



Addressing Social Isolation *and* Other Social Determinants of Health

THE METROHEALTH-OPEN TABLE COLLABORATION



by Byron R. Johnson and William Wubbenhorst



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In 2017, The MetroHealth System, a public, safety-net health system based in Cleveland, Ohio, that serves more than 300,000 patients annually, partnered with an organization called Open Table.



INTRODUCTION

The healthcare sector and policymakers have been increasingly focused on factors that impact health outcomes outside of the formal clinical setting as part of a shift towards population-based health. These factors, known as Social Drivers¹ of Health (SDOH), include everything from specific needs, such as the availability of transportation to get to medical appointments, to broader issues relating to social isolation, employment, housing, food insecurity, and others. Research on the impacts of SDOH on health status project that 80% of the drivers of health outcomes occur outside of the world of healthcare interventions.

In 2017, The MetroHealth System, a public, safety-net health system based in Cleveland, Ohio, that serves more than 300,000 patients annually, partnered with an organization called Open Table. Open Table trains and develops proprietary models that organize community relational and social capital -- Open Table names them as Relational Assets™ – that support individuals and families to overcome SDOH barriers to lead healthier and better lives. MetroHealth licensed the Open Table model and training to launch a unique relationship-focused initiative for addressing a variety of challenges facing vulnerable individuals and families. MetroHealth's decision to engage with Open Table was part of a larger vision of their CEO at the time, to re-align the health system's resources and priorities based on SDOH. Their hope was that the partnership, which draws volunteers from among MetroHealth employees and from the community, would be helpful in re-orienting the healthcare system culture to be more aware of how SDOH impacts the ability to deliver quality care effectively.

The first section of this case study provides a brief history of MetroHealth. The second section offers a brief overview of the SDOH framework and the distinction between the traditional medical model of healthcare services delivery and the emerging population-based healthcare model. The third section provides an overview and description of the Open Table model for leveraging relational assets to meet the needs of vulnerable individuals and families and how and where this model dovetails with SDOH and MetroHealth's vision for a more community-focused approach to healthcare service delivery.

The fourth section of this case study delves into the initial steps taken in launching the MetroHealth/Open Table partnership, including the participation of key senior-level staff within MetroHealth and the lessons learned through their efforts to recruit and train volunteers and identify individuals facing social isolation and other SDOH barriers. The final section of this case study will evaluate the implementation of the MetroHealth/Open Table partnership, including a set of recommendations to guide other healthcare systems and planned future steps for MetroHealth to sustain the partnership. This section will also examine the preliminary impacts of the Open Table initiative on the individuals served (known as Table 'Friends') and its impact on MetroHealth employees, community volunteers, and the overall culture within the healthcare system.

¹ Also referred to in the literature as 'Determinants'.

I. METROHEALTH SYSTEM - A BRIEF HISTORY

MetroHealth was founded in 1837 and was originally referred to as City Hospital, with a primary focus on the city's population experiencing poverty. With Cleveland's population growth from 160,000 in 1880 to 800,000 in 1920, the hospital broadened its mission to an institution providing care for all. By 1937, the hospital campus on Scranton Road in Cleveland had 16 buildings and 1,650 beds and was the 6th largest hospital in the U.S. at the time. In 1958, the hospital was transferred from private to county control and was renamed the Cuyahoga Hospital. In 1989, it was renamed again as MetroHealth, which now operates four hospitals, four emergency departments, and more than 20 health centers and 40 additional sites throughout Cuyahoga County. The system serves more than 300,000 patients, two-thirds of whom are uninsured or covered by Medicare or Medicaid.

Since 2013, MetroHealth has been working toward a goal of transforming how and where healthcare services are delivered. Health system leadership recognized the critical importance of providing health care before people became sick, considering a whole person approach that looked at more than just a patient's medical condition but also considered a variety of factors that impact a person's health. Health system leadership also acknowledged that good health depends far less on your doctors than on what happened to you as a kid. The stressors of a tough life can change the biology of your brain and severely impact your physical well-being.

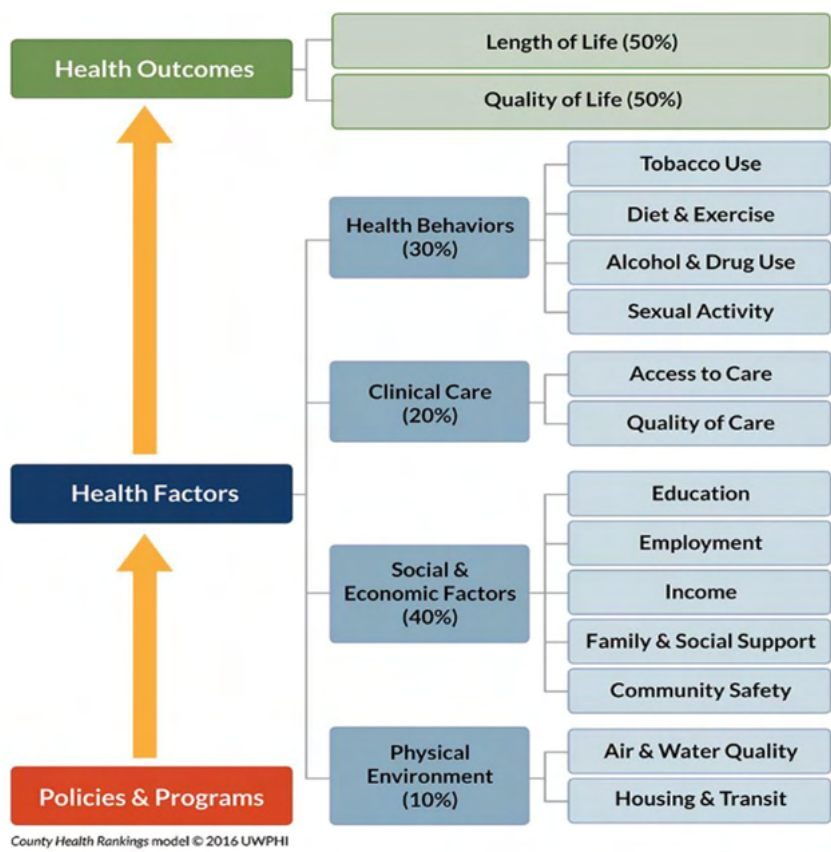
Public hospitals can play an important role in economic development, housing, education, violence, poverty and other social drivers of health.

