Anchor Institutions Task Force

2018 Annual Conference

November 15-16, 2018

Welcome and Agenda

Opening Keynote Plenary

Sheena Wright

Chief Executive Officer

United Way of New York City

United Way of New York City

United Way of New York City

United Way of New York City: building self-sufficiency

United Way of New York City

Self-sufficiency is…

*the ability to meet **basic living expenses** (i.e., housing, food, childcare, healthcare, taxes, transportation, miscellaneous costs, emergency savings fund) **without accessing public benefits***

The persistent barriers to progress

United Way of New York City

Despite the countless time and resources that have been invested to address the needs of low-income New Yorkers, progress has been slow

Barriers to Progress	Resulting in…
• **Insufficient focus** on neighborhoods of concentrated poverty facing the greatest need • Local organizations have a **single-issue focus** and/or **lack capacity** to address the multi-faceted needs of struggling families • Efforts focused on **supporting individual beneficiaries** and ignore focus to move entire households out of poverty • **Lack of shared vision and effective coordination** across governments, schools, nonprofits, foundations, and corporations • **No unified approach** for local-level data collection, aggregation, and dissemination exists • **Missing: an equity mindset**	• A **lack of urgency** to address poverty • Difficulty **holding leaders and institutions accountable** for progress • Insufficient **identification of gaps, collaboration, and evidence-based decision making** • **Lost opportunity to build on the inherent assets and strengths** of neighborhoods of concentrated poverty

Our purpose

United Way of New York City

We aim to….

1. Help low-income New Yorkers make **meaningful and measurable** progress toward the pivotal milestone of **self-sufficiency**
2. Convene **communities and sectors** around a **shared agenda for impact and learning** centered on an **equity mindset**
3. Drive **systems and policy change** that will help all low-income New Yorkers

…by leveraging our unique assets and capabilities

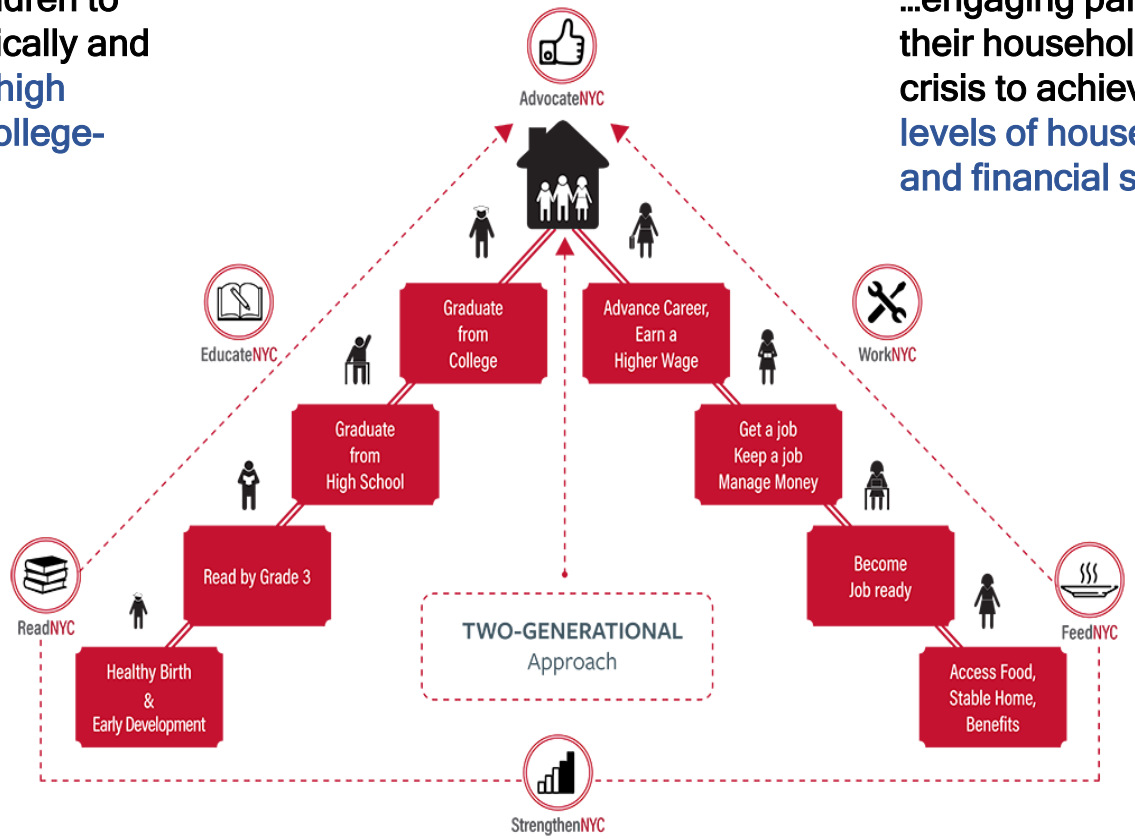
- Raise **broad awareness of the complex challenges** facing low-income New Yorkers in neighborhoods of concentrated poverty
- Bring together **corporate, community, and government partners** around the need for new approaches and collective action
- Build the **capacity of partners to collaborate** more effectively, engage in shared learning, and achieve greater outcomes
- Invest in **proof points** and ensure that lessons learned from collaborative efforts are widely disseminated

Our two-generational approach

United Way of New York City

Key milestones to advance two-generational progress toward self-sufficiency

…empowering children to succeed academically and to graduate from high school on time, college- and career-ready



…engaging parents to move their households out of crisis to achieve increasing levels of household income and financial security

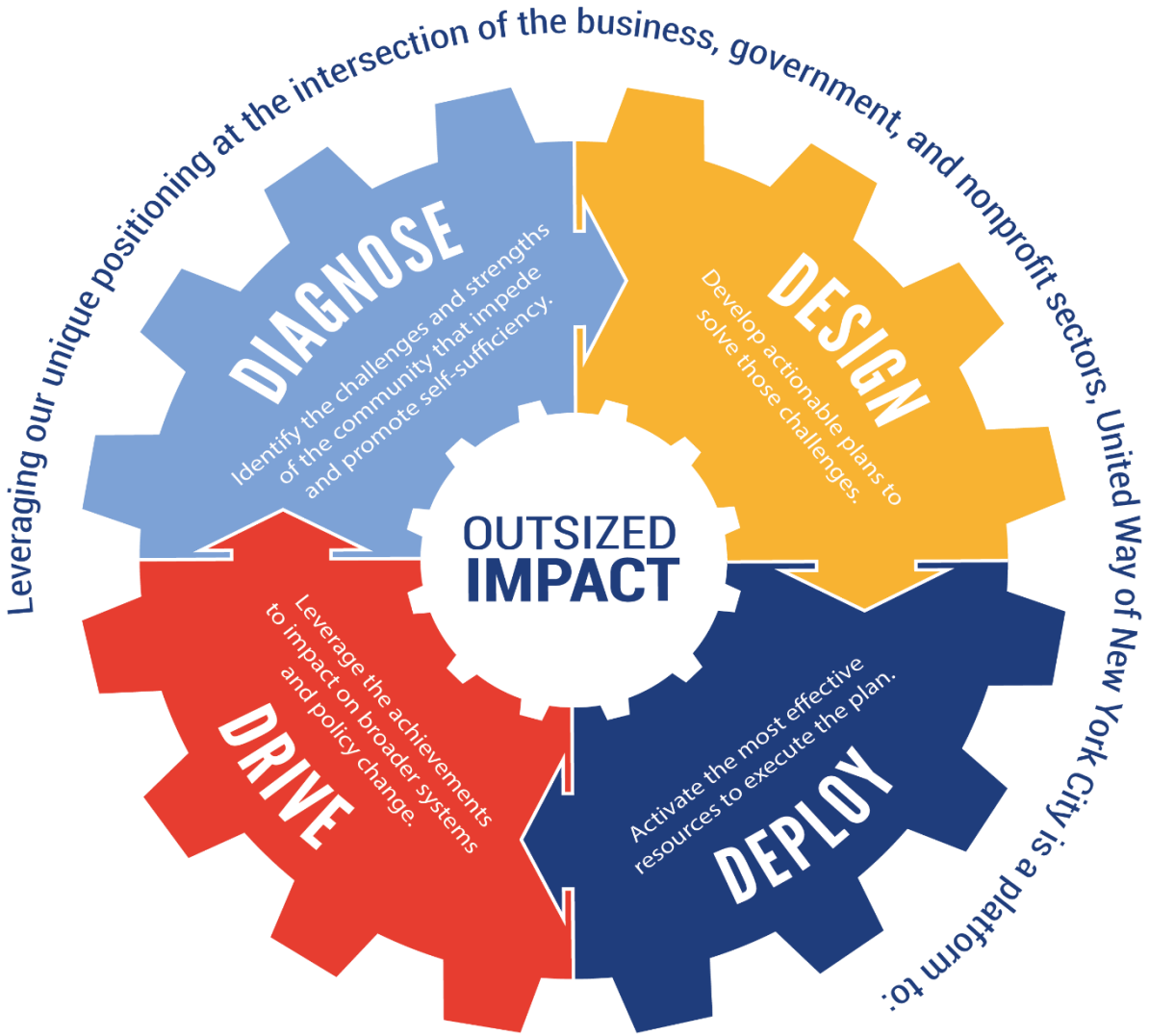
How we seek to drive change

United Way of New York City

We bring together corporate, community, and government partners to:

- **Establish a shared community vision** around helping low-income New Yorkers achieve self-sufficiency
- Adopt **evidence-based decision-making** to prioritize community efforts that improve outcomes
- Engage in **coordinated action, collaborative learning, and collective accountability** to identify, adopt, and scale what works
- Foster **community ownership and investment** to ensure the long-term sustainability of the outcomes

United Way of New York City's role:



Anchor Institution Community Partnership Award

Eduardo J. Padrón
President, Miami Dade College

Concurrent Sessions

Engaging Businesses Across Sectors to Improve Employee and Community Health – *Times Square Room, 7th floor*

Localizing Institutional Supply Chains: Hands-On Workshop – *Gotham Room, 7th floor*

Building Cultural Awareness in Teacher Candidates Through Urban Community Partnerships – *Harlem Room, 7th floor*

Where Will the Next Generation of Anchor University Leaders Come From? ACE Fellows (2017-18) on Anchor Universities, Anchor Leadership, and Developing the Anchor Leaders of Tomorrow – *Empire Complex, 7th floor*

Rethinking Community Safety – *Gilbert Room, 4th floor*

Luncheon Plenary

Nancy Cantor

Chancellor

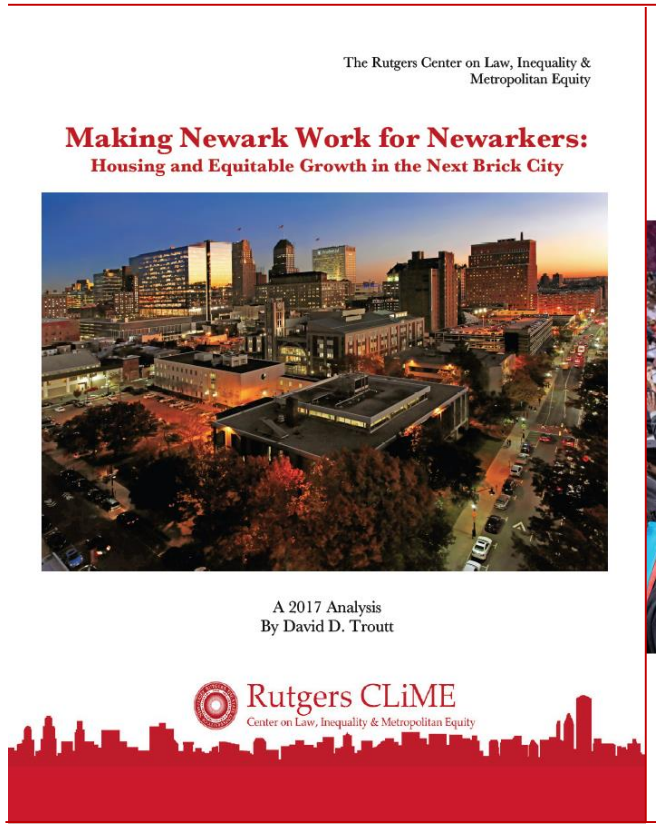
Rutgers University-Newark

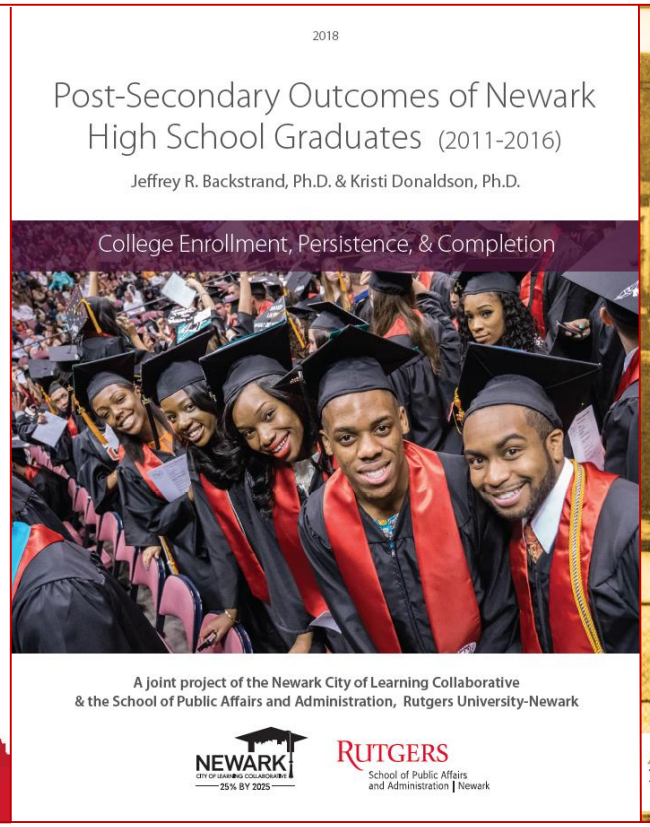
Ryan P. Haygood

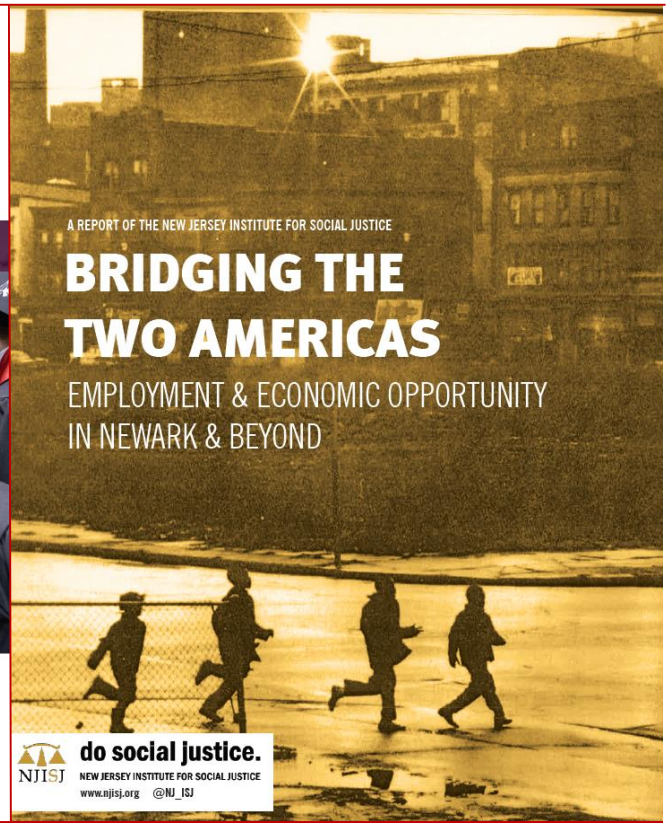
President & CEO

New Jersey Institute for Social Justice

Anchor Institutions 2.0 and the Challenge of Racial Equity







Nancy Cantor
Rutgers University – Newark
Ryan Haygood
New Jersey Institute for Social Justice

