Evaluation of Invest Health: Findings

FINAL REPORT

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Robert Wood Johnson Foundation

August 2018

ACKNOWLEDGMENTS

Mt. Auburn Associates would like to thank all who contributed their time, provided support, and shared their views to inform this evaluation. In particular, we thank the hundreds of individuals from the 50 Invest Health cities who generously gave of their time and insights regarding their Invest Health accomplishments and experiences.

This report would not be possible without the significant contributions of many individuals whose time, research, and wisdom informed the content and findings. In particular, Oktawia Wójcik and Amy Gillman from Robert Wood Johnson Foundation not only oversaw the evaluation but also contributed their insights and provided effective editing to hone the final report. In addition, we are grateful for the engagement of Abbey Cofsky and Jane Lowe, who guided both the initiative and the evaluation, as well as Donald Schwarz, who had the vision to develop this initiative and provided important context for thinking about creating a culture of health in our nation's midsize cities. We are especially appreciative of the entire Reinvestment Fund team, Amanda High, Sophie Bryan, and Jennifer Fassbender, as well as the Bennett Midland team, Sara Mogulescu, Dalia Mechanic, Bjorn Whitmore, Alexis Medina, Jesse Weiss, Xiuhui Lim, and Karya Lustig from Center for Health Leadership and Practice, who all collaborated in the learning throughout the evaluation process and provided critical data and insights that informed the evaluation.

We want to thank our partners, Karl Seidman and Keri-Nicole Dillman, who worked with us over the two-and-a-half years of the evaluation effort, leading the assessment of specific cities and, in the case of Keri-Nicole, leading our work on the analysis of network connections and the level of touch. Ryan Flynn and Alison Gold also provided assistance in making meaning of the data in the deep dives of the senior public officials and the hospital. Alison's extensive experience and understanding of cross-sector collaboratives was critical to informing that component of the analysis. We are also grateful for the participation of Marilyn Darling from Fourth Quadrant Partners who ensured that the evaluation team, along with RWJF and the RF team, made meaning of insights throughout the initiative and worked to bring a learning orientation to the evaluation.

This report would not have been possible without Alyssa Saunders, Emily Doglio, and Jasmine McNenny of the Mt. Auburn team whose tireless research and analysis provided rich data that formed the foundation of the report. Finally, we want to thank Judi Luciano of Mt. Auburn Associates who led all of the administrative efforts, making the engines run behind the scenes, scheduling hundreds of interviews, managing survey implementation, and painstakingly editing all of the evaluation documents.

Beth Siegel and Devon Winey,
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INTRODUCTION

Initiative overview

In 2014, the Robert Wood Johnson Foundation (RWJF) released *Time to Act*, a report that provided recommendations on how to improve the health of all Americans.[1] One of the key recommendations of this report was to "fundamentally change how we revitalize neighborhoods, fully integrating health into community development." In the years since the RWJF Commission made this recommendation, RWJF has supported a wide range of multisite initiatives and other activities that are working at the intersection of health and community development. Invest Health, a multisite initiative involving 50 midsize cities, is one of these efforts.

RWJF designed the 18-month initiative, which Reinvestment Fund (RF), a national community development finance institution (CDFI), managed, with the goal to "increase and influence investment in midsize cities that improve well-being and equity."

Invest Health was distinctive in a number of elements of its design:

1. *Focusing on midsize cities*. RWJF decided to focus exclusively on midsize cities, defined as those with population ranges between 50,000 and 400,000.
2. *Building cross-sector teams.* Invest Health required the engagement of a five-person "travel team" in each city, which had to include an anchor institution, a public sector representative, and a community development representative. The expectation was that the travel team would serve as the core leadership for the work on the ground and would attend each of the convenings.
3. *Learning community approach*. The primary intervention of the initiative was a series of convenings in which the city teams had an opportunity to learn from national experts and to share experiences with each other. Instead of providing large grants and intensive technical assistance, RWJF awarded the cities a modest amount of grant funds primarily to cover travel expenses to attend the multi-team gatherings.
4. *Targeting the built environment.* Rather than addressing all strategies and approaches related to the intersection of community development and health, this initiative was seeking to focus on the relationship between the built environment and health.
5. *Addressing the community investment system*. Invest Health's initial design built on the capital absorption framework developed by the Center for Community Investment that supports community partnerships to mobilize investment capital in service of community priorities.[2]
6. *Integrating community engagement and data analysis into the work with a strong equity frame.* Invest Health encouraged teams to pursue "data-driven strategy development," to engage in

[1] https://www.rwjf.org/en/library/research/2014/01/recommendations-from-the-rwjf-commission-to-build-a-healthier-am.html

[2] Hacke, Robin, David Wood, and Marian Urquilla. *Community Investment: Focusing on the System.* Revised March 2018: http://centerforcommunityinvestment.org/sites/default/files/2018-03/CIFocusingOnTheSystem.pdf.

deep community engagement, and to focus the work on seeking equitable outcomes that address existing disparities in their community.

Site selection occurred between January and April 2016. The first step was announcing the initiative in December 2015 and requesting that interested cities respond with a Letter of Intent (LOI) by the end of January 2016. Cities submitted a total of 182 LOIs. Following a review process, RF and RWJF invited 102 cities[3] to submit full proposals and, after a rigorous review process, the team selected 50 cities. (See Exhibit 1.)

Once selected, each city had access to the following:

- $60,000 in funding to cover travel and other costs related to city work;
- four national convenings;
- subscription to PolicyMap, a data platform;
- five "pods," smaller convenings focusing on a specific theme;
- webinars and web content; and
- city support and technical assistance.

Exhibit 1. Map of Invest Health cities

[3] One hundred three invitations, including two groups from Little Rock.

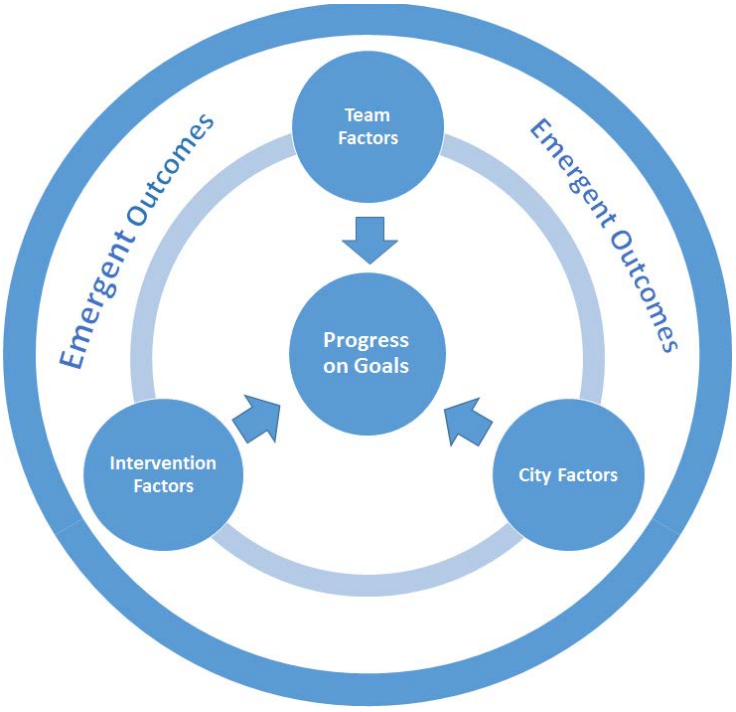
RWJF, along with RF, identified the following site-related goals over the 18-month period of the initiative:

- *Mindset shift:* Increase understanding of formerly unfamiliar domains (health or community development) and build a deeper appreciation for the relationship between well-being, equity, and the built environment.
- *Built environment projects:* Engagement of community, focus on equity, and use of data lead to a long-term pipeline of and significant progress on specific built environment projects that intentionally address prioritized social and economic factors that impact well-being and equity.[4]
- *Community investment system:* Identify new streams of capital, potentially including from the health sector, to finance investment in built environment projects that promote well-being and equity.
- *Collaborative infrastructure:* Teams forge strong cross-sector collaboration—including community development, health sector, and public sector—aligned around a vision for well-being and equity.
- *Enabling environment:* Invest Health teams identify and take steps to improve the systems, policies, practices, and incentives that facilitate community investment in built environment projects that support more equitable and healthier communities.
- *Network:* Strong relationships are built among the 50 Invest Health teams/cities.

Evaluation framework and methods

Mt. Auburn Associates conducted the evaluation of Invest Health, which focused on assessing progress on the initiative's goals, as well as other emergent outcomes, and learning about some of the factors, including team characteristics, city context, and the interventions of the initiative that may have influenced this progress. (See Exhibit 2.)

Exhibit 2. Evaluation framework



The evaluation team's approach to assessing progress on the goals was to develop a detailed rubric based on the evaluator's understanding of the intentions of both RWJF and RF in implementing Invest Health.

Methods for assessing cities along this rubric included a review of all data and documents from RF, observations at four

[4] The goal related to the built environment links the tools, "engagement of the community, focus on equity, and use of data," with the "progress on the project/pipeline." Given the importance placed on making progress on a built environment project/pipeline and the complexity of trying to link the tools and the progress in one goal, the evaluation team made the decision to separate how cities used the tools and the actual progress made on the built environment project/pipeline.

convenings and five pods, three rounds of interviews with travel team members, including the final round that involved 215 city stakeholders, and baseline and final surveys of city teams, with the final survey including city stakeholders involved in the work who were not part of the five-member travel team (324 responses). The evaluation team had all of the interviews transcribed and analyzed them using NVivo software.

