INITIATIVES TO IMPROVE SOCIAL CONDITIONS

Multi-partner initiatives addressing adverse social conditions are emerging across the country and offer many ideas to adapt and apply to the Olympic region. Over 75 multi-partner initiatives were reviewed, 25 of which were profiled in more depth. The review included understanding partnership type, intervention focus and strategies, social risk factors addressed, funding mechanisms, and outcomes.

There is no standard playbook of how best to improve social conditions in a community. Specific initiatives are often customized to local community needs and context, and as a result vary in scope, scale, and factors addressed. Initiatives showing promise, however, share the following common elements: 1) mobilize a broad range of partners, 2) design and partner with community, 3) utilize an integrator organization to align partners around shared goals and strategy and manage the cross-partner work, 4) coordinate funding from multiple sources, 5) invest in data sharing, and 6) take a long-term view.

Four categories of organizing structures emerged from the initiatives reviewed:

1. **Programmatic partnerships**: Partnerships formed around interventions focused on specific social needs or risk factors such as healthy food access or housing. These single factor interventions can be expanded and combined with other interventions in a broader portfolio of strategies.

2. **Community connectors:** Non-profit organizations that coordinate a portfolio of local interventions, manage a coalition of partners, and leverage funding streams towards unified vision and goals.

3. **Anchor institutions:** Hospitals and universities that use their prominent role in local economies to improve the health of the communities where they are based. Investment strategies include local hiring and procurement, workforce training, living-wage jobs, creating/improving affordable housing, and increasing access to and safety of public spaces.

4. **Community wide initiatives**: Place-based initiatives that focus on the community from a systems perspective. They address a broad range of upstream social conditions through an integrated portfolio of investments, and often include mobilization and power building among community members as strategies for long-term sustained change.

Programmatic Interventions

The following interventions focus on healthy food access, housing access, employment, income, and other economic support activities. The county health rankings data and county-based Community Health Improvement Plans indicate these are shared need areas across the Olympic region.

Food as Medicine

Food as medicine is a growing movement as sectors are increasingly valuing the importance of access to healthy food in promoting health. Some strategies include:

- **Nutrition prescriptions**: Provide prescriptions with healthy eating goals for patients and families and partner with local markets where prescriptions for fruit and vegetables can be redeemed.
- **Fruit and vegetable incentive programs**: Participants receive matching funds to purchase healthy foods such as fresh fruits and vegetables; often called bonus dollars, market bucks, produce coupons, or nutrition incentives.
- **Healthy food in convenience stores**: Convenience stores, corner stores, gas station markets, or other local food outlets are encouraged to carry fresh produce and healthy food options. This is often coupled with marketing and display support as well as nutrition education to increase demand for healthy food.
- **Mobile markets**: Mobile food carts, vehicles, or pop-up markets travel to neighborhoods or clinical sites with less access to healthy foods to sell fresh fruits and vegetables.

Providence Hood River Food Security Initiative
Community driven and non-profit led multi-strategy initiative to improve food security

Columbia Gorge Region, Oregon and SW Washington
https://foodcommunitybenefit.noharm.org/case-studies/community-voices-leading-community-benefit

Intervention type: Nutrition prescription, nutrition education, advocacy

Social risk factors addressed: Food security, access to healthy food, income support

Integrator organization: Non-profit, Gorge Grown Food Network web of organizations working to build a vibrant local food system

Partners: Gorge Grown Food Network, Providence Hood River Hospital, Next Door Inc. are lead organizations that bring partners together across sectors for the various initiatives

Intervention Description
Food insecurity identified by community members as a priority area through a region-wide community health needs assessment. Found 1 in 3 people experienced food insecurity. This insight shaped a series of food security interventions that Providence Hood River Hospital is investing in and are led by local non-profits:

- **Veggie Rx:** fruit and vegetable "prescription" program provides vouchers for fresh produce to community members who screen positive for food insecurity. Coupled with nutrition education. Over 35 partners participate in this intervention that is managed by the integrator organization Gorge Grown Food Network.

- **Gorge Food Security Coalition**: convenes local partners to develop partnerships to strengthen the local food system and address gaps and barriers to healthy food access. Also provide grant support to food security initiatives. This Coalition is managed by Gorge Grown Food Network.

- **Cooperative farm**: co-op farm teaches organic gardening in Spanish and offers free farmland to community members. This intervention is led by The Next Door Inc.

Outcomes

- **Veggie RX:** Since 2015, the program has served approximately 10,000 individuals. From August 2015 to January 2016, the program issued $70,000 in vouchers.

- **Coalition:** The coalition has helped convene and connect community stakeholders to identify and work on solutions to food issues.

- **Cooperative Farm:** Program serves approximately 100 individuals a year. Participants have reported increased access to healthy food and improved the health of their families.

