Clinical-Community Collaboration
around Social Determinants of Health

Health centers in the United States are increasingly implementing progressive and innovative models to shift the healthcare paradigm from individual-centered and treatment-based to community-centered and prevention-based. These initiatives are meant to challenge broken systems that perpetuate a disconnection between clinical care and social determinants of health.

Our healthcare system concentrates too many resources on clinical care and patient-centered treatments while neglecting equity, preventive care and population health. The Institute of Medicine reported in 2013 that, given the United States' healthcare spending, the country's poorer health outcomes can be attributed to the effects of health systems, health behaviors and social and environmental factors.[1] Similarly, Americans' behavior and environments account for at least 60 percent of their health, while genes account for 20-30 percent and healthcare accounts for only 10 percent.[2,3] Therefore, we cannot simply rely on medical treatment to improve health outcomes. We must also change our behavior and environments.

One method of bridging healthcare, behavior and environments is being pioneered by clinical-community partnerships. These partnerships are necessary to address social determinants of health, but it is difficult to form them and ensure that they are strong, effective, efficient and sustainable. Active Living By Design (ALBD) is well-positioned to support these partnerships through that process. By helping clinical groups coordinate with public agencies, residents, businesses and community organizations, ALBD is supporting these partnerships as they address social determinants of health and make policy, systems and environmental changes. These long-term changes will lead to improved health behavior and community-level health outcomes.

To advance this work in North Carolina, ALBD has partnered with Blue Cross and Blue Shield of North Carolina Foundation and Care Share Health Alliance to assist clinical-community partnerships that want to improve community prevention and health. Together, we are helping each partnership make challenging systems changes that require long-term planning and capacity-building.

One component of ALBD's support is to expand and enrich a learning network with useful material regarding clinical-community collaboration. This allows partnerships to learn from others facing similar challenges while creating positive change. As a contribution to the field, ALBD has identified and written case studies about clinical-community partnerships around the United States which have successfully addressed social determinants of health and have advocated to change community conditions. These case studies explore how the partnerships were developed and what processes, structures and practices were implemented to integrate upstream preventive actions with clinical practice.

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[1] National Academies (U.S.) and Institute of Medicine (U.S.), U.S. Health in International Perspective: Shorter Lives, Poorer Health, ed. by Steven H. Woolf and Laudan Y. Aron (Washington, D.C: The National Academies Press, 2013).
[2] J. Michael McGinnis, 'Actual Causes of Death in the United States', JAMA: The Journal of the American Medical Association, 270.18 (1993), 2207 <http://dx.doi.org/10.1001/jama.1993.03510180077038>.
[3] J. M. McGinnis, P. Williams-Russo and J. R. Knickman, 'The Case For More Active Policy Attention To Health Promotion', Health Affairs, 21.2 (2002), 78–93 <http://dx.doi.org/10.1377/hlthaff.21.2.78>.

Best Practices

In writing these case studies, ALBD recognized specific actions and processes that made it possible for these partnerships to succeed. Clinical-community partnerships can benefit from employing some of these "best practices" that are appropriate to a given situation. While reading the case studies, look out for a few of the following "best practices" identified on the first page and described within the story.

ADDRESSING COMMUNITY CONDITIONS

In order to build trust with residents and to understand the local social determinants of health, clinics need to develop relationships and extend themselves into the community. Community health workers can improve the relationship between clinical organizations and the community by acting as liaisons and exchanging information about social, cultural and environmental conditions. Community health workers are often well-positioned to identify issues beyond clinical concerns and bring the power of the larger clinical-community partnership to advocate for improvements. They can affect change in areas of community health such as safety, transportation, access to healthy foods, indoor air quality, or access to recreational space.

ALIGNING STAKEHOLDERS' MISSIONS AND GOALS

Clinical-community partnerships derive much of their power to address complex issues from an ability to align partners' work behind a shared agenda. Partnerships can do this by developing reliable processes, consistent communication, a willingness to compromise and a spirit of adaptability. This is especially important because of the shifts that often occur within partnerships and organizations, including staff turnover, leadership changes and organizational restructuring.

BROAD AND ACCOUNTABLE COALITION BUILDING

It is common for advocates to feel unsupported or dismissed when trying to make policy, systems and environmental changes. Developing a strong, broad coalition with credible political leadership, representation from the private sector and a variety of individuals and community organizations can diversify a partnership's network and increase its influence. A coalition grows stronger and more successful when each coalition member is held accountable for their contribution. By forming and growing this type of coalition, a partnership will increase awareness of the issue, strengthen its base of support and be more likely to overcome adversity and catalyze lasting change.

CAPACITY BUILDING

Systems changes and paradigm shifts require organizations to adapt and grow. With every change made and every opportunity taken, clinics and their partners can build leadership, strengthen staff skills and competencies, adopt appropriate technologies and provide time and space for meaningful change. Capacity building is not just about increasing funding and staff, but is also about developing relationships and structures to facilitate community engagement and cultivate constructive interaction between institutional, clinical, governmental and community players.

CLINICAL AND NON-CLINICAL COLLABORATION

Clinical-community partnerships are learning to step beyond traditional programs and referral relationships and work together to focus on changing policies and environments. This often involves examining assumptions, overcoming differences, embracing humility and self-awareness and creating a forum for continuous communication. A collaborative forum should provide a space to identify group and individual assets, encourage mutual learning and understand each group's working systems and language.

COMMUNITY ENGAGEMENT AND LEADERSHIP DEVELOPMENT

Partnerships addressing social determinants of health on a community level often rely too heavily on data from medical records and partner organizations' staff, thereby ignoring or undervaluing the community's knowledge and voice. Community engagement and leadership development attracts funding; shifts power; builds trust, credibility, accountability and a strong constituency; broadens community and partnership capacity; promotes a health equity focus and a more intentional process; and improves understanding of both context and data.

DETERMINING EVALUATION METHODS AND MEASURES

Though partnerships often know to make evidence-based decisions, it is important to be strategic and collaborative in choosing indicators and methods. Choosing indicators is a powerful way to focus work, increase impact, ensure accountability and understand what is already occurring. By determining measures of success and evaluative methods and then constantly re-evaluating them, partnerships can also increase support from funders and optimize future projects.

DIVERSE FUNDING

At the beginning of a change process, it is frequently difficult to secure reliable funding. Until there is reliable payment reform throughout the healthcare system, partnerships must creatively assemble different kinds of funding. By securing multiple financing sources over time, a partnership can balance risk, build a stronger financial portfolio highlighting successes and compete for higher levels of funding.

HEALTH CENTER AS ADVOCATE

Systems and environments cannot change without policy changes, and policy cannot change without advocates. Health centers and clinics are positioned to be excellent advocates for a community's health, because they know the community, have the respect of the public and private sectors and can leverage the voices of their staff and patients.

INNOVATIVE LEADERSHIP

In order to shift the healthcare paradigm from a patient-centered, treatment-based system to a community-centered, prevention-based system, we need leaders to be bold, caring and unafraid of failure. Leaders should push for innovation and adapt their institution's culture while simultaneously helping staff, partners and community members feel safe and incentivized.

OPPORTUNISTIC CHANGE MAKING

There are various pathways to systems changes. In order to maximize the resources, networks, tools and spaces for change, clinics need to seize opportunities when they arise. These can include new partnerships, a change of leadership, funding or even new conversations resulting from disastrous events. In any of these cases, these opportunities can build momentum, grow a partnership's track record and attract more opportunities.

PROCESS EVALUATION

Whether a partnership succeeds or fails, it is valuable to formalize a time and space to look at strengths and weaknesses and evaluate how changes were made. Understanding how a process led to certain results can benefit partners and inform future decisions to maximize effectiveness, efficiency, equity and the potential replicability of an approach.

STRATEGIC COMMUNICATION

Clinical-community partnerships may find it challenging to effectively communicate their mission and purpose across the partnership and in the broader community. Smart marketing and branding can be important for establishing an identity and a consistent message that attracts partners, funding and buy-in. Communicating in an intentional way can create the necessary foundation for positive exposure, inclusiveness and effective promotion of change.

Brockton Neighborhood Health Center

BEST PRACTICES

Opportunistic Change Making

Clinical and Non-Clinical Collaboration

Diverse Funding

ISSUE FOCUS

Access to Primary Health Care

Access to Healthy Food

Neighborhood Revitalization

Background

Brockton Neighborhood Health Center (BNHC) is a nonprofit, multicultural, federally qualified community health center (FQHC). BNHC is designated as a Qualified Low-Income Community Business (as defined by New Market Tax Credit program regulations) and is incorporated as a Community Development Corporation (CDC) with the primary purpose of creating jobs in the community.

> **Demand for BNHC has accelerated after it started in 1994 as a mobile medical van in a church parking lot.**

BNHC has since constructed and expanded its main site to accommodate the growing demand for local healthcare. The cost of its main site is about $30 million, including the $17 million for initial construction in 2007, a $2.5 million expansion in 2010 and an $11 million expansion in 2012. BNHC has positioned itself as a leader in community health through collaborative partnerships in Massachusetts; the clinic provides primary care services at its location at **Father Bill's and MainSpring** shelter for homeless people, coaches partners in the community's REACH (Racial and Ethnic Approaches to Community Health) program and works with the Brockton Area Community Health Network Area to address health service gaps in the community.

