Safety-Net Enhancement Initiative Cross-Site Evaluation:

Final Report

June 30, 2014

THE CENTER FOR MANAGING CHRONIC DISEASE
Putting People at the Center of Solutions

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Background

In January 2011, the Kresge Foundation awarded $6 million to eight public health agencies and community nonprofit organizations to develop demonstration projects to integrate community health and prevention with primary care for vulnerable populations. Each grantee of the Safety-Net Enhancement Initiative (SNEI), which previously received $75,000 for program planning and design under phase one of the initiative, was awarded an additional $750,000 in part-two funding to support work on its proposed demonstration project over the next three years. Since that time, these communities have worked through multi-sector, community-based partnerships that include local public health departments, community-based organizations, and community health centers (CHCs) to design creative approaches to reduce health disparities and improve public health in underserved communities.

In April 2011, the Center for Managing Chronic Disease (CMCD) was contracted to coordinate and conduct a cross-site evaluation of SNEI. The CMCD team has since worked closely with the Kresge Foundation Health Team and representatives from the eight local SNEI sites to collect and analyze data regarding the initiative's process and outcomes. This report presents the findings of the cross-site evaluation.

SNEI Approach

The Kresge Foundation envisioned SNEI as a strategic approach, building on the assets within local communities to identify and develop strategies to address health disparities. In acknowledging the significance of health disparities faced by minority populations in the United States, the Centers for Disease Control set forward to "achieve health equity, eliminate disparities, and improve the health of all groups" as one of the overarching goals for its Healthy People 2020 initiative[1]. It further acknowledged the critical importance that social determinants of health—"the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness"—play in efforts to address poorer health status among vulnerable communities across the country[2].

Through SNEI, eight communities with vulnerable populations were selected to develop and implement demonstration projects to address social determinants of health. By targeting vulnerable populations, SNEI was designed to improve the health and health status of those most in need in order to reduce health disparities and increase health equity. Although varied by population density (i.e., urban, rural, frontier), racial and ethnic composition, and physical

[1] US Department of Health and Human Services. (2014). About Healthy People: Introducing Healthy People 2020. Retrieved from http://healthypeople.gov/2020/about/default.aspx

[2] Centers for Disease Control and Prevention. (2014). Social determinants of health. Retrieved from http://www.cdc.gov/socialdeterminants/

and social environments, each SNEI community presented data to demonstrate that significant health disparities experienced within its community. SNEI communities all established challenges to health, including high rates of poverty and unemployment, poor health outcomes related to diabetes and hypertension, and/or barriers to care including lack of transportation and safety. During a participatory planning process, residents and stakeholders in each community reviewed the community's needs and assets and prioritized a set of health disparities to address through SNEI (See Table 1).

Table 1: SNEI Sites and Health Disparities of Interest

Site/Project	Health Disparity*
Flagstaff, AZ *Hermosa Vida*	childhood overweight & obesity
Oakland, CA *Food to Families*	overweight and obesity among pregnant women and their families; local economic and employment opportunities for young adults
Honolulu, HI *Returning to Our Roots*	social isolation and overall well-being
Boston, MA *Building Vibrant Communities*	hypertension, depression, and stress
Detroit, MI *IMPACT*	diabetes, hypertension, and neighborhood safety
Peñasco, NM *Kids First*	childhood trauma and chronic conditions resulting from adverse childhood events (ACE)
East Cleveland, OH *EC Teen Collaborative*	violence and community connectivity; overall well-being of adolescents
Sheldon Township, SC *Pathways in STEP*	hypertension and related risk factors

**Source: SNEI Sites' Implementation Proposals*

The focus and design in each site uniquely addressed the interests of the community and the local context including the physical and social environment, systems of care (both clinical and social), and the local culture or cultures. Although the selected health disparity of interest was similar across several sites, local models varied significantly to reflect the local context and social determinants of health at play. Throughout the planning and implementation period, SNEI sites were provided significant support and flexibility to develop creative methods through which to address these social disparities. Sites identified barriers to health and healthy living in

their communities and established models to address those barriers. SNEI models addressed a range of barriers, including those related to:

- **Access to care:** e.g., lack of transportation, culturally appropriate care, and affordable services
- **Healthy nutrition:** e.g., access to healthy food, and knowledge and skills for healthy eating
- **Economic development:** e.g., the development of sustainable employment opportunities for residents
- **Violence:** e.g., safe places to exercise, garden, and receive care and services
- **Social cohesion:** e.g., building community and connection among community residents, and between residents and the services available

SNEI stakeholders, including members of the Kresge Foundation Health Team and local site leadership, understood that improving health disparities is a long-term endeavor and that addressing the social determinants of health is a first step. As this report will demonstrate, SNEI sites designed promising models to address these social determinants of health and change the way systems and structures work to support these efforts. Perhaps as importantly, SNEI sites built critical community capacities to address social determinants of health, including changes to both individual and organizational approaches to health, and implemented changes to organizational policies and systems that lay a foundation for sustainable change.

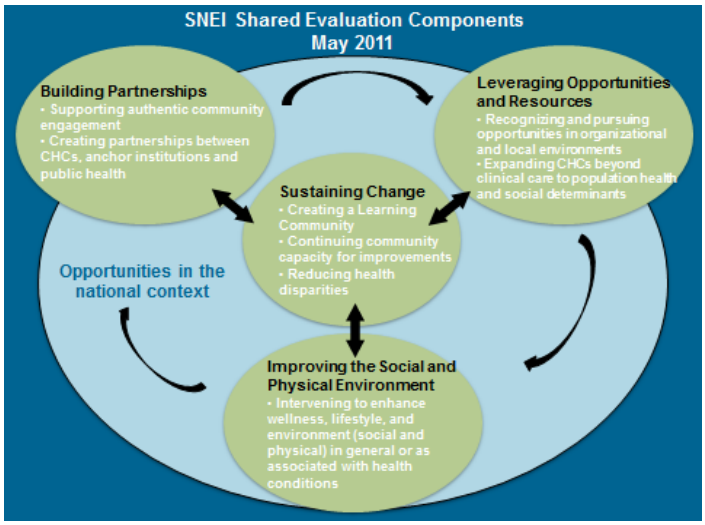
Cross-Site Evaluation

Development of the Evaluation

At an initial meeting with the Kresge Foundation Health Team, the CMCD team worked closely with Foundation staff to document the critical elements of the initiative (Figure 1):

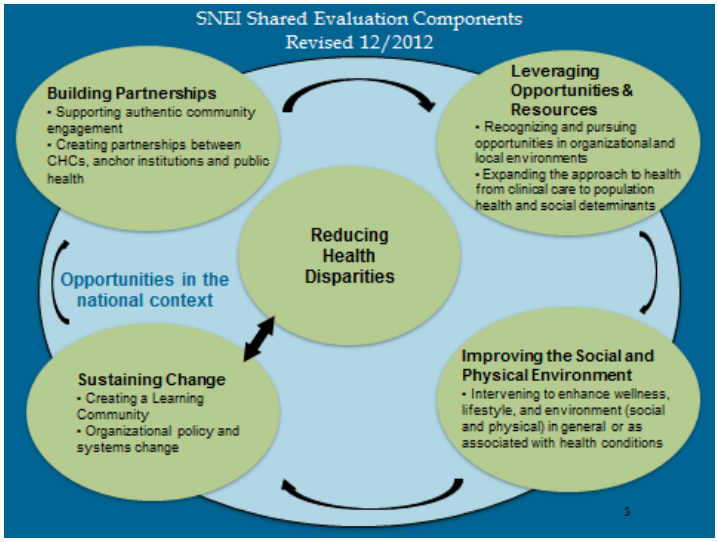
- *Building Partnerships* among CHCs, anchor institutions, local public health departments, and community organizations;
- *Leveraging Opportunities* and Resources to expand the approach to health;
- *Improving the Social and Physical Environment* through demonstration projects; and
- *Sustaining Change* through a learning community that would reduce health disparities.

Figure 1: SNEI Evaluation Components - 2011



From the outset it was acknowledged that while reduction of disparities in health outcomes would be unlikely within the brief time period of this initiative, it was agreed that the models developed within the sites should demonstrate movement in the right direction. The evaluation team therefore worked collaboratively with the sites to develop data collection tools and efforts to measure the process and outcome of changes within the SNEI communities.

Figure 2: SNEI Evaluation Components, Revised - 2012



Over time, as the initiative evolved, certain key areas remained central to the initiative, while new concepts and themes emerged (Figure 2). Rather than simply focusing on partnerships, questions arose regarding the **quality** of partnerships and **contributions** of key partners. Changes to **organizational policy and systems change** arose as an important element of sustaining

change. And **increased connections,** among organizations and residents, as a strategy to improve health and reduce health outcomes, became a key objective of many sites. As these changes evolved, the evaluation also evolved in order to capture both the process and outcomes of the SNEI initiative.

Process

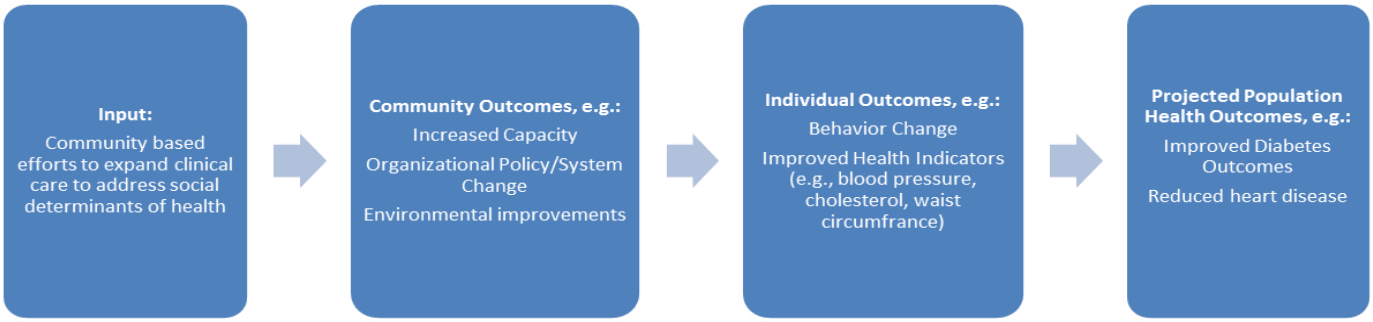
The CMCD team worked collaboratively with the Kresge Foundation Health Team and the local sites to design and implement the cross-site evaluation. Throughout most of the initiative, the CMCD team held regular (monthly or bimonthly) calls with the local evaluator and/or project coordinator from each site in order to engage the site in the cross-site evaluation and provide evaluation-related technical assistance. These calls played an important role in gaining the input of sites into the development and implementation of the cross-site evaluation and also enabled the evaluation team to remain up to date regarding the status of the initiative and how it was evolving at each site, including identifying technical assistance needs related to both evaluation and program development. Along with the monthly calls, the CMCD team utilized annual networking meetings in order to get input into the evaluation design and provide feedback and updates regarding the evaluation process and results. Throughout the initiative, evaluation-related technical assistance was provided by the CMCD team on an ongoing basis and programmatic technical assistance needs were forwarded to the Kresge Foundation Health Team for follow-up.

The level and type of interest in evaluation and capacity of local evaluators varied throughout the initiative. At the outset of the initiative, the Kresge Foundation asked each site to identify a local evaluator to measure local outcomes and participate in the cross-site evaluation. Five of eight sites engaged evaluators early in the process and developed an evaluation plan to assess their local process and outcomes, although the content and focus of their local evaluation plans varied. The evaluators from these five sites were quite responsive to the CMCD team, providing input on the design of tools and instruments and submitting data responsively. Many of our regular conversations included technical assistance including help designing the local evaluations, help identifying evaluation tools, and supporting the local evaluators' relationship with the implementation staff, partners, and community residents. After some delay, two additional sites engaged staff to oversee evaluation efforts, and worked quickly to design and implement an evaluation process. One site faced significant challenges identifying a local evaluator, and was unable to participate in some elements of the cross-site evaluation. In all sites the evaluators and project coordinators worked enthusiastically with the CMCD team to provide input into the development and implementation of the cross-site evaluation.

Design

The objective of SNEI was to support the development of demonstration projects aimed at addressing social determinants of health. With improvements to population health as a long-term goal, the Foundation supported inputs implemented by the local sites (i.e., partnership and demonstration models) that would lead to short-term community and individual-level changes to social determinants of health. Given the resources available from the implementation grant (i.e., 3 years and $750,000 per site), the Kresge Foundation Health Team as well as the local sites acknowledged that reducing health disparities and improving population health was not expected. In order to measure the promise of the demonstration projects, the cross-site evaluation was therefore designed to measure whether outcomes appeared to be "moving in the right direction." Through a participatory process, the cross-site team worked closely with the Kresge Foundation Health Team and the eight local sites to design an evaluation that would assess this movement, capturing both the input (i.e., local efforts) as well as community and individual-level outcomes (Figure 3).