Anchor Institutions Task Force
Annual Conference
November 16, 2018

The Evolving Anchor Movement

- ***MORE*** emphasis on reciprocal collaborations and sharing of anchor-community voice and control, evolved from cult of the expert to community of experts, with and without pedigree
- ***MORE*** multi-sector, cross-sector, cross community engagement, no longer just "Eds and Meds," including corporate, arts, philanthropy, CDCs, local government, neighborhood groups
- ***MORE*** genuinely place-based, even as work resonates nationally and globally—more sensitive to community context – one size doesn't fit all, and less driven by national policy and more by local needs and opportunities, and uses a global focus to reflect on local
- ***LESS*** of a "service" orientation and ***MORE*** recognition of genuine interdependence of sustainable futures, anchors and community locked together

A New Moment: Heightened Vulnerabilities

On one hand:

Widening post-recession inequality layered upon long-standing racialized inequality, despite the exploding diversity of the population

On the other hand:

New massive investments in the growth of cities in particular, adding to the vulnerability of some neighborhoods and groups within those communities

- To do the kind of democratic, reciprocal, mutually empowering anchor institution work that AITF has always stood for, we need to be even more cognizant of racial equity issues, using a **broad racial equity** lens that reflects the complex intersections today of:

Race Ethnicity Indigeneity Immigration status Religion Class

- Goal: **equitable growth**

Key Arenas of Anchor Work

- Education
  - ➢ Double segregation by race and class in K-12
    - E.g. In New Jersey, 46% of black and Latinx public school students attend schools that are more than 90% nonwhite, largely in high-poverty communities; 43% of white public school students attend schools that are at least 75% white
  - ➢ College demographics still largely lag population as a whole
  - ➢ Many racialized populations still left on side-lines of opportunity
  - ➢ Highly racialized populations of: disconnected youth; re-entry adults
  - ➢ Vulnerability of fast-growing immigrant communities
  - ❖ Example: Cleveland, OH—Higher Education Compact of Greater Cleveland

- Neighborhood development
  - ➢ Sequelae of an architecture of segregation ("Color of Law")
  - ➢ Gentrification/displacement concerns (with persistent durable racial disparities)
  - ➢ Post-recession "recovery" has been very hard on communities of color
  - ➢ Foreclosure, eviction, homelessness
  - ➢ Racial disparities in lending/credit/banking
  - ➢ Stalled post-recession wealth growth for college-educated black and Latinx "middle class;" Native American communities left far behind economically
  - ❖ Example: Community Builders Network, St. Louis, MO—70 organizations working collaboratively on issues such as affordable housing & economic development

Key Arenas of Anchor Work

- Economic development
  - ➢ "Future of work" impact on already vulnerable populations (e.g., technology-intensive fields and industries are highly non-diverse; digital divide still highly racialized)
  - ➢ Capital for women and minority entrepreneurs (e.g., via local sourcing)
  - ➢ Overcoming racialized disparities in employment (e.g., local hiring)
  - ❖ Example: Prosper Portland—community economic development authority with explicit focus on racial equity in economic growth

- Public health and public safety
  - ➢ Racial disparities in health continue to grow
  - ➢ Environmental justice
  - ➢ Impact of mass incarceration and sequelae of trauma and need for trauma-informed practices
  - ➢ Community policing issues
  - ➢ Algorithmic justice issues (e.g., sentencing; facial recognition)
  - ❖ Example: Black to the Future – San Francisco – Human Rights Commission, police, economic and workforce development, higher eds, and CBOs collective initiatives on community safety, economic mobility, education, with focus on black youth.

Key Arenas of Anchor Work

- Empowering civic democracy
  - ➢ Splintering of groups in contemporary communities
  - ➢ Surfacing of hibernating bigotry; need for racial healing
  - ➢ Diversifying the American religious narrative; interfaith youth organization
  - ➢ Disenfranchisement of communities of color
  - ❖ Example: Envisioning Justice, Chicago—broad coalition of organizations including arts, humanities, criminal justice, CBOs, and higher ed focused on community impact of mass incarceration

A Half-Century Later...

Newark's Anchor Work

Educational Opportunity with a Racial Equity Lens

Collaborating for educational opportunity with a focus on prioritizing racial, ethnic, class equity and making sure that talent that is often left on the side-lines of opportunity is cultivated and taking that to scale**:**

- ***State-wide consortia***
  - NJ Coalition for Diverse and Inclusive Schools (lawsuit against State)
  - New Jersey State financial aid for Dreamers
  - New Jersey Scholarship & Transformative Education in Prisons (NJ-STEP)
  - Bridges to the Baccalaureate (5 HSI-community colleges to NJ universities)
- ***City-wide anchor coalitions***
  - Newark City of Learning Collaborative (25% post-secondary degrees by 2025)
  - Opportunity Youth Network & Reengagement Center
  - Children's Cabinet (across City agencies, School District, Newark Trust for Education, and Community Schools Initiative)
  - Newark Literacy Initiative (e.g., Mayor's book club; intergenerational literacy coaching)
- ***Rutgers-Newark programs***
  - High School to College Pathway Programs
  - Honors Living-Learning Community & Newark residents
  - Full last-in Scholarship for Newark residents and community college transfers with adjusted family incomes of $60k or less
  - UnDocuRutgers, legal and social support for Dreamers
  - University-Assisted Schools Partnership in South Ward
  - Parent Engagement Program in West Ward
  - City of Coding Partnership with Apple (e.g., coding labs in schools)

Newark's Anchor Work

Economic Opportunity with a Racial Equity Lens

Collaborating with community partners, local government, corporate anchors, NJISJ, Newark Community Development Network, & Newark Alliance to create economic opportunity for local citizens and capitalize local businesses, with focus on resident communities of color:

- ***State-wide coalitions***
  - NJISJ's coalition on statewide plan to diversify apprenticeships and develop adult apprenticeships; tax credit programs for apprenticeships; tuition fee waivers
- ***City-wide anchor coalition***
  - Newark 2020/Hire Local /Buy Local/Live Local
    - Hire 2,020 by 2020 (currently Newark residents hold only 18% of jobs in the City)
    - Create training/hiring hubs working with Newark Community Development Network
    - Buy Local – increase anchors' local sourcing to 20%, spending $200m annually
    - Supply-chain management experts matching vendors to anchors
    - Newark Anchor Collaborative – sharing best practices and creating a live-local fund
- ***Rutgers-Newark and Rutgers Biomedical and Health Sciences***
  - Hire.Buy.Live Local
    - 220 jobs for local residents by 2020
    - Increase Rutgers-Newark's local sourcing to 30% by 2020
    - Entrepreneurship capacity building – re-entry entrepreneurs; business hub for community arts entrepreneurs at Express Newark Arts Collaboratory
    - Participate in Live Local fund for employees scaled by income

Newark's Anchor Work

Equitable Growth with a Racial Equity Lens

Working to ensure that the flood of new investments in Newark both encompasses local residents and spreads to strengthen otherwise marginalized low income neighborhoods of color:

- ***City-wide programs and coalitions***
  - Equitable Growth Advisory Council (representatives of City, business, CBOs, non-profits, higher ed)
    - Inclusionary zoning ordinance
    - Rent regulation enforcement
    - Legal support for residents subject to eviction and foreclosure
  - Anchor tenancy – develop housing targeted to specific needs and groups (e.g., artists, LGBTQ community, veterans, teachers); experimental housing models for low-income; homelessness interventions
  - Community benefit agreements
  - Inclusive development of city-owned land and vacant parcels and community land bank
  - Safer Newark Council
    - Citizen-focused and community policing model (e.g., Newark Street Team)
    - Domestic violence interventions
    - Trauma-informed care
    - Re-entry support
    - Juvenile justice interventions
- ***Rutgers-Newark programs***
  - Center for Law, Inequality, and Metropolitan Equity (e.g., displacement risk index; trauma-informed school practices)
  - School of Criminal Justice's place-based crime risk analysis
  - Collaboration with NJISJ and Department of Justice and Newark Police (on Consent Decree reforms)
  - Juvenile Justice Consortium
  - Health Education Advocacy Law Collaborative

Newark's Anchor Work

Strengthening Civic Democracy with a Racial Equity Lens

Empowering communities of color with voice in civic democracy:

- ***State-wide Initiatives:***
  - NJISJ's movements for voting rights for people on parole and probation, reducing youth incarceration and closing juvenile detention centers
- ***City-wide Initiatives:***
  - Truth and Racial Healing and Transformation Collective – Rutgers-Newark, NJISJ, Newark Public Library, and City of Newark
  - Newark People's Assembly—organized by Mayor, encompassing all Wards
- ***Rutgers-Newark Initiatives:***
  - Newest Americans—stories of immigrant communities in Newark with Ironbound Community Coalition
  - Humanities Action Lab's States of Incarceration Curriculum and Exhibitions
  - For Freedoms—inviting re-articulation of freedoms for a diverse democracy
  - New Jersey Ballot Bowl Champs—RU-N diverse student leaders catalyzed most successful effort among NJ colleges to register new voters (1,000+)

Health Anchors and Strategies to Improve Community Health

Elsie Stines

Assistant Vice President, Special Projects and Initiatives, Office of the President
University of Maryland-Baltimore

Kitty Hsu Dana

Senior Health Policy Advisor
Institute for Youth, Education, and Families
National League of Cities

City-Anchor Partnering:
Collaborations to Build Cities of Opportunity

Kitty Hsu Dana
Senior Health Policy Advisor
National League of Cities
AITF 2018 Conference - November 16, 2018

NLC NATIONAL LEAGUE OF CITIES
CITIES STRONG TOGETHER

NLC Health & Wellness Framework: Cities of Opportunity

NLC NATIONAL LEAGUE OF CITIES

Cities of Opportunity are places where all people can reach their full potential and live productive, fulfilling and healthy lives.

A HOLISTIC FRAMEWORK for City Leaders – to advance health, equity and well-being for their cities and residents by working across multiple, inter-connected factors that affect how long we live and how well we live.

City Leaders: unique role to impact SDOH!

Cities of Opportunity: Initial Issues for Pilot- Align and Integrate Actions

NATIONAL LEAGUE OF CITIES

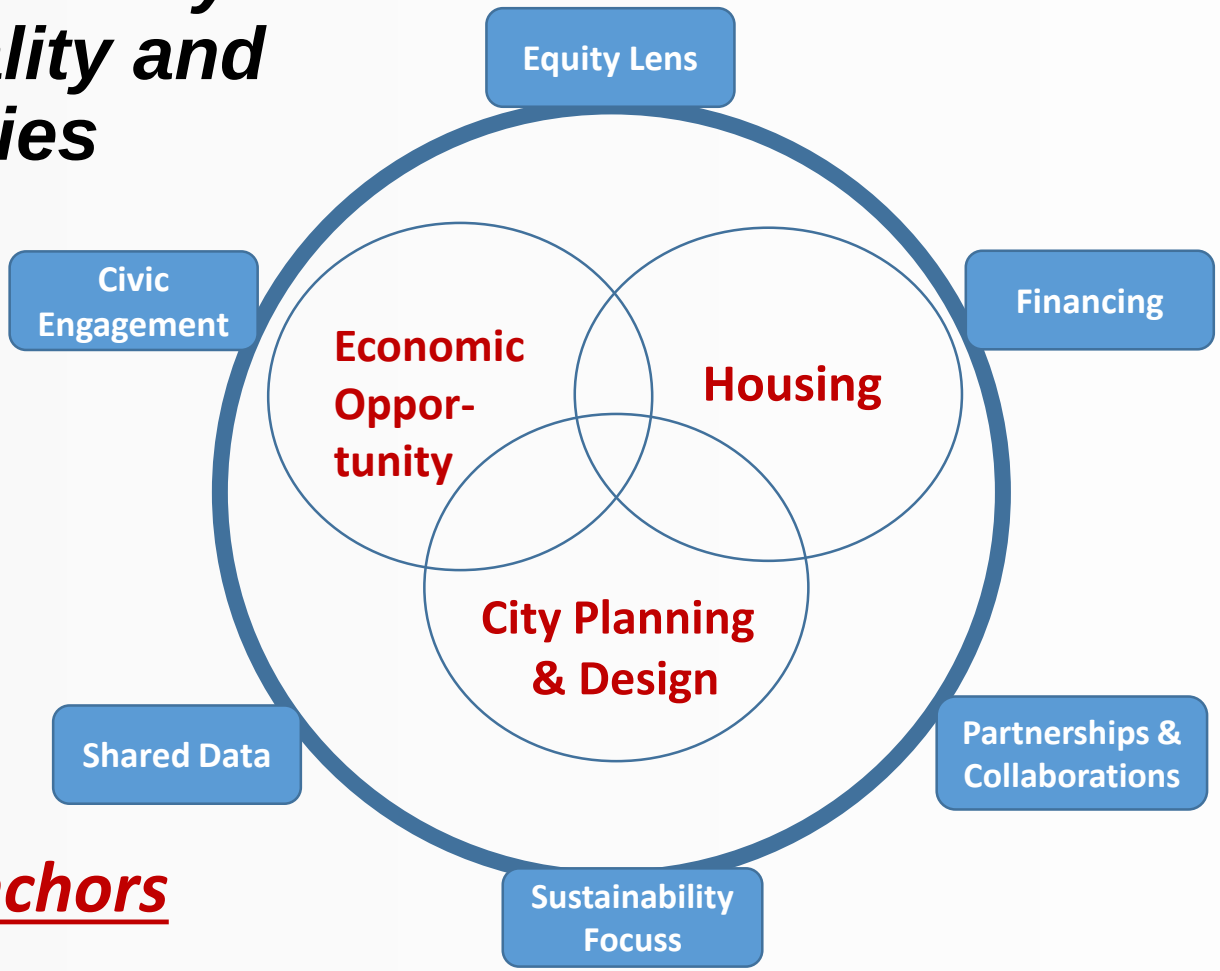
Housing
- Affordable, Healthy

City Planning & Design
- Safe, Beautiful, Connected

Economic Opportunity
- Thriving, Accessible

City Residents
- *Healthy, Engaged & Resilient*

Cities of Opportunity - Intersectionality and Core Capacities



At every point:

