NORTH CAROLINA HEALTHCARE FOUNDATION

Social Impact Playbook

Social Impact Playbook:
A guide for addressing non-medical drivers of health and driving systems change.

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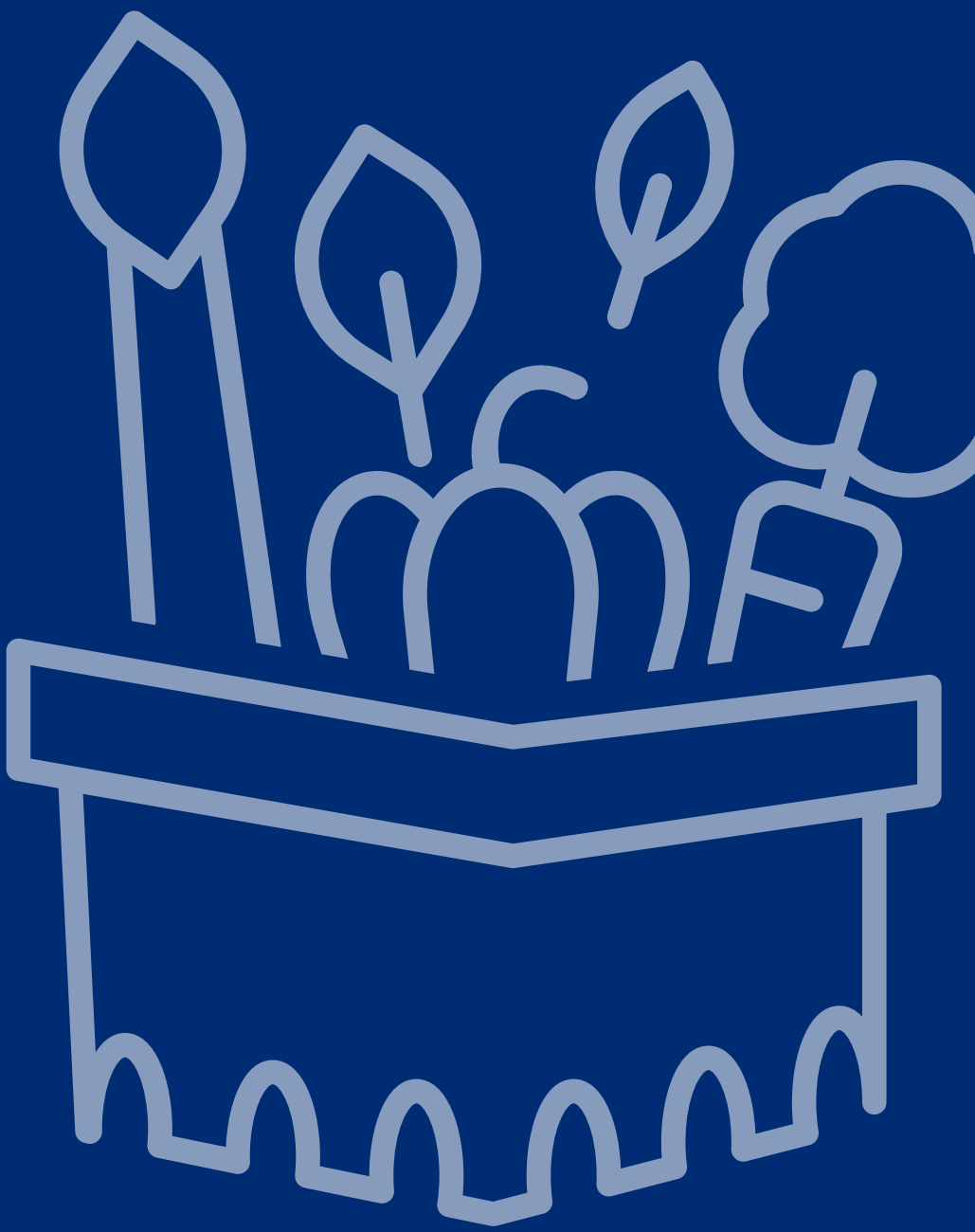

PREFACE

A Message from NCHF

At the North Carolina Healthcare Foundation (NCHF), we believe that lasting change begins with connection and shared purpose. As the charitable, nonprofit arm of the North Carolina Healthcare Association (NCHA), our mission is to strengthen the health of our communities by bringing hospitals, health systems and community partners, together to tackle the challenges that influence health across our state.

Our work is rooted in partnership and guided by the understanding that meaningful transformation must come from the community itself. From idea to implementation, we focus on what works - practical, collaborative approaches that improve lives and strengthen systems for the long term.

We often ask ourselves a simple yet powerful question: if systems produce unfavorable results, who designed them, and who should be part of redesigning them? We are committed to widening that circle. By working alongside hospitals and community partners, we are helping to rethink the practices that create barriers to good health, especially for those most affected.

This Social Impact Playbook is an invitation to join us in that work. Social impact is about creating lasting, positive change in people's lives by improving conditions, expanding access, and building resilience through collective efforts. It reflects our shared responsibility to ensure every North Carolinian has the opportunity to live a healthy and fulfilling life.

With support from the Kate B. Reynolds Charitable Trust, NCHF is developing a model to help hospitals, health systems, and community partners co-design solutions that address local priorities. In rural Robeson County, we have launched a pilot focused on removing barriers tied to the social determinants of health, one of the most persistent challenges to better health outcomes. This work is grounded in trust, shared leadership, and a belief that communities know what they need to thrive.

Our goal is to create and share a framework that others can adapt - one that centers community voices, aligns resources, and supports sustainable change. This Playbook captures that approach, offering tools, insights, and lessons that can help strengthen your own efforts to create social impact.

Whether you represent a health system, a nonprofit, or a community organization, your leadership matters. Together, we can build healthier, more resilient communities across North Carolina.

With appreciation,

LaPonda Edmondson, DrPH, MHS
President, North Carolina Healthcare Foundation
Senior Vice President, North Carolina Healthcare Association

Acknowledgments

Acknowledgement of support to KBR:

The North Carolina Healthcare Foundation (NCHF) extends our deepest gratitude to the Kate B. Reynolds Charitable Trust for their generous support of our Social Impact Program. Their investment has made it possible for us to expand our reach and deepen our impact in Robeson County—supporting both new and existing efforts that address the non-medical drivers of health.

We are honored to be recognized by the Trust as a partner in advancing social impact work across North Carolina. Their support empowers us to advance sustainable, community-driven solutions and build a healthier future that benefits everyone. Through this partnership, we are proud to unveil the **Social Impact Playbook**—a resource designed to guide and inspire individuals and organizations embarking on their own social impact journeys. This work would not be possible without KBR's continued trust and commitment.

Acknowledgement of NCHF:

We would also like to extend heartfelt appreciation to the incredible team at the North Carolina Healthcare Foundation whose vision, leadership, and collaboration laid the foundation for this work. This playbook would not exist without the input, expertise, and dedication of the individuals who helped shape it from the very beginning.

A special thank you to **Marissa Franks** (Sr. Program Manager, Clinical Implementation), **Shakeerah McCoy** (Director, Rural Health Innovation), **Emily Roland** (Executive Director, Program Implementation), **Trish Vandersea** (Director, Performance Improvement and Population Health), **LaPonda Edmondson** (President, NCHF; SVP, NCHA), **Miriam Tardiff-Douglin** (Associate Director, Program Evaluation), **Shannon Twist** (Implementation Research Analyst), and **Jamie Wildgoose** (Program Manager, Social Impact).

Each of you has served as a guiding North Star throughout this journey, helping to turn an idea into a tangible resource with the potential to catalyze meaningful change.

Your insight, creativity, and dedication have made this work stronger and more impactful. We are deeply grateful for your contributions and proud to carry this vision forward together.

Acknowledgement of support to partners:

We extend our sincere appreciation to **Bart Grimes** (Chief of Behavioral Health at Robeson Health Care Corporation), **Nancy Hunt** (Grant Facilitator at Southern Carolina Housing), and **Bridgett Pierce** (Manager, Transitions of Care at Scotland Memorial Foundation) for allowing us to feature your organizations and projects in this **Social Impact Playbook**—and for being part of the inaugural round of funding through our program.

Your willingness to share your work has allowed us to truly explore how our program supports grantees through technical assistance and how the tools provided have impacted project outcomes. It has also given us valuable insight into challenges encountered along the way, helping NCHF refine how we can better serve and strengthen community-driven efforts moving forward. We are deeply grateful for your partnership and commitment to creating lasting, local impact.

Acknowledgement to Do Tank:

Finally, we are immensely grateful to our external partner, **Do Tank**, whose expertise in **Human-Centered Design** was instrumental in shaping the playbook's structure and content.

Do Tank's ability to quickly align with NCHF's mission and brand, while fostering thoughtful, respectful dialogue that welcomes a range of perspectives, ensured this resource reflects both the values and goals of our organization.

Together, through partnership, expertise, and shared purpose, we are proud to offer a tool that we hope will empower communities across North Carolina.

Playbook Background

The Kate B. Reynolds Charitable Trust and North Carolina Healthcare Foundation supported a suite of transportation-focused pilot projects in Robeson County to tackle barriers to healthcare, food access, employment, and behavioral health services. These initiatives deployed innovative models—including mobile markets, stigma-free ride services, and community health transportation—directly to underserved populations. By convening local health systems, nonprofits, and community groups, the program advanced shared accountability for making transit more accessible. These pilots are the first step towards sustainable systems-level change in transportation access throughout rural North Carolina.

This playbook is an extension of the work that has begun in Robeson County, and it serves two purposes. First, it presents a replicable framework for approaching social impact initiatives, developed through work in Robeson County. While grounded in that specific experience, the framework is designed to be adaptable and applicable to a wide range of social impact efforts across North Carolina. Second, it highlights the achievements of the Robeson County Community Development Team and the five pilot sites. Their progress offers practical, real-world examples to inspire and guide other communities interested in launching their own social impact initiatives.

Playbook Audience

The target audience for this playbook includes all entities interested in social impact, systems-level change, and how to make it happen across their communities. This includes hospitals and health systems, community-based organizations, existing community development teams or similar groups, funding organizations, and community members at large. Our inclusive approach is designed to ensure community-based programs are relevant, impactful, and built on trust and long-term commitment.

Playbook Focus

Social impact in healthcare is about making a positive difference in communities by addressing non-medical drivers of health and improving the well-being and quality of life of individuals. This involves implementing policies, programs, services, and interventions that extend beyond the hospital setting. By fostering collaboration between healthcare, public health, and community organizations, social impact seeks to create sustainable solutions that improve health outcomes and contribute to a healthier, more resilient society.

Social impact through a hospital lens: Social impact in regards to healthcare is moving beyond hospital walls to ensure certain health issues are addressed outside of clinical care to ensure a healthy life.

Social impact through a community lens: Making a positive difference in social conditions, such as improving health, education, economic opportunities, or the environment.

Social impact and systems-level change: Shifting structures, policies, practices, and norms that are holding an issue in place through cross sector collaboration that are needed to ensure sustained social impact.

Topics Addressed in this Playbook

Social Impact	• Elevating social impact as the pivotal force for enhancing community well-being.
Community Engagement	• Recognizing that the community *IS* the soul of all social impact initiatives.
Community Development Teams	• Positioning community development teams as the vital link bridging community needs and systemic solutions.
Pilot Partners	• Empowering sites to serve as catalysts for transformative change within their community.
Critical Success Factors	• Utilizing a shared framework to guide social impact actions.
ROI Storytelling	• Employing compelling narratives to secure additional funding and foster long-term sustainability.

Playbook Tools

Design thinking visual tools (called canvases) help communities structure complex social challenges in a clear, collaborative way. These tools make abstract ideas more tangible, enabling teams to align on goals, map stakeholders, and identify key opportunities for impact. By guiding conversations and decision-making, canvases foster inclusive participation and drive more strategic, human-centered solutions.

This playbook consists of a collection of visual canvas tools. They are introduced in the playbook and can be easily downloaded here:

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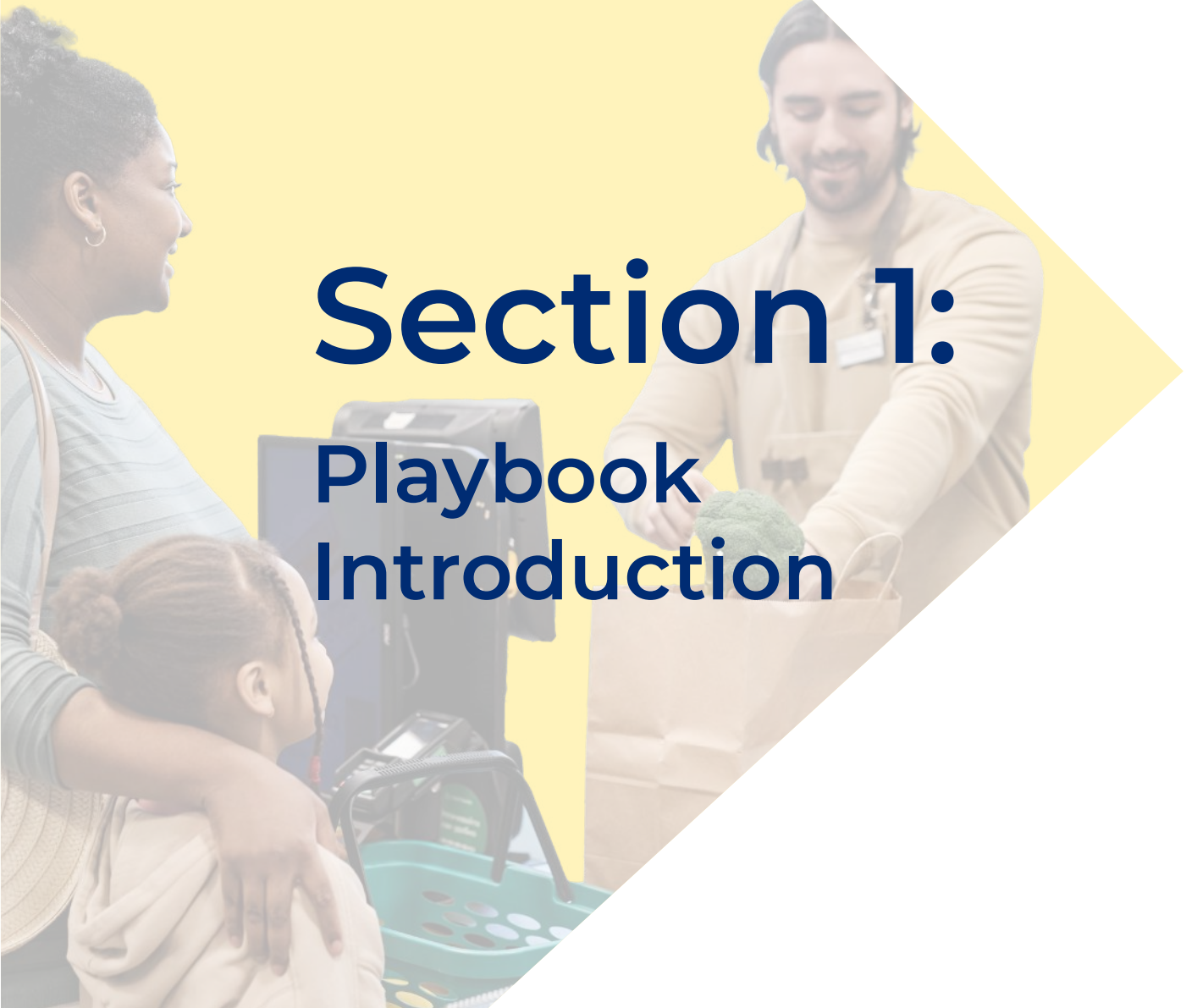


Section 1:

Playbook Introduction

1A. An Overview of Social Impact and Systems Level Change

Focus on social impact in healthcare is growing because it is seen as a way to address many of the non-medical factors that influence health outcomes. One of the key lessons that we have learned over the past two decades is that non-medical factors (such as environment and lifestyle) influence around 40% of health outcomes (and costs), and that more than 80% of health is determined by what happens outside of the doctor's office. Or, put another way, our current care-delivery system is reactive (focusing on sick care rather than health) and is expensive. As a result, hospitals are increasingly building partnerships with community organizations to enhance health and well-being and focusing on social impact.