ASSESSMENT OF OUTCOMES

The big picture

✓ **Participants in Invest Health reported that their cities made moderate to significant progress across a range of outcomes.**

When asked on the Final Mt. Auburn Participant Survey to rank their progress on a scale of 0–100, participants rated their progress on many elements of Invest Health relatively high. The perceived progress on addressing equity, developing a greater understanding of the social determinants of health, developing a stronger cross-sector collaborative, and making progress on a built environment project were particularly noteworthy. (See Exhibit 3.)

Exhibit 3. Survey respondents' ranking of their sites' progress on a scale of 0-100

Source: Mt. Auburn Invest Health Participant Survey

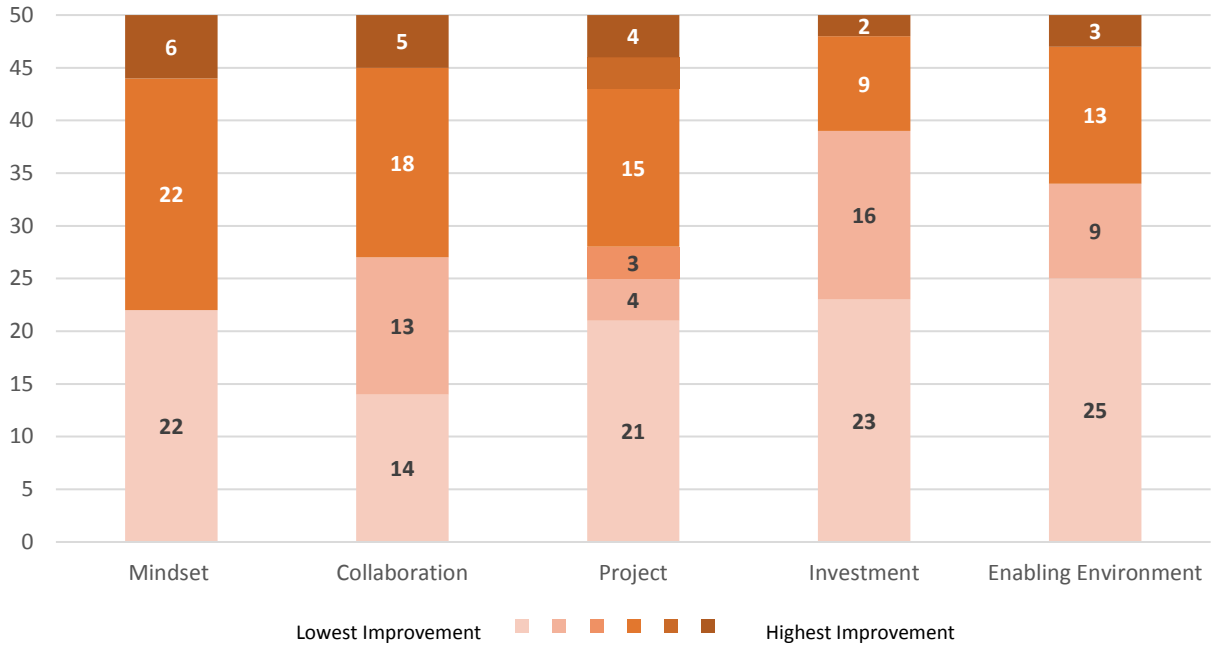
✓ **A detailed assessment of the 50 cities' progress based on a rubric found that 30 percent, or 15 cities, are well positioned to advance a systems approach to attracting and aligning capital investment for built environment projects that address well-being and equity.**

Aggregating city progress on each Invest Health goal, the evaluation identified a core of 15 highly successful cities that demonstrated significant progress in many of the goal areas set out for Invest Health. These cities are likely in the best position to make additional progress. They have generally developed a strong collaborative infrastructure,[5] have made progress on implementing built environment projects, and have begun to address some of the larger system issues that could impact the flow of community investment and the overall well-being of low-income residents. At the other end of the spectrum, 12 (24 percent) of the Invest Health cities made very limited progress on the goals.

"I understand the social determinants of health and I understand the public health world. But connecting it to our Planning Department and Housing, connecting it to development, to economic development and finance was a fabulous learning experience." — City Public Health Director

Progress on specific goals

Exhibit 4. Rubric assessment of 50 sites' progress across Invest Health goals



Source: Mt. Auburn Invest Health Participant Survey

[5] Teams with a strong collaborative infrastructure were likely to have clarity on their vision/purpose; a shared commitment to achieve that vison; inclusion of key cross-sector stakeholders needed to advance that vision; established infrastructure for collaboration; trust, credibility, and accountability built among core members, and able to demonstrate that they had learned, problem-solved, and identified solutions together.

✓ **Involvement in Invest Health has led to some significant *mindset changes* among both individual stakeholders as well as teams.**

The evaluation looked at mindset change at the individual level and then aggregated feedback on mindset shifts for individuals serving on the same team to assess how teams' mindsets changed as well. At the individual level, analysis of the final survey found that individual participants generally noted an increase in their level of understanding of previously unfamiliar domains. Health stakeholders noted particular gains, with many reporting changes in their thinking about what it takes to advance a built environment project. Changes related to equity were particularly strong with many participants noting that they now think differently about the causes and impacts of disparities.

The evaluation considered team changes in mindset as well. For individual gains in understanding to translate to a team change in understanding, multiple participants need to have noted a gain in understanding of the same domain. Invest Health contributed to a significant mindset change within six city teams (12 percent), a moderate level of mindset change within 22 city teams (44 percent), and limited change within 22 city teams (44 percent). (See Exhibit 4.) Rather than a broad change in understanding of the social determinants of health, interviews suggest that Invest Health nurtured a deeper understanding of how the built environment interacts with health or the social determinants.

✓ **Given the very short timeframe for Invest Health, the number of cities that made moderate to significant progress on both financeable and nonfinanceable *built environment projects* was a significant accomplishment.**

Making progress on a specific built environment project or pipeline of projects was a strategic focus of the work with Invest Health teams, particularly early in the initiative. As the initiative evolved, teams embraced a variety of approaches to addressing health through the built environment, not exclusively through financeable projects.

Twenty-eight (56 percent) Invest Health teams made moderate to significant progress on a built environment project. Of these, seven (14 percent) cities have secured or are close to securing funding for a financeable project. An additional six (12 percent) cities made significant progress on projects, primarily involving physical infrastructure, which would require public funding or grant funding. Through Invest Health, these six cities have improved sidewalks, lighting, parks, and community gardens.

While a number of cities worked on more than one project, only 13 (26 percent) identified a pipeline of projects that aligned with their vision. Twenty-two (44 percent) cities never identified or made minimal progress on a built environment project. These teams used their engagement in Invest Health to work on planning or programmatic activity.

✓ **Close to half of the Invest Health teams have built strong *collaborative* structures and are positioned to advance the work that they began as part of Invest Health.**

In general, the Invest Health teams believe they have made significant progress on building cross-sector collaboration in service of the teams' vision. When asked on the Mt. Auburn Participant Survey to rank their perception of their team's accomplishments on a scale of 0 to 100, respondents ranked "contributing to the development of a strong cross-sector collaborative" very high, particularly when compared to other Invest Health goals. Similarly, when asked what they learned through Invest Health, "what it takes to build an effective cross-sector collaborative" was the area where the most stakeholders believe that Invest Health had the greatest effect.

Overall, the evaluation team concluded that 23 Invest Health sites (46 percent) have built the collaborative infrastructure required to advance the vision developed through Invest Health. Most of these teams are well positioned to advance the built environment projects or pipeline that they had identified. Five teams (10 percent) are looking beyond specific projects and have developed the collaborative infrastructure to address the system issues related to achieving their vision.

✓ **Fifty percent of the teams focused on the *enabling environment* through their involvement with Invest Health, and approximately 30 percent of teams made some progress in that work.**

Invest Health always envisioned that teams might play a role in shaping their cities' enabling environment so that community investment better flowed to built environment projects that support equitable and healthy communities. However, many of the teams did not recognize this as a priority of the initiative and there was limited focused effort to identify and address system challenges. Ultimately, 25 of the 50 teams focused on changing the enabling environment to varying degrees.

One of the most common areas for teams to contribute to a change in the enabling environment was around shifting city priorities in terms of neighborhood focus. Zoning, or other city policies guiding the use of city land, was an equally common area of the enabling environment on which teams focused. Seven teams (14 percent) contributed to the enabling environment by supporting the development of new capacity in their cities, for example, strengthening capacity of community development corporations (CDC).

✓ **Overall, when compared to other goals and areas of learning, sites made the least progress on the Invest Health goal related to *community investment*.**

The initial framing of Invest Health was around attracting and aligning capital investment for built environment projects that address well-being and equity. The expectation was that through working on built environment projects, cities would emerge better positioned to see capital flowing to priority projects. However, the Mt. Auburn Invest Health Participant Survey revealed, in general, that the Invest Health stakeholders did not feel like their cities made as much progress on community investment as they did on the other goals. When asked to rank their accomplishments on a scale of 0-100, the choice "contributed to new streams of capital to finance built environment projects" was the only category that had a ranking of less than "50." In the survey, participants reported the least progress on developing a new understanding of the community investment system and were the least positive about their progress in attracting new financial resources to their community.

Given the generally low level of community investment experience among the 50 teams, the rubric assessment considered an indicator of progress when multiple members of a team noted an understanding of community investment that did not previously exist. Members in 15 (30 percent) cities articulated a greater understanding of the community investment system and new awareness of community development finance organizations with whom the team could potentially collaborate. Nine (18 percent) more advanced sites had actually taken steps to forge new relationships with CDFIs or other sources of community investment and were actively seeking to increase the flow of investment capital in their community. Two sites (4 percent), the most advanced, were successful by the end of Invest Health in actually tapping new sources of funding or creating new community investment capacity in their cities.