<u>Partnering with Anchors</u>

<u>- Greater Impact</u>

Tales of Four Cities

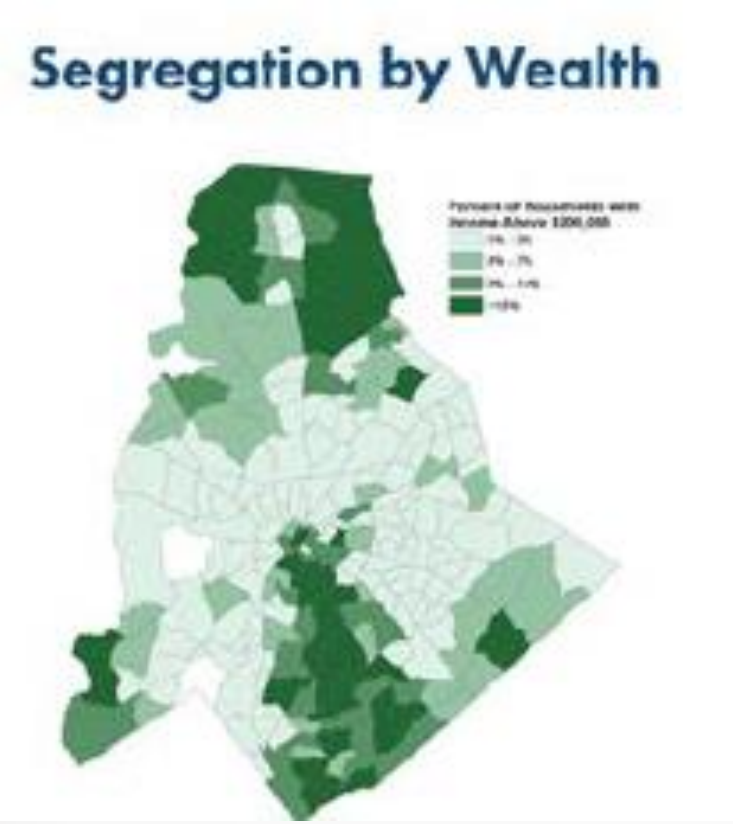
NLC NATIONAL LEAGUE OF CITIES

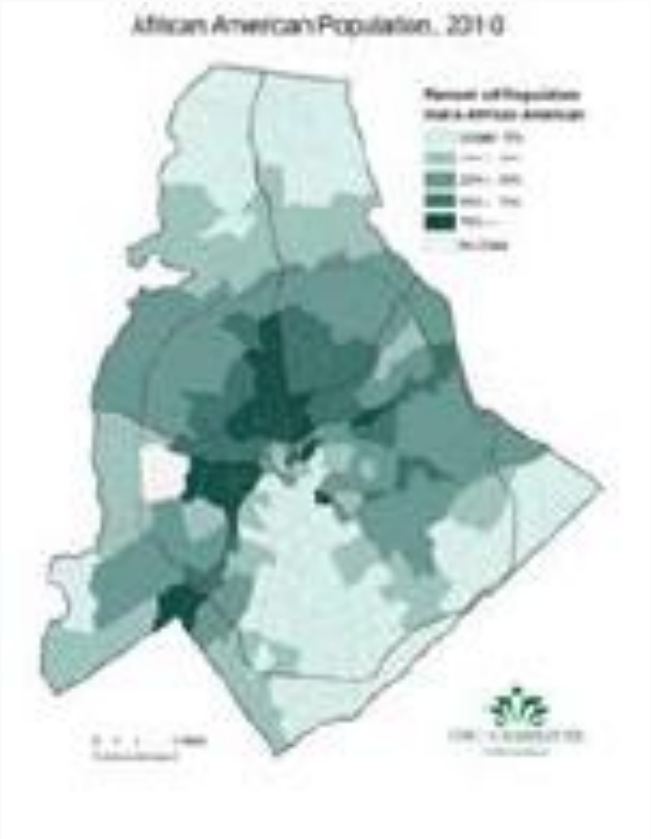
City	Population (2017)	7-Year % Pop. Change	% Poverty	% White	% Black	% Hispanic
Charlotte, NC	842,000	16.8	13.4	50.7	35.5	13.7
Huntington, WVA	48,000	-4.3	30.8	86.3	8.3	1.8
Lansing, MI	116,000	2.4	29.5	61.2	21.7	12.0
Roanoke, VA	99,000	3.0	22.2	63.8	28.3	6.0
U.S. Average		5.5	12.3	76.6	13.4	18.1

City of Charlotte

City of Charlotte

NATIONAL LEAGUE OF CITIES

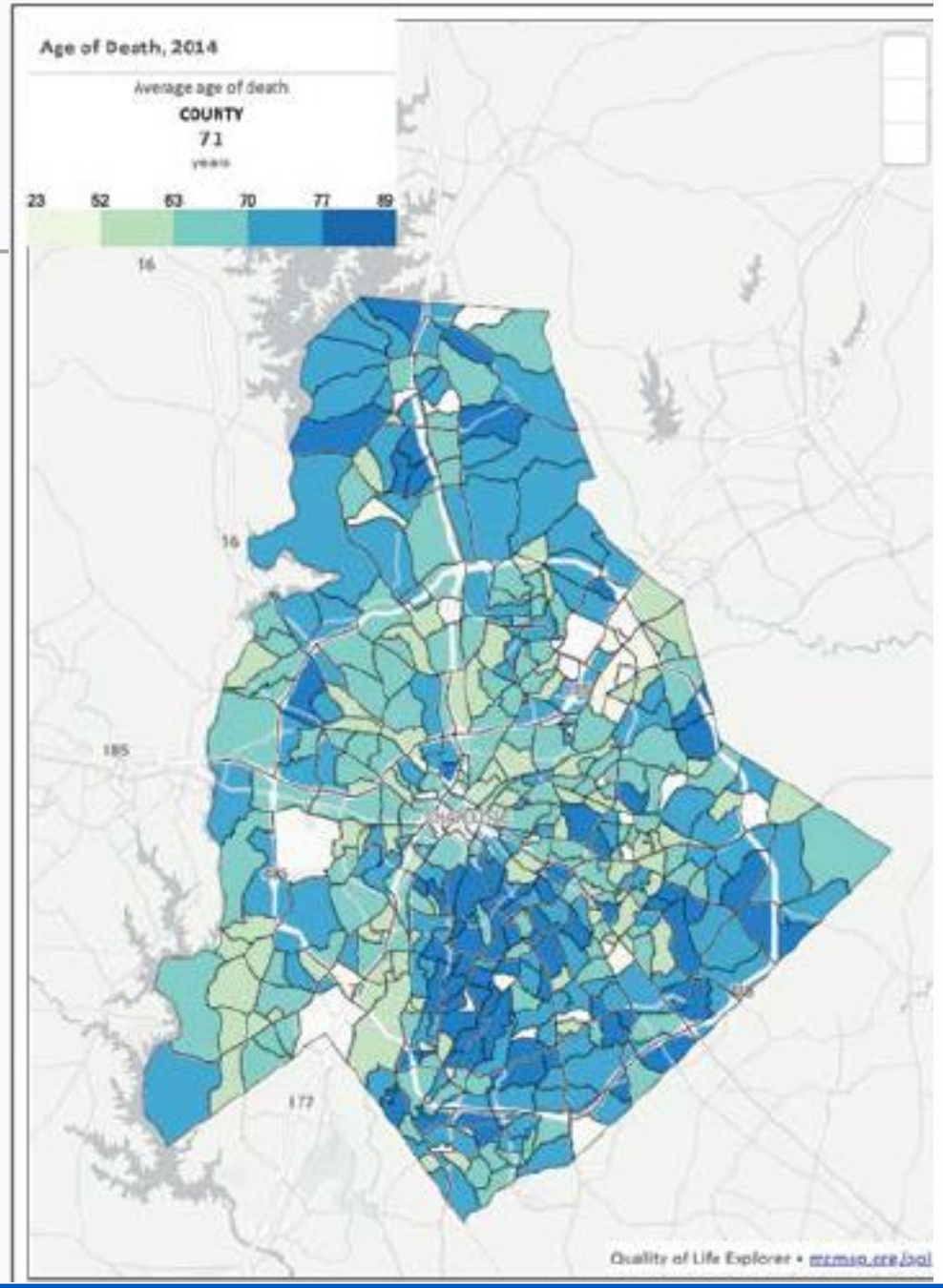




Charlotte, NC

Quality of Life Map – Age of Death (2014):

- **79 years (south east)**
- **67 years (surrounding crescent)**



NLC NATIONAL LEAGUE OF CITIES

City of Charlotte

NLC NATIONAL LEAGUE OF CITIES

Context:

- Rapidly growing – 17th largest city in U.S.
- Strong economic growth – banking hub, corporate investments, educational institutions, business center revitalization
- Historical legacy of segregation and exclusion, public policies that perpetrate inequities and racial discrimination (e.g., zoning, land use)
- Low expectations and low accountability for benefits of growth to be accessible to disadvantaged communities

Anchors:

Charlotte Center City Partners: Norvant Health, Johnson C. Smith University, Central Piedmont Community College, Johnson & Wales University, Foundation for the Carolinas

+ business community – Chamber, BoA, Wells Fargo, Developers, Civic Leaders

City of Charlotte

NATIONAL LEAGUE OF CITIES

What's Happening:

- **Equitable Economic Development partnering - small business, talent development, corridor revitalization**
- **Project P.I.E.C.E.S. - invest to connect individuals with multiple barriers to employment to entry/mid-level construction jobs: residential & commercial, highway, broadband & fiber-optics cabling**
- **Public Transit - Engaging community to identify needed changes to system, including First Mile-Last Mile access to light rail**

What's Next:

- **Charlotte 2040 – creating first comprehensive plan in 45 years: Livable, Connected, Inclusive and Healthy City - opportunity for all**
- **Improve communications & information access**
- **Better coordinate projects and programs with different timeframes, financing, operating procedures**

City of Huntington

City of Huntington

NATIONAL LEAGUE OF CITIES

Context:

- Thrived as coal transport and manufacturing hub
- Population: 90,000 in 1950 - under 50,000 today; 30+% in poverty
- Labeled "worst" American city - multiple issues: Most Obese, Most Economically Depressed, Center of Opioid Crisis (2008 – 2016)
- Mayor/City leadership: catalyze cross-sector, multi-level work to mitigate opioid overdose and tie recovery to jobs/economic development

Anchors:

Marshall University (medical school, Center for Rural Health), Cabell Huntington Health, St. Mary's Hospital Center

+ Huntington Housing Authority, Huntington Municipal Development Authority, neighborhood and faith groups

City of Huntington

NATIONAL LEAGUE OF CITIES

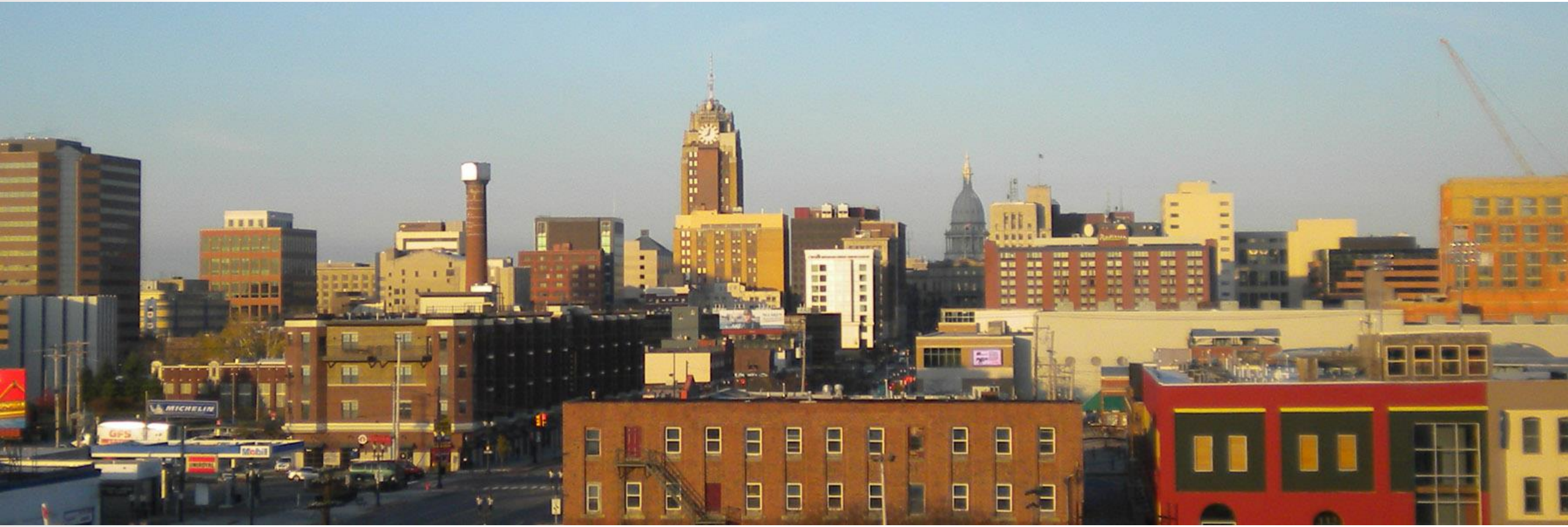
What's Happening:

- **Poly-TeCH – transform closed factories and brownfields to advanced manufacturing hub with mixed-use development**
- **Choice Neighborhood – transform deteriorating public housing to mixed-use health district, affordable housing, access to recreation & local food**
- **Workforce Development – youth, dislocated workers (solar, craft, commercial jobs)**
- **From: Epicenter of Opioid Crisis / To: Epicenter of Solutions (smallest of 9 cities to win 2018 Bloomberg Mayors' Challenge $1M)**

What's Next:

- **Data sharing, collection & analysis**
- **City leaders - improve peer-to-peer connections**
- **Additional resources and alignment: better health & economy**

City of Lansing



City of Lansing

NATIONAL LEAGUE OF CITIES

Context:

- Longtime leader in advanced manufacturing, technology innovation, health care and higher education
- Struggled with decline in traditional industries, poverty, economic loss, brownfields, neighborhood deterioration, health disparities (poor rankings)
- Design Lansing Comprehensive Plan: population loss, affordable housing crisis, aging housing stock, aging population

Anchors:

Michigan State University, Sparrow Health System, McLaren Greater Lansing, Lansing Community College

+ Regional Planning Commission, Housing Partnership, non-profits

City of Lansing

NATIONAL LEAGUE OF CITIES

What's Happening:

- New Economy Plan for Regional Prosperity: placemaking, smart growth, transit-oriented design, green development, green infrastructure & complete streets
- Stakeholder-driven and neighborhood-based engagement, GIS/data-driven approaches
- Major health-focused economic investments: Sparrow Health System & McLaren Greater Lansing – expand access, create jobs, attract employees

What's Next:

- More holistic and integrated approaches – reach neighborhoods & populations left behind, outside downtown area
- Better data tools for identifying and focusing action – specific sub-populations
- Establish robust, sustainable cross-sector approach – more systemic, city-wide change

City of Roanoke

City of Roanoke

NATIONAL LEAGUE OF CITIES

Context:

- Population 100,000 - urban center of a region of 300,000
- Post-Civil War Reconstruction – "Magic City"
- Late 20th C - Rapid Economic and Population Growth started to rewind

  21st C – Struggled for place in new economy
- Recent decade: Transforming from "Train City" to "Brain City"

  However, greater divide along socio-economic lines threaten sustainability

Anchor Partners:

Carillion Health, Virginia Tech University, Virginia Western Community College, United Way of Roanoke Valley

City of Roanoke

NATIONAL LEAGUE OF CITIES

What's Happening:

- Multi-sector Partnerships: CHNA + Comprehensive Plan (HiAP embedded)
- Target CDBGs + Home funding + other city public-private efforts into most disadvantaged areas
- Healthy Roanoke Valley – partnership w/ 50 CBOs & Regional Planning District promote economic opportunity & quality of life
- Civic Engagement fully integrated into culture of city organization

What's Next:

- What it takes to implement plan – esp. issues of Poverty & Quality Health Care
- Race Equity, Diversity & Inclusion – conversation just started

Common Themes:

NATIONAL LEAGUE OF CITIES

Partnerships = *Essential Precondition* for Readiness

Produce Results, Attract Funding *("Money in plain sight!")*

Plan/Progress toward: Collaborative, Inclusive and Locally-Controlled Economies

AND Challenges Remain

- **Lack integrated, shared data – responsibility dispersed**
- **Still need - disaggregated data**
- **Enhance Civic Engagement – do more, and more with the right people**
- **Improve integration – across City Agencies, with Residents, with Partner Organizations**
- **Race, Equity, Inclusion – ongoing journey**
- ***City Leadership/Anchors – raise expectations of each other***

Other City-Anchor Partnerships

City of Columbus and Nationwide Children's Hospital

- **Healthy Neighborhoods Healthy Families - Affordable Housing**

City of Memphis and Memphis Medical District Partnership

- **8 institutions/250+ acres – Housing, Strengthen Commercial Corridor, Improve Public Life & Safety, Capture Value of Institutions**

NLC-AITF Web Forum Series:

City-Anchor Partners Leverage Assets to Improve Community Health

How Cities and Anchor Institutions Can Work Together to Improve Health and Wellbeing in Their Communities

CITIES OF OPPORTUNITY

https://citiesofopportunity.nlc.org/

City-Anchor Partnerships

NLC NATIONAL LEAGUE OF CITIES

THANK YOU!