Demographics		BNHC	Brockton City, MA	MA
Population		28,000 patients	93,810	6,605,058
White Alone		21%	44%	76%
Black: 65%	Cape Verdean	30%	35%	2%
	Haitian	15%	27%	5%
	African American	12%	37%	6%
	Other Countries	8%	NA	NA
Latino/Hispanic		9%	10%	10%
Persons below poverty level		74%	18%	11%
Unemployment		NA	15%	8%
Non- English Speaking		42%	37%	22%
Lack health ins.		31%	4%	7%
Public health ins.		47%	32%	47%

Vicente's Tropical Grocery, opened in 1994, is an international grocery store specializing in Cape Verdean, Haitian and Portuguese foods as well as typical items. It has grown into an 18,000 square foot, full-service supermarket, employing 105 people and serving 56,000 customers annually. Jason Barbosa is Vicente's Operations Manager, taking the helm after his father started the original Vicente's grocery store. BNHC's CEO, Sue Joss, estimates that Vicente's and BNHC are two of the fastest growing businesses in Brockton.

ACTIVE LIVING BY DESIGN
Catalyst for a culture of health

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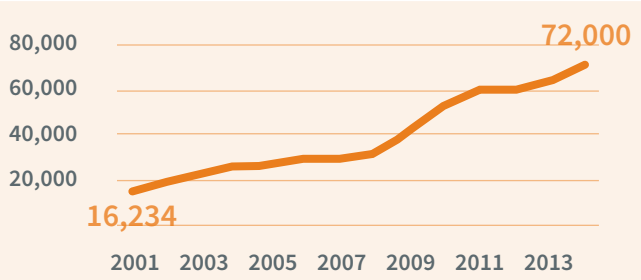
Community Challenge

Despite expansions in 2007 and 2012, BNHC eventually outgrew its capacity for adult primary care services. Based in a medically underserved area and a federally qualified food desert, BNHC's community faces high rates of poverty and unemployment as well as low access to healthy food. Reliance on SNAP and EBT programs and rates of obesity, diabetes and other illnesses in Brockton are higher than those of Massachusetts in general.

BNHC Adult Primary Care Visits



Similarly, Vicente's owners found that their store was too small to accommodate the high demand for healthy foods. Based on the need to expand to meet the growing demand for their services within the community, they found a building in a lot that had been vacant for almost 20 years, and that had also contributed to the community's deterioration and high rates of crime. They decided to purchase the building and then looked to partner with a business to lease building space or to develop a new, adjacent building in order to make Vicente's expansion financially feasible. However, the only business that showed interest in partnering was McDonald's, and a partnership with it would only have exacerbated the existing healthy food access challenges in the neighborhood.

Solution

OPPORTUNISTIC CHANGE MAKING

In 2013, Sue Joss attended a meeting made up of community organizations and leaders. Vicente's Jason Barbosa also attended and was excited to announce that a new partner had been selected to co-locate with the grocery store. When he announced that the new partner was McDonalds, jaws dropped. Joss asked if there was anything the Brockton community could do in order to convince him to end this new partnership. "Find someone else to join the project," Jason responded.

Joss knew that BNHC had to expand, and quickly decided to propose to her team that BNHC could be Vicente's new partner. She went back to the Board of Directors and to stakeholders to discuss the idea. Two weeks later, they called Jason back to formalize the proposed partnership to address social determinants related to nutrition. With McDonald's eager to move in, Joss had to advocate for the community's health, and the team had many conversations so that the project's developer, Affirmative Investments, could eliminate McDonalds from the deal.

Joss recognizes that this project was spurred by networking and keeping their ears to the ground. She says, "It was just an opportunity—we had to grab it." Joss's intuition and ability to jump on opportunities exemplifies the strong and innovative leadership necessary for this type of change making. By focusing on poverty, cultural traditions, transportation, healthy food access, literacy and language barriers, this partnership targets three local public health issues: diabetes, hypertension, and obesity.

COLLABORATION BETWEEN CLINICAL AND NON-CLINICAL ORGANIZATIONS

BNHC and Vicente's collaborated through the architectural design process, project development and final stages of the development. Meeting once a week to discuss design, nutrition and operational plans gave time and space to coordinate and openly communicate from the beginning. Furthermore, using the mission-driven developer **Affirmative Investments** allowed for a better alignment of goals.

Reflecting on the community and political support of this development, the President of Affirmative Investments, David Ennis says, "It was such a positive impact on the neighborhood and city, so I think we had a lot of people rooting for us and helping us out." However, BNHC and Vicente's did face challenges. For instance, they wanted to share an entrance but were restricted by licensing regulations. Not surprisingly, the biggest challenge of all was financing this project. Luckily, Affirmative Investments was aware of unique financing tools and connected the project to a financing partner.

FINANCIAL MECHANISM

> **To cover the total development costs of roughly $23 million, BNHC worked with LISC (Local Initiatives Support Corporation) as the lead investor.**

Massachusetts Housing Investment Corporation (MHIC) was also a significant contributor to Vicente's. LISC is a Community Development Financial Institution (CDFI), which supports community development activities in low-income neighborhoods. In addition to providing a low-cost loan with federal **Healthy Food Financing Initiative** (HFFI) resources to help fund Vicente's expansion, LISC also organizes the **Healthy Futures Fund**, which funds FQHCs using the **New Markets Tax Credits** (NMTC). In addition to managing the Healthy Food Financing Initiative (HFFI), which helped fund Vicente's expansion, LISC also organizes the Healthy Futures Fund, which specifically funds FQHCs with New Markets Tax Credits (NMTC). The NMTCs were used to leverage financing and were capitalized with equity and a loan from Morgan Stanley, as well as a junior leverage loan from the **Kresge Foundation**.

Additionally, LISC partnered with the Opportunity Finance Network (OFN) and the Leviticus Fund to provide financing. Programming and other expenses are being funded through large grants from sources like the United States Department of Health and Human Services, the **Office of Community Services' Community Economic Development HFFI** and **Health Center New Access Point Grant** (NAP). Since the clinic is well-funded and located in a neighborhood lacking primary care services with growing primary care needs, BNHC expects to break even in annual operating expenses before the second year.

Outcomes

NEIGHBORHOOD REVITALIZATION

Vicente's opened in July, 2015, and the new clinic opened in September 2015, creating safe community space and spurring revitalization to a blighted corner. The original Vicente's remains in business, and the BNHC's Main Street location will remain open. At least 75 percent of the new positions at Vicente's will be targeted to low-income community residents in order to combat the neighborhood's unemployment rate, which is greater than 15 percent.

New Community Impacts		
Demonstration/teaching kitchen		
Increased access to healthy food		
Increased access to health care (40,000 patient visits)		
Developed previously high-crime, vacant area		
	BNHC	**Vicente's**
Space (square feet)	13,600 (new construction)	32,000
Full-time, living wage jobs	52	150

With such a high demand for primary health care, the neighborhood will now have more people coming through, which also means more business for Vicente's. The clinic's influence on the neighborhood is already beginning to show. The developer and BNHC are beginning to discuss bringing a pharmacy and a medical diagnostics testing company to the area. Ennis says the area is "on the way to downtown so it's going to have a great impact."

OTHER BENEFITS

This new partnership flourished. Vicente's staff had never thought of themselves as nutritionists, but BNHC staff, including a dietician, helped them to understand their role in the community's health. They quickly became advocates for healthy foods and nutrition. The partnership benefits Vicente's, BNHC and the community. To gauge its impact, the partnership will be measuring three main indicators of health on a community level:

1. Hemoglobin A1c to calculate the prominence of diabetes
2. Low-density lipoproteins (LDL)
3. Weight to calculate body mass index (BMI)

The benefits of the partnership are obvious through neighborhood revitalization, employment and increased access to healthy food and adult primary care. A number of other outcomes include:

- Nutrition classes tailored to healthy ethnic foods will be offered at the clinic's teaching kitchen and Vicente's open grill.
- Marketing and promotion of healthy eating at Vicente's as advised by the clinic.
- Labelled nutritious food placed on eye-level shelves, ensuring that healthy food is the easiest choice. The partnership even plans on installing televisions throughout the store that will exclusively broadcast healthy cooking shows.
- A rewards program to incentivize patrons to buy healthy food. Food items have assigned points, with healthier foods counting for more points than unhealthier foods. When residents improve their scores, they can earn reward points and receive coupons for healthy foods. This system is based on **Syracuse's Shopper Rewards Program**, a larger city-wide program in which many businesses are involved, and which mentored BNHC during its planning phases.

Through these environmental and programming strategies, Vicente's and BNHC are providing preventive healthcare and encouraging healthy eating to the entire community.