Figure 3: SNEI Evaluation Model



This report presents the results of this evaluation which demonstrate:

- ***Inputs:*** SNEI efforts resulted in the development of authentic partnerships and implementation of demonstration projects designed to address social determinants of health
- ***Community Outcomes***: SNEI sites increased the capacity of communities to address social determinants of health, implemented changes to organizational policies and systems to expand services beyond clinical care, and implemented improvements to the physical and social environments
- ***Individual-Level Outcomes***: Involvement in SNEI activities resulted in behavior change among individuals who participated in SNEI activities

As more fully described throughout this report, the outcomes brought about through SNEI represent both immediate and long-term impacts that will contribute to improved health throughout the SNEI communities.

Methods

Participatory Evaluation Process

To assess the accomplishments and outcomes of SNEI, the CMCD team worked collaboratively with the Kresge Foundation Health Team and the local evaluators and program coordinators to develop and implement cross-site evaluation tools. Tools were completed by the local sites annually and submitted to the CMCD team for analysis. Analysis of data from these tools was supplemented by review of program documents including annual reports, as well as notes from regular conversations with the local evaluators and program coordinators, both individually and as a group. These conversations helped provide background regarding the sites' progress and provide a more "complete picture" of the local context.

The CMCD team also provided ongoing evaluation technical assistance to the local evaluators and program coordinators. Through regular phone calls and ongoing interaction, the team facilitated completion of the cross-site evaluation tools as well as provided advice and input regarding the local evaluation design. As is more fully addressed in the Discussion section, from the outset we found that conceptualization and commitment to evaluation varied by site. All sites were responsive to data requests related to partnership, demonstration projects, and short-term outcomes. Interest and commitment to measuring changes to health outcomes was less consistent.

Data Collection

Given the challenges noted above, the cross-site evaluation team focused its analysis on the cross-site tools developed in partnership with the sites, as follows:

Table 2: Cross-Site Evaluation Data Collection Tools

Source	Provides Information About	Collected From	Years
Collaborative Partners	Type and contribution of partners	All sites	2011, 2012, 2013
Demonstration Project Reach	Describe and document 1-3 major activities	All sites	2011, 2012
Story Documentation	Significant changes within the partnership or community	All sites; 26 stories	2011
Project Documents (annual reports, site visit reports, etc.)	Process and impact of SNEI efforts	All sites	2011, 2012, 2013
Key Informant Interviews	Process and impact of SNEI efforts	All sites; 99 interviews (2012) 101 interviews (2013)	2012, 2013
Cross-Site Survey	Impact of SNEI efforts on participants	7 of 8 sites; 400 individuals	2013
Organizational System and Policy Changes	Impact of SNEI efforts	All sites	2012, 2013
Population Health/Reach	Reach of efforts	7 of 8 sites	2013
ACA Key Informant Interviews	Perspective of ACA on SNEI communities	All sites; 16 individuals	2013

Collaborative Partners: Collaborative Partners forms were completed by local staff at each site, usually either the evaluator or program coordinator. Local site staff were encouraged to establish a system of review to ensure that multiple perspectives were reflected. Forms were submitted to the CMCD team annually, and an interactive process between CMCD staff and the local sites was established to clean and verify data.

Demonstration Project Reach: Project Reach forms were completed by local staff at each site, usually either the evaluator or program coordinator. Local site staff were encouraged to establish a system of review to ensure that multiple perspectives were reflected. Forms were

submitted to the CMCD team at the end of 2011 and 2012, and an interactive process between CMCD staff and the local site was established to clean and verify data. During the first two years of implementation, data from the Project Reach forms were compiled to provide descriptive data regarding the sites' interventions, participants, and objectives. In year three, this data became obsolete as the evaluation moved toward analysis of outcomes rather than descriptive process.

REACH: The REACH form was developed to replace the Demonstration Project Reach form in order to document the scope of demonstration projects, including the number of individuals that were reached directly and indirectly through SNEI efforts. In addition to the number of individuals documented through the project, the REACH form asked sites to estimate the potential reach of projects if sustained over time. REACH forms were completed by local staff at each site, usually either the evaluator or program coordinator. Again, local site staff were encouraged to establish a system of review to ensure that multiple perspectives were reflected. Forms were submitted to the CMCD team in May 2012, June 2013, and at the end of 2013, and an interactive process between CMCD staff and the local site was established to clean and verify data.

Story Documentation: Local sites expressed significant interest in collecting stories as a means to document their process and outcomes. During the first year, the evaluation team explored multiple methods to use stories for evaluation purposes, but found that the stories were better used as case study descriptions and examples rather than to measure outcomes. A recommendation was made to the Foundation to provide support and technical assistance for local story gathering, and many sites continued their story collection at a local level.

Project Documents: Annual reports, site visit reports, and technical assistance call notes provided both background and descriptive data to supplement the process and outcomes being described through the cross-site evaluation. In some cases (e.g., annual reports) qualitative analysis was conducted to identify key challenges and successes reported across sites. In other cases (e.g., site visit reports, call notes) data were utilized to help understand and interpret the local context and process at each site.

Key Informant Interviews: CMCD conducted interviews with key informants representing all eight sites at two points in time. To complete the survey of key informants at SNEI sites, the CMCD team worked with the local sites to develop an interview protocol that included qualitative, open-ended questions and quantitative questions for which participants were asked to respond using a Likert type scale.

The cross-site team identified informants by categorizing individuals listed in the Collaborative Partners Form, and randomly selected individuals to ensure representation from staff,

evaluators, ongoing partners, and strategic partners. Individuals who were interviewed in the first round were included in the follow-up interview if they were still active partners, and new partners were added to replace those who were no longer involved.

Informants received an email inviting them to participate in the interview, and CMCD staff worked with them to schedule an interview at a time convenient for them. Most interviews took approximately 40 minutes to complete. Data from the first ten interviews were reviewed to ensure the questions elicited quality data. Interviews were recorded by CMCD and then transcribed by an independent contractor.

Table 3: Key Informants by Site

Site	Number of Key Informants	
	2012	*2013*
Hermosa Vida	15	13
Food to Families	14	14
Returning to Our Roots	13	12
Building Vibrant Communities	13	10
IMPACT	14	14
Kids First	4	12
East Cleveland Teen Collaborative	13	12
Pathways in STEP	13	14
Total	*99*	*101*

Cross-Site Survey: At the Evaluation Meeting held in December 2012, CMCD staff worked with local evaluators and project coordinators to develop a set of common survey questions that could be integrated into existing local participant surveys (where applicable) in order to capture cross-site data regarding three common areas of interest: (1) connectedness, (2) food-related behavior and access, and (3) overall well-being. Data was collected by local sites based on the following conditions:

- The survey focused on a definable population
- The survey had identifiers for follow-up
- The survey was conducted with the same individuals more than one time

CSS data was collected locally from individuals exposed to SNEI activities and submitted to the CMCD team as available. Given the unique design of local models, each site identified a cohort of individuals to follow over time. Individuals from the different sites were exposed to a variety of different activities, and follow-up timeframes varied by site (See Table 4). A cover form was submitted to document background information including the types of activities to which respondents were exposed and the timeframe for baseline and follow-up. Seven of 8 sites submitted data, although two sites were unable to collect follow up data in time for the cross-site analysis. A total of 400 surveys were submitted, and statistical analysis -was conducted on the 99 surveys for which both baseline and follow-up were available.

Table 4: SNEI Cross-Site Survey Data Collection			
Site/Project	**Collected From**	**Exposed To**	**Timeframe**
Flagstaff, AZ *Hermosa Vida*	Recipients of produce distribution (parents/caregivers)	School programs (e.g. Parent Academies); some community programs	*1st collection:* May 2013 *2nd collection:* March 2014
Oakland, CA *Food to Families*	Women visiting partner CHCs for prenatal care	At least one visit with a health educator; received Produce Rx; some also attended other classes (health education, cooking, etc.)	*1st collection:* Apr - Aug 2013 *2nd collection:* Oct - Nov 2013
Honolulu, HI *Returning to Our Roots*	Adults participating regularly in Roots activities	Nutrition education; food preparation classes; communal meals; gardening activities	*1st collection:* Jun – Jul 2013 *2nd collection:* N/A
Boston, MA *Building Vibrant Communities*	Participants of 8-week wellness program	Life coaching; nutrition, cooking & physical activity classes; referrals to primary care and other services	*1st collection:* Mar 2013/Jul 2013* *2nd collection:* Jun 2013/Sep 2013*
Detroit, MI *IMPACT*	Members of IMPACT	Some of all of the following—wellness checks; cooking and canning classes; yoga, Zumba, and walking club; referrals to primary care	*1st collection:* Feb - Jun 2013 *2nd collection:* Jul - Oct 2013
Peñasco, NM *Kids First*	Participants in Nurturing Parenting classes	12-week parenting class curriculum; behavioral health screenings; community gathering event	*1st collection:* Jun 2013/Sep 2013* *2nd collection:* Sep 2013/Dec 2013*
East Cleveland, OH *EC Teen Collaborative*	Teens in ECTC program	10-month empowerment program that includes various activities	*1st collection:* May 2013/Jul 2013* *2nd collection:* N/A

*Collected data from two cohorts of participants
Source: Cross-Site Survey submission cover forms

Organizational System and Policy Change Forms: The Organizational Policy and Systems Change form was introduced in 2012 to document and categorize changes in organizational systems and policies that were brought about as a result of the SNEI effort. Policy change forms were completed by local staff at each site, usually either the evaluator or program coordinator. Local site staff were encouraged to establish a system of review to ensure that multiple perspectives were reflected. Forms were submitted to the CMCD team at the end of 2012 and 2013, and an interactive process between CMCD staff and the local site was established to

clean and verify data. Changes documented on this form included changes in the following categories:

- *Capacity:* Changes that build personal or collaborative capacity for, or engagement in, policy, practice, infrastructure, or systems change.
- *Programs, Practices & Products:* Changes in practice, procedures, or norms in schools, communities, or organizations.
- *Infrastructure:* Changes/improvements to the physical environment intended to improve public health and decrease health disparities.
- *Organizational Practice and Policy Change:* Written requirements, rules, agreements, or guidelines; adoption of a new policy or implementation of a current policy.

A set of criteria was established to ensure that only permanent, long-term changes were documented, including:

- Long-term formal changes that are expected to stay in place after SNEI funding ended;
- Changes that are expected to sustain the initiative's *impact* (i.e., not simply maintain a program); and
- Changes that are expected to impact population health and/or health disparities.

In addition to these criteria, organizational practice and policy changes were to be:

- Documented in writing (e.g., organizational policies, procedural manuals, etc.)

ACA Key Informant Interviews: Between June-August 2013, the evaluation team interviewed 16 individuals who represent community health centers (CHCs) in SNEI communities to gather their perspectives regarding the impact and promise of the Affordable Care Act (ACA) in their communities. To identify potential informants, project coordinators from each of the eight SNEI sites were asked to identify two individuals in their community who were knowledgeable about the ACA and its impact on the site. Informants received an email inviting them to participate in the interview, and CMCD staff worked with them to schedule an interview at a time convenient for them. Telephone interviews were conducted by CMCD staff June-August 2013. Most interviews took approximately 40 minutes to complete. Data from the first five interviews were reviewed to ensure the questions elicited quality data. Interviews were recorded by CMCD and then transcribed by an independent contractor.

Data Analysis

Qualitative data was analyzed from community key informant interviews, ACA key informant interviews, collaborative partners forms, stories, systems and policy changes, reach of efforts, and project documents.

Key Informant Interviews: All interviews were digitally taped and transcribed. Content analysis was conducted on the written transcripts by two independent coders at CMCD. Qualitative themes were developed and analyzed in relation to specific research questions and protocols. Data were entered into Excel and NVivo 10 data management software to help organize and provide structure for analysis[3,4]. Common themes were identified across all informants and those distinct across sites. Closed-ended questions (categorical, Likert scale) were entered into Qualtrics software to tabulate frequencies of responses, and quotes were extracted from transcripts and mapped to codes[5]. All other qualitative data were entered into separate NVivo files and coded as described above for the interviews. These data were analyzed both within and across sources (e.g., collaborative partners, stories, project documents) for completeness and to triangulate the data over multiple sources to increase validity.

Quantitative data from the surveys and other tools were first analyzed for descriptive findings, including frequencies within the different measurement sources.

Collaborative Partners: Frequencies were examined at baseline, follow-up, and for change over time both within sites and overall.

Key Informant Interviews: Frequencies were examined from both baseline and follow-up interviews. The following dependent variables were identified from the interview protocols:

- Involvement, over the past year, in making important decisions about the initiative and its direction
- Changes in the way health is approached in community are happening (not at all, a little, somewhat, or a lot)
- Changes in thinking and conducting work (not at all, a little, somewhat, or a lot)
- Extent partnership involves community residents in developing and implementing its efforts
- Extent changes in the physical environment have been brought about by the work
- Extent changes in the social environment have been made by the community
- Extent residents are more connected to services
- Confidence that changes will continue once the Kresge Foundation funding has ended (sustainability)

Linear models were created to assess the association between dependent variables and key independent variables, including: length of involvement with the initiative, whether or not the

[3] Microsoft. (2010). Microsoft Excel [computer software]. Redmond, WA: Microsoft.
[4] QSR International Pty Ltd. (2012). NVivo qualitative data analysis software, Version 10 [computer software]. Burlington, MA: QSR International (Americas) Inc.
[5] Qualtrics. (2013). Qualtrics software [computer software]. Provo, UT: Qualtrics.

respondent was paid by the initiative, who they identified as representing in the work, race/ethnicity and other demographic variables. Type of organization was examined in relation to two of the dependent variables: extent of changes in the way health is approached in the community and changes in thinking and conducting work.

