 88 completed or in-process grants. CCHE drew from NWHF materials including grantee proposals, NWHF reviews of proposals, and grantee progress or final reports.

To gather additional information about grants, 16 of the most exceptional projects were selected and key informant interviews were conducted with representatives from those projects. Criteria for identifying the most exceptional projects were the extent proposed outcomes were achieved, magnitude of impact (a combination of number

FIGURE 1 Kaiser Permanente Community Fund Logic Model



of people likely to be affected and the strength of the intervention effects), sustainability of project benefits, quality of cross-sectoral collaboration, and vulnerability of the target population. All criteria were weighted equally and the ratings were completed by CCHE. In addition, NWHF staff used the same criteria to judge projects they considered exceptional in order to triangulate the CCHE rating process. Results were compared and the projects that ranked highest from CCHE ratings and those identified as exceptional by NWHF staff were the same. This process resulted in a sample of 16 grantees that were interviewed to better understand how and why they were able to be so successful. During interviews, open-ended questions were asked about:

- familiarity with the social determinants of health,
- contribution of the fund to grantee knowledge and appreciation of SDOH,
- discussion of project accomplishments,
- examples of sustained accomplishments or impacts from funded projects,
- grantee success factors, and
- suggestions to improve the fund's impact on SDOH.

A web-based survey was distributed to all grantees (excluding the 16 grantees that participated in the key informant interview, to limit data-collection burden). Of the 61 grantee organizations that received the survey, 52 responded (an 85 percent response rate). The web-based survey sought information on grantee accomplishments, factors enabling sustainability, and the extent of cross-sectoral collaboration during the life of each grant.

The evaluation included 11 macro-level key informant interviews. Informants included current and former advisors to the fund and individuals from public health, philanthropy, and academia. They were selected for their knowledge about the fund, their diverse perspectives, and high levels of engagement in different systems that interact with the social determinants of health.

BOX 2 Social Determinant Goals and Definitions

Community cohesion • cultivate social capital, enhance cross-cultural understanding and community building, and increase civic engagement
Access to care and disease prevention • policy advocacy to expand access to health care, cultural competency in health care, and health-promotion activities
Food access and nutrition • increased nutrition through farmers markets and healthy lunches and eradicating root causes of food insecurity
Economic opportunities • access to credit, job training, and the development of co-ops
Education and childhood development • tutoring programs, pre-kindergarten programs and advocacy, school-based activities
Housing • access to housing and improving housing conditions
Built environment, transportation, and environmental justice • access to active modes of transportation • local or regional planning with an equity and health lens

Source: (Ramirez, Baker, & Metzler, 2008).

BOX 3 The Community Guide: Social Determinant Categories and Definitions

Neighborhood living conditions • housing, farmers markets, smoke-free policy, built environment, physical environment changes
Opportunities for learning and developing capacities • early education centers and school-based mentoring as well as individual capacity development
Economic opportunities • individual and community economic-development programs
Civic engagement and social cohesion • community and civic engagement, social capital
Cultural customs and social norms
Health promotion, disease and injury prevention • culturally appropriate care, health advocacy, expansion of services

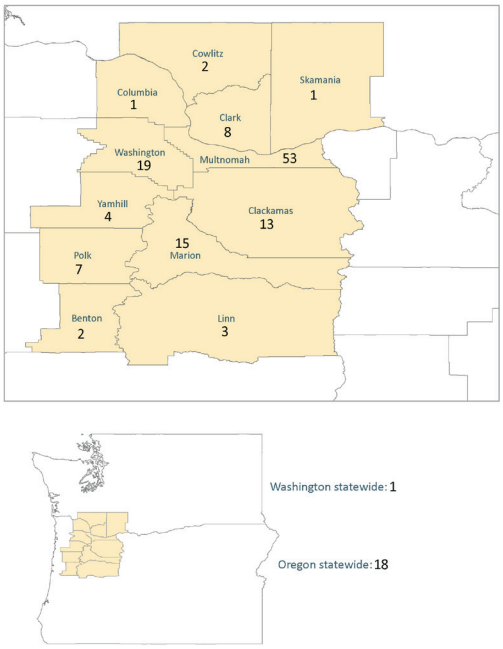
Source: (Anderson, Scrimshaw, Fullilove, Fielding, & Task Force on Community Preventive Services, 2003).