✓ **The extent and strength of cross-team connections, *building the network*, are modest, but promising.**

Inherent in the Invest Health initiative design was a desire for the 50 cross-sector teams to learn with and from each other. The evaluation team identified 123 unique one-to-one connections among the 50 participating teams, a relatively modest number given the possibility of 50^49 connections. The strength of the one-to-one connections was also relatively limited when considering the nature of the exchange. That is, teams *communicating* about common experiences is most common; communicating about tools and models specific to Invest Health projects is somewhat less so. Analysis of interviews, however, suggests that the seed has been planted, has borne some fruit, and the number and strength of relationships will likely grow. Many participants anticipate "following-up" on specific Invest Health connections in the future.

Other Invest Health outcomes

In the course of evaluative research exploring city progress relative to the initiative goals laid out by RWJF and RF, Mt. Auburn Associates identified positive outcomes that do not directly correspond to the stated goals but to which the initiative appears to have contributed. These spillover outcomes, primarily system changes, were not accomplished because they were a strategic goal of the team, but rather emerged as a result of organizations working together in new ways or making use of new tools or concepts.

✓ **Involvement in Invest Health led to new and deeper relationships among community stakeholders, which, in turn, has contributed to tangible changes in Invest Health cities.**

More than 20 (40 percent) city teams noted new or improved relationships that crossed sector boundaries of health and community development. Examples would be a health system or county public health department developing a new relationship with a CDC or CDFI. These new relationships have led to coordination of services, joint planning, joint funding proposals, and partnering on new programs.

"Biggest accomplishment we could show them as far as Invest Health wouldn't be something you could see or something you could put your hands on. It would be the importance of the relationships that you could build and how we went about that."

"If something comes up regarding a project one person is working on or another, we call each other and we figure it out. That's a great benefit of this program that I don't think Robert Wood Johnson Foundation would have thought would occur, but it's a natural occurrence when you start to talk to people in your community who are leaders in different organizations. And sometimes that breaks down those barriers and the work gets done faster."

"We have built some solid relationships that weren't there 18 months ago. And I think that is going to help move this Invest Health work, but also some other unrelated work together in the community…you can't really put a value on that…aside from anything else, the foundation for those relationships is huge."

✓ **The priority placed on community engagement, data, and equity has led to some changes in practice within the Invest Health cities.**

Invest Health stressed the importance of teams pursuing data-driven approaches to their planning, provided multiple sessions focused on how teams might make use of data, and bolstered teams' data capacity by offering free subscriptions to PolicyMap. The data-driven approach appears to have generated some emergent outcomes in which partners are making policy and practice changes to enable better use of data on an ongoing basis in their cities.

Invest Health also emphasized community engagement as critical for identifying community needs and gaining community support for the team's work. The community engagement work has generated some unexpected spillover benefits for several cities that will further support or expand resident voice in decision-making and planning. These Invest Health cities have plans to expand community engagement in different neighborhoods, apply it in different programs unrelated to Invest Health, allocate additional funds, or create new positions in recognition of its importance. The evaluation also identified a handful of cities with equity-related emergent outcomes to which Invest Health appears to have contributed such as 1) equity considerations in city funding allocations, 2) application of an equity lens in political conversations and actions, and 3) pursuit of additional training or participation in national efforts to address issues of racial equity.

THE RELATIONSHIP BETWEEN TEAM CHARACTERISTICS AND PROGRESS

In the initial design of Invest Health, RWJF and RF required that cities identify five individuals who would serve on what they referred to as the "travel team." The funders were somewhat prescriptive in terms of who should be on the team, asking that cities include a representative from the community development sector, the public sector, and an anchor institution. The definitions for each of these categories, however, were relatively broad. Beyond these three defined categories, each city could select the remaining two members of the travel team. While there was clearly recognition that there would be transitions in this team over the course of the initiative, there was some expectation that the "travel team" would be relatively consistent and that these individuals would attend the convenings. In addition to the "travel team," there was also the idea that a "home team," a broader stakeholder group, would play some role in the initiative.

What teams worked on

✓ **Issues related to food access and production, affordable housing, and physical infrastructure/community amenities were the focus areas of a majority of the teams. The teams that focused on housing and community infrastructure/amenities made up a higher percentage of the cities categorized as making the most progress on the Invest Health goals.**

Through the community engagement and data collection processes, what the cities eventually ended up working on (see Exhibit 5) looked relatively different from what they proposed in their applications. Most notably, there was a shift toward greater focus on food systems and away from a focus on public safety and employment. This shift resulted from a growing understanding of the initiative's built environment focus and the community engagement process that, in many cases, shifted the emphasis to community infrastructure and amenities. Overall,

Exhibit 5. Final focus of team's work (n = 86)

Focus Area	Number of Sites	% of Sites
Amenities/infrastructure (sidewalks, lighting, parks)	9	18%
Build community capacity	3	6%
Commercial revitalization	6	12%
Community center	8	16%
Early childhood	4	8%
Food systems	23	46%
Health access	3	6%
Housing	17	34%
Public safety	6	12%
Transportation	4	8%
Employment	3	6%

Source: Mt. Auburn Invest Health Participant Survey

cities focusing on housing and community infrastructure were overrepresented in the cities with a ranking of above average.

- ✓ **Teams that lacked a clear result focused on a specific health outcome or social determinant of health had difficulty making progress against Invest Health goals.**

Many of the Invest Health cities tried to define a specific health outcome or outcomes in the early stages of the work, spending considerable time reviewing existing data in order to identify specific health disparities. However, in the end, a majority of the sites never identified a specific health outcome or reported a very general outcome. Of the cities that did identify a health outcome, five (10 percent) targeted obesity, three (6 percent) focused on behavioral health, two (4 percent) identified asthma, and the rest focused on high rates of chronic diseases such as diabetes or heart diseases. Other teams identified a specific focus on a social determinant of health, most notably healthy food access and housing.

Teams that more broadly focused on poverty in a neighborhood or on general health disparities rather than a specific health outcome or social determinant of health had greater difficulty getting to a vision and making progress on many of the Invest Health goals. Their focus was so broad that it made it difficult to develop specific strategies or projects. In effect, everything was possible and important, making it difficult to set priorities and reach consensus on an approach.

- ✓ **Twenty-two (44 percent) cities started their work with Invest Health with the idea of developing a grocery store in a food desert, but most pivoted and developed other solutions to addressing food access.**

The idea of developing a grocery store was one of the most common starting points for many Invest Health teams, with approximately 22 sites considering a grocery store. By the end of the 18 months, however, very few sites were still thinking about standalone stores. Some sites discovered that the feasibility of developing a standalone store was unlikely. In other cities, efforts to develop a grocery store led by different groups were much further along than the teams realized. Finally, a number of the cities recognized there were other solutions to healthy food access that could achieve the same goals, but without a brick and mortar store.

- ✓ **One-third of the teams spent most of their time trying to advance one or two specific projects, many of which built upon existing activity. Teams focusing only on advancing a project were less represented in the most advanced teams.**

A large number of the Invest Health cities spent much of their time during the 18 months either furthering an existing project that had been identified in their city or identifying a new project and taking steps to advance it. While some cities worked on a project that emerged completely through the team's Invest Health work, a large number of cities struggled to find a focus for their Invest Health team and decided to contribute to some ongoing development activities in their community. In other cases, the work involved furthering a pipeline of projects that had already been defined, usually by a member of the Invest Health team. While the teams that focused intensely on a "project" made progress on that component of the rubric, across all of the Invest Health goals only 20 percent of these teams were ranked in the most advanced category as compared to 30 percent of all teams.

Travel team composition

✓ **Representatives from colleges and universities were the largest group in the Invest Health cohort, with some playing an important role in supporting the team's work.**

Seventeen (34 percent) cities designated a higher educational institution as the "anchor," and another nine (18 percent) included someone from a college or university on their team. The role that higher education partners played on their respective teams ranged widely. In many cases, the university partner was able to provide much needed data on community health statistics and neighborhood demographics. In a small number of cities, university and college partners were able to get students involved in the teams' work. There were, however, few examples where the engagement of the higher education institution enhanced the institution's commitment to taking a deeper and ongoing role in neighborhood improvement.

✓ **Over half of the cities included a hospital on the travel team. Hospital representation was associated with above average team progress on the Invest Health goals. However, RWJF's aspiration that involvement might lead healthcare institutions to make actual investments in the built environment did not come to fruition.**

Twenty-seven teams (54 percent) had a hospital representative involved in Invest Health sites. Most of the hospitals reported some increased understanding of community development, community engagement practices, public sector operations, as well as deepening relationships with other stakeholders in their cities. However, few reported that their institutions had made any significant changes in how they are working within their community, and none reported that they are now looking differently at how they can invest directly in community development projects.

While hospital representatives did not report a significant impact on their institutions as a result of Invest Health participation, the evaluation found that hospital participation is associated with greater team progress on Invest Health goals. While 54 percent of all of the Invest Health teams included a hospital, among the cities that had an above average assessment, 80 percent had a hospital on their team.

"So we had high-level people on this travel team, but we needed to get the workers, a working group that had the time and the energy and the focus. So that's how we really moved our project forward."

"The people that were on the team were all people who had the ability and the authority to be committing resources and making decisions. They didn't need to go check it…. And I think that's crucial."

"We were five people and most of us are middle-management level. None of us were high-level players in our organization. I really feel like that probably made a different for progress, because there were teams that we would see….that were really moving quickly…they had either like a mayor, or city manager, or some high-level person on their team."

✓ **Most of the cities that made significant progress on identifying a pipeline and advancing a project had travel team members with development experience.**

Although all teams had individuals with some community development background, far fewer had members who had previously played the role of the developer on financeable built environment projects. In terms of development capacity, 15 (30 percent) cities included on their team an organization that had actual experience in developing a built environment project. This included CDCs and private developers. While only 30 percent of the cities had a travel team member with development expertise, 57 percent of the cities that the evaluation team assessed highly in terms of advancing a financeable project and pipeline

had this expertise. This suggests that being able to quickly identify and make progress on a project is more likely when there is someone on the team who has developed projects in the past.