Diving into social impact means that organizations begin to examine the influence that policies, programs, services, and interventions have on the overall well-being and quality of life within the communities they serve. This, in turn, informs holistic strategies for improving health beyond hospital walls.

Social impact initiatives encourage health systems to partner with their communities to develop solutions that transform the availability of resources at a systems level. This collaborative approach is driven by the recognition that many community organizations are also attempting to address similar issues and are likely serving overlapping populations. By working together, clinical and community-based organizations can align efforts, reduce duplication, optimize financial resources, and more effectively improve community health. Given their size, it may seem logical for health systems to lead social impact initiatives. However, lasting success requires meaningful participation from all stakeholders—healthcare, public health, community services, and the greater community itself.

Social Impact Defined

Making a positive difference in social conditions, such as improving health, education, economic opportunities, or the environment.

But social impact without systems change is like watering a plant with no roots. To grow anything lasting, we need to reshape how decisions get made, who holds the pen, and what values are built into the blueprints.

Connecting Social Impact and Systems-Level Change

Social impact without systems change can lead to isolated successes that are difficult to sustain or replicate. Conversely, systems-level change without a grounding in real community needs may result in policy shifts that are disconnected from on-the-ground realities. Lasting change happens when people work together, fueling a cycle of innovation, collaboration, and continuous improvement.

Aligning Pilots to Policy Change: Social impact initiatives often begin as pilot projects targeting specific populations or issues. When successful, these pilots provide the evidence base and momentum needed to advocate for systems-level reforms—such as changes in funding structures, regulatory adjustments, or statewide mandates—that scale and sustain the impact.

Shifting Power and Governance: One of the deepest connections between social impact and systems change lies in governance. Social impact initiatives that elevate the voices of marginalized communities lay the groundwork for systems-level reforms that embed community representation in decision-making bodies, ensuring long-term accountability to those most affected.

Building the Engine of Integrated Change: Community development teams are the critical link between social impact initiatives and systems-level transformation. These groups bring together diverse stakeholders—hospitals, public health agencies, housing authorities, schools, faith-based groups, businesses, and residents—who collectively design, implement, and sustain integrated solutions.

Keeping Community at the Core

Human-centered design (HCD) offers a transformative approach to social impact initiatives and systems-level change by centering on the lived experiences of those most impacted by systemic challenges. HCD engages deeply with people to uncover root causes of complex problems. Teams gain a real world understanding of how systems function in practice versus on paper. This unyielding focus on problem exploration ensures that interventions address underlying structural barriers, making change more sustainable and impactful across a community.

This playbook uses HCD-based canvas tools designed to welcome a wide range of perspectives and promote deeper understanding. By using these tools, stakeholders from across sectors can work together to analyze the system, identify overlooked areas, and align around common goals. And, done right, their use will also ensure that the pilot programs address not just symptoms but also the structural roots of social challenges.

1B. The Importance of a Community Development Team

What is a community development team? A community development team is a group of (1) established businesses, charitable organizations, and other influencers that have a vested interest in social impact; (2) grass roots organizations that are embedded within community, and (3) community members themselves. Think of them as the architects of local transformation. These teams bring together the usual suspects—healthcare systems, nonprofits, local government—but also the vital voices that are too often left out: neighborhood organizers, faith leaders, small business owners, and residents with lived experience. Together, they form a kind of civic brain trust—each voice adding dimension, texture, and relevance to the work.

At first glance, a community development team may seem an unnecessary layer between funders and social impact pilot sites. However, for complex social issues such as food insecurity, homelessness, transportation (as examples), the coordinated participation of multiple organizations is needed to address the multi-faceted nature of the challenge.

Community development teams can accomplish objectives beyond the scope of any single organization, especially when the goal is systems-level change.

They can improve efficiency by streamlining activities, reducing duplicative efforts, and achieving more widespread reach within a community. By acting together, they have more power which can help open doors to initial funding and lasting financial sustainability. They can also be a stronger advocacy voice to affect policy that drives systems-level change.

Key Functions of a Community Development Team

As mentioned on the previous page, community development teams play a vital role in advancing systems-level change by bringing together partners from various backgrounds to address complex challenges that no single group can solve alone. They act as the glue that holds together efforts across a fragmented system, aligning different players toward shared goals and ensuring that the voices of those most affected are included in shaping solutions. Specific functions include:

- **Conveners:** Unite different sectors and populations around a common vision for change.
- **Bridge Builders:** Connect healthcare systems to social services, education, housing, and faith groups.
- **Advocates:** Push for policy changes that address upstream determinants of health (poverty, racism, or access).
- **Problem Solvers:** Identify local root causes and co-create solutions based on lived experience and evidence.
- **Accountability Agents:** Monitor progress, push for transparency, and ensure systemic reforms benefit all communities.
- **Amplifiers of Voice:** Lift up the perspectives of marginalized or historically excluded groups to influence systems design.
- **Sustainability Drivers:** Help build models that last beyond grant cycles by embedding changes into practice, policy, and funding streams.

The Need for a Community Development Team

Without a community development team, social impact initiatives will take longer to reach their full potential. Challenges/risks facing social impact initiatives without a community development team in place include:

Fragmented Efforts	Without a community development team to coordinate stakeholders, efforts often become scattered. Different organizations might duplicate work, pursue conflicting strategies, or miss opportunities for synergy, reducing overall impact.
Limited Legitimacy	Community members and key institutions may view initiatives as outsider-driven or top-down. Without a trusted group representing local voices, there is often skepticism, resistance, or apathy toward the change effort.
Gaps in Representation	Underrepresented groups within key populations may not have the opportunity to take part in planning and decision-making. As a result, solutions could miss root causes and community needs, which undermines both the sustainability and overall effectiveness of the impact.
Weaker Resource Mobilization	Community development teams help pool resources (funding, expertise, relationships). Otherwise, initiatives may struggle to secure the broad support, human resources, or money needed for large-scale, systemic change.
Slower or Stalled Progress	Systems-level change is complex and requires coordinated action across sectors. Without a community development team aligning players, bureaucratic inertia, siloed thinking, and misaligned incentives can stall progress.
Reduced Adaptability and Learning	A good community development team creates mechanisms for feedback and course correction based on community input. Without it, initiatives risk staying rigid, disconnected from on-the-ground realities, and failing to adjust as conditions change.
Failure to Sustain Change	Even if an initiative gets initial traction, without a local group to steward and institutionalize the change, improvements often fade once initial funding or leadership energy wanes.

1C. Social Impact Critical Success Factors

For social impact to be successful, funding organizations, community development teams, and pilot partners need a shared framework that outlines key activities and the critical success factors associated with them. The critical success factors are summarized here and drilled into more deeply in subsequent sections of the playbook.

Critical Success Factors

Building Infrastructure

#1. Community Engagement Plan: Success requires collaboration between healthcare providers, community-based organizations, government agencies, and the community itself. This step is focused on developing and executing a community collaboration plan to seek input to validate assumptions of the scope of the challenge and/or need and to solicit on-going feedback and gather impact insights.

#2. Alignment on Vision, Objectives, and Goals: When preparing to embark on social impact initiatives, it is important to acknowledge that different stakeholders within organizations and across communities come to an opportunity with varied lived experiences and different views of the opportunity. This step of the strategic framework ensures that all key stakeholders are aligned on the magnitude of the challenge, the potential for impact, and the value of the solution.

#3. Effective Governance: Governance models will vary depending on the complexity and duration of initiatives. At a minimum, a core team needs to be assembled and 'rules of engagement', roles/responsibilities, and participation expectations need to be outlined.

Taking Action

#4. Initiative and Selection: Most social impact initiatives start small and then scale once early success is demonstrated. This step in the framework focuses on developing a gameplan for initial launch (with process-oriented success metrics).

#5. Evaluation and Impact Measurement: Impact will be defined differently by different stakeholders. As such, effective impact measurement requires an understanding of what matters to whom.

Changing Communities

#6. Sustainable Funding: If initial launch provides favorable results, then focusing on sustainability comes next. 'Where next', 'how much,' and 'who can help us' are vital considerations as one plans for scaling and for long term sustainability.

#7. Communication and Storytelling: Making 'noise' about success is essential for maximizing impact and for driving change. This final step of the strategic framework provides guidance on how to make noise locally and how to effectively advocate for policy change.

Section 2:

Engaging Community

2A. The Role of the Community in Community Development Teams

If a community development team doesn't include the community, then it's missing its soul. Involving community members in community development teams is essential because they bring invaluable local knowledge and lived experiences. They understand the challenges, needs, and opportunities within their communities far better than external stakeholders. This ensures that any proposed solutions are relevant, culturally sensitive, and reflect the actual priorities of those most affected. Without this input, interventions risk being ineffective, inappropriate, or even harmful.

Additionally, meaningful involvement of community members fosters trust, legitimacy, and shared ownership. When communities see that their voices are respected and integrated into decision-making processes, they are more likely to engage. This collaborative approach not only strengthens social bonds but also empowers communities to take leadership roles in addressing their own challenges, contributing to more sustainable and long-lasting, systems-level change.

Including community members also promotes accountability and innovation within community development teams. Community participation ensures that organizations remain transparent and focused on real community needs, while also opening doors to creative, locally-driven solutions that outsiders might overlook. By centering community voices, community development teams can develop social impact strategies that truly make a difference.

2B. Approaches for Capturing Community Voice

Community voice refers to the active participation and inclusion of the affected communities in the decision-making processes regarding investments and initiatives. It emphasizes that those who are directly impacted by social issues (such as poverty, healthcare access, education, etc.) should have a say in how resources are allocated and how solutions are developed.

CONTINUUM OF COMMUNITY VOICE IN SYSTEMS-LEVEL CHANGE*

Community voice in systems-level change operates along a continuum of engagement, influence, and power. The most basic level is consultation, where community members offer opinions, experiences, and feedback via surveys, town halls, focus groups, or meetings. While this yields valuable data, the community's role remains passive. However, their input, reflecting lived experiences, is crucial for informing and guiding new social impact initiatives and should be incorporated into final decisions.

Moving beyond consultation, participation involves deeper engagement. Community members serve on advisory groups, steering committees, or working groups, contributing ideas, and shaping initiatives or policies. Nevertheless, significant decision-making authority typically rests with organizations or institutional leaders at this level.

The next step on the continuum is partnership or co-design, where community members are engaged as equal partners throughout the entire process—from identifying issues and designing solutions to implementing and evaluating initiatives. This stage is characterized by shared decision-making, mutual respect, and the recognition of community expertise as vital to the success of systems change efforts. Finally, at the highest end of the continuum is leadership or ownership, where community members lead the change themselves. In this stage, they set priorities, design strategies, make decisions, and advocate for systemic reforms, with institutions playing supportive or ally roles. This level of engagement ensures that those most affected by systemic issues have direct control over the processes and outcomes, fostering fairness by promoting long term, impactful systems change.

* The Spectrum of Community Engagement to Community Ownership, Credit: Rosa Gonzalez and Movement Strategy Center, 2019.

Levels of Community Engagement within Community Development Teams

Most community development teams will begin with community engagement that is a blend of consultation and participation. Over time, the goal is to expand engagement to partnership and ultimately leadership.

Level of Engagement	Description	Typical Roles
Consultation	Community members are asked for feedback; minimal influence on decisions.	Survey respondents, focus group participants, attendees at town halls.
Participation	Community members contribute through committees or task forces; some influence but limited decision-making authority.	Community development team members, working group participants, community liaisons.
Partnership/Co-Design	Community members collaborate as equal partners; shared power and co-creation of solutions.	Co-creators, decision-makers, project co-leads, joint evaluators.
Leadership/Ownership	Community members lead initiatives and decision-making processes; institutions play a supportive role.	Community development team backbone responsibilities.

2C. Critical Success Factor #1: Community Engagement Plan

Success requires collaboration between healthcare providers, community-based organizations, government agencies, and the community itself. This step is focused on developing and executing a community collaboration plan to seek input to validate assumptions of the scope of the challenge and/or need to solicit on-going feedback and gather impact insights.