Tools

- **Market Analysis for Vicente's Tropical Grocery**
- **Syracuse's Shopper Rewards Program Presentation**

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COACHELLA VALLEY, CALIFORNIA

CLINICAL-COMMUNITY COLLABORATION CASE EXAMPLES

Get Tested Coachella Valley

BEST PRACTICES

Broad and Accountable Coalition Building

Strategic Communication

ISSUE FOCUS

Regional Movement

HIV Testing

Background

The Coachella Valley is a region within Riverside County in Southern California with a high percentage of older adults and Hispanics. The population of the Coachella Valley also has an incredibly high rate of HIV. Compared to the United States' HIV prevalence of 0.4 percent, cities in western Coachella Valley have an HIV prevalence rate of 1.6 percent, according to the **Coachella Valley Blueprint for Action**.

Desert AIDS Project, a comprehensive HIV/AIDS service provider and Federally Qualified Health Center in Palm Springs, has an on-site medical clinic, a full range of client support services and a comprehensive HIV education and prevention program. **Desert Regional Medical Center** is a general medical and surgical hospital in Palm Springs. Both organizations serve the Coachella Valley.

Demographics	Coachella Valley*	Riverside County	California
Population	365,648	2,125,440	36,961,664
65 and older	23%	12%	11%
Hispanic	47%	45%	37%
HIV Prevalence (per 100,000)	467	269**	363**
Median Household Income	$57,125	$53,981	$57,664

* Coachella Valley Blueprint for Action
** County Health Rankings, 2015

Community Challenge

More than half of Coachella Valley residents have never been tested for HIV[1]. Behavioral studies have shown that when people do not know they are HIV-positive, they are more likely to engage in behaviors associated with HIV transmission, whereas people who have been tested and know they are HIV-positive make behavioral changes to reduce their risk of exposing others to the virus. The Centers for Disease Control and Prevention (CDC) estimate that approximately one in eight people with HIV do not know they are infected. Once people know they have HIV, they can then be connected to treatment, which reduces the risk of transmission to others. In 2011, the HIV Prevention Trials Network (HPTN) 052 study showed that if an individual who is HIV positive takes the right medications, he or she is 96% less infectious. Testing for HIV, therefore, is an effective way to reduce HIV transmission.

[1] Health Assessment and Research for Communities (HARC) 2013.

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Solution

Based on the knowledge that increasing the number of people being tested for HIV can lead to decreased transmission of HIV, the CEO of Desert AIDS Project initiated a campaign to increase HIV testing in Coachella Valley called **"*Get Tested Coachella Valley*" (*Get Tested*)**. Beginning in 2012, the **Clinton Health Matters Initiative** (CHMI) began to focus on health issues in the Coachella Valley. By using the **County Health Rankings** model, CHMI identifies community-level health issues to develop key recommendations or "Bold Steps." Local organizations then implement these "Bold Steps" to improve health by addressing the physical environment, social and economic factors, clinical care and health behaviors. *Get Tested* is a "Bold Step" for Coachella Valley's CHMI, as described in the Coachella Valley Blueprint for Action.

> ***Get Tested* would be the first campaign of its kind to be targeted in a region rather than a major city, and the first that was not established and managed by a city or county health department, but rather driven by a community-based coalition.**

One of the first phases of organizing *Get Tested* was hiring Susan Unger as the Project Director. Unger is a management and marketing consultant and led the design and implementation of the campaign. She began by researching similar programs around the country to learn best practices and challenges, learning that this apparently would be the first campaign of its kind to be targeted in a region rather than a major city. The *Get Tested* campaign is also the first that was not established and managed by a city or county health department, but rather driven by a community-based coalition. In her role, Unger has effectively utilized business and marketing strategies to make improvements to the culture surrounding HIV testing and the community's health.

STRATEGIC COMMUNICATION

In 2014, the Desert AIDS Project launched *Get Tested*, a three-year, $5 million campaign to increase HIV/AIDs testing in Coachella Valley. Communicating *Get Tested*'s mission and the research behind its strategies is crucial to changing the clinical and community environment. If clinics, community organizations and individuals do not understand the effectiveness of testing in reducing HIV prevalence, they are less likely to support the initiative and testing rates are less likely to change.

Early on, *Get Tested* developed reliable platforms like reports and a website to spread the word about the initiative. The campaign consistently relays its messaging, mission and values with contemporary and culturally relevant imaging, marketing, language and campaign branding that includes a bright-orange color scheme. The goals and strategies of *Get Tested* are well-stated in the **Get Tested Coachella Valley Annual Report 2014** and **2015,** and their accomplishments are described in the **Get Tested Midpoint Report**. The initiative's purpose, list of community partners, events, surveys, media coverage and other information are available on the website. There are specific sections on the website for community partners, for people who want to get tested and for people who test positive for HIV or AIDS.

The initiative also includes a comprehensive media campaign; its website promotes an opportunity for individuals to be involved in the campaign by signing up online to be a **Social Ambassador** and help to spread the word about *Get Tested* on social media. This Social Ambassador member website utilizes a digital advocacy platform **to raise awareness, engage community members and spark dialogue about *Get Tested***. The media campaign includes advertisements throughout the region, bilingual regional mailings and public service announcements by one of the campaign's champions, United States Representative Dr. Raul Ruiz.

Get Tested has established itself in the region as a positive, engaging presence. In 2014, the cities of Palm Springs, Rancho Mirage and Indio declared National HIV Testing Day "Get Tested Coachella Valley Day" to raise community awareness and bring together local leaders at a free testing day. In a **2014 article from The Desert Sun**, many regional residents discuss how the bright-orange campaign materials grabbed their attention at events and led them to get tested, which is especially easy to do at the Get Tested Coachella Valley mobile clinic. In select locations serving low-income communities, test incentives, such as a $10 grocery store gift card, are offered. The mobile testing unit even has heavy-duty suspension and tires so it can access all terrain; the *Get Tested* team has driven through dirt fields to reach farm workers. The mobile unit makes its way to parades, festivals, churches, food banks, senior centers and more.

> ***Get Tested* has established itself in the region as a positive, engaging presence.**

Get Tested has its own **YouTube channel** with over 150 videos (most of which are less than 30 seconds) featuring local celebrities, community leaders and community members. The diverse range of spokespeople announce their support for and commitment to *Get Tested* and provide educational tips and personal HIV testing stories in Spanish, English and sign language.

To educate and inspire younger people, *Get Tested* encourages them to host grass-roots Orange Parties at their homes or student clubs. At Orange Parties, *Get Tested* provides a 15-minute presentation that addresses stigma about HIV and HIV testing.

CLEAR GOALS AND STRATEGIES

According to its 2014 annual report, *Get Tested* aims to reduce the spread of HIV by:

1. Making voluntary HIV testing standard and routine medical practice.
2. Making HIV testing and care available to everyone, including those who don't see healthcare providers regularly.
3. Addressing fear, judgment and stigma by educating the community about HIV testing, how to protect their health and prevent infection.

Get Tested will succeed in its mission by implementing four strategies:

1. Engage the local healthcare community to make HIV testing a standard of care.
2. Expand the network of HIV and STD/STI testing sites, including mobile units, to reach individuals at higher risk and those who lack regular contact with healthcare providers.
3. Create a new, regional Linkage to Care Network that enables providers to quickly and easily refer their patients, ensuring that any individual who tests positive for HIV receives early intervention to facilitate needed medical treatment and appropriate care and counseling.
4. Produce a communications campaign in both English and Spanish to educate and motivate individuals, whether HIV-negative or –positive, to reduce stigma, protect their own health and prevent others from becoming infected.

According to the **Get Tested 2015 Annual Report**, in 2016 Desert AIDS Project will establish a new Community Health department which will maintain and expand the programs and services that the *Get Tested* campaign has instituted.

BROAD AND ACCOUNTABLE COALITION BUILDING

From the beginning, *Get Tested* has been growing its coalition, which, as of early 2016, consists of over 96 community partners. The broad coalition includes local organizations, major regional hospitals, health clinics, medical practitioners, pharmacies, foundations, businesses, faith-based organizations, local government, elected officials and community leaders. Examples include The Salvation Army, city senior centers, Safe Schools Desert Cities, Shelter from the Storm (a shelter for victims of domestic violence), Equality California, GayDesertGuide.com, Hard Rock Hotel Palm Springs and the Center for Employment Training. Each community partner is asked to complete a **Partnership Pledge Form**, which asks them to commit to certain strategies in the following categories: endorsement, expertise, education or implementation. This form aims to create accountability among partners, and *Get Tested* staff regularly check in to learn how they are following through with their pledge form.

The *Get Tested* team also published a **Quick Start Guide** to encourage senior clinic leadership and clinic personnel to take concrete steps to make HIV testing a routine standard of care for all patients at their clinics.

Get Tested has also developed a unique public-private partnership with Walgreens. *Get Tested* counselors provide free and confidential testing at seven Walgreen stores. This helps reduce the stigma of HIV testing by making it more mainstream and allows people to get tested without having to go to a clinical setting.

According to the Project Director, a best practice they are applying is connecting to higher-level leadership to cultivate effective partnerships. This is especially important in the clinical setting, where it is difficult to make systems changes from the bottom-up. Borrowing strategies from the business world, the Director starts at the top. She said, "If you can get the CEO or the senior leadership buy-in, then the rest of the staff will buy in. So we go to the leadership team." One example of this is when *Get Tested* reached out to senior clinic leadership at Desert Oasis Healthcare, a clinical group in the Coachella Valley with over 100 primary care physicians. Rather than calling on an individual doctor or office, the *Get Tested* team first approached Desert Oasis Healthcare's Vice President of Operations, who brought the campaign to the attention of the Medical Director of all clinics.