- ✓ **Having a CDFI or financial institution on the team did not lead to advancement in the community investment goal or greater progress on the other Invest Health goals.**

Thirteen (26 percent) cities had a CDFI on their travel team, while four (8 percent) had another type of financial institution. Five (29 percent) of the 17 financial institutions were not engaged participants in the local team. In some cities, they dropped out early; in others, they stayed on the team but rarely attended meetings or convenings.

The most common roles played by the more engaged CDFIs/financial institutions were educating other team members on the community investment system and assisting in the community engagement. In these roles, they used their expertise to identify and vet projects and tapped their connections to aid teams in undertaking community engagement. No CDFI provided financing to a built environment project that its Invest Health team identified. This was because the projects were in the early phases or the team decided to focus on infrastructure or projects that were not within the CDFI's area of interest. This frustrated several CDFI team members who had joined Invest Health with the expectation that it would lead to specific project financing opportunities.

Interestingly, the cities that did include a CDFI/financing entity did not perform any better on the goal of improving the community investment system and, overall, actually were overrepresented in the low-performing cities. While, in general, only 34 percent of the cities had a CDFI or financing entity on their teams, six of the 12 cities (50 percent) categorized as making little progress had a CDFI/financial entity on their team. This may be related to the fact that CDFIs and financial institutions do not necessarily bring a finance systems lens to their work and their communities. CDFIs have a strong focus on completing transactions and on providing financial services, and they are not necessarily working to improve the city or regional community development finance system.

- ✓ **Teams that had a preponderance of members with a community development perspective were able to make greater progress across the Invest Health goals than those with a majority of individuals with a health perspective.**

Overall, most of the travel team members had either a health perspective or a community development perspective. Those with a health perspective represented healthcare service providers, public health staff, and academic staff from public health-related departments. Most of these individuals came to the Invest Health team with little understanding of community development, though many expressed either knowledge of or interest in the social determinants of health. Those with a community development perspective were involved in a range of public and nonprofit organizations that were focusing on planning, housing, commercial development, and economic development. While, overall, the rubric ranked only 30 percent of the sites as above average, it ranked 40 percent of the sites with high representation from community development as above average.

- ✓ **Having both high-level decision-makers and "boots on the ground" accelerated the teams' work.**

Most of the teams had a mix of senior level and less senior staff. There were some travel teams, however, where less senior staff, considered the "boots on the ground," dominated the team, and some travel teams in which staff with a high level of authority dominated.

Where the entire team lacked decision-makers, there were limits to what the city could achieve through Invest Health. In these cities, the team members lacked the authority to act on behalf of their organizations and had to get approvals from high-level managers for any significant action that they wanted to take. Sites with a preponderance of members in high-level decision-making positions also faced challenges, mostly in terms of the time commitment involved in the work and lack of capacity for actually making progress on projects.

Teams that were most successful usually had high-level decision-makers involved, but also involved other staff in the efforts through working groups or on an expanded home team. Other effective strategies included involving higher-level leadership through reporting structures that kept them in the loop about the work the team was doing in the city.

- ✓ **Having an elected official or city manager with considerable influence can be a critical factor in advancing the partnership's work, sustaining the work, and facilitating broader system changes.**

Twelve (24 percent) of the Invest Health cities had elected officials or top city executives, including three mayors, on their travel teams. Evidence suggests that the involvement of public sector leaders played a major role on some of the cities that have been most successful in achieving the goals that were set out for the initiative. Of the 12 cities with high-level leaders, the evaluation team assessed five as above average in the rubric (42 percent), while, for comparison, only assessed 30 percent of the sites overall as above average.

Having the city leaders provided a number of benefits, including lending credibility to the work, providing the team with needed staff capacity, and getting leaders in other sectors to engage in the work. In the longer term, the engagement of these leaders may have additional benefits as this analysis suggests that having city leadership engaged may lead to deeper system changes in the cities and a redirection of attention and resources to the most high-need neighborhoods and residents.

Functioning of the travel team

- ✓ **The level of instability on the travel teams was higher than anticipated, with most teams experiencing at least one transition over the 18 months. Most of the cities making the least progress had a high degree of instability.**

Contrary to expectations, only 13 (26 percent) of the 50 sites consistently had the same five members on the travel team throughout the initiative, and only three (6 percent) teams sent the same five members to all four convenings. Most teams had less than two-thirds of their members attend all four convenings, with some teams having four or less of their members in regular attendance. In some cases, this low attendance was due to senior-level members sending junior staff in their place. Some teams expressed that the lack of consistent attendance at the national convenings was a detriment to their progress.

The majority of teams experienced at least one transition, primarily due to changes in jobs. In these instances, teams would generally try to replace their former team members with another representative from the same organization. A number of cities, however, saw many changes in the composition of their travel team over the 18 months. In a handful of instances, team transition was deliberate. As teams worked with their communities and began to plan their projects, some realized that the direction of their work needed to change and, therefore, so did the makeup of their team. Team members on these teams viewed the transitions in a positive light, believing that they could not have achieved the work they did if the team had not transitioned.

Many of the cities with the lowest performance on the Invest Health goals had a high level of instability, meaning that they experienced a large number of transitions in their travel team and did not have a consistent set of team members who attended the convenings. Over 60 percent of the teams categorized as making the least progress on the Invest Health goals also had a high degree of instability in their travel teams. In contrast, very few (6 percent) of the sites making the most progress had teams categorized as unstable.

✓ **Having a strong team lead, dedicated staffing, or administrative capacity was important to team progress.**

The time commitment required by Invest Health for teams to both attend the convenings as well as to advance the work at home was a challenge. In 19 (38 percent) cities, at least one member of the team raised the issue of how the time commitment exceeded their expectations and was problematic. Interviews suggest that having some "backbone" capacity for the team helped it to address this challenge and make progress on the work.

One way sites addressed the capacity issue was to have a clear "lead" who played a convening role, scheduling meetings, developing agendas, and, in some cases, facilitating the meetings. A few teams used their Invest Health funding to pay for a consultant who would manage the work of the team and/or facilitate its meetings. While the evaluation did not find evidence that a particular model worked better than others, it was clear that having additional team support was helpful, and, in some cases, critical.

"It's hard to move a huge initiative forward like this when it's a side job of all five of us."

"But the reality is that this is a completely volunteer effort on our part and we're balancing our regular workload with the need and the desire to pull this plan together. That's been a real source of frustration."

"This project took a back seat to everybody's day job. So depending on how stressful and pressing people's regular responsibilities were, Invest Health was sometimes falling by the wayside."

Role of the home team

✓ **Having an active home team was an accelerant, with many teams reporting that they wished they had spent more time building a home team and engaging them more actively in the work.**

When looking across all 50 cities, there is a wide range of the definition of "home team," with each group varying greatly in both makeup and function. Each team approached the creation of its home team slightly differently, with 14 (28 percent) cities never creating one at all. The evaluation team identified three main approaches to a "home team":

- *Formal:* Twenty (40 percent) sites have established a formal home team, which this evaluation considers as a clearly defined group of stakeholders whom the travel team meets with regularly.
- *Ad hoc:* Seven (14 percent) sites ran "home teams" on a more ad hoc basis. In these cases, the teams identified key stakeholders and met with them one-on-one or invited them to relevant team meetings.
- *Expanded:* Nine (18 percent) of the sites operated with an expanded travel team. These teams typically have staff members from the team's core organizations join the meetings, offer additional capacity, and sometimes attend Invest Health convenings.

Several teams who established formal home teams felt that this larger group was an accelerant to their work, and data based on the rubric confirms that perception. While 40 percent of all teams had a formal home team, 53 percent of teams making the most progress on the Invest Health goals had a formal home team. Conversely, while 28 percent of all teams had no home team at all, 58 percent making the least progress on Invest Health goals did not have any type of home team. When asked for feedback about what they could have done differently, a number of team members noted that they wished they would have engaged other stakeholders in their community earlier in the process, or that they would have more deeply engaged their home team in the Invest Health work.

THE RELATIONSHIP BETWEEN CITY CHARACTERISTICS AND PROGRESS

While the 50 cities engaged in Invest Health all fell within the general category of midsize cities, there was considerable variability in terms of the characteristics of the cities, their "readiness" when they started their engagement with Invest Health, the broader community development and health ecosystem that was operating in their community, and the political and economic context within which they operated.

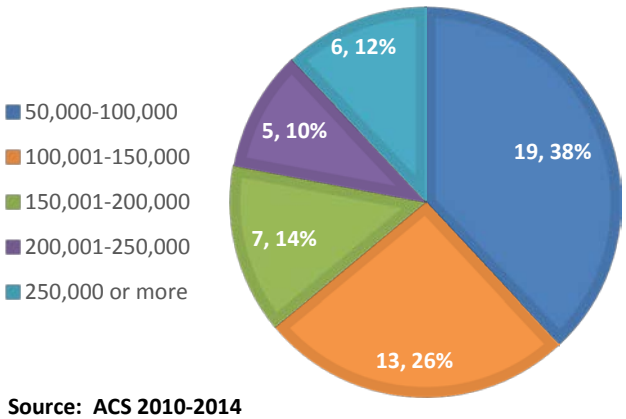
Demographic and economic characteristics

✓ **There is some evidence that the largest cities, those with over 250,000 residents, made more progress across the Invest Health goals, and "suburban" cities that were not the primary cities in their MSA were more likely to be among the lowest performing sites.**

The size of the cities selected to participate in Invest Health ranged from Grand Forks, North Dakota, with a population of about 54,000 to St. Louis, Missouri, a city with a population of about 320,000. While most of the cities selected, 32 (64 percent), had populations below 150,000, there was a small cohort of larger cities, including Buffalo, New York; Greensboro, North Carolina; Henderson, Nevada; St. Louis, Missouri; St. Paul, Minnesota; and Riverside, California. (See Exhibit 7.)