Analysis Approach

Organizing and analyzing categorical and narrative data about interventions across the spectrum of the social determinants of health required creative thinking. To be able to identify social-determinant areas where projects had the greatest impact, CCHE coded each project with a single, primary social-determinant goal based on a brief description of the project provided by the program officers at the NWHF. Then, during the document review, the accuracy of the primary goal was validated. Discrepancies were brought to the team and discussed until consensus on the appropriate primary goal was achieved. The list of primary goals was adapted from *Promoting Health Equity* (Ramirez, Baker, & Metzler, 2008) and are defined in Box 2.

Data about accomplishments from the document review, the grantee interviews, and the web survey were compiled into a database organized by grantee, with fields for primary goal, accomplishment type, and other areas of interest. We coded all accomplishments for each grant by social-determinant category. These categories (including terms and definitions) were adapted from *The Community Guide's Model for Linking the Social Environment to Health* (Anderson, Scrimshaw,

FIGURE 2 Geographic Distribution of Grants



Fullilove, Fielding, & Task Force on Community Preventive Services, 2003). *The Community Guide* is the guiding document used by the fund and NWHF staff to design the initiative. (See Box 3.)

For interview text and open-ended survey responses, we applied qualitative techniques to draw inferences. Data were hand-coded by topic area (i.e., success factors, challenges, accomplishments, lessons learned) and reviewed to uncover the most common themes that emerged from that process. Data were reviewed a second time specifically to identify and highlight policy and environmental changes. Coding was primarily conducted by one person and checked for validity by another member of the evaluation team.

Evaluation Findings

Grant Portfolio Description

A basic description of the initiative's portfolio was derived from the document review. Eighty-eight grants comprised the portfolio. The grant amount ranged from $10,000 to $450,000; the average grant amount was $141,160. The number of grants increased in 2008, reflecting the addition of the capacity-building track, which created opportunities for organizations less experienced in addressing the social determinants of health – particularly grassroots organizations with few resources – to develop clear strategies and partnerships.

The fund supported a variety of projects – short- and long-term, large and small – at a total funding level over the five-year period of $12.4 million. The mean project-implementation grant was $175,350 and 2½ years in length; capacity-building grants averaged $50,000 for 1½ years. The fund primarily supported community nonprofit or advocacy organizations. At the time of the evaluation, 44 grants were still in process, 38 were complete, and reports were not available for six recently funded, in-process grants.

For each proposal, grantees identified one or more counties served by their proposed project. In some instances, the intervention was statewide (as with many policy-advocacy projects) or targeted multiple counties. Figure 2 illustrates the geographic distribution of grants within the Kaiser Permanente Northwest service region, which stretches from Longview, Wash., to Corvalis, Ore.

Accomplishments in the SDOH Initiative

As described in the analysis section, CCHE used two social-determinant frameworks to organize and analyze data on accomplishments. Data on accomplishments were derived from the document review, the grantee survey, and the grantee key-informant interviews. Table 1 presents the portfolio of the grants' primary goals. The largest portion of proposals had the goal of community cohesion; 34 percent (n = 30) of grants described projects intended to cultivate and support social capital, community building, civic engagement, and cross-cultural understanding. The goal of access to care and disease prevention followed with 16 percent (n = 14) of grants to expand health-policy advocacy, improve cultural competency, and conduct health-promotion activities. Fourteen percent (n = 12) of grants aimed to improve food access and nutrition through access to farmers markets, healthier school lunches, and addressing root causes of food insecurity.

Table 2 summarizes the social-determinant accomplishments of all 88 grants. In all, 323 social-determinant accomplishments were identified. The social determinants with the greatest number of accomplishments were improvements in neighborhood living conditions (74 accomplishments); health promotion, disease and injury prevention (74); and civic engagement and social cohesion (71). Neighborhood living conditions included attention to housing, farmers markets, smoke-free policies, and changes in the physical environment. Grants with accomplishments in health promotion, disease and injury prevention did not provide direct service, but instead aimed to improve health through culturally appropriate care, health advocacy, and expansion of services. Civic engagement and social cohesion accomplishments included activities that supported community and civic engagement and social capital.