Funding

Each intervention leverages and coordinates funding from a variety of sources. Providence Hood River Community benefit dollars support all three initiatives. Other funding sources include:

- Local FQHC
- Oregon Community Foundation
- Local foundations and individual donors
- RWJF culture of health prize money
- Funding from state of Oregon

Hospital Farm and Food Pharmacy

Health system builds an onsite farm as a hub for food access programming with onsite food distribution and nutrition education

Houston, TX
https://harrishealthannualreport.org/population-health/

Intervention type: Nutrition education, clinical site 'food farmacy' pop up market

Social risk factors addressed: Healthy food access, food security

Integrator organization: Lyndon B. Johnson Hospital

Partners: Houston Food bank, Texas Medical Center, MD Anderson, UTHealth School of Public Health

Intervention Description
A farm-to-hospital nutritional program that includes:

- **Community farm:** Farm aims to provide fruits and vegetables to patients and community members with limited access to grocery stores that stock fresh produce. The hospital is using the farm as a hub to host programming about produce, healthy eating, and wellness.

- **Food Rx program:** Produce harvested on the farm coupled with fresh food from the Houston Food Bank is distributed to patients with diabetes, hypertension, and expectant mothers through a hospital-based onsite "food farmacy." Patients receive a six-month prescription for the food pharmacy, where they can receive fresh fruits, veggies, and other food items, along with education, nutritional guidance and personal assistance qualifying for other social services.

Outcomes
Initiative still in early implementation stages but they are measuring clinical outcomes of A1C levels which calculate blood sugar, low-density lipoproteins also known as "bad" cholesterol, and blood pressure reduction. It is projected that each one-point reduction in a patient's A1C levels translates to a savings of about $8,300 for the hospital by avoiding unnecessary medical services.

Funding
- Grants: American College of Physicians Innovation Challenge; TMC Health Policy Institute Grant
- Health system funding: LBJ Hospital, Texas Medical Center, MD Anderson University of Texas MD Cancer Center

Geisinger Fresh Food Pharmacy

Hospital system tests food prescription coupled with onsite food distribution and nutrition education

Shamokin, PA
https://www.geisinger.org/freshfoodfarmacy/our-purpose

Intervention type: Nutrition prescription, nutrition education

Social risk factors addressed: Healthy food access

Integrator organization: Geisinger Health

Partners: Central PA Food Bank, Weinberg Regional Food Bank, Degenstein Foundation, Weis Markets

Intervention Description
A hospital-based food security initiative that includes:

- **Food prescription and onsite food distribution**: Offers participants prescriptions for five days of breakfast and dinner ingredients for the patient and all household members. Food purchased from local food banks at reduced cost.

- **Nutrition education:** Comprehensive care teams provide recipes and hands on instructions, close care gaps, make education/resources available.

Outcomes

- 600 individuals served by programs
- Significant HBA1C improvements
- Most participants started exercising
- Participants have been able to reduce or even eliminate their diabetes medications
- Every point decline in A1C saved approximately 8K against annual investment of 1K per patient

Funding

Philanthropy, Geisinger Health System

Housing as Healthcare

There is strong evidence characterizing the relationship between housing and health. Housing stability, quality, safety, and affordability all affect health outcomes. Strategies related to housing for health include:

- **Housing First:** A housing model that provides rapid access to permanent housing along with wrap around support including crisis intervention, needs assessment, care management.

- **Service-enriched housing**: A housing model to provide permanent rental housing with social services available onsite or by referral, usually for low income families, seniors, veterans, or people with disabilities.

- **Home environment assessments and remediation**: Volunteers, professionals, or paraprofessionals help residents assess and remediate environmental home health risks through tactics such as improved ventilation, integrated pest management, weatherization, radon mitigation.

- **Housing rehabilitation loans & grants**: Funding is provided primarily to low- or median-income families, to repair, improve, or modernize dwellings and remove health or safety hazards.

- **Legal support:** Lawyers are used to help individuals secure housing subsidies, improve substandard housing conditions, prevent evictions, and/or prevent utility shutoff.

Housing is Health Initiative

Six health systems to pool resources to build affordable housing

Portland, OR
https://www.centralcityconcern.org/housingishealth

Intervention type: Service-enriched affordable housing

Social risk factors addressed: Housing stability

Integrator organization: Non-profit, Central City Concern: organization focused on homelessness, poverty, and addictions

Partners: Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Providence Health & Services–Oregon, Legacy Health and the Oregon Health and Science University, FQHC, and affordable housing developers

Intervention Description

The Housing is Health Initiative is a multi-sector partnership between six health systems to pool resources to build affordable housing. Partners invested $21.5 million in three different affordable housing developments, each of which serves a specific and unique population.

- **Housing:** Creation of 379 units of affordable, workforce units, as well as supportive and transitional housing, in conjunction with an FQHC.
- **Supportive services:** Housing includes supportive units for people with behavioral health disorders as well as a site for an FQHC providing primary care and behavioral health services.
- **Neutral convener:** Initiative led by Central City Concern a non-profit that understands the housing sector including tax credit financing, architecture of partnership, and regulations.