Collaborative Partners forms were analyzed at baseline, follow-up 1, and follow-up 2, and for change over time within and across sites. Frequencies were created to better understand how partners were structured in the communities.

Cross-Site Survey data were analyzed at the baseline (1st collection) and follow-up (2nd collection) and for change over time. Frequencies were created for all variables, and examined for their relationship to improvement in general health. Other variables examined were overall diet and exercise, social connectedness, and demographics. General health and overall diet were compared with NHANES data to understand findings in relation to population level change in the US[6].

Linking Multiple Data Sources: Type of change and power to create change were examined in more depth to better understand outcomes in relation to the focus of the work in different communities. Power to create change was examined in relation to: change in the way health is approached in the community, change in thinking and conducting work, extent partnership involves community residents, extent of changes in physical environment, and extent particular disparities have improved. Types of changes the initiative focused on were categorized according to leadership development/capacity building, direct service/individual-level change, policy and systems change/community-level change and examined for association with changes in how health is approached in the community and changes in thinking and conducting work. Finally, these types of changes were examined for their relationship with type of partner.

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. (2012). National Health and Nutrition Examination Survey 2009-2010 data. Retrieved from http://www.cdc.gov/nchs/nhanes/nhanes 2009-2010/DBQ_F.htm#DBQ700

INPUT: Partnerships

Authentic Partnerships

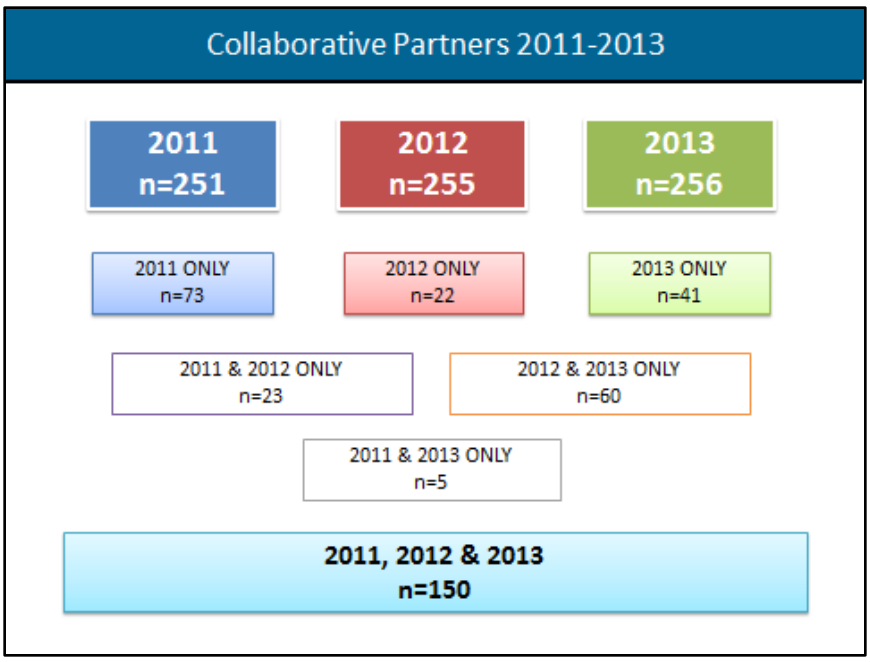
The Kresge Foundation established SNEI as a partnership-based initiative through which community health centers, local public health departments, and community-based organizations would collaborate to address health disparities. In addition to these specific partner types, sites were asked to identify an "anchor institution" that would have the expertise and credibility to help facilitate the projects' development and support sustainability. **The cross-site data demonstrate that SNEI has supported the development of authentic partnerships in which key organizations played critical roles and changed the way health is viewed and approached in SNEI communities.**

> *"I think often people say they have partnerships because they have a name on a piece of paper, but they don't really work together, they don't think through projects together. It's just kind of a stamp. And I think this is one of the very few projects that I have ever worked on that it's a true partnership where everyone is kind of circular around the table. It's like the Knights of the Round Table. Everyone has input, and it's been a work in progress. Versus, 'Okay, I'm the lead, just give me a letter of support and this is what you do.' It's been thoughtful from the very beginning. Everyone can weigh in on what we think is best as a group."*
>
> *– SNEI Key Informant*

Partner Composition

In each of the three years of implementation, approximately 250 individuals were identified as SNEI partners across the eight sites, with 150 individuals represented in all three years (See Figure 4). **Although individuals have moved in and out of the partnerships, the total number of partners has remained stable across time, demonstrating that the sites were able to maintain partners throughout the development and implementation of the initiative.**

Figure 4: Collaborative Partners 2011-2013



The role partners played also remained fairly consistent over time, with approximately 65%-75% of partners identified as "general partners," approximately 10% as staff (i.e., individuals funded via SNEI), and small numbers of partners identified as evaluators or fiduciaries (See Figure 5). These data suggest that these were not staff-heavy partnerships, but were primarily comprised of representatives from organizations and individuals who were involved because of their shared goals and interests.

Although the percent of partners who were identified as "core partners" remained fairly consistent over time, some shift was documented from the first to the second years of implementation, as partners shifted from being core and ongoing to strategic partners (See Figure 6). As the demonstration project was implemented it is likely that individuals who were involved in helping to plan and establish the initiative found their input less needed on a day-to-day basis and become more important for strategic decisions.

Among active partners (i.e., not including "targeted partners"), years one and two saw a notable shift in the proportion of individuals representing organizations rather

Figure 5: Partner Roles 2011-2013

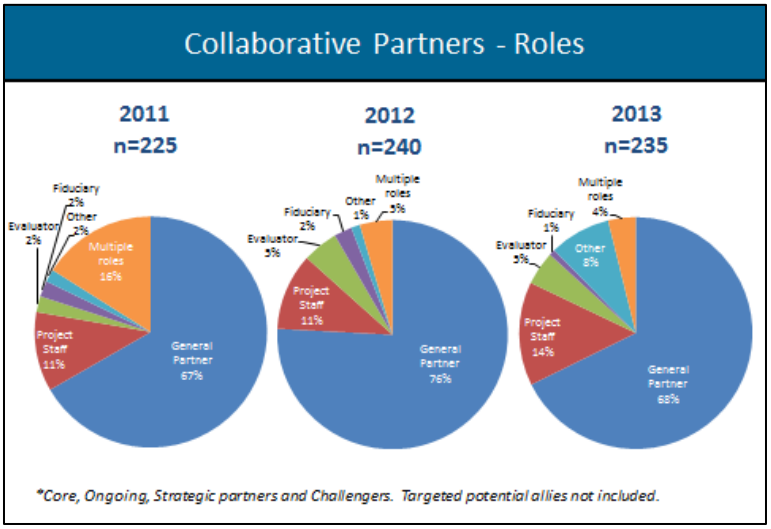


Figure 6: Partner Types 2011-2013

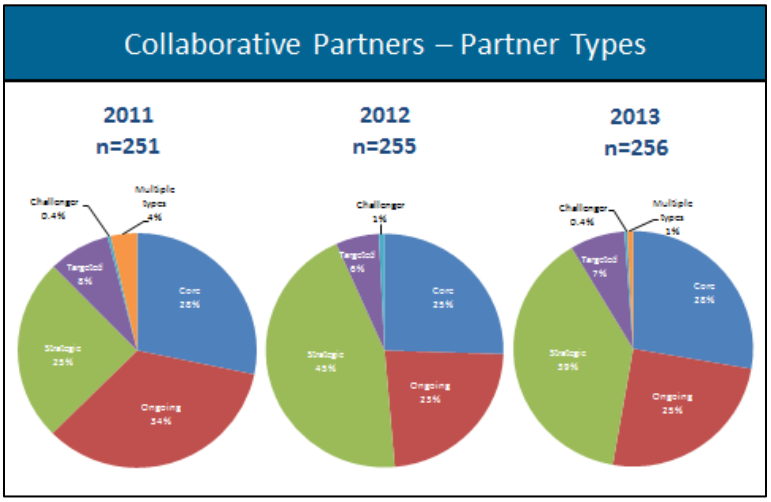
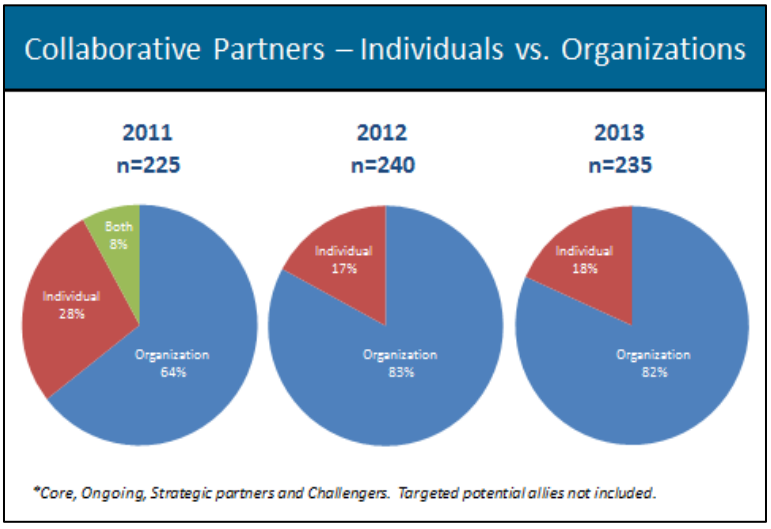


Figure 7: Individual and Organizational Partners 2011-2013



than themselves (See Figure 7). While a change in the way data were collected accounts for the deletion of the "both" category from year one to two, there remains a clear increase in the number of individuals who were identified as organizational rather than individual partners. While this might be explained by a need to recruit new organizational members as the interventions themselves got up and running, it also might reflect a loss in representation from individual community members/representatives who were involved in the planning process but dropped out as the project progressed.

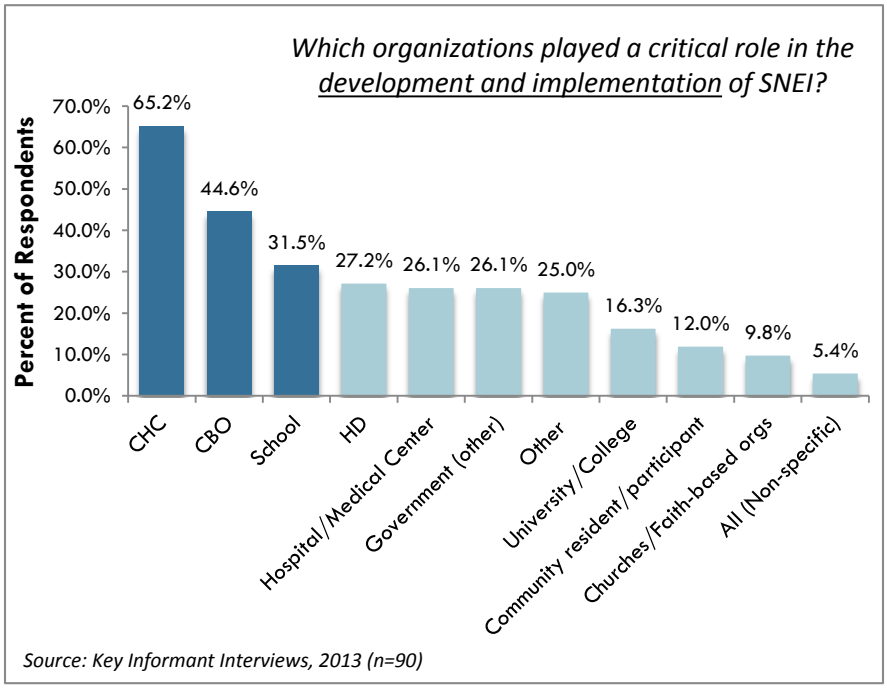
Collaborative Partners data confirm that the SNEI sites were able to not only engage but also maintain participation from all of the organization types required by the Kresge Foundation across the implementation period. During those three years, approximately 20% of partners represented community health centers, 15-20% represented community-based organizations, and 5-7% represented local health departments. Although they were not required by the Foundation, schools and universities also had significant representation in the partnerships, as did other organizations including businesses, pharmacies, and churches.

As discussed more fully below (see Discussion section), throughout implementation, all eight sites included participation from institutions identified as an "anchor institution," although how that term was interpreted seemed to change over time.

Partner Contributions

To get a better sense of the authenticity of partnerships, and what different partners offered their collaborative, key informants were asked to identify the organizations that played the most critical role in their community. **When asked specifically which organizations played a critical role in the *development and implementation* of the initiative, the most common responses were community health centers, community-based organizations, and schools** (See Figure 8).