Table 3 shows the dynamic quality of an SDOH initiative by demonstrating that grantees had accomplishments in multiple social-determinant categories. For example, the goal of one grantee was to expand access to high-quality pre-kindergarten child-development services. To achieve

TABLE 1 Results of Coding Grants By Primary Goal

Grant Goal	# of Grants
Community cohesion	30 (34%)
Access to care and disease prevention	14 (16%)
Food access and nutrition	12 (14%)
Economic opportunities	10 (11%)
Education and childhood development	8 (9%)
Housing	7 (8%)
Built environment, transportation, and environmental justice	7 (8%)
Total	88

TABLE 2 Results of Coding Accomplishments in Social-Determinant Categories

Social-Determinant Category	# of Accomplishments
Neighborhood living conditions	74 (23%)
Health promotion, disease and injury prevention	73 (23%)
Civic engagement and social cohesion	71 (22%)
Economic opportunities	52 (16%)
Opportunities for learning and developing capacity	30 (9%)
Cultural customs and social norms	23 (7%)
Total	323

TABLE 3 Social-Determinant Accomplishments Organized By Primary Goal

Primary Goal	Social Determinant Category						
	# grants with primary goal	Neighborhood living conditions	Opportunities for learning and developing capacity	Economic opportunities	Civic engagement and social cohesion	Cultural customs and social norms	Health promotion, disease and injury prevention
Community cohesion	30	10	6	7	26	10	5
Access to care and disease prevention	14	1	3	4	5	2	41
Food access and nutrition	12	10	1	9	11	2	18
Economic opportunities	10	7	3	27	9	1	0
Education and childhood development	8	11	17	3	6	2	6
Housing	7	19	0	1	8	2	1
Built environment, transportation, and environmental justice	7	16	0	1	6	4	2
Total	88	74	30	52	71	23	73

this goal, the grantee had accomplishments that were coded as contributing to cultural customs and social norms and opportunities for learning and developing capacity. The accomplishment within cultural customs and social norms was the use of a public opinion survey that demonstrated popular support for expanded access to early-childhood programs. The passage of a statewide bill to increase access to pre-kindergarten services was categorized as contributing to opportunities for learning and developing capacity. This example makes clear that while the goal of a project may have one focus, the activities that were required to achieve that goal contributed to multiple social determinants. Table 3 also shows that, as expected, the majority of work on a particular social-determinant goal is supported by accomplishments in the corresponding social-determinant category.

To further explore the question of which social-determinant area was achieving the most impact to date, data from Table 3 were aggregated and a ratio of grants to accomplishments was calculated for each primary goal. (See Table 4.) The ratios demonstrate substantial returns in all goal areas, with education and economic goal areas yielding the most accomplishments per grant. Education and childhood development had the highest ratio, with 6:1 accomplishments per grant. Economic opportunity followed with 5:1 accomplishments per grant.

Data on accomplishments were reviewed a second time to identify policy or environmental changes. CCHE identified 85 policy or environmental changes. Policy and environmental changes included a bill on landlord smoking-policy disclosure, new state legislation on menu labeling, newly built healthy and affordable homes, and expansion of a community garden in a low-income area. Table 5 summarizes the number of policy and environmental changes for each primary goal and provides an example of change.

Grantee Success Factors

In response to open-ended questions, key informants from the 16 exceptional projects attributed their success to a number of factors. The most frequently mentioned were:

TABLE 4 Ratio of Grant Goals to Accomplishments

Grant Goal	# of grants	# of Accomplishments	Approximate ratio of accomplishments to grants
Community cohesion	30	64	2:1
Access to care and disease prevention	14	56	4:1
Food access and nutrition	12	51	4:1
Economic opportunities	10	47	5:1
Education and childhood development	8	45	6:1
Housing	7	31	4:1
Built environment, transportation, and environmental justice	7	29	4:1
Total	88	323	4:1

- grantee relationships with other organizational partners,
- positive grantee reputations and relationships within target communities,
- grantee relationships with the NWHF, and
- a philosophical alignment of the social determinants with grantee approaches.

The most frequently identified success factor was collaboration among grantees as well as with partners outside of the grantee cohort (n = 9). The value of collaborations among grantees and partners is captured in a comment from a grantee:

> [Grantee] has been around for 10 years and because we've been so frugal we have had to leverage other kinds of resources. So the history of 10 years of those existing relationships made it possible for us to move ahead.

Relationships with organizations outside of the grantee cohort often contributed to success by expanding the grantee's capacity in a specific area.