After securing buy-in at the senior level, the *Get Tested* team made its first presentation at the clinics with full-time physicians, and *Get Tested* is now rolling out the program at clinics where Desert Oasis Healthcare physicians are contractors.

UNDERSTANDING STAKEHOLDERS AND COMMUNITY MEMBERS TO INFORM CAMPAIGN

To understand local attitudes, behaviors and knowledge related to HIV testing, *Get Tested* partnered with Health Assessment and Research for Communities (HARC) to develop a survey for community members and physicians. HARC then worked with local students from the Future Physician Leaders (FPL) program, founded by Representative Raul Ruiz, MD, to distribute the survey. Almost 1,000 people between 12 and 93 years old were surveyed from nine cities. Over half of the participants were Hispanic, and over half were from households with annual incomes below $25,000. The results of the community survey will guide the campaign to overcome barriers and encourage people to be tested. Fifty physicians in the Coachella Valley completed the physician survey, which asks about patients' characteristics, physicians' perspectives and suggestions, and training, attitudes, barriers and opportunities around HIV Testing. HARC also wrote reports describing the survey results (see Tools), which inform *Get Tested*'s strategies and campaign.

INCREASING ACCESS TO TESTING

Get Tested employs different strategies to increase access to HIV testing. These strategies include cultivating partnerships, encouraging healthcare organizations to increase their testing capacity and outreach and establishing new places for community members to get tested. By cultivating relationships with a wider network of healthcare providers, *Get Tested* has increased patient access to testing in clinical settings. By partnering with Walgreens and a variety of community service organizations, *Get Tested* has also increased access to testing in nonclinical health and consumer settings. And with its mobile testing unit, the initiative has increased access to testing in public and community spaces.

Outcome

DATA COLLECTION AND EVALUATION

Counting the number of HIV tests actually conducted in the Coachella Valley is challenging because so many medical providers are involved, and not all can devote the necessary time and resources to accessing and reporting this information. Rather than requesting data from each individual provider, *Get Tested* has reached out to the smaller subset of organizations that process HIV tests, like LabCorp, the laboratory service provider that processes HIV tests for many Coachella Valley medical providers. In addition to LabCorp, *Get Tested* receives statistics from Desert Regional Medical Center, Desert AIDS Project, Eisenhower Medical Center, Planned Parenthood of the Pacific Southwest and the Riverside County Department of Public Health.

After 2016, *Get Tested* plans to conduct a follow-up community survey which will reassess the percentage of members of the public who report they have been tested for HIV and the factors that inspired them to take action. Thus far, emerging lessons based on surveys and the team's experience have revealed that people are more likely to get tested when the opportunity is directly presented to them and they are invited or offered to take the test, especially by a healthcare provider.

RESULTS

Get Tested Campaign at the Midpoint is a report on the campaign's highlights 18 months into the campaign:

- 40 percent increase in the overall average number of HIV tests reported per month for the first six months of 2015 as compared to the monthly average in 2014, the first year of the campaign.
- The number of free community test sites has increased by 79 percent. This includes a 92 percent increase in public sites and a 71 percent increase in private sites like drug rehabilitation centers.
- 89.9 percent of newly-diagnosed HIV positive patients are linked to care, higher than the CDC target goal of 80 percent and of the the national rate (80 percent) and state rate (52 percent).

The campaign continues to expand and make deeper impacts on the community's health. By developing a media campaign, establishing testing sites at non-clinical centers and partnering with community organizations and leaders, *Get Tested* is making community-level environmental changes and shifting the region's culture around HIV testing.

Tools

- **Get Tested Coachella Valley Partnership Pledge Form**
- **Community Survey Report 2014**
- **Physician Survey Report 2015**

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DORCHESTER, MASSACHUSETTS

CLINICAL-COMMUNITY COLLABORATION CASE EXAMPLES

Codman Square Health Center

BEST PRACTICES

Innovative Leadership

Health Center as Advocate

ISSUE FOCUS

Poverty

Low Educational Attainment

Background

Codman Square Health Center in downtown Dorchester, MA, exemplifies how a health center can build and advocate for a healthy community. Established in 1979 by William J. Walczak and a local civic organization, the health center began with a two-physician staff in the basement of an old library and a goal to revitalize the community and its commercial district.

The health center, now the largest employer in Central Dorchester, has grown to over 280 multilingual and multicultural employees, most of whom live in the community. This Federally Qualified Health Center, designated as a level-3 Patient-Centered Medical Home, is a community-based, outpatient health care and multi-service center. Serving over 23,000 patients, 87 percent of whom live 200 percent below the federal poverty level, the health center prides itself on valuing the patient, the community, the staff, advocacy, innovation and partnerships.

Community Challenge

Residents of Dorchester, the largest and most diverse neighborhood in Boston, face poverty and chronic diseases such as obesity, heart disease and asthma. They also struggle with an underperforming education system: while 86 percent of residents in Boston have graduated from high school, only 58 percent of Dorchester's residents have. Approximately 42 percent of children in Dorchester live in low-income households, and despite above-average obesity rates, 30 percent of schools in Boston lack physical education programs.

> **Addressing social determinants of health has always been a mission of the Codman Square Health Center. The health center's core belief that the health of individuals, families and the community are inextricably linked is tangible in its programs, services and community-level advocacy.**

ACTIVE LIVING BY DESIGN
Catalyst for a culture of health

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Solution

INNOVATIVE LEADERSHIP

Addressing social determinants of health has always been a mission of the Codman Square Health Center. The health center's core belief that the health of individuals, families and the community are inextricably linked is tangible in its programs, services and community-level advocacy. In an inspiring **interview with New Prosperity**, founder Bill Walczak said,

> *"The way success is defined by Codman Square Health Center is much different than it is defined by other organizations. Most health centers across the country . . . would define success as seeing X number of patients and providing some kind of quality of service that's measurable. Codman Square Health Center defines its success as . . . making an impact in the community, making a difference and creating more opportunity for people."*

The health center takes its core mission to heart and has established systems to address community-level needs that impact health. Among residents and organizations, the health center has become an institution that advocates for the community's needs and changes the environment to support healthy living.

> **"The health center takes its core mission to heart and has established systems to address community-level needs that impact health."**

STRATEGIES

In 1982, the clinic co-developed an old building into housing for the community. As more nonprofits established themselves in Codman Square in the 1980s, the clinic formed partnerships with nonprofits and community members to create the Codman Square Action Agenda, which created initiatives to benefit the neighborhood.

After the community called for more local healthy food options, the health center helped to start two farmers' markets, including the **Codman Square Farmers' Market**, from which it runs a fruits- and vegetable-prescription program. To promote healthier living and reduce chronic illnesses attributed to unhealthy diets, doctors participate in the Veggie Prescription Program and provide patients with vouchers that they can use to buy fruits and vegetables at the Farmers' Market each week.

> **The clinic formed partnerships with nonprofits and community members to create initiatives that would benefit the neighborhood.**

In 2008, through a partnership with **Healthworks Community Fitness**, the health center built a **fitness center** for women and children. The fitness center, which offers free childcare, is made affordable with a sliding-fee-scale for as little as $10 per month, and many of the 1,000 members receive a free three-month "prescription" from the health center physicians. The health center partners with a variety of community organizations to provide financial health courses, a food pantry and a civic engagement program to cultivate leaders among community members. In addition, the Codman Square Health Center has calculated that it attracts 15,000 people to the Codman Square merchant district every month, contributing to the vitality and economic strength of the neighborhood center.

HEALTH CENTER AS ADVOCATE

The most impressive and large-scale change the health center has made for the community is through improving its education system. Recognizing the correlation between health and education and identifying a need for a stronger college preparatory system in order to stop the local cycles of poverty, Codman Square Health Center worked with leaders of a developing charter school to create a partnership between the two organizations. In a recent **interview by the Boston Globe**, Bill Walczak explained, "Providing health care wasn't transforming the community. If we really wanted to make more of a difference in this community, we needed to get into education."

> **"Providing health care wasn't transforming the community. If we really wanted to make more of a difference in this community, we needed to get into education."**

The **Codman Academy Charter Public School** opened within the health center in 2001 and serves 145 students from grades 9-12. In 2013, the school expanded to serve 345 students from grades K-12. The building is the country's first co-located health and education partnership, offering a potential model for other communities to emulate. The school's goal is for every student to not only graduate from high school, but to also graduate from college.

In pursuit of that goal, the health center coordinates with the charter school through a variety of shared spaces and programs, including teaching gardens, a teaching kitchen, a two-week internship and health services for every student. Through this partnership, the health center and charter school created a position for a nurse to spend half the time at the clinic and half at the school; the clinic provides clinical supervision to the nurse as well as the school's social worker.

The partnership also established a joint Wellness Council that organizes health related programs across both organizations. In addition, the health center is partnering with nonprofit organizations to develop the **Clemente Course in the Humanities**, which offers a free college-level course load to low-income adults living in the local area. For seven months, participants can take classes that qualify for college credits.