Figure 8: Critical Organizations for Development and Implementation



Source: Key Informant Interviews, 2013 (n=90)

Key informants also helped describe the different types of resources contributed by key organizations. When asked about the roles these critical organizations played and the resources they provided during the development and implementation of the initiative, the most common response for community health centers related to providing leadership and expertise, followed by resources such as space and training, and then implementation of activities. Although resources were also mentioned for community-based organizations, the order varied, with implementation of activities the most common response, and leadership and expertise the third. Schools were also noted as providing resources, but were the only organization type in which one of the top three roles was noted as providing access to the target population. **These data might suggest that to many informants, the most critical contribution of the community health centers was to spearhead the conceptual aspects of the project through leadership and expertise, while community-based organizations played a critical role in conducting the work, and schools provided important connection (physically and programmatically) with the community.**

Table 5: Top Three Roles Played During Development and Implementation by Most Important Organizations

Community Health Centers (CHCs)	Community-Based Organizations (CBOs)	Schools
Leadership & expertise	Implementation	Resources (e.g., space)
Resources (e.g., space, training)	Resources (e.g., food, space)	Access to the target population because of established trust with the community
Implementation	Leadership & expertise	Implementation

Source: Key Informant Interviews, 2013 (n=92)

INPUT: Demonstration Projects

All eight SNEI sites built on local priorities and assets to develop demonstration models that addressed social determinants of health within the local culture and context. During the planning process each site utilized a participatory planning process whereby community residents and representatives of community organizations and agencies identified the health disparities of greatest concern as well as the social determinants that create barriers to health. Community strengths and assets were assessed, and demonstration projects that built on the unique culture and context of each community were designed to address those social determinants of health.

Demonstration Projects

Flagstaff, AZ: Hermosa Vida

Hermosa Vida focused on reducing childhood obesity and related chronic diseases among primarily Hispanic and Native American children and their families by increasing access to physical activity, recreation, and nutrition. The program utilized school-based initiatives such as structured recess, a walking school bus program, and Parent Academies and broader community-based initiatives such as distribution of CSA produce and development of a policy coalition to engage children and families in becoming more active, eating more nutritious foods, and creating a healthy environment.

Oakland, CA: Food to Families

The Food to Families (F2F) initiative's efforts centered on decreasing obesity among pregnant women and their families through health education and improved access to and intake of fresh fruits and vegetables. The program also sought to increase the local economy and provide employment opportunities for youth in the community. F2F implemented a fresh food prescription program at two local CHCs ("Produce Rx") and in partnership with local farms, developed a produce distribution system that trained and employed youth to stock corner stores with fresh, local foods.

Honolulu, HI: Returning to Our Roots

Returning to Our Roots aimed to reduce social isolation and improve health and well-being for community residents, particularly among Asian/Pacific Islander and immigrant populations, through community farming and sharing of cultural traditions. The program was grounded at Hoʻoulu ʻAina, a 100-acre community garden and forest, where participants learned to grow and use traditional Hawaiian foods. Other program activities utilized the knowledge and expertise of community elders to share and facilitate dialogue about culture and health. Additionally, the Roots program worked to expand access to fresh fruits and vegetables by enabling farmers' markets to accept EBT benefits and developing a café at the associated clinic that produces fresh, healthy meals using local produce.

Boston, MA: Building Vibrant Communities

Building Vibrant Communities focused on reducing hypertension, obesity, and depression, among residents within five public housing developments. The primary strategy of the initiative was the use of five Social Health Coordinators, residents from each of the housing developments who were trained to engage other residents in program activities, to help navigate health and social services, and conduct wellness assessments. Another key component of the program was a structured 8-week wellness program that incorporated physical activity and nutrition education. The program also held a summer camp to engage youth residents and help relieve stress among the adult caregivers.

Detroit, MI: IMPACT

The IMPACT program aimed to reduce diabetes and hypertension in a Detroit neighborhood by establishing the Conner Creek Campus, a safe, central location for providing services and activities. Led by various partner organizations, IMPACT offered various nutrition and fitness activities at the Conner Creek Campus including cooking and canning classes, Zumba classes, a walking group, and connection to a local food distribution program. The IMPACT program also collaborated with local community health centers to both connect residents to primary care services and engage them in the wellness activities offered at the Campus. Additionally, IMPACT utilized the expertise of pharmacists to help improve residents' medication adherence.

Peñasco, NM: Kids First

Kids First focused on the prevention of childhood injury and trauma within rural families by increasing parents' social support and parenting skills. A main component of the program involved teaching the Nurturing Parenting curriculum to build parents' capacity. Community health workers also conducted home visits to provide education and help engage families in community activities. The program also aimed to change the health and social service landscape in Peñasco by expanding service availability in the remote community and integrating behavioral health into local clinics and schools.

East Cleveland, OH: East Cleveland Teen Collaborative

Using a youth empowerment approach that incorporated health education, the East Cleveland Teen Collaborative worked to prevent violence and improve the quality of life for adolescents in East Cleveland. The program's central strategy involved utilizing health and social service providers as Navigators to work with teen participants. The Navigators provided the teens with information and resources and helped them to build relationships with adults and community organizations. The teen participants also engaged in peer education activities passing along their skills and knowledge to friends, family, and classmates.

Sheldon Township, SC: Pathways in STEP

Pathways in STEP (Sheldon Township Empowerment Program) sought to reduce hypertension and obesity in a rural, predominately African American community through increased access to preventive and primary care and community empowerment. A primary strategy of Pathways in STEP was to increase community capacity to address social determinants of health among individuals and organizations, including the creation of the Leadership Institute, which trained community members to become leaders and develop programs and activities to improve health in the community. Other elements of local efforts included the formation of the Healthy Churches Consortium, a coalition of local churches that worked together to address health among their congregations and provide services, and the development and institutionalization of organizations to continue SNEI efforts including the establishment of STEP as a 501(c)(3), and the creation of the Consortium of Local Independent Businesses (CLIB) of Sheldon Township.

With support from the Kresge Foundation, approximately 7,750 individuals have been exposed to at least one of the activities described above. These individuals have benefitted directly from education and exposure to activities and experiences designed to reduce barriers to health and improve the physical and social environment in which they live. **In addition to individuals who participated directly in SNEI activities, an estimated 83,402 individuals have been exposed to SNEI efforts indirectly,** including the families of SNEI participants who are likely to learn from the participant, or other community members who benefit from SNEI efforts such as the increased availability of fresh fruits and vegetables in community locations (e.g., stores, farmers' markets).

Models

Although there was significant variation among the sites related to population density (i.e., urban, rural, frontier), racial and ethnic composition, and physical and social environments, the evaluation team has been interested in identifying common elements that appear across multiple SNEI models. These elements may be of interest in considering replicability, and matching promising models with local context.

Integrating Activities that Address Social Determinants of Health into Community Structures

A primary feature of all SNEI models was the integration of activities designed to address social determinants of health into existing community environments.

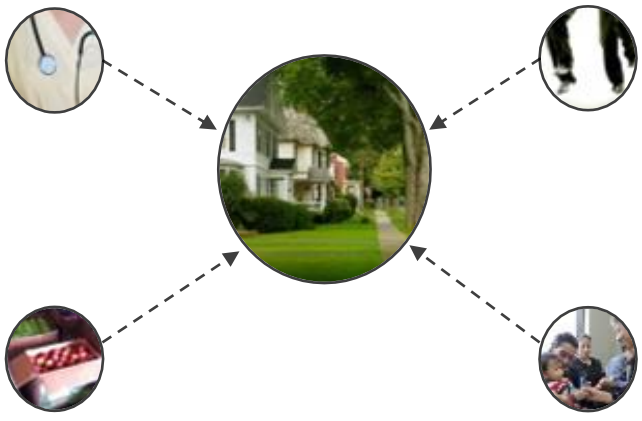
For many community members, access to clinical and health-related services is limited due to competing life problems, lack of transportation, lack of safety, etc. SNEI models concentrated on bringing education and services to places truly accessible to residents and/or where they are already spending their time. At least six sites, for example, integrated access to healthy food into health care clinics, schools, and other community locations where residents are already present, by developing produce distribution or community gardens. In five sites, health screening and referrals have been integrated into drug stores, public housing communities, and churches. And in one site, behavioral health and social support are being integrated into a school. These efforts reflect the recognition that impacting social determinants of health requires adjusting the daily environments in which individuals live, integrating these changes into existing political and social institutions.

Community Health Center Role

A particular interest of the Kresge Foundation included how SNEI might expand the clinical care provided by community health centers to address social determinants of health since CHCs are often the primary safety-net providers to provide clinical service in vulnerable communities. **In recognizing this critical role, the Foundation required that SNEI partnerships include CHCs, but provided flexibility to determine how its local CHCs would be involved with the initiative to reflect the local culture and system of care, and significant variation unfolded.** Community health centers were the lead organization in four sites, and provided administrative oversight of the initiative. In two sites, health systems acted as lead organizations. In one site, the local health department was the lead organization, while in another a community-based health care coalition played this role. Interestingly, these variations did not determine the role of the community health centers in implementing the intervention. In most (6) sites the CHC partners provided staff and expertise for the initiative, but did not provide recruitment for the project. Only one site, for which the local health department acted as the administrative lead, utilized a community health center as the primary center of intervention activities.

"Hub" Models

Four sites **developed a "hub" model, through which multiple efforts are concentrated on a specific geographic location within the community.** For example, Hermosa Vida utilized a neighborhood elementary school as the "hub" which served as the center for programs to increase physical activity (e.g., structured recess, walking school bus, Zumba classes) as well as access to healthy



food (e.g., CSA distribution). In Detroit, Michigan the Conner Creek Campus served as both a symbolic and logistic center for services, including recruitment/health screening events, health education programs, and physical activity classes for the IMPACT program. And the Returning to Our Roots program founded a community garden to provide spiritual and logistical "grounding" for efforts to connect individuals to their health and to each other.

Engaging Residents in Program Implementation

While all sites were charged with including residents in the planning process, **at least four sites developed structures that engaged community residents in *conducting* the initiative's activities.** For example, the Pathways in STEP model was based on a Leadership Institute, through which community leaders were trained in issues related to public health and provided support to design and implement health interventions. In Oakland, California, residents who emerged as leaders in the Food to Families program received "mini-grants" to conduct services including health education and stress reduction classes.

Community Organizing/Mobilization

While all sites included community input in their planning process, **at least four sites developed structures to support the mobilization of individual community members in policy and leadership positions.** Building Vibrant Communities, for example, supported the development and election of Tenant Task Forces within the five public housing developments. Through Pathways in STEP, individual community leaders participated in a year-long training program designed to increase their knowledge and engagement in public health. And a policy coalition was developed through Hermosa Vida to mobilize individuals to support public policy change relevant to health. Although the form of community organization/mobilization varies across these sites, a common feature is the establishment of infrastructures to engage individual community members in ongoing public health efforts. This approach to capacity building addresses not only the immediate success of the initiative, but builds capacity within community residents and leaders, which will be sustained into the future.

Community Outcomes

With signification variation among the SNEI sites in terms of both program design and focus, it is important to acknowledge the uniqueness of each site's approach when interpreting data. The SNEI initiative provided significant flexibility and opportunities to address numerous factors, as determined by each site based on the local context. Although sites documented significant outcomes and byproducts of their efforts, not all sites set out to build capacity or change physical infrastructure. In this context, each site had its own unique focus to reflect the local context and priorities set forth by the community during the planning period. With that in mind, it is also important to acknowledge the important outcomes that were achieved through the initiative. **The contribution of the partnerships and demonstration projects in SNEI communities has led to changes at both the community and individual levels.** Community outcomes documented by the cross-site evaluation include:

- Increased capacities of individuals and organizations to address social determinants of health;
- Community-level improvements to the physical and social environment, including increased access to healthy foods and safe spaces for physical activity, and increased social networks among residents; and
- Organizational policy and systems change, through which organizations, agencies, and institutions changed "business as usual" to address social determinants of health.

While programs and practices may or may not survive the test of time, many of the outcomes documented through the cross-site evaluation will provide sustainable, lasting change in the communities.

Increased Capacity

The cross-site evaluation data suggest that both of the inputs implemented through SNEI, the partnerships and the demonstration projects, led to important changes in individual and organizational capacities. Engagement in the partnership and demonstration projects changed the way individuals think about health and provide services to community residents.