What are Social Determinants of Health

Social Determinants (i.e., Drivers) of Health (SDOH), as defined by Healthy People 2020, is simply:

conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.²

Research conducted on a variety of these Social Drivers of Health underscores how significantly these various social drivers correlate with health outcomes. The following figure, developed by the University of Wisconsin's County Health Rankings, lists four overall health factors (i.e., Clinical Care, Health Behaviors, Socio-Economic and Physical Environment) and the degree to which each factor contributes to health outcomes. As the figure shows, 40% of health outcomes is associated with socio-demographic factors, such as education, employment, income, family social supports, and community safety.



The increased attention on SDOH is part of a shift in the healthcare system from a medical model, whereby health services is in a reactive mode, with a focus on serving sick patients, to a population health/public health model, characterized by a more proactive approach that seeks to address factors that negatively impact health through non-health factors. As part of this shift, healthcare providers are expanding their data collection and screening and subsequent referral processes to recognize and capture information on various social, and non-health, needs they may also be experiencing.

In 2019, MetroHealth began screening adult patients for their health-related social needs. The health system uses a 22-item SDOH screening tool embedded within the electronic health record, covering 10 areas of risk, including social isolation. Risk for social isolation, determined by four screening questions and consideration for marital status, has consistently appeared as the area of highest risk across all SDOH domains included in the screening. Generally, 47% of those screened are at high risk for social isolation, with an additional 45% at medium risk.

Healthcare Reform and the Shift to Population Health

One aspect of healthcare reform that does not receive much media attention is an effort by the federal government to shift the basis for healthcare reimbursements away from traditional fee-for-service (FFS) models toward a more population-based approach. Initiatives such as the Shared Savings Program (SSP) allow healthcare systems to enter voluntarily into an agreement with Medicare, whereby providers make more deliberate efforts to manage annual per-patient health costs for a defined population (i.e., Medicare patients). If these SSP health partners can keep costs below a targeted amount, they can share the savings with Medicare. To do so, many healthcare providers are forming what is known as Accountable Care Organizations (ACOs), which comprise a full array of health services from preventive and primary care to hospital care. Under a population health reimbursement scenario, in which SSP represents a first step, the incentive shifts towards prevention and primary care. Hospitals and emergency depart-

ments are no longer revenue centers, as they are in an FFS system, but now become cost centers. Effective strategies for success under SSP tend to focus more on community-based approaches, especially those relating to health promotion and wellness, rather than institution-based care.

II. ABOUT OPEN TABLE

The Open Table initiative began in 2005 when Ernie, a man experiencing homelessness in Arizona, asked members of a church that came to serve men at a local homeless shelter in Phoenix if he could come and visit their church. As Jon Katov, a member of that congregation and Founder and CEO of Open Table explained:

I began to understand there is no generational poverty, just generational judgment. It was about transactions, not transformation. We bought food, made sandwiches, loaded vans, set up tables to distribute the food items — like a supermarket checkout to move people quickly through a line, and bag the granola bar and a sandwich. But Ernie wanted something more. He wanted friendship. So, what's judgmental about a granola bar? It's the belief that people need the bar more than the relationship."

This experience led to the formation of Open Table in 2007 as a 501c3 nonprofit organization, with the mission of training congregations and their members to form these groups, now referred to as Tables, to utilize their vocational and life experiences and social networks as tools for helping individuals and families experiencing poverty. This effort is represented through the development and implementation of a life plan developed by the Table Friend, along with the skills for achieving economic mobility and moving toward the lives they envision for themselves and their children. The volunteers, known as Table Members, commit to a year of service to meet with the Table Friend, at a mutually agreed upon time, on a weekly basis, and, most importantly, to enter into direct, one-on-one reciprocal relationships with that Table Friend.

Open Table is a community-based developer and training organization of models and processes that support solutions to social challenges. While the model was originally implemented primarily by faith communities, beginning in 2019 an array of community sectors, including business, education, government, healthcare, social services agencies, and others, began implementing the model. Open Table grew into a broader vision of community co-investment of relational assets. Through this expansion and growth, Open Table became a shared purpose movement and model, with a broad constellation of diverse people and community sectors that focus on the investment of relational assets to overcome barriers in a manner fundamentally different from the fragmented, transactional approach that characterizes much of social services delivery across the country.

From 2014 – 2022, more than 5,000 volunteers have given more than 750,000 hours of reciprocal, long-term relationships with individuals and families and have served more than 800 individuals and families in 33 states and districts across the United States. The original Open Table model serves one individual or family at a time for a year. However, new Table models now in expansion can serve 25-50 people a year.

How Open Table Works

In the Open Table model, through a Table, individuals are trained to use their relational capital and social networks to positively impact the social drivers of health for an individual or family. The activities of the Table center around a life plan, defined by the Table's Friend, which outlines goals specific to the Table Friend and their family. The team of volunteers forming a Table (Table Members) varies in size from 6-8 when serving

an individual to 10-12 Table members when serving a family. Open Table provides 15-20 hours of online training through Open Table University based on the Open Table Theory of Change and teaches Table Members how to support Table Friends as they develop their own goals and plan. Each Table member selects a 'chair' representing a component of SDOH, as shown in the figure.



Despite these models and figures, Tables operate in a somewhat non-linear manner, taking shape and direction based on the unique relational dynamics among the Table Members and Friend(s). While this model can't be said to represent the 'typical' way a Table works, it is a helpful visual for Open Table's commitment to come alongside the Table Friend to whom they provide comprehensive support and recognizing that, as with all relationships, these benefits are ultimately bi-directional, with benefits flowing in both directions.

Social Drivers and Open Table

Within the context of Social Drivers, a Table provides access to relational assets, which Table Friends can tap into. Table 1 below provides examples of how Open Table helps support Table Friends with various Social Drivers and the potential cost savings associated with those supports.