Outcomes

As of 2014, Codman Academy Charter School has reported great success based on limited data collection capacities, suggesting positive changes for the larger Dorchester community. Differentiating itself from other Boston schools, Codman Academy offers physical education, and 100 percent of its students participate in athletic and wellness classes every term for all four years of high school. Students had a 97 percent attendance rate during the 2012-13 school year. One hundred percent of graduating seniors are accepted to college and 68 percent of graduates have graduated from or are enrolled in college. Across Massachusetts, the school's Student Growth Percentile (SGP) was ranked fourth in Math and one of the top three highest in English Language Arts.

This indicates a remarkable improvement in students' academic progress compared to other students statewide with similar scores in previous years. Besides these outcomes, the partnership has taken steps to gather more measures: through collaborative discussions, the partnership has established goals and indicators of outcomes to measure success which are listed in the **Codman² Blueprint Report**.

Another recent sign of the success of Codman Square Health Center and the Codman Academy Charter School is that this partnership has become a model for other schools. Mark Zuckerberg, founder of Facebook, and his wife, Priscilla Chan, are preparing to open a charter school inspired by Codman Academy. After Chan served part of her rotation as a pediatric physician at Codman, she was motivated and impressed by how the partnership addressed the impact that education and poverty have on health outcomes.

Learn More:

- The founder's **Ted Talk** on what it takes to form a health clinic that addresses community health

- Best practices in forming and sustaining the charter school from the **Codman²: A Blueprint for Health and Education Partnerships**

- The Clemente Course in the Humanities **video**

- The history of Codman Square and the health center's role as an advocate in ***Codman Square: History, Turmoil, Revival: Factors which lead to Racial and Ethnic Placement, Racial Segregation, Racial Transition, and Stable Integration*** by William J. Walczak

Hermosa Vida at North Country HealthCare

BEST PRACTICES

Addressing Community Conditions

Community Engagement & Leadership Development

ISSUE FOCUS

Displacement of Low Income Residents

Health Impact Assessment

Background

North Country HealthCare is a Federally Qualified Health Center in Flagstaff, AZ, serving fourteen communities in northern Arizona. In 2010, North Country received a grant from the **Kresge Foundation** to create a program called **Hermosa Vida** that works upstream to improve the community's health outcomes. Hermosa Vida does this by reducing barriers and increasing access to resources that allow people to live healthy lives. Hermosa Vida later received funding from the Centers for Disease Control and Prevention's **Racial and Ethnic Approaches to Community Health** (REACH) **Su Comunidad program**, which works to advance health equity in Hispanic and Latino communities.

Hermosa Vida is located within and managed by North Country HealthCare and engages community members to address social determinants of health on the individual, family, community and policy levels. Its staff consists of a program coordinator, a community organizer and a community health worker (CHW), who are sponsored by North Country HealthCare to be trained by the renowned **Industrial Area Foundation**. North Country values its clinical and non-clinical staff's cultural competency skills. According to the CHW, the organization promotes "the use of strategies that will help address social determinants of health such as meaningful patient engagement." This type of prioritization strengthens the clinic's ability to support community-driven, upstream, preventive health work.

Various local organizations partner with Hermosa Vida, including the Sunnyside Neighborhood Association, Northern Arizona University's department of Anthropology and Interdisciplinary Health Research Institute, Flagstaff Unified School District, the City of Flagstaff Recreation Department, Flagstaff Community Supported Agriculture, Northern Arizona Interfaith Council and Coconino Coalition for Children and Youth.

American Community Survey 2008-2013	Arrowhead Village Census Tract	Coconino County
Population	6,714	134,795
White Alone	68%	62%
Latino/Hispanic	30%	14%
American Indian & Alaskan Native Alone	8%	27%
Persons Living in Poverty	37%	23%
Persons Living in Mobile Home	22%	16%
Median Household Income	$33,224	$49,555
Renter-Occupied Housing Units	69%	40%
Median Gross Rent as a % of Household Income	49%	33%

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Community Challenge

ADDRESSING COMMUNITY CONDITIONS

In 2013, Hermosa Vida's community organizers began working in Flagstaff's Arrowhead Village Mobile Home Park within La Plaza Vieja neighborhood to address environmental conditions that were impacting health and quality of life. Around 80 percent of Arrowhead Village residents are patients at North Country HealthCare, and most residents live in poverty. When the Hermosa Vida team began working with the neighborhood, they initially intended to focus on access to healthy foods and safe spaces for physical activity. However, understanding that community health decisions needed to be informed by the community members' needs, the CHW went door-to-door to discuss personal and community-level barriers to health. After talking directly with many residents, the CHW realized that the residents' main concern was not access to physical activity or healthy eating, but rather a serious housing issue they faced.

> **After talking directly with many residents, the CHW realized that the residents' main concern was not access to physical activity or healthy eating, but rather a serious housing issue they faced.**

Residents of the 56 mobile homes in Arrowhead Village own their homes. However, they rent the land on which those homes sit. Landmark Properties, a real estate and developing company, had recently proposed to develop a mixed-use, five-story building for luxury-student housing and retail development. This development, called "The Standard," would have displaced more than 100 residents from Arrowhead Village. The developer would have given each displaced family $3,500 to move, but that would not have been enough to compensate for the immense financial implications of dislocation. While the families lived in "mobile" homes, most could not afford to move their homes or rent a new one. Many of the homes were also too old to be relocated due to Arizona state statutes that prohibit the relocation of older mobile homes that have not been modernized to meet current state standards. Given these restrictions and the limited affordable housing options in Flagstaff, the community desperately needed help to prevent being dislocated and subsequently falling deeper into poverty.

Solution

EXPANDING THE CLINIC'S FOCUS

After learning about the role of affordable housing as a social determinant of health, Hermosa Vida's staff promptly began working with Arrowhead Village residents to increase awareness around the new development and the looming displacement. In order for The Standard to be developed, City Council and the Planning and Zoning Commission would need to approve of a zoning change. The time between the zoning change proposal and the city's decision gave Hermosa Vida an opportunity to help Arrowhead Village residents learn how to meaningfully voice their concerns and engage others around the development. Internally, North Country Healthcare had to justify working on this project because they were focusing on housing (which some interpreted as a topic seemingly unrelated to health) and were about to engage in a publically controversial issue that would result in publicity and unwanted attention.

RESIDENT ENGAGEMENT & LEADERSHIP DEVELOPMENT

During the next few months, the Hermosa Vida Community Organizer and CHW began to plan and take action. They partnered with the Arrowhead Village residents, the La Plaza Vieja Neighborhood Association and other community members to publicize the controversy by sharing stories with the media and attending public meetings. By meeting with local officials and City staff, the partners learned about their options and the decision-making processes involved with zoning and development approval.

> **The partners learned about their options and the decision-making processes involved with zoning and development approval.**

Around this time, the Hermosa Vida team attended a healthy communities conference and learned about Health Impact Assessments (HIAs), which identify potential health effects of proposed policies, regulations, projects and programs. The health effects an HIA considers tend to be broad and include social, economic and environmental factors. With full support from North Country HealthCare, the Hermosa Vida team decided to conduct an HIA as a tool to defend Arrowhead Village residents and stop the development. In a few months, the Planning and Zoning Commission and City Council would decide to approve or reject the development. Given Hermosa Vida's limited time and resources, the CHW, Community Organizer and an independent health impact assessment consultant began to conduct a *rapid* HIA that would provide unbiased, evidence-based research to determine the health impacts of the development.

The HIA process helped further foster and supplement community engagement, education and leadership already occurring. Hermosa Vida and stakeholders met to discuss the planning of the HIA, which included scheduling, interpreting Spanish and English materials and aligning the differing goals of La Plaza Vieja Neighborhood Association and Arrowhead Village residents. Stakeholders learned the process of organizing as a united community, voiced their feelings and concerns regarding displacement and developed effective communication skills to defend their stance.

Through this process, it became clear that participants' concerns, whether they involved physical displacement or a loss of social cohesion, were all associated with health. The Hermosa Vida team also met with community members, researchers and city staff members to prepare for public meetings related to the City Council's final decision. In order to better represent residents' concerns, Hermosa Vida trained resident leaders to testify in front of the Planning and Zoning Commission on behalf of their community.

It was essential for Hermosa Vida to not only conduct an accurate and meaningful HIA, but also to use the HIA effectively and ensure that it would be acknowledged by the City and inform its ultimate decision. The HIA's recommendations were incorporated in the City's Planning and Zoning packet that covered the Standard development. During the hearing in June 2014, dozens of speakers defended the Arrowhead Village residents, citing the HIA's findings.

Outcomes

The Planning and Zoning Commission voted against the proposed Standard development, and weeks later the developer withdrew its proposal. This was quite an accomplishment in a city that rarely rejects development projects. The publicity and dialogue surrounding Arrowhead Village had long-term implications for the public sector: affordable housing and displacement are now pressing issues that the city's planning department is addressing. On a community- and policy-level, there is an understanding and a recognition that affordable housing is directly associated with health. The new 2015 **La Plaza Vieja Neighborhood Plan**'s policies and goals are highly informed by the feedback and comments from The Standard rezoning case. Largely due to this case, the plan promotes new affordable housing to replace the mobile home village, taking into account safety and temporary and permanent relocation costs. The plan explicitly discusses the Arrowhead Village Mobile Home Park, recognizing the social and land-use challenges involved with the property. Planners are now teaming up with developers to address displacement in Flagstaff, and the city even considered a relocation ordinance soon after the case ended. The CHW has heard by word of mouth that developers view this case as a lesson on community-engagement.