SNEI Partnerships Have Changed the Way Individuals Think and Made Organizations More Resourceful

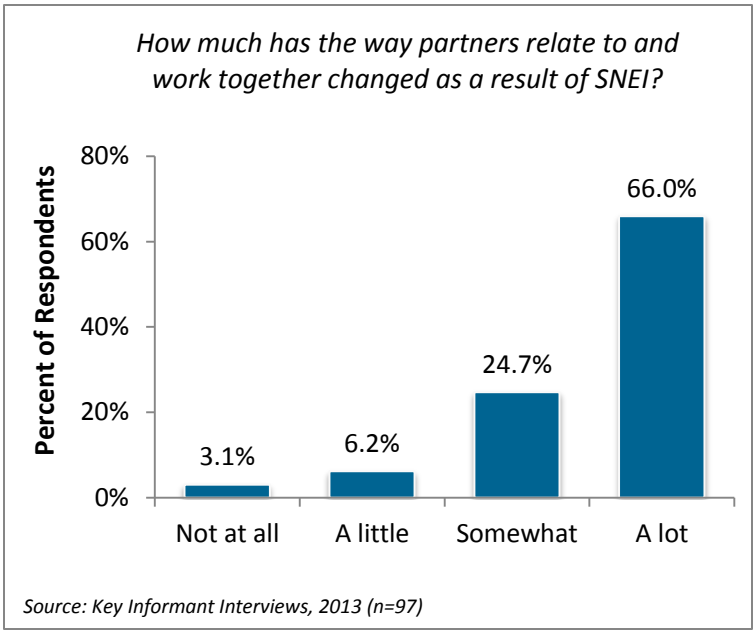
Data from the key informant interviews confirm that the SNEI partnerships have changed the way individual partners think and act, and have brought about changes in the way services are provided.

Almost all (99%) of key informants reported that working as a partnership has been more effective than working as individual organizations. Key informants report that SNEI has enhanced relationships among partners and brought people together to work on a common goal. Whether through the development of new partnerships or enhancement of existing relationships, key informants report that SNEI partnerships were formed around a common vision, which enabled partners to focus efforts on common areas of interest.

> *"It has brought partners together for a common goal and reason. So we're working collaboratively as opposed to in silos."*
>
> *– SNEI Key Informant*

Over 90% of key informants said that partner interaction has changed somewhat or a lot since being involved in SNEI (See Figure 9). Partners reported developing partnerships with new organizations with which they had not previously worked and/or expanding their partnerships into new, related work. Through SNEI, partners also developed a better understanding of other organizations' work and the resources available to the community. Informants reported that these changes make them more resourceful and effective:

Figure 9: Change in Partner Interaction as a Result of SNEI



Source: Key Informant Interviews, 2013 (n=97)

> *"Different organizations have certain resources and expertise…and really take the lead in making those happen. So a project this big really wouldn't be able to happen if it was just one organization doing it because there isn't the manpower to stretch that wide nor the expertise in any one organization."*
>
> *– SNEI Key Informant*

Key informant data demonstrate that the SNEI partnerships have established local learning communities, and by working in partnership, informants report that they learn from each

other and view each other as assets. In fact, when asked about the greatest assets in their community, more than a third (38.5%) of key informants mentioned *community organizations and programs* and/or *dedicated and engaged partners*. Informants noted that partners were assets not only because of their skills and resources, but also because of their openness to other opinions and ideas, their flexibility to change policies and practices, and their connection to the community.

> *"…especially when you're looking at things like social determinants of health, which is what this project looks at, you cannot accomplish—or you cannot be successful working on your own because we're talking about dealing with really large, systemic issues. So I think working together is the only way to make a difference.*
>
> *– SNEI Key Informant*

As one outcome of these partnerships, **key informants report that SNEI has brought about sustainable change in the way health is approached at both the individual and organizational levels.**

Individually, partners report that as a result of participating in the SNEI initiative they have changed their mindset, approach, and/or perspective of health in a variety of ways, including viewing health more broadly/holistically. They have expanded their approach to health to include not just clinical care but wellness – treating the "whole person."

> *"…we are thinking more in terms of health now rather than medicine. And I make a distinction in terms of medicine because medicine is related to the art of treating a disease and you have doctors and nurses and health professionals who will provide medicine, pills or whatever to help people control their disease process. The approach that we're taking related to health now is not only the—medicine is included, but health is not defined by medicine treatment; it is defined more broadly in terms of a person's lifestyle and their relationship to how they think about their health and how they can prevent disease."*
>
> *– SNEI Key Informant*

This change in perspective has helped support change in the way services are provided, both by changing the way individual providers interact with patients/community residents and in the way organizations provide services.

> *"I think the caregivers [are] becoming more cognizant of the cultural preferences for care and being more holistic in their consultations… consulting on support systems to asking about family, asking them about their access to certain support, asking them—making sure that they accommodate any language barriers within the consultation, talking about food and diet, and if there's any cultural preferences to care… they might talk about other kinds of spiritual healing or their sort of culturally-based ideas about what constitutes care that brings about wellness."*
>
> *– SNEI Key Informant*

> *"I think our community health center is taking more seriously the prevention-based approach and really trying to embrace opportunities to incorporate that into some clinical services. And I think that that's evident in the community health worker model and then also trying to improve interpretation services…ultimately we're hoping to take the findings from our patient and provider communication assessment and enhance some training for providers around communication with patients and culturally appropriate messages. And the clinic is open to the idea…so that will be a change in the way our community health center does business."*
>
> *– SNEI Key Informant*

Increased Capacity of Individuals and Organizations to Address Social Determinants of Health

As either an intentional or unintentional element of their work, every site identified at least one way in which SNEI activities increased the local community's capacity to address social determinants of health. As an important outcome of their efforts, SNEI sites documented 33 instances of increased personal or collaborative capacity for, or engagement in, policy, practice, infrastructure, or systems change. These represent sustainable changes in the community that will be maintained beyond the SNEI initiative. For example:

- **Formal agreements to change the way organizations work together**: As a result of Kids First, the Peñasco Health Clinic and Taos Clinic for Children and Youth in New Mexico have established a Memorandum of Understanding so that a social worker can provide assessments and referrals for families in Peñasco. This agreement provides a structure through which behavioral health can be integrated into clinical systems beyond the SNEI initiative.
- **Increased capacity among individuals to engage in policy efforts:** The Change Action Network (CAN), a policy coalition started through Hermosa Vida, engages residents in addressing community-identified policy needs. Creation of CAN has increased education and involvement of community members in local policy.

- **New grants:** As a result of the SNEI accomplishments, Pathways in STEP's lead organization was awarded a Healthy South Carolina Initiative grant for an "Access to Healthy Food" Program to construct three community gardens in the main geographical areas of Dale/Lobeco, Sheldon, and Big Estate.

Although the SNEI models were developed as demonstration projects, the capacities built and policies changed as a result of the efforts are critical stepping stones in the movement toward population health improvement. Leaders and providers in the community are more aware of the barriers to health, and are better prepared to address social determinants of health more broadly. Organizations have implemented policies that may lead to broader implementation of the changes brought about through SNEI, which in turn could affect more people. As successful demonstration projects end, the next phase will be replicating the programs or scaling them up to impact a greater portion of the community. These increased community capacities are the building blocks of movement toward population health and reducing health disparities.

Changes in Organizational Systems and Policies

Although SNEI was not designed to be a policy initiative, through the course of their efforts many sites identified areas in which changes to organizational and/or community systems and policies could have a significant and sustainable impact on population health. While some sites, such as Food to Families, began with an eye on systemic change, other sites identified the potential for organizational policy and system change along the way. **By the end of the implementation period, six sites documented 16 formal organizational practices or policy changes that were brought about as a result of SNEI.** Specific examples include:

- **Changes to clinical services**: In Detroit, Michigan, a formal referral system utilizing electronic medical records was established so that Advantage Health providers can write patients 'prescriptions' to the IMPACT program. Over 300 residents are estimated to have become involved with IMAPCT as a result of these referrals, which are expected to continue beyond SNEI funding.
- **Hiring of permanent employees:** Through the efforts of Hermosa Vida, North Country HealthCare institutionalized the role of Community Organizer through the development of a formal job description that will continue beyond SNEI. The creation of this position recognizes the importance of community engagement and involvement in the clinic, as well as the clinic's interest in serving more adequately the needs of community members beyond clinical care.
- **Changes to organizational policies:** Through the work of Returning to Our Roots, the University of Hawaii School of Nursing institutionalized orientation visits to Hoʻoulu ʻAina for all incoming nursing students. As a result, approximately 150 nursing students will visit each year as part of their orientation, gaining an understanding of holistic

health, the importance of community and connections, and how the land and food to contribute to health.

These guidelines, policies, or rules represent significant opportunities for sustainable change, since they are formally documented changes that are ongoing and expected to continue beyond the program.

Changes to the Physical Environment

An initial element of the initiative included improving the social and physical environment in order to address social determinants of health. **The primary infrastructure changes brought about through SNEI included physical changes to increase access to healthy foods or physical activity. Although not every site set out to make such changes, seven sites documented 8 permanent infrastructure changes that were brought about through SNEI.** Examples include:

- **Increased access to healthy foods:** The Roots Café was established at the CHC by Returning to Our Roots, offering healthy lunch options and catering to staff and the community. The café serves approximately 700-750 people each month.
- **Increased access to physical activity:** St. John's Health System dedicated facilities for an indoor walking path to serve as a safe place for community members to walk during all seasons through the IMPACT program.
- **Increased access to healthy foods and physical activity:** Food to Families, Returning to Our Roots, IMPACT, and the East Cleveland Teen Collaborative established community gardens.

These changes to the physical environment are significant outcomes, as they are all permanent changes that will continue beyond SNEI.

Changes to the Social Environment

Early in the initiative, several SNEI sites identified issues related to the social environment as priority social determinants. The East Cleveland Teen Collaborative and Building Vibrant Communities, for example, both targeted violence in the community as a primary barrier to health. Returning to Our Roots addressed the breakdown of community systems and networks within and between cultural sub-populations. All three of these projects identified increasing social networks as one strategy to address these social determinants of health. Over time, the concept of "connection" spread and evolved throughout the initiative. As discussions were held within the SNEI learning community, key staff from other local sites also began to recognize that a key element within their work was an effort to increase "community connectivity." **Over time, the cross-site evaluation documented two primary types of "connection" being increased through SNEI—connection between residents and services that address social determinants of health, and connection between and among residents.**

Community Connection to Services

A common objective among SNEI sites was to address barriers community members face in accessing health services and other services that address social determinants of health. Building on existing community assets, many sites developed strategies to connect residents to programs and services that were already available but inaccessible, while some developed new programs and services to meet a need. As a result, **over 90% of key informants reported that residents are more connected to services because of SNEI.** SNEI has improved the quantity and quality of services available in the community and has made services more accessible. For example:

- Five sites increased access to fresh fruits and vegetables in community locations such as schools, corner stores, and farmers' markets;
- Three sites increased cultural awareness and skills among clinical and social service providers, for example, by changing the language used to communicate with patients and educating providers regarding diversity in cultural approaches to health;
- Three sites implemented clinical screening and referrals at community locations such as churches and schools; and
- Six sites provided community education to increase awareness of and linkage to services already available in the community.

Key informants report that SNEI has educated residents regarding the resources available in their communities and has made services more accessible.

> *"I definitely think now it's more welcoming. We had heard before the parents didn't feel welcome [at the school]. But now, having more Spanish speaking staff, having more opportunities for them to be involved…they feel more connected to the school. They feel more connected to their child. They feel more connected to their community in general."*
>
> *– SNEI Key Informant*

Community Connection to Each Other

The public health community has come to recognize the importance of social structures and social interaction as an important determinant of health. The CDC acknowledges the importance of "social capital," including activities that create social bonds between individuals and groups, and the importance of building physical and social infrastructure to support the development of relationships and cohesiveness of a community[7]. **At the SNEI Evaluation Meeting held in December 2012, all eight SNEI sites identified increasing "connectivity" as an**

[7] Centers for Disease Control and Prevention. (2013). Healthy places: Social capital. Retrieved from: http://www.cdc.gov/healthyplaces/healthtopics/social.htm

important element in their model. Each site developed a unique approach that built on the local assets and culture to build relationships among community members. Examples of common elements of these models included:

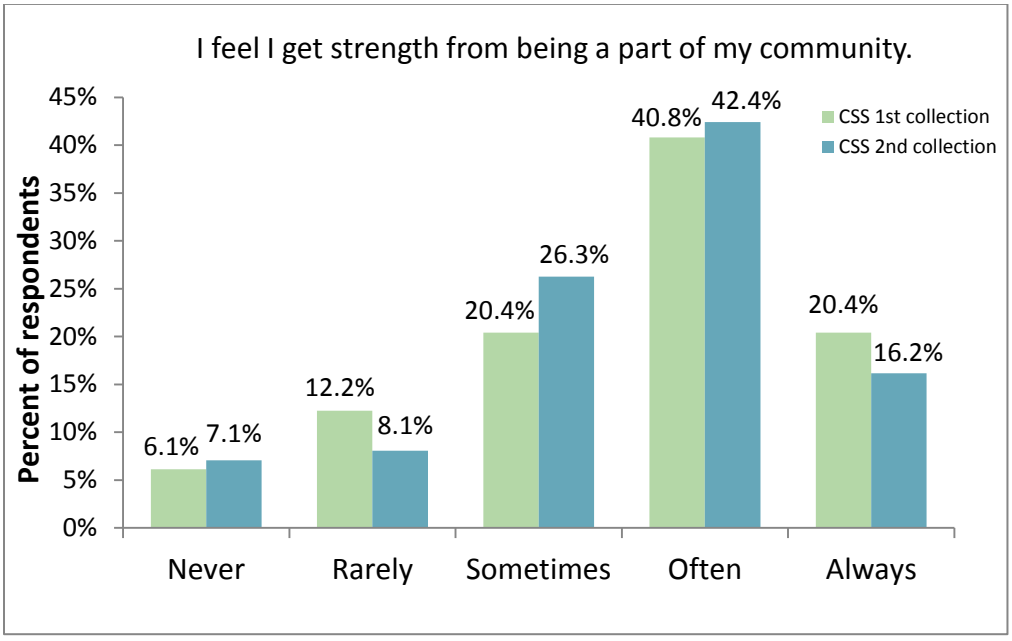
- Residents working alongside each other in community gardens in four sites;
- Residents participating in Zumba and yoga classes, walking clubs, and line dancing, increasing physical activity in fun and interactive ways in four sites; and
- Children and young adults gathering to cook meals, read poetry, create posters, put on performances about healthy living, and play sports in five sites.