Kitty Hsu Dana
Senior Health Policy Advisor
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National League of Cities
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Michellene Davis

Executive Vice President & Chief Corporate Affairs Officer

RWJBarnabas Health

SOCIAL IMPACT AND COMMUNITY INVESTMENT

PRACTICE

Achieving Health Equity

How an anchor strategy can help improve well-being by building an inclusive and sustainable local economy

Fall 2018

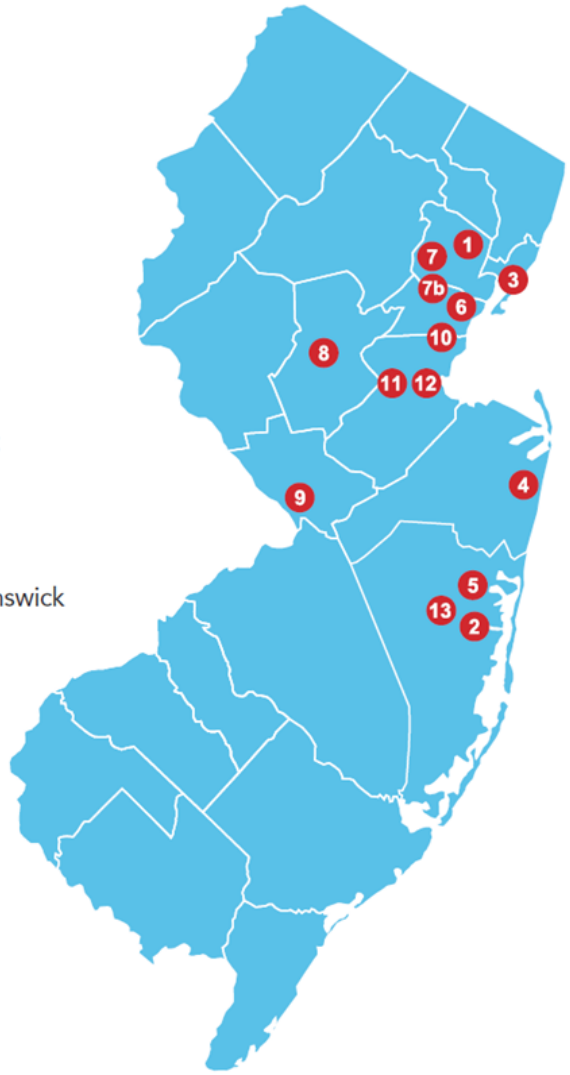
RWJBarnabas HEALTH

RWJBarnabas HEALTH

MAKE A *UNIQUE* IMPACT IN LOCAL COMMUNITIES THROUGHOUT THE STATE.

1. Clara Maass Medical Center
2. Community Medical Center
3. Jersey City Medical Center
4. Monmouth Medical Center
   The Unterberg Children's Hospital at Monmouth Medical Center
5. Monmouth Medical Center, Southern Campus
6. Newark Beth Israel Medical Center
   Children's Hospital of New Jersey at Newark Beth Israel Medical Center
7. Saint Barnabas Medical Center
   Barnabas Health Ambulatory Care Center
8. Robert Wood Johnson University Hospital Somerset
9. Robert Wood Johnson University Hospital Hamilton
10. Robert Wood Johnson University Hospital Rahway
11. Robert Wood Johnson University Hospital New Brunswick
    The Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital
12. PSE&G Children's Specialized Hospital
13. Barnabas Health Behavioral Health Center

RWJBH.org



- RWJBarnabas Health is New Jersey's largest integrated health care delivery system, providing treatment and services to more than three million patients each year.

Patients Treated Per Year:

- Patients Treated: Over 3 million
- Outpatient Visits: 2 million
- Inpatients and Same Day Surgery Patients: 283,000
- Emergency Department Patients: 700,000
- Pediatric Patients: 200,000
- Births: 23,000

Staff:

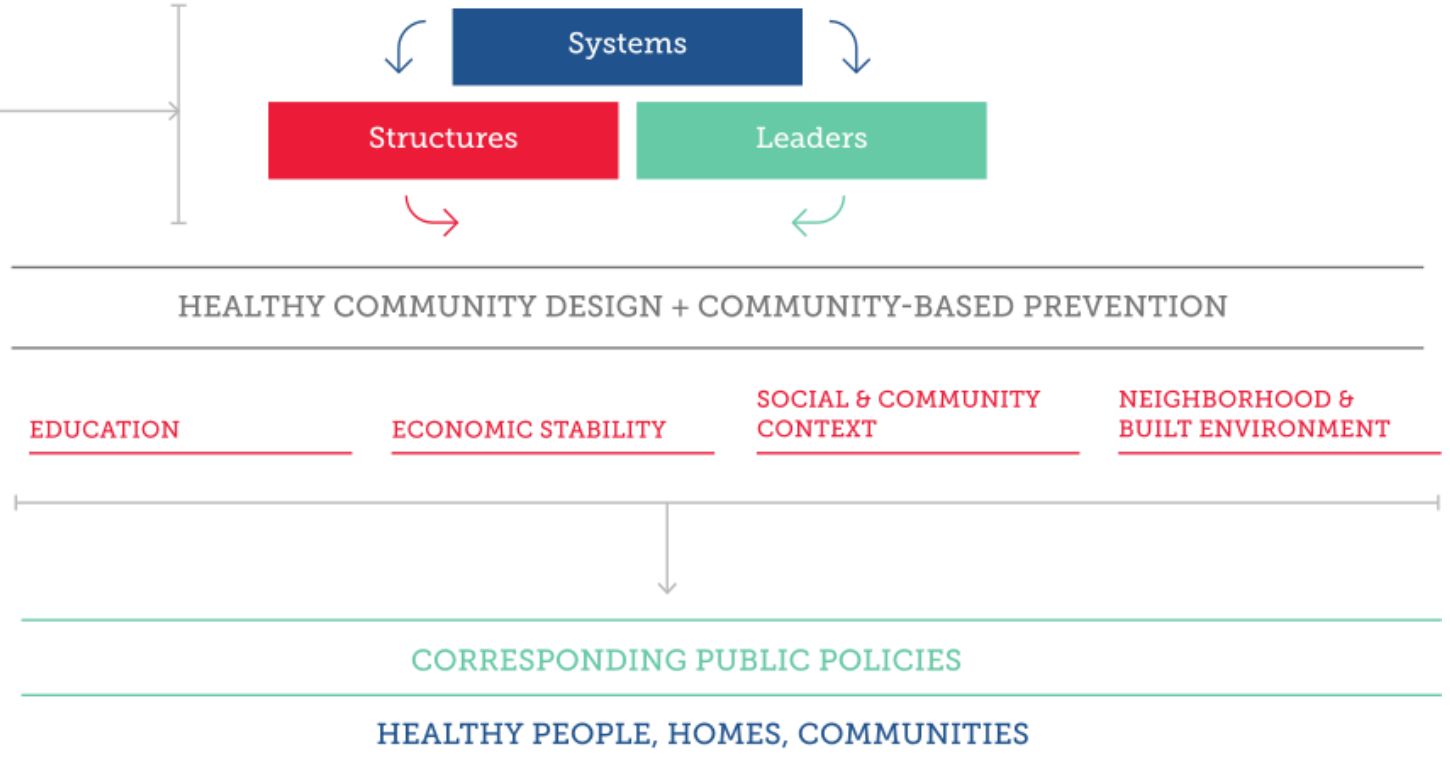
- Employees: 32,000
- Physicians: 9,000
- Residents and Interns: 1,000

RWJBH CHANGE FRAMEWORK: THEORY OF CHANGE

HEALTHY COMMUNITY DESIGN

All New Jerseyans live in—and contribute to—socially connected and economically thriving resilient communities.

Foster health promoting environments and conditions across key social determinants of health



Vision & Mission

Vision

All New Jerseyans live in—and contribute to—socially connected and economically thriving resilient communities.

Mission

The mission of the social impact and community investment practice is to improve health for all New Jerseyans by strategically working to foster health promoting environments and conditions across the key social determinants of health. Our work contributes to healthy people, healthy homes, and healthy communities. We place special emphasis on the needs of vulnerable communities.

America's Health Rankings, 2016

NJ HEALTH Challenges

Declining infant mortality rate

decrease in cancer deaths

Heart disease and cancer — half of all deaths

27.3% of adults are obese

40TH among the states in health disparity

16TH in overall senior health

90% increase in drug deaths

12% of the adult population has diabetes

32ND low birth weight (8.3% of births)

37TH per capita public health funding

29TH cardiovascular deaths

17% decrease in public health funding

University of Wisconsin Population Health Institute, Talkpoverty.org, New Jersey State Police Uniform Crime Report

Vulnerable Populations

NEW JERSEY

$72,062	Median household income was $72,062 in 2014
10.7%	of people were living in poverty
11.6%	of residents did not graduate from high school

ESSEX COUNTY

$54,499	Median household income was $54,499 in 2014
17.2%	of people were living in poverty in Essex County
16.2%	of residents did not graduate from high school
19.9%	of the homeless population is in Essex County
18%	almost 1 out of 5 residents lacks adequate access to food
30%	of households report severe housing problems
674	High rates of violence, 674 offenses per 100,000

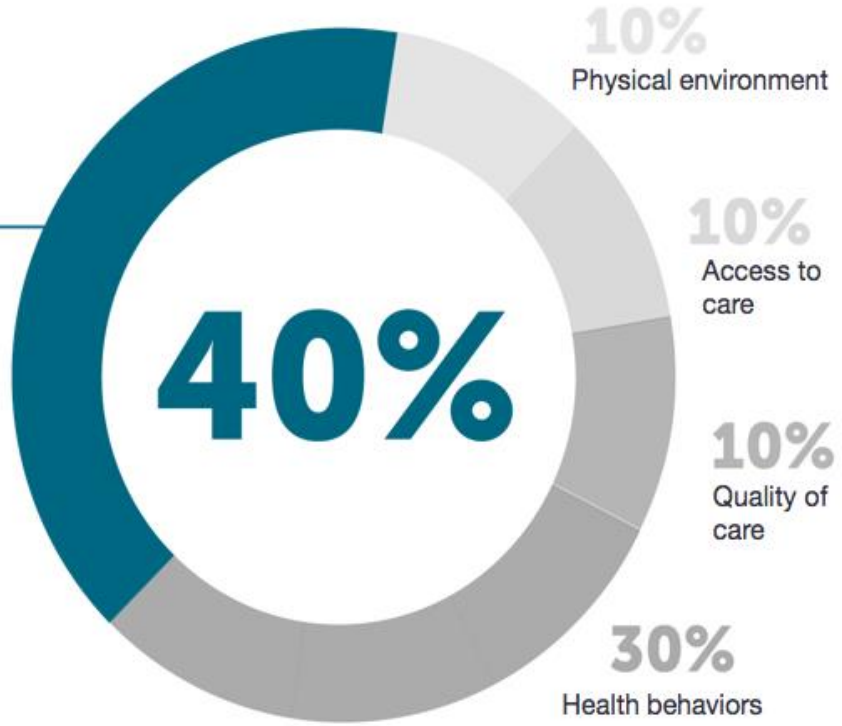
NEWARK

$31,698	Median household income was $31,698 in 2014
32.5%	of people were living in poverty
26.7%	of residents did not graduate from high school (more than 2x statewide percentage)
52%	Poverty rate of non-graduates
29%	of 89,183 Newark households were housing insecure
1 in 90	The chance of being a violent crime victim in Newark vs 1 in 392 in the state

WHY INVEST IN HEALTH EQUITY?

Social & Economic Factors

- **Education**
- **Employment**
- **Income**
- **Family & Social Support**
- **Community Safety**

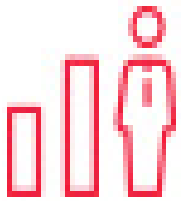


Data from "County Health Ranking & Roadmaps," University of Wisconsin Population Health Institute

Although our healthcare system has spent many resources trying to improve health through quality and access, models suggest that approximately 40 percent of the factors that contribute to health outcomes are related to social determinants.

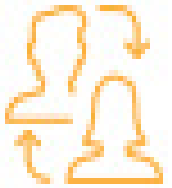
Action framework

Intervention Priorities

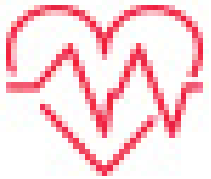


ECONOMIC STABILITY
Food Security
Youth Workforce Development
Access to Social Services & Supports

EDUCATION
Early Childhood Development
Family Health Literacy
Parenting Education



EMPLOYEE ENGAGMENT & VOLUNTEERISM
Skills-based Volunteerism
Service Rallies

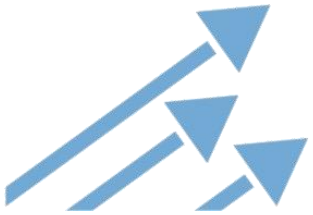


GLOBAL HEALTH
International Outreach
Domestic Outreach

NEIGHBORHOOD & BUILT ENVIRONMENT
Safe & Affordable Housing
Violence Prevention

RWJBH ANCHOR INSTITUTION STRATEGY

INCLUSIVE, LOCAL HIRING



- **Outside In** - equip local residents for quality, high-demand frontline jobs that are connected to job pipelines

- **Inside Up** - connect frontline workers to pathways for career advancement within the institution

Build community hiring pipelines that create opportunities for employment & career advancement

NEWARK 2020 + HIRE NEWARK

Newark 2020: Cut the unemployment rate between the City of Newark and New Jersey in half by connecting 2,020 unemployed Newark residents to full-time work that pays a living wage by the year 2020.

Hire Newark is contributing to RWJBarnabas Health's commitment to hire 350 Newark residents with career pipelines and livable wage pathways by the year 2020 across the RWJBH system.

Increase Employment & Labor Force Participation

Decrease Unemployment

Increase Wages & Earnings

RWJBH ANCHOR INITIATIVE: NEWARK 2020 + HIRE NEWARK

- Class I, II, & III 100% graduation rate, 56 of the 56 participants who have matriculated in the program have graduated
- 95% employment rate, all participants have received multiple job opportunities via employer partners

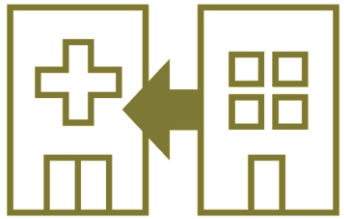
- 82% currently employed; many are considered "superstars" by their managers

NEWARK 2020 CHALLENGES

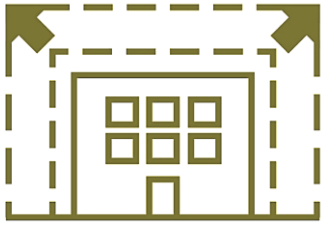
Infrastructure issues include**:**

- **Accountability:** Score card or other mechanism should have been developed and shared with anchor employers and community partners to measure their progress over time.
- **Data Reporting:** The data collection, standardization and evaluation was not invested in from the onset. Baseline data was requested a year after launch.
- **Tech infrastructure:** Anchors did not have access to Newark2020 website directly nor received real time alerts/notifications when candidates applied. Technology should have been invested in to better assist in accountability and tracking progress.
- **Lack of marketing:** There was no marketing strategy because the infrastructure issues were not resolved. This meant some Newarkers applied through the Newark2020 website while others did not.