There were also differences in terms of the size of the MSA the city was part of and the city's role within the MSA. For example, cities such as Kansas City, Kansas; Roseville; St. Louis; and St. Paul, while classified as midsize cities, are actually the principal cities in relatively large regions. This contrasts to cities such as Grand Forks, Missoula, and Pueblo, Colorado, which are the principal cities in very small metropolitan regions. There was also a handful of cities, such as Framingham, Massachusetts, that were not the primary cities in their larger metropolitan areas and could fall into the category of "suburban" cities.

Exhibit 7. City size by category



Source: ACS 2010-2014

Three of the six cities (50 percent) with populations exceeding 250,000 were among those making the most progress across the Invest Health goals. However, it is also important to keep in mind that being a larger size city did not assure success in Invest Health. Some of the largest cities were also among the cities that made the least progress. Seven (14 percent) Invest Health cities had a suburban classification. While, overall, only 24 percent of the Invest Health

cities had a below average ranking in terms of the goals, three of the seven "suburban" cities, or 43 percent, were among the lowest performing Invest Health cities.

City "readiness"

Often when choosing communities to involve in a multisite initiative, funders consider their level of readiness. An assessment based upon the baseline conditions in the Invest Health communities found that there were differences across the cities on the following elements related to readiness:

1. the level of pre-existing planning work that had already taken place;
2. the degree of pre-existing relationships;
3. the community development capacity needed to successfully achieve the initiative's goals;
4. the collaborative ecosystem in their community; and
5. the political and economic conditions the communities faced.

✓ **A number of the cities were building off existing planning efforts, some of which specifically focused on low-income neighborhoods and health disparities. Cities that started with these plans were able to make greater progress on advancing a project or pipeline.**

Master plans, neighborhood plans, and plans focusing on specific social determinants of health form the foundation of the work in close to one-third of the Invest Health cities. In these cities, the planning documents often identified priority strategies and projects. In addition to these planning processes, five of the cities had developed applications for a Federal Promise Zone or Choice Neighborhoods grant and, in some cases, the neighborhood overlapped with the Invest Health targeted neighborhood. These applications, even if they did not result in implementation grants, contributed to the city's baseline capacity. Cities that had already undertaken significant planning work in the targeted community were able to make more progress on Invest Health.

✓ **In midsize cities, many stakeholders already know each other, but most had not worked together in the past. The level of pre-existing relationships did not seem to be related to how successful the city was in achieving the Invest Health goals.**

Overall, the baseline stakeholder survey found that respondents from 23 (46 percent) teams reported knowing all or most of their fellow team members and, in 12 (24 percent) teams, more than half of members reported having worked with most or all of their team members in the past. In a number of instances, the Invest Health work was a natural progression of an ongoing partnership involving cross-sector stakeholders who had been working together. At the other extreme were sites where very few of the members knew each other or had worked together prior to the Invest Health application. There was little evidence overall suggesting that teams whose members knew or worked with each other previously performed any better across the Invest Health goals.

✓ **There was a broad spectrum of capacity among the cities, with many having more capacity than anticipated in addressing the social determinants of health and in community development. With limited objective data on the level of capacity, the evaluation was not able to assess its importance in terms of progress on the goals.**

In developing the Invest Health initiative, there was an underlying assumption that this effort would be targeting relatively low-capacity cities that would benefit from the learning activities Invest Health was

offering. In fact, some Invest Health cities had very limited experience in thinking about the connections between community development and health and well-being, and weak community development capacity. However, a surprising number of teams had already engaged in some similar activities, and there were teams that had relatively sophisticated community development capacity. For example, in the baseline survey of Invest Health travel team members, 64 percent indicated that they had been part of a formal collaborative table focused on similar goals with at least one represented organization.

It is important to note that some of the Invest Health teams with relatively low community development capacity were in relatively high-capacity cities or regions. In other words, some of these cities had organizations with development capacity and knowledge that were not included on the Invest Health team, or the city itself had significant capacity, but did not apply this capacity to Invest Health.

- ✓ **A relatively large number of Invest Health cities had already been engaged in some type of healthy community-related collaborative. Cities that built upon this existing collaborative activity were able to accelerate the work; cities with multiple partnerships addressing related issues that were distinct from Invest Health had a difficult time developing a "vision" for their Invest Health work.**

Although not specifically focused on the built environment, a surprising number of Invest Health cities were part of other national multisite initiatives (see sidebar) or had other partnerships that were working on efforts related to obesity, healthy food access, health disparities, and addressing the social determinants of health. In some cases, there was some overlap or alignment between the Invest Health team and the other initiative. In other cities, the other work was on a parallel course.

Having another national or community initiative related to health and community well-being was an accelerating factor in some cities, but was also a serious detriment to progress in others. Cities that built on the existing collaborative work were able to make progress. On the other hand, some teams that were working in communities with a dense set of relationships and initiatives had difficulty identifying the specific value add of Invest Health. The question of how the Invest Health team fit within this ecosystem and what role it could play was a critical factor in why a few of the teams never really identified a vision for their work together.

Invest Health Cities Involved in National Health and Community Initiatives

RWJF Culture of Health Prize: RWJF awarded four cities the RWJF Culture of Health Prize and one city was a finalist: Durham (2014), Grand Rapids (2016), Richmond (2017), Spokane (2014), Lansing (2017 finalist).

Green and Healthy Homes: Five cities participated in the Green and Healthy Homes Initiative (Buffalo, Flint, Grand Rapids, Lansing, and Syracuse).

SCALE: Two cities were part of the RWJF SCALE initiative: Akron and Pueblo.

Build Health: One city was part of Build Health 1.0 (Des Moines) and three cities (Des Moines, Greensboro, and St. Louis) are now part of Build Health 2.0.

Trinity Transforming Communities Initiative: Syracuse Health Coalition and Hartford.

Other: ReThink Health Ventures (Rochester), SPARCC (Westminster), Road to Wellville (Hartford), and CACHI (Riverside and Napa).

✓ **Exogenous factors related to crises, political transitions, and economic conditions can have a large effect on the progress cities are able to make.**

Given that Invest Health was only an 18-month initiative, it is surprising how many of the cities felt the impact of the changing context in which they were operating. During the 18 months, there were many cities that saw political transitions and other staffing changes, cities and states that were facing both fiscal and natural crises, and cities with healthcare institutions that were having financial challenges or were in the midst of ownership transition. For the most part, these changes slowed the Invest Health work.

THE IMPLEMENTATION OF INVEST HEALTH

Invest Health's primary "inputs" were a small grant of $60,000 per city, mostly to cover travel; a set of four national convenings and five small pod convenings; "city support," which included aspects of program monitoring, light coaching, and, in some cases, technical assistance; and virtual learning opportunities through a series of webinars, a web portal with a significant library of resources, and access to online resources for data analysis.

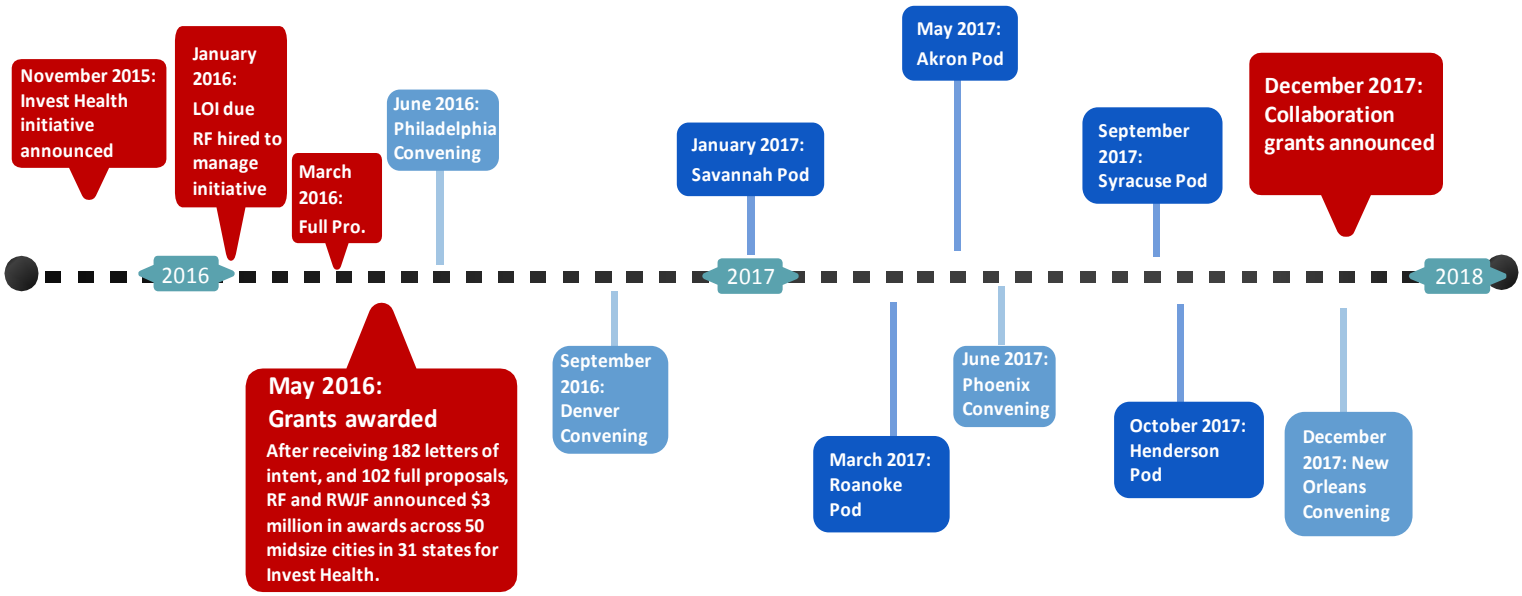
RF assembled a program team to carry out the implementation of the varied interventions. RF was responsible for overall management, developing and managing the communication efforts and online learning platform, overseeing the team of consultants working on the project, and planning the logistics of the convenings and pods. RF contracted with Bennett Midland, a management-consulting firm that provided a team of consultants to carry out the city support function. RF also engaged the Center for Health Leadership and Practice (CHLP) to help design the convenings, to develop and deliver much of the curriculum, and to oversee all of the webinars.

