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Innovations in Health Equity

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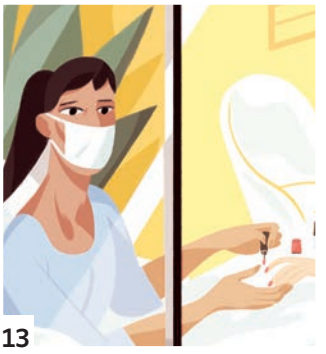
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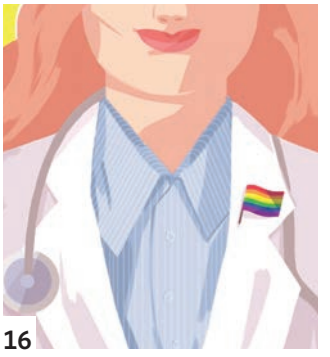
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Supplement illustrations by Rebekka Dunlap

Innovations in Health Equity and Health Philanthropy

Funders are devising new approaches that account for the impact that social issues have on people's health.

BY FAITH MITCHELL

Grantmakers In Health (GIH) is pleased to publish this supplement to *Stanford Social Innovation Review* on innovations in health equity, and we thank the Aetna Foundation for sponsoring it. GIH is a philanthropic affinity organization that informs and advises health foundations, corporate giving programs, and other funders, and provides opportunities for them to share knowledge and experiences. We are a voice for health philanthropy, and through our programming we advance the field.

Health equity is an area of intense focus for philanthropy, fueled by a sense of urgency about the need to reverse long-standing destructive trends. It is an area in which health philanthropy has shown consistent leadership in support of innovative work. Our goal in this supplement is to lift up new voices and approaches in health equity and to highlight the work of funders and community organizations that use health equity as a lens for grantmaking and partnerships. Although it was impossible to include profiles of all the good work occurring in communities across the country, we did our best to select a cross-section of programs that are concerned with some of this nation's most vulnerable populations, such as youth, LGBT people, low-income communities, immigrants, and people of color.

The leading edge of health equity work illustrated here encompasses a wide range of strategies. Settings include LGBT community centers, racially and ethnically diverse urban communities, and rural Indian country. Frameworks include promoting health equity through organizing and advocacy, grantmaking, research and data collection, regional and cross-sectoral collaboration, and community engagement. Many aspire to change policy in order to achieve sustained systems-level change. Consistently, there is a focus on community involvement, which is very different from the perspective of the traditional health-care system.

The work spotlighted in this supplement is energetic and exciting. Progress made from these various strategies will inform our understanding of what works while also—ideally—moving us closer to the goal of improved health for all.

THE QUEST FOR HEALTH EQUITY

The quest for health equity has its roots in more than a century of data showing that morbidity and mortality rates for poor Americans and people of color are significantly worse than those for the white mainstream. Even in the 19th century, the lack of health equity in the United States was a subject of concern for advocates, scholars, and health professionals. For example, in 1899 sociologist W. E. B. DuBois noted in his book *The Philadelphia Negro* that "[there] is a much higher death rate at present among Negroes than among whites: this is one measure of the difference in their social advancement."

In 1914, Booker T. Washington commented publicly on the high rate of preventable death among blacks, and in 1915 he organized National Negro Health Week, hoping to generate broad support for improving black health. Black public health leaders sustained this effort by continuing to promote National Negro Health Week for several more decades. In the meantime, trends in black and white health changed little, with large differences between the two groups in life expectancy, chronic disease prevalence, and causes of death.

In 1985, the federal government accomplished Booker T. Washington's then-70-year-old goal of bringing racial health disparities to national attention with the publication of the landmark Heckler Report, or "Report of the Secretary's Task Force on Black and Minority Health." The report's finding—"a sad and significant fact [is the] continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole"—began to galvanize action.

Since 1985, the United States has made some progress in reducing health disparities, but it is far from enough. In fact, the federal Agency for Healthcare Research and Quality's most recent "National Healthcare Disparities Report, 2014" rated national progress in reducing disparities in health care as "poor." It concluded that people of color and people in poverty had worsening quality and access on many disparity measures, and that there had been no significant change over time. In addition, the report found that whereas disparities are decreasing in a few areas, such as the number of deaths from HIV, they are continuing to increase in others, such as cancer screening and maternal and child health. The Affordable Care Act (ACA) promises to expand the number of Americans eligible for these and other preventive health services, but it is not a given that health disparities will decrease as a result.

HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH

Research has consistently shown that race and socioeconomic status are important causes of health disparities. Simply put, disadvantaged social groups systematically experience worse health or greater health risks than more advantaged social groups. From birth to death, race and class have an

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effect on rates of disease risk, exposure to environmental hazards and socioeconomic stressors, and access to health necessities such as healthy food and safe housing.

The concept of the social determinants of health, introduced by the World Health Organization (WHO) about a decade ago, has been an important tool for explaining how the social and economic structures that shape how people live also affect their health. WHO's determinants cover a broad spectrum of social, economic, and environmental factors. Included among them are access to health care and education; the distribution of power, income, and goods and services in a community; and other conditions at work, at home, in neighborhoods, and in the surrounding environment.

Access to high-quality health services is just one of several contributors to good health status. Once thought to be the key to good health, access is now understood to have about half the influence of education, employment, and other socioeconomic factors. (See "Social Determinants of Health" below.)

Health funders' adoption of the social determinants approach has required them to think differently about how they want to target their grantmaking in order to support healthy people and communities. The transition has occurred gradually. In the past, many philanthropic efforts to reduce health inequalities focused on individuals. There was an emphasis on primary prevention (such as community health education and screening), improvements in the delivery of health care, and use of data to track trends and outcomes.

With growing evidence of the social determinants of health, health funders began to focus their attention on "upstream" strategies—for example, improving housing or increasing access to education—alongside continued "downstream" work to improve health-care services. Interest in issues like access to healthy food, toxic exposure and other environmental issues, early childhood education, and investing in communities has grown.

MAKING PROGRESS ON HEALTH EQUITY

Health philanthropy offers several promising examples of progress in achieving health equity. Admittedly, the problem is enormous, and even successful investments can bring about only incremental improvements. Nonetheless, these bright spots lay the groundwork for positive change.

For some funders, supporting equity means working to influence federal policy change. Many did so in the years leading up to the passage of the ACA. Their grantmaking elevated health reform as a critical issue and helped keep it on national and state policy agendas over the course of many years. They also invested in outreach and enrollment activities—especially in low-income communities—and provided sustained support to advocacy organizations and coalitions.

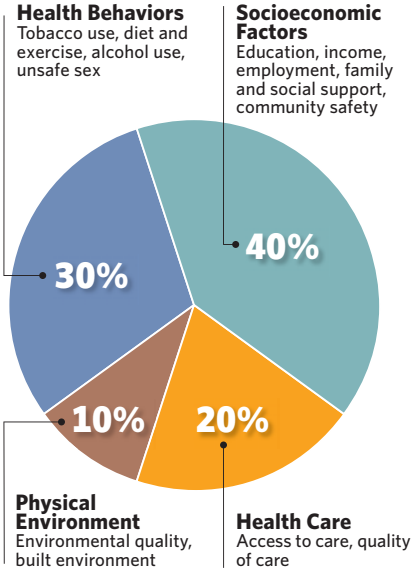
Post-ACA, many health funders continue to support health system reform as one strategy for eliminating health disparities. For example, the Con Alma Health Foundation is partnering with a national funder, the W. K. Kellogg Foundation, to monitor the implementation of the ACA in New Mexico, with a special focus on low-income and rural communities of color.

Other funders are taking a broader view that addresses inequalities by moving beyond health care and, in some cases, outside the health sector. For example, the California Endowment's $1 billion, 10-year Building Healthy Communities initiative supports health equity, but it intentionally does *not* fund direct health-care services. Instead, its goal is to "change rules at the local and state levels so that everyone is valued and has access to the resources and opportunities essential for health: affordable housing and fresh food, jobs that are safe and pay fair wages, clean air, and the other ingredients essential for a healthy life."

Health funders who have partnered with non-health organizations are an example of a growing interest in working across sectors to improve health equity. Many health funders recognize that in low-income urban neighborhoods, community development offers a vital pathway for improving the underlying conditions that shape health. By partnering with community development organizations, they have begun to invest in affordable housing, community clinics, grocery stores, child care, and other health-promoting initiatives.

One example of these partnerships is the Healthy Futures Fund, an initiative of the Local Initiatives Support Corporation, Morgan Stanley, and the Kresge Foundation. The fund supports development of federally qualified health centers in underserved areas, as well as affordable housing that incorporates health programs for low-income residents. If successful, these grantmaking strategies could potentially lead to larger wins and could be an opportunity for health philanthropy to broaden its sphere of influence outside the boundaries of the traditional health sector.

Social Determinants of Health



Source: Author's analysis and adaptation from the University of Wisconsin Population Health Institute's County Health Rankings model, 2010. http://www.countyhealthrankings.org

THE ROAD AHEAD

Because health equity is ultimately part of the larger issue of social and economic inequality, worsening economic inequality in the United States threatens health philanthropy's ability to make meaningful improvements. In recent months, the Ford Foundation's strategic shift to fighting inequality has raised the question of the role philanthropy can play in this arena.

Looking ahead, it is likely that there will be increasing pressure for funders to recognize the structural underpinnings of many social problems—including health disparities—and to commit to transforming those structural elements. This level of effort would require focusing on root causes—in the case of the Ford Foundation, these include the distribution of wealth, education and opportunities for young people, and justice based on race, ethnicity, and gender—and the willingness to take risks, invest for the long term, and work across sectors. Such work would be difficult and controversial, but because of its ability to act independently and break new ground, philanthropy may be particularly suited for taking it on.

Illuminating the Health Equity Challenge

The causes of health inequity are diverse and entwined; the solutions will be as well.

BY GARTH GRAHAM, MARYLYNN OSTROWSKI, & ALYSE SABINA

This supplement to the *Stanford Social Innovation Review* explores the diverse social factors that affect population health and health equity. The articles move far beyond focusing on the obvious weaknesses in our health systems to examine how socioeconomics and culture, environment and geography, race, sexual identity, and more influence population health. They illuminate the heart of the health equity challenge and reveal a common perspective: that solutions will come not from a single source, but rather from the combined forces of policymakers, legislators, national and community leaders, private companies, nonprofits, foundations, and many other stakeholders.

We're proud to sponsor this supplement because at the Aetna Foundation, we view all of our initiatives, partnerships, and grantmaking activities through the lens of health equity; we concentrate on innovations that can improve the health of underserved populations. We hope the articles you are about to read will help to enrich the dialogue surrounding one of the most serious challenges our nation faces today—and spark potential solutions to it.