Throughout many of these events residents were engaged in talking about health issues through formal and informal conversations and learned new healthy living skills. As a result, **key informants describe that in SNEI communities, a social network has formed around health**. Through this social network, for example:

- Residents are interacting and bonding;
- It is more socially acceptable to focus on health and engage in healthy behaviors; and
- Participants are engaging in conversations about diabetes, nutrition, and safety.

To assess the impact of these efforts the SNEI Cross-Site Survey (CSS) asked individuals who were exposed to SNEI interventions whether they "get strength from being a part of my community." Individuals were asked to rank these questions on a scale of 1 (never) to 5 (always). Interestingly, results were varied and generally showed little change over time (See Figure 10).

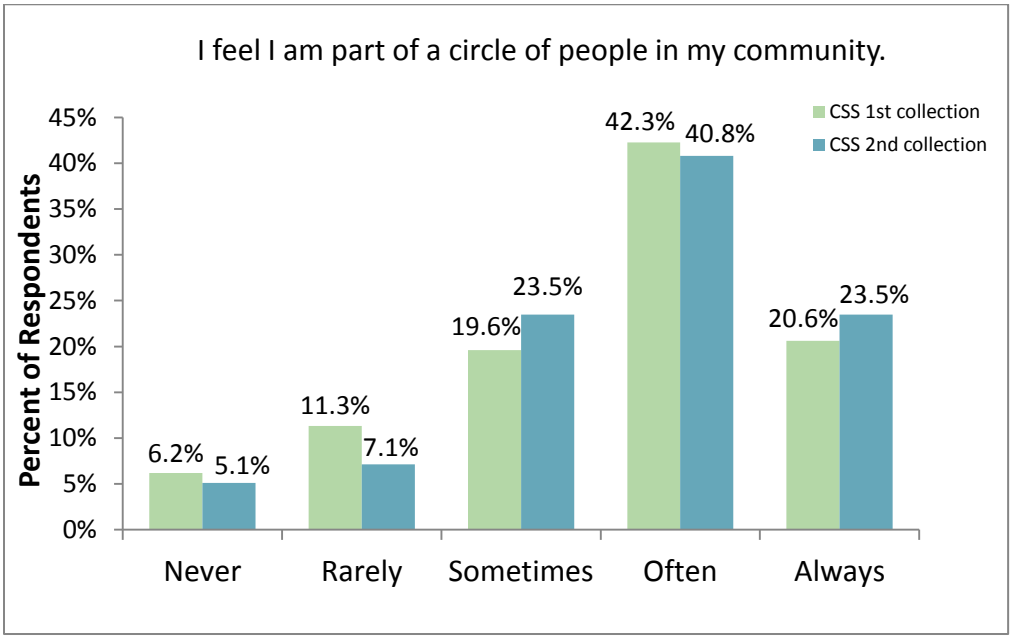
Figure 10: Community Connectedness among SNEI Participants (1)



Source: SNEI Cross-Site Survey (n=99)

Similarly, when asked "I feel I am a part of a circle of people in my community who help me be healthy," respondents' responses were varied, with increases among those reporting "always" and "sometimes," but decreases among those reporting "often" (See Figure 11). The changes reported are fairly small and the data give no clear sense of a pattern.

Figure 11: Community Connectedness among SNEI Participants (2)



Source: SNEI Cross-Site Survey (n=99)

Although these results are mixed, there are significant limitations to these data. As small numbers of individuals were surveyed and there was significant variation of exposure to activities across sites, it is difficult to interpret these results. It is possible that individuals did not participate for enough time or intensity to feel more connected to others. It is also the case that "connectivity" was not the primary objective of most of the activities to which respondents were exposed, and an intervention more targeted to that outcome may have been more successful. A study with interventions more specifically designed to measure these outcomes and with a larger sample size would help understand whether the mixed results are due to the study design, sample size, and/or effectiveness of the intervention itself.

When analyzed in relationship to general health questions, however, CSS data show a statistically significant relationship between respondents' perception of their health and their getting strength from the community, as well as feeling they are part of a circle of people who help them to be healthy (See Table 6). That correlation becomes even stronger in the follow-up data. In addition, in the follow-up data, there is a significant relationship between these factors of "community connection" (getting strength from the community and feeling

they are “part of a circle of people who help them be healthy”) and how healthy people report their overall diet to be.

Table 6: Correlation Coefficients for the Relationship Between Community Connectedness and Health

	1st collection		2nd collection	
	In general, how healthy is your overall diet?	Would you say your health in general is…	In general, how healthy is your overall diet?	Would you say your health in general is…
I feel I get strength from being part of my community	0.30*	0.33*	0.55**	0.51**
I feel I’m part of a circle of people in my community who help me be healthy.	0.30*	0.30*	0.47**	0.33*

*Correlation is significant, p<0.01
**Correlation is significant, p<0.001
Source: Cross-Site Survey (n=99)

These data support the concept that community connection is important to individuals feeling healthy, a key value that emerged as part of the SNEI initiative, and suggest that efforts to increase “connectivity” are promising avenues to improve individual health.

Individual-Level Outcomes

The community-level changes documented reflect efforts that are ultimately tied to the way individuals in a community experience their health and environment. Measuring changes to individual-level outcomes, including individuals' health behaviors and health indicators, is a critical step in assessing the promise of new models to address social determinants of health. Despite the limited time in which interventions were conducted, **the cross-site evaluation data suggest that SNEI has made progress in moving communities in the right direction to improve health and healthy behaviors among participants.**

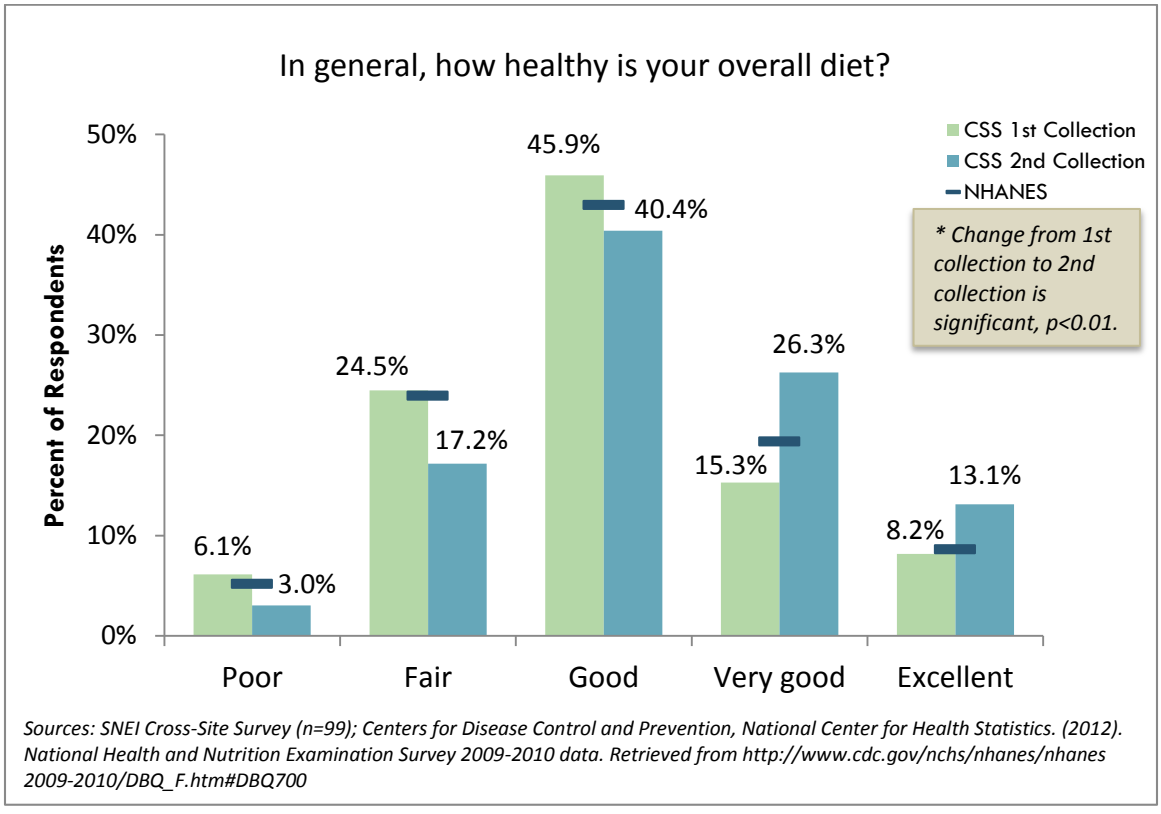
To assess individual-level outcomes, cross-site survey data (CSS) was collected from 400 individuals across seven SNEI sites who participated directly in SNEI interventions. In six of the seven sites, individuals had minimal or no exposure to the intervention prior to the survey, and in one site there was minimal exposure to SNEI activities. The activities in which respondents participated varied significantly across sites, as did the length of exposure and follow-up period for each site (See Table 4, p.14).

The CSS included 8 questions related to general health, healthy diet, access to and intake of fruits and vegetables, and community connection. Although not all SNEI sites concentrated efforts on dietary behavior, participants in six of the seven sites who collected survey information participated in activities related to healthy eating and/or efforts to increase access to fruits and vegetables. **Analysis of SNEI cross-site survey data demonstrates a significant improvement in the way individuals who participated in SNEI activities reported the health of their overall diet as well as their overall feelings of health. Further, when compared with national statistics, after participating in SNEI activities participants respond to these questions as well as, and sometimes better than, the general US population.**

As Figure 12 demonstrates, over time SNEI respondents reported a decrease among individuals who responded that their overall diet is “poor,” “fair” or “good,” and an increase among those who reported that their diet is “excellent” or “very good.”

In order to compare SNEI survey participants with individuals at the national level, the cross-site evaluation team compared CSS data with data from the National Health and Nutrition Examination Survey (NHANES), a national survey conducted by the Centers for Disease Control and Prevention (CDC) (See Figure 12). Compared with NHANES respondents, SNEI survey participants are not only improving, but in some cases are demonstrating better outcomes than the national statistics. When asked how healthy is their overall diet, the percentage of individuals who reported “very good” or “excellent” in the first SNEI data collection was less than the NHANES data. By the second data collection, the percentage of SNEI respondents who responded positively not only increased but was greater than the national data.

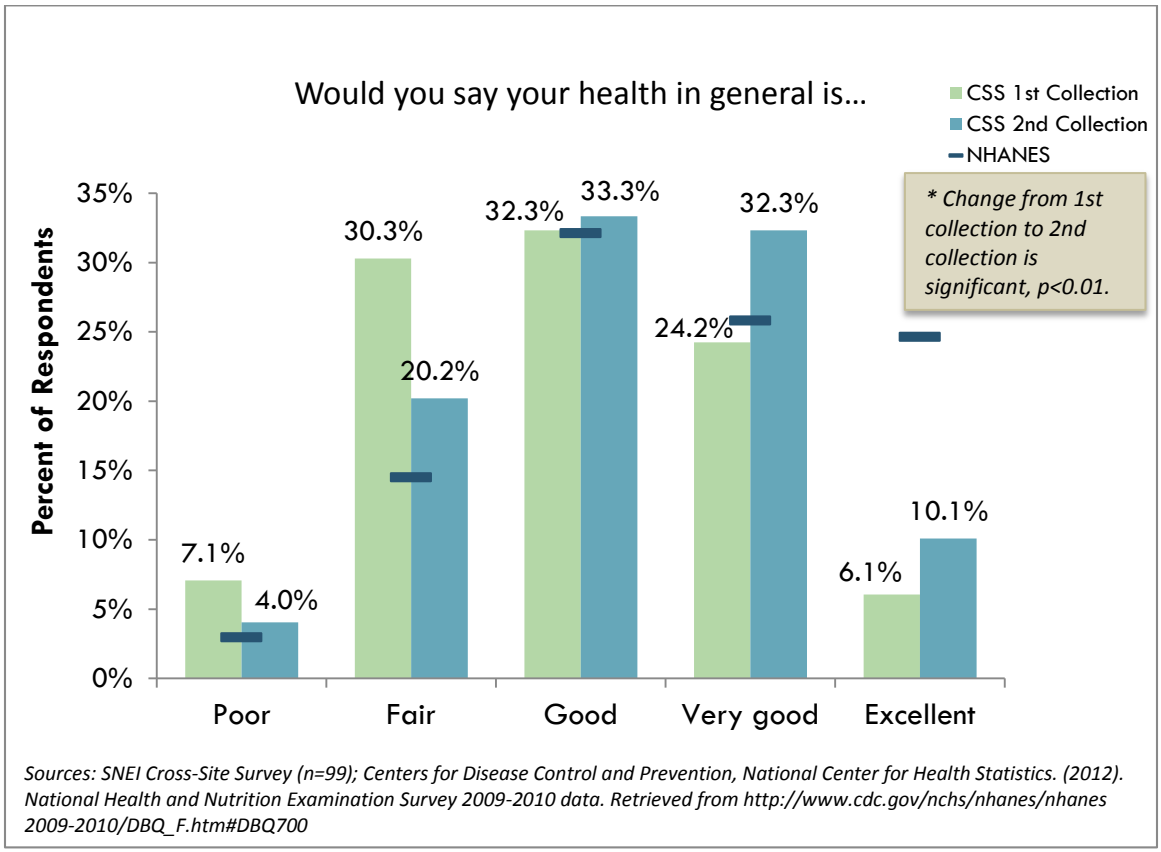
Figure 12: Overall Diet Improvement among SNEI Participants Compared to US Population