Funding

Pooled funding model financed by partner health systems community benefit dollars

Housing and Neighborhood Revitalization Initiative

Health system foundation improving housing and neighborhood conditions in areas surrounding hospital

Camden, NJ
https://foundation.cooperhealth.org/new-pages/who-we-are/transforming-our-community/housing-and-neighborhood-revitalization

Intervention type: Housing rehabilitation

Social risk factors addressed: Housing quality, neighborhood safety, parks, and playgrounds

Integrator organization: Foundation, Cooper Healthcare Foundation: philanthropic, community outreach and community development arm of Cooper University Health Care

Partners: Cooper University Health System, St. Joseph's Carpenter Society, City of Camden, Camden County, and Camden County Habitat for Humanity

Intervention Description

Multipronged approach to support housing, stimulate economic development and improve neighborhood conditions in Cooper Plaza neighborhoods surrounding the Cooper Health System.

- **Employer assisted housing program:** Provide Cooper Hospital employees with funding assistance for down payment and closing cost for the purchase of a home.

- **Affordable housing**: Foundation supported new construction of six affordable homes and rehabilitation of two vacant homes.
- **Renovation**: Initiative to acquire vacant homes for rehabilitation and residential facade improvements.
- **Neighborhood environment:** Implement a maintenance and security program for the neighborhood to ensure a clean and safe neighborhood. Expanded outdoor play areas and installed art at local parks.
- **Community park improvements:** Works with the city to design neighborhood parks and improve streets. The Foundation maintains a variety of parks in the city and hosts free events in the parks.

Funding

- Cooper Health Care
- Payers: Horizon Healthcare New Jersey, NJ Manufacturers Insurance,
- Private sector: Campbell Soup Company, PNC Bank, PSE&G, RTC Properties and Sun Bank
- State government: New Jersey Department of Community Affairs Neighborhood Revitalization Tax Credit Program

Bronx Healthy Buildings Program

Non-profit led initiative that organizes and builds power with residents to improve quality and remove health hazards in multifamily buildings

Northwest and Central Bronx, NY

Intervention type: Home environment assessments, remediation, community power building, employment

Social risk factors addressed: Housing quality, employment, social cohesion

Integrator organization: Non-profit, Northwest Bronx Community and Clergy Coalition (NWBCCC) a member-led grassroots organization fighting for racial and economic justice

Partners: Montefiore Health System, the New York City Department of Health and Mental Hygiene, MIT Community Innovators Lab, Emerald Cities Collaborative, BlocPower

Intervention Description

Cross sector initiative promoting holistic community health by addressing upstream causes of asthma-related emergency department visits and hospitalizations through green and healthy retrofits of multifamily buildings.

- **Integrated data**: The initiative integrates housing and hospital admissions data, to identify asthma "hotspots"— areas with high rates of asthma and asthma-related ED and hospital admissions- to intervene.
- **Building assessments:** Team members perform energy audits and building inspections looking at general structural needs, energy usage and efficiency, presence of pests and mold, overall air quality, and tenant-identified improvements to identify necessary retrofits and improvements.
- **Remediation**: The initiative helps building owners secure financing to complete the identified improvements needed. Improvements usually include structural repairs, energy efficient upgrades, integrated pest management (IPM), and green cleaning training for building staff.
- **Support local jobs**: The initiative connects building owners with local Bronx based, certified contractors to complete the necessary retrofit and improvement work which increases local jobs and wealth.

- **Power building**: Residents are engaged and organized into tenant associations to advocate for improvements to buildings. Building leaders are trained on social determinants of health, relationship between environmental triggers and asthma, green cleaning, local resources, and tenant rights.
- **Community health workers:** Tenant leaders are hired and trained as community health workers responsible for education of other tenants on behavioral interventions and asthma self-management practices, which increases access to asthma self-management and local jobs.

Outcomes

- Reached landlords and tenants in six buildings, securing integrated pest management in three buildings.
- Trained more than 300 people about housing rights.
- Made over 140 referrals to in-home asthma assessments.
- Secured $3 million in capital funding from the NYC Housing Authority for identified building repairs.

Funding

- BUILD Health Challenge funding
- Federal programs: Federal Weatherization Assistance Program
- State funding: New York City-funded grant and loan programs for retrofits, New York State Medicaid reform and the NYC Department of Health
- Health systems: Montefiore and St. Barnabas Hospital providing community health workers and integrated pest management funding.

Employment and Income Support

There is a clear link between income, health, and life expectancy. Adult life expectancy increases with increasing income. Income and employment are pathways to safe and health promoting neighborhood environment, improved housing quality, food security, and education. Strategies include:

- **Vocational training**: Individuals are supported in acquisition of job-specific skills through education, certification programs, or on-the-job training.

- **Youth apprenticeship and employment programs:** Short-term employment opportunities are provided for youth, especially those from disadvantaged backgrounds. Students are provided with professional opportunities combining academic and on-the-job training or mentorship.

- **Earned Income Tax Credit (EITC)**: Volunteers, professionals, or paraprofessionals, help low to moderate income working individuals/families receive refundable earned income tax credits from the government.