The community now knows how to organize around important causes. According to the Hermosa Vida's main CHW, "Something that helped to change the course of this story was meaningful civic engagement through capacity building. Many of these residents learned how to advocate for themselves and others, and that is easily transferrable to other issues that may come up. They now have skills that can potentially help ensure they are at the table for issues that affect them directly." This shows how Hermosa Vida's community engagement is a long-term investment with the potential to improve social determinants of health within the community.

Due to Hermosa Vida's success, the program is currently involved with many community-based changes to promote CHWs and even expanding their own efforts. They are participating in statewide efforts to recognize and sustain the **Arizona Community Health Worker Workforce**. The success of Hermosa Vida's CHW's efforts to address social determinants of health is generating demand for more staff to work on these issues. For example, North Country HealthCare recently received funding to hire more CHWs. Hermosa Vida is also helping to form a new statewide coalition of former REACH grantees that will identify and secure funding to sustain present and future local strategies.

Tools

- **A Model for Evaluating the Activities of a Coalition-Based Policy Action Group: The Case of Hermosa Vida**
  Hardy, L. J., Wertheim, P., Bohan, K., Quezada, J. C., & Henley, E. (2013). A Model for Evaluating the Activities of a Coalition-Based Policy Action Group: The Case of Hermosa Vida. Health Promotion Practice, 14(4), 514–523. http://doi.org/10.1177/1524839912461253
- **Defying Displacement: Organizing for a Beautiful Life in Flagstaff, Arizona**
  Hardy, L. J., Wertheim, P., Bohan, K., Quezada, J. C., & Henley, E. (2013). A Model for Evaluating the Activities of a Coalition-Based Policy Action Group: The Case of Hermosa Vida. Health Promotion Practice, 14(4), 514–523. http://doi.org/10.1177/1524839912461253
- **The Role of Community Health Centers in Health Impact Assessments: One organizer's account of a HIA's impact on her community** by Michelle Thomas
- **A Beautiful Life – Hermosa Vida – Rapid Assessment, Response and Evaluation (RARE): Results and Implementation 2012**

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SOUTH BRONX, NEW YORK

CLINICAL-COMMUNITY COLLABORATION CASE EXAMPLES

Claremont Healthy Village Initiative

BEST PRACTICES

Process Evaluation

Community Engagement

Aligning Stakeholders' Missions and Goals

ISSUE FOCUS

Crime and Poverty

Diabetes

Background

Claremont Village is an enormous **New York City Housing Authority** (NYCHA) public housing development in the South Bronx and home to over 13,000 residents. The Village consists of a group of NYCHA buildings, a few of which are near to or house community resources managed through **Claremont Neighborhood Centers**. There are two community centers, one senior center, a day care center, a Child Health Clinic and several resident associations.

Demographics	Neighborhood	NYC
Population	13,000	8,405,83
African American	39%	26%
Latino/Hispanic	41%	29%
Persons below poverty level	41%	20%
Median income	$23,452	$52,259
SNAP/EBT recipient	51%	21%
Health Stats	**Neighborhood**	**NYC**
Obese	27%	20%
Diabetes	16%	9%
Does not exercise	54%	43%

Community Challenge

As outlined in the table, Claremont Village and its surrounding neighborhood suffer from immense poverty and poor health outcomes like obesity and diabetes. In addition, Claremont Village has low availability of and access to healthy foods. Unhealthy environmental conditions like poor sanitation, crime and overcrowding are pervasive.

Solution

INITIAL COLLABORATION

In the fall of 2011, the **American Diabetes Association** (ADA) and Bronx-Lebanon's **Department of Family Medicine** (BLFM) partnered to reduce the high rate of diabetes in Claremont. Through interactions with patients and community members, the partnership was well aware of the problems, which were confirmed by long-term trends identified by the city's Health Department. In addition to partnering with community organizations, ADA and BLFM jointly developed an intervention program to target people with the highest risk of developing health complications from type 2 diabetes. Within a few months, program staff members were talking and partnering with experts at the Mailman School of Public Health at Columbia University and the **Community Health Worker (CHW) Network of NYC**.

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By January 2012, Bronx-Lebanon Hospital Center, where approximately a third of the Claremont residents are patients, joined ADA and NYCHA's partnership to improve the health outcomes of residents in the Village. BLFM provided health records data on the community and advocated for improvements through relationships with its patients and the community.

The growing partnership met with NYCHA resident representatives to connect to community leaders and members. The Leon Lowenstein Foundation awarded ADA a grant to implement a CHW program within Claremont Village, where they recruited two community members to become CHWs. Of the two, one successfully completed the training and went on to engage, recruit and educate community members. Meanwhile, BLFM hired a project-designated CHW to conduct training and outreach to the community as well as to Bronx-Lebanon patients, with responsibilities including health education, care coordination and the recruitment of clinical program participants.

HealthFirst, an HMO that covers 11 percent of Claremont Village's residents, joined the partnership between ADA, NYCHA and the Bronx-Lebanon Hospital Center in May 2012. Representatives from each organization committed to a three-year initiative called **Claremont Healthy Village Initiative** (CHVI). CHVI aims to improve the health of the community at Claremont Village and is the first phase of a continuous, iterative project.

During phase one, CHVI partners met on a bi-monthly basis to share information, build relationships with one another and develop goals. The main goal was to "create a comprehensive, multi-disciplinary, coordinated program that would engage residents in creating and maintaining a healthy lifestyle" through a "four-pronged approach: medical wellness, physical wellness, nutritional wellness and social wellness."

DEVELOPING PROGRAMS

To achieve this main goal, the CHVI partners organized many services and types of programming for the community including:

- **Physical Activity:** weekly fitness classes, zumba workouts, Bronx Run
- **Youth Engagement:** self-esteem and fencing program for girls, midnight basketball league
- **Diet and Nutrition:** nutrition sessions, food box distribution (GrowNYC)
- **Health and Wellness:** health screenings, diabetes management training, walking clubs
- **Community Engagement:** gun-violence-in-our-community forum, immigration seminar, career day, teaching garden/plant day, Community Council meeting

PROCESS EVALUATION

In September 2013, **Fordham University's Center for Community-Engaged Research** conducted an evaluation (see Evaluation of the Claremont Housing Healthy Village Partnership under Tools) that outlined successes and challenges of the initiative as well as recommendations for future programming. The evaluation team collected data through many sources, including site visits with key informants, focus groups and observations of staff, stakeholders and partnering organizations. Below are recommendations from the evaluation:

- Improve strategic planning through ongoing refinement of goals, commitments and roles.
- Foster cohesion, positive group dynamics and shared goals among partnership.
- Formalize processes: logic models, bylaws, goal development and timeline.
- Increase collective impact—leaders have their own agendas. One united agenda is necessary.
- Create a Community Advisory Board, which is a distinct board of community member representatives.
- Plan for long-term sustainability:
  - Foster skills and partnerships in grant writing, data analysis, and data dissemination to develop a sustainable, long-term plan.
  - Enrich partnership by cultivating relationships with more community organizations.
  - Develop a resource center to help other groups implement this model.
  - Create a plan to engage policymakers, funders and media outlets.
- Implement a strategy to collect concrete feedback from community.
- Build trust and respect within the community.

- In terms of marketing, develop and maintain a web-portal allowing the community to access information. Create physical hubs where information can be accessed and shared.
- Procure a care management software package and employ at least one person to manage it.

Outcomes

COMMUNITY ENGAGEMENT

In May 2014, Bronx-Lebanon Hospital Center's Department of Family Medicine assigned an existing employee, Maria Murphy, as the Healthy Village Coordinator to lead the project. The Coordinator had previously worked as a CHW for the Department and was already connected to community members and aware of their personal barriers and environmental challenges. Fordham University's "Evaluation of the Claremont Housing Healthy Village Partnership" is helping the Coordinator to prioritize process and program development, demonstrating the importance of process evaluation throughout the implementation of a program or model. The Evaluation recommended more engagement and trust-building within the community. As a result, Claremont Healthy Village Initiative (CHVI) developed a Community Advisory Board in which Claremont Village's community leaders provide feedback and offer a representative voice.

As Maria, the Coordinator, said in an interview in March 2015, "we need the community at the table because we can't just have professionals around the table and think we know the best." She is creating new opportunities to involve the community and engage them in activities that improve their environment and health. For instance, the third Friday of every month is now a time to clean up the neighborhood as part of the new Community Beautification Project. Community members attend, clean up and provide feedback so that the Bronx-Lebanon team can address program gaps.

> **"We need the community at the table because we can't just have professionals around the table and think we know the best."**

The Coordinator is also increasing community engagement by cultivating new relationships with community resources and organizations; for example, Community School 55 is now partnering with CHVI to help engage youth. Similarly, knowing that the West African population of Claremont Village is increasing, the Coordinator reached out to the local Community Board, which connected her to local faith-based organizations serving this population so she could engage them in these efforts.