WHERE YOU LIVE IS HOW LONG YOU LIVE

It's startling how strongly a person's health and longevity correlate with where he or she lives—a person's ZIP code is a stronger predictor of overall health than many other factors, including race and genetics.[1] For example, the life expectancy for a child born in New Orleans can vary by as much as 25 years between neighborhoods that are only a few miles apart.[2] In Boston, one census tract in the Roxbury community has the city's lowest life expectancy,[3] and at 58.9 years it's similar to how long the average American lived in the early 1920s. In Back Bay, just a neighborhood away, the life expectancy is 91.9 years. Premature death, lower worker productivity from illness, and more treatment of medical conditions constitute the economic cost of health disparities—up to $309 billion annually in the United States.[4]

Access to care and health information, as well as to basic necessities such as affordable, healthy foods and safe places to engage in physical activity, influence quality of life and well-being. Our health is significantly affected by the social, economic, and environmental conditions of the communities where we live. Because disparities vary with geography, we must reach people in the places where they spend time—in their homes, schools, jobs, neighborhoods, and faith-based groups. We must work to strengthen community-based infrastructure and find innovative ways to affect people in their daily lives. From different vantage points, and with different strengths, we must pursue a variety of strategies that complement one another. Here are three of the strategies that the Aetna Foundation is investing in to achieve health equity.

Solutions will come from the combined forces of policymakers, legislators, national and community leaders, private companies, nonprofits, foundations, and other stakeholders.

USING DATA TO DRIVE THE RIGHT STRATEGIES

Some US states experience lower premature death rates from various causes than others. If all states were to achieve the lowest observed mortality rates for the top five causes of premature death (for people under 80 years old), we could prevent 250,000 deaths annually.[5] But with myriad economic, social, and policy factors affecting these outcomes, it is challenging to draft strategies that will achieve the lowest premature death rates in every state and community. A critical first step is gaining a comprehensive understanding of the root causes of health disparities at the community level, to inform the decision making that will result in meaningful changes in health laws, policies, programs, and educational institutions.

The Camden Coalition of Healthcare Providers is testing one model for how we can achieve such understanding. The Coalition works in Camden, N.J., one of the nation's poorest cities, where an estimated 30 percent of health-care costs are devoted to 1 percent of the population.

With the Aetna Foundation's support, the Camden Coalition is creating a social determinants of health database (SDD) that collects health data and integrates them with social data from agencies serving the Camden community. Aggregated social data include educational attainment, law enforcement records, employment status, and homelessness. Analyzing the SDD data will profile vulnerable groups and reveal social issues that affect care. By clarifying the flow of services across Camden, the SDD will also generate cost savings by revealing how service providers might distribute limited resources more efficiently. The database will be accessible by researchers, policymakers, community leaders, advocacy groups, the media, private foundations, and most important, the public.

HARNESSING TECHNOLOGY

The Aetna Foundation is also investing in digital health technology. According to data from the Pew Research Center, a majority of

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low-income adults have access to a mobile phone (84 percent)[6] or a smart phone (50 percent),[7] and nearly two-thirds (62 percent) of smartphone owners report having used the phone to look up health information.[8] The increased use of mobile technology in these communities may facilitate the spread of information and tools helpful for making good health-related decisions. In addition, as mobile technology continues to improve, health policies and initiatives will benefit from the data generated by sensors that can monitor, among other things, heart rate, steps taken, and routes traveled, and also whether a user is running, walking, ascending, or descending.

An important first step in adopting healthy behaviors is to have clarity about one's current health status and disease risks. To this end, the Washington University School of Medicine in St. Louis has published an evidence-based smart phone app called Zuum. The app asks each user to complete a brief survey and then lists the individual user's healthy habits alongside lifestyle modifications that could further reduce her various disease risks. Users can send these results to doctors, family members, or friends, thereby enabling positive reinforcement. With Aetna Foundation support, Washington University is assessing the feasibility of integrating Zuum into various clinical care settings in urban St. Louis and rural Illinois, where the population is largely low-income and underinsured.

The Aetna Foundation also recognizes that healthy eating is an important component of healthy living. Residents in areas with the highest economic need often have the least access to affordable healthy food. To improve the availability of healthy foods in these communities, the Fair Food Network is drawing on Aetna Foundation funding to test a smart phone app that processes food assistance benefits more simply and affordably at farmers' markets. This method may allow for widespread adoption of Supplemental Nutrition Assistance Program (SNAP) benefits by individual farmers, thereby increasing the demand for fresh foods while also increasing the likelihood that they reach dinner tables.

At the Aetna Foundation, we believe so strongly in the potential benefits of emerging technology that we also recently dedicated significant funding to an initiative designed to highlight and elevate some of the most promising innovations. The "Healthier World Innovation Challenge" is designed to support digital health innovations that measurably improve chronic health outcomes in underserved communities. This challenge is part of a larger, three-year commitment to digital health innovations that the Aetna Foundation is making to address public health concerns.

COMMUNITY FOCUSED FUNDING

The third strategy we employ to promote health equity is community focused funding. Our funding model includes partnerships with both national and local organizations to stimulate positive impact at both the population and community levels. With greater health equity as the common goal, our partners and grantees are advancing new models or expanding on standard practices for chronic disease prevention and management; promoting community-centered health systems that integrate data from public health, social services, health care, and other sources to improve chronic disease outcomes; and elevating promising practices that build racial and ethnic diversity in health leadership.

Beyond a fundamental focus on underserved populations, we look at every funding or partnering decision through two different lenses. The first is impact. We challenge our partners with this question: How will this project effect change and for whom? Part of this exercise is to define specific goals, strategies, and tools and to use well-defined metrics to measure progress and success. The second lens is scalability. Here the challenge for partners is to answer this question: If this project works out well, how can we replicate it elsewhere? We want success to spawn numerous other successes, working from models that are proven, flexible, and sustainable. The combination of impact and scalability has the potential to deliver results that are exponentially more profound than projects that don't have this focus, changing lives in communities far removed from those where an original approach was invented.

As the Aetna Foundation has intensified its focus on funding innovation, we have learned several lessons that may be useful to other funders seeking novel solutions to the health equity problem. We have learned to:

- *Accept heightened risk*. Innovation naturally involves exploring new ideas, which means that funders must be comfortable with risk. Nevertheless, it's important not to get swept up in the hype surrounding new technologies, but instead to concentrate on whether an innovation will truly meet a community's needs.
- *Be flexible with the innovators.* True game-changers can be difficult to find, so funders themselves must be innovative in how they solicit novel concepts from the field and engage prospective grantees. Finding game-changers requires an iterative process: If you don't find what you are looking for right away, refine your methods and try again.
- *Consider strategic and human dimensions.* When you are funding innovation, it's important to consider both the broader strategy—evaluating it rigorously through multiple methods—and the human interface, ensuring that disruptive practices are developed with the end user's complex needs always at the forefront.
- *Design with the best available insights.* Addressing health equity through innovation should include community-centered design and implementation strategies, as well as a cross-sectoral approach that takes into account social determinants of health.

BROADENING THE CONVERSATION

The health equity challenge is complex because it is not just about health and medical care. As the authors contributing to this supplement aptly demonstrate, it is intertwined with advocacy, social justice, grassroots organizing, environmental health, workers' rights and safety, community development, racial equity, LGBT health, housing, transportation, and an array of other issues. The conversation about health equity, then, must be broad. And *everyone* has a role to play in carrying it out.

Notes

1 Centers for Disease Control and Prevention. "Vital Signs Telebriefing on Heart Disease and Stroke Deaths," September 3, 2013.

2 Robert Wood Johnson Foundation Commission to Build a Healthier America, "Metro Map: New Orleans, Louisiana," June 19, 2013.

3 Emily Zimmerman, Benjamin Evans, et al., "Social Capital and Health Outcomes in Boston," Virginia Commonwealth University Center on Human Needs, September 2012.

4 Kaiser Family Foundation, "Focus on Health Care Disparities," November 30, 2012.

5 Paula Yoon, Brigham Bastian, et al., "Potentially Preventable Deaths from the Five Leading Causes of Death—United States, 2008-2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, vol. 63, no. 17, May 2, 2014, pp. 369-374.

6 "Pew Research Center Internet Project Survey," Pew Research Center, January 9-12, 2014.

7 Aaron Smith, "U.S. Smartphone Use in 2015," Pew Research Center, April 1, 2015.

8 Ibid.

Partnering with Philanthropy in Native America

Community-based organizations, philanthropic institutions, and federal agencies—all are needed to support and sustain revitalization efforts.

BY NICK TILSEN

If you look at a map of South Dakota, you'll see that the southwestern corner shows the outline of a border within the state. That border demarcates the boundaries of the Pine Ridge Indian Reservation, more than 2.8 million acres of rolling hills, prairie, scattered pine trees, and creeks, brimming with an abundance of wildlife including buffalo, elk, deer, antelope, and turkey.

The reservation, a sovereign nation, is home to the Oglala Lakota people—approximately 40,000 residents living in more than 50 small communities and governed by the Oglala Sioux Tribe. The vibrant culture of the Lakota people is apparent there. Our culture is centered on a strong spiritual connection to the land, and our many traditional ceremonies focus on healing the human spirit and honoring all living things.

Although Pine Ridge is a place of breathtaking natural beauty and rich culture, it is also ground zero for poverty in America. Oglala Lakota County, which is entirely within the boundaries of the reservation, is often labeled the poorest county in the United States. Unemployment rates hover between 60 and 80 percent, and 48 percent of the population lives below the federal poverty line. The county is also burdened by overcrowded and poor-quality housing, coupled with a severe lack of opportunities for economic growth and progress.

Pine Ridge is also ground zero for health disparities in America. The life expectancy on the reservation is age 48 for men and 52 for women, the lowest in the Western Hemisphere with the exception of Haiti. More than 50 percent of the population is under the age of 18, and young people on Pine Ridge are 10 times more likely to commit suicide than in any other community in America. Chronic diseases such as diabetes and heart disease are also at epidemic levels.

But there are signs of improvement. The percentage of young people on the reservation clearly reflects the area's low life expectancy, but it also represents an opportunity to transform the region by empowering young people to become leaders who can change the future of their community. That shift is already beginning to happen. Over the past decade, Native American youths there have begun reconnecting to their culture, spirituality, and identity, spurring the emergence of a movement toward regional equity that will change Pine Ridge forever.

A COMMUNITY DEVELOPMENT CORPORATION APPROACH

The current youth movement on Pine Ridge began in late 2006 and early 2007, when a group of us came together to see how we could improve our situation. We were all from the reservation, and we all felt a deep conviction and responsibility to create a better future on Pine Ridge.

We wanted to run youth programs, build housing, create jobs, improve health, and do anything else needed to strengthen our communities. But we also wanted to make progress that would stick. So we began to search for the root of the systemic barriers facing our communities. As we did that, we realized that all the issues our people were

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confronting were interconnected. The policies, statutory decisions, and bureaucratic processes that exist today have created silos, separated people from resources, and most important, discouraged people from feeling empowered to create their destiny.

To tackle these interconnected problems we chose a community development corporation (CDC) model and created the Thunder Valley Community Development Corporation—we didn't want to be confined to a narrow focus. That's also why we adopted a framework focused on equity and empowerment through the lens of our Lakota cultural identity.

In Lakota we say "*Mitákuye Oyás'iŋ*"—we are all related. All living things—people, plants, animals, organisms, and systems—are collectively part of a living, breathing entity that encompasses all creation. Through time, conflicts, wars, and the oppression of our people and culture, this connection between us all has broken down. As Oglala Lakota people working through these issues on Pine Ridge, we recognize that we need to return to our ways and live in harmony with one another.