Strong relationships with the target communities was the second most frequently mentioned factor related to success (n = 8). These relationships enhanced access to the community and allowed for quicker uptake and buy-in of project activities. Five grantees indicated that those relationships were maintained through active and transparent listening and engagement by grantee with the target community through mechanisms like community events, meetings, community advocacy, and civic education. One grantee described the way nurturing relationships with the target population were established and maintained: "We work hard to build relationships. Having the café where we are in community every day - building community, by just providing food – supports people in a basic way."

A third type of relationship identified as a success factor was the relationship between grantees and NWHF (n = 5). The fund provided grantees – especially those from nonhealth sectors – with technical assistance. That partnership provided not only the structure for funding, but also a community-health leader to provide technical assistance to nonhealth sector applicants and applicants from low-resourced communities to enable them to become competitive grantees. Nonfinancial support was mentioned by grantees as a key factor of success. Specifically, one grantee attributed her capacity to leverage more funds from larger donors to the support, encouragement, and technical assistance from NWHF staff:

TABLE 5 Total Policy and Environmental Changes, With Examples

Primary Goal	Total Policy and Environmental Changes
Community cohesion	23
Example policy change: One grantee is actively crafting an interpretation policy with the mayor's office.	
Housing	15
Example environmental change: Across 2 grants 67 affordable homes were built, many of which adhered to green-building standards.	
Economic opportunities	15
Example policy change: Local government environmental programs adopted inclusive procurement practices, which create incentives for work force diversity and minority contractor participation in publicly funded environmental projects.	
Food access and nutrition	12
Example environmental change: Youth have taken ownership of the entrepreneurial Livestock Project. Coops were built and chickens purchased in 2010.	
Education and childhood development	8
Example policy change: Oregon's February 2010 supplemental legislative session ended with first-time state funding for Early Head Start.	
Access to care and disease prevention	7
Example environmental change: Wiring, hardware, and connectivity were established in the new dental facility serving low-income individuals in Yamhill County.	
Built environment, transportation, and environmental justice	5
Example policy change: Public health criteria were included in SB 1059, which mandates that Oregon cities plan to reduce pollutant emissions.	

> The grant had everything to do with our success. We had talked to [NWHF] about our idea for this program. When I went [to NWHF] for an update after first year, I talked about an opportunity with Robert Wood Johnson, and would [NWHF] nominate us for that? We won the grant with [NWHF's] help [and] brought in [an] additional four years of support in addition to the Kaiser funding.

A fourth factor of success, reported by five grantees during interviews, was the dovetailing of grantees' organizational philosophy and the social determinants of health. Focusing on the social determinants expanded the funding pool to partners outside of the health field, allowing projects to bring fresh approaches and new concepts of solutions. These grantees described their work through a health lens for the first time. Being part of the initiative provided credibility, respect, and a boost in confidence to those doing grassroots work on social-justice issues traditionally maintained outside of public health.

Discussion

NWHF and Kaiser Permanente Northwest created the fund to address health improvements through a social-determinants framework in the Kaiser Permanente Northwest service region. The foundation identified a gap in public health and philanthropic approaches in the field, and the evidence that social determinants are critical factors in health and well-being led the fund to invest in the social determinants as a way forward. Over five years, 88 grantees, mostly community nonprofits and advocacy organizations, implemented $12.4 million worth of projects. Accomplishments toward project goals were made across a broad spectrum of social-determinant categories and sectors. Those accomplishments were largely supported by strong partnerships and collaborations among grantees, target communities, and the NWHF. The fund's investments in projects to boost economic opportunities and improve education and childhood-development systems resulted in the highest return of accomplishments.

Based on the evaluation findings and recommendations, the fund's advisory board reached consensus on seven priorities for strengthening the fund.

The translation of social-determinants concepts into practice, both for interventions and the field of evaluation, presents a major challenge. While guidance on methods, framing, and definitions for designing and launching SDOH initiatives is available, evidence of what works and validated tools for measuring effectiveness are lacking.

Limitations

This evaluation has several limitations. First, the majority of evaluation data were self reported (web-based survey, grantee key-informant interviews, and grantee documents). Data sought through the web-based survey and grantee key-informant interviews emphasized grantee accomplishments over challenges and barriers. Positive response bias and differences in recall are risks of self-reported data. Triangulating that data through reflections with NWHF staff and data from macro-level key informants lessened the impact of that bias.