INCLUSIVE, LOCAL SOURCING



- **Creating Connections** - connecting existing local, veteran, minority and women owned businesses to contracting opportunities within your institution



- **Building Capacity** - building up the capability of the local business community to meet health system supply chain needs

Direct your institution's everyday spending to support inclusive local businesses and uplift the community

RWJBH ANCHOR INITIATIVE: SUPPLY CHAIN

- **Terminating contracts = local purchasing opportunity**
- **Leverage HPG contracted suppliers:** Vital Records Control Companies, LLC (VRC) is a GPO portfolio vendor
- VRC to establish a records management center in Newark, NJ (100,000+ square foot facility)
- The facility will house medical and business records for all RWJBarnabas Health facilities
- We are evaluating other opportunities to further expand the relationship and business presence in Newark.

IMPACT:

Total Initial Investment: $3+ million

Annual Revenue: $4 million

Newark vendors and suppliers: TBD under review

Newark hires: 20 full time (expected)

RWJBH Savings: $1 million per year

Expected Start Date: May 2018

Example of: BUY. INVEST. HIRE LOCAL.

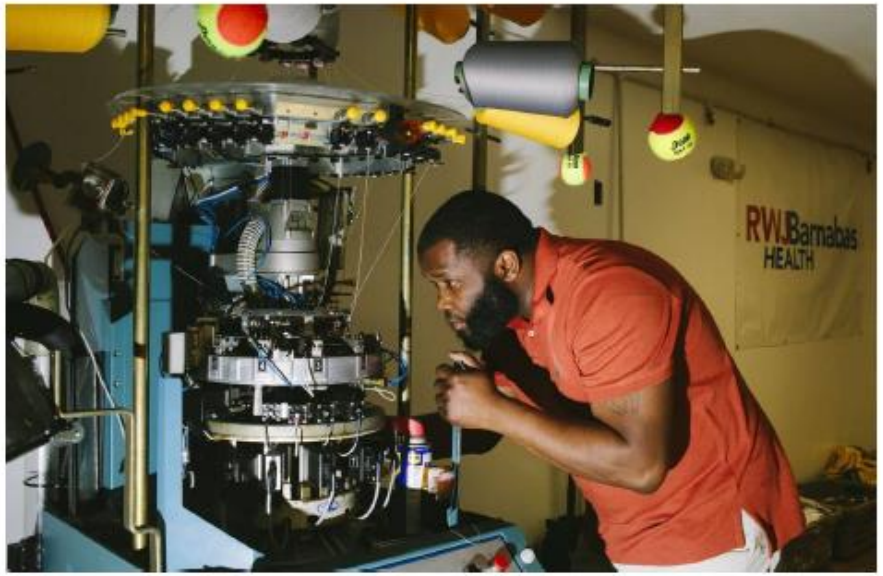
THE WALL STREET JOURNAL.

https://www.wsj.com/articles/a-new-role-for-hospitals-boosting-the-local-economy-1521547201

- U.S.
- New York
- Region

A New Role For Hospitals: Boosting the Local Economy

More health-care facilities are helping to improve the well being of residents by hiring and buying in communities



Khalif Thomas—was operating Rock Ya Sock, a small side business making novelty and sports-themed socks—in addition to working as an HVAC mechanic at Newark Beth Israel Medical Center in Newark. Photo: John Taggart for The Wall Street Journal

By Kate King

March 20, 2018 8:00 a.m. ET

Rock Ya Sock LLC. @Sock_Gang · 1d

When the biggest healthcare system in #NJ @RWJBarnabas believes in buying local. @MichelleneEsq #SmallBusiness #RWJBarnabas #WeAreNewark – at Newark Beth Israel Medical Center CPR Training Cen

1 2

CONSTRUCTION COLLABORATION WITH *COMPETITIVE EDGE* BY JINGOLI

Real Estate Sports & Entertainment

Hard Rock Hotel & Casino Atlantic City slated for summer opening

By **Elana Knopp**, April 18, 2018 at 2:32 PM - Last modified: April 18, 2018 at 3:07 PM

The **Hard Rock Hotel & Casino Atlantic City** is set to open on June 28 on the iconic Atlantic City boardwalk.

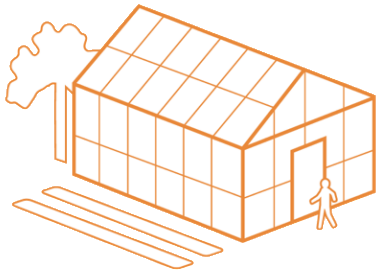
Hard Rock International, owned by the **Seminole Tribe of Florida**, purchased the hotel in March 2017 from real estate magnate Carl Icahn and began its massive renovation.

A group of investors including **Edgewood Properties** CEO Jack Morris and **Joseph Jingoli & Son** CEO Joe Jingoli have poured $500 million into the project, which is expected to generate more than 3,000 jobs.

The property will boast a rock-chic interior and feature 2,000 hotel rooms, 2,200 slots, 125 game tables and 20 restaurants.

Joe Jingoli, CEO, Joseph Jingoli & Son Inc.; Jim Allen, chairman,Hard Rock International, and Jack Morris, CEO and president, Edgewood Properties at the Hard Rock Cafe in Atlantic City, last year. - (NJBIZ FILE PHOTE)

PLACE-BASED INVESTING



- **Place-Based Investment:** Designate a percentage of investible assets within investment portfolio across asset classes

- **Upstream Community Benefit:** Address community health needs by allocating discretionary operating dollars to sustainable solutions

Align your institution's financial and operational resources to address the upstream economic determinants of poor health

RWJBH ANCHOR INITIATIVE: SOUTH WARD COMMERCIAL CORRIDOR

- RWJBH has partnered with Newark LISC and the Bergen Lyons Clinton Special Improvement District (BLC SID) to commence Phase 1 of a commercial corridor assessment to develop a retail strategy for our commercial corridor's revitalization.
- Newark Beth Israel Medical Center is currently collecting employee survey responses to help us understand what the unmet commercial demand is for our NBIMC employees and South Ward residents.

IMPACT:

Phase 1 Investment: $150,000

Community Partners Newark LISC and BLC Special Improvement District

Expected Study Outputs:

1. Commercial district assessment and retail strategy for corridor revitalization
2. Identify hotspots and employ design strategies (e.g., visibility, lighting, landscaping, foot traffic) to deter criminal activity
3. Provide a cohort of 5 veteran, minority, and women-owned small businesses in the target areas with financial resources and expertise

RWJBH ANCHOR KEY METRICS

- $ of direct spend directed towards local, veteran, minority and women owned businesses
- % of vendor employees at livable wage
- % of vendor employees from the target neighborhoods
- % of spend with local (MWBEs and VOBEs) including primary vendor contracting
- # of local construction companies sub-contracted with
- % construction spend with local, MBE, WBE, and VOBE businesses
- % of construction hours worked by Anchor Mission zip code residents
- % of wages paid to Anchor Mission zip code residents

FOOD FOR THOUGHT

THE PATH TO FOOD SECURITY IN NEWARK, NJ

FOOD FOR THOUGHT

THE PATH TO FOOD SECURITY IN NEWARK, NJ

https://www.youtube.com/watch?v=ByUqRZW5biU

RWJBarnabas Health,

the state's largest integrated health care delivery system, is poised to significantly improve the overall health and well being for more than the five million patients that it currently treats.

CONCLUSION

In establishing its social impact and community investment practice and working to fulfill the system's anchor mission, RWJBH can become a force multiplier in state and local efforts that help communities close equity gaps and sustainably bolster the health of each resident.

The practice is an essential part of the system's value proposition as it actually enables the system to realize the vision of improving the health, quality of life, and vitality of New Jersey communities.

Terri Lipman

Assistant Dean for Community Engagement and
Professor of Nursing of Children

University of Pennsylvania, School of Nursing

Alison Marx

Operating Officer, Department of Pediatrics

Children’s Hospital of Philadelphia

STRATEGIES TO IMPROVE COMMUNITY HEALTH

Alison Marx, MBA,
Operating Officer, Department of Pediatrics, Children's Hospital of Philadelphia

Terri Lipman, PhD, CRNP
Assistant Dean for Community Engagement and Professor of Nursing of Children, University of Pennsylvania School of Nursing

Children's Hospital of Philadelphia®

GOALS:

- Context of Work
  - The Children's Hospital of Philadelphia (CHOP)
  - Our Community:
    - Health Challenges and Needs
  - Department of Pediatrics Chair's Initiatives Program

- Opportunities and Successes – Community Health Worker Initiative: Enhanced Care Management for Complex Patients

- Future Opportunities

THE CHILDREN'S HOSPITAL OF PHILADELPHIA

- Founded in 1855 as the first hospital in the nation devoted exclusively to pediatric medicine
- Main Hospital:
  - 561 beds
  - > 29,000 admissions per year.
- Over 50 primary and specialty "Care Network" locations in Pennsylvania and New Jersey
  - >1.2 million outpatient visits per year.
- World leader in pediatric research
- Approximately 14,000 employees
- Train > 400 residents and fellows annually

KEY ISSUES:

- Inpatient Capacity Management
- Outpatient Access
- Patient and Family Experience; Meeting the Unmet Needs of our Patients
- Clinical Effectiveness: Keeping Patients out of the Hospital
- Care Coordination and Management for Complex Patients; Population Health
- Partnerships – with our Community and Beyond
- Attracting and Engaging Top Talent – Practicing at the Top of their Scope
- Value Based Care (Quality, Cost); Financial Stewardship

CHALLENGES TO HEALTH AND WELLBEING IN OUR COMMUNITY

- Health-related social needs, such as food insecurity and unstable housing, have significant impact on children's health and health care utilization.

- Philadelphia is the 2nd poorest among the country's 11 largest cities, and, CHOP's district - one of the hungriest.
  - More than 29% of residents in Philadelphia's 1st Congressional District live in poverty
  - Children are the hardest hit by this economic deprivation.

- In Philadelphia, 21% of the population is food insecure.

- Approximately 15,000 people access shelter in Philadelphia each year. 45 % of those experiencing homelessness are a part of a family unit.

- Two thirds of all Philadelphia third graders cannot read at grade level

IDENTIFIED COMMUNITY HEALTH NEEDS

1. Access to primary care and preventive care for vulnerable children
2. Increased access to education, primary care, and other health services for children who do not speak English
3. Access to healthy food, opportunities for physical activity, and wellness education
4. Access to sex education, sexual health services, and OB-GYN services for adolescents
5. Access to mental health, behavioral health, and substance abuse screening, education, and services
6. Increased collaboration and communication to create a more seamless approach between services
7. Access to dental, vision and specialty care for children

DEPARTMENT OF PEDIATRICS
CHAIR'S INITIATIVES

- Medical subspecialty physician practice within CHOP
  - 18 Divisions: General Pediatrics and 17 Pediatric Subspecialties
  - >700 Faculty and Physicians
- Internal grant funding program started in 2006 to support innovation, improvement, collaboration and investment in the future of child health.
- Multidisciplinary teams respond to RFP every 2 years.
- Emphasis on impact: What will be different in 2 years if we invest now?
- 6 rounds to-date; 7th RFP in process; 39 initiatives; Rounds 1-5: 157 publications, 253 presentations; $17 million in external funding

CHAIR'S INITIATIVES PROGRAM

https://www.chop.edu/about-us/chairs-initiatives

Goals:

- Enhancing quality and patient safety
- Delivering high value, high reliability health care
- Coordinating complex care, communication and collaboration across disciplines – and the community
- Improving our clinical effectiveness and efficiency
- Improving patient access, family-centered-care and the patient experience and meeting unmet needs

Striving for Better

Chair's Initiatives Fund Innovative Ideas to Improve Care

When Alan Cohen, M.D., was physician-in-chief at The Children's Hospital of Philadelphia, he would hear about potential ways to improve pediatric healthcare from the doctors, nurses and other staff. But putting those ideas into action was sometimes constrained by lack of time and funding.

That's why in 2004, Cohen, with the backing of the Department of Pediatrics and support from operating officer Alison Marx, launched the Chair's Initiatives, an internal grant program that funds promising improvement projects – giving those with the ideas the means to develop them. Operating on a two-year cycle, teams submit proposals, and a multidisciplinary team selects the winning projects.

"It's been rewarding that the Chair's Initiatives have given life to so many great ideas," says Cohen, a hematologist who stepped down as chief in 2013 and now serves as medical adviser to CHOP President and CEO Madeline Bell. "Projects have touched every corner of the Hospital, gone into our CHOP Care Network primary care practices and even entered our patient families' homes."

Over the years, Chair's Initiatives have addressed a wide array of healthcare challenges, everything from developing a system that reduces missed appointments to drafting guidelines that improve the effective use of anticoagulant (blood thinner) therapy and creating a web portal to help families manage their child's chronic disease.

Vanessa, left (with her mom, Delia), became very sick with a rare heart condition when she was 13. Her heart was so damaged that a transplant was necessary. Vanessa is one of the patients who have benefited from improved thrombosis prevention and anticoagulant management.

Iris, 13, received encouraging messages as part of a Chair's Initiative that tested texting as a tool to improve follow-up care for cancer patients.

Some Chair's Initiatives have spawned new centers or programs that focus on a specific disease or condition, such as the Intestinal Rehabilitation Program (for children with short bowel syndrome), the Center for Bone Health, and Minds Matter: Concussion Care for Kids.

When Joseph W. St. Geme, M.D., became physician-in-chief, he continued the Chair's Initiatives in collaboration with Kathy Shaw, M.D., M.S.C.E., associate chair, Quality and Safety, Department of Pediatrics, and Marx.

"This program has had a remarkable impact on patient care across our organization, fueling continuing advances that distinguish CHOP from other top children's hospitals," says St. Geme.

The 2014 – 15 round, the program's fourth, continued earlier focuses on quality and patient safety, including clinical guidelines, outcomes measurement and piloting of different care models to deliver accessible, high-quality care at lower cost and coordinate complex, accountable care across disciplines. ■

Read about all 33 Chair's Initiative projects at chop.edu/chairs-initiatives.

Chair's Initiatives Fourth Round Project Summaries

- Dermatologists and computer specialists developed an app that will help standardize and improve care of adolescents with acne treated by their primary care pediatricians.
- A team of CHOP psychologists, pediatricians and other healthcare professionals created screening tools and handouts to help pediatric practices better assist victims of bullying. Youth and teens gave their input so that the materials reflected their experiences. The screening tool is now in use by many CHOP practices, and more than 60,000 patients have been screened.
- One project studied healthcare delivery among children with a variety of inflammatory, allergic and neoplastic conditions and those who have had a transplant rejection. A team used the data to create best practice recommendations for the use of glucocorticoids, also known as steroids, which are commonly given to this patient population.
- A team of CHOP psychologists, physicians, a nurse practitioner, and computer specialists created and tested a text message intervention to help adolescents and young adults completing cancer treatment stay healthy and adjust to life after cancer.
- A team created guidelines and better care practices to prevent thrombosis (blood clots) and improve anticoagulant (blood-thinner) management for cardiac patients. Children with heart defects that prevent normal pumping of blood, who require surgeries and use of long-term IV lines, plus other factors, may be at higher risk for complications.