Throughout implementation, the RF team sought to balance a customer service approach of being responsive to the teams, designing interventions to serve the initiative's goals, and managing the logistical challenges of orchestrating four complex national convenings for 50 cities and organizing five smaller pod meetings over an 18-month timeframe. However, the strategic intent of the interventions, particularly how the varied interventions aligned and reinforced each other, was at times unclear.

Management of the initiative

✓ **The compressed timeframe to organize and execute four national convenings and five pods meant there was limited time for initiative planning and strategic reflection.**

RWJF was operating on a fast track in terms of conceiving of Invest Health, getting board approval, and hiring the intermediary who would be responsible for implementing the initiative. RF came on board at the end of January 2016 and had to not only develop a site selection process and select the 50 sites, but also to staff up for the initiative and organize and run a large national convening for the selected sites in June 2016. For RWJF, it meant that it spent limited time developing its own theory of change. For RF, it meant that it had to staff up quickly and focus its attention on managing the complex logistics of executing nine events. This left limited time for strategic reflection and for developing the feedback loops and systems that might have facilitated more targeted and customized interventions.



✓ **Responsiveness to the teams and flexibility became the underlying principles of the initiative. This approach, while having some benefits, created challenges in terms of progress on some of the specific Invest Health goals.**

RF's approach to Invest Health revolved around serving the customer, which Invest Health viewed as the 50 cities. Given this, the RF team did not seek to impose a set pathway for each site. There was not a sustained, directive emphasis on ensuring that cities' work aligned with the specific goals set out for Invest Health. For example, the initial framework stressed that city teams work to advance *financeable* built environment projects, yet many cities ended up focusing on small grant-funded infrastructure projects. Similarly, few cities explicitly addressed the challenges in their community investment system.

✓ **Cities did not have clarity about the underlying framework for Invest Health and about what success would look like, hindering the progress of a number of the cities.**

While RWJF and the RF team established goals for the initiative shortly before the first convening, the level of importance or priority placed on each goal was not clear to sites. A pervasive theme in the final interviews with travel team members was that they struggled to understand what they were supposed to be working on, and many cities reported that this hindered their progress. A large proportion of the cities perceived an early message that they should be working on a single built environment project, and they further believed that, if successful, there would be some type of financial support at the end of the initiative.

A number of cities heard this message and decided that they were going to continue to pursue their own agenda, whether that was focusing more generally on community engagement, focusing on a strategy that did not involve a built environment project, or focusing on public amenities funded with grants. These sites made progress, but not necessarily on the specific goals laid out for Invest Health.

Other cities, particularly those that were trying to conform to what they thought were the expectations, reported spending many months seeking to identify a specific project, or floundering because they did not fully understand the expectations of Invest Health.

As the initiative evolved, there was a distinct shift in the "messaging," with both RWJF and RF making it clear that Invest Health was not about a single project. In addition, RF and RWJF thought they made clear to teams that Invest Health would not play a direct role in helping cities access foundation or private funding. However, one of the surprises in the final interviews was the number of travel team members who continued to believe that at the end of Invest Health there would be some pot of money to finance their project.

> "And so I think having that clarity in the first two convenings would definitely have saved a lot of time and brain-wracking of teams trying to figure out how they're going to do this. I just think that would have been, for me, the most critical change for me on how things happened."
>
> "I think there was some confusion at the beginning in terms of what we were charged with doing, whether it was actually going out and getting money, or just having a plan. And I guess I felt like there was going to be more opportunities for Invest Health to link us with funders than actually happened."

- ✓ **The initiative was fairly consistent in its support of team progress related to a built environment project or pipeline both through content at pods and convenings as well as through the guidance of city support staff. Curriculum and/or follow-on support to assist teams on other topics relevant to Invest Health goals was more limited.**

Although in the initial design of Invest Health RWJF emphasized the concepts of "system change," "community investment," and "cross-sector collaboration," they received varying levels of attention in implementation. For instance, Invest Health always articulated a goal that teams would change the enabling environment so that future development could better address community health and well-being, but there was limited curriculum or attention paid to defining the enabling environment that affects equitable built environment development or approaches to system change. Similarly, RWJF hoped that the initiative would change the community investment system; however, there was limited emphasis placed on working with the cities directly on the challenges in their systems. The interventions, particularly city support, focused on applying financing to a project or pipeline, not reforming the investment system.

A particular challenge at times appeared to be a somewhat siloed nature of delivery of initiative interventions. Specific concepts or frameworks were introduced in plenary or workshop settings at convenings, but there was limited follow up with individual teams on how they were applying the learning to their site-specific work.

- ✓ **The limited effort to periodically group cities or team members based on their commonalities (geographic location, focus of the work, type of organization, level of capacity, or stage of development) led to frustration on the part of some participants, constrained the ability to provide more differentiated interventions, and may have hampered the potential for deeper cross-site relationships.**

While a few sessions during the convenings grouped teams by organizational type (e.g., county public health staff or philanthropy) or by issue area, there was generally no differentiation of most of the offerings and assistance, and there were few efforts to create subcohorts within the Invest Health population of cities. Given the fact that there were 50 cities in Invest Health, the lack of segmentation in the implementation proved to be a challenge.

A large number of team members came into Invest Health with previous experience working on social determinants of health, a relatively high level of capacity in community development, or a strong commitment to addressing equity. Some of these individuals found many of the sessions at convenings and webinars too basic. Similarly, they noted they would have had more commonality with team members in other cities who were at a similar level. Some of the high-level decision-makers representing hospitals, for example, reported that they would have found it helpful if they had more opportunity to meet with their peers. Many of the cities that started with some of the more sophisticated team members made limited progress on the goal related to changes in mindset because they did not have access to either content or network opportunities that could have pushed their thinking even further.

Some cities came into the initiative building on existing planning efforts with a very clear "project" or "vision" and really needed some advanced technical help, while others really had no idea what they were working on and were starting at the very beginning of the planning process. The support and technical assistance needs of these two types of cities were very different, yet there were rarely different "tracks" during pods or convenings that acknowledged these differences.

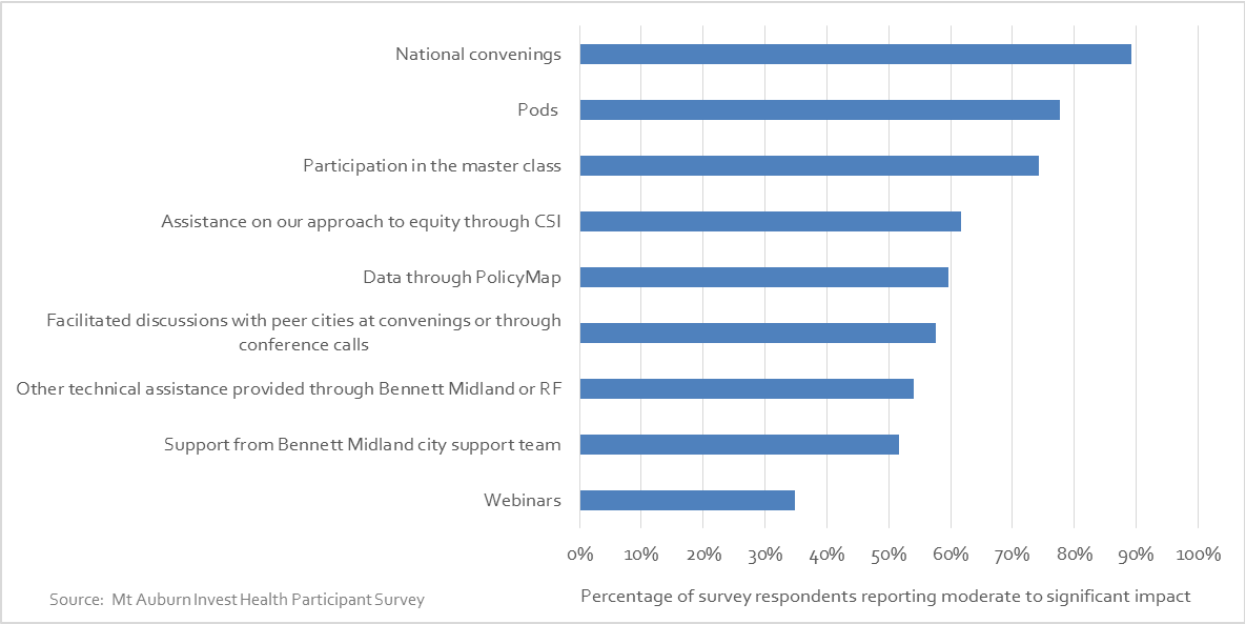
The lack of segmentation also may have hindered the level of potential cross-city networking. Interviews revealed that many cities were unaware of exactly which other cities were working on the same issues or facing the same challenges until the very end of the Initiative. In interviews, a number of the cities in the same state or region noted that they wished they had opportunities to meet as a group. Some of the larger cities indicated that they did not consider the really small cities their "peers," and others thought that they would have developed stronger relationships with other cities if they could more easily identify which cities shared commonalities.