- **Legal support**: Lawyers are utilized to help individuals appeal denials for benefits (i.e. food stamps, disability, insurance), or prevent and remedy employment discrimination.

- **Childcare subsidies**: Working parents or parents attending school are provided with financial assistance to pay for childcare.

StreetCred

Non-profit that provides free tax preparation to families while they wait for their health appointments.

Massachusetts, Connecticut, North Carolina, and Texas
https://www.mystreetcred.org/about

Intervention type: Tax assistance in pediatrician's office, EITC expansion

Social risk factors addressed: Income

Integrator organization: Non-profit, StreetCred: tax assistance and benefit enrollment at clinical sites

Partners: Coalition of nonprofits, businesses, and community organizations, safety net hospital. Boston Medical Center and Boston Tax Help Coalition

Intervention Description

Organization launched as a pilot site in partnership with Boston Medical Center and Boston Tax Help Coalition, now in multiple sites across four states. Focus is to help families increase their earnings and improve health outcomes by accessing the Earned Income Tax Credit (EITC) and public benefits.

Tax preparation assistance: Volunteers work with families waiting to see care providers to help families prepare and file taxes, maximize tax refunds, and apply for other anti-poverty programs at their clinical visit. Their model includes the following steps:

- Partner with health clinics serving high volumes of families with low income
- Partner with local Volunteer Income Tax Assistance (VITA) coalitions
- Recruit and train volunteers from community in tax preparation
- Provide free tax preparation and wealth-building programs to maximize tax returns and increase access to EITC and other federal programs
- Study impact, iterate, and scale

Outcomes

- From 2016 to 2019, StreetCred returned over $5.3 million to about 2700 families.
- Expanded to other health services locations in eight states

Funding

- Anchor institutions: Boston Medical Center, BU Initiative on Cities, Brandeis School for Social Policy and Management
- Foundations: The Paul and Phyllis Fireman Charitable Foundation, The Claneil Foundation
- Private: Santander Bank

Community Works Career Development

Health system supporting vocational training and employment initiatives for their community members

West Baltimore, MD
https://www.bonsecours.com/about-us/community-commitment/community-programs/baltimore

Intervention type: Vocational training and employment

Social risk factors addressed: Employment, incarceration, built environment

Organization: Bon Secours Health System

Intervention Description
Bon Secours health system supports a series of interventions focused on vocational training and increasing employment. Programs described below.

- **Clean & green landscaping**: Program that trains local workers to transform vacant lots in West Baltimore into green, well-maintained, usable spaces. For six months, participants learn on-the-job skills, such as plant identification, equipment operation, safety and teamwork. They also receive financial counseling and learn to create career and life goals.
- **Youth Employment and Entrepreneurship Program (YEEP): T**rains and mentors young people ages 14-21, helps them find after-school and summer jobs, and provides career planning.
- **Job-readiness and job-placement program:** Provides participants, 18 or older, a wide range of support to succeed in the workplace including educational opportunities, workforce skills, and financial literacy.
- **Community job hub:** Daily computer lab and computer literacy training for proficiency in computer basics and Microsoft Office applications.

Funding
Bon Secours Health System

Medical Legal Partnerships (MLPs)
Placing lawyers and paralegals at clinical sites to help patients address legal issues that affect health

Multiple sites across the U.S.
https://medical-legalpartnership.org/

Intervention type: Medical legal partnership

Social risk factors addressed: Income, housing, education, employment, social community

Partnerships: Various models and partnerships across the U.S.

Intervention Description
Medical-Legal Partnerships (MLPs) place lawyers and paralegals at health care institutions to help patients address legal issues that affect health. MLPs play an important role in addressing social conditions and are a community-based solution for advancing health equity.

There are a multitude of success stories related to MLPs. Examples of what MLPs address include:
- **Income:** appeal denials for benefits-food stamps, disability, insurance.
- **Housing:** help secure housing subsidies, improve substandard conditions, prevent evictions, prevent utility shutoff.
- **Education:** help secure specialized education services.

- **Employment:** prevent and remedy employment discrimination, enforce workplace rights.
- **Social community context:** assist with asylum applications, clear criminal histories, clear credit histories, secure custody and guardianship for children, secure restraining orders for domestic violence.

Outcome Example

Medical legal partnership of Southern Illinois (Illinois): Medical Legal Partnership of Southern Illinois (MLPSI) was formed to create a system where medical providers can refer patients in need of legal assistance to local attorneys.

- Over 4,300 patients have utilized MLPSI since its founding in 2002.
- The program has relieved over $8.1 million in medical debt for hospitals and patients.

Neighborhood Environment

Interventions focused on revitalizing the neighborhood environment including community safety, walkability, and available green spaces (parks and playgrounds).