Initiatives have allowed us to:

- Partner with our patient populations, and community, in new and novel ways
- Explore different models of care that address unmet needs and enhance our effectiveness
- Define and understand those needs more broadly, with an enhanced understanding of social determinant of health
- Look at our challenges in a different way, identify opportunities, demonstrate success and spread best practices (incubator)

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COMMUNITY IMPACT AND PARTNERSHIP

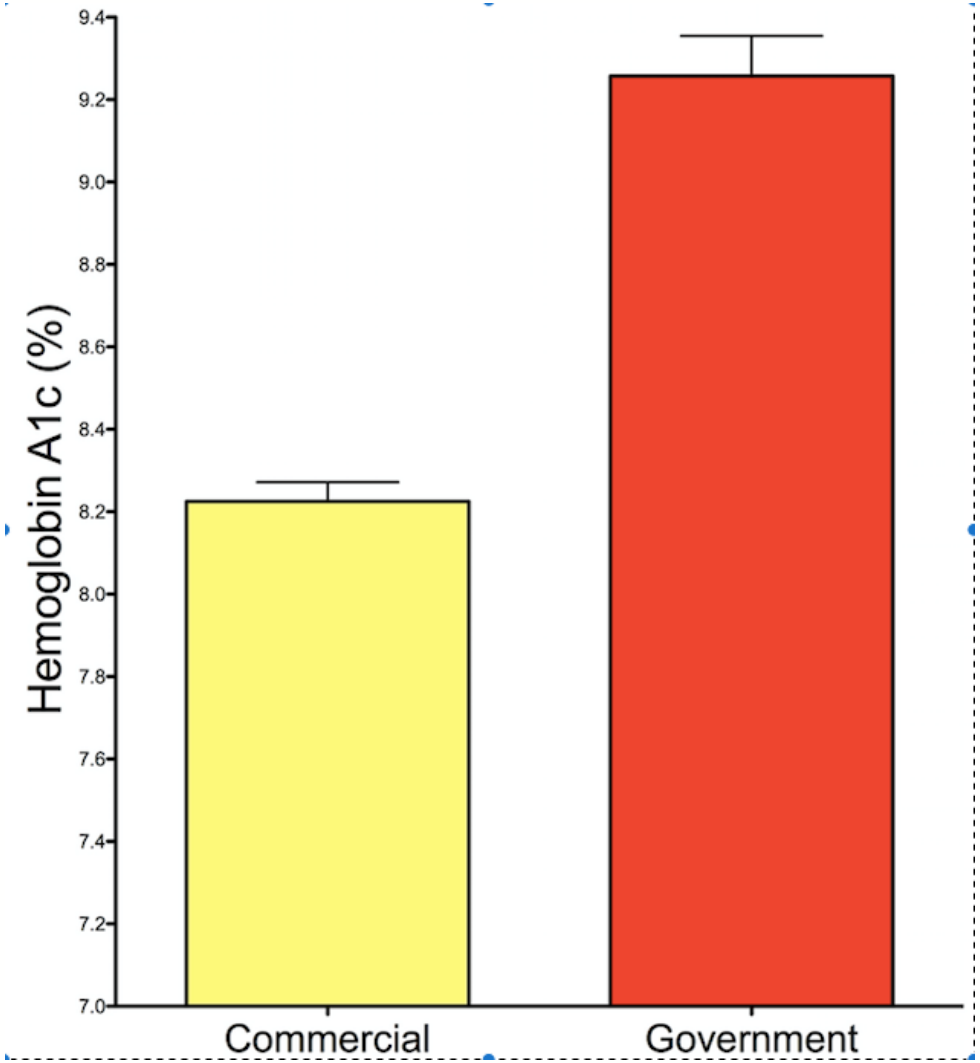
- Sudden Cardiac Death Prevention
  - Partnership with 200 schools to screen > 2,500 children with electrocardiography
- Minds Matter: Improving Pediatric Concussion Management:
  - Comprehensive program for Pediatric Concussion including significant education, advocacy and community partnership
- Responding Effectively to Bullying and Victimization
  - >100,000 patients screened per year for bullying
- Improving Health Care for Foster Children:
  - Created a model for successful, coordinated care, ensuring linkage to a medical home
- Helping Patients with Intellectual Disabilities and Chronic Illness Transition to Adult Care:
  - Created a consultative service to support transition along with network of adult practitioners willing to accept young adult patients

COMMUNITY HEALTH WORKER INITIATIVE: ENHANCED CARE MANAGEMENT FOR COMPLEX PATIENTS

Colin Hawkes, MD; Terri Lipman, PhD CRNP; Rachel Biblow, MSW; Kim Smith-Whitley, MD; Sophia Jan, MD, MSHP; Symme Trachtenberg, MSW; Leigh Wilson, MSW

Children's Hospital of Philadelphia

OVERVIEW OF THE PROBLEM
CHILDREN WITH DIABETES



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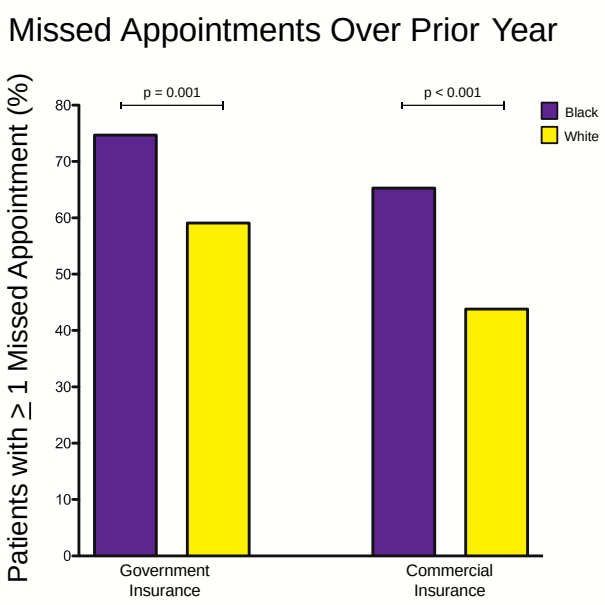
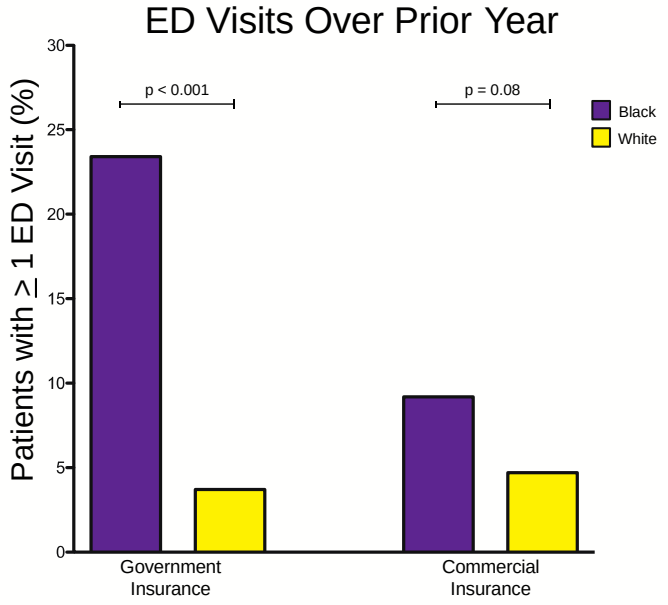
OVERVIEW OF THE PROBLEM

Utilization / Engagement





- ↑ HbA1c
- ↑ Missed Appointments
- ↑ ED Visits

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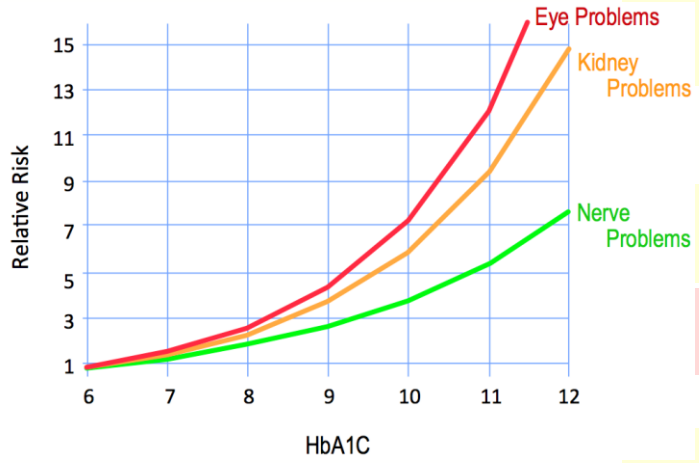
When		Type	Class	Dept
01/25/2017		Telephone		Division of Endocri...
01/25/2017		ED	Emergency	Emergency Depart...
01/17/2017		No Show		Division of Endocri...
01/17/2017		No Show		Division of Endocri...
6 Months Ago				
11/23/2016		Telephone		Division of Endocri...
11/23/2016		Telephone		Division of Endocri...
11/23/2016		Telephone		Division of Endocri...
11/22/2016		Telephone		Division of Endocri...
11/22/2016		Social Work E...		Division of Endocri...
11/22/2016		Appointment		Division of Endocri...
11/17/2016		Telephone		KOP Endocrinology
11/13/2016		Telephone		BUC Endocrinology
11/12/2016		Telephone		Division of Endocri...
10/20/2016		Canceled (PR...		Division of Endocri...
10/17/2016		Telephone		Division of Endocri...
10/11/2016		Canceled (Oth...		Division of Endocri...
10/11/2016		Canceled (Oth...		Division of Endocri...
10/11/2016		Telephone		Division of Endocri...
09/16/2016		Telephone		Division of Endocri...
09/16/2016		Social Work E...		Division of Endocri...
09/16/2016		Appointment		Division of Endocri...
09/09/2016		Telephone		Division of Endocri...
09/09/2016		Telephone		Division of Endocri...
08/30/2016		No Show		Division of Endocri...
08/30/2016		No Show		Division of Endocri...
08/22/2016		Social Work E...		Division of Endocri...
07/08/2016		Telephone		Division of Endocri...

Component	Hemoglobin A1C, POC
Latest Ref Rng & Units	3.8 - 5.9 %
5/4/2015	10.4 (H)
8/6/2015	10.3 (H)
11/19/2015	9.8 (H)
4/7/2016	10.0 (H)
9/16/2016	11.9 (H)
11/22/2016	12.1 (H)
2/23/2017	12.8 (H)
4/6/2017	11.0 (H)
6/1/2017	11.8 (H)



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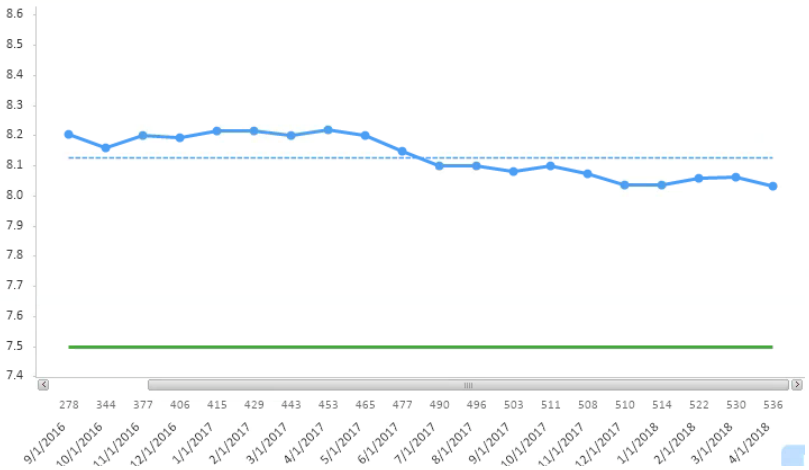
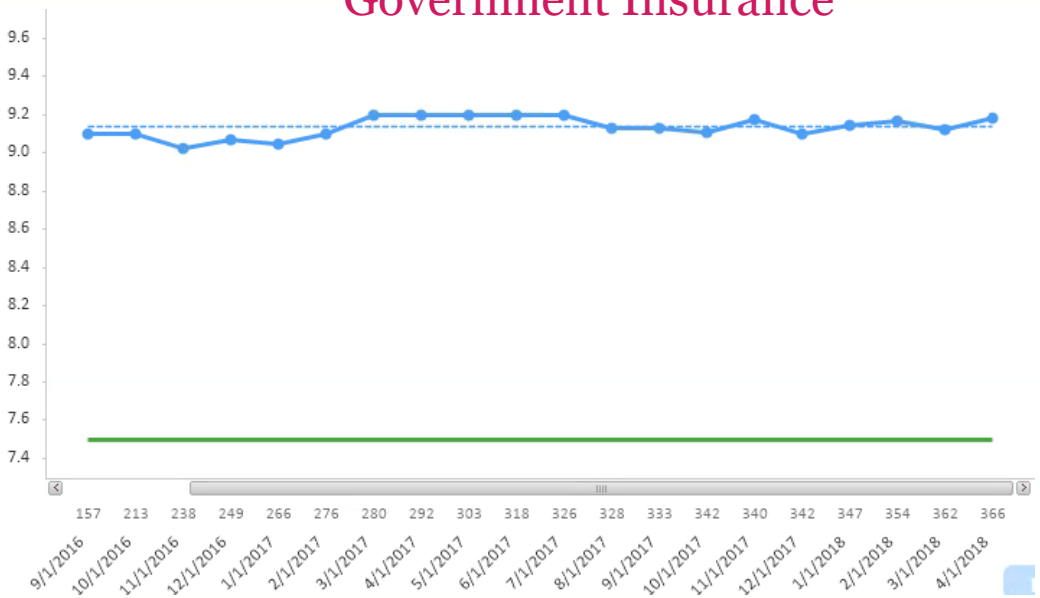
OVERVIEW OF THE PROBLEM
IMPACT OF AN INTENSIVE DIABETES EDUCATION PROGRAM

Commercial Insurance



Government Insurance



Data from patients living in Philadelphia

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CONCLUSIONS

- Current hospital-based interventions for socially complex children with chronic illnesses
  - Have not been effective in improving the health outcomes
  - Are reliant on health professionals addressing needs they are ill prepared to address

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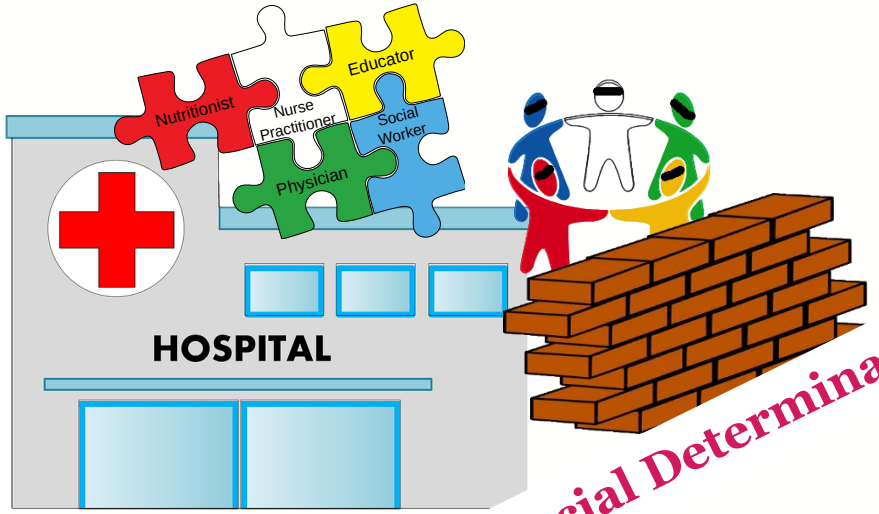
CURRENT CARE