Invest Health interventions

✓ **Overall, team members from the Invest Health cities were very positive about their experience.**

Over 50 percent of those stakeholders who had participated in a specific intervention as part of Invest Health reported that it had moderate to significant impact on the work that their city was undertaking. However, their experiences differed across these various activities. (See Exhibit 8.)

Exhibit 8. Perceptions about how various Invest Health activities impacted team progress



✓ **The travel team members were most positive about the national convenings, valuing most the time for team building, learning from other cities, and some of the content.**

The four national convenings were the foundation of the entire Invest Health initiative. While the basic structures of these convenings were relatively consistent, involving large plenary sessions, breakout sections, workshops that explored various components of the curriculum, and some work time for the teams, each had distinctive elements. (See Exhibit 9.)

Interviews with the travel team provide strong evidence of the impact that the national convenings had on embedding new thinking, helping to strengthen relationships within the team, and inspiring the cities.

Exhibit 9. Overview of the national convenings

	Philadelphia June 7-10, 2016	Denver September 27-30, 2016	Phoenix June 6-9, 2017	New Orleans December 5-7, 2017
Competency Areas	Use of data, data sources, and tools Community Development 101 Social Determinants of Health	Collaboration across sectors Inclusive community engagement Capital absorption and capital investment Using data and tools to measure impact	Equity and inclusion Metrics and target setting Capital absorption and capital investment Leadership to move the work forward Using data and tools to measure impact Communications/storytelling	Sustaining the work Equity and inclusion Capital absorption and capital investment Leadership to move the work forward Using data and tools to measure impact Communications/storytelling
Highlights	Keynote: Dr. Lavisso-Mourey, RWJF, and Annie Donovan, CDFI Fund Keynote: Glenn Harris, Center for Social Inclusion Myer Briggs for teams Reception with Reinvestment Fund and other investors	Pre-convening tour TOD in Westminster Keynote: Tyler Norris TED Talks: Grand Forks, Jackson, Napa, Richmond Success Measures contest Sector-based discussion groups Capital Absorption workshop with Robin Hacke	Optional pre-convening equity training CSI TED Talks: Missoula Choose your own adventure: Workshops Site Visits Moderated discussions with Buffalo, Des Moines, Flint Master classes Give-get exchanges Office hour with RF, Robin Hacke and Burness	Keynote: Jamie Bennett Artplace, Mayor Mitch Landrieu Site visits Workshops: Burness, Racial Equity, CSI, Sustainability Workshops: Working with Developers, Practicing your Pitch, Strategies for Fundraising Master classes Showcase of all sites

✓ **Almost all the cities that participated in the master classes found them valuable and, for some, the guidance was critical in terms of advancing their projects.**

Prior to the Phoenix and New Orleans convenings, all of the cities were offered the opportunity to participate in a "master class," a session where they could present their project to a set of investors and community development experts. About half of the cities took advantage of this opportunity. In most instances, the projects that cities brought to the master class were built environment efforts on which the Invest Health team had already been working. The panelists included representatives of national CDFIs, community investment bankers from national financial institutions such as JPMorgan Chase, lending staff

from RF, and representatives of community-based developers. Each city made a presentation to the panel, which would then ask questions and offer advice on how to advance the project.

Team members who participated in the master class valued the opportunity for a number of reasons. First, having to make the presentation to a panel of experts forced the team to clarify what it was trying to accomplish and why. Second, some noted that having to put together a "pitch" helped their team in terms of communication. Finally, for many, the feedback from the panel, while sobering, also helped to push them in their approach to moving their specific project or projects forward.

✓ **Participants greatly appreciated the consistent focus on equity at convenings and ongoing engagement with the Center for Social Inclusion (CSI), and this appears to have contributed to a stronger equity orientation in many cities.**

Invest Health stakeholders were very positive about their new understanding of equity. The increased understanding is not surprising given the emphasis placed on equity throughout the initiative. Equity was a consistent topic of discussion at every national convening, in most cases presented by CSI, an organization dedicated to crafting and applying strategies and tools to achieve racial equity. The president of CSI, Glenn Harris, was a particular favorite, with many stakeholders describing his talks as the most powerful and memorable of the convenings. CSI presented at every national convening and participated in the Invest Health webinar series. In Phoenix, CSI hosted a six-hour, pre-convening training workshop on racial equity that included a focus on identifying personal biases, recognizing structural racism, and communicating about race and racial inequities in a conscientious, yet powerful, way. This emphasis appears to have resonated for a number of teams, generating changes in mindset as well as emergent system changes. The final Invest Health survey asked participants how convenings had changed their understanding on a variety of topics. Participants particularly noted increased understanding of best practices and strategies to address inequities, the second highest change in understanding just behind their improved understanding of the built environment. In a few cities, increased understanding of equity issues likely contributed to emergent practice changes, although it is not possible to establish a causal link between the curriculum offered at convenings and the changed practices in the cities.

✓ **Those participating in the pods highly valued the opportunity to see work on the ground in other cities and being able to expand the Invest Health experience to home team members in their cities.**

The RF team designed and executed five smaller pod meetings:

- Savannah 1/31/2017: Public Safety
- Roanoke 3/28/2017: Public Private Partnerships
- Akron 5/2/2017: Housing
- Syracuse 9/19/2017: Healthy Food Access and Walkability
- Henderson 10/18/2017: Community Engagement

Overall, about 300 individuals participated in the five pod convenings. While a majority of those were travel team members, 83 individuals representing the "home teams" also attended the events. While some of these individuals were not actively involved in the Invest Health travel team's work, their involvement broadened the engagement of other local leaders in Invest Health.

"I think the pod meetings was one of the best things for me. Just because you got to be there, see it, do site visits, and talk to the people and learn from them about their story and how they kind of made the progress they did. And it was smaller than the national convenings, so a chance to network a little bit more."

"I thought the pods were outstanding, because I thought that you we could see the application of the work in a more meaningful way, like how you actually get the work done."

Almost all of the team members who had attended pod convenings reported that the smaller size and deeper dive into specific issues were very helpful. The more manageable number of teams was important in fostering the cross-team relationships. Site visits also provided inspiration to pod participants, and they often came away with new ideas that they brought home to share with the rest of their team.

- ✓ **The experience with the city support team was mixed; those that were positive reported that interactions with city support staff were important to keeping them "on track."**

City support was the frontline staff interacting with each of the 50 Invest Health cities. They provided a single point of contact for each of the 50 cities, checking in regularly with teams on their progress and connecting teams to subject matter experts or peer cities. City support staff had regularly scheduled calls with their teams, had "office hours," set times where staff would be available for cities to call in to participate and ask questions, and met with and facilitated sessions at national convenings.

The survey results provide evidence that, overall, the city support team was not one of the most highly valued services provided through Invest Health. Some teams highlighted a mismatch between the experience and expertise of the travel team and that of the city support staff. However, in the final interviews, 56 percent of those responding believed the city support team helped to keep them focused, provided a structure for their work, and, for some, provided critical support when addressing challenges in the work.

- ✓ **Webinar participation was not particularly strong and, overall, teams saw this intervention as contributing the least toward the teams' progress.**

Attendance varied, but was generally fairly low on webinars. There was significant variation in the extent to which teams benefitted from the webinar content. When asked in the 2018 Mt. Auburn Participant Survey to rate the contribution of various interventions to team progress, respondents rated webinars as the least impactful intervention.

CONCLUSION

Invest Health was an ambitious and somewhat unique multisite initiative seeking to change systems and to demonstrate tangible results in the built environment in 50 midsize cities across the country. Given the initiative's ambitions and its constraints, there was recognition from the start that the effort was high-risk, the outcomes were somewhat unknown, and there was the expectation of a reasonable rate of failure. In this context, Invest Health successfully made progress across many of the goals set out for the program and achieved additional emergent outcomes not explicitly anticipated at the outset. The most noteworthy results include:

1. **New understanding and capacity of core Invest Health concepts among cross-sector teams in a number of midsize cities.** Some of the more significant gains include a clearer understanding of the intersection between the built environment and health outcomes, a deeper commitment to addressing issues of racial inequity and the tools needed to achieve more equitable outcomes, and a deeper commitment to engaging the community in planning efforts. Many stakeholders without significant previous community development exposure, particularly those from the health sector, developed a deeper understanding of the steps involved in advancing a built environment project. Some in community development gained a deeper appreciation for the connection between their work and health outcomes.

2. **Tangible progress on a built environment project in more than half of the cities**. Given the short timeframe for Invest Health, the number of cities that made moderate to significant progress on both financeable and nonfinanceable built environment projects was a significant accomplishment.
3. **Effective cross-sector collaborative infrastructures in close to half of the cities**. Close to half of the Invest Health teams have built relatively strong collaborative structures and are in a position to advance the work that they began as part of Invest Health.
4. **New and deeper relationships, beyond the specific mission or functions of the team, catalyzed in more than 80 percent of cities.** In interviews with 41 of the 50 teams, stakeholders offered unsolicited information about strengthened relationships across sectors. The new and deeper relationships are leading to collaboration on grant proposals, coordination of services, new collaborative planning efforts, and partnerships on new programs.

There were some areas, however, in which the cities made less progress:

1. **Limited progress on system change.** Given RWJF's articulated goal of advancing a systems approach, it is disappointing that most cities did not focus on the enabling environment and few made even modest progress.
2. **Lack of focus on community investment.** Perhaps even more disappointing given the overall goal of increasing and influencing investments in midsize cities, progress related to community investment was quite limited.