Creating Healthy Places: Arnot Health

Health system partnering with 30 community service providers and businesses to create a healthier community

Chemung County, NY
https://www.arnothealth.org/creating-healthy-places

Intervention type: Healthy neighborhood

Social risk factors addressed: Neighborhood safety, parks/playgrounds, walkability, access to healthy food

Integrator organization: Arnot Health

Partners: Arnot Health leads a joint effort of 30 community service providers and businesses

Intervention Description

Arnot Health is a nonprofit three-hospital system with 589 beds based in Elmira, New York. Initiative to create healthy places to live and play. Some programs described below.

- **Park restoration project:** Initiative restored parks and renovated playgrounds with new play structures, learning trails, benches, and new lighting.
- **Sustainable community gardens:** Created community gardens in parks and schools. Produce from gardens is donated to local food banks and to school children.
- **Park and playground access:** Increased cross walks, curb cutouts, benches, and lights to make parks and playgrounds more accessible.
- **Increase restaurants with healthy options:** Arnot Health nutrition experts partnered with local business restaurants to add healthy options to their menus.

Outcomes

- Eleven parks restored since 2011
- Five community gardens developed

- Increased physical activity access opportunities
- Five local restaurants added healthier food options to their menus

Funding
Arnot Health's community outreach programs cost an estimated $423,000, with approximately 40% of this amount coming from grant funding yearly.

Screening and Referral

Over the past several years healthcare organizations have begun implementing screening and referral interventions to identify and address health-related social needs. These interventions usually include the following elements:

- **Web-based community resource library**: System to collate and map available social care resources in a geographic area.
- **Screening:** Standardized screening at clinical delivery sites to identify unmet social needs.
- **Referral:** Low or high-touch referrals to community-based services that may be able to address identified social needs (print out/text of referrals, navigation support to referrals, closed loop referrals where data on referral resolution is shared between partners).

There are many associated technology platforms in the marketplace to facilitate screening and referrals these include: Unite Us, Healify, Aunt Bertha, NowPow, Health leads. The CMMI Accountable Health Communities initiative is testing whether screening and navigation impacts healthcare cost and utilization.

Accountable Communities of Health
Federal initiative to accelerate the development and testing of social needs screening, navigation, and referral
Multiple sites across the U.S.
https://innovation.cms.gov/innovation-models/ahcm

Intervention type: Social needs screening, referral and community navigation

Social risk factors addressed: Various based on needs identified in screening

Partners: Various models and partnerships across the U.S.

Intervention Description
29 different sites across the country testing whether systematically identifying and addressing health-related social needs through screening, referral and community navigation services will impact health care costs and reduce utilization.

Some participating organizations include:

- Denver Regional Council of Governments, Denver, CO
- MyHealth Access Network, Tulsa, OK
- Partners in Health Network, Charleston, WV
- The Health Collaborative, Cincinnati, OH

- United Way of Greater Cleveland, Cleveland, OH
- University of Kentucky Research Foundation, Lexington, KY

Outcomes
Intervention is currently being tested and evaluated.

Funding
Centers for Medicare and Medicaid Innovation funding

Community Connectors

Non-profit organizations that coordinate a portfolio of local interventions, manage a coalition of partners, and leverage funding streams towards unified vision and goals.

Community Outreach & Patient Empowerment (COPE)

Native-controlled non-profit focused on healthy, prosperous, and empowered American Indian/Alaska Native communities. Invest in existing community resources and align work with the vision of tribal leadership.

Navajo Nation
https://www.copeprogram.org/

Community connector: Native-controlled non-profit organization

Social risk factors addressed: Food security, healthy food access, early childhood education/development, health literacy, cultural competency, access to healthcare, support systems, power

Partners: Brigham & Women's Hospital (BWH), Navajo Community Health Representative Outreach Program, Navajo Area Indian Health Service (IHS) and 638 Facilities, and Partners in Health (PIH)

Description
Native-controlled non-profit organization and community collaboration focused on health, prosperous, and empowered American Indian/Alaska Native communities.

Focused on listening, breaking down silos and fostering multi-sectoral collaboration to improve health. Believe that the power to overturn long-standing, historical health inequalities lies inherently in Native communities themselves. Their mission is based on investing in existing community resources and aligning their work with the vision of tribal leadership. Some programs described below.

- **Fruit & vegetable prescription program (FVRx):** Families meet with a community outreach worker each month to learn about healthy habits. They get a monthly prescription (voucher) to buy fruits & vegetables at local stores in Navajo Nation.
- **Healthy Navajo Stores Initiative (HNSI):** Program harnesses potential of small convenience stores and trading posts in Navajo Nation by increasing the amount of healthy fruit and vegetables and traditional foods in these stores. Promotes increases in produce purchasing through stocking, display and promotional changes.
- **Growers initiative:** Program focuses on connecting local growers with markets to facilitate access to markets, revitalize traditional growing practices in Navajo communities, and grow the local food systems.

- **Happy Homes:** Evidence-based program to help families start healthy habits with preschool aged kids.
- **Navajo community health outreach:** Youth leadership program focused on food literacy, physical exercise, emotional well-being, and power building.
- Cancer support program.
- Culturally appropriate health education.
- Community Health Representative training and outreach program.
- Patient-Centered Outcomes research.