Another limitation was that our evaluation weighted all accomplishments equally. The creation of a community garden was considered of a magnitude equal to establishing a process to facilitate successful prison-to-community transitions. The inclusive quality of the social determinants of health, and the limited evidence on which improvements in determinants have the greatest health effects, led the evaluation team to agree on equal treatment of accomplishments.

Finally, gathering quantitative data about the number and types of the individuals who benefitted from the projects was beyond the scope of this evaluation, which was aimed at gathering a broader understanding of success factors and overall impact. Our data allow us to explore the overall impact of the initiative as a whole and generate lessons learned for funders interested in developing grantmaking programs aimed at the social determinants of health.

Lessons Learned

Based on synthesis and interpretation of all evaluation data, several lessons emerged that may be of interest to other funders considering work in the social determinants of health. The translation of social-determinants concepts into practice, both for interventions and the field of evaluation, presents a major challenge. While guidance on methods, framing, and definitions for designing and launching SDOH initiatives is available, evidence of what works and validated tools for measuring effectiveness are lacking.

The broad, inclusive qualities of the SDOH framework allowed the fund to reach multiple sectors and establish new partners and relationships, but the corresponding risk is lack of depth in any particular area. The lack of depth may limit opportunities to make a profound and measurable difference within any specific domain.

An SDOH initiative that uses a clear framework with explicit outcomes would provide grantees much-needed guidance and ensure that concrete activities are consistent with the initiative's overall vision. Translating the theory, philosophy, and expansive nature of the social-determinants framework into specific effective projects is challenging, but a framework with anticipated outcomes would allow for a much more precise evaluation of strategies and relative impact. Components of a useful structure include a clearly articulated vision of success framed within the sponsor's resources and time frame; the use of a logic model as a planning tool to articulate intermediate and long-term outcomes; regular, frequent reflection on and discussion of how projects fit within the framework; and a system

organized by the framework to track what is funded and to capture progress and impact.

Seeking out and welcoming "nontraditional" partners into the field of public health is a key mechanism for translating the social determinants from theory to practice. Nontraditional partners are those who come from sectors outside of health, as well as from organizations traditionally underserved and under-resourced, with limited capacity to compete for grants. The breadth of potential partners in an SDOH initiative expands the pool of public-health practitioners. For the Kaiser Permanente Community Fund, this enabled cross-sector collaborations among grantees, which led to cross-pollination of ideas, new opportunities for public-health improvements, and expanded alliances and support. It also allowed new partners to understand their efforts through a health lens and allowed them to frame their own successes in a new light. Dismantling silos is the way forward for public health, despite the potential risks of competing interests in lean economic times and the challenges of communication.

A funder can accelerate success in an SDOH initiative by fostering networks, framing issues, and sharing power with community grantees. Relationships between the NWHF and grantees were critical for success. Fund advisors and staff were constantly open to new ideas, changes in plans, lessons, and criticism from grantees and were constantly seeking ways to improve their practice towards justice and equity. They purposefully reached out to individuals and communities that did not see themselves as "target" participants in this work. This practice of humility and openness created space for sharing power, making decisions, and learning.

Relationships between grantees and target communities are critical to success. Kaiser Permanente Community Fund grantees grounded their community engagement in terms of justice, equity, and creating opportunities. The structure of the fund allowed grantees to be flexible and responsive to community momentum, strengths, and needs. This took positive advantage of and built upon pre-existing relationships between grantees and communities.

Conclusion

The fund was created to address health improvements through a social-determinants framework in the Kaiser Permanente Northwest service region. A gap in public-health and philanthropic approaches was identified, and the evidence that social determinants are critical factors in health and well-being led the fund to invest in the social determinants as a way forward.

Moving forward, the use of a logic model as a planning tool, in conjunction with a single social-determinants framework that includes desired outcomes, will facilitate clearer goals and expectations for such an initiative, with the capacity for results to be more readily identified. Funders might consider narrowing the scope of their SDOH initiative based on early data that point to discrete determinants that do show some capacity to generate a larger return on investment. Or, funders may consciously decide to be expansive, spreading investments across the entire spectrum of determinants. Either way, funders should spell out their expectations clearly, using a logic model to articulate their desired outcomes and assess their progress.

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