Table 1: Open Table Impacts on Social Drivers

Social Determinant	Open Table Example	Potential Economic savings
Clinical Care (Healthcare)	<ul style="list-style-type: none"> - Support to wait and make appointment with PCP when a medical issue arises. Because of anxiety, rushing to the ED tends to be the default. - When a hospitalization occurs, discharge happens sooner because table members provide natural support for at-home care, including overnight. - Support for regular psychiatric and therapy appointments to decrease a visit to the ED seeking inpatient psychiatric treatment. 	<ul style="list-style-type: none"> - Reduced costs from ED overutilization. - Reduced hospital costs from shorter length of stay. - Reduced costs from fewer days of psychiatric hospitalization.
Housing (Social and Economic Factors/ Physical Environment) Diet and Exercise (Health Behaviors)	<ul style="list-style-type: none"> - In one instance, a young lady was living in poverty in the inner city of Richmond, and her children were going to inner city schools. One Table member was a realtor and also had homes that she rented out for a low cost. This Friend was able to transition to a home in the county with access to good schools, parks, and playgrounds close by for her children. 	<ul style="list-style-type: none"> - Better educational outcomes for children. - Better health outcomes for children.
Transportation (Social and Economic Factors)	<ul style="list-style-type: none"> - Tables have helped Friends buy cars, used social capital to assist with mechanic services, assisted with finding affordable car insurance coverage 	<ul style="list-style-type: none"> - Greater economic mobility due to better employment opportunities.
Diet and Exercise (Healthy Behaviors)	<ul style="list-style-type: none"> - Table members are helping Table Friends have access to food. Many of them live in food deserts. - Teaching Table Friends how to prepare and learn what healthy food is. 	<ul style="list-style-type: none"> - Reduced healthcare utilization, and more stability for employment due to fewer sick days for parents and children.
Income/ Economic Stability (Social and Economic Factors)	<ul style="list-style-type: none"> - Tables help Table Friends make a budget, follow the budget, and problem-solve when her budget did not pay her bills. 	<ul style="list-style-type: none"> - Cost savings due to reduced or no dependence on government support programs (TANF/SNAP/SSI) and improved economic mobility.
Education (Social and Economic factors)	<ul style="list-style-type: none"> - Young people aging out of foster care were given the opportunity to go to college through opportunities provided to them from their Table. - Tables support Friends with access to internship opportunities and professional training programs. 	<ul style="list-style-type: none"> - Greater earnings potential and economic mobility through educational advancement.
Family & Social Support (Social and Economic factors)	<ul style="list-style-type: none"> - The Table's primary goal is to build support for individuals and families through relationship. All Tables are increasing social engagement and support systems. 	<ul style="list-style-type: none"> - Variety of impacts from social supports.

IV. METROHEALTH AND OPEN TABLE

MetroHealth first became aware of Open Table in February of 2017 through an Open Table licensee in Cleveland implementing the model to serve youth aging out of foster care. MetroHealth already had a close association with the Cuyahoga County Division of Children and Family Services, as it was the identified healthcare provider for foster youth in the county. Jon Katov, CEO of Open Table, met with MetroHealth's CEO and select staff later that spring to discuss further. MetroHealth represented a new kind of partner for Open Table, using the lens of SDOH to shape and direct their efforts. MetroHealth had been actively incorporating the SDOH framework into their work, and the Open Table approach looked to fit in well with the organization's culture. In particular, MetroHealth saw the value of Open Table in addressing social isolation among their patient population and how to solve it with a more systematic approach. In an SDOH screening of over 88,000 MetroHealth patients, over 90% screened at risk for social isolation (48% at high risk, 44% at some risk). It is important to note that these patients were also at higher risk for a number of other factors, including Financial Resource Strain, Physical Activity, Stress, and Food Insecurity; approximately 23% of patients at risk for Social Isolation have 3 or more other risks. These patients were also associated with higher rates of depression, drug abuse and various chronic illnesses, as well as being 91% more likely than other patients to have a hospital stay of one week or longer and a higher level of emergency department utilization (see Exhibit 1 for a detailed analysis of SDOH barriers of MetroHealth's patient population).

Following the meeting with Katov, MetroHealth assigned a senior leader and project manager to oversee the Open Table implementation and Eduardo Munoz to serve as the on-the-ground program manager in addition to other responsibilities within MetroHealth. Munoz explained how his work with MetroHealth was a perfect fit for this role:

My role prior to the Open Table assignment was my connection with the local community. Because of the relationships I had with various numbers of profit, nonprofit and religious organizations in the community, as well as the clinical connections I had from being a registered nurse.

MetroHealth became the first healthcare system in the country to adopt the model in service to families and individuals living near the hospital system's main campus, officially introducing the partnership during its 2018 annual meeting. MetroHealth's initial commitment was to form 15 Tables.

Implementing Open Table – Laying the Groundwork

For starters, Munoz worked to create a landing page on the MetroHealth website, with a volunteer application to serve on a Table sent out through a dedicated email address (<https://www.metrohealth.org/open-table>). Within the first few months, MetroHealth recruited approximately 50 volunteers, of which about a third were MetroHealth

While there is a well-established training process for Table Members, Open Table works with partners such as MetroHealth to ensure population-specific training is provided by the partner as well. For example, MetroHealth was able to add some additional education on trauma as well as connecting Tables to resources within MetroHealth.



employees. The original plan was to onboard all Table Member volunteers as they did for other volunteers at MetroHealth, which included criminal background checks, but over time this was found to be too burdensome for the volume of volunteers being recruited and was replaced with a more streamlined process.

While there is a well-established training process for Table Members, Open Table works with partners such as MetroHealth to ensure population-specific training is provided by the partner as well. For example, MetroHealth was able to add some additional education on trauma as well as connecting Tables to resources within MetroHealth. As the Open Table program supervisor at MetroHealth explained:

We were supplementing the Open Table training with subject matter experts from MetroHealth. This included live speakers from within our system who could speak to it. For example, we brought in staff from our Trauma Recovery Center and others to speak with the Table Members trainees. We also had someone from our organizational development office to provide information on group dynamics and relationships and a social worker to talk about navigating resources.

This enhanced Open Table/MetroHealth training was very well-received by both community-based and MetroHealth employee Table Member volunteers.

At the outset of a new Open Table initiative, one of the major challenges can be identifying the appropriate referrals for Table Friends. This challenge is addressed through Open Table's referral process training and usually abates once a program is established and there is a greater understanding of the purpose and approach of the Tables, especially in contrast to how people generally received 'social services' from government and non-profit organizations. Some Table Friend referrals were MetroHealth patients, which were primarily based on those identified as having multiple social needs, and others were referrals from community partners. MetroHealth also employed a screening tool to provide more detailed information about the SDOH challenges facing potential Table Friend candidates (see Exhibit 2).

However, with the time pressures of launching 15 Tables, some of the criteria for community-based referrals were relaxed. For example, MetroHealth initially required all Open Table volunteers to go through the MetroHealth volunteer training and onboarding process but determined that this was not necessary, since these volunteers were not technically hospital volunteers. One challenge in identifying Table Friends was to communicate how Table Members would or could help them. Some Table Friends thought they would receive direct financial support from Table Members, and although this does occur in rare special cases, the primary function for Table Members is to provide their Relational Assets.