Funding

Multiple funding sources including:

- Research and foundation grants: CDC, PCORI, First things first, Rx Foundation, NB3, Partners in Health
- Healthcare: Brigham and Women's Hospital

Mandela Partners

Non-profit working with residents, family farmers, and community-based businesses to improve health, create wealth, and build assets through local food enterprises

Oakland, CA
https://www.mandelapartners.org/

Community connector: Non-profit organization

Social risk factors addressed: Food security, healthy food access, employment, income, and community wealth building

Description

Non-profit organization that works in partnership with local residents, family farmers, and community-based businesses to improve health, create wealth, and build assets through local food enterprises in low-income communities. Through community engagement, education, business cultivation, and financing, Mandela Partners supports and resources the development and growth of locally owned economies and sustainable food systems. Some programs described below.

- **Healthy Grocery Initiative**: Program that helps corner stores sell fruits and vegetables with little to no risk. All inventory is delivered, maintained, and sold on consignment by the Mandela team. Program also includes support services and technical assistance to store owners and the community to encourage consumption of healthier food options including store environment improvements, marketing, nutrition education, and sourcing and procurement assistance.
- **Community produce stands:** Mobile markets that bring fresh, high quality and sustainably grown fruits and vegetables to communities that are under-served by more established markets.
- **Mandela Food Distribution**: Program that supports small local farmers by establishing an alternative distribution network that passes on wholesale prices to neighborhood stores and other community-based businesses.

- **Mandela Entrepreneurs Program**: Program that provides support to entrepreneurs including one-on-one advising to local entrepreneurs, workshop series on starting, growing and expanding businesses; and connections to community resources to build businesses.
- **Access to capital:** Provide low and no cost financial loans and tools coupled with culturally relevant technical assistance to support locally owned business grow.
- **Re-Generate Opportunity**: Program that provides food-based job training to formerly incarcerated individuals to build skills for the food and hospitality sector, with a specific focus on Prep Cooks, Line Cooks, and Kitchen Management positions.

Funding

Multiple funding sources including:

- Government contracts and grants: DHHS, USDA, CA State government
- Program service fees
- Foundations

Camden Coalition of Healthcare Providers

Multidisciplinary non-profit focused on integrating medical and social care. Theory of change is community engagement, integrated data, and cross-sector convening to redesign of how care systems operate.

Camden, NJ

https://camdenhealth.org/

Community connector: Non-profit organization

Social risk factors addressed: Wide variety of social risk factors addressed related to economic stability, social and community context, health and healthcare access, housing, and power.

Partners: Coalition made up of over 20 local non-profits, 4 hospitals, primary care offices, and FQHCs

Intervention Description

Multidisciplinary non-profit focused on developing programs that integrate and address medical and social care needs. Core to their approach is community engagement, integrated data, and cross-sector convening to inform the redesign of how care systems operate. Some programs described below.

- **Care management intervention:** An interprofessional team of nurses, social workers, and community health workers visit participants in the community, identify needs and goals, develop care plans with individuals, and work with individuals to connect with applicable services and achieve goals.
- **Housing First intervention**: Provides housing and supportive services to patients who are experiencing chronic homelessness.
- **Integrated data:** Regional Health Information Exchange (HIE) provides real-time integrated data to providers across South Jersey; 33 sites contribute data including hospitals, primary care, labs, correctional facilities, and other healthcare facilities.
- **Medical legal partnership:** Partnership with Rutgers Law school for free legal support to resolve social needs that undermine health.
- **Community Advisory Committee**: Committee guides the strategic direction of the organization by advising the Board and staff on community needs.

- **Advocacy:** State and local advocacy aimed at removing barriers to health and wellbeing including increasing access to substance use treatment, housing, state identifications and medical transportation.
- **Community resource library (MyResourcePal)**: Online resource library for 3 counties in NJ used by residents and care providers to identify and access local social care resources. Platform is Aunt Bertha.
- **Accountable Health Communities test site**: Practices in Camden, Burlington, and Gloucester counties screen Medicare and Medicaid beneficiaries for health-related social needs and refer them to the appropriate services.
- **Faith-in-prevention**: Evidence based intervention using faith-based organizations to deliver health prevention activities, nutrition, and health promotion education, and encourage healthy lifestyles.

Funding

Multiple funding sources leveraged including:

- Foundation grants
- Membership fees
- Federal and state grants
- State and local budget allocation
- Service contracts with insurance providers and local government

DotHouse Health

FQHC that provides comprehensive health and wellness services and connects patients to services in the community

Dorchester neighborhood of Boston, MA
http://www.dorchesterhouse.org/services/index.html

Social risk factors addressed: Wide variety of social risk factors addressed related to economic stability, education, social and community context, health and healthcare access.