ALIGNING STAKEHOLDERS' MISSIONS AND GOALS

Fordham University's Evaluation also recommended formalizing the leadership meetings and developing more structured decision-making and strategy processes. The Coordinator has also developed five sub-committees that include community members and leaders, and representatives from local community boards, community organizations, civic groups and city agencies. These groups will develop priorities and an action plan, identify partners and resources needed to implement and sustain the plan and then record outcomes. These five sub-committees ensure that CHVI is building capacity and programming in areas imperative to its success: community engagement and public relations; data collection and management; youth engagement and leadership;

program sustainability planning; and environmental change and beautification. As the sub-committee list reveals, the future of this program relies on:

a) changes to data inquiry, collection, management, and sharing;
b) community engagement and leadership;
c) sustainability; and
d) environmental factors including the built environment and social determinants of health.

In January 2015, the Claremont Neighborhood Center was awarded $45,000 from the **New York Community Trust's South Bronx Healthy and Livable Neighborhoods Initiative** to plan a comprehensive neighborhood health improvement program. Bronx-Lebanon Hospital Center is a sub-awardee of the grant. During the planning period of this grant, the CHVI partners met monthly, reviewing their process and recognizing the nature of this project as iterative, requiring commitment and persistence. Through working with community members and peer organizations, reviewing existing programs and looking closely at local data, the partners became more actively engaged in the decision-making process and developed a powerful vision statement together:

The Claremont Healthy Village Initiative envisions a Claremont Village of empowered residents who, both as individuals and collectively, have the motivation, information and resources needed to take charge of their own health and wellbeing while also building a vibrant, nurturing and sustainable community.

The first step toward this vision was identifying three main strategies:

1) youth engagement and advocacy,
2) active and creative placemaking, and
3) nutrition and food access.

Bronx-Lebanon is working hard to expand, solidify and institutionalize processes and programs in CHVI. The program coordinator, Maria, is cultivating relationships, building and strengthening committees and developing programing. She is including community leaders in CHVI activities so that they can be trained and lead workshops in the future, and the project leaders attend training events to develop mutual goals and break down siloes within the group. Her work is leading to stronger organization between partners and collective action among the partnership's leaders.

PARTNERSHIPS

The CHVI program continues to cultivate new relationships and enhance its partnerships. Here is a list of some of them, in addition to American Diabetes Association (ADA) which withdrew its participation in 2015, HealthFirst, and New York City Housing Authority (NYCHA):

- William Hodson Senior Center
- **Community Partnership for Health Equity** through **MEDICC** (funded a health education exchange trip for hospital staff to visit Cuba)
- **Butler Houses Community Center**
- **Partnerships for Parks**
- **NYCHA Tenant Association**
- **Grow NYC**
- **Bronx Documentary Center** (which along with teens created a fantastic short film)
- **MAPSCorps**
- **Mayor De Blasio's Community Parks Initiative**
- **Bronx District Public Health Office**

DATA COLLECTION

While the hospital already has capacity to collect data on its patients, it is increasing its data collection abilities and sharing this capacity. In June 2015, the CHVI Coordinator began to work with a public health graduate student from Columbia University to utilize data from NYCHA and the Department on Health in order to write a Community Needs Assessment.

The CHVI Coordinator is also working with NYCHA leadership to exchange more information about residents so that activities can be informed by community-wide data and adapted to community-wide needs. In 2015, the CHVI partnership worked with public health graduate students to write a Community Needs Assessment Report that identified social determinants of health that are particularly impactful in the Claremont neighborhood. When asked to choose a major problem in the neighborhood, the community reported crime as number one, followed by employment, cleanliness of the environment, food access, access to healthcare and physical inactivity. The community's self-reported needs align with the program's mission and functions.

SUSTAINABILITY:

As Bronx-Lebanon delves into the second phase of CHVI, it is excited to make lasting changes to the community's environment and health behavior in order to improve health outcomes. Partnerships continue to develop and grow, pushing the movement forward with committed groups and goals appropriate to the community's needs. The idea that health disparities can be reduced to improve community health is contagious; the Healthy Village model is already being replicated by HealthFirst and local hospitals in impoverished parts of Brooklyn, like Brownsville. The environmental changes, cultivation of relationships and continuous capacity building ultimately strengthened the sustainability of this project.

> **The leadership of Bronx Lebanon's Department of Family Medicine has been innovative and supportive, improving sustainability.**

The leaders of the Department of Family Medicine recognize that it is necessary for their staff to integrate into the community in order to make long-term changes to quality of life, not simply taking fast action for quick results. They have been patient and committed to cultivating longstanding relationships with the community. In addition, leaders have recognized the importance of supplementing administrative and back-office support as the program evolves and builds.

To further ensure sustainability, the Program Developer at Bronx Lebanon's Department of Family Medicine is applying for funding and developing a business plan. New opportunities are developing: the Robert Wood Johnson Foundation is supporting the Bronx Community Partnership for Health Equity's "Building Capacity that Supports Change" to strengthen community leadership, which will help the community advocate for itself and foster community engagement; the Levitt Foundation is funding "Food Justice For All" to build Claremont youth's knowledge and advocacy skills around food systems; and the Fan Fox and Leslie R. Samuels Foundation awarded a 2-year grant to support an integrated mental health program for seniors that connects BLFM to various partners including a behavioral scientist, the William Hodson Senior Center, and **Dances for a Variable Population**. The progress they are making reinforces the concept that real community change is an iterative process and requires reflection, evaluation, team alignment, community engagement, leadership development and a strong-willed commitment.

Tools

- **Fordham University's Evaluation:**
  Edwards T, Olazabal A. Evaluation of the Claremont Housing Healthy Village Partnership. New York: Fordham University, Center for Community-Engaged Research; 2013.
- **Claremont Healthy Village Initiative, Community Needs Assessment Report, Summer 2015**
  - Healthy Village Community Needs Survey

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Yuma District Hospital and Clinics

BEST PRACTICES

Capacity Building

Determining Evaluation Methods and Measures

ISSUE FOCUS

Diabetes, Hypertension and Obesity

Lack of Exercise

Park and Recreational Facility

Background

Yuma, Colorado, is a rural county 125 miles east of Denver, bordering Nebraska and Kansas. Adjacent to Yuma is Washington County, Colorado, a similar rural space with a population of about 4,500 and high rates of chronic illnesses and poverty.

Yuma District Hospital and Clinic (YDHC) is one of two hospitals in the county and opened in 2007. YDHC is a 22-bed **Critical Access Hospital** (a category of ACA-certified Medicaid hospitals that provide cost-base reimbursements) and serves roughly 7,000 people from Yuma and Washington counties. Services offered at YDHC include inpatient care, surgical care, a 24-hour emergency room, diagnostic imaging, a laboratory, rehabilitation services, swing bed care and home health care. There are two provider-based rural health clinics affiliated with YDHC, one of which is located within its main facility.

Demographics	Yuma County	Colorado
Population	10,093	5,119,219
Population Density (persons per square mile)	4.26 (2,368 mi^2)	49.18 (104,185 mi^2)
Non-Hispanic White	78%	70%
Latino/Hispanic	21%	21%
Median income	$44,308	$58,433
Health Stats	**Yuma County**	**Colorado**
Overweight or Obese	80%	59%
Does not exercise	33%	17%

TABLE 1: Yuma County Statistics

Community Challenge

The community faces serious health risks as described in Table 1. Eighty percent of Yuma's population is obese or overweight, and 33 percent does not exercise. According to the Behavioral Risk Factor Surveillance System (2000-2006), obesity and limited access to fruits and vegetables (affecting 89.5 percent of the population) are major risk factors for premature death in the county. Similarly, participation rates in youth sports and recreation activities in Yuma are declining while childhood obesity is increasing.

ACTIVE LIVING BY DESIGN
Catalyst for a culture of health
This resource was developed by Active Living By Design to enrich a learning network with useful material about clinical-community collaboration. For more information, visit activelivingbydesign.org.

Solution

CAPACITY BUILDING

In 2010, YDHC's leadership learned that its patients' overall satisfaction was disappointingly low at 54.3 percent. Around this time, YDHC recognized the opportunity to convert to a Patient-Centered Medical Home (PCMH), thereby improving population health, individual care and lowering costs. The **Colorado Community Health Network** selected YDHC to take part in a five-year demonstration project to successfully adopt the PCMH model.

YDHC now has three provider teams, two patient navigators, and by 2013 had improved its patient satisfaction to 74.4 percent. YDHC now participates in a regional care collaborative organization (RCCO) contract, which is similar to an Accountable Care Organization (ACO) but is part of Colorado's Medicaid Accountable Care Collaborative. The RCCO works to analyze data, maintain consistency among Medicaid providers, increase provider participation and provide support services like housing, food and transportation.

In terms of data collection and inquiry, YDHC is in a special position as a rural hospital. As one of only two hospitals in the county, YDHC can actually ascertain its community's health through the County Health Needs Assessment. In 2009, a Health Needs Assessment identified some of the biggest health problems in Yuma: poverty, obesity, lack of accessibility to healthy foods, lack of physical activity and related chronic diseases. In 2012, YDHC partnered with the **Colorado Rural Health Center** to write another Community Health Needs Assessment, develop a strategy to improve community health and create a presentation to disseminate the information. YDHC is keen on building its capacity to collect and analyze data.