Social Capital Versus Social Services

Many Open Table graduates (i.e., Table Friends) have had numerous interactions with the social services system through caseworkers, mental health professionals and foster parents. The relational experience through Open Table was something quite different. As one Friend from an Open Table program in Virginia explained:

I actually had a relatively stable foster care situation for most of my time in foster care, but I didn't really share myself emotionally or personally with them. My first experience with Open Table was during the Breaking of the Bread³, where all these people I had never met started by sharing personal things about themselves and their lives, before I was asked to share anything about myself. Over time, I was able to make the kind of personal and emotional connections with Table Members that really helped me to grow and move forward with my life in a positive and productive way.

These types of personal relationships are quite distinct from those that these Table Friends often had with human services professionals. Katya Fels-Smyth, in an article she wrote entitled Leveraging Social Networks in Direct Services: Are Foundations Doing All They Can? describes the relationship dynamic for these professionals:

Professional distance undercuts the judicious development of bridging and linking relationships that may be critically needed.⁴

Open Table Friends often begin the process by talking about their Tables and Table Members, but towards the end of their Table experience and afterward tend to use the term "friends" and "family" to describe their relationship. This unique relational dynamic, at least in the context of social services and client referrals, is not something that is sufficiently appreciated in the policies and programs developed to assist an individual or family in need. Katov and Open Table staff are often challenged with explaining how these relationships work and how they matter. As Katov explains:

When I am in meetings, especially with policymakers at higher levels, I am always making the point that Open Table is a non-clinical, volunteer-based intervention leveraging community relational assets and working in partnership with the healthcare sector. This is the strength of Open Table; that Table Members are able and willing to partner with formal clinical systems of care, provide access to their own social capital and make the commitment to a personal relationship with their Table Friend. It acts to combine the clinical and social drivers people need to develop healthier lives.

³ Breaking of the Bread refers to the first Open Table meeting where the Open Table Friend shares a meal with the Table Members. After the meal they have their first meeting, which consists primarily of Table Members introducing themselves and sharing their lives with the Table Friend

⁴ Smyth-Fels Katya; Leveraging Social Networks in Direct Services: Are Foundations Doing All They Can?; Foundation Review; Volume 2:4, pp. 101-118

Open Table Up and Running

MetroHealth had a robust Open Table program underway in the Spring of 2020, just as COVID was surfacing across the country. COVID restrictions made face-to-face meetings no longer possible, so Tables shifted to online meetings, which diminished some of the personal aspects of relationships between Table Members and Table Friends. However, Open Table outcomes documented the effectiveness of virtual meetings. During this time, however, MetroHealth continued with the all-important community outreach efforts with presentations to various community groups and also through outreach to MetroHealth employees to recruit more Table Members.

In part due to the ambitious goal of having 15 Tables up and running, some Table Members had a limited amount of time to gel as a group before engaging with a Table Friend. Based on interviews with Table Members, those who had more time to meet together before engaging with a Table Friend seemed to be more successful and sustainable in their efforts. Like volunteer programs across the country, the stresses associated with COVID and the attendant restrictions sometimes presented challenges to recruitment and retention of Table members. Nonetheless, MetroHealth staff were inspired by the level of commitment that many Table Members dedicated towards assisting their Table Friends.

By January of 2021, MetroHealth produced a year-end summary, showing 18 Tables launched, seven of those still operating within their one-year period and others having completed the one-year period. For Tables that were completed, many Table Members reported ongoing contact and relationship with their Table Friend, an outcome encouraged by Open Table but not part of the initial commitment.

Open Table: The Table Member's Perspective

Volunteers both within MetroHealth and in the community signed up as Table Members based on a variety of motivations. When Table Members were asked about how the Open Table experience differed from other volunteer efforts in which they had been involved, many spoke of the personal connection and hands-on involvement with their Table Friend, combined with the longer-term commitment:

I've done a lot of community service and a lot of different efforts, and many of those things seem like they're more lip service, where you show up for a few hours at an event or may do something once or twice at a facility. It wasn't impactful and it wasn't connecting or really helping someone in the long term. It was kind of a temporary thing to make you feel good, but it really didn't do anything to help an individual or group of individuals in a lasting way.

Other Table Members had lived experience with previous struggles and hardships and wanted to be there for someone else during that time:

So, I know what hardship is like. I know what it is like to have financial and economic challenges. And once again, I feel that I'm very fortunate and blessed to be where I am today, but I know I did not get here without the help of others.

Other Table Members spoke about how the experience helped them to re-frame through thoughts about what success is for different people and the importance of respecting that person's decision-making process. As one Member shared:

I would say that I am a fixer by nature and a driver in many ways, but that is not what this process is about. The biggest personal challenge was setting my emotions and decision-making skills aside and humbling myself to just listen to the reasoning why our Table Friend was making the decisions they were making and not take it personally when they didn't think my ideas were the best.

One Member spoke of how Open Table aligned with her efforts in ministries through her church:

Originally when I started [at MetroHealth], I worked in the medical staff office, and Eduardo [Munoz] would come in and talk to our employee resource group at MetroHealth about different programs. And for me, it just seems like a part of me, and this is what I do. I do mission work at my church with 150 teens on Saturdays, so I was like 'Oh, this is me. I'll do this'.

A Table Members' commitment is for 12 months. Many Table Members maintained at least monthly, if not weekly, contact with their Table Friend, which is an outcome hoped for, though not required, by the Open Table model. Previous research on Open Table on this subject found that 95% of young adults/families (19 of 20) remained in relationship with at least one (and often more) of their Table Members after the 12-month engagement.⁵ This transition from the formal 12-month engagement to the informal friendship between Table Member and Friend is hoped for and expected in the Open Table approach.

Recommendations for Improvement from Table Members

A number of Table Members recommended efforts to further integrate the MetroHealth Open Table with corporate resources to assist on issues such as housing, childcare, and legal aid. One Table Member even thought that identify-

ing a point person within MetroHealth for each of these areas would help achieve more success in their support of their Table Friend's life plan. Another key recommendation was to provide Table Members with more time to work out group dynamics and roles before introducing them to their Table Friend.