CULTURALLY BASED COLLECTIVE PROBLEM SOLVING

We have also adopted a philosophy of regeneration that is both about healing the human spirit and about fixing the unsustainable systems that perpetuate poverty, create health disparities, and fuel the injustice and inequality that affect us every day. It is a culturally based approach to collective problem solving.

So far, our regeneration work has led to the creation of two major initiatives that are catalyzing Pine Ridge to build more equitable communities. The first, our Regional Equity Initiative, started with a HUD Sustainable Communities Planning Grant in 2011. Through this process, Thunder Valley CDC partnered with the Oglala Sioux Tribe and a 22-member consortium of local organizations to create the first sustainable development plan for this region—the Oyate Ominiciyé Oglala Lakota Plan.

This plan, which includes 12 initiatives, was published in both Lakota and English. Since it passed the Oglala Sioux Tribal council in 2012, it has brought more than $12 million into the region in the form of grants, loans, and investments to improve roads, build homes, and create more livable communities. In addition, the plan was instrumental in the selection of Pine Ridge as a Promise Zone. In a Promise Zone, the federal government works collaboratively with multiple agencies—in this case, the Oglala Sioux Tribe, Thunder Valley CDC, and other local partners—to make targeted investments that will reduce crime, expand job opportunities, improve education, and take other steps toward building healthy communities on the reservation.

THE EXTENDED FAMILY NEIGHBORHOOD

Our approach to creating regional equity is to build an actual physical community and to create the associated models for development that will sustain that community. We are doing this so that we can have a physical location as a base for generating ecosystems of opportunity. We are now building a 34-acre affordable, eco-friendly, place-based community in the Porcupine district on Pine Ridge. The mixed-use and mixed-income development is the largest creative place-making project in the history of the region. It will emphasize home ownership and include healthy, livable neighborhoods with walking paths, a community wellness center, outdoor youth spaces, artist live-and-work spaces, an organic garden and farm, a workforce development training center, and spaces to incubate local businesses. The new homes are being located in circle patterns to create positive interactions among the families, reflecting the historical way we organized our tipis. We are calling this the *thiyóšpaye* (extended family) pocket neighborhood design.

Thunder Valley CDC is carrying out this work through an intensive community engagement process. It pairs the physical and cultural ideas and needs of the community with a design team of award-winning architects and planners that include BNIM of Kansas City, Mo.; Pyatt Studio of Boulder, Colo.; and KLJ of Rapid City, S.D. Ultimately, we have a net-zero energy goal, with 100 percent water reclamation, passive solar homes, and 30 percent cost savings on construction.

The development has brought together federal agencies, foundations, and banks to collaborate in a place where the majority of them had never invested. In June 2015, we marked the beginning of Phase 1 with an emotional groundbreaking ceremony. More than 300 people from the reservation and around the country came to Pine Ridge to participate. We shared stories, poetry, songs, and prayers for the future. And rather than have a few people pose with shovels to commemorate the event, hundreds of people picked up shovels and turned the ground over together to put our energy into this place and to symbolize the unity and collectivity that guides our vision of regeneration.

THE IMPORTANCE OF COMMUNITY-BASED ORGANIZATIONS

Our holistic approach to problem solving offers systems-based solutions for cultivating healthy, sustainable communities. Cross-sector collaboration and community leadership are absolutely essential to creating regional equity. Community-based organizations are just as important to change making as multi-million-dollar philanthropic institutions and federal agencies. And so our message to philanthropy is this: If the goal is fostering sustainable social and economic change on a national scale, then funding grassroots community organizations working to create holistic pathways to healthy and prosperous communities is crucial—especially if the change you seek is in the poorest and most challenged communities.

We are working with and actively engaging our community, and we are challenging foundations and other private partners to help us disrupt the status quo and build a long-lasting commitment to the principles of equity, regeneration, and social justice. We have a long way to go to create a lasting ecosystem of opportunity so that our people, and others who experience the effects of generations of oppression and failed development, can become their own agents of change. We have a long way to go, but there is hope. Fierce, electric, contagious hope.

We have the ability to end poverty in Native American communities in our lifetime if the philanthropic community is ready to partner with us, take risks, and invest in long-term, community-led capacity-building programs. Today, less than 1 percent of all philanthropy in America goes to rural Native American communities. We need to change this now, and we need to change it together. There is a growing nonprofit sector in Native America, the community development finance institution movement is in full swing, and we have powerful, resilient cultures to rely on. Cross-sector collaboration will be the next step in the pathway forward as we all start working toward a vibrant, just, and sustainable world. The movement is here and the time is now.

Building Power, Building Health

By catalyzing the power of people to make change, community organizers equip people at every level to overcome the myriad barriers to health.

BY DORAN SCHRANTZ

By the time PBS aired the documentary *Unnatural Causes* in 2008, most viewers already knew that "inequality is making us sick." The series illustrated what decades of research had made clear: our health is affected by the social circumstances in which we are born, work, and live. Health disparities are closely tied to race, class, and gender and rooted in unequal community conditions.

This inequality doesn't occur by chance. Small groups of people with clout wield the political power to make decisions that benefit themselves and people like them, in city councils, zoning boards, state legislatures, and school boards. The good news is that we can design a new way of organizing our society to promote health equity. But to do so, we need to transform the arrangements of power. This is where the principles and practices of community-based organizing have something to contribute. If powerlessness is contributing to what makes us sick, then building community power can help make us well.

COMMUNITY ORGANIZING

ISAIAH is a faith-based community-organizing project in Minnesota. Our 100 member churches represent about 250,000 people from white, Latino, African-American, and multiracial congregations, including Catholic, Lutheran, Baptist, and Evangelical denominations. We officially began working on health equity in 2008, after our clergy and congregations watched and discussed *Unnatural Causes*, but we have always understood the connections between our faith, our commitment to racial and economic justice, and the conditions that help communities thrive.

ISAIAH is the vehicle through which a quarter of a million people of faith exercise power. The project amplifies their voices and provides them with tools to articulate their needs and engage in the public sphere. Together, ISAIAH and our member churches pursue (and often win) policy changes that shift the social determinants of health. Here are three examples:

- *Using public transit to improve health.* It was evident in the planning stages that the new light rail line connecting Minneapolis and St. Paul had the potential to improve health for those who lived along its path. The service and associated development could connect residents with jobs and schools, bring new businesses into their neighborhood, make streets safer for pedestrians, and create parks. But in 2009, developers cut costs by eliminating three planned stops in low-income neighborhoods of color. ISAIAH swung into action. We joined the Stops for Us Campaign, held neighborhood meetings, alerted the media, and met with city council members, state legislators, and the governor. In the end, we took our demands all the way to Congress to overturn federal guidelines and clear the way for restoring those three stops.
- *Raising the minimum wage.* In 2014, Minnesota's minimum wage was among the lowest in the country, but lawmakers were conflicted about whether to raise it and, if so, by how much. ISAIAH members asked the legislature to explore the health implications of wages. The resulting report from Minnesota's Department of Health was shocking: low-wage workers died eight years earlier than people earning higher incomes. ISAIAH clergy and congregation members urged lawmakers to consider the health consequences of their actions. The legislature raised the wage to $9.50 an hour, indexed to inflation, without a tip penalty.
- *Ending the school-to-prison pipeline.* School suspensions and expulsions disproportionately affect children of color and exacerbate academic achievement gaps between white students and African-American, Latino, and Native American youth. Harsh disciplinary policies restrict education and economic opportunities and push children into the criminal justice system. ISAIAH's African-American congregations have led the way in seeking a statewide moratorium on school suspensions. In 2014 we persuaded two school districts to join us, and one has already begun to implement a district-level ban on push-out discipline.

BUILDING POWER AND VOICE

Many of our communities suffer from ill health not just because they lack economic resources but also because they lack political power. Powerlessness, in and of itself, is bad for your health. Community organizing has a unique role to play—not just in winning policy changes—but in building the power, voice, and leadership of people themselves to change systems and policies.

Foundations have a critical role to play in supporting health equity organizing. Rather than target their resources solely on improving health care and access, philanthropists can help communities thrive by investing in building the leadership skills and power of individuals and constituencies who have been excluded from public discourse.

Through ISAIAH and other community organizing efforts, people become experts on policies affecting their lives. We provide tools so that our faith community can identify pressing problems, research solutions, build coalitions with allies, and advocate change with public officials. Through training and mobilization, people of faith emerge as skilled, powerful leaders working to advance equity and health for their communities.

DORAN SCHRANTZ is the executive director of ISAIAH, a faith-based community organization of 100 member congregations in the Minneapolis and St. Paul metropolitan area, and greater Minnesota.

Philanthropy on the Frontlines of Ferguson

The Deaconess Foundation seeks to shift public policy, mobilize community members, and strengthen advocacy efforts related to children and youth.

BY REV. STARSKY D. WILSON

Few moments in life are filled with the hope and promise of a high school graduation. Marked by celebration and anticipation of the future, commencement is one of the most important milestones in a young person's life. For students in Normandy High School's class of 2014, though, graduation was also a stark reminder of the deep inequities facing many of America's young people. The district, in a suburb of St. Louis, had lost its accreditation in 2012, and in 2013 it found itself at the center of a school transfer debacle that at one point saw dozens of white parents from nearby suburbs yelling for Normandy's predominantly black young people to leave the schools in their communities and "go home." Shortly after graduation in 2014, the Missouri State Board of Education announced that the Normandy School District would close that same year.

Then Michael Brown Jr. was shot. Brown was one of the last students to fulfill the requirements for graduation in the Normandy School District. The events in Ferguson since his death have underscored the health impact and trauma of racism, from incidents experienced on the street to the implicit bias found in institutions. In brief, the summer of 2014 marked the very public diagnosis of an unhealthy community with suffering youth and racial inequity as the most prominent symptoms.

Brown's death at the hands of former Ferguson police officer Darren Wilson sparked a national dialogue about racial inequality. It brought home the point that, just as place and poverty are social determinants of health, racial equity is an important indicator of our communities' health. This dialogue has been a critically important step toward addressing the complex challenges and deep fissures that exist in communities plagued by racial tension and economic instability. But we at Deaconess Foundation strongly believe that in order to overcome these challenges and heal the fissures, the dialogue must be followed by action on a systemic level.

BEYOND GRANTMAKING

At Deaconess, we came to the conclusion that a systemic approach to change was the best course of action—for us, and for other foundations seeking to effect lasting change—a few years ago. Deaconess is the successor of the Evangelical Deaconess Society of St. Louis; it began its grantmaking in 1998 with proceeds from the sale of the Deaconess Incarnate Word Health System.

In the spirit of its United Church of Christ faith heritage, our mission is to improve the health of the St. Louis metropolitan community and its residents. The foundation envisions a community that values the health and well-being of all children and gives priority attention to the most vulnerable. The first of our five core values is justice, as we believe that "a just society is essential for the full achievement of individual and community health."

In November 2013, Deaconess decided to build on a decade of knowledge and deep relationships with child-serving agencies and congregational partners to expand impact through a community capacity-building plan. The plan aims to shift public policy, mobilize community members, and strengthen advocacy efforts related to children and young people. The plan also seeks to expand the role of the foundation by providing the community with resources in addition to funding—specifically, by investing reputational and relational capital as an influencer, convener, and broker.

Those efforts set the stage for our response after the shooting. Ten days into the uprising and widespread civil unrest in Ferguson, Deaconess made a flexible funding commitment of $100,000 to support youth organizing. In 2015, Deaconess followed up by establishing the Ferguson Youth Organizing Fund, which allows other donors to invest through Deaconess. We also launched a new grant opportunity that provides dedicated annual funding for youth organizing. Deaconess's response to the uprising attracted the interest of funders outside the region. To date, outside funding partners have been as diverse as the Public Welfare Foundation, the Ford Foundation, the NBA Players' Association Foundation, Casey Family Programs, and Anheuser Busch InBev.

To advance racial and socioeconomic equity post-Ferguson, the foundation's ability to build and sustain relationships at both grasstops and grassroots levels is even more important than the dollars invested. From nonviolent direct actions (including being arrested with clergy leaders attempting to enter the US Attorney's office on the anniversary of Michael Brown's death) to closed-door strategy meetings, Deaconess staff members have engaged directly, taking on coordinating roles with community organizers, elected officials, law enforcement, local clergy, civil rights activists, and national funders.

THE FERGUSON COMMISSION

The various roles Deaconess played in the wake of the unrest led to an invitation from Missouri Governor Jeremiah Nixon for me to co-chair the Ferguson Commission. Created by executive order in November 2014, the Ferguson Commission has been

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called an experiment in inclusive democracy. It has engaged more than 2,200 citizens and 100 subject matter experts in more than 60 public meetings, and it has marshalled nearly 20,000 volunteer hours to explore issues such as citizen-law enforcement relations, municipal courts and governance, racial and ethnic relations, regional disparities in health, education, housing, transportation, child care, and family and community stability.

The commission's nearly $1 million budget was funded primarily by the State of Missouri through economic development, community service, and community development block grant dollars. Funding was also provided by the Robert Wood Johnson Foundation, Missouri Foundation for Health, and Deaconess Foundation. The United Way of Greater St. Louis served as the commission's fiscal agent.

The Ferguson Commission report, *Forward Through Ferguson: A Path Toward Racial Equity*, was released on September 14, 2015. It includes 189 calls to action for regional and statewide policymakers. Priority recommendations are organized into four categories: racial equity, justice for all, youth at the center, and opportunities to thrive. The life expectancy gap among citizens in this region differs by almost 40 years depending on ZIP code, with residents of majority white municipalities outliving majority black ones by decades.[1] The state of Missouri ranked 50th in the racial discipline gap among primary-school-aged children and 47th among secondary school students.[2] According to the University of Missouri-St. Louis Public Policy Research Center, the 2012 gross domestic product for the St. Louis region would have been $13.56 billion greater (at $151.3 billion) if there had been no racial income gap.[3]

The commission's findings and recommendations were telling, but the report's frame is vital. The report is about race, regionalism, and responsiveness to community outcries. The very first page states, "We know that talking about race makes a lot of people uncomfortable. But make no mistake: this is about race." With the numerous studies and increased attention focused on the area—from US Department of Justice reports to President Obama's Task Force on 21st Century Policing—it was important that the Ferguson Commission produced a "People's Report," informed and owned by citizens rather than elected officials or policy wonks.

Leading the commission gave Deaconess the opportunity to influence the prioritizing of policy recommendations, and we emphasized the need to advance racial and health equity, as well as to create policies that are supported by research and that will have generational impact. As the commission moved toward implementation and evaluation, the foundation's experience supporting collective impact further informed the discussion. Since the recommendations became public, Deaconess has convened a group of community organizing and advocacy organizations to coordinate campaigns and public actions to assure accountability for civic leaders. In November 2015, we worked with activists to host two public accountability meetings where civic leaders—including the attorney general, the city mayor, legislators, the Chamber of Commerce president, and school superintendents—pledged support for Ferguson Commission calls to action.

In many ways, the Ferguson Commission gave Deaconess an opportunity to learn and explore its emerging approach to social change in real time. Public testimony from people directly affected assured robust community engagement in policy development. Foundation leaders advocated with partner organizations within work groups and with elected officials. Foundation funding undergirded each element of the process. This experiment in inclusive democracy has accelerated staff learning and validated relatively new governance platforms, including a policy and community advisory board that includes youth voices and elected officials informing our long-term program.

LOOKING AHEAD

Michael Brown Jr.'s death was singular in its impact on raising national awareness about racial inequities, but his experience in the St. Louis region was not uncommon. His classmates effectively started their adult lives through the haze of tear gas. They still face barriers that limit their quality of life and life expectancy. The disparities are vast and the need is pressing. If philanthropy wants to continue to be venture capital for social change, health foundations and others must recognize the root causes of the problems they are trying to solve. They must invest in our most vulnerable young people's future by supporting systemic change.

Notes

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Promoting Health Impact Assessments

Health impact assessments can be used to bring the social determinants of health into the policymaking process.

BY LILI FARHANG & JONATHAN HELLER

Public health practitioners understand that our health is determined by social, economic, and environmental conditions and by underlying patterns of racial, gender, and economic injustice. They're not alone. There is a burgeoning movement across the United States to take action on the social determinants of health. Yet when policymakers make decisions about housing, transportation, criminal justice, labor, and many other domains, they rarely consider the extensive evidence that connects the dots between their actions and our health.

How can we get more policymakers to bring the social determinants of health into the policymaking process? Promoting health impact assessments (HIAs) may be the answer. An HIA is a structured research and public engagement practice used to identify the likely health and equity impacts of proposed public policies and to provide recommendations to reduce identified impacts. HIAs have been used effectively to influence social, economic, and environmental policy and to advance equity in local, state, and federal decision-making. In fact, they have led to concrete health and equity-promoting changes, such as improvements in building design, land use, and transportation plans; increased funding for affordable housing and alternatives to incarceration; adoption of paid sick days and other labor policies; and changes in school funding and integration.

But HIAs should not be viewed only as tools to change policy. They can also advance equity in and of themselves. In our experience, the HIAs that have been most successful at changing policy include significant community engagement and deep partnership between public health practitioners and community organizers. Although the final report that results from an HIA is important for achieving policy change, the process by which the HIA is conducted is equally important, because it can empower participating communities to have more control over the decisions that affect their lives. The process itself helps build the leadership, voice, and influence of marginalized communities.

On the basis of our experience conducting HIAs and providing training and technical assistance to practitioners across the country, we propose four measurable objectives for public health practitioners and grantmakers to embrace if they envision using HIA as a tool to advance equity. These objectives can also be employed more broadly in public health research projects; that's why we frame them expansively:

- *The research and research products must focus explicitly on equity and be conducted to advance equity.* There are several ways to achieve this focus. To begin, the research topic should ideally be identified by—or at a minimum, be relevant to—communities facing inequities. In addition, the goals of the research project as well as the research questions and methods should explicitly address equity. The knowledge of those facing inequities should be integrated into the research as evidence, and those conducting the analysis should make sure to examine the distribution of effects among various populations. And communities facing inequities should have a role in communicating findings and recommendations.
- *The research process should build the capacity of the communities facing health inequities for engaging in future research. The process should also build the ability of those communities to engage in decision making related to the social determinants of health.* To accomplish this goal, communities facing inequities should lead or be meaningfully involved in every step of the process, from choosing research questions to collecting data and reporting findings. The process should also explicitly include leadership development training for community participants.
- *The process should result in a shift in power that benefits the communities facing inequities.* At the end of an HIA, the communities that face inequities should have increased influence over decisions, policies, partnerships, institutions, and systems that affect their lives. In addition, the government agencies and other institutions involved should be more transparent, inclusive, responsive, and collaborative.
- *The research should contribute to changes that improve the social determinants of health and reduce health inequities.* It should result in a decreased difference in the social, economic, and environmental determinants of health between communities facing inequities and other communities. It should positively influence physical, mental, and social health within communities and decrease inequities. Although this may be the most obvious objective, it may be the most difficult to measure because it is often a long time between when a policy is implemented and when we can see health improvements.

When public health practitioners and funders adopt these four objectives, HIAs will realize their potential as tools that meaningfully improve health and advance equity. By engaging community members in conducting research and by squarely focusing on equity, we will be much more effective at getting policymakers to understand the connection between their decisions and the people whose lives and health are most affected.

LILI FARHANG and JONATHAN HELLER are co-directors of Human Impact Partners, a nonprofit organization based in Oakland, Calif., whose mission is to transform the policies and places people need to live healthy lives by increasing the consideration of health and equity in decision making.

Building a Healthier Nail Salon Industry

A coalition of organizations in New York has made progress in improving the lives and health of nail salon workers.

BY SUSAN MCQUADE, MÓNICA NOVOA, & CHARLENE OBERNAUER

When Narbada Chhetri moved to New York City, she labored as a domestic worker during the week and worked at a nail salon on the weekends. At first she was happy interacting with other workers at the salon, but the low pay was not enough to sustain her. She found another nail salon where the pay was slightly better, but there she didn't have set breaks, and when she did take time to rest—to eat, or to get some distance from the polish fumes, which bothered her eyes—she was continually interrupted by an abusive employer who demanded that she return immediately to tending to customers. Her co-workers were treated the same way, even one who suffered from backaches. When the employer refused to provide employees with toilet paper and asked them to bring their own, that was the last straw.

Having worked for a human rights organization in Nepal, Chhetri knew that her employer was exploiting her and the other workers. She started laying the groundwork to create a community organization to support other Nepali and Tibetan workers who were doing domestic or nail salon work.

Then, in 2005, she co-founded Adhikaar—which means "rights" in Nepali—to advocate for the rights of recently arrived Nepali immigrants, as well as Nepali-speaking immigrants and refugees from Tibet and other countries. Adhikaar opened a formal community center in 2007, and Chhetri continues to play a crucial role; today she is the center's director of organizing and advocacy.

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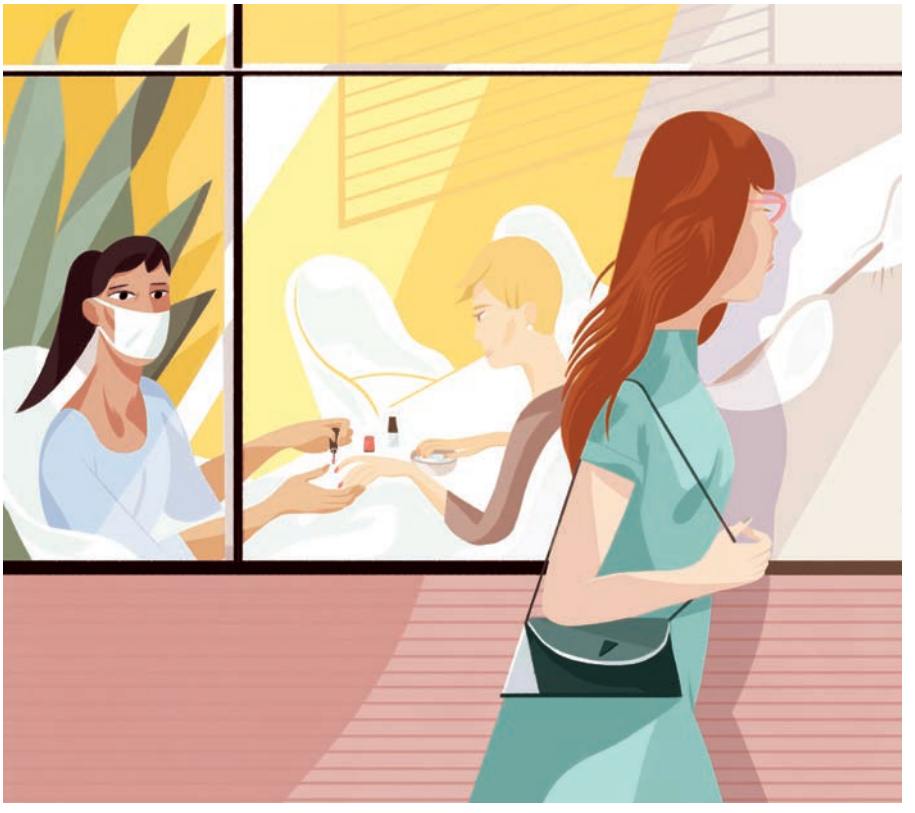
Mónica Novoa is communications director at NYCOSH, where her strategies are informed by human rights, racial justice, and public health.

Charlene Obernauer is the executive director of NYCOSH. She co-founded the New York Healthy Nail Salons Coalition.



MAKING NAIL SALONS A HEALTH EQUITY ISSUE

The nail salon business is flourishing in the United States. Approximately 375,000 technicians spend long hours buffing, scraping, painting, and polishing Americans' nails. According to *NAILS* magazine, consumers spent $8.4 billion on their nails in 2014.[1] But the nail salon worker population in New York City, comprising mostly Asian and Latina immigrant women, toils in an industry that has often operated under the radar of labor laws and regulations. Employers often take advantage of recently arrived and undocumented immigrant women, many of whom speak little English and have varied literacy skills.

Too often, nail salon workers are underpaid, undervalued, exposed to dangerous chemicals, overworked, and abused. Hired at a daily rate as low as $35, many depend on tips for their livelihood. They work long hours in the summer and many fewer hours in the winter, when they lose steady income. They often work with no lunch or bathroom break. Many nail salon workers are also intentionally misclassified as "independent contractors" in an effort to deny them basic employee benefits such as Social Security, worker's compensation, paid vacation, and sick time.

The health consequences of these jobs are impossible to ignore. Workers have reported skin and respiratory irritations, difficulty breathing, headaches, and trouble concentrating.[2] There are an estimated 10,000 chemicals found in nail products, and 89 percent of those have not been tested

by an independent agency for safety.[3] Most nail products, in fact—including nail polish, solvents, acrylics, and gels—contain harmful chemicals such as formaldehyde, toluene, dibutyl phthalate (the "toxic trio"), and methacrylates. Regular exposure to these chemicals is associated with asthma, cancer, neurological disorders, and reproductive harm.[4]

Nail salon workers have also reported a high prevalence of work-related musculoskeletal issues; neck, lower back, hand, wrist, and shoulder injuries are common.[5] Exposure to biological hazards such as fungi, bacteria, and viruses, including bloodborne pathogens such as hepatitis B, is also a concern.[6]

Unsurprisingly, because nail salon workers are often undocumented and uninsured, they face significant challenges in accessing health-care services. Many fall through the safety net. If they suffer from a chronic condition that requires regular medical attention, they must endure long waits at clinics, and then many times find themselves trying to communicate with a doctor who doesn't speak their language.[7] Although most nail salon workers know that their jobs may be responsible for their ill health, their options for changing careers are limited.

BUILDING THE COALITION

Nail workers' conditions are deplorable. But Adhikaar's work is making a difference, as are the organization's partnership with the New York Committee for Occupational Safety & Health (NYCOSH) and the subsequent creation of the New York Healthy Nail Salons Coalition. NYCOSH first started working to improve nail salon working conditions in 2004 by conducting a health and safety survey of 100 Korean nail salon workers. Then Adhikaar held a gathering for nail salon workers, where they were encouraged to identify campaign priorities related to health and safety. In 2012, Adhikaar and NYCOSH hosted a forum to highlight exploitative conditions of immigrant women in the beauty services industry and strategize about how to work together.

In 2014, NYCOSH partnered with Adhikaar to launch a campaign to transform health and labor conditions within nail salons. By expanding the definition of health to include workers' rights and living wages, the two organizations attracted the interest of other organizations and agencies, and New York Healthy Nail Salons Coalition was born. The coalition quickly began to push for policy change, first in New York City and then in New York State. Coalition partners were initially funded by foundations like Mertz Gilmore and the North Star Fund in New York City.

The coalition has made tangible progress: NYCOSH and Adhikaar partnered with the New York City Public Advocate on an industry-wide report that resulted in an increase in NY Department of State inspectors. More recently, the coalition introduced a package of nail salon reforms to the New York City Council. The council was responsive, and on May 10, 2015, shortly after the city introduced the new legislation, the *New York Times* published a widely publicized exposé on the industry that garnered the attention of New York Governor Andrew Cuomo and the entire nation.

Governor Cuomo quickly introduced emergency regulations and began strategizing with the coalition about new legislation to establish permanent statewide nail salon regulations. New regulations, developed as a result, include the mandatory posting of a Nail Salon Workers' Bill of Rights in all salons, featuring information about the legal wage, health and safety protections such as mandatory goggles and respirators, and a hotline for workers to call in case of violations. New regulations also require that the licensing exam be translated into several other languages, including Nepali, Tibetan, and Vietnamese.

The summer of 2015 saw another promising initiative launch: the Nail Salon Worker Organizing Project, organized by NYCOSH, Adhikaar, and Workers' United. The project seeks to support workers with trainee and licensing application support, Know Your Rights training, and training on health and safety in the workplace. Within one month, hundreds of workers had come to these organizations, eager to understand how the media attention and the governor's new legislation would affect their lives.

Since the new regulations were announced, workers have encountered retaliation from some employers: firings, reduced hours, bullying, and threats. But as they discover their rights and public support, workers are showing great courage and leadership—standing up, reporting abuse, and becoming their own best advocates. They are also increasingly realizing that they are not alone in facing down unfair practices, and that they have allies in many of their customers. After the *New York Times* exposé, thousands of consumers came out in support of nail salon workers.

NYCOSH has also begun crafting a plan for a Healthy Salons Program that would get salons to agree to a set of standards, including living wages, health and safety protections, and a commitment to training workers and monitoring worker conditions. Through those standards, we plan to develop a list of model salons that can be promoted to socially conscious consumers. In addition, we plan to work on citywide policy campaigns that institutionalize the training and education of business owners and the implementation of a letter-grading system. We will move at the state level to eliminate toxic products and encourage the use of safer alternatives.

Ultimately, improving the health of nail salon workers will require collaboration with a diverse set of partners. Health funders, in particular, have a transformative role to play to support us as we seek to create healthy nail salons in New York and across the country, conduct medical monitoring and research on the short- and long-term health impacts of working in nail salons, and improve workers' access to health care. We are calling for new collaborators as we seek to transform the nail salon industry—and the lives of workers, consumers, businesses, and the environment in the process. We believe that our model of worker-influenced campaigns to create healthy nail salons can be replicated in other cities and states, and we're working toward that end.

Notes

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Embracing Healing Justice in California

A Stockton, Calif., organization is striving to transform its city through culturally rooted, healing-centered practices and a pedagogy of love.

BY SAMUEL NUÑEZ, ALEJANDRA GUTIERREZ, & EMILY BORG

When people hear about Stockton, Calif., in the news, they usually hear about crime, bankruptcy, and foreclosures. Not surprisingly, many assume that this city in San Joaquin County is a place with no opportunities, no hope, and no love—and the data don't discourage that point of view. In 2012, Stockton had a crime rate of 857.6 per 100,000 people, more than four times the national average. Young people ages 10 to 24 in the county suffer a murder rate of 21.29 per 100,000 people, nearly three times California's overall rate. Graduation rates are low and incarceration rates are high. According to US Census data, more than 20 percent of Stockton's population is living below the poverty line. Moreover, according to the US Department of Housing and Urban Development, Stockton ranks among the four metropolitan areas nationwide highest in homelessness.

It's true that Stockton is up against incredibly difficult challenges. Yet the city is also full of resilience, strength, and heart. We see these qualities at Fathers and Families of San Joaquin (FFSJ) every day. FFSJ works to build healthy communities by supporting the social, cultural, emotional, and economic renewal of the most vulnerable families in Stockton and the San Joaquin Valley. But our work goes far beyond delivering services. We are committed to individual and community transformation and creating change through healing-centered organizing—an emerging practice that places individual and collective emotional and spiritual well-being at the center of social justice efforts. We are striving to transform Stockton through culturally rooted, healing-centered practices and a pedagogy of love. We believe that if others commit to this same approach, the city will turn around.

PUTTING HEALING AND JUSTICE AT THE CENTER

Healing-centered organizing is based on four core principles: healing responds to the needs of the community; healing is political; healing and organizing intersect; and healing is found in culture and spirituality.

One way we're incorporating healing-centered organizing is by serving as a lead partner for the San Joaquin County Alliance for Boys and Men of Color, one of 15 alliances throughout California composed of organizations trying to improve the lives of boys and men of color. This coalition fosters dialogue between youth and adults and engages law enforcement, philanthropy, local government, and other sectors of society to develop strategies to support boys and men of color. The alliance primarily involves young men of color, but FFSJ also engages a wide range of ages, ethnicities, and genders in healing justice work. The alliance is also connected to larger national efforts to expand opportunities and reduce disparities for boys and men of color.

Another way we support healing-centered organizing is through research and community engagement. FFSJ partners with the Center for Regional Change at the University of California, Davis, to teach community residents about participatory action research, the politics of data, and how to analyze social inequities. We also support youth organizers working to dismantle the alarming school-to-prison pipeline in Stockton by challenging policies and practices that contribute to the criminalization of youth and overwhelmingly affect young people of color.

We also provide Stockton residents with safe spaces where they can share experiences and heal from trauma they have suffered. Such healing circles are steeped in the values of *La Cultura Cura* (Culture Heals), a practice of reconnecting to cultural teachings and restorative practices to tap resilience and build well-being.

SUSTAINING AND SUPPORTING HEALING

Despite its importance in social change, healing is often unacknowledged and unfunded. We encourage philanthropists to consider the long-term and holistic benefits of providing resources to support community organizations dedicated to healing-centered organizing. We also encourage funders to follow these three recommendations, each of which will help the people who live in marginalized communities strengthen their neighborhoods and create new opportunities for themselves and the generations that follow:

- *Listen to youth leaders and community organization staff; their front-line vantage point will yield valuable insights.* The top-down approach has been largely ineffective. To create transformative change, we must engage the people who are most affected.
- *Establish an innovation fund that supports healing, arts, and culturally based approaches to improve outcomes for boys and young men of color.* Such a fund could support implementation and evaluation of healing justice practices.
- *Provide more flexible grants—including general operating costs, multi-year grants, and delayed expectation of immediate outcomes—based on trusting relationships and agreement on shared outcomes.* Doing so would support grassroots efforts to build infrastructure and capacity, develop local leadership, respond to emerging community needs, and support those working closest to the ground.

SAMUEL NUÑEZ is the executive director of Fathers and Families of San Joaquin and a recognized expert in the field of youth development and responsible fatherhood.

ALEJANDRA GUTIERREZ is the program director of Fathers and Families of San Joaquin.

EMILY BORG is the policy & resource director of Fathers and Families of San Joaquin.

The authors thank Miguel Gavaldon and Aurey Jordan for their contributions from the Bright Spot Report.

Ending LGBT Health Inequities

Philanthropy can pursue several effective approaches to improve LGBT health.

BY SAMANTHA FRANKLIN & ANDREW LANE

Despite recent advances in civil rights protections for lesbian, gay, bisexual, and transgender (LGBT) people, these communities still face significant health disparities. Continued marginalization and bias put LGBT individuals at increased risk for negative health outcomes related to mental health disorders, substance abuse, homelessness, HIV and other sexually transmitted infections, and suicide.[1] LGBT youths are particularly at risk for homelessness, and elders are particularly at risk for isolation. LGBT individuals are also more likely to lack health insurance, delay medical care, visit emergency rooms for treatment, and encounter prejudice from health-care providers.[2]

These disparities are challenging. But they can be overcome. Our experiences at the Johnson Family Foundation (JFF) indicate that philanthropy can—and should—play a leading role in improving the health of LGBT people.

Founded in 1990, JFF promotes the development of healthy, vibrant, and just communities by improving the health of the environment, promoting equality and social progress, and supporting education and youth. Growing out of our interest in improving the everyday experiences of LGBT people who may be most at risk, we began funding LGBT mental health in 2006 through a donor-advised fund at the North Star Fund. Since then, JFF has contributed more than $2 million to these issues. Today, between 20 and 25 percent of our grantmaking is focused on LGBT issues, with about a third of that dedicated to mental health. Overall, we take a holistic approach to promoting LGBT health equity by supporting efforts in three areas: health-related services (and access to those services); research on anti-LGBT discrimination and its repercussions for LGBT health; and advocacy and grassroots organizing for social and political change.

SAMANTHA FRANKLIN, MSW, is a program officer at the Johnson Family Foundation. She currently serves on the advisory boards of the Brown Boi Project and the Third Wave Fund.

ANDREW LANE, MSEd, is executive director of the Johnson Family Foundation. He currently chairs the Movement Advancement Project, an independent think tank aimed at speeding the path to LGBT equality.

SUPPORTING HEALTH-RELATED SERVICES AND ACCESS

JFF supports LGBT-affirming and LGBT-specific services through our LGBT Mental Health Initiative (MHI), which provides capacity-building and technical assistance funding to LGBT community centers across the United States that want to improve the mental health services they offer. Our partner in this initiative, CenterLink, helped us develop our plan. CenterLink also helps with implementation by providing training and coaching to community center leaders and training for program evaluation.

MHI grantees use funding for hiring personnel, fundraising and development, coordinating interns, and marketing their services. They use technical assistance funds to support professional development for staff, purchase computers and other equipment, and invest in office renovations and construction.

Three years after we launched MHI, our first cohort of grantees had served 2,000 more people than they had previously been able to, at an average cost per additional client of around $340.[3] Those cost levels bode well for these organizations' ability to sustain programming over the long term. What's more, it's likely that the programming is reaching many more low-income LGBT individuals than before, given that many centers report that most of their visitors have incomes of less than $30,000 per year.[4]

But these centers still face significant challenges. One is the lack of control they have over the length of time it takes to obtain certain government certifications, such as licensure to provide outpatient addiction and recovery services or certification to accept Medicare or Medicaid. In addition, of the centers that have chosen to implement client-tracking systems, a handful have found that the price of such systems is higher than anticipated and inappropriate for the number of clients maintained.

The MHI continued this year with support for a new cohort of seven centers in California, Washington, Pennsylvania, and Michigan, and we are always trying to improve it. For example, JFF has collaborated with CenterLink to refine the program model so as to offer a range of "right-sized" grants that allow centers to focus more intentionally on their most pressing capacity needs rather than divide their attention among several capacity-building activities that yield varying returns on their investments.

Opportunities for Philanthropy

The Johnson Family Foundation suggests the following potential strategies to other funders concerned about LGBT health disparities:

- Funding targeted outreach efforts to enroll LGBT people in affordable insurance options.
- Providing capacity-building support for organizations that deliver LGBT wellness and HIV/AIDS-related programming to build their leadership and develop new revenue-generation strategies.
- Providing grants to health-care providers and medical education programs to include LGBT competency standards in their practice.
- Funding advocacy and policy efforts to combat discrimination and promote the availability of affordable health care.
- Providing flexible, multi-year support to LGBT organizations that address the social determinants of health, including stigma, economic opportunity, family acceptance, and safe schools.[6]

We're proud of the progress our grantees have made, and we're excited about the new cohort. Nonetheless, we're also keenly aware that LGBT centers alone cannot meet the demand for care that is LGBT responsive and affirming, and not every LGBT person has convenient, consistent access to these organizations. For that reason, we're also working to ensure that mainstream service providers and institutions know how to provide the best and most affirming care to LGBT clients.

To that end, as a complement to the MHI, we work in partnership with Rainbow Heights Club to promote LGBT cultural competency. This organization works with hospitals and health-care providers to promote settings in which clients can disclose their identities safely and receive appropriate care that is sensitive to LGBT issues. In addition, JFF is working with the National Center for Lesbian Rights to enact bans on harmful conversion therapy practices targeted at LGBT minors by mental health practitioners, thus making service settings safer for LGBT youth.

THE BENEFITS OF SUPPORTING RESEARCH

In 2007, the American Foundation for Suicide Prevention (AFSP) launched a national effort to better understand and address suicidal behavior and suicide risk in LGBT populations. In 2008, JFF began supporting AFSP in its work to determine whether LGBT people die by suicide more frequently than the general population and which subgroups within the overall LGBT population are most at risk. Through a sexual orientation and gender identity data collection project begun in 2014, AFSP is collaborating with a working group of death investigators, medical examiners, and coroners to design and implement a protocol whereby investigators would collect and report on the sexual orientation and gender identity of people who die by suicide. Post-mortem data could provide crucial information to service providers about how successful targeted interventions are at reducing LGBT suicides.

JFF also serves as a funding partner to a number of other organizations that collect, analyze, and report data on LGBT issues. These data increase the ability of advocacy and policy organizations in the LGBT equality movement to advance protections in areas such as school safety, relationship recognition, parenting, housing, public accommodations, and employment discrimination. They also provide messaging tools to build the communications capacity of advocacy organizations and organizations that work to foster movements. These groups include the Center for American Progress, the Movement Advancement Project, and the Williams Institute. We also support Funders for LGBTQ Issues to provide the philanthropic sector with timely information about the state of LGBT funding and to identify areas of need so that grantmakers can maintain ongoing awareness of health disparities.

SOCIAL JUSTICE

In addition, JFF works to create a social and political context that is conducive to positive health outcomes for LGBT people. Through our support of advocacy groups, we have focused on changing laws and policies—including marriage equality—that have implications for health equity and health-care access for LGBT individuals.[5] Through our partnerships with community foundations such as the North Star Fund and the Samara Fund, we support leadership development and organizing. Our goal is to help LGBT people increase their political power and also increase their general safety; LGBT individuals are at a disproportionally high risk for criminalization and physical violence, and they often suffer from additional factors that put their health at risk as well, such as racial and economic inequity, discrimination based on immigration status, and transphobia.

We believe that this approach will prove more effective than dictating a "solution." It empowers people who live at the intersections of multiple marginalized identities to take leadership in designing and implementing their own innovative solutions to the problems their communities face while advocating for bold, systemic change.

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Achieving Healthy Communities Through Transit Equity

Expanding public transit systems to connect low-income communities to healthy environments, high-quality education, and well-paying jobs isn't enough. Transit has to be affordable as well as accessible.

BY DACE WEST

The connection between public transit and health is clear. Research shows that transit helps increase physical activity, lowers levels of disease related to environmental factors, and results in greater pedestrian and vehicular safety. But transit can also perpetuate inequity. In many communities, for example, expansion of public transit improves quality of life for white, upwardly mobile, car-less millennials and suburban commuters, but simultaneously displaces low-income communities, as areas around new transit stations are gentrified with higher-end mixed-use developments.

An initiative in Denver called Mile High Connects (MHC) is showing how to counter the displacement. In 2004, Denver voters approved FasTracks, a $7.8 billion transit expansion, adding 122 miles of new light rail, 18 miles of bus rapid transit, and enhanced regional bus service to the region. Construction is currently under way on the multi-decade project, with four new rail and bus rapid transit lines opening in 2016 alone. Bolstered by early support from the Ford Foundation, local nonprofits and funders came together to take advantage of a historic opportunity and formed MHC in 2011. MHC is a cross-sector collaborative of nonprofits, foundations, businesses, and government leaders in the Denver region that makes an explicit connection between public transit and health equity.

MHC's goal is to ensure that Denver's transit build-out benefits low-income communities and communities of color by connecting them to affordable housing, healthy environments, high-quality education, and well-paying jobs. MHC serves as a backbone organization, influencing local and regional policies, leveraging and deploying resources, and helping residents of low-income communities and communities of color engage directly in decision making that affects their lives.

MHC's first public act was to create the Denver Regional Equity Atlas. The document starkly contrasted the relationship between new transit lines and issues of importance to the region's low-income communities, including the location of affordable housing, job centers, health-care institutions, and high- and low-performing schools, and how they were connected (or not) to the new tax-funded transit lines. Now an online interactive tool used by both community residents and decision makers, the Equity Atlas demonstrates that areas with lower incomes and higher concentrations of people of color have less access to healthy food, walkable blocks, and health centers, as well as significantly higher numbers of households that are burdened with relatively high housing and transportation costs. Over time, the tool has become important not only to document current disparities, but also to show population-level outcomes across the region.

Initially, MHC's work was based on the premise that ensuring that people could live near and use transit would have a positive impact on families' budgets. But MHC soon learned that for many, the cost of transit itself was unaffordable. Residents were making choices between fares and meals, medicine, and other basic necessities. When low-income people have access to affordable public transit, they are better able to access health clinics and hospitals, grocery stores, and recreation centers, an important health resource in communities where outdoor exercise is not always possible or safe. But transit without affordability wasn't going to have the intended effect. Transit affordability thus became a central theme, galvanizing hundreds of community members and more than 100 nonprofit, public sector, and business partners.

MHC also learned that physical access to transit was a crucial barrier for many neighborhoods, where low levels of infrastructure investment had been endemic for years. Crumbling or missing sidewalks, poor lighting, inadequate drainage, and other obstacles made it difficult for residents to get to transit stops. In some communities, reaching the closest bus service required walking up to a mile. In other neighborhoods, bus routes that took riders to places like human service agencies or hospitals were being eliminated as light rail service expanded.

LINKING PUBLIC TRANSIT AND SOCIAL DETERMINANTS OF HEALTH

The Housing + Transportation Affordability Index has been an important resource informing MHC's early efforts. As housing costs rise in newly developing areas, affordable housing gets pushed outward to less dense suburban communities that often have fewer services and less transit. Transportation costs increase for those same households, and they arrive at a tipping point where any savings they achieve because of affordable housing are offset by increased transportation costs. Knowing that households that use mass transit can save up to $10,000 a year, MHC seeks to ensure that low-income communities and communities of color benefit from the expanding transit system by preserving and building affordable and workforce housing in close proximity to transit stations, as well

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creating opportunities for new nonprofit services and businesses that will provide good jobs for local residents.

Under the leadership of Enterprise Community Partners, nine local partners worked together to create the Denver Transit Oriented Development Fund, which paved the way, almost literally, for this effort. The fund used public, philanthropic, and financial institution capital to purchase land near future transit stations to maintain the affordability of housing and community facilities as station areas were developed. These MHC partners preserved and created more than 600 units of affordable housing in the first three years of the fund's existence, and the fund has grown to a regional scale, added new investors, and increased the number of qualified borrowers.

IMPLICATIONS FOR FUNDING

MHC's work is opening up new opportunities for philanthropy to think differently about resources and funding structures. We are studying how capital might be most effectively leveraged and invested at a large scale to support the Denver region's transit buildout and related community development. It's clear that tracking large-scale public investments opens up opportunities to try new or scale-proven strategies to achieve health equity. We are also seeing early success in combining philanthropic investment with private sector impact investment capital to achieve greater impact in the built environment and community development efforts.

Creative thinking about philanthropic capital is also encouraging public sector innovation. For example, as MHC continues to explore the essential question of transit affordability, it is developing a low-income pass for riders in partnership with the Denver region's transit agency. Implementation is a core challenge because of the lost revenue to the transit agency as a result of subsidized fares. To help close the gap over the next five years, MHC is crafting a strategy layering transit agency investment with philanthropic and private funds. Through this strategy, we anticipate building the case and political support for a sustainable public revenue source.

THE BENEFITS AND CHALLENGES OF CROSS-SECTOR PARTNERSHIPS

MHC believes that systems will change to benefit low-income communities and communities of color only if members of those communities and their allies work in partnership with grass-tops leaders—and if these partners share decision-making authority. MHC's decision-making table today includes 17 core nonprofit, philanthropic, and business partners, and the collaborative has built relationships with nearly 300 additional partners.

This broad approach means that sometimes the work takes more time than we would like it to. But it's important to ensure that everyone's perspective is heard. Partners must devote time, attention, and effort to build trust among those who do not normally work together, as well as work to ensure that collaborative partners share language and values. Effective cross-sector partnerships must learn to live with, and even embrace, the constant creative tension that comes from the mix of cultures, backgrounds, and professional and personal experiences that members bring to the group. One of MHC's central tenets is that unless everyone is feeling at least a little uneasy about at least one of the collaborative's strategies, MHC is probably not doing its job.

This creative tension can lead to successful outcomes. MHC has forged strong cross-sector relationships that have led to the preservation and restoration of lifeline bus service routes in low-income communities, significant movement toward a regional low-income fare program, creation of economic opportunity strategies linking good-quality jobs and transit, and the development of new policy priorities focused on affordable housing in proximity to transit.

Public investment in large-scale transit projects can lead to dramatic improvements in the most important factors determining the long-term health of families and communities. By enabling families to live close to transit, these investments increase access to good jobs, housing, schools, and health care. Cross-sector collaboratives that engage low-income communities and communities of color with funders, nonprofits, and private and public sector decision makers have the ability to ensure that public transit fosters healthy and equitable neighborhoods for all.

TRANSIT EQUITY PROFILES

Here's just one example of the tangible progress MHC has seen. Guadalupe lives in a neighborhood only a few miles from Denver's thriving downtown, but back in 2010, you would not have known it from the neighborhood amenities. Her neighborhood was a food desert; she had to take a 50-minute ride on two buses to get to the nearest grocery store. Though she knows that fresh food is important, she often found herself exhausted at the end of the workday, shopping at a nearby convenience store for groceries. By 2014, however, MHC's partners created a new mixed-use development in Guadalupe's neighborhood that added affordable housing near a transit stop and spurred the addition of more community-serving amenities, including a library, a child-care center, and a culturally appropriate fresh-food market.

Manolo's experience provides another example. Manolo is a single father of three children who works two custodial jobs to support his family. Over the past year, he has seen development begin around a rail station near his home that will be opening in 2016. Rent prices are increasing, and he is seeing some of his neighbors forced to move. Manolo feels lucky that he lives in a building owned by a nonprofit that keeps the rents low enough for him to afford. He says he does not know what he would do otherwise and would worry that his kids would have to change schools and leave friends, as he has seen happen to many of his neighbors. "I want to be here for all the change. I want to be able to be a part of the neighborhood when it's good, not just when it's bad."

Maria's experience illustrates progress, but also underscores the fact that there are still great challenges to overcome. Maria has lived her whole life in a neighborhood on the city's west side and is now raising her own children there. She works full-time at a fast-food restaurant and used to have to walk more than a mile to get to the nearest bus route to work. Two years ago, she began working with some neighbors to get the transit agency to put a bus route put back into their neighborhood. When the group took a victory ride on the day the route opened, she described it as one of her proudest moments. But Maria still worries that the bus fares are too high for her and other neighbors to afford. At a recent meeting where more than 60 community residents testified, Maria had tears in her eyes. She said, "It is beautiful to see us all speaking with one voice. Hopefully they will listen and give us a pass based on our income, not thinking everyone can pay the same."

Using Fair Housing to Achieve Health Equity

Fair housing initiatives that focus on dispersion ignore the social structures and processes that result in the inequitable distribution of resources necessary for health.

BY KELLEE WHITE & GEORGE LIPSITZ

Life expectancy rates continue to improve for the overall US population, yet disparities persist and race remains a powerful predictor of them. Blacks continue to have lower life expectancy rates than their white counterparts, and higher morbidity and mortality from the leading causes of death. Neighborhood context is a critical determinant, as it shapes the conditions in which people live and explains, in part, why some people are healthier than others.

In fact, residential segregation—the degree to which two or more groups live separately from one another in a geographic region—is a characteristic of neighborhoods linked to persistent racial health disparities. Although the policies that created segregation are now illegal, the political and social legacy of those policies remains. Particularly among blacks, it has profoundly shaped individual and community well-being. The result is neighborhoods lacking opportunities and fraught with social and physical conditions harmful to health.

Living in segregated neighborhoods creates major barriers to health, education, and employment for black populations. Higher levels of segregation are commonly linked to neighborhood economic deprivation and disinvestment, lower home values, concentrations of toxic hazards and nuisances, increased targeting for the sale of alcohol and tobacco products, higher density of fast food restaurants, and a lack of grocery stores and spaces for physical activity.

These conditions result in environments that constrain healthy decision making essential to promoting health, preventing disease, and managing illness. In addition, studies have shown that segregation plays a major role in shaping access, quality, utilization, and availability of health care and services.[1] Thus the cumulative effects of exposure to segregation across one's life span—prenatal, infancy, childhood, adolescence, on through older adulthood—have devastating consequences for life expectancy and overall well-being.

Effective efforts to eliminate racial inequalities must seriously confront the vestiges of the social policies that led to residential segregation. Today, increasing interest in federal and local fair-housing initiatives that foster neighborhood opportunity holds great promise to improve health and promote health equity.

IMPACT OF FAIR HOUSING PROGRAMS

Fifty years ago, the passage of Title VIII of the Civil Rights Act of 1968 (known as the Fair Housing Act) prohibited discrimination in the sale, rental, and financing of housing based on race, color, religion, sex, or national origin. Since then, the US Department of Housing and Urban Development (HUD) has played a central role in developing and executing policies that support the Fair Housing Act and that aspire to "create strong, sustainable, inclusive communities and quality affordable homes for all." Several Fair Housing programs emphasize the redevelopment of distressed public housing and the dispersal of high-poverty areas by altering the spatial distribution of residents.

Some Fair Housing programs have had notable accomplishments. Consider the Moving to Opportunity for Fair Housing (MTO) initiative, a 10-year demonstration project that provided rental assistance and housing counseling to randomly selected families to help them move out of poverty neighborhoods. Recent studies show that families who moved out of public housing have experienced less weight gain, better diabetes control, and less psychological distress than those who stayed in public housing and in low-income neighborhoods.[2-7]

Other initiatives, however, have encountered significant challenges, with the dispersal of concentrated poverty in some cases having the unintended consequence of neighborhood destabilization through displacement, gentrification, and minority political disempowerment, all of which undermine community development.[8]

The Housing Opportunities for People Everywhere (HOPE VI) initiative, for example, sought to improve the housing conditions of residents in "severely distressed" public housing by demolition, rehabilitation, or replacement with mixed-income housing. HOPE VI grants were awarded to more than 150 cities and municipalities. In some areas, HOPE VI resulted in an increase in quality and affordable mixed-income housing and revitalized surrounding neighborhoods. In other sites, however, residents of the demolished public housing units were not able to return. Furthermore, some evidence suggests that when residents moved out of public housing, they ended up moving to other areas that were of equal or lower quality.

EXPANDING THE AGENDA

Strategies that are focused on helping individuals move out of poverty may reproduce and reinforce neighborhood differences because they do not address the root causes of segregation. A case in point is the tort model of individual injury commonly used in housing discrimination cases. Damages are typically awarded to people who have successfully filed a lawsuit in a federal or state court. Although the damage awards in Fair Housing cases attempt to quantify the monetary cost of experiencing discrimination for those who file suit and win, they do not account for other difficult-to-measure factors such as the health, economic, educational, and psy-

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chological consequences of discrimination for those who chose not to file a complaint or try to negotiate a settlement.

Getting individuals out of disadvantaged neighborhoods rather than addressing collective damages does not alter the fundamental factors that shape residential segregation. But by expanding the fair housing agenda to include and promote neighborhood equity, opportunity, place-based investment, and development, we can address the collateral consequences of segregation.

Not surprisingly, the biomedical, individual-based approach to population health parallels the person-based approach to housing segregation. For example, in the past, medical and public health efforts largely focused on individual-level approaches (such as changing health behavior and promoting health education) to combat persistent racial health disparities. In recent years, however, the health sector has increasingly recognized the need to improve social, economic, and physical conditions in order to reduce health disparities.

INVESTING IN PEOPLE AND PLACE

Recent place-based community development programs that seek to transform neighborhoods through capacity building and economic development are promising. Relatedly, incorporating a Health in All Policies (HiAP) approach can also be used to complement person-based fair housing remedies to achieve neighborhood and health equity. HiAP refers to a systematic approach in which health is integrated and prioritized within planning and decision making. Further, HiAP approaches involve inter-sectoral collaborations instead of reliance on individual organizations and agencies. Reforming housing policy legislation, regulation, implementation, and practice to incorporate these approaches would be an important step to promoting health equity.

An anti-discrimination agenda that addresses structural racism is another critical strategy. A recent US Supreme Court ruling (*Texas v. Inclusive Communities*) upheld the use of disparate impact and makes new rules to target segregation vital to tackling structural racism in housing. Seemingly race-neutral policies and practices, such as zoning laws that disproportionately affect the housing choices of blacks and other racial minorities and have the unintended consequence of perpetuating segregation, are prohibited.

The new HUD rule requires local municipalities to track, monitor, and report the results of housing patterns and racial bias that may produce indicators that could lead to evidence-based policies and monitoring. Evaluating and monitoring neighborhood social and economic conditions should be coupled with indicators of health to further assess the cumulative impact of segregation on housing and health equity.

A PLATFORM FOR HEALTH EQUITY

Addressing the underlying social and economic conditions of neighborhoods is a critical challenge and opportunity for fair housing. A healthy living environment should ensure the equitable distribution of resources, services, facilities, and institutions that give people access to information, education, employment, housing, and health care. The integration envisioned by the Fair Housing Act entails not just the desegregation of physical places, but also the desegregation of opportunities and life chances. As Dr. Martin Luther King Jr. insisted, integration does not merely involve a romantic blending of colors, but rather a real sharing of rights, responsibilities, and opportunities.[9] Policymakers, practitioners, advocates, researchers, and foundations have a stake in realizing the full potential of fair housing and broadening its scope to include neighborhood opportunity, bringing us closer to achieving health equity.

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Reducing Health Disparities in Atlanta

A coalition of organizations is improving the health of low-income communities.

BY KAREN MINYARD, KATHRYN LAWLER, ELIZABETH FULLER, MARY WILSON, & ETHA HENRY

In Atlanta a person's ZIP code is often the biggest predictor of his or her health status. The region's staggering health disparities were made clear in a map released by Virginia Commonwealth University and the Robert Wood Johnson Foundation in 2015 that vividly shows how short distances can translate into large differences in health. (See "Short Distances to Large Gaps in Health" on page 23.) In some Atlanta communities people are expected to live 84 years, while just a few miles away life expectancy is only 71 years.

The good news is that a coalition of diverse organizations called the Atlanta Regional Collaborative for Health Improvement (ARCHI) came together to address this issue. ARCHI offers a promising systems approach to reducing health disparities and creating place-based change for people living in the metropolitan area. The coalition's origins, and its early efforts, could serve as a model for organizations seeking solutions to health inequality in other cities.

ARCHI'S ORIGINS AND STRUCTURE

In 2011, 12 Atlanta leaders, including representatives from the Atlanta Regional Commission, the United Way, and the Georgia Health Policy Center, convened to discuss how hospital community benefit efforts and collective impact could be used to address the city's health disparities. They agreed that incremental improvements to various programs weren't the answer and that a new approach was needed. The group became the core of the 15-member ARCHI steering committee, which includes representatives of area hospitals, insurers, state and local public health agencies, behavioral health providers, the US Centers for Disease Control and Prevention, educators, federally qualified health centers, and community members.

The steering committee recommended that ARCHI's leadership should be shared between the United Way, the Atlanta Regional Commission, and the Georgia Health Policy Center, with each organization's representative being an equal participant on the three-member executive leadership team. The team provides strategic direction for the collaborative as well as ongoing staff support. The team also convenes, sets the agenda for, and presides over the steering committee. The steering committee's primary responsibility is to articulate and promote ARCHI's vision of creating and sustaining a healthy population and a vibrant economy in Atlanta, with all citizens having an equal opportunity for health.

The broader ARCHI collaborative consists of more than 100 diverse organizations, agencies, and individuals in Atlanta. Membership is open to any organization that (or individual who) embraces its goals.

Funding for the collaborative has evolved. Initially, the three leadership groups provided considerable in-kind support. Steering committee members all contributed core funding. The steering committee realized the importance of broadening ARCHI's support and funding, but in a way that allows members to do so in a way that works best for their organizations. Local and national health delivery systems, along with the federal government, provided additional funding to support backbone functions. The collaborative's long-term funding plan includes increased use of financing mechanisms that capture and reinvest cost savings (derived from improved health outcomes) to further the goal of health equity.

RETHINKING HEALTH

To identify the Atlanta area's health challenges and develop potential solutions, ARCHI first reviewed the areas health-care delivery system and analyzed health data. It produced a collaborative, regional health assessment, along with short- and long-term improvement plans designed to encourage members to invest according to their individual interests and needs.

This phase of ARCHI's work culminated in a work session in 2012 where 70 stakeholders (including business, insurers, physicians, hospitals, community and faith-based organizations, and educators) were introduced to the Fannie E. Rippel Foundation's ReThink Health computer modeling tool that had been calibrated for Atlanta. ReThink Health allows communities to test innovative ideas for redesigning their health-care systems. Loaded with extensive data on resident health and area health-care systems, the tool enables stakeholders to run intervention and investment scenarios, simulate their short- and long-term impacts on a region's population and economy, identify opportunities, set priorities for action, and measure progress. Interventions can be simulated individually or in combinations to study the likely impact over time on multiple metrics of health, care, cost, productivity, equity, spending, savings, and return on investment.

Meeting participants devised scenarios that they thought would give Atlanta the best overall outcomes in health, productivity, equity, and health-care system efficiency. The six most promising scenarios were presented at the work session, and a set of priorities emerged. A majority of participants supported the scenario titled Atlanta Transformation.

This scenario now forms the basis of ARCHI's agenda. It includes four intervention priorities: encouraging healthy behaviors; increasing income and economic prospects; increasing care coordination; and expanding health insurance coverage.

A PLAYBOOK FOR ACTION

The coalition's next step was to develop a "Playbook for Action" based on the four priorities. Subcommittees were formed to create a plan for each intervention and financing

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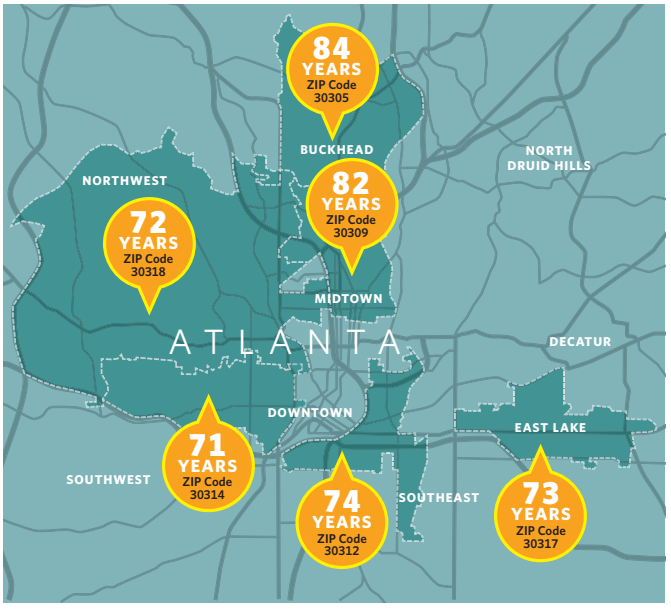
area. The playbook includes evidence-based programs or policy interventions for each priority. For example, to encourage healthy behaviors, the subcommittee focused on proven programs and interventions to reduce smoking and tobacco use, improve diet and nutrition, increase exercise and physical activity, reduce alcohol and drug use, cut the incidence of unprotected sex and sexually transmitted infections, and expand preventive care for physical and mental health.

The playbook also identifies policies and programs (such as living wage policies, tax credits and subsidies, and housing vouchers) that can improve the economic prospects for disadvantaged families. Further, it describes how improved care coordination is possible through integrated information systems, coaching arrangements, and protocols for shared decision making.

The playbook articulates ARCHI's long-term strategies for financing innovative initiatives related to ARCHI priorities. These include an innovation portfolio, increased use of contingency payments tied to outcomes, and the capture and reinvestment of a portion of the savings generated, which will in turn fund more priority-based initiatives. In the initial phases of the program, however, philanthropic support is necessary. For example, the United Way of Greater Atlanta has provided $3.6 million and national foundations, such as the Robert Wood Johnson and Kresge foundations, have also provided support for ARCHI pilot programs.

Short Distances to Large Gaps in Health



TRI-CITIES PILOT

The Tri-Cities area in Atlanta, which includes College Park, East Point, and Hapeville, is near the Hartsfield-Jackson Atlanta International Airport. Although there are tremendous assets in this area—including public transportation, strong community cohesion, and green spaces—there are also significant challenges. Many of the storefronts are vacant. Houses are abandoned. Many of the schools receive the lowest rankings. These adverse community conditions fuel health disparities and limit opportunities for residents.

In 2014, ARCHI brought together civic leaders, concerned citizens, health-care providers, faith- and community-based organizations, government representatives, and other community leaders to learn more about health challenges in the Tri-Cities area. ARCHI's leadership provided administrative support; demographic, socioeconomic, and health data; and technical assistance to inform and guide the event and to catalyze a community engagement process. In addition, the ARCHI playbook provided comprehensive strategies and best-practice solutions to address health disparities in the targeted Tri-Cities pilot communities for the group to consider.

The result? A resident-driven Tri-Cities Stewardship Committee—made up of participants in that original work session—is currently setting the goals for a pilot program and selecting targeted priorities to match the needs and desires of the community.

THE AHEAD INITIATIVE

Also in 2014, ARCHI was selected as one of five sites for the national Alignment for Health Equity and Development (AHEAD) initiative. AHEAD is a partnership led by the Public Health Institute and the Reinvestment Fund, with support from the Kresge Foundation. The initiative recognizes that real health improvement cannot be achieved by investing in the health-care system alone. It is also dependent on upstream interventions that address social, economic, and community conditions. AHEAD provides technical assistance to selected communities to help them bring together different investment streams to advance community priorities for health.

ARCHI selected East Point as a pilot for the AHEAD initiative. East Point is a city of about 35,000, adjacent to Atlanta, where 43 percent of the children under 18 years old live in poverty.[1] Since April 2015, with AHEAD's support, ARCHI has brought together stakeholders to assess their willingness to consider new and convergent investment strategies and to establish shared goals and evaluation measurements. The outpouring of support has been overwhelming, with many organizations signing on as partners.

Community members have worked with the East Point AHEAD partners to identify priorities, including more stable and affordable housing, expanded opportunities for physical activity, more transportation options, improved health literacy and health-care access, and increased food security. The group will develop joint investment strategies with unified goals that can maximize the knowledge, resources, and actions of the organizations that have converged to improve the health of East Point residents.

COLLABORATION

The Tri-Cities pilot and the AHEAD initiative are just two examples of work going on under the umbrella of the ARCHI collaborative. ARCHI understands that no organization can singlehandedly reduce health disparities. From ARCHI's inception, its leadership has maintained a focus on strengthening the collaboration and the potential power of a collective impact approach. The collaborative provides organizational capacity and a platform for the community to come together to improve health outcomes in metropolitan Atlanta. Working collaboratively offers a pathway for revitalizing physical environments, increasing civic engagement, supporting high-quality education, improving economic well-being, and fostering the positive conditions that promote health.

Note

1 "American Community Survey 2009-2013," US Census Bureau.

Grantmakers In Health (**GIH**) is a nonprofit educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness.

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