DEVELOPING A PLAN

Beginning in 2012, YDHC's Board of Trustees, led by Polly Vincent and CEO John Gardner, developed a plan to reduce obesity and related chronic illnesses. Their plan revolved around developing a park adjacent to YDHC that would be accessible to the entire community and that would increase physical activity and social cohesion. This was feasible because YDHC owned the land on which its facilities are located as well as the adjacent acres. The idea to make this land into a park was spurred by Gardner's visit to Europe. In Europe, he was inspired by exercise stations in public parks and returned to Yuma with a challenge to Polly and YDHC's board: to make a health park at YDHC.

To determine what the park would look like and to confirm its feasibility, YDHC's CEO and Board partnered with the **Colorado Center for Community Development** at the College of Architecture and Planning within the University of Colorado Denver. They created a preliminary plan for a multigenerational park master plan. The plan was free because it provided the students with practicum work to build their portfolios. Meanwhile, Polly took classes on grant writing, applied for grants and met with foundations to present the plan.

Outcomes

IMPLEMENTATION

In 2013, the Colorado Health Foundation awarded YDHC with $273,365 to create a health park. YDHC leveraged funding through community donations and by cultivating strong partnerships. The Colorado Center for Community Development worked with YDHC to develop a **Final Master Plan for Life Trails at Yuma District Hospital**, and construction began quickly. The **Life Trails Health Park** opened on May 11, 2014.

The Master Plan includes the following features and incorporates their expenses into the budget:

- Walking trails
- Two gathering areas
- Fitness stations with roofs for elderly and active adults

- Fitness stations for all-ages
- Central gathering area: shade-sail, picnic tables and fitness station hub
- Wheelchair accessible throughout including ramp to gathering area
- Picnic tables
- Bike racks
- Walking trails
- Art space
- Trees and shrubs
- Vegetable garden area: raised planters, some wheelchair accessible
- Sustainable features including earthwork, irrigation and drainage

The plans to increase *patient-usage* include:

- Practitioners prescribing weekly fitness routines and walks
- Physical therapists and occupational therapists bringing their patients to the park for therapy
- The nutritionist bringing patients to gardens
- Doctors want an obstacle course to measure children's progress
- Patient-navigators helping patients learn to use machines and answer any questions

The health park is open to the public 24/7 to impact the entire community, not just the patient population. YDHC and the park are located within walking distance of schools, a day care center, churches, stores and residential areas. Also within walking distance is an elderly housing development whose residents often utilize the YDHC's cafeteria for meals. One goal of the park is to increase the pedestrian connectivity to and from these locations.

There is currently solar lighting to allow people to use the park in the evening, but the park's wish list includes more lighting to extend its usability. The plans to increase *community engagement* include:

- Events where residents at the neighboring elderly housing development visit the park
- Events where elderly residents visit at the same time as day-care center visits to create informal "grandparent" relationships
- Elementary school visits with "to do" check-lists to increase physical activity
- Weekly community gatherings for nursing home and assisted living patients

PARTNERSHIPS

Given the rural nature of Yuma, where there are fewer opportunities for partnerships, YDHC has managed to cultivate relationships with local leaders and agencies as well as statewide organizations and national companies. In addition to the partners below, other local organizations plan to be involved in the park and encourage community participation.

- University of Colorado, Denver Architecture Department: Colorado Center for Community Development
- Live Well Colorado will help teach individuals and families how to cook and eat healthily by using the gardens
- Children's Place Structure and NEOS are providing exercise equipment
- Colorado Rural Health Center
- City Manager of the City of Yuma
- Improving Communication and Readmission (iCARE) are developing a statewide health improvement program

DETERMINING MEASURES OF SUCCESS AND EVALUATIVE METHODS

YDHC plans to evaluate the park's success in a few ways. First they have committed to four measurable results created by the Colorado Health Foundation:

1. Increased number of children and adults who engage in moderate or vigorous physical activity.

2. Increased number of children and adults who eat adequate amounts of fruits and vegetables daily.

3. Increased number of under-served Coloradans who have convenient access to recreational exercise and fruits and vegetables.

4. Increased number of Coloradans who are educated about chronic disease management.

While these are short-term evaluative strategies, there are also a number of indicators YDHC will choose to measure in the upcoming year and will decide which types of information are most effective at showing positive health changes. The data in the Electronic Health Record (EHR) system is consistent with the Community Health Needs Assessment, and YDHC will follow these trends, hoping that the park will result in a reduction in morbidity and better maintenance of chronic illnesses. YDHC will also be recording attendance rates and numbers for patient-based and community-based events.

As written in the Master Plan, the goal of the park is "to promote intergenerational use, but especially to provide services to the young, the elderly, the obese and residents suffering from chronic diseases like high blood pressure, stroke and diabetes." The Master Plan also states that the park "will increase the number of underserved citizens in Yuma, Colorado, with access to moderate physical and vigorous exercise not now available." This goal seems achievable and feasible given that practitioners are in direct contact with so many of the community members, and patient navigators are promoting use of the park and follow-up care.

One challenge YDHC is facing is that it is finding it hard to capture data addressing park usage since so much of the activity takes place after business hours. However, to mediate this, thanks to the support of the YDHC Foundation, YDHC signed up to offer the **Weigh and Win Program**. The hope is that that by bringing this program to the park, YDHC will be able to capture more meaningful data that links health outcomes of community members to park utilization.

SUSTAINABILITY AND THE FUTURE

The staff and board have made some systems changes to ensure the sustainability of the park. In this case, systems changes come in the form of staff members integrating the park into their work routines and responsibilities. Having already built capacity by hiring patient navigators and incorporating EHR systems, YDHC was well positioned to make these internal changes.

Goal Attainment and Park Utilization:

- As of August 2015, YDHC's patient navigators have worked hard to encourage monitored patients to use the park. They are also available to assist non-patients who have questions about the fitness equipment.
- YDHC has organized morning and evening walking groups.
- The rehabilitation staff has developed park exercise guides to assist their cardiac and pulmonary rehabilitation patients and to monitor their patients' improvements based on their use of these guides.

Maintenance:

- YDHC's maintenance team is caring for the park as part of its weekly work routine.
- The Board has organized volunteer groups to help with the park maintenance. For instance, one day the tumbleweeds became a physical barrier to the park's visitors, so the Board gathered a group of volunteers and fixed the problem in a day.
- A local gardening group will work with the community and the new garden beds to increase access to healthy food education and healthy food access.
- Local community advocacy and support help make the park sustainable and well maintained. Leadership of YDHC and its Board are supportive and committed to these changes, giving their time and expertise, and connecting to pro-bono work and grants. This front-end work allowed for the park to be built and for the wider community to benefit.

Within the region, the park has become known as a success, pointing to YDHC's future as an inspirational health institution. For instance, a mental health group, Centennial Mental Health Center, in Sterling, Colorado, has already reached out to YDHC to learn more about its process. The Center wants to turn a parking lot, which it shares with a bank, into a small-scale park with the bank as an investor. The Center recognizes

the limitations of medication as treatment and wants to change the built environment to increase physical activity and social engagement. YDHC's willingness to mentor this health center demonstrates an ability to participate in a learning network, which is an important element to clinical projects that address social determinants of health on the community level.

As for the Life Trails Health Park, it is still an ongoing project. The programming development as well as the implementation of fitness equipment is continuous, and the park will eventually include gardens, more fitness equipment and other amenities. In terms of political support, the new City Manager is leveraging the impact of the park by developing plans and securing funding for new bike and walking trails that will connect the health park to other city resources and destinations. YDHC's CEO, John Gardner, is excited to see how the park changes YDHC's relationship with the community and the community's understanding of health.

> **"The value of this park continues to grow. It is a great resource to the community as our members seek healthier lifestyles … I would hope that the park is a disruptor of the traditional patient/healthcare provider relationship where the patient looks to us as a partner and resource for achieving health rather than just someone to reach out too when they are ill." — John Gardner**

Gardner's leadership and support for this project was essential to its development and the speed at which it was implemented. His commitment to the long-term goals exemplifies the attitude and dedication a clinical leader must have for these types of changes. The city is now participating in the **Healthy Eating, Active Living (HEAL) Cities and Towns campaign**, which provides training and technical assistance to help municipalities adopt policies that improve access to physical activity and healthy food in their communities.

As part of this campaign, Yuma City signed **a resolution** in 2014 in which its government recognized the park as an integral part of the overall HEAL program.

> **With the support of the City Manager and the City's additional commitment to healthy living, the park is increasingly becoming a long-term, permanent and sustainable community space.**

The more support the park receives from the City government and other local organizations, the more relevant it will be to the community. Establishing evaluative measures to this iterative process of developing the park and park programming will help ensure the achievement of health goals and strengthen future financial support for the park.

Tools

- **Final Master Plan for Life Trails at Yuma District Hospital**
- **County Health Needs Assessment**
- **Life Trails at Yuma District Hospital**

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