Open Table: Evaluating Table Friend Outcomes

The unique nature of the Open Table Model, which does not specify particular outcomes (e.g., housing, employment, etc.) for its Table Friends, is a particular challenge for evaluation purposes. In the future, when the MetroHealth/Open Table initiative has a larger sampling of Table Friends served, it will be possible to conduct a more rigorous evaluation to capture some of the longer-term impacts of Table interventions in a more quantitative fashion.

For example, a previous case study on Open Table, also published through Baylor University, included a preliminary ROI analysis of outcomes for ten individuals served by Open Table in Virginia. The purpose of the preliminary ROI analysis below was to demonstrate how the Savings (Return) exceeds the Investment (Cost) of the Open Table. There was both a short-term return, based on direct and immediate savings from employment and commensurate reductions in public support programs, and long-term savings, which can generate significant returns over time from changes in an individual's life trajectory through transformation.

Based on research demonstrating the public costs associated with these outcomes, there was an estimated \$915,806 in future public program costs avoided and additional tax revenues generated through increased lifetime earnings. Compared to an estimated annual cost of \$44,300 for Open Table implementation and administration, this results in an estimated ROI of \$20.07 for every \$1.00 invested in the Open Table program.⁶

For purposes of this case study, we will rely upon a brief narrative of a sampling of Table Friends served through MetroHealth/Open Table to provide some insight into the various activities and outcomes of the intervention. Some of these narratives are provided by Table Members and others by Table Friends themselves. The names of the Table Friends here are changed to preserve anonymity.

Monique – Monique was a well-educated single mom that nonetheless faced circumstances preventing her from thriving. For her, the Table was most helpful in helping her to organize herself and improve her mental clarity. Although regarding employment, she is not where she wants to be, she has started a nursing degree towards becoming a sexual assault nurse examiner. While meeting with the Table was a little intimidating initially, she gradually developed trust with her Table Members and felt at all times to be in control of the process. While at the start of the Table, she was living with her parents, she now has

⁶ https://www.baylorisr.org/wp-content/uploads/2020/05/BaylorISR_OPENTABLE-CaseStudy-FINAL-web.pdf

lived in her own apartment for the last 1.5 years. Monique also noted that the experience helped develop her relationship skills. She maintains contact with all the Table Members at least every month or so and has frequent contact with two Table Members in particular.

Frank – Frank has been married for 40 years and has four children, three of whom have struggled with sickle cell anemia. Originally, Frank saw the signs about Open Table and wanted to volunteer as a Table Member. The challenges of dealing with chronic illness has defined and shaped much of Frank's life in terms of location (they have moved twice to receive treatment for their children). Although the Table helped Frank and his family periodically with groceries and vehicle repairs, Frank was most appreciative of the relational support and friendship offered by the Table Members. As Frank described:

I know that sometimes Table Members wanted to help with bringing about tangible results, but I think the biggest impact for me from the experience was my spirit was different. Just knowing the level of concern they had for my challenges with my children's health was a real comfort to me.

Sherry – Sherry was a mom with three kids living in her car. The first action for the Table was to pick her and her family up from Columbus, three hours away due to car trouble. Over the next several months, the Table came alongside Sherry to organize her finances to pay the car debt and her other debts and get her kids into school. For Sherry, the Table Members were especially valuable as informal mentors and role models for her children, aged 17-23, helping them think and plan for their future. As one Table Member explained:

It occurred to me that the mom was trying to tell us all the time, 'I'm going to be OK, just take care of the kids,' and she appreciated us just texting back and forth with the kids. That's what she wanted. Just somebody to be there for them.

Richard – Richard was staying in a shelter at the beginning of the Table. Richard was very structured in terms of his life plan: 1) move out of the shelter; 2) become eligible for disability payments; and 3) get a driver's license and a car. One Member, who worked at Ohio's Job and Family Services, helped Richard in navigating through the paperwork and process, and organizing Richard's files and documentation. By the end of the year, Richard had moved out of the shelter to live with his mother, and the two of them are planning to upgrade to a 2-bedroom apartment. With the disability income, Richard was able to buy his mom a car while he went through a remedial driving course to get his license. Richard was very appre-

ciative of the help he received through the Table, which assisted him to find better living conditions and establish a stable income.

These narratives underscore the unique nature of how Tables function in the same way as any relationship-centric effort. For some Table Friends, the need was for general social support and encouragement of Table Friends as they considered their future life plan. For others, there were immediate needs related to transportation and housing that required immediate attention, after which Table Members could help their Table Friends achieve greater stability in their lives going forward.

These types of changes in Friends' lives can also have significant economic and financial impacts. Exhibit 3 provides some estimates on some of the outcomes cited above in terms of potential tax-payer savings and increased tax revenues associated with the positive outcomes associated with a sampling of Table Friends.

V. THE METROHEALTH OPEN TABLE - LESSONS LEARNED AND LOOKING FORWARD

As of October of 2022, the MetroHealth/Open Table program has accomplished the following since its 2018 launch:

- 147 volunteers trained to serve on a Table. MetroHealth employees comprised 36% of volunteers.
- 23 Tables formed, five of which are currently active. The remainder of Tables have completed their one-year commitment.
- 5 Table Members returned to serve again on another Table.

The initial years of any Open Table implementation are crucial, given its distinctive relationship-intensive approach in comparison to many other types of human services programs that are alternatively focused on charity rather than relationship.

Positive Takeaways from the MetroHealth/Open Table Initiative

Some of the successes associated with this effort are as follows:

Training: Member training, including the additional resources of trauma and other related topics, was very well received by volunteers. They felt prepared, although some still underestimated the level of effort expected.

Employee Perceptions of MetroHealth: Table Members, especially those within MetroHealth, were proud of being part of this effort and believe MetroHealth is genuine and serious in making this investment of time and effort to transform the lives of vulnerable individuals and families. As one Member described:

I was proud of Metro for taking on this program, which is not the easiest program to run, manage or be a part of. And also, it really opened my eyes to how many resources Metro does offer to not only employees but also the community in terms of support.

Strengthening MetroHealth's connections with community and faith leaders in Cleveland: The Open Table program provided MetroHealth with a concrete opportunity to develop and grow its relationships with community leaders in the city, particularly as a means of identifying potential Table Friends to be served.

Overcoming COVID challenges: Although COVID presented many challenges, it actually facilitated some Tables due to the limited transportation available to Table Friends (Pre-COVID, MetroHealth made its facilities available for on-site meetings if desired by the Tables).