Learning from the most and least successful teams

Looking across the **cities that made the most progress**, a number of themes stand out:

1. **Leveraged prior work.** Many highly successful cities did not start from scratch, but rather built on prior work in their community. Team progress often depended on building on a pre-existing foundation rather than creating a strategy de novo. Previous plans offered a roadmap of strategic priorities and contained ideas that the community had already vetted. In other cases, teams built on the work of other collaboratives that might have already established a vision and desired outcomes, enabling the team to align with or contribute to that vision.
2. **Established clear vision.** Many successful teams established a clear, shared vision of what they were trying to achieve in terms of a health or social determinant of health outcome. The "difference" they were trying to achieve guided their work. The clear vision helped them prioritize their work, focusing on the areas they believed would have the highest impact.
3. **Representation from decision-makers.** Many successful teams included representation from senior leaders, particularly from the city and the anchor institution. Senior leaders from the city or a healthcare organization can shift internal policies, priorities, or resource flows to better align with the teams' desired outcomes.
4. **Involved team members with the expertise needed to advance built environment projects**. Given the focus was on the built environment, it was critical that the team had individuals involved who understood the development process and what it takes to advance a built environment project.
5. **Outreach and engagement beyond the five-person travel team**. Many of the highly successful teams recognized that they could not achieve their goals relying solely on those represented on the travel

team. Above average cities were more likely to build home teams and more likely to significantly engage community residents compared to the low-performing cities.

At the same time, there are common characteristics among the **cities that made the least progress** that offer additional learning for future work:

1. **Unstable teams.** Teams making the least progress almost always had an ineffective collaborative infrastructure. Without effective collaboration, addressing the other goals of Invest Health was a non-starter. These teams were rarely able to settle on a clear vision for what they were trying to accomplish; they often experienced higher rates of turnover; and they frequently had lower engagement with the Invest Health interventions.
2. **Inability to navigate or align this effort with other activities underway in the city.** Many of the Invest Health cities already had other cross-sector initiatives underway, and many even had nationally funded health-related initiatives in progress. While some cities figured out how to build on the prior work, it was common among low-performing cities that the teams struggled to find where they "fit" in the dense landscape. In addition, some cities were unable to assemble the most strategic representation on the team because key stakeholders were already spread thin by serving on other collaboratives.
3. **Overly focused on a single built environment project**. An early attachment to a specific built environment project limited some teams' vision of what they could achieve or prevented them from being nimble when facing setbacks on their project. When teams narrowed quickly to a specific project, such as the reuse of a particular building, they were less likely to take steps to address system change.
4. **Poor timing.** For some of the cities making the least progress, the "moment" does not appear to have been right for the work. In some cases, this could have been anticipated. In other cases, the circumstances were less predictable—changes in political leadership, natural disasters (e.g., the fires in Napa), and unstable market conditions in the case of healthcare institutions, are some of the less foreseeable factors making for poor timing.

Exhibit 10 summarizes the evaluation's primary findings with respect to the factors influencing city progress:

Exhibit 10. Factors influencing city progress

Potential Accelerating Factors	Potential Hindering Factors
Related to Team	
• Having a hospital on the team • Having team members with development expertise • Staffing and administrative capacity for the team • Both decision-makers and boots on the ground engaged through travel or home team • Attention to developing an appropriate home team and keeping them engaged in the work • High-level elected officials or senior executives on the team	• Focusing too broadly on poverty and health inequities vs identifying specific health outcome or SDOH focus • Focusing on one project • Lack of appropriate mix of community development and health stakeholders • Multiple transitions and instability within the travel team
Related to City	
• Time of the work "right" given city political and economic context • Project/pipeline identified as part of broader, pre-existing planning process • Work builds on existing collaborations and working relationships • Location in larger size city with development capacity	• Developing a new table in communities with existing cross-sector work in related areas • Urgent issues or crisis • Political transitions • Unstable market conditions in healthcare institutions • Location in a suburban or non-central city in a large metropolitan region
Related to Intervention	
• Smaller pod convenings with time for cross-team discussions • Facilitating connections among affinity groups • Intensive focus on core concept such as equity and inclusion • Master classes that provide opportunity to present projects to experts • Convenings with informal time, inspirational speakers, and team time • Site visits	• Lack of clarity about initiative expectations and goals • Limited time for initiative planning and theory development • Insufficient segmenting of teams based on capacity and issue focus • Little emphasis on targeting strategic support to floundering teams or cross-sector collaboration challenges • Siloing of team support/TA and content dissemination

Emerging lessons from Invest Health

For cities

1. **Leverage and align with other work.** Spend time before settling on a vision and strategy to understand fully the existing ecosystem of activity related to the built environment and social determinants of health. Think carefully about how to align and leverage existing initiatives, collaboratives, or work of key organizations.

2. **Engage diverse constituencies.** Look 360 degrees from the core team and think about the key constituencies that the team should learn from, engage with, and keep informed. This will likely involve reaching out to decision-makers to get their buy-in and to keep them in the loop during the process, and also will involve engaging residents to shape the vision, inform strategies, and build coalitions to carry the work forward. The home team is one way to engage diverse constituencies.

The home team can also fill gaps in the skills, competencies, and manpower of the core team, allowing the team to carry out its work more effectively.

3. **Include leaders from hospitals on the core team**. Include hospital representatives with sufficient seniority who can align resources to support the planning effort or the broader outcome. The "right" hospital representative might be able to sway hospital policies on data sharing, envision a role in leasing space in a built environment project, or provide investment capital for the project itself.
4. **Do not assume that anyone in the community development sector has development experience**. Search for someone with significant real estate development experience, whether a for-profit or not for profit developer.
5. **Before engaging a community investment partner, carefully consider both the timing of involvement and the expertise the partner brings to the team.** Not all community investment organizations are identical in capacity and expertise. Select a partner with experience on relevant built environment projects. The best partner may not even be a CDFI but perhaps representatives of public or private sources of community finance. Timing of engagement may also be an issue; the evaluation finds that CDFIs tend to be highly transactional and often had limited patience for drawn out planning processes. Teams should seek input and expertise of, but perhaps not engage, investment partners in every stage of the planning process.
6. **Secure the involvement of a city representative with sufficient authority.** Making progress on the complex goals associated with Invest Health requires an individual with the capacity to align city priorities and practices to support the team's vision.
7. **Articulate a compelling vision**. The vision the team articulates matters, and teams need to avoid being too broad or too narrow in focus. Do not try to solve the problems of the world; choose a clear focus such as a social determinant or health outcome, and then assess how various system and built environment levers affect that vision.
8. **Address missing city development capacity.** As part of any early ecosystem scan, consider what capacity the city has or does not have to advance a built environment pipeline. Who are the players in the community investment system? Are there local organizations or developers with the capacity to make progress on an identified pipeline? Are there major challenges in the enabling environment that need to be addressed? Cities need to consider these questions early in the process and strategies for addressing any identified gaps need to be an initial priority.

For the funders and the field

1. **Particularly in midsize cities, do not overburden the ecosystem of civic-minded public, private, and nonprofit organizations with new partnerships—incentivize communities to build on what is there**. Given the multitude of local, state, and national efforts targeting upstream social determinants of health, communities being considered for a multisite initiative should be asked in the selection phase to identify what other collaboratives previously or currently exist that may overlap with their focus. Funders should be aware of the existing collaboratives when making funding decisions and consider when a new initiative could represent a tipping point in overwhelming the existing ecosystem.
2. **Recognize the importance communities see in upgrading public amenities and physical infrastructure.** While Invest Health encouraged teams to explore financeable built environment projects, teams often saw more direct connections between the health disparities they identified and

substandard infrastructure and amenities that discouraged walking or other forms of exercise. Resident engagement often reinforced the priority on amenities and infrastructure.

3. **Address the capacity gaps that can impede a built environment response to improve health and well-being.** For some Invest Health teams, the lack of a local mission-oriented developer and local sources for community investment, a key element of the development infrastructure, hampered their ability to act on opportunities identified through the initiative. Funders and the field may want to be more deliberate about conducting a baseline assessment in the targeted midsize cities and develop approaches to intentionally address missing capacity with particular consideration to the role of national CDFIs, larger regional, state, or national development entities, and nonprofit developers.
4. **Take the time to hash out a theory of change for a complex multisite initiative**. Develop a clear and realistic articulation of what an initiative intends to achieve and ensure that all stakeholders—the city teams, the program team, and the funder—share that understanding of what success looks like. Seek stronger synergy between learning content, convening, planning, coaching, and technical assistance to ensure that each initiative component aligns with the theory of change and complements the other components in achieving the stated goal.
5. **Develop a common "lexicon" for key terms used and ensure that cities and all program staff have a shared understanding.** Terms such as "systems," "enabling environment," "pipeline," "community investment system," and "built environment project" could mean many different things to participants and to the staff implementing an initiative. When designing and implementing a multisite initiative, it is particularly important to ensure that all of those involved understand how the initiative is defining the terms.
6. **Build teams' understanding and competency to apply a system lens to their work**. If an initiative goal focuses on *system* change, it is important to spend time building the capacity of teams to apply a system lens and to understand what the levers are for system change. This is a complex concept that is often difficult to grasp, particularly for stakeholders who have been very transactional or program focused in the past.
7. **Ensure that a champion exists within each team.** Teams seemed to function best when there was a champion or leader able to think strategically about team composition and stakeholder engagement, to identify opportunities for strategic alignment with other work in the community, and to feel a deeper sense of ownership for team progress.

As Invest Health enters its next stage, there remains considerable potential. Many of the cities are committed to continuing to work on the vision developed through Invest Health. After only 18 months, it is difficult to assess fully how the changes in mindset, the relationships developed, and the capacities that they have built will contribute to advancements in community well-being and equity. There is evidence, however, that seeds have been planted in many midsize cities that have rarely received this type of national philanthropic attention.