Community connector: Federally qualified health center (FQHC)

Description

FQHC and patient centered medical home that provides comprehensive health and wellness services to the community. Services include:

- **Healthcare services**: Provides comprehensive healthcare services including medical, dental, behavioral and substance use disorder services.
- **Social services case management**: Patients are screened to identify needs related to housing, finances, federal/state benefits, and legal issues. Case managers develop care plans with patients and support them in connecting to applicable community services/benefits.
- **Medical legal partnership:** A local law firm provides free legal services to patients related to immigration, housing, family law, income support and education.
- **Generation Next Academy Teen Center (GNA):** Youth leadership development programs, mentoring, healthy lifestyles education, and recreation opportunities are provided for youth in the community.
- Patients have on site access to:
    - Farmers market
    - Financial counseling

- Food pantry
- Health gym, swimming pool
- WIC office

Anchor Institutions

Hospitals and universities that use their prominent role in local economies to improve the health of the communities where they are based. Investment strategies include local hiring and procurement, workforce training, living-wage jobs, creating/improving affordable housing, and increasing access to and safety of public spaces.

ProMedica

Community-based anchor institution on over 10-year journey towards integrated health and wellness

Toledo, OH
https://democracycollaborative.org/learn/publication/embracing-anchor-mission-promedicas-all-strategy

Institution type: Non-profit mission-based healthcare organization

Social risk factors addressed: Focused healthy food access, neighborhood improvement, community wealth building, employment

Description

ProMedica has embraced their role as a community-based anchor institution and have been on an over 10-year journey to shift their focus from healthcare to integrated health and wellness. In addition to providing traditional healthcare services, they implement a portfolio of broad-based, multifaceted initiatives aimed at improving employment, education, food security and housing in the communities they serve. They take an "all-in" approach to addressing adverse social conditions; connecting traditional interventions like food clinics to strategies that build community wealth such as establishing a grocery store in an area lacking affordable healthy food and connecting this to employee training programs. Some areas of intervention described below.

- **Advocacy fund**: Provides funding to nonprofit community partners that provide basic needs services.
- **Screening for social needs:** Screen patients for social needs at clinical sites and connect patients to community resources to address needs.
- **Food reclamation initiative:** Collect prepared but unserved food to repackage for use in area soup kitchens.
- **Onsite food clinic:** Provide ProMedica primary care patients 2-3 days' worth of food for their household, coupled with nutrition services and connections to community resources.
- **Market on the Green:** Established a full-service grocery store in an area that lacks access to healthy food.
- **Ebeid Institute:** Neighborhood institute that provides job training programs, life skills training, and a Financial Opportunity Center that offers financial coaching in group and one-on-one settings.
- **Expanding school nurses:** Increased health services throughout the school district by funding nine additional school nurses in the elementary schools.
- **Ebeid Neighborhood Promise**: $50M philanthropic investment to create a model for neighborhood revitalization. Using a place-based approach, the initiative focuses on jobs, education, health, stability, and resident engagement.

- Partnership with local **Community Development Financial Institution (CDFI)** to create a $25 million dollar loan pool to support capital projects and minority- and women owned businesses in distressed communities.

Metro Health: Institute for H.O.P.E (Health, Opportunity, Partnership and Empowerment)
Neighborhood hub to bring together programs and resources to improve community health and wellbeing

Cleveland, OH
https://news.metrohealth.org/institute-for-hope-to-bring-services-programs-to-w-25th-street-to--create-opportunities-and-make-life-easier/

Institution type: Health System

Social risk factors addressed: Focused on employment and income building, food access, housing, and internet

Description
Metro health is in the process of launching an Institute for H.O.P.E. on their main campus that will function as a neighborhood hub and bring together programs and resources to improve health and wellbeing for community residents. Some of their investments are described below.

- **Affordable housing:** $60 million investment to build 250 affordable housing units with expanded green space and community programs.
- **Economic Opportunity Center:** Will provide skill building training in resume writing, interviewing, and internet navigation.
- **Grocery store and food pantry**: Establish grocery and food pantry to provide access to fresh food in an area that lacks access to healthy food.
- **Legal counseling:** Legal services to community members.
- **Job training program**: Will train individuals for jobs in health care, public safety, information technology and other vocations.
- **Internet access**: Working with AT&T, MCPc and Digital C to bring affordable internet access to up to 1,000 homes near its campus.

HopkinsLocal
Anchor institute focused on economic opportunities that are inclusive of diverse people and create wealth for individuals and communities

Baltimore, MD
https://hopkinslocal.jhu.edu/

Institution type: Health system and university, Johns Hopkins University and Medicine

Social risk factors addressed: Focused on income and community wealth building

Description

Johns Hopkins is the largest private anchor institution in Baltimore. It focuses on supporting economic growth, employment, and investment in Baltimore. Contributions described below.

- **Buy local**: $54 million spent on buying locally generated products.
- **Hire local**: 1,017 city residents hired; Hired 402 citizens returning from incarceration.
- **Contract local**: $48.5 million spent on contracts with local, women-owned, or minority-owned design and construction firms.
- **Train local**: 66 small, local, minority-owned, women-owned businesses expand skills and networks through BLocal BUILD College.
- Created development plans with 26 nonlocal suppliers to increase those companies' efforts to hire, procure, or invest in Baltimore.