Challenges

Integration of Open Table with MetroHealth: Many Table Members expressed the desire to interface and access other resources with MetroHealth to address Table Friends' needs in such areas as housing, childcare, and legal aid. Some felt ill-equipped to assist Table Friends with some of the challenges they faced and were bewildered by the disconnected nature of social services programs available to Table Friends. Fortunately, when concerns of the Table are brought to the attention of program managers, MetroHealth can leverage resources such as Social Work and Trauma Recovery staff or work with Open Table to help facilitate solutions. As one Member explained:

Some of the paperwork processes alone are so difficult to manage, and it's so time-consuming. But also, you're filling out housing forms and food stamp forms, and assistance forms multiple times. There's no


connection between any of these organizations, so it's not like you talk to CMHA [The county housing authority] and they're also helping you with food stamps and WIC. I know one of our Table Friends said multiple times 'It's just not even worth all the paperwork.'

Voice and Choice: In Open Table, the Friend always makes final decisions about their own life, and Table members join Tables with preconceived notions about personal transformation based on their own life experiences. Even with deliberate and in-depth training about suspending judgment and allowing relationship and trust to grow, sometimes Table members need time, through engagement with the Friend, to transform their own thinking. This is a natural part of the Open Table process. MetroHealth understood this as part of the Open Table process and adopted a patient and supportive approach to its Tables as members grew in understanding and perspective.

V. GUIDANCE FOR HEALTH SYSTEMS CONSIDERING OPEN TABLE

The experience of MetroHealth, as the first healthcare system to partner with Open Table, can provide valuable insights, based on their efforts, especially in using this partnership to delve further into efforts to address the health impacts of social isolation and other Social Drivers of Health.

- **Integrate your own employees:** Health systems typically are large employers and employers of people with a commitment to caregiving and service. This workforce is ideal as a base of volunteers for an Open Table program.
- **Use your varied resources to strengthen and enhance the program:** Draw on your expertise as a health system by including your own subject matter experts as adjuncts to Open Table training and as resources to Tables throughout their year of service. This may include social workers, trauma-informed experts, and others. Health system facilities can also be leveraged as meeting spaces for Tables.
- **Integrate this work into your Community Benefit or your work to address the social drivers of health:** There is ample research and evidence related to the deleterious effects of social isolation on a person's health. While it is the most complex and challenging SDOH to address, it also can pay significant dividends, in terms of community benefits. The Open Table model provides an effective strategy for addressing these issues, which in turn go towards strengthening the community as well.
- **Benchmark and measure the impacts of Open Table using existing health system tools, such as SDOH screening:** The need to collect data for measuring the impact of Open Table is not something new and



MetroHealth hopes to incorporate various health status and health functioning metrics in tracking and evaluating the Friend's health impacts that are at least associated with Open Table engagements.



unfamiliar to healthcare providers, who utilize data in their day-to-day work. The challenge is to identify the type of data most relevant to the Open Table intervention. In the future, MetroHealth hopes to incorporate various health status and health functioning metrics in tracking and evaluating the Friend's health impacts that are at least associated with Open Table engagements.

- **Integrate the model into your population health approach as much as possible:** Open Table is very much consistent with the principles of population-based health and should be woven into other community-based strategies aimed at reducing healthcare costs through strategic investments for redressing a variety of Social Drivers of Health.

VI. THE VISION FOR METROHEALTH / OPEN TABLE IN THE FUTURE

Reflecting on the first three years, MetroHealth envisions three goals for this partnership moving forward.

1. To recruit and provide (through MetroHealth employees) a steady stream of experienced OT volunteers on a regular basis. The experience of Table Members in OT, particularly MetroHealth employees, would give them a better understanding and appreciation for the life challenges that their low-income patients face, in order to be better at addressing their health needs within that context.
2. To develop a smaller, nimbler version of Tables in the future in order to meet Table Friends' needs more effectively, (Open Table has this through Network Table now expanding in healthcare) particularly for those that may not require a 12-month engagement. In fact, partly in response to this issue, Open Table has formed a new Open Table model, called Network Tables, which provide more flexibility as well as capacity to serve more vulnerable individuals and families (see Exhibit 4 for more on the OT's Network Table model).
3. To transfer lessons learned through OT into the **Institute for H.O.P.E.TM**, established in June 2019. The **Institute for H.O.P.E.TM** (Health, Opportunity, Partnership, and Empowerment) at The MetroHealth System is focused on fixing the root causes of health problems, by removing obstacles and engaging community partners so more people can access what they need to help them grow, succeed and be healthier. Housing instability is a significant challenge for many Table Friends, and MetroHealth hopes that the experience generated through Open Table could positively impact the organizational culture of the Institute in its efforts to address patients' SDOH and thus redirect and rethink MetroHealth's model for health services delivery.

Conclusion

The MetroHealth/Open Table collaboration has provided an effective bridge for healthcare organizations engaged in efforts to reshape their mission and role in supporting public health through Social Drivers of Health. In particular, the MetroHealth emphasis on social isolation was a good fit with the Open Table's focus on providing relational and social supports as a means for bringing about sustainable health and well-being in the lives of individuals and families with complex needs and SDOH barriers.

The Open Table collaboration was also helpful as a part of MetroHealth's effort to strengthen and expand its networks among community organizations and faith leaders as a means for accessing those facing multiple SDOH barriers in their lives. Finally, this collaboration is about supporting people in a manner that empowers them in their lives and decisions, respecting them as capable and competent.

The preliminary evidence from this case study can serve as a guide for other healthcare providers seeking new ways to envision their mission of serving the health needs of their respective communities in more lasting, impactful ways. Katov reflected on the opportunity for Open Table to partner with MetroHealth, and how this effort can help shape a more holistic and integrated approach for meeting human and healthcare needs:

We are grateful to MetroHealth for their partnership, funding, and leadership in inviting the community to be an SDOH outcome partner. We offer our heartfelt thanks to the MetroHealth pioneering teams who managed the initiative, to those who served on Tables, and to the Friends the Tables served. MetroHealth is advancing a new understanding that communities and healthcare systems can move beyond siloed supports to form a collective of support. No one sector or system alone can empower people to live their best lives. This initiative demonstrates how a community and a healthcare system with shared purpose and shared action can transform us all. Open Table is continuing its development of models at the healthcare system, health insurance, and medical practice levels to combine medical care and Relational Assets to empower the human potential of people with complex needs.