Sources: SNEI Cross-Site Survey (n=99); Centers for Disease Control and Prevention, National Center for Health Statistics. (2012). National Health and Nutrition Examination Survey 2009-2010 data. Retrieved from http://www.cdc.gov/nchs/nhanes/nhanes 2009-2010/DBQ_F.htm#DBQ700

Similarly, **CSS data shows significant improvement in overall health among individuals who participated in SNEI activities.** Again, over time these data reflect a decrease in individuals who responded that their overall health is "poor," "fair," or "good" and an increase among those who reported that their health is "excellent" or "very good" (See Figure 7). And, as with the question related to diet, in comparison to the general US population, SNEI participants are moving in the right direction. Not only are they improving over time (i.e., from first to second data collection), but the percentage of individuals who report "very good" or "excellent" health is notably greater than the NHANES results (See Figure 13).

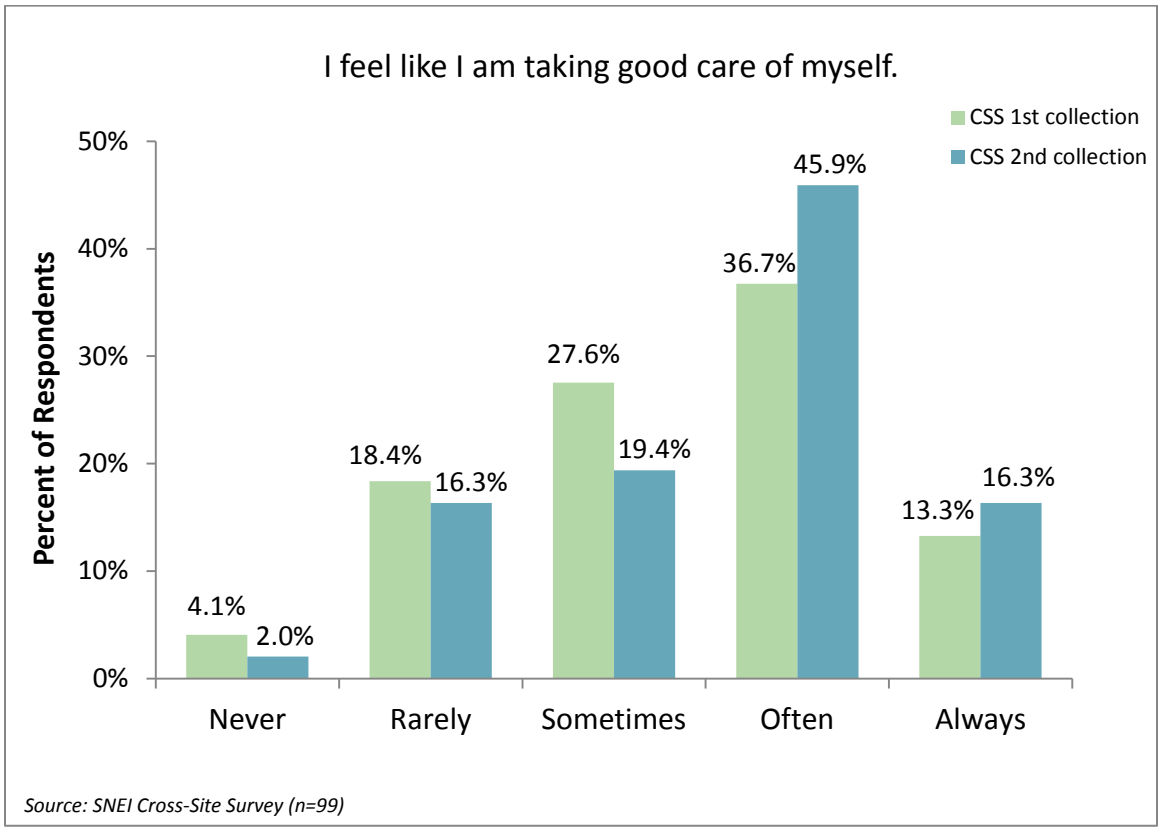
Figure 13: General Health Improvement among SNEI Participants Compared to US Population



Sources: SNEI Cross-Site Survey (n=99); Centers for Disease Control and Prevention, National Center for Health Statistics. (2012). National Health and Nutrition Examination Survey 2009-2010 data. Retrieved from http://www.cdc.gov/nchs/nhanes/nhanes 2009-2010/DBQ_F.htm#DBQ700

SNEI survey respondents also report feeling that they are taking better care of themselves. Although the results were not statistically significant, when asked whether they are taking "good care of myself," after participating in SNEI activities data show movement in the right direction, with fewer individuals providing a negative response (e.g., "never" "rarely" or "sometimes") and more responding positively (i.e., "often" or "always") (See Figure 14).

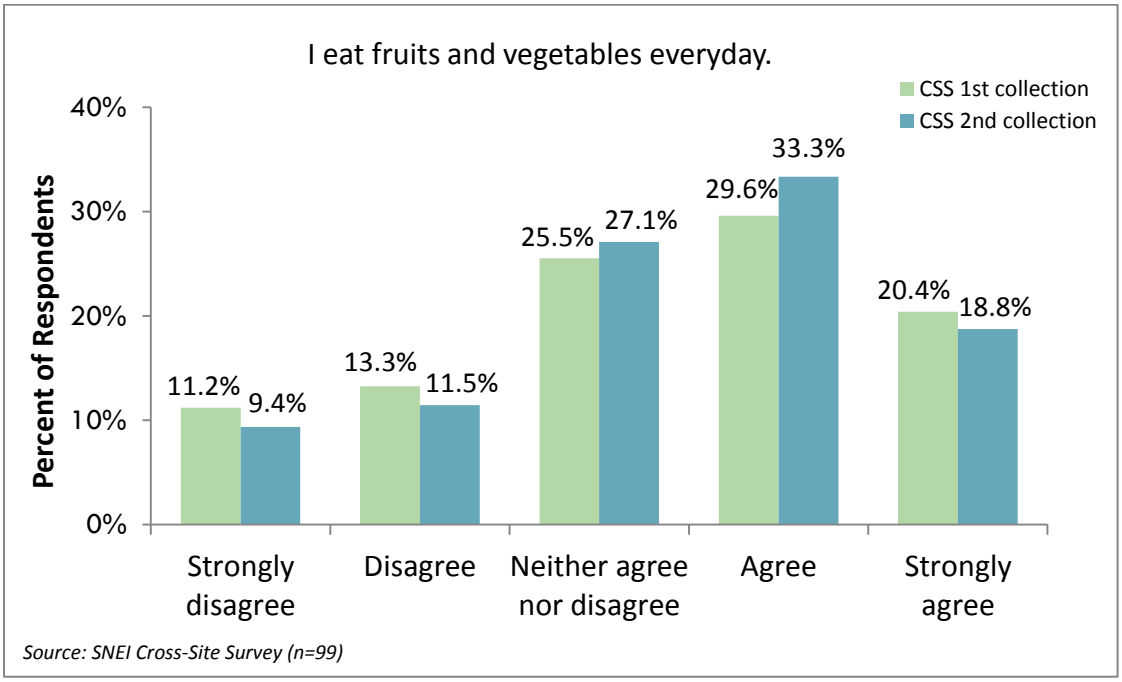
Figure 14: General Care Improvement among SNEI Participants



Source: SNEI Cross-Site Survey (n=99)

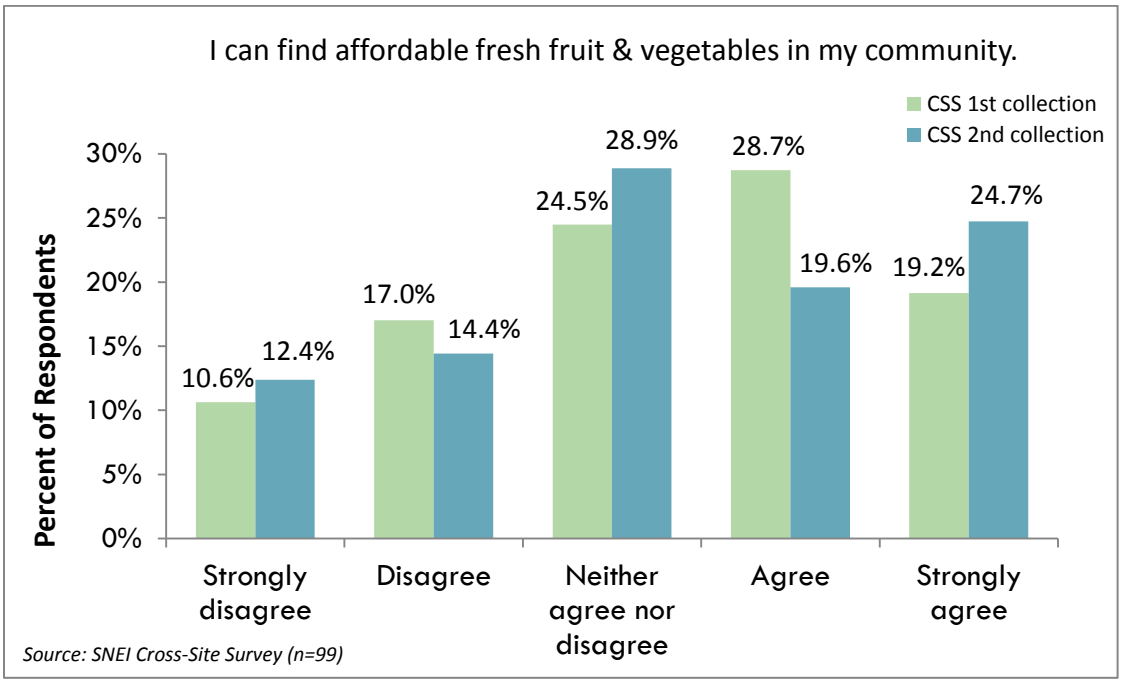
Results were less clear for questions related to the intake of and access to fresh fruits and vegetables (See Figures 15 and 16). Responses to these questions were mixed, without a clear pattern. This may be, in part, a reflection of the varied objectives of the different sites, which weren't all focused on increasing fruit and vegetables.

Figure 15: Produce Intake among SNEI Participants



Source: SNEI Cross-Site Survey (n=99)

Figure 16: Access to Affordable Produce among SNEI Participants

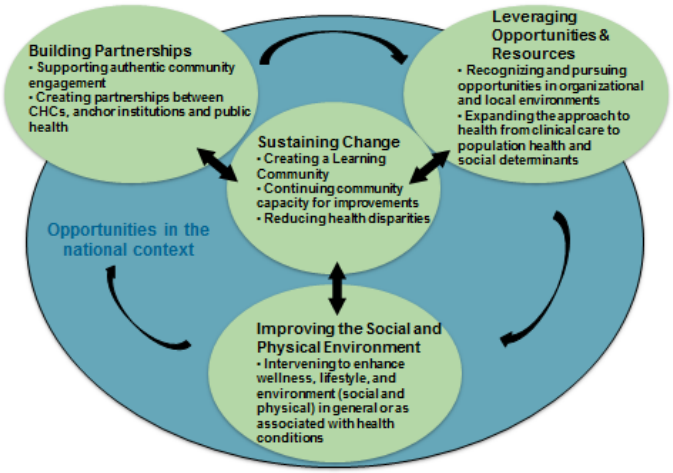


Source: SNEI Cross-Site Survey (n=99)

Discussion

In its request for proposals for the planning and implementation phases, the Kresge Foundation set forward key elements and criteria to establish the SNEI vision. Those included both programmatic and administrative requirements designed to support the development and implementation of a national, multi-site initiative with common key elements, yet with the flexibility to support local communities in identifying their own priorities and building on local assets. Reflecting back on the original evaluation framework established by the cross-site evaluation team in partnership with the Foundation provides a framework to explore the original SNEI elements and consider implications for next steps.