Community-Wide Initiatives

Place-based initiatives that focus on the community from a systems perspective. They address a broad range of upstream social conditions through an integrated portfolio of investments, and often include mobilization and power building among community members as strategies for long-term sustained change. These initiatives usually involve an integrator organization that convenes diverse partners around a common agenda and facilitates progress around a shared portfolio of interventions.

Thrive Allen County (RWJF Culture of Health Prize Winner)
Rural health advocacy organization- mobilizing community to improve community health, healthcare access, and economic development

Allen County, KS
http://thriveallencounty.org/

Organization type: Non-profit organization

Social risk factors addressed: Power building, build environment, food access, healthcare access

Partners: Local healthcare institutes and foundations, insurance provider, department of health, department of parks, department of commerce, and local private and non-profit organizations

Description
Thrive Allen County is the largest and most prominent rural health advocacy organization in Kansas. The coalition played a key role in the county's community improvement journey by catalyzing and supporting efforts to improve healthy lifestyles, health care access, and economic development and serving as a connector across efforts. Some initiatives described below.

- **Community engagement/mobilization:** The basis of their work is finding resources and building public and political will to meet community needs. Initiatives are resident identified and often implemented through community mobilizing and petitioning.

- **Healthcare access:** Built resources, political and public will to construct a new county hospital and establish local FQHC, including passing a sales tax measure to fund the hospital.
- **Built environment-trails:** Developed over 27 miles of trails, contributing to environmental restoration and opportunities for active transportation.
- **Built environment-playgrounds/gyms:** Worked with school districts to develop open use agreements to encourage use of school facilities (gyms, playgrounds) by the community when not in use for school purposes.
- **Food access**: Secured nearly $400,000 in public incentives needed for the construction of a supermarket in a USDA-designated "food desert," bringing new jobs and sales tax revenues to the country
- **Advocacy**: Built a state-wide rural advocacy coalition called Thrive Kansas, whose mission is to strengthen Kansas non-metropolitan communities by ensuring their voices are heard and they have a seat at the legislative table.

Healthy Klamath County (RWJF Culture of Health Prize Winner)
Multi-sector partnership established to guide community health improvement efforts in Klamath County

Klamath County, Oregon
http://www.healthyklamath.org/

Organization type: Non-profit coalition

Social risk factors addressed: Employment, health care access, education, built environment, food access

Partners: Core Four agencies that guide Healthy Klamath: Cascade health alliance (local coordinated care organization that brings together health care providers) Sky lakes medical center, Klamath county public health, Klamath health partnership (federally qualified health center).

Over 25 additional non-profit, county, and private sector partners in the Coalition

Description

Multi-sector partnership established to guide community health improvement efforts in Klamath County, Oregon. Many initiatives have emerged from and partnered with Healthy Klamath. Action is driven by Community Health Improvement Plan, priority issues, shared goals and objectives for each issue. Priority health issues are food insecurity, housing, maternal and childhood health, oral health, physical well-being and suicide prevention.

A few initiatives include:

- **Education**: Klamath Promise is focused on improving high school graduation rates, includes early learning hub, college and career preparation, dual enrollment programs, and one year of free tuition at Klamath Community College.
- **Employment:** Klamath Works offers adult job skills training programs, employment coaches, and a centrally located social services hub to streamline the delivery of services and connect clientele to resources needed to overcome barriers to employment.

- **Access to care:** Access to clinical care was expanded for the residents of Gilchrist, a rural, remote town with no medical clinic, by extending the hours of operation of their school-based health center and opening it to all town residents.
- **Built environment:** Klamath trails alliance leveraged the county's natural landscape to build trails and bike paths for outdoor activities.
- **Health care professionals:** In response to shortages of healthcare professionals, Oregon Health and Science University and Sky Lakes Medical Center developed a rural medical residency program to recruit and retain medical residents and place them in Klamath Falls clinics.

Sources used to identify case examples

Source	Website
All In Data for Community Health	https://www.allindata.org/
Build Healthy Places Network	https://www.buildhealthyplaces.org/
Building a Culture of Health: What Works for Health	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health
Communities Driving Health Equity, National Academy of Medicine Spotlight Series	https://nam.edu/programs/culture-of-health/driving-health-equity/
Delivering Community Benefit: Healthy Food Playbook	https://foodcommunitybenefit.noharm.org/case-studies
Healthcare Anchor Network	https://healthcareanchor.network/2019/11/embracing-an-anchor-mission/
Invest Health: Strategies for Healthier Cities	https://www.investhealth.org/
National Center for Medical Legal Partnerships	https://medical-legalpartnership.org/
Quantifying Health System Investment in SDOH, Health Affairs Article	https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01246
RWJF Culture of Health Prize Winners	https://www.rwjf.org/en/library/features/culture-of-health-prize.html
The BUILD Health Challenge	https://buildhealthchallenge.org/
UCSF Social Interventions Research & Evaluation Network, Evidence Library	https://sirenetwork.ucsf.edu/tools/evidence-library