EXHIBIT 1: PATIENT SDOH SCREENING RESULTS

88,758 Patients Screened as of October 31, 2022

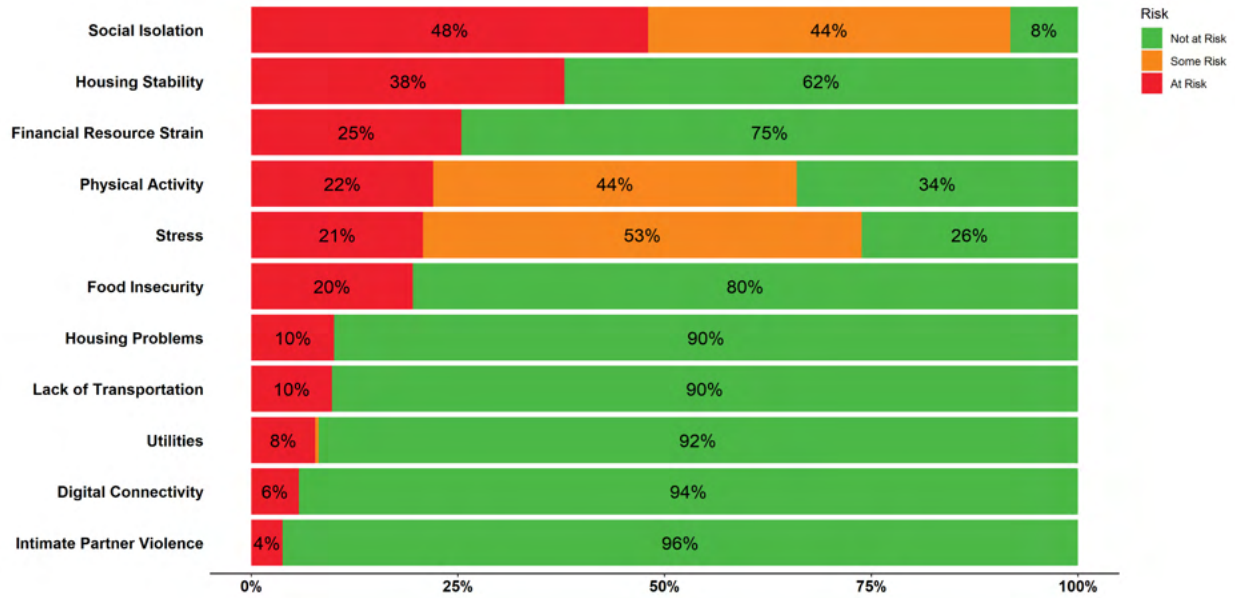


EXHIBIT 2

Name: _____
 Date of Birth: _____



Notes: _____

MetroHealth is committed to providing quality health care and resources to help you live a healthy life. The questions below will help us understand how you are doing and if you would like additional assistance.

1. **Food**

In the last 12 months:

- Have you worried your food would run out before you had money to buy more?
 Never Sometimes Often
- Did the food you bought just not last and you didn't have money to buy more?
 Never Sometimes Often

2. **Transportation**

In the last 12 months, has the lack of transportation:

- Kept you from medical appointments or from getting medications? Yes No
- Kept you from meetings, work, or getting things needed for daily living? Yes No

3. **Internet Access**

Do you currently have internet access at home?

Yes No

Do you have internet access on a device or in another location?

Yes No

If Yes, where? On a cell phone At work Other (such as Library) Multiple access options

4. **Housing Stability**

In the last 12 months, were you ever **unable** to pay the rent or mortgage on time? Yes No

In the last 12 months, how many places have you lived?

In the last 12 months, did you ever sleep in a shelter or **not** have a steady place to sleep? Yes No

5. **Housing Problems**

Do you have any problems at home with: Pests Mold Lead Paint or Pipes Water Leaks

Smoke detectors missing/not working Oven/stove not working Lack of heat None

6. **Utilities**

In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services?

Yes No Currently shut off

7. **Personal Safety**

In the last 12 months, have you been:

- afraid of your partner or ex-partner? Yes No
- humiliated or emotionally abused by your partner or ex-partner? Yes No
- kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? Yes No
- forced to have any kind of sexual activity by your partner or ex-partner? Yes No

8. Financial Stability

How hard is it for you to pay for basics like food, housing, medical care, and heating?

- Very hard Hard Somewhat hard Not very hard Not hard at all

9. Employment

What is your current employment status?

- Employed Full time Not employed On Active Military Duty
 Employed Part Time Retired Self Employed
 Student – Full time Student – Part time

10. Education

What is the highest level of school you completed, or the highest degree you have received?

- Never attended school Associates degree (2 year)
 (____) grade Bachelor's degree (4 year)
 High school graduate or GED Master's degree (MA, MS, MSW, MBA)
 Some college, no degree Professional school degree (MD, DDS, JD, PhD)

11. Stress

How often do you feel stress these days (tense, restless, nervous, anxious, or trouble sleeping)?

- Not at all Only a little To some extent Rather much Very Much

12. Social Connections

In a typical week, how often do you talk on the phone with family, friends, or neighbors?

- Never Once a week Twice a week Three times a week More than 3 x week

How often do you get together with friends or relatives?

- Never Once a week Twice a week Three times a week More than 3 x week

How often do you attend church or religious services?

- Never 1 to 4 times per year more than 4 times per year

Do you belong to any clubs or organizations (such as church groups, unions, fraternal, athletic, or school)?

- Yes No

How often do you attend meetings of the clubs or organizations you belong to?

- Never 1 to 4 times per year more than 4 times per year

Are you currently:

- Married Widowed Divorced Separated Never married Living with partner

13. Physical Activity

On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?

- 0 1 2 3 4 5 6 7 Days

On average, how many minutes per day do you engage in exercise at this level?

- 0 10 20 30 40 50 60 70 80 90 Minutes

EXHIBIT 3: HIGHLIGHTS OF METROHEALTH OPEN TABLE OUTCOMES/ROI

Open Table Friend ¹	Year Table Started	Pre-Table Status	OT Members Assistance - Current Status	Outcome	Estimated \$ impact for outcome (adjusted for inflation)
Monique	2020	Living with parents.	Has lived in her own apartment for 1.5 years. Started a nursing degree program towards becoming a sexual assault medical examiner.	- No need for SNAP/ TANF/SSI - Increased tax revenues from higher lifetime earnings from college education ²	\$16,241 (annually) \$52,610 ³
Frank	2020	Married with 4 children (3 with chronic health issues) and 1 grandson	Periodic assistance with groceries and car repairs.		
Sherry	2020	Unstable housing (living in her car with 3 kids) Kids absent from school Unstable transportation	Stable housing Kids back in school Paid off car debts	- Prevention of homelessness ⁴ - Prevention of foster care ⁵ -Increased tax revenues from higher lifetime earnings from graduating high school ²	\$9,897 \$62,736 ⁶ \$147,944 ⁷
Richard	2020	Living in shelter Unstable income	Living with mother, plans to upgrade 2-bedroom apartment. Stable income	- Prevention of homelessness ⁸ - Increased tax revenues from improved earnings	\$9,897 \$3,094 ⁹

¹ The names of OT Friends have been changed to insure privacy.

² Labor Market Consequences of an Inadequate Education; Rouse, Cecilia Elena; Princeton University and NBER; Prepared for the Equity Symposium on "The Social Costs of Inadequate Education" at Teachers' College, Columbia University; September 2005.

³ Based on an estimate \$303,000 increase in lifetime earnings, times a tax rate of 15%, and adjusted for inflation.

⁴ Evans, William N. et al; The impact of homelessness prevention program on homelessness; Science Magazine; Vol, 353, Issue 6300; pp. 694-699.

⁵ Gellis, Richard J., & Perlman, Staci, 2012: Estimated Annual Cost of Child Abuse and Neglect; Chicago, IL: Prevent Child Abuse America.

⁶ Based on a 25% probability of CPS involvement at an annual estimated cost of \$83,648 per child, adjusted for inflation.

⁷ Including Social Security contributions, a high school dropout will contribute nearly \$147,944 (in 2020 dollars) less in taxes than a high school graduate. Assumes 1 of 3 children would not have graduated high school with unstable housing.

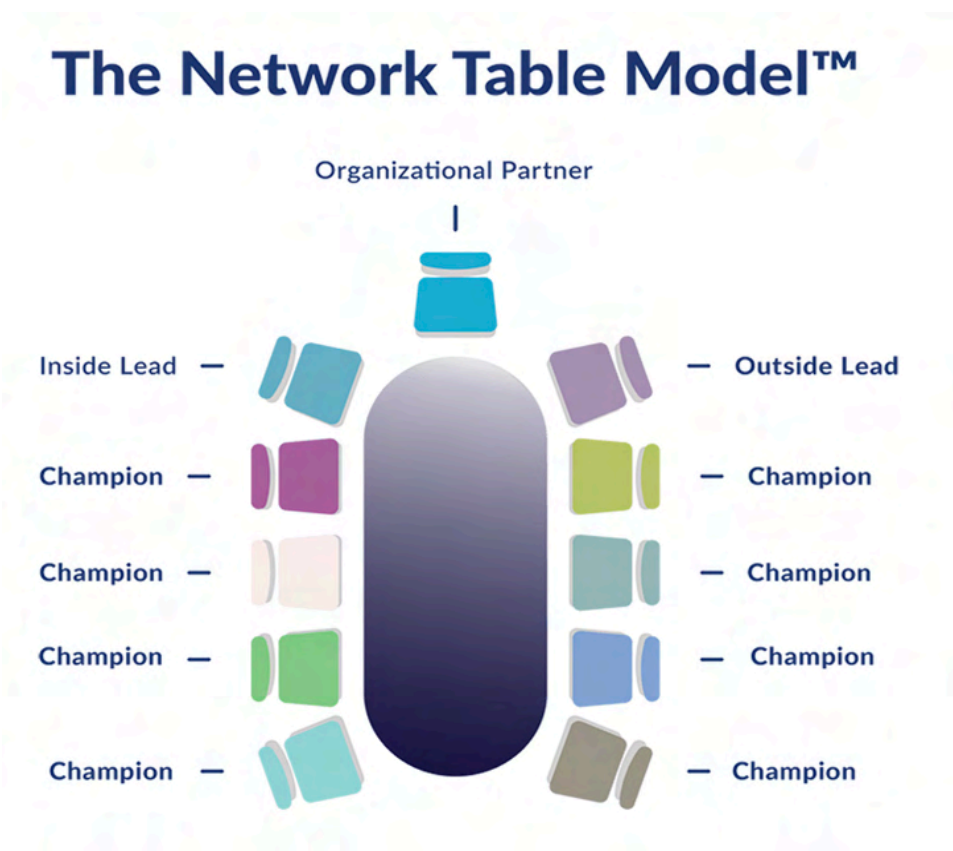
⁸ Evans, William N. et al; The impact of homelessness prevention program on homelessness; Science Magazine; Vol, 353, Issue 6300; pp. 694-699.

⁹ Calculated as the incremental annual income of \$12,000 (\$24,000-\$12,000) times 15% estimated tax rate.

EXHIBIT 4: THE NETWORK TABLE MODEL™

Communities are implementing the Network Table Model to empower people to develop the better lives they envision for themselves and their children. The Network Table is a research-driven model training people to form teams that access who and what they know to empower people with complex needs to achieve goals they could not realize on their own. Complex needs include poverty, chronic and mental illness, substance use recovery and others.

Network Tables are trained to access their combined relational and social capital – their skills and personal, social, and business networks. The multiplication impact of social networks scales capacity to access supports and creates broad and deep access to solutions that help people with complex needs eliminate barriers to achieving better lives. The Network Table process recognizes that we all have many needs, and some are more crucial than others. Prioritizing needs and selecting the most crucial support can remove a barrier an individual or family cannot overcome on their own.



ABOUT THE AUTHORS

Byron R. Johnson is Distinguished Professor of the Social Sciences at Baylor University. He is the founding director of the Baylor Institute for Studies of Religion (ISR) as well as director of the Program on Prosocial Behavior. Johnson is a senior fellow at the Sagamore Institute (Indianapolis). He is a leading authority on the scientific study of religion, the efficacy of faith-based organizations, and criminal justice. Recent publications have examined the impact of faith-based programs on recidivism reduction and prisoner reentry. Before joining the faculty at Baylor University, Johnson directed research centers at Vanderbilt University and the University of Pennsylvania. He has been the principal investigator on grants from private foundations as well as the Department of Justice, Department of Labor, Department of Defense, National Institutes of Health, and the United States Institute for Peace. He is the author of more than 200 articles and a number of books including *More God, Less Crime: Why Faith Matters and How it Could Matter More* (2011), *The Angola Prison Seminary: Effects of Faith-Based Ministry on Identity Transformation, Desistance, and Rehabilitation* (2016), and *The Quest for Purpose: The Collegiate Search for a Meaningful Life* (2017).

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