Actions

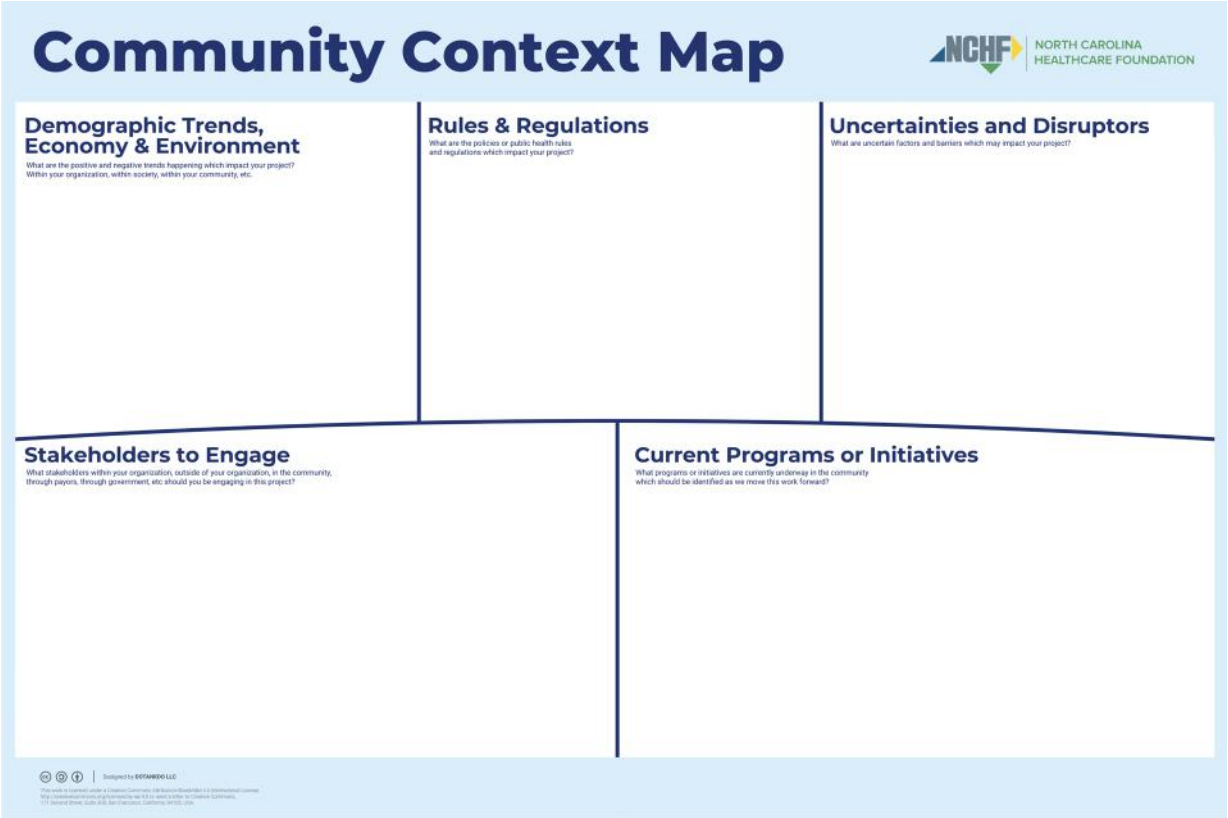
- Engage community in problem validation and solution design. Develops engine for on-going feedback.
- Engage community to broadly understand root causes of challenges impacting community health and/or hospital utilization.

Tools

- **Community Context Map Canvas:** to understand gaps and opportunities within a community.
- **Empathy Map Canvas:** to understand community members themselves.
- **Community Stakeholder Plan Canvas:** to identify community influencers.

TOOL Community Context Map Canvas

USE CASE(S): UNDERSTAND GAPS AND OPPORTUNITIES WITHIN A COMMUNITY



The Community Context Map helps communities explore the broader ecosystem surrounding a challenge or opportunity. It is a platform for community members to share their lived experiences, knowledge, and insights about the various forces, stakeholders, policies, technologies, and cultural factors that shape their environment.

By engaging the community directly in the mapping process, participants work together to identify and discuss key influences that impact their daily lives and the systems they interact with. This approach ensures that the map reflects the realities, priorities, and nuances of the community itself, rather than assumptions made by outsiders.

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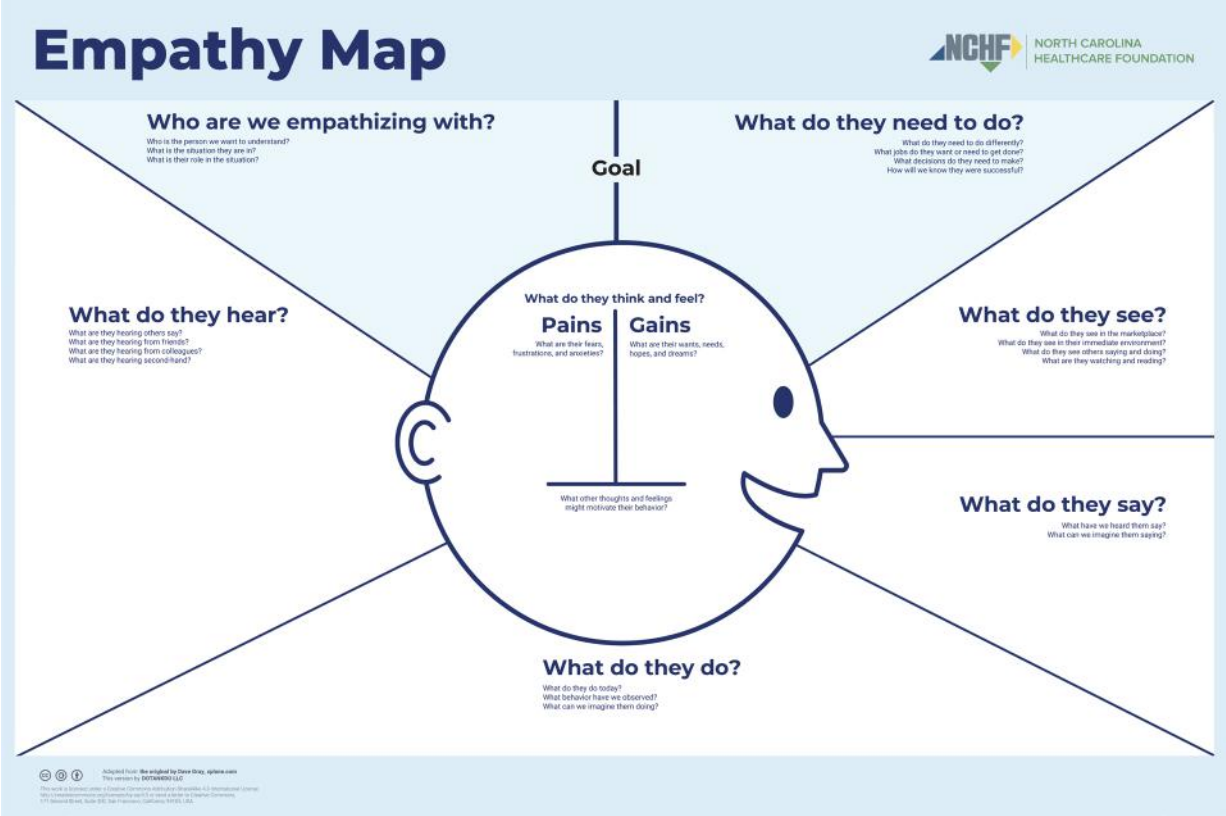
TOOL Empathy Map Canvas

USE CASE(S): UNDERSTANDING OF COMMUNITY MEMBERS THEMSELVES



The Empathy Map is used by community development teams to deeply understand the feelings, needs, challenges, and motivations of the people they aim to serve. When used with community members, the Empathy Map becomes more than just a research tool—it becomes a shared space for listening, storytelling, and reflection.

It allows the community development team to explore what community members see, hear, think, feel, say, and do in relation to a specific issue or experience. By collectively filling out the map, participants can surface insights about people's hopes, fears, pain points, and daily realities, which may often go unspoken. This approach helps ensure that planning and actions are grounded in real, lived experiences rather than assumptions or external agendas.

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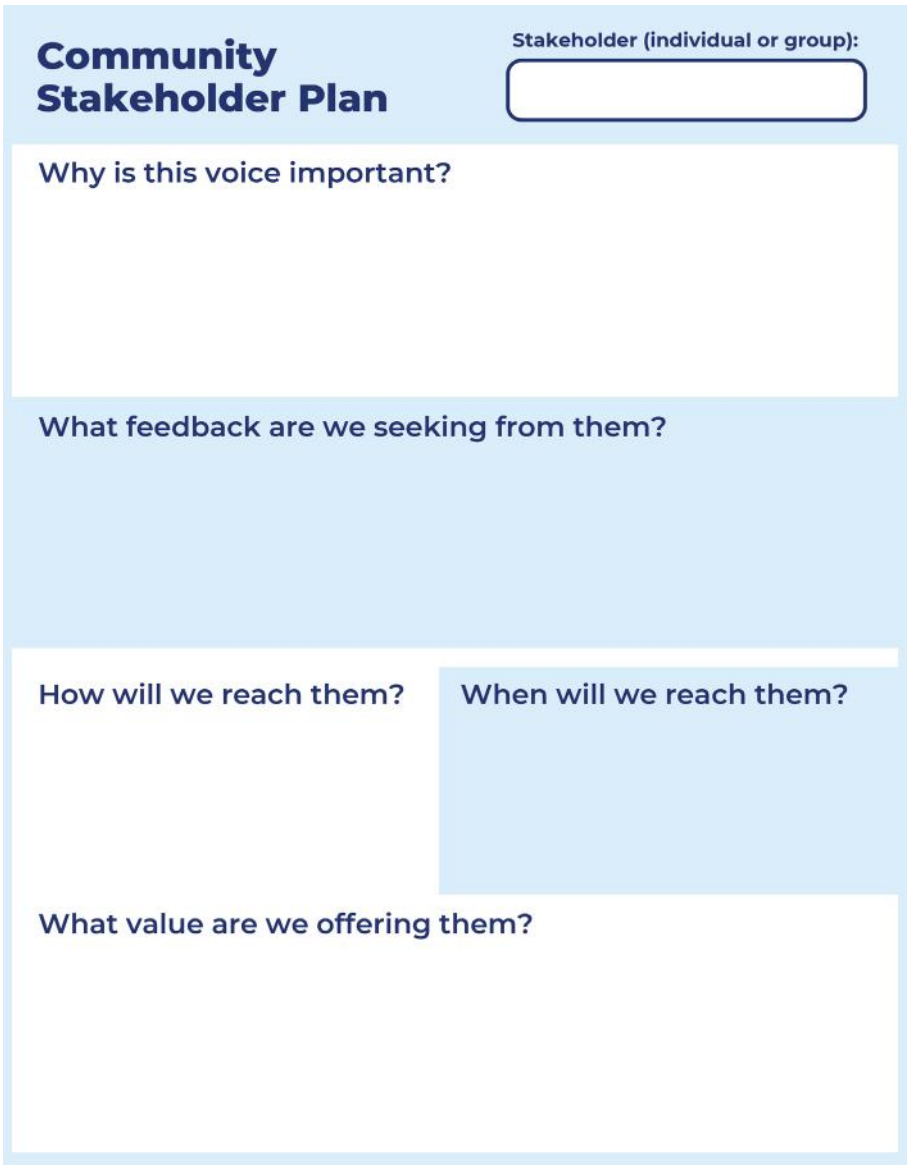
TOOL Community Stakeholder Plan Canvas

USE CASE(S): IDENTIFYING COMMUNITY INFLUENCERS



The Community Stakeholder Plan is used by existing community development teams to add/adjust their membership and/or for new community development teams who are starting the process of considering who should be part of that team (more detail on this in Section #3). The Community Stakeholder Map delves deeply into the key players, alignment, and the value that potential members could bring to the table.

The community stakeholder plan should also link to the continuum of representation described earlier in this section.

ACCESS TOOL HERE

Section 3:

Building or Leveraging Community Development Teams

3A. Composition of Community Development Teams

When it comes to driving real change, who's at the table matters just as much as what is on the agenda. Community development teams aren't just collections of people. They are a nexus of power, purpose, and perspective. Think of them as the connective tissue between community need and systemic action.

Don't rush to build something new if you don't have to. Look around. Are there already groups doing the work—collaboratives, alliances, task forces—who have been working on social impact issues? Start there. Honor what already exists. Strengthen it; don't steamroll it. Once you determine that you need to build or expand a team, ask: who must be here to see the whole picture?

WHO BELONGS AT THE TABLE?

The heavy lifters: Health systems, housing authorities, schools, public health agencies—people who move dollars, data, and decisions.

The heart of the community: Faith leaders, grassroots organizers, local businesses, and advocates.

The people most impacted: Not token reps, but real leaders with lived experience, trust, and perspective.

The resource engines: Funders, investors, policy makers, and anyone who can fuel scale and sustainability.

In addition to identifying potential organizations and individuals to provide multiple perspectives, it is also important that organizations have complementary skills. For example, if several seats are filled by people who are strong in advocacy, but no one is gifted in effectively using data, then the group will be sub-optimal in its ability to showcase impact and/or systems-level change.

To aid with the selection of members, it is good to know specific details about an organization. Either through an external assessment or a self-assessment that is provided to an organization, digging deeper into strategic and operational characteristics of potential members is important.

POTENTIAL ORGANIZATION TYPES TO CONSIDER:

	Category	Examples	Role
VESTED COMMUNITY ORGANIZATIONS	Large community organizations	Social service organizations, food banks, park services, homeless shelters, housing, and transportation authorities	Share insights on priorities and provide resources (and possibly funding) that can help produce the biggest impact
	Educational organizations	Early childhood centers, primary, secondary, and post-secondary schools	Serve as an access point for services that impact both children and adults
	Faith-based organizations	Temples, churches, and/or other spiritual congregations	Serve as a trust-creating partner within communities
	Government	Local, state or federal agencies, prisons, fire/police departments, and libraries	Aid with operationalization, potentially funding, and/or regulatory guidance
	Local businesses	Chambers of commerce, grocery stores, restaurants, and manufacturing organizations	Serve as funders and operationalization partners
	Public health organizations	Public health departments, foundations, and institutes	Provide essential data to aid with impact demonstration
	Large service organizations	Lions, Rotary, United Ways, YMCAs, and Boys and Girls clubs	Serve as an access point for services that impact both children and adults
	Healthcare organizations	Hospitals in the community, FQHCs, community health centers, rural or free clinics, mental health organizations, pharmacies, walk-in clinics, professional associations, and state hospital associations	Serve as access/ engagement points
	Investment community	Philanthropic organizations, insurance companies, banks, community development orgs, social impact investors, and government associations	Provide economic fuel
GRASS ROOTS ORGANIZATIONS	Small community organizations	Social service organizations, food banks, park services, homeless shelters, housing, and transportation authorities	Share insights on priorities that can help produce the biggest impact
	Advocacy organizations	Social justice, patient advocacy, and other groups	Share insights on priorities that can help produce the biggest impact
COMMUNITY ITSELF	Community members	Intended beneficiaries	Ensure that initiatives are responsive to community needs, aspirations, and priorities

3B. The Importance for a Backbone

Big ideas are exciting. Coordinating them? That's the hard part. That's why every strong community development team needs a backbone—someone (or a group of someones) who can hold the center when things get messy, as they always do.

That's why community benefits from identifying or understanding the concept of a backbone. The job of a backbone is to maintain focus and direction on the collective strategy and aid with closing the strategy-to-execution gap. Backbones serve as coordinating bodies that bring stakeholders together and lead a synchronized effort to achieve a common goal.

Backbone Responsibilities:

- Lead partnership development to build out the community development team.
- Manage the governance structure.
- Guide vision and strategy development.
- Oversee multiple work groups that could include data and metrics work groups, community engagement work groups, sustainability and financing workgroups and a portfolio of interventions workgroups.

Historically, the backbone function has been played by a single institution within a community development team, and has served as the autonomic "nervous system" that carries the signals generated by the "brain (strategy)" to the "arms and legs (implementation)". It has acted as an administrative centerpiece and convening body for the other collaborative members.