Missed Appointments
Emergency Room Visits
Complications

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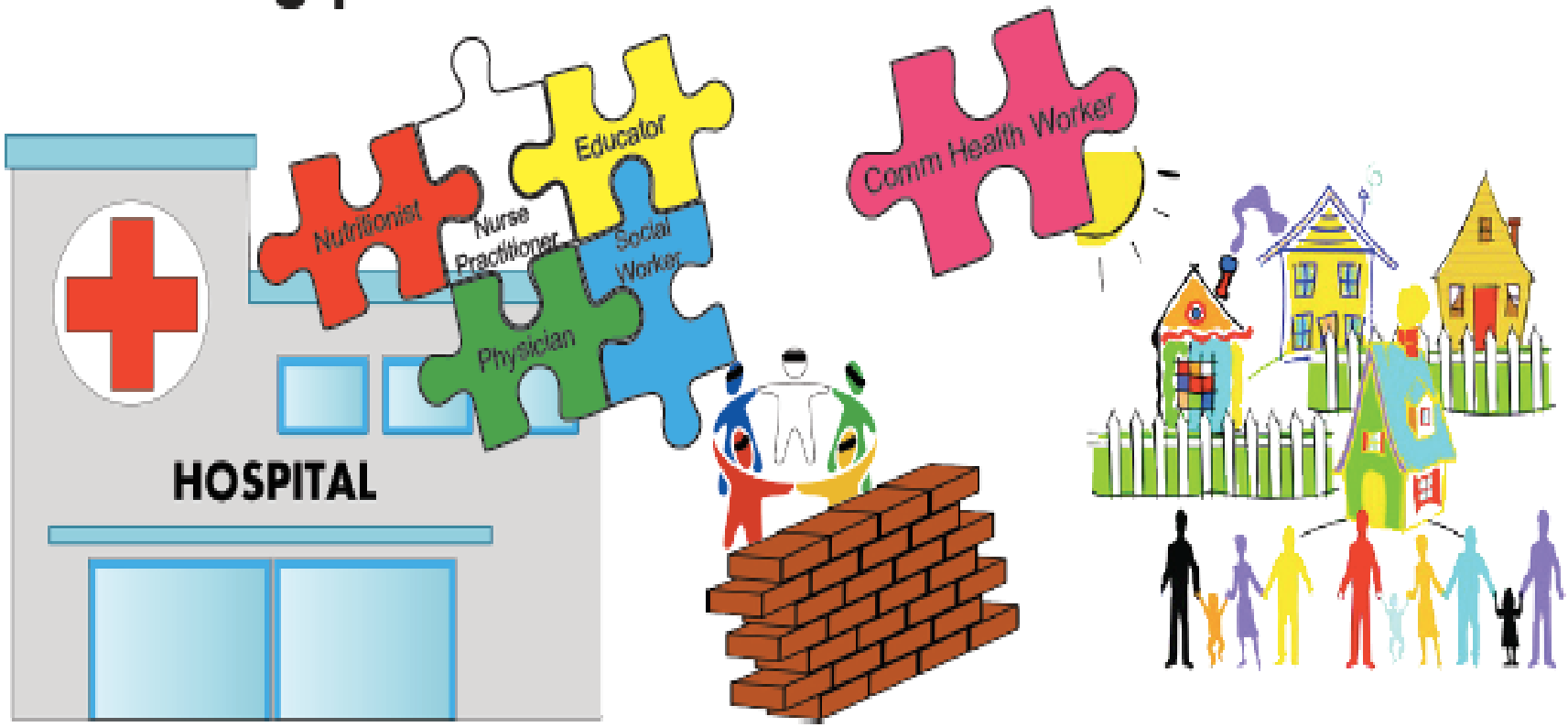
The missing piece of the team model for Diabetes Care



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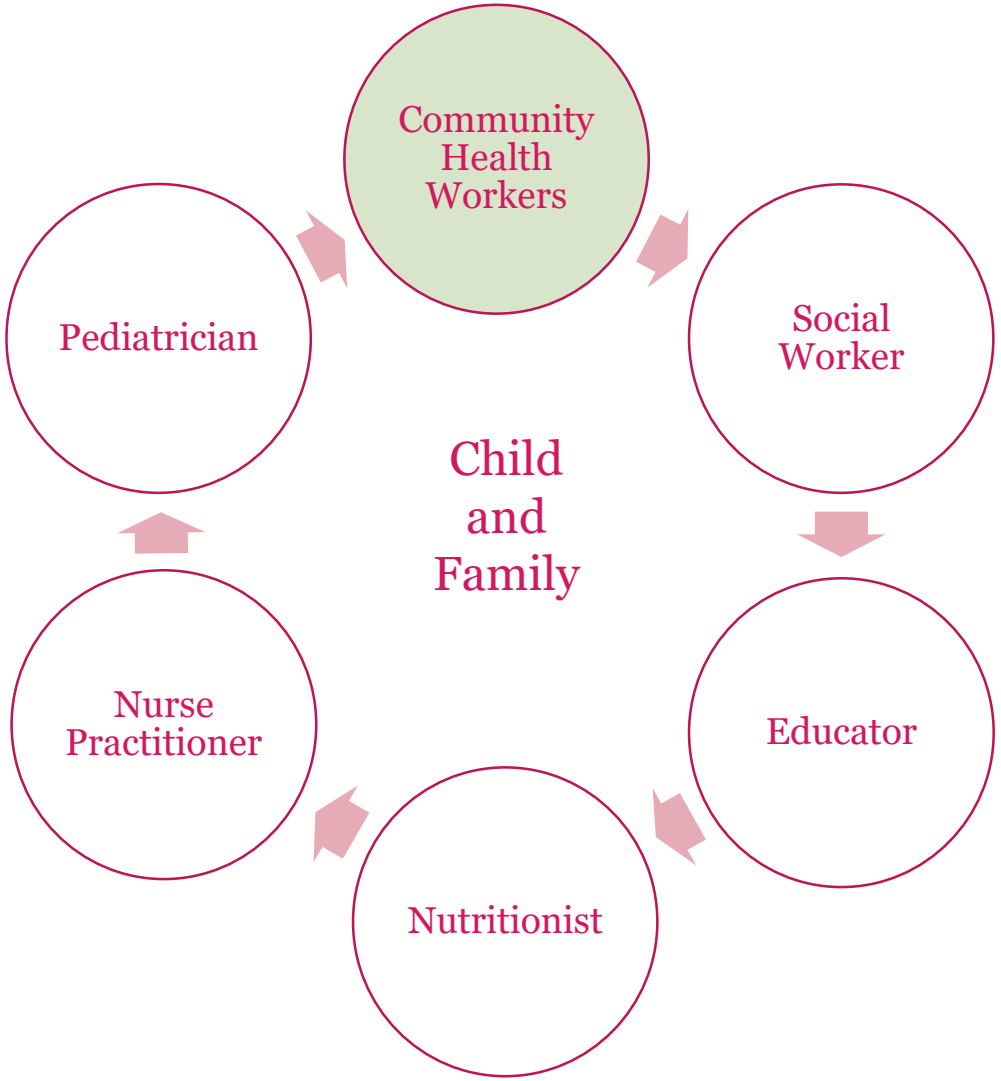
THE DIABETES TEAM



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COMMUNITY HEALTH WORKER (CHW) INITIATIVE: ENHANCED CARE MANAGEMENT FOR COMPLEX PATIENTS

- CHWs are “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community they serve”.
- CHWs have been historically used to provide culturally-relevant services that address health disparities and families’ social determinants of health critical to managing their child’s chronic condition.
- Existing studies on CHW interventions for pediatric chronic disease show promising results that include
  - reducing hospitalizations and length of stay
  - reducing emergency department visits
  - increasing parental confidence
  - cost savings

Raphael JL, et al *Acad Pediatr*. 2013;13(5):408-420.
Bryant-Stephens et al. *Am J Public Health*. 2009;99 Suppl 3:S657-665.

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GOALS

- This Chair's Initiative
  - proposes building evidence and infrastructure for enhanced care management through the development of a generalizable and scalable Community Health Worker (CHW) role at CHOP.
  - will be aligned with CHOP's efforts around capacity management and improved patient and family experience, as well as increased focus on value-based contracting.
- The primary goal of this initiative is to develop an intervention that can be readily utilized for patients whose social needs negatively impact the management of their chronic condition

CHW KEY ROLES AND RESPONSIBILITIES

- Family support
  - Identify and address social determinants of health
  - Identify resources related to their social needs
  - Link with community resources and social services
  - Accompany families to meetings and appointments (when needed)
- Teamwork and communication
  - Help families communicate with their clinical team
  - Work closely with the social workers at CHOP
  - Work collaboratively with the clinical team at CHOP

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METRICS TO MEASURE THE OUTCOMES OF THIS INITIATIVE: RANDOMIZED CONTROLLED TRIAL

- Healthcare utilization (hospital admissions, emergency department visits, no shows)
- Payments (dollar amount of the total claim)
- Patient satisfaction scores (quality of life, patient activation score)
- Provider satisfaction scores (time saved by various members of the medical team)
- Process metrics (number of patients and patient encounters, quality of patient encounters, number of care coordination efforts between care teams, referrals to community organizations)
- Disease-specific outcomes (e.g. hemoglobin A1c in type 1 diabetes, adherence to health care recommendations, prescribed medications, and engagement with medical care)

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PRELIMINARY DATA

Question	Number (%) answering 'yes'
In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	12 (25%)
In the last 12 months, has your utility company shut off your service for not paying your bills?	10 (21%)
Are you worried that in the next 2 months, you may not have stable housing?	7 (15%)
Do problems getting child care make it difficult for you to work or study?	7 (15%)
In the last 12 months, have you needed to see a doctor, but could not because of cost?	4 (8%)
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	2 (4%)
Do you ever need help reading hospital materials?	3 (6%)
Are you afraid you might be hurt in your apartment building or house?	2 (4%)
If you checked YES to any boxes above, would you like to receive assistance with any of these needs?*	17 (35%)
Are any of your needs urgent?* For example: I don't have food tonight, I don't have a place to sleep tonight.	4 (8%)

IMPACT THIS PROGRAM CAN HAVE ON THE DEPARTMENT, THE INSTITUTION AND POTENTIALLY BEYOND:

- ***Scalability*:** Has the potential to be scaled across the institution to improve the outcomes of children with diverse chronic medical conditions facing common social circumstances.
- ***Increased availability of resources*:** A knock-on effect of the CHWs taking on some of the outreach burden will be the increased availability of multidisciplinary resources for patients not directly impacted by this intervention.
- ***Data and Sustainability*:** Will provide critical data to inform value-based contracts that offer an opportunity to make a cost-effective investment in addressing the medical and social needs of complex patients.

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Community
Health
Worker
Assistant
Peer
Resource
Educator
CHOW
Trusted
Advocate
Counselor
Support
Family
Specialist
Patient
Navigator
Outreach
Promotora
Facilitator
Asthma
CHR
Case
Cultural
Nutrition

"NEIGHBOR IS NOT A GEOGRAPHIC TERM. IT IS A MORAL CONCEPT. IT MEANS OUR COLLECTIVE RESPONSIBILITY FOR THE PRESERVATION OF MAN'S DIGNITY AND INTEGRITY."

DR. JOACHIM PRINZ
AUGUST 28, 1963
WASHINGTON, DC
AT THE MARCH ON WASHINGTON

Samuel L. Ross

Chief Executive Officer

Bon Secours Mercy Health

Anchor Institutions Taskforce Conference

November 16, 2018
Bon Secours Baltimore Health System

A CENTURY AHEAD
1919 - 2019

BON SECOURS MERCY HEALTH

OUR MISSION:

Bon Secours Mercy Health extends the compassionate ministry of Jesus by improving the health and well-being of our communities and brings good help to those in need, especially people who are poor, dying and underserved.

OUR VALUES:

HUMAN DIGNITY — We commit to upholding the sacredness of life and being respectful and inclusive of everyone.

INTEGRITY — We commit to acting ethically and modeling right relationships in all of our individual and organizational encounters.

COMPASSION — We commit to accompanying those we serve with mercy and tenderness, recognizing that “being with” is as important as “doing for.”

STEWARDSHIP — We commit to promoting the responsible use of all human and financial resources, including Earth itself.

SERVICE — We commit to providing the highest quality in every dimension of our ministry.

Bon Secours Mercy Health

ONE OF THE 5 LARGEST
Catholic health care systems in the nation

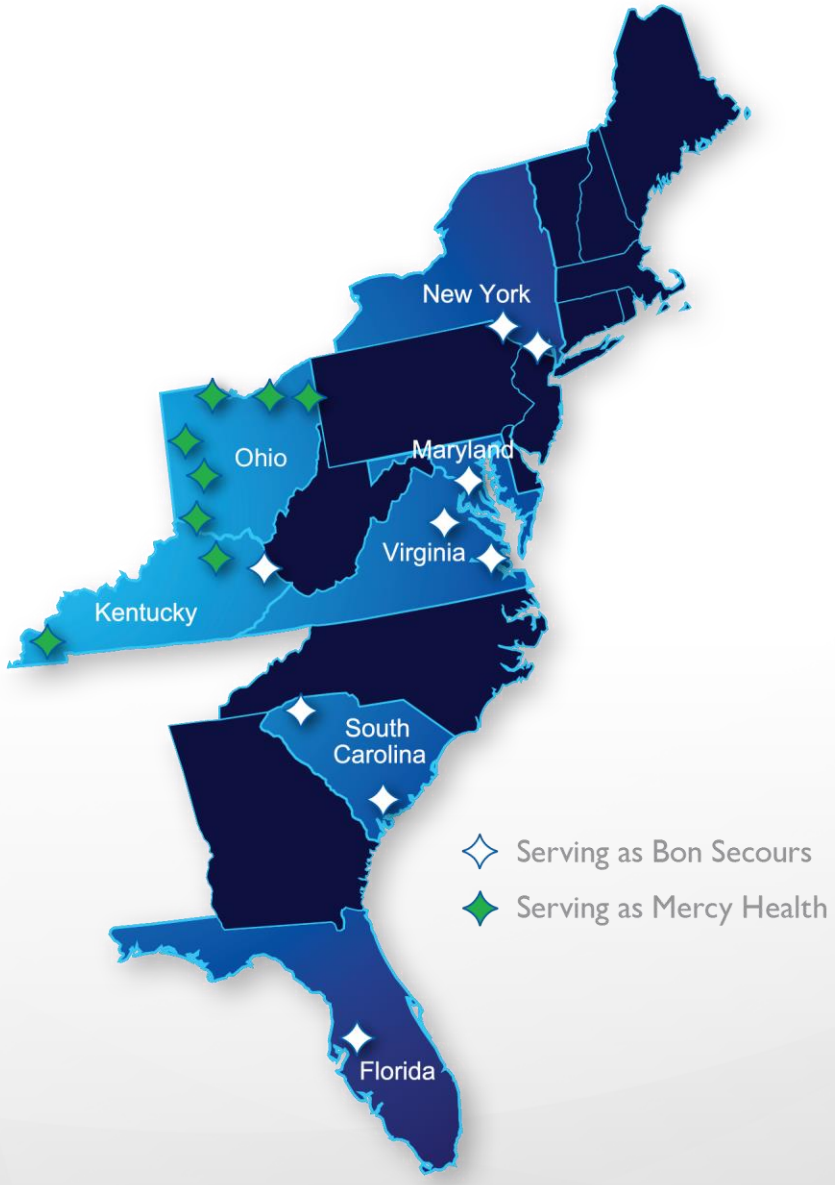
OVER **1,000** SITES OF CARE ACROSS 7 STATES

OVER **$8 BILLION**
in net operating revenue

NEARLY **$2 MILLION** A DAY
IN COMMUNITY BENEFITS

43 HOSPITALS

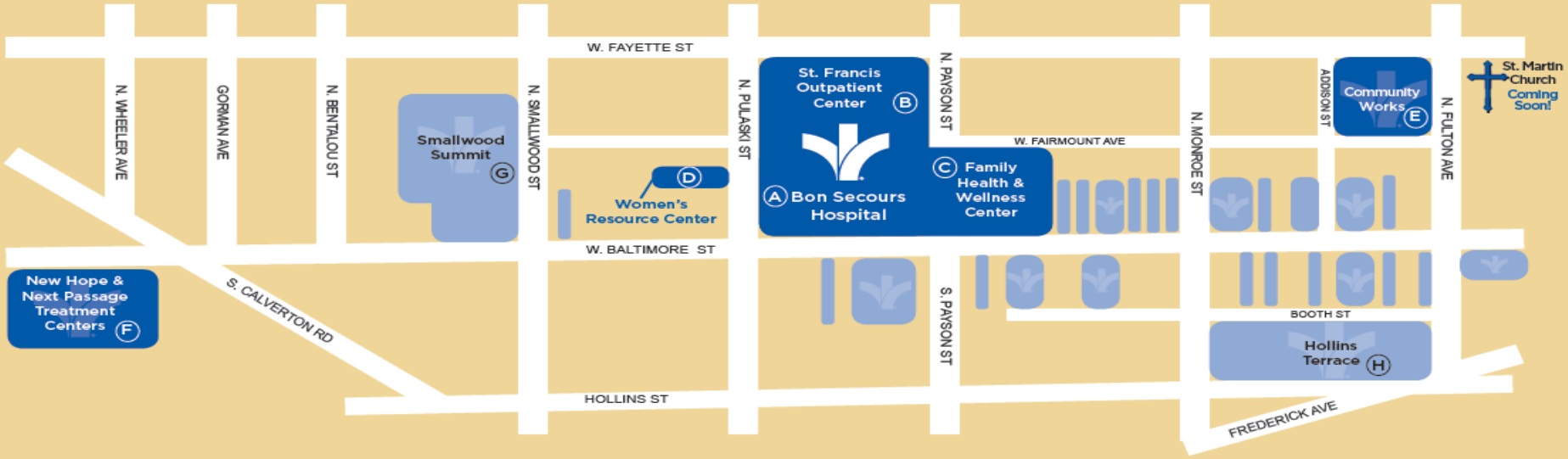
2,100 EMPLOYED PHYSICIANS &
57,000 TOTAL EMPLOYEES



BON SECOURS MERCY HEALTH

Our Footprint in West Baltimore

Bon Secours Campus & Service Locations



Bon Secours Services

Bon Secours Residential

(All additional items shaded light blue represent Bon Secours Apartments, row homes that have been converted into multi-unit housing.)