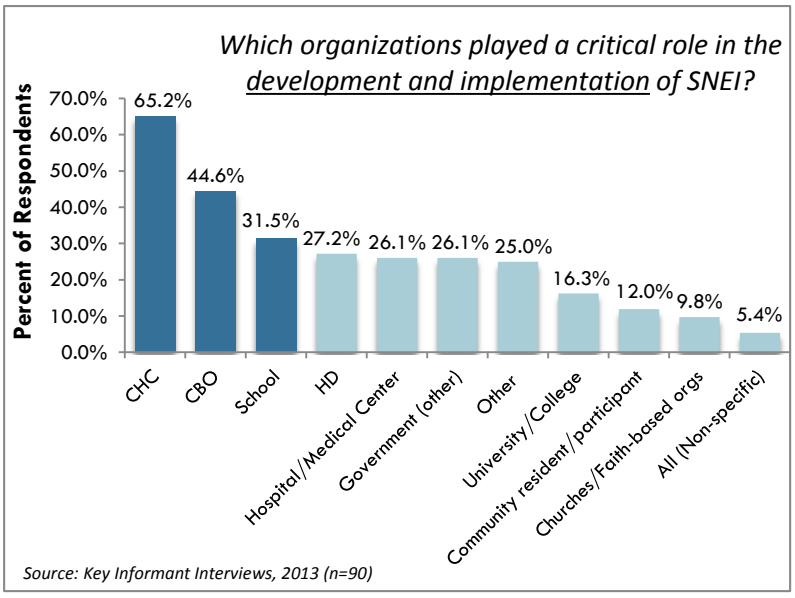
Figure 17: SNEI Evaluation Components - 2011



Partnerships

The Kresge Foundation required that successful applicants build partnerships that included community health centers, anchor institutions, local public health agencies, and community-based organizations. **Cross-site data presented throughout this report demonstrate that important partnerships were both created and strengthened through the SNEI initiative, resulting in new ways of engaging residents and addressing social determinants of health.** Those involved in SNEI overwhelmingly report that working as a partnership was more effective than working as individuals organizations, and that the partnership has facilitated change among both individuals and organizations.

Figure 18: Critical Partners for Development and Implementation

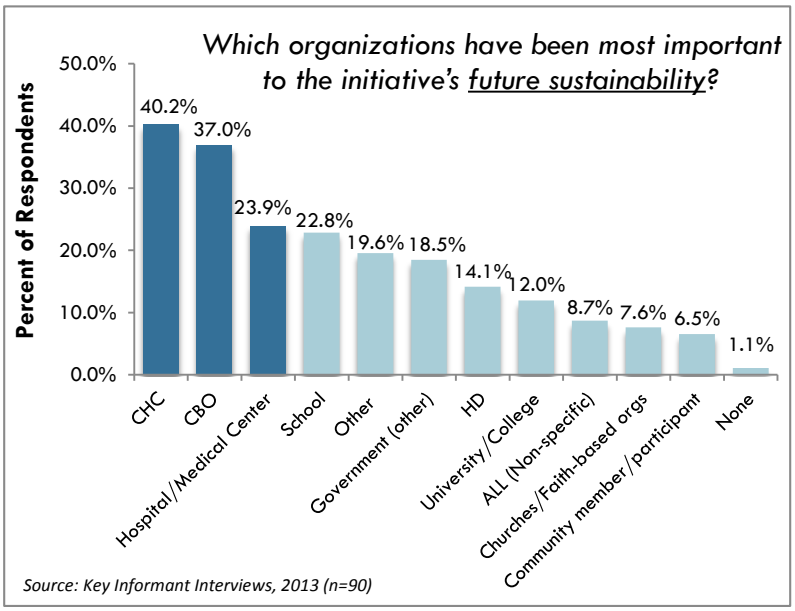


Source: Key Informant Interviews, 2013 (n=90)

As the definition of "authentic partners" was considered during the implementation period, the cross-site evaluation explored the roles and contributions of various

partner types. Of particular interest is the role of "anchor institution." As introduced by the Kresge Foundation in the original call for proposals, "anchor institution" was defined as "higher education and/or hospitals or health systems" that "provide technical skills, services, support, and financing of safety-net services." When asked to identify anchor institutions in the Collaborative Partners Forms, however, several sites identified organizations such as schools/school systems and community-based organizations, perhaps suggesting that project leaders perceived such organizations to be critical partners at that time in the initiative. The concept that different types of organizations play important roles at different points in the initiative was supported by the key informant interview data (See Figures 18 and 19). Hospitals/Medical Centers, which had been identified as anchor institutions in several sites, were not identified by key informants as one the top three "most important" partners during implementation. However, **when asked specifically which organizations played a critical role in the *sustainability* of the initiative, these organizations resurfaced, perhaps supporting the Foundation's original concept of "anchor institutions" as organizations with the expertise and community influence to support sustainability**.

Figure 19: Critical Partners for Sustainability



Leveraging Opportunities and Resources

An original component of SNEI was to recognize and pursue opportunities in the local and national context. The most obvious opportunity at the time seemed to be changes brought in consort with the Affordable Care Act, as the SNEI communities were already responding to pressure to improve primary health care, data sharing, and system coordination. As part of the cross-site evaluation, the evaluation team conducted a separate set of key informant interviews to explore the impact of the ACA on SNEI communities. Analysis of these Affordable Care Act key informant interviews demonstrated, in most sites, SNEI efforts were seen as separate from ACA-related changes, but as conceptually supported by the changes and, perhaps laying a ground work for future integration. Based on other cross-site data, the only site that directly and specifically designed programmatic efforts to respond to opportunities provided by the ACA was Kids First, which sought to integrate behavioral health services into clinical services in

a way that would be reimbursable in the new systems of care unfolding. Some SNEI sites did *create* opportunities, however, due to their success. For example, a new non-profit organization developed through Pathways in STEP received funds to support its economic development activities.

Improving the Social and Physical Environment

Improvements to the environment became a focal point of SNEI, as sites focused efforts on addressing social determinants of health. **All eight sites developed demonstration models to enhance wellness, lifestyle, and the environment specific to health conditions identified as being important to their local community. Changes to the social environment, especially, became a focus of efforts, and the concept of "community connection" became a common area of interest across all sites.** Although only two sites identified social relationships as a primary interest in their initial proposals, when the sites were asked to identify important outcomes of their work that might be measured through a cross-site survey, all eight sites identified "community connectedness" as an important outcome of their efforts. Interestingly, although perhaps unintended, data from the Cross-Site Survey demonstrate the important relationships between this single common element—community connection—and overall health.

Sustaining Change

> *"Sustainability is not about sustaining projects, but rather is about sustaining the outcomes of successful projects."*
>
> *– Dr. Noreen Clark*

The cross-site evaluation has demonstrated that SNEI has brought about important outcomes that will have a sustained impact on the way health and health care are approached in SNEI communities.

- Relationships formed through the partnerships will continue;
- The capacity to address social determinants of health has increased among individual partners, organizations, and residents;
- Organizational policies and practices have been changed to better address social determinants of health; and
- Community networks have been built to support improved health knowledge and behaviors.

In some sites, SNEI approaches have been institutionalized into existing organizations, and in other sites new efforts have been established building on the SNEI approaches.

> *"Even if there [is] no funding I think the fact that we have started a process of self-monitoring and education among our residents, there will be improvement… Knowledge is power."*
>
> *– SNEI Key Informant*

Linking SNEI Efforts to Population Health and Health Disparities

Perhaps the most important contribution SNEI can make to the field of public health is to help demonstrate the ways links can be established between community-identified interests and assets, models to address social determinants of health, and improvements to population health and health disparities. During the planning period, SNEI communities identified both the assets and challenges within their communities, and identified important social and physical environmental conditions that create barriers to health for community members. Social determinants of health, including safe places to exercise and play, access to quality clinical care, and opportunities for employment, were identified as critical elements of health. **SNEI communities developed demonstration models to improve these social determinants of health, and along the way increased the community capacity to sustain these changes, including changes to individual and organizational relationships, perspectives, and policies. These changes in community capacity are the stepping stones to population health. They are the newly developed assets upon which SNEI communities will be able to bring demonstration projects to scale, reach more individuals, and build more sustainable programs.** Reducing health disparities and improving population health is a long and complex road. These are the stepping stones to making inroads toward increasing equity of access to health and decreasing disparities in communities.

Challenges

The SNEI key informant interview data provide important lessons learned from the challenges SNEI sites faced in developing and implementing this complex initiative. In addition to the common and expected responses "not enough time" or "not enough resources (funding, staffing)," a variety of other challenges were noted by informants, primarily related to two topics: 1) engaging the community, and 2) working with and engaging partners.

Given the social and health status of the communities selected to participate in SNEI, it is not surprising that the challenges most often noted by informants involved community members' distrust of organizations and providers, especially in cases where services and staff were coming from outside of the local community. It was also acknowledged that in many communities, residents are skeptical that promised services and resources will last beyond grant funds, and are often concerned that programs are being implemented solely to get data

from the community, rather than to support the community and residents themselves. Trust was also identified as a potential barrier to accepting help and services even when needed:

> *"A lot of our community is very guarded… [there's] a guardedness in the community to be open to receiving services in a way that didn't make community members feel threatened or somehow insecure or degraded. We really had to work on overcoming people's protective shield so they would open up to services and feel trusting and able to open up to what the Initiative has to offer. I think that was a major challenge. It's an ongoing challenge."*
>
> *– SNEI Key Informant*

When asked how these challenges were overcome, the most common response was time. **Involving the community and gaining their buy-in is essential for success, and building trust with the community takes time and patience.** Informants noted that it was important to acknowledge the community's views and beliefs and consider how to convey their programs in ways that the community would respond to.

Additionally, the SNEI projects took place in communities without significant financial resources, which created additional barriers to participation. Several informants cited safety issues as being a barrier to resident participation. And informants from several sites identified community members' lack of transportation as a barrier to participation.

Informants from several sites noted a lack of time and competing priorities as a challenge to community engagement. Residents in these communities are often working multiple jobs, caring for children, etc., which makes it difficult to engage in programs and activities, even when interested. In response, informants suggested that program staff and partners promote the value of the program/activities to help encourage participation—everyone has competing priorities, especially in underserved communities, but individuals seem more likely to make time and engage in activities if they feel they have relevant value. It was also suggested that rather than having separate health education sessions, education should be integrated into activities that people are more excited about. For example, in one site, health screening was integrated into well-attended Zumba classes.

In sites that aimed to work with children, some informants commented that getting parents involved was a challenge. On the other hand, some site coordinators have noted that working with children is often a good strategy to reach parents, as they are sometimes more motivated to address issues surrounding their children than their own health.

> *"…trying to blend together very different agendas…it can be challenging to blend [a] holistic perspective on health and on community health with the more clinical or segmented or fragmented approaches that different organizations use. Sometimes that can actually cause challenges in building the partnership."*
>
> *–SNEI Key Informant*

Although key informants overall reported that working in partnership was significantly more effective then working as individual organizations, it was often acknowledged that simply bringing together diverse organizations to work in partnership brings about inherent challenges. Several informants noted that a lack of established procedures for how the partnership would function created challenges in trying to work together effectively; one informant described the process of working together as "building the plane as we were flying it." It was suggested that **early in the process partnerships should establish a common vision and goals and as well as formal agreements for how partners would work together.**

Several informants also mentioned struggles with communication between partners as a challenge to their work, and in one site, having a single lead organization in charge of the overall budget and be responsible for distributing funds to the other partners created tension. Informants in two sites noted that there were partners involved with SNEI that had a challenging history of working together in the past, which required patience and time in order to form new relationships and mend old wounds.

Many informants also mentioned struggles with power dynamics and the "politics" of working with large organizations. Some informants noted that certain partners were more dedicated to the initiative than others, in part, because some organizations had other work they were carrying out which shifted away their attention, resources, and time. Even when not faced with competing priorities, multiple informants noted that smaller organizations, often community-based organizations, had limited resources to invest in SNEI compared to larger organizations. Additionally, multiple informants acknowledged that it often takes longer to get things accomplished when working through large, bureaucratic organizations.

Conclusion

The Safety-Net Enhancement Initiative supported the efforts of eight communities to develop demonstration models that built on local resources and assets to address social determinants of health. By targeting vulnerable communities, SNEI was designed to improve the health and health status of those most in need in order to move toward reductions in health disparities and improved population health. The cross-site evaluation demonstrates that through the development of authentic partnerships, all eight sites developed promising demonstration projects that uniquely addressed the interests and assets of the local community. The contribution of these partnerships and demonstration projects has led to both community and individual-level changes within SNEI communities. SNEI increased the capacities of individuals and organizations to address social determinants of health within communities. SNEI also brought about changes in the physical and social environment, including increased access to healthy foods and safe spaces for physical activity, improved access to care related to health and social determinants of health, and increased social networks among residents. And SNEI sites created organizational policy and systems change, through which organizations, agencies, and institutions changed "business as usual" to address social determinants of health. Reducing health disparities and improving population health is a long and complex road. SNEI has helped lay stepping stones that represent a building block for increased health equity in the future.

> *"I really appreciate the incremental changes that lead to big health changes down the line a lot more now and realize that our project is part of what's planting the seeds of health in our community."*
>
> *– SNEI Key Informant*