Centralized Backbone:
A community partnership where a single organization serves as a centralized backbone (fiscal agent) and fulfills most of the functions of operational management and stakeholder engagement to achieve well-defined goals.

Blended Backbone:
A community partnership where the functions of a backbone are delegated to multiple organizations who are then responsible for the management of specific partnership tasks and driving towards specific outcomes.

Today, research exists to push beyond the notion that a backbone function needs to be played by a single organization. In fact, it is now more common to think of the backbone not as one single entity, but as a function, in which various partners, organizations, or committees can play a role in fulfilling.

Viewing the backbone as a function rather than an entity, allows for more flexibility in the way a specific community supports the operational work. Regardless of how the backbone function is realized, it is important that authority and power do not solely lie within one organization.

3C. Critical Success Factor #2: Alignment on Vision, Objectives, and Goals

When preparing to embark on social impact initiatives, it is important to acknowledge that different stakeholders within organizations and across communities come to an opportunity with varied lived experiences and different views of the opportunity. This step of the strategic framework ensures that all key stakeholders are aligned on the magnitude of the challenge, the potential for impact, and the value of the solution.

Actions

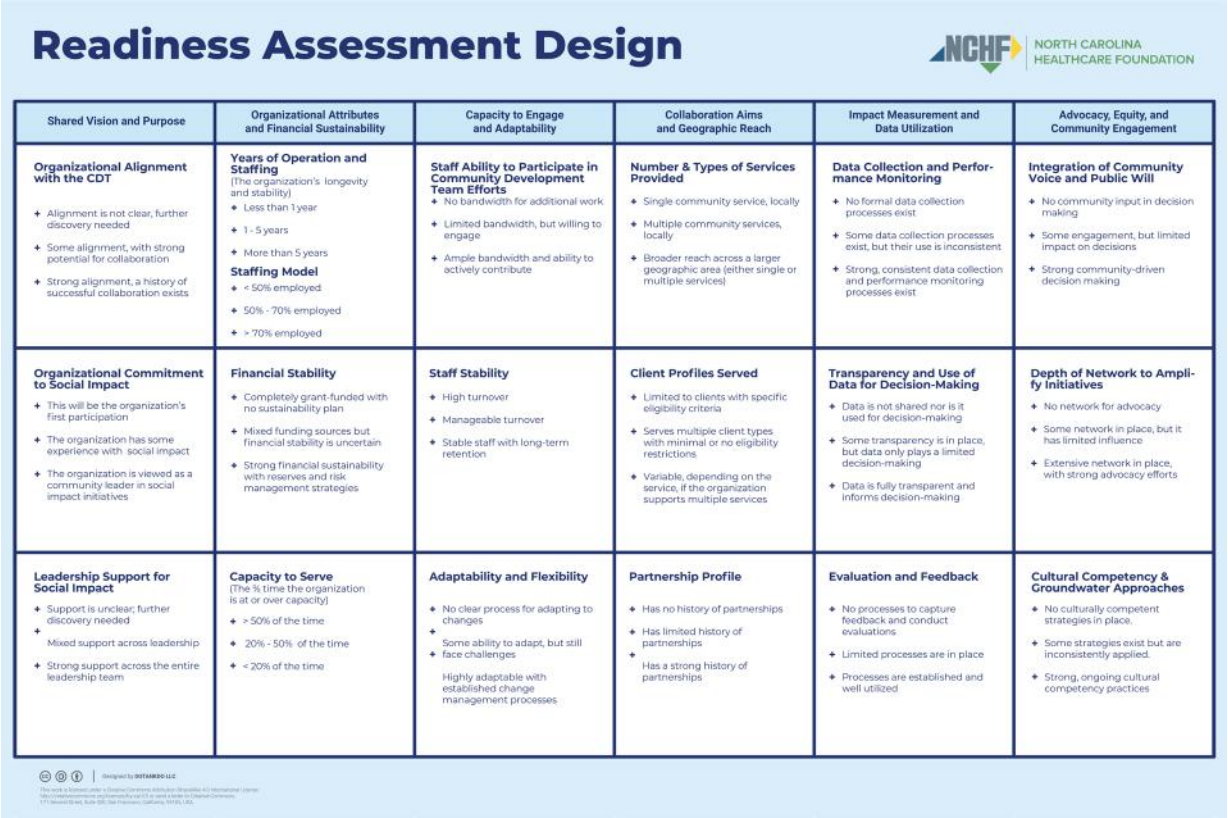
- Select a broad mix of community members who can commit their time and talents to making a positive impact within the community.
- Define the coalition's purpose within the community to enable it to serve as a catalyst for systems-level change.
- Determine the scope and detailed insights on initiatives aligned with a coalition-defined specific area of focus.

Tools

- **Readiness Assessment Design Canvas:** to align, coordinate, and amplify community activities.
- **Organizational Persona Canvas:** to dig deeper into community organization.
- **Visioning Canvas**: to determine the north star for a community development team.
- **Systems-Thinking Logic Model Canvas:** to begin with the end goal in mind.

TOOL Readiness Assessment Design Canvas

USE CASE(S): IDENTIFY IMPACTFUL MEMBERS FOR THE COMMUNITY DEVELOPMENT TEAM



Readiness Assessment Design

NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

Shared Vision and Purpose	Organizational Attributes and Financial Sustainability	Capacity to Engage and Adaptability	Collaboration Aims and Geographic Reach	Impact Measurement and Data Utilization	Advocacy, Equity, and Community Engagement
Organizational Alignment with the CDT ✦ Alignment is not clear, further discovery needed ✦ Some alignment, with strong potential for collaboration ✦ Strong alignment, a history of successful collaboration exists	**Years of Operation and Staffing** (The organization's longevity and stability) ✦ Less than 1 year ✦ 1 - 5 years ✦ More than 5 years **Staffing Model** ✦ < 50% employed ✦ 50% - 70% employed ✦ > 70% employed	**Staff Ability to Participate in Community Development Team Efforts** ✦ No bandwidth for additional work ✦ Limited bandwidth, but willing to engage ✦ Ample bandwidth and ability to actively contribute	**Number & Types of Services Provided** ✦ Single community service, locally ✦ Multiple community services, locally ✦ Broader reach across a larger geographic area (either single or multiple services)	**Data Collection and Performance Monitoring** ✦ No formal data collection processes exist ✦ Some data collection processes exist, but their use is inconsistent ✦ Strong, consistent data collection and performance monitoring processes exist	**Integration of Community Voice and Public Will** ✦ No community input in decision making ✦ Some engagement, but limited impact on decisions ✦ Strong community-driven decision making
Organizational Commitment to Social Impact ✦ This will be the organization's first participation ✦ The organization has some experience with social impact ✦ The organization is viewed as a community leader in social impact initiatives	**Financial Stability** ✦ Completely grant-funded with no sustainability plan ✦ Mixed funding sources but financial stability is uncertain ✦ Strong financial sustainability with reserves and risk management strategies	**Staff Stability** ✦ High turnover ✦ Manageable turnover ✦ Stable staff with long-term retention	**Client Profiles Served** ✦ Limited to clients with specific eligibility criteria ✦ Serves multiple client types with minimal or no eligibility restrictions ✦ Variable, depending on the service, if the organization supports multiple services	**Transparency and Use of Data for Decision-Making** ✦ Data is not shared nor is it used for decision-making ✦ Some transparency is in place, but data only plays a limited decision-making ✦ Data is fully transparent and informs decision-making	**Depth of Network to Amplify Initiatives** ✦ No network for advocacy ✦ Some network in place, but it has limited influence ✦ Extensive network in place, with strong advocacy efforts
Leadership Support for Social Impact ✦ Support is unclear, further discovery needed ✦ Mixed support across leadership ✦ Strong support across the entire leadership team	**Capacity to Serve** (The % time the organization is at or over capacity) ✦ > 50% of the time ✦ 20% - 50% of the time ✦ < 20% of the time	**Adaptability and Flexibility** ✦ No clear process for adapting to changes ✦ Some ability to adapt, but still face challenges ✦ Highly adaptable with established change management processes	**Partnership Profile** ✦ Has no history of partnerships ✦ Has limited history of partnerships ✦ Has a strong history of partnerships	**Evaluation and Feedback** ✦ No processes to capture feedback and conduct evaluations ✦ Limited processes are in place ✦ Processes are established and well utilized	**Cultural Competency & Groundwater Approaches** ✦ No culturally competent strategies in place. ✦ Some strategies exist but are inconsistently applied. ✦ Strong, ongoing cultural competency practices

A readiness assessment is a valuable tool for identifying strong partners for a community development team. The process begins by clearly defining what readiness means in your community —this could include factors such as alignment with community goals, leadership capacity, willingness to collaborate, availability of resources, and a commitment to fairness and sustainability.

The Readiness Assessment Design Canvas provides examples of information that could be included in a readiness assessment, with the understanding that each community will want to customize a readiness tool to reflect their own needs. Once customized, the assessment can then be distributed to a wide range of potential partners, including nonprofits, faith-based groups, local government agencies, and grassroots organizations. Ultimately, the results of the readiness assessment will guide the selection of partners who are well-suited to be part of a community development team.

ACCESS TOOL HERE

TOOL Organizational Persona Canvas

USE CASE(S): UNDERSTANDING OF ORGANIZATIONS WITHIN THE COMMUNITY DEVELOPMENT TEAM

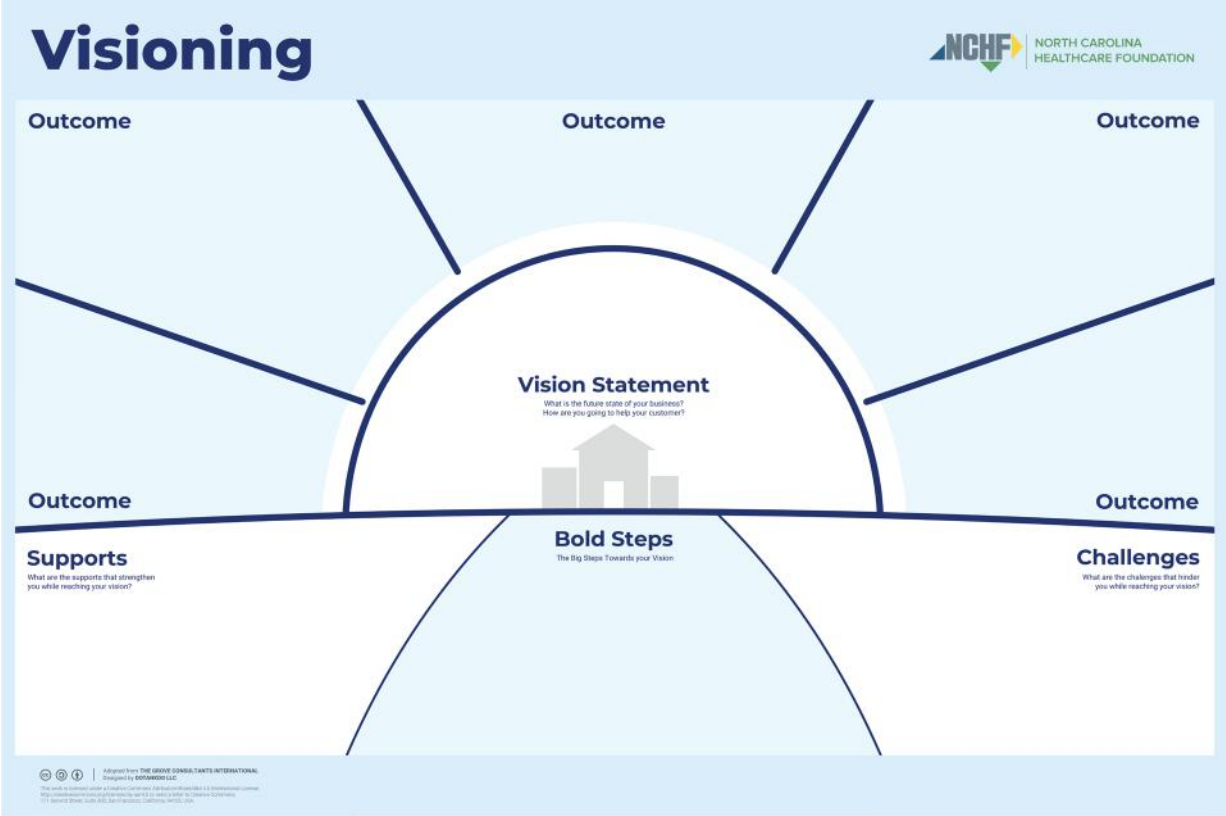
The Organizational Persona Canvas is used in conjunction with the readiness assessment to get a complete picture of potential community development team members. The goal is to get a clear view from the different potential members of where they believe their power, passion, expectations, values, and goals exist.

It is operationalized at an individual level and ensures that the different lived experiences and views of the potential members are captured at the outset.

ACCESS TOOL HERE

TOOL Visioning Canvas

USE CASE(S): DETERMINES THE 'NORTH STAR' FOR THE COMMUNITY DEVELOPMENT TEAM

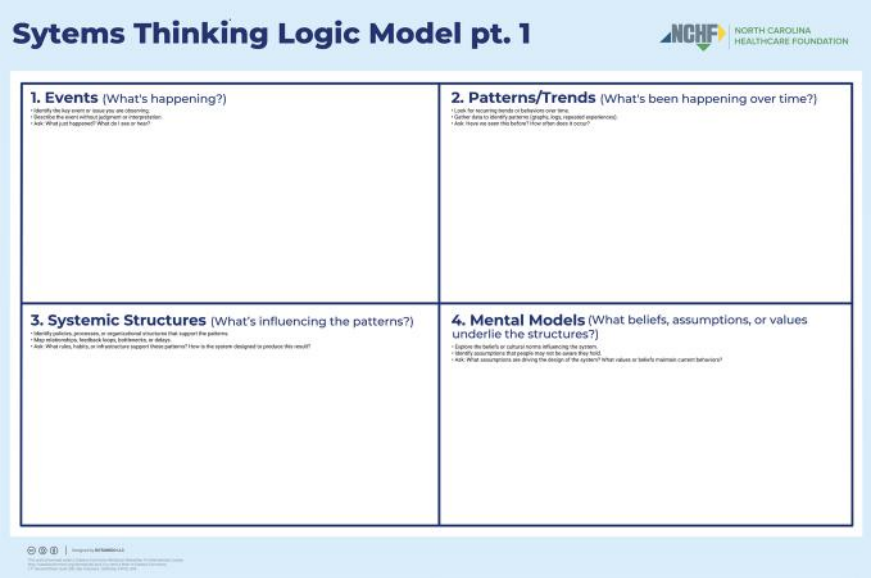


The Visioning Canvas enables community development teams to envision how big and how far they desire to go regarding social impact. Ultimately, a shared vision needs to be agreed upon. This is a shared understanding of the problems being solved and states what the community development team wants to achieve together. This acts as a critical foundation for guiding objectives and goals. An effective vision statement provides an organizing framework for the work. Strong objectives define the work as relating to the entire geographic population; clarify the role of addressing social, economic, and environmental factors that influence health; and explicitly aim to improve health for all.

ACCESS TOOL HERE

TOOL Systems Thinking Logic Model Canvases

USE CASE(S): A ROADMAP FOR SYSTEMS-LEVEL CHANGE



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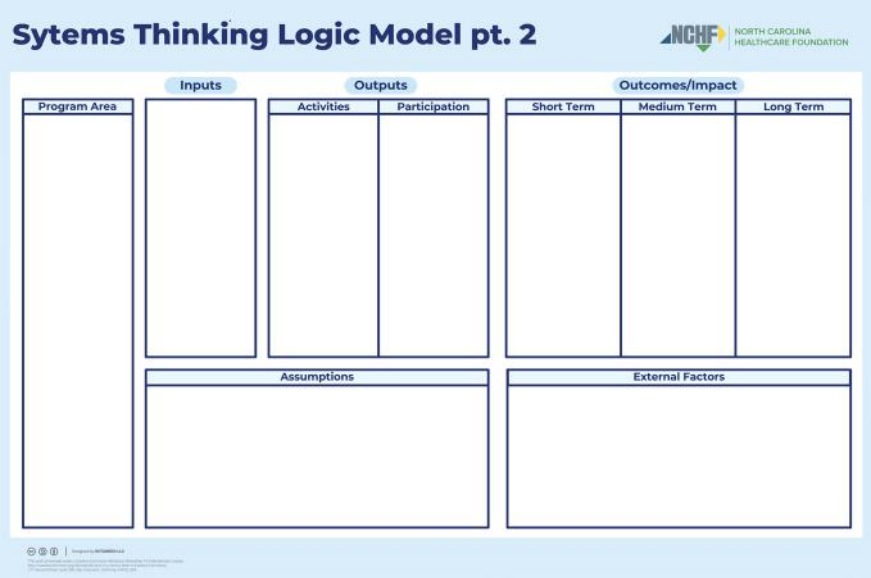


ACCESS TOOL HERE

The Systems Thinking Model Pt. 1 helps community development teams move from understanding complex systems to planning concrete actions. Based on the Iceberg Model, this canvas goes beyond the visible events or symptoms of a social problem by unpacking the deeper patterns, structures, and mental models that sustain it. At the top of the "iceberg" are events and outcomes—what is happening that we can observe. Beneath the surface lie the patterns and trends, the systemic structures, and finally, the deeply held beliefs, values, and narratives that drive the system's behavior over time.

The Systems Thinking Model Pt. 2, on the other hand, is a logic model that provides a structured pathway to change by articulating the inputs, activities, outputs, outcomes, and long-term impacts needed to shift those deeper layers. By using the Iceberg Model first, community development teams can uncover the hidden forces and root causes behind social issues, ensuring that subsequent Logic Models are not just reactive to symptoms, but address the underlying structures and beliefs.

3D. Critical Success Factor #3: Effective Governance

Governance models will vary depending on the complexity and duration of initiatives. At a minimum, a core team needs to be assembled, 'rules of engagement', roles/responsibilities, and participation expectations need to be outlined.

Actions

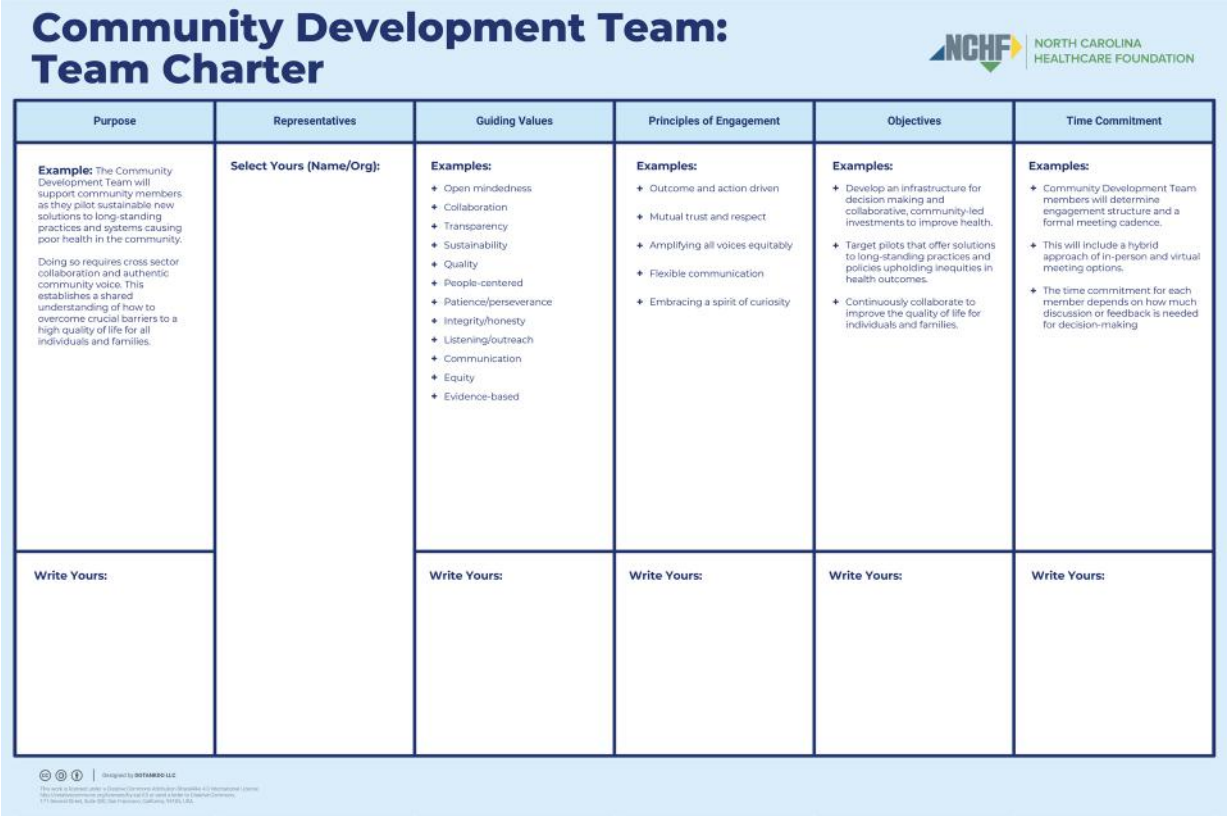
- Determine the 'rules of engagement', including alignment of backbone responsibilities within the community development team.
- Determine the 'rules of engagement' for extended collaborators and additional community stakeholders for the short and long terms goals of proposed initiatives.

Tools

- **Community Development Team Charter Canvas:** to clarify roles and responsibilities.
- **Design Criteria Canvas:** to frame scope for social impact initiatives.
- **Aims Canvas:** to frame the aim of the community development team.
- **Project Governance Canvas:** to create a project charter.

TOOL Community Development Team Charter Canvas

USE CASE(S): TO CREATE A TEAM CHARTER



Community Development Team: Team Charter

NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

Purpose	Representatives	Guiding Values	Principles of Engagement	Objectives	Time Commitment
Example: The Community Development Team will support community members as they pilot sustainable new solutions to long-standing practices and systems causing poor health in the community. Doing so requires cross sector collaboration and authentic community voice. This establishes a shared understanding of how to overcome crucial barriers to a high quality of life for all individuals and families.	**Select Yours (Name/Org):**	**Examples:** + Open mindedness + Collaboration + Transparency + Sustainability + Quality + People-centered + Patience/perseverance + Integrity/honesty + Listening/outreach + Communication + Equity + Evidence-based	**Examples:** + Outcome and action driven + Mutual trust and respect + Amplifying all voices equitably + Flexible communication + Embracing a spirit of curiosity	**Examples:** + Develop an infrastructure for decision making and collaborative, community-led investments to improve health. + Target pilots that offer solutions to long-standing practices and policies upholding inequities in health outcomes. + Continuously collaborate to improve the quality of life for individuals and families.	**Examples:** + Community Development Team members will determine engagement structure and a formal meeting cadence. + This will include a hybrid approach of in-person and virtual meeting options. + The time commitment for each member depends on how much discussion or feedback is needed for decision-making
Write Yours:		**Write Yours:**	**Write Yours:**	**Write Yours:**	**Write Yours:**

The Community Development Team Charter Canvas is used to define the team's purpose and aligning it with community needs. This includes writing a mission statement that captures the team's reason for existence and establishing objectives that guide the team's efforts. Each team member's role and responsibilities should be outlined to promote clarity and accountability. Additionally, identifying key stakeholders and their expectations helps ensure alignment and support.

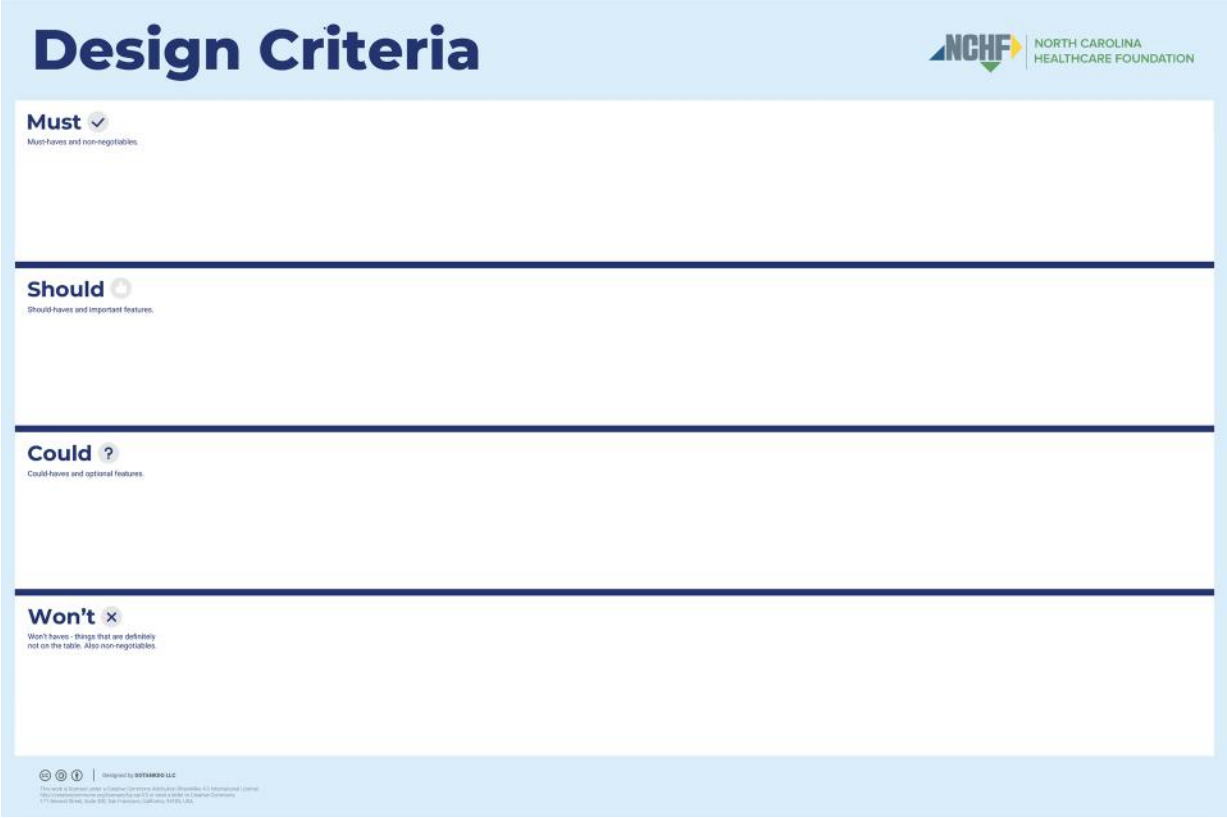
Operating guidelines—such as how often the team will meet, how decisions will be made, and how conflicts will be resolved—should also be agreed upon early to establish a solid foundation for collaboration. Equally important are the team's behavioral norms, communication preferences, and performance expectations. These elements foster a culture of trust, respect, and productivity. Once drafted collaboratively, the charter should be revisited periodically to ensure it remains relevant as the team evolves. A well-crafted team charter not only sets direction but also helps maintain focus and cohesion throughout the team's lifecycle.

This canvas contains example information from the Robeson County Community Development Team Charter. Leverage this charter 'as is' or use it as a starting point and modify it to the needs of a specific community.

ACCESS TOOL HERE

TOOL Design Criteria Canvas

USE CASE(S): FRAMES SCOPE FOR SOCIAL IMPACT INITIATIVES

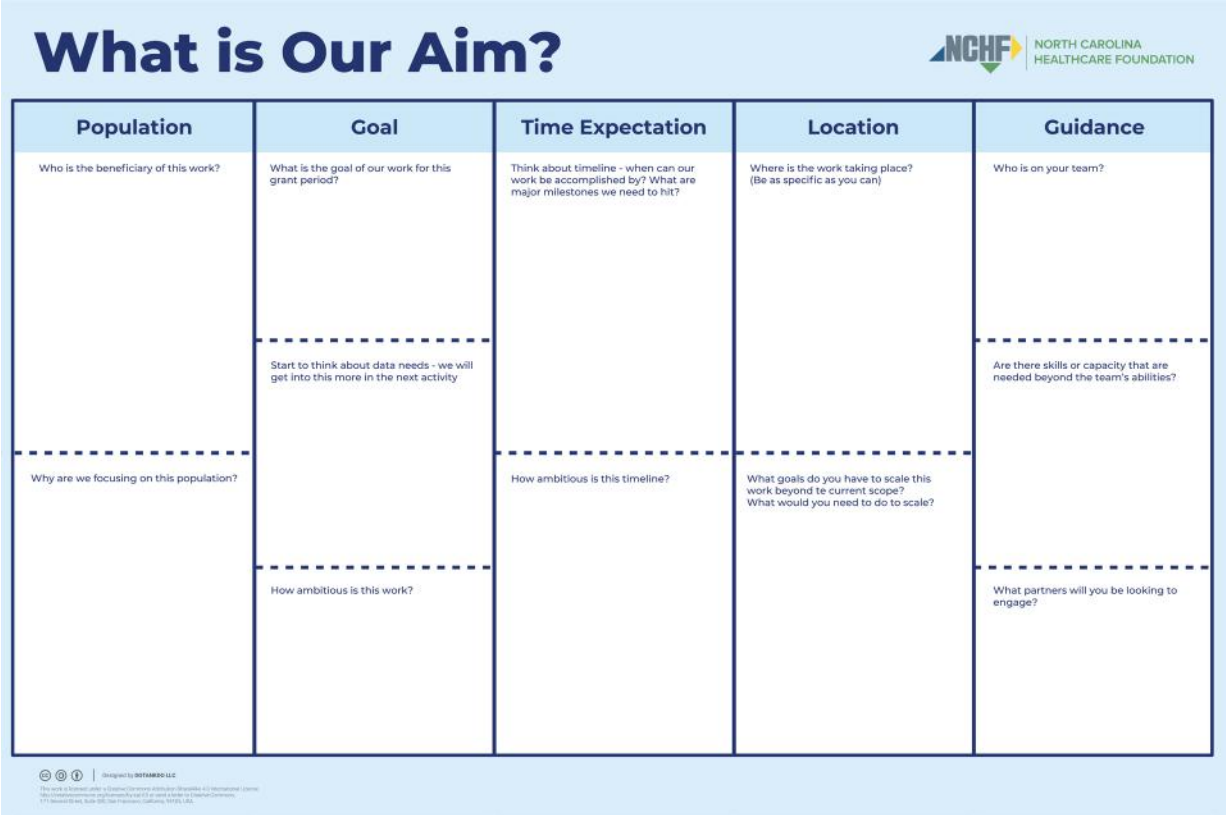


The Design Criteria Canvas is used to place some guardrails around what is and what is not in scope for social impact initiatives. One of the biggest challenges that community development teams face is the risk of losing sight of the impact being pursued. This canvas helps teams agree on the vital 'must haves'.

ACCESS TOOL HERE

TOOL Aims Canvas

USE CASE(S): FRAMES SCOPE FOR SOCIAL IMPACT INITIATIVES



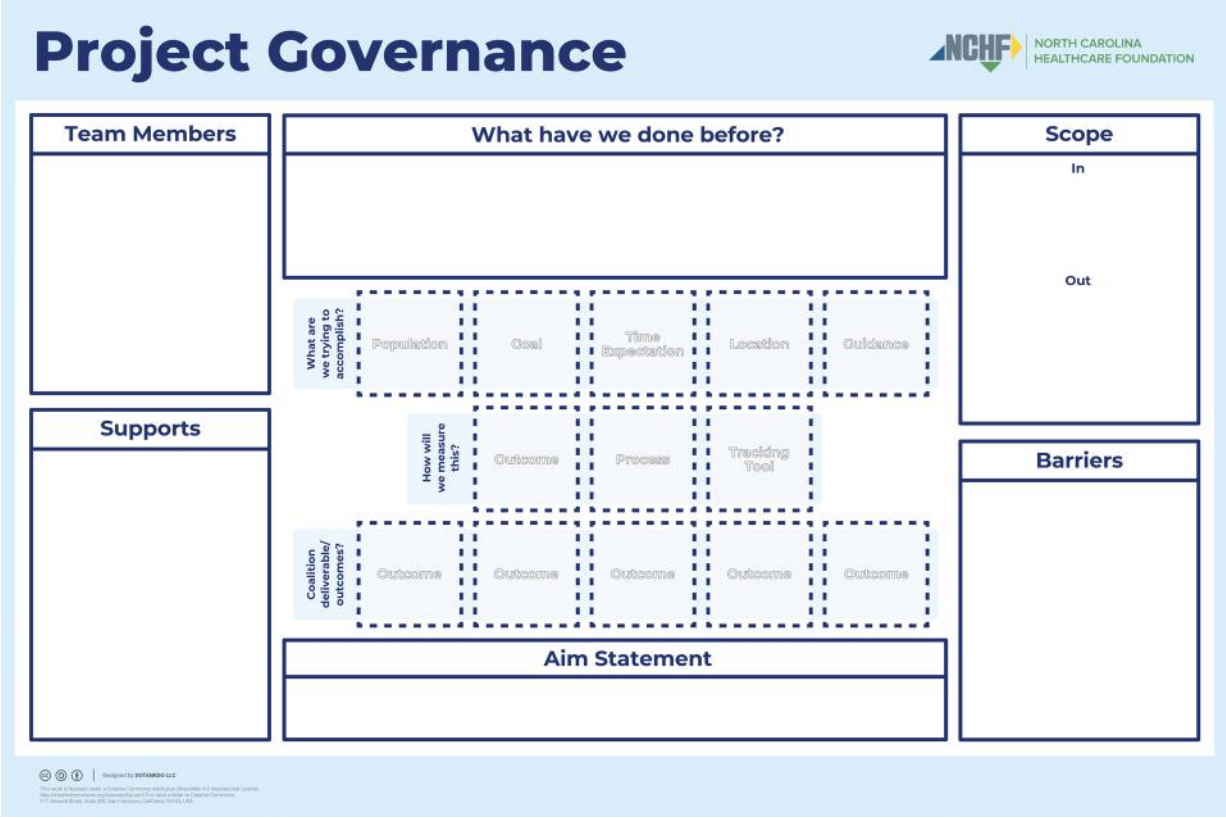
The Aim Canvas is used to craft an unambiguous, explicit aim statement for the community development team. Once the team has garnered insights from the community and framed out a vision (using the Visioning Canvas), they will be in a position to articulate the specific aim the team would like to achieve.

This canvas focuses on five elements of any aim statement which must be identified: the population, goal, time expectation, location, and guidance of the work to be done. With an explicit aim statement in place, the community development team can move toward scoping a project charter.

ACCESS TOOL HERE

TOOL Project Governance Canvas

USE CASE(S): CREATES A COMMUNITY DEVELOPMENT PROJECT CHARTER



The Project Governance Canvas gives the community development team a chance to flesh out the projects and outcomes they aim to achieve. This canvas enables the team to articulate their aim statement, identifying how they will measure success, and identify the types of projects they would like to support.

This canvas serves as the operational north star for the community development team as they move toward deciding which pilot projects might benefit the community, as well as which gaps to identify for where new partnerships or existing partnerships could work together.

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Section 4:

Engaging Promising Pilot Partners

4A. Identifying Impactful Initiatives

Once a community development team is established and a focus area is identified, the next step is to pinpoint promising practices worthy of support. The most direct method is to launch an outreach campaign throughout the community. Engaging promising pilot partners begins by ensuring their values and objectives align with those of the community development team.

Considerations:

Number of pilots: The community development team can use the amount of funds available from funding sources to inform the number and duration of pilots that can be supported.

Risk appetite: Each community development team will have a different tolerance for risk.

If the desired impact is short-term and the tolerance for failure is low, pilot projects should be "new to your community" but, not "new to the world." They should have pre-existing evidence from work in other communities that can be adapted.

If time horizons are longer and risk thresholds are higher, it's possible to support pilot initiatives with less existing evidence.

Pilot Partner Evaluation Criteria:

- Is the initiative "new to the world" or "new to this community"?
- While the pilot is intentionally smaller, is the bold end goal clear?
- What health outcome measures are impacted during the pilot, and at scale?
- What healthcare utilization measures are impacted during the pilot, and at scale?
- Does the proposing partner possess the necessary experience and/or collaborators for success?

After pilots are selected, the community development team should assess them collectively to ensure they reinforce each other, creating a "whole greater than the sum of the parts." If this synergy is not present, the team should re-evaluate their decisions and make necessary adjustments, otherwise, the work will not lead to systems-level change.

4B. Providing Pilot Partners with Technical Assistance

While the main responsibility for the community development team is to **(1)** identify social impact areas of focus, **(2)** be a connector to external funding to drive community-based work, **(3)** develop means for data sharing to drive community-wide impact narratives, and **(4)** demonstrate aggregate ROI, they also have a vital role to play in supporting pilot partners with technical assistance.

Training and Workshop Ideas

Linked with Critical Success Factors

+ Evaluating systems-level impact
+ Storytelling
+ Data collection
+ Human-centered design methods for community engagement
+ Sustainability

Additional Ideas

+ Racial healing
+ Economic development strategies
+ Cross-site learning collaboratives

This is a vital role that NCHF strives to play with both new community development teams and pilot sites across the state of North Carolina.

4C. Critical Success Factor #4: Initiative and Selection

Most social impact initiatives start small and then scale once early success is demonstrated. This step in the framework focuses on developing a gameplan for initial launch (with process-oriented success metrics).

Action

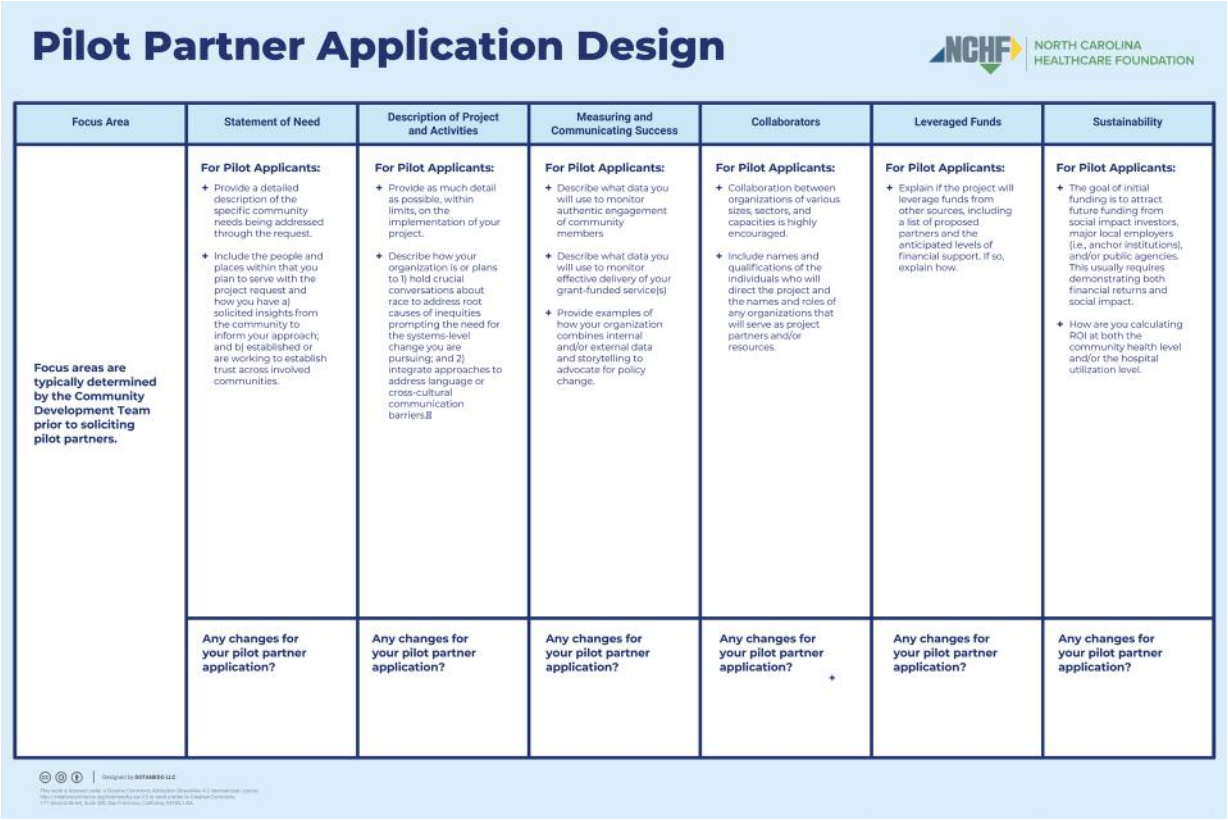
- Engage identified partners to select pilot initiatives.

Tools

- **Pilot Partner Application Design Canvas:** to prioritize what to ask potential pilot partners.
- **Project Matrix Canvas:** to aid with pilot selection.
- **Gameplan Canvas:** to operationalize activities within a project.

TOOL Pilot Partner Application Design Canvas

USE CASE(S): TO PRIORITIZE WHAT TO ASK POTENTIAL PILOT PARTNERS



Pilot Partner Application Design

NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

Focus Area	Statement of Need	Description of Project and Activities	Measuring and Communicating Success	Collaborators	Leveraged Funds	Sustainability
Focus areas are typically determined by the Community Development Team prior to soliciting pilot partners.	**For Pilot Applicants:** + Provide a detailed description of the specific community needs being addressed through the request. + Include the people and places within that you plan to serve with the project request and how you have a) solicited insights from the community to inform your approach; and b) established or are working to establish trust across involved communities.	**For Pilot Applicants:** + Provide as much detail as possible, within limits, on the implementation of your project. + Describe how your organization is or plans to 1) hold crucial conversations about race to address root causes of inequities prompting the need for the systems-level change you are pursuing; and 2) integrate approaches to address language or cross-cultural communication barriers.[i]	**For Pilot Applicants:** + Describe what data you will use to monitor authentic engagement of community members + Describe what data you will use to monitor effective delivery of your grant-funded service(s) + Provide examples of how your organization combines internal and/or external data and storytelling to advocate for policy change.	**For Pilot Applicants:** + Collaboration between organizations of various sizes, sectors, and capacities is highly encouraged. + Include names and qualifications of the individuals who will direct the project and the names and roles of any organizations that will serve as project partners and/or resources.	**For Pilot Applicants:** + Explain if the project will leverage funds from other sources, including a list of proposed partners and the anticipated levels of financial support. If so, explain how.	**For Pilot Applicants:** + The goal of initial funding is to attract future funding from social impact investors, major local employers (i.e., anchor institutions), and/or public agencies. This usually requires demonstrating both financial returns and social impact. + How are you calculating ROI at both the community health level and/or the hospital utilization level.
	Any changes for your pilot partner application?	**Any changes for your pilot partner application?**	**Any changes for your pilot partner application?**	**Any changes for your pilot partner application?**	**Any changes for your pilot partner application?**	**Any changes for your pilot partner application?**

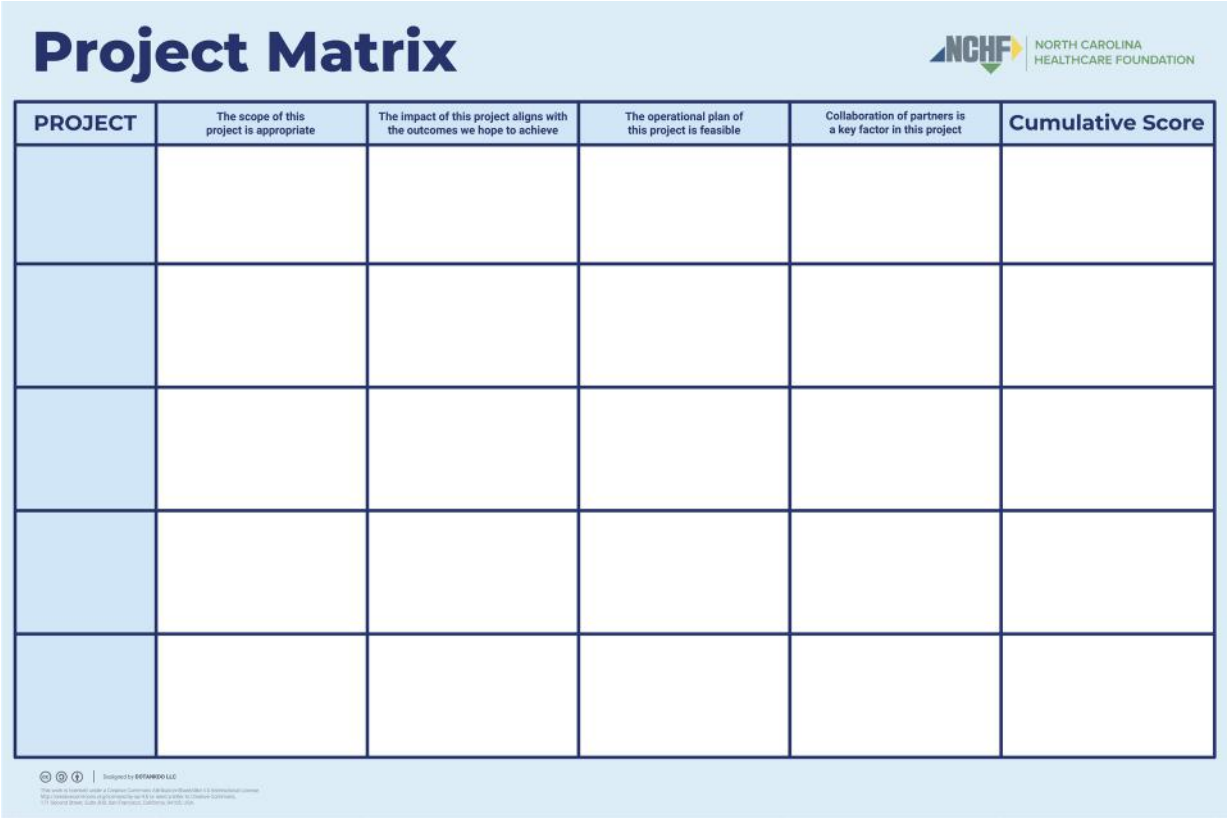
The Pilot Partner Application Design Canvas helps the community development team develop a pilot project application. This begins by defining the purpose and scope of the pilot program. Additional elements of the application can include: what types of projects are eligible, the strategic goals they should support, and the criteria by which they will be evaluated. Expected outcomes and how success will be measured are also useful to include as part of the application.

This canvas contains example information from the Robeson County pilot partner application. Leverage this application information 'as is' or use it as a starting point and modify it to the needs of a specific community.

ACCESS TOOL HERE

TOOL Project Matrix Canvas

USE CASE(S): SELECT POTENTIAL PILOT INITIATIVES



Project Matrix

NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

PROJECT	The scope of this project is appropriate	The impact of this project aligns with the outcomes we hope to achieve	The operational plan of this project is feasible	Collaboration of partners is a key factor in this project	Cumulative Score

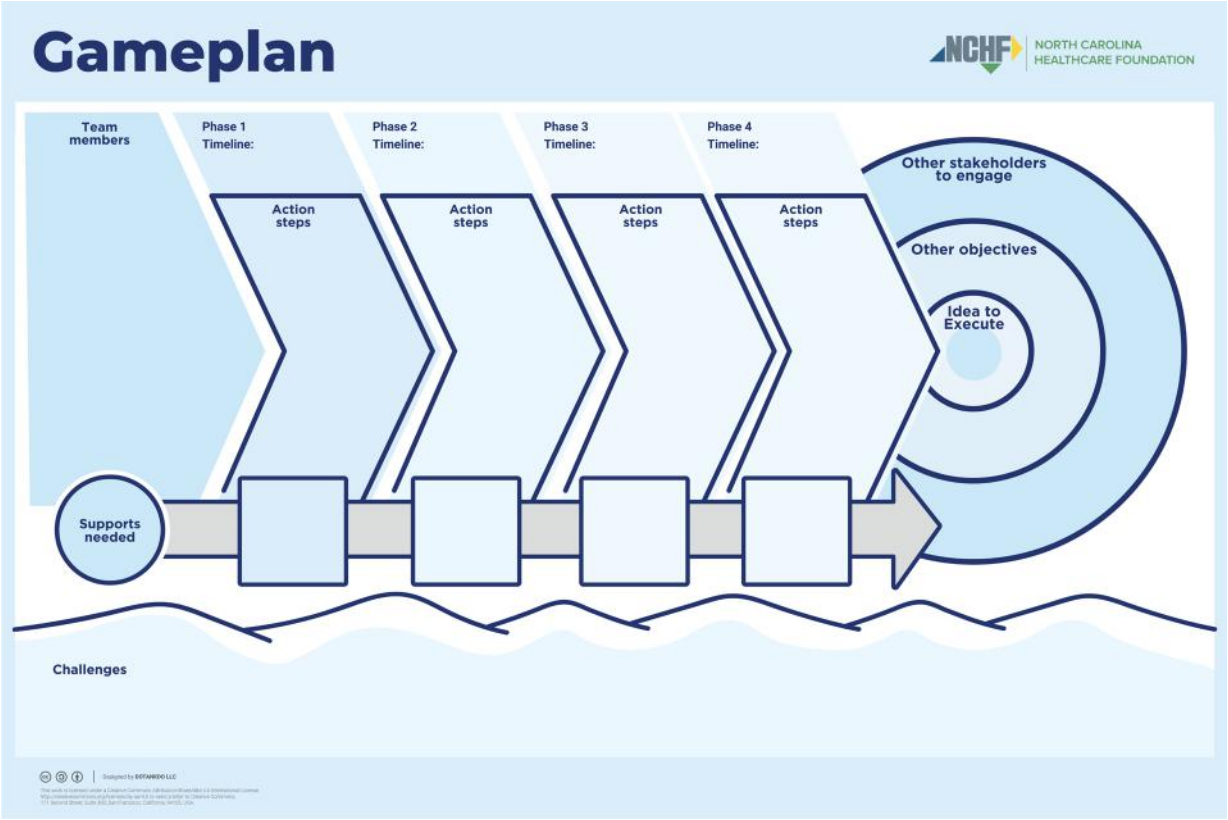
The Project Matrix Canvas assists in the decision making process the community development team must engage in when deciding what pilot projects to pursue. This canvas provides a standardized structure to prioritize and vet potential pilot projects being considered by the community development team.

Potential grantees or pilot projects are listed on the canvas and four prompting questions are embedded within the canvas to help guide a meaningful discussion targeted at identifying the projects which are most aligned with the community development team's vision and aim. This canvas will ensure that projects are vetted through the lenses of scope, impact, operations, and collaboration.

ACCESS TOOL HERE

TOOL Gameplan Canvas

USE CASE(S): OPERATIONAL PLAN OF ACTIVITIES WITHIN A PROJECT



The Gameplan Canvas enables the community development team and pilot project teams to build their implementation plan by articulating action steps, supports needed, challenges, and timelines by phase.

This canvas is meant to be populated in partnership between the community development team and any pilot project sites. Jointly populating this canvas will ensure an aligned approach as pilot projects get underway. Ultimately, this canvas helps create a step-by-step plan to operationalize a pilot project in a timely and feasible manner.

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4D. Critical Success Factor #5: Evaluation and Impact Measurement

Impact will be defined differently by different stakeholders. As such, effective impact measurement requires an understanding of what matters to whom.

Actions

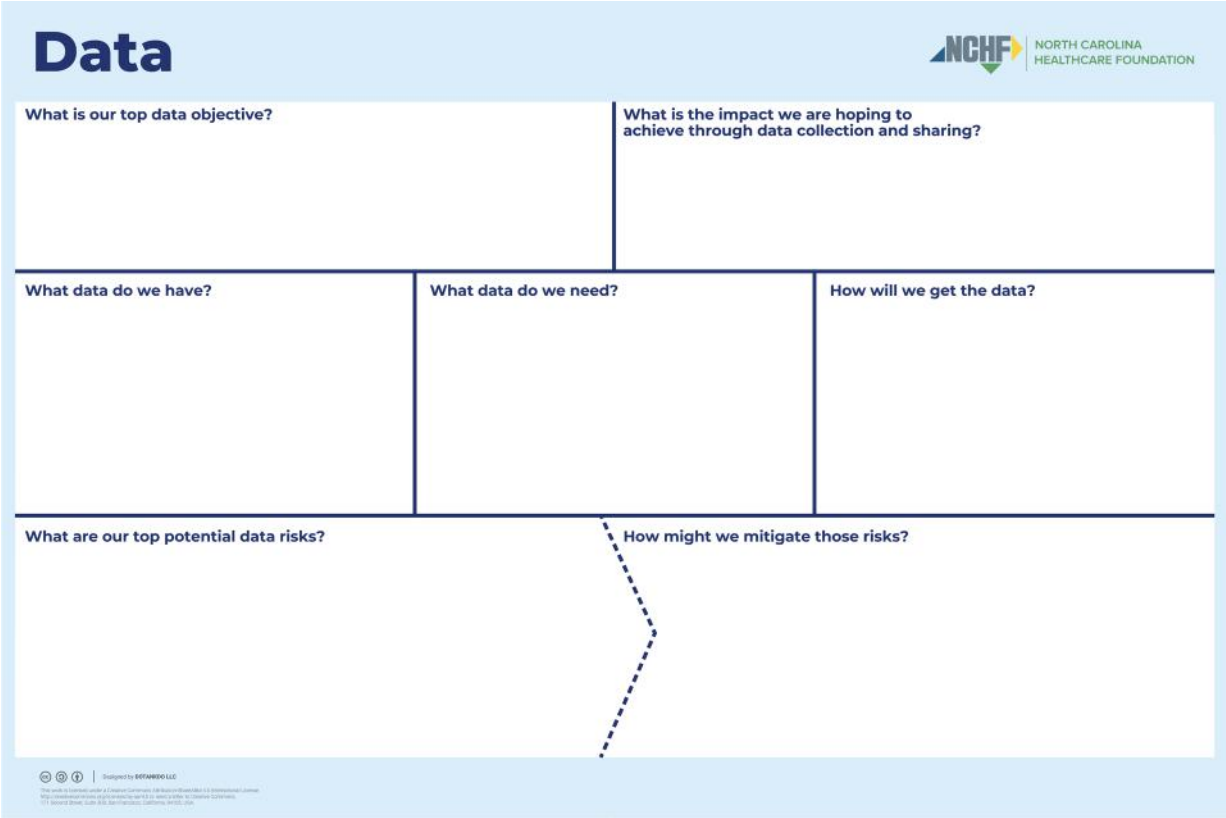
- Look at specific pilots and determine impact.
- Look across initiatives to aggregate impact within an area of focus.
- Describe impact at the pilot level and what impact could look like deployed more broadly.

Tools

- **Data Canvas:** to aid with data scoping.
- **Project Measurement Canvas:** to create a measurement plan.
- **Pilot Scalability Canvas:** to plan for broader impact.

TOOL Data Canvas

USE CASE(S): DATA SCOPING

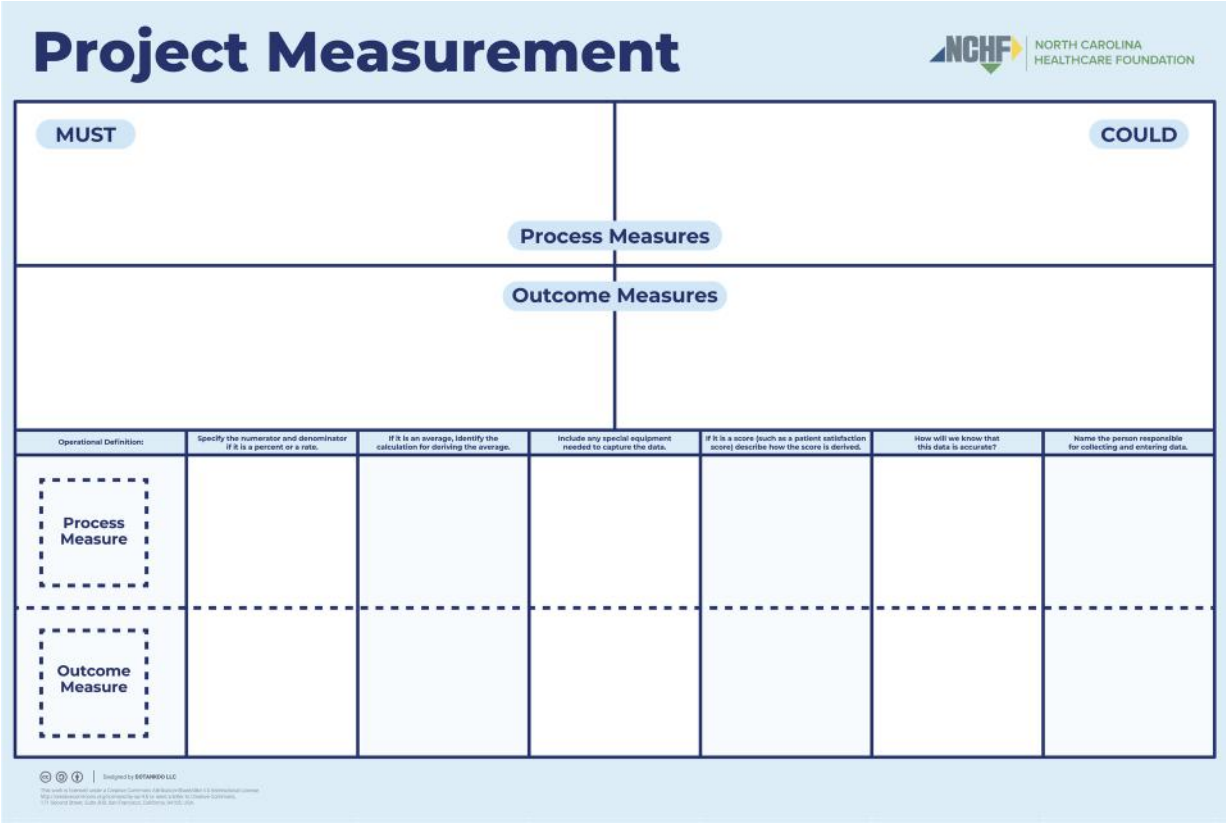


The Data Canvas is operationalized by the community development team and pilot project sites. The goal of this canvas is to come to consensus on what data is needed to demonstrate the impact the community development team and pilot projects would like to achieve. Once the teams have a strong data canvas, the pilot project sites can frame out their measurement plan.

ACCESS TOOL HERE

TOOL Project Measurement Canvas

USE CASE(S): CREATION OF A MEASUREMENT PLAN FOR A PILOT PROJECT



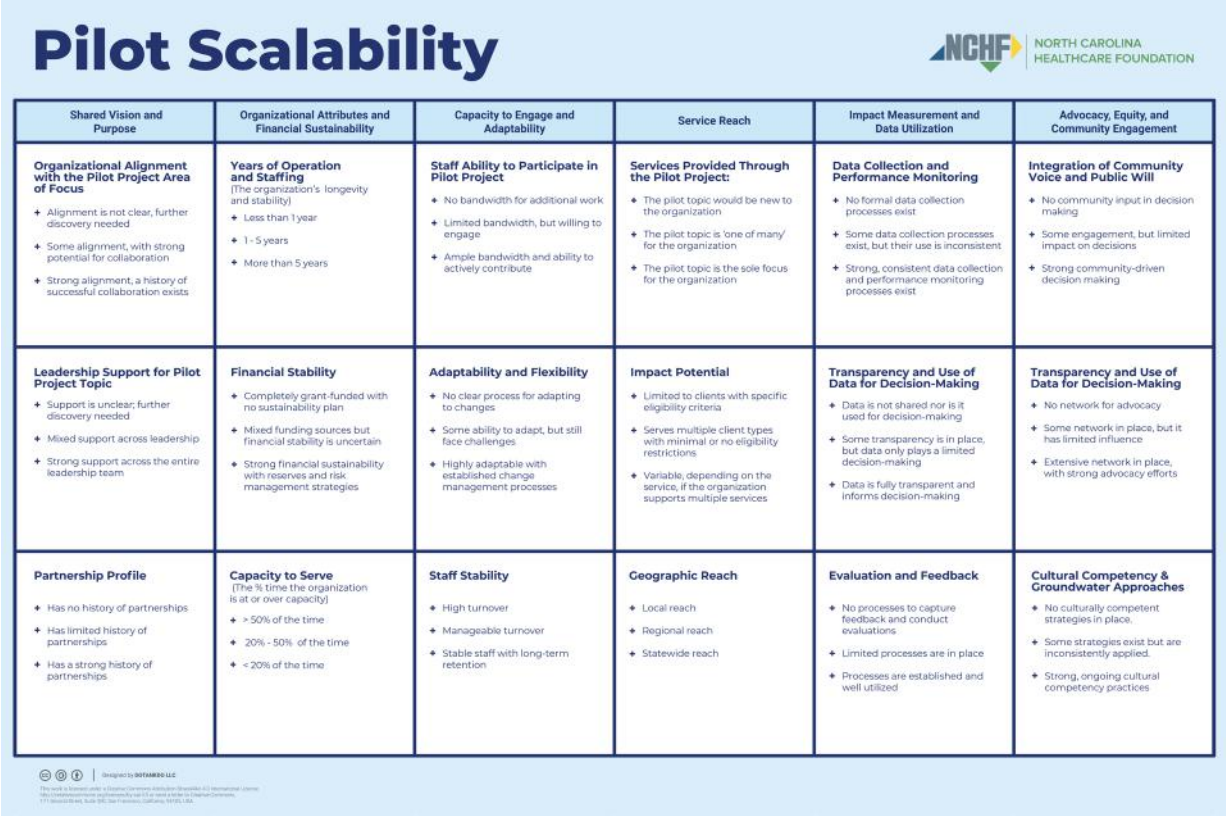
The Project Measurement Canvas gives direction on the evaluation and impact metrics, so that pilot sites can map out their data measurement plan. The goal of this canvas is to give the pilot partner organizations a chance to identify the specific metrics they need to track to demonstrate success.

This canvas gives space for the pilot project sites to ideate the potential process and outcome measures they would like to track. In addition, the canvas ensures that each pilot project site will explicitly outline the main process and outcome measures they intend to track to demonstrate impact.

ACCESS TOOL HERE

TOOL Pilot Scalability Canvas

USE CASE(S): TO PLAN FOR BROADER IMPACT



Pilot Scalability

NCHF NORTH CAROLINA HEALTHCARE FOUNDATION

Shared Vision and Purpose	Organizational Attributes and Financial Sustainability	Capacity to Engage and Adaptability	Service Reach	Impact Measurement and Data Utilization	Advocacy, Equity, and Community Engagement
Organizational Alignment with the Pilot Project Area of Focus + Alignment is not clear, further discovery needed + Some alignment, with strong potential for collaboration + Strong alignment, a history of successful collaboration exists	**Years of Operation and Staffing** (The organization's longevity and stability) + Less than 1 year + 1 - 5 years + More than 5 years	**Staff Ability to Participate in Pilot Project** + No bandwidth for additional work + Limited bandwidth, but willing to engage + Ample bandwidth and ability to actively contribute	**Services Provided Through the Pilot Project:** + The pilot topic would be new to the organization + The pilot topic is 'one of many' for the organization + The pilot topic is the sole focus for the organization	**Data Collection and Performance Monitoring** + No formal data collection processes exist + Some data collection processes exist, but their use is inconsistent + Strong, consistent data collection and performance monitoring processes exist	**Integration of Community Voice and Public Will** + No community input in decision making + Some engagement, but limited impact on decisions + Strong community-driven decision making
Leadership Support for Pilot Project Topic + Support is unclear; further discovery needed + Mixed support across leadership + Strong support across the entire leadership team	**Financial Stability** + Completely grant-funded with no sustainability plan + Mixed funding sources but financial stability is uncertain + Strong financial sustainability with reserves and risk management strategies	**Adaptability and Flexibility** + No clear process for adapting to changes + Some ability to adapt, but still face challenges + Highly adaptable with established change management processes	**Impact Potential** + Limited to clients with specific eligibility criteria + Serves multiple client types with minimal or no eligibility restrictions + Variable, depending on the service, if the organization supports multiple services	**Transparency and Use of Data for Decision-Making** + Data is not shared nor is it used for decision-making + Some transparency is in place, but data only plays a limited decision-making + Data is fully transparent and informs decision-making	**Transparency and Use of Data for Decision-Making** + No network for advocacy + Some network in place, but it has limited influence + Extensive network in place, with strong advocacy efforts
Partnership Profile + Has no history of partnerships + Has limited history of partnerships + Has a strong history of partnerships	**Capacity to Serve** (The % time the organization is at or over capacity) + > 50% of the time + 20% - 50% of the time + < 20% of the time	**Staff Stability** + High turnover + Manageable turnover + Stable staff with long-term retention	**Geographic Reach** + Local reach + Regional reach + Statewide reach	**Evaluation and Feedback** + No processes to capture feedback and conduct evaluations + Limited processes are in place + Processes are established and well utilized	**Cultural Competency & Groundwater Approaches** + No culturally competent strategies in place. + Some strategies exist but are inconsistently applied. + Strong, ongoing cultural competency practices

The Pilot Scalability Canvas helps pilot partners plan for what's next. Much like there was a need to understand organizations who could be a good fit for the community development team, there is also the need to understand organizations who might be good candidates to embrace a pilot solution once the pilot is complete. Attributes to consider fall into six categories and include (1) shared vision and purpose, (2) organizational attributes and financial sustainability, (3) capacity to engage and adaptability, (4) service reach, (5) impact measurement and data utilization, and (6) advocacy, fairness, and community engagement.

This Canvas provides examples of information that could be used to identify scaling partners, with the understanding that each pilot is unique and that pilot sites will want to customize to reflect their own needs.

ACCESS TOOL HERE

Section 5:

Return on Investment (ROI) and Sustainability

5A. Healthcare Utilization: Return on Investment (ROI)

When adoption and sustainability are the goals, it is not enough for an intervention just to improve health without regard to costs. Instead, healthcare leaders are trained to expect a ROI. Often, healthcare systems aim to align social-needs investments with opportunities that can demonstrate a return - such as generating savings through reduced, potentially preventable utilization - ensuring that efforts to address community needs are both impactful and sustainable.

To aid in crafting ROI projections, this playbook addresses two specific types of impact: optimized health system performance and improved community outcomes. The language used for each of these types of impact is different, and each is equally important. For health systems it is vital to develop a business case using the language of utilization. Examples include reducing expensive ED visits, shortening the length of hospital stays, and nursing home stays.

This playbook utilizes a ROI calculator developed by the Commonwealth Fund/ Health Begins to assist community-based organizations and their health care partners in creating financial arrangements to fund social services for patients with complex needs. It is intended to help health systems, payers, medical providers, social service providers, and community-based organizations calculate the overall ROI from integrating social services such as nutritional support, transportation, and housing with medical care.

TOOL ROI CALCULATOR

ROI Calculator Applications	
Determining ROI	Define the healthcare cost savings and return on investment (ROI) that can be expected from the provision of selected social services to an identified population.
Making a Business Case	Develop a business case based on expected ROI to inform planning and negotiations for a contract between a healthcare entity and a community-based organization to deliver social services under a variety of payment methods.
Assess Different Financing Models	Compare and select between different types of financing models including full cost recovery, fee-for-service, case rates, capitation, and shared savings.

CLICK HERE TO ACCESS THE ROI CALCULATOR

5B. Beyond Traditional ROI: Additional Monetary and Non-Monetary Benefits

It is important to identify, anticipate, and monitor benefits that extend beyond the financial utilization metrics captured in the ROI Calculator. These may include improved quality of life and health outcomes, enhanced patient experience, strengthened community trust, and increased staff retention. Such benefits can generate both direct and indirect financial value for the investing institution(s).

- **Time to impact:** Upstream investments often only address short-term downstream results that may require more time to see a meaningful impact. Most ROI tools are based on savings within a short time horizon. But for some interventions, especially high-intensity or expensive interventions such as supportive housing, programs may not be "budget neutral" or show an ROI until years two or three. In the case of children and youth, it may take up to twenty years to show an ROI. While calculators won't often show multi-year returns, you can start to estimate them by reducing your fixed costs and assuming those costs are spread over a two to three year period.

- **Centering Community Voice:** As health systems seek to maximize ROI for social impact, intentional strategies to engage communities and co-create solutions are essential. Historical inequities, systemic barriers, and mistrust have long limited engagement in many communities. Addressing these challenges requires centering community voice to improve outcomes and capture the full scope of returns not only financial, but also social and relational.

By deepening their understanding of lived experiences through ongoing dialogue and reflection, healthcare systems can position themselves as authentic partners in advancing whole-person care. In doing so, they help shift narratives, rebuild trust, and strengthen relationships within the communities they serve. In this context, Social ROI reflects not just financial gains, but the measurable improvements in health outcomes and engagement that emerge from solutions designed with communities rather than for them.

As health systems transition toward value-driven care, they must establish clear mechanisms to engage community members and cross-sector partners in identifying the root causes of access challenges and poor health outcomes. Framing these challenges in language that elevates community perspectives alongside sector leaders makes goal setting more meaningful and grounded in shared experience. This approach enables the development of well-defined interventions and measures of success that drive community-led, systems-level change. Leveraging both qualitative and quantitative data allows leaders to more effectively understand, respond to, and sustain improvements over time.

5C. Critical Success Factor #6: Sustainable Funding

If initial launch provides favorable results, then focusing on sustainability comes next. 'Where next', 'how much,' and 'who can help us', are vital considerations as one plans for scaling and for long term sustainability.

Actions

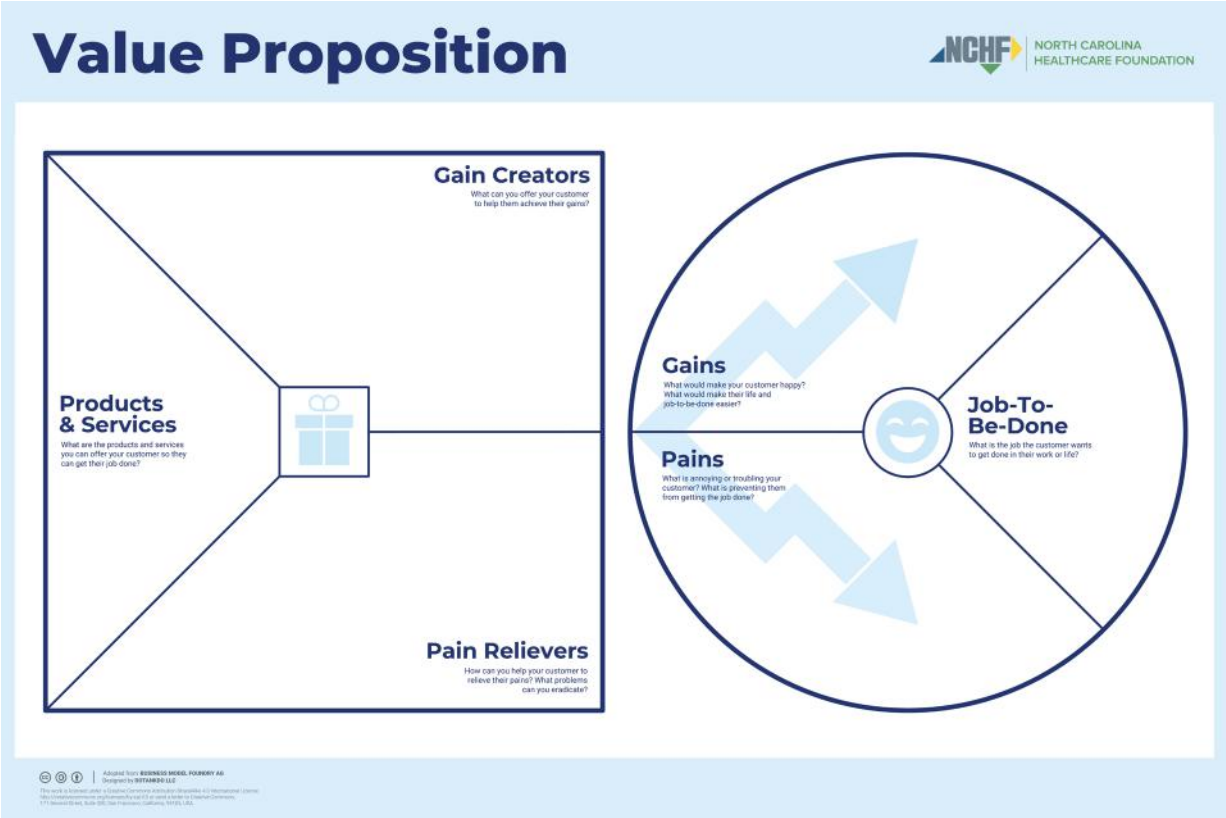
- Use data to calculate ROI.
- Use data from individual pilot projects to secure additional funding from funding agencies.
- Use data from all pilot activities as a means to engage current and prospective funders.

Tools

- **ROI Calculator:** a qualitative tool to aid with ROI calculations.
- **Value Proposition Canvas:** to create the call to action for on-going investment.

TOOL Value Proposition Canvas

USE CASE(S): VALUE FOR INVESTMENT



The Value Proposition Canvas helps articulate how social impact initiatives deliver value. The tool focuses on two key areas: the target audience, which explores their jobs, pains, and gains, and the value map, which outlines how the activities of a community development team or a pilot partner relieve pains and/or create gains.

When framing return on investment (ROI) stories, this tool provides a clear structure to connect the community pain points with pilot outcomes. It allows teams to translate the value they create—such as cost savings, efficiency gains, or risk reduction—into quantifiable benefits that resonate with stakeholders. Moreover, it supports storytelling that goes beyond numbers by illustrating how the solution contributes to both tangible and intangible gains, ensuring that ROI narratives are both empathetic and