BON SECOURS BALTIMORE HEALTH SYSTEM

BonSecoursBaltimore.com

A **Bon Secours Hospital**
2000 West Baltimore Street
410-362-3000

B **Bon Secours St. Francis Outpatient Center**
10 North Payson Street
410-362-3400

C **Bon Secours Family Health & Wellness Center**
1940 West Baltimore Street, 3rd Floor
410-362-3612

D **Bon Secours Women's Resource Center**
10 North Pulaski Street
410-362-3547

E **Bon Secours Community Works**
26 North Fulton Avenue
410-362-3629

F **Bon Secours New Hope & Next Passage Treatment Centers**
2401 West Baltimore Street
New Hope 410-945-7706
Next Passage 410-728-8901

Not Pictured:
Bon Secours Community Institute for Behavioral Services (CIBS)
6000 Metro Drive, Suite 110
410-383-4989

Adapt Cares
3100 Towanda Avenue, 21215
410-383-4962

HOUSING FACILITIES

G **Bon Secours Smallwood Summit**
2 North Smallwood Street
410-566-5792

H **Bon Secours Hollins Terrace**
1800 Hollins Street
410-566-2701

Not Pictured:
Bon Secours Wayland Village
3020 Garrison Boulevard, 21216
410-542-4580

Bon Secours New Shiloh Village
1901 Elgin Avenue, 21217
410-523-1649

Bon Secours Benet House
400 Millington Avenue, 21223
410-566-0701

Bon Secours Liberty Village
3000 Towanda Avenue, 21215
410-523-1113

Bon Secours Baltimore provides care to a population that needs significant social support

BSBHS' CBSA performs worse than the Maryland state average across most population health metrics:

	Bon Secours CBSA[1,2,3,5]	Maryland[3,4,5]
Median household income*	$15,950 - $52,623	$75,847
% Households w/ incomes below poverty line, 2010-14	27.3%	10.0%
% Ethnic Minorities, 2014	77.4%	46.7%
Infant Mortality (per 1,000), 2014	10.4	6.5
Life Expectancy, 2014	72.4	79.8
Violent Crime (per 100,000), 2016**	1,340.1	452.8

Due to the expansion in Medicaid, the uninsured population has decreased:

	Bon Secours CBSA[1,2,3,5]	Maryland[3,4,5]
Medicaid enrollment*	28.6%	17.3%
Uninsured population, 2010-14	9.3%	9.9%

Note: *Bon Secours CBSA statistic applies to 2010-2014; Maryland statistic applies to 2015; **Violent crime includes homicides, forcible rapes, robberies, and aggravated assaults; Bon Secours CBSA level data is suppressed (Baltimore city data used);

(1) Spring 2016 Vital Signs 14; (2) American Community Services 2010-2014 Estimates; (3) Maryland Vital Statistics Information; (4) 2016 Maryland Poverty Profiles, Maryland Alliance for the Poor; (5) 2016 Community Health Needs Assessment

BON SECOURS MERCY HEALTH

Our Community

- **Bon Secours' primary service area of West/Southwest Baltimore is home to Maryland's poorest and sickest citizens.**

  - **Employment:** 24.9% are unemployed vs. 14.2% in Baltimore City as a whole
  - **Household Income:** 44% of households make less than $25,000
  - **Education:** 31.4% do not have a high school diploma
  - **Crime:** 32% higher than the overall city
  - **Transportation**: 54.2% of households have no vehicles available

  - **Housing**: 27% Vacant and Abandoned residential properties (Median Price of Homes Sold: $22,000)
  - **Leading causes of health-related deaths:** heart disease, HIV/AIDs, substance abuse and diabetes

Addressing Social Determinants of Health

"Meeting the community where they are"

	Population Health Program	Impact to Community
Community Institute of Behavioral Services (CIBS)		
	Assertive Community Treatment (ACT) - Mobile intensive OP services	Reduces readmissions and healthcare utilization rate
	ACT - Vocational program	Improve Workforce Development & reduces unemployment rate through job coaching
	New Phases - Residential & adult day program	Reduces readmissions and healthcare utilization rate, and reduction in law enforcement and other criminal justice costs
	New Phases - Vocational program	Improve Workforce Development & reduces unemployment rate
	New Phases - Psychiatric Rehabilitation	Provides residential and PRP services for clients from Spring Grove hospital and other providers
	Specialized Case Management Program (SCMP)	Diversion from judicial system and reduction in law enforcement and other criminal justice costs
	New Hope, Next Passage & ADAPT - Substance abuse treatment program(s)	Reduces readmissions and healthcare utilization rate, and reduction in law enforcement and other criminal justice costs
Hospital based programs		
	Rapid HIV testing	Positive clients linked to treatment; early detection and reduces delay in treatment
	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Reduction in law enforcement and other criminal justice costs
	Diabetes Educator	Provides diabetes education, assists chronic care management, and reduces healthcare utilization

Housing

Bon Secours Baltimore Health System Housing Units	
Seniors/Disabled	530
Low-Income/ Affordable	272
Total Housing Units	802

- Leveraged $115M in capital investment for housing construction in West Baltimore resulting in over 800+ housing units and $7M+ in rental activity annually.

Bon Secours Community Works

- **Family Support Center:** Offers facility-based and in-home services including:
  - GED prep classes
  - parenting education
  - employment preparation
  - teen parent and fatherhood groups
  - Service 170 at-risk, young families annually
- **Women's Resource Center**: provides supportive services to women who are homeless or at-risk to become homeless. Serves at least 200 women annually
- **Housing**: 802 units, low income and senior

- **Financial Services:** Financial education, eviction prevention assistance,(105 annually), tax preparation (1,200 annually), and benefit screenings (620 annually).
- **Open Space Management:** Vacant lot maintenance (450 city lots), neighborhood beatification, workforce training (8 trainees annually).
- **Career Development:** Job preparation, placement, work-related services and post-placement follow-up for 55 youth and 100 adults annually.

Bon Secours Baltimore

Healthy Community Initiatives

- Back-to-School Open House
- Early Childhood Education
- CNA/GNA Training Program
- Workforce Development
- Clean & Green Team
- Gibbons Apartments
- Eviction Prevention
- Re-Entry Program
- Reading Partners
- Training to Work
- Community Day
- Hoop House

150+
HELPED PLANT THE FIRST CROPS

HOOP HOUSE

Community partners and schoolchildren constructed a hoop house to grow fresh produce year-round and provide workforce development.

GIBBONS APARTMENTS

Constructed safe, affordable, low-income housing within a larger development in inner-city Baltimore for families, individuals and adults with disabilities.

80
AFFORDABLE APARTMENT UNITS BUILT

CNA/GNA TRAINING PROGRAM

Bon Secours Community Works provides Certified/ Geriatric Nursing Assistant training. 300+ clients attended registration for next event.

50
EMPLOYED AS NURSING ASSISTANTS

Participating in a national volunteer-driven tutoring program to help improve reading skills in elementary school students

9
EMPLOYEES TUTORING READING

READING PARTNERS

Community Works provides early childhood education for children ages 3 and under through the Early Head Start program.

60
CHILDREN ENROLLED PROGRAM

EARLY CHILDHOOD EDUCATION

52
VACANT LOTS MAINTAINED

The Workforce Development program provides training in urban landscaping, job readiness, and financial education

WORKFORCE DEVELOPMENT/ CLEAN & GREEN TEAM

RE-ENTRY PROGRAM

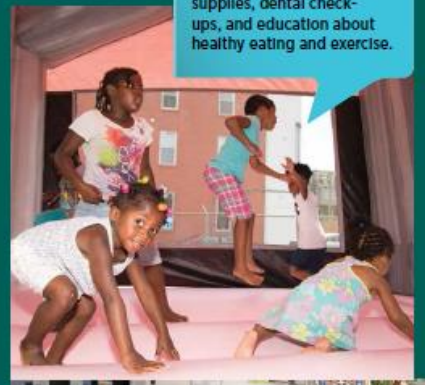
212
ENROLLED IN LIFE SKILLS PROGRAM

A 12-week character development program for men (TYRO) and women (SHERO) who are returning from the corrections system.

224
Families received grants to prevent imminent eviction.

EVICTION PREVENTION

Back to School Open House—provides school supplies, dental check-ups, and education about healthy eating and exercise.



BACK TO SCHOOL OPEN HOUSE

BON SECOURS COMMUNITY DAY

254
COMMUNITY DAY HEALTH SCREENINGS

Partnering with two local churches to sponsor two annual community festivals for the whole family, free food, school supplies and free health screenings.

BON SECOURS MERCY HEALTH

Health Enterprise Zone (HEZ)

- A project of the Lt. Governor, State Health Department (DHMH), and Maryland Community Health Resources Commission(CHRC)
- 4 year pilot project with a budget of $4 million per year
- The HEZ initiative aims to:
  1) Reduce health disparities among racial and ethnic minority populations and among geographic areas
  2) Improve health care access and health outcomes in underserved communities
  3) Reduce health care costs and hospital admissions and re-admissions

HEZ Members

SENATOR VERNA JONES-RODWELL

BON SECOURS BALTIMORE HEALTH SYSTEM

UNIVERSITY of MARYLAND MEDICAL CENTER MIDTOWN CAMPUS

UNIVERSITY of MARYLAND MEDICAL CENTER

SAINT AGNES HOSPITAL

SINAI HOSPITAL a LifeBridge Health center

BALTIMORE Medical SYSTEM

Park West Health System

People's Community Health Centers

Total Health Care, Inc.

EQUITYMATTERS PROMOTING EQUITY-IN-ALL POLICY

MOSAIC Community Services

NCADD MARYLAND

UNIVERSITY of MARYLAND THE FOUNDING CAMPUS

COPPIN STATE UNIVERSITY

HEALTHY BALTIMORE 2015

LIGHT HEALTH & WELLNESS

Future Baltimore

Partnership between Bon Secours, Kaiser Permanente, and the residents from three communities in the 21223 zip code

Education

Program Name: Returning Citizens
CNA/GNA Training

Partners: Baltimore City State Attorney's Office

Two Year Outcomes

- 100 clients receive CNA/GNA training
- 72% placement rate in allied health professions
- 60 returning citizens receive case management support and GED training
- < 22% recidivism rate of program participants
- 50% of participants receive job training, placement, or education

Economic Wellbeing

Program Name: Baltimore Works! Incubator Program
Last Mile Urban Co.
Baltimore Economic Assessment

Partners: Chesapeake Food to Table
Southwest Partnership*
Enterprise Community Partners*

Two Year Outcomes

- > 8 new job-generating businesses identified for incubation
- Address the critical dearth of healthy food options in 21223 for 75 families per week

Mental Health & Wellbeing

Program Name: First Responder Mental Health
Frederick Elementary School Sponsorship
Community Health Worker
BH-Works Onsite Assessment

Partners: Bon Secours Department of Behavioral Health, BH-Works

Two Year Outcomes

- 100 first responders receive training
- 10 tailored programs developed to meet mental health needs of students
- Mental health referral process for local residents established

Partnership

Program Name: West Baltimore Neighborhood Revitalization Project

Partners: Baltimore Mayor's Office of Employment Development, Baltimore City Public Schools

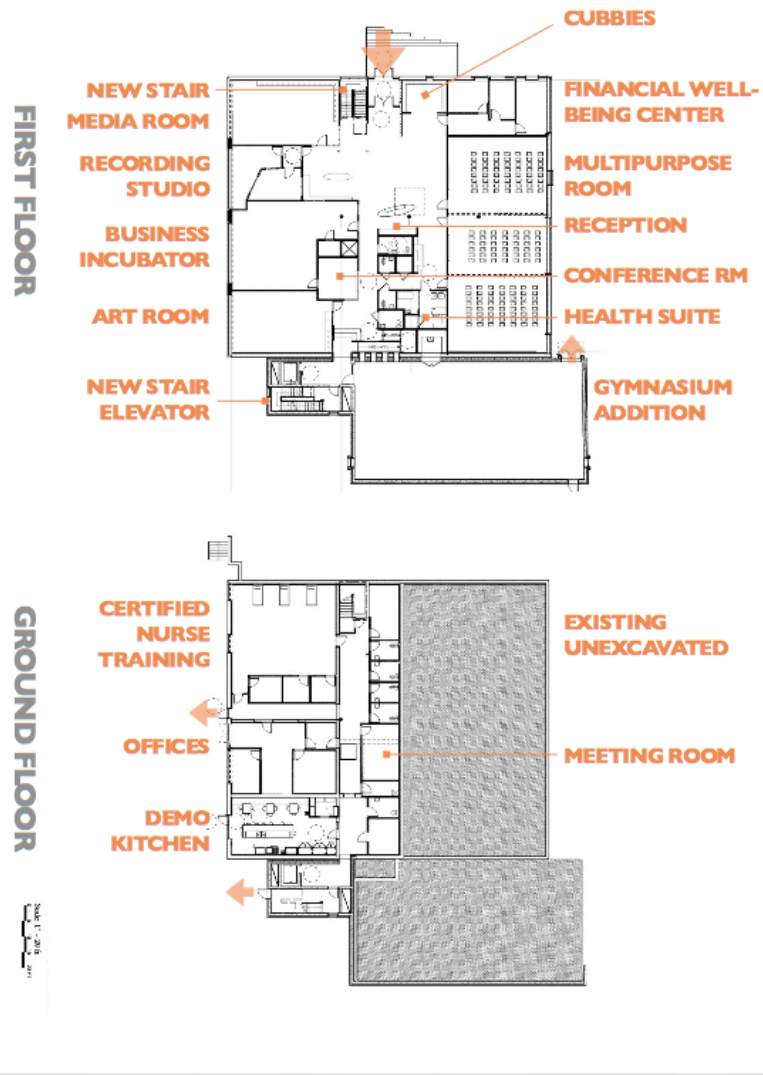
Two Year Outcomes

- Achieve $5.5M fundraising goal
- Build community resource center
- Leverage assets knowledge and trust through shared ownership of initiative, agenda, and metrics

BON SECOURS MERCY HEALTH

Community Resource Center

VIEW FROM HOLLINS




Never Give Up!

Thematic Breakout Groups

Education – *Gilbert Room, 4th floor*

Economic Development – *Empire Complex, 7th floor*

Health – *Harlem Room, 7th floor*

Racial Equity – *Times Square Room, 7th floor*

Rural Anchors – *Gotham Room, 7th floor*

Group Highlights

Empire Complex, 7th floor

Closing Remarks & AITF Next Steps

Closing Reception

7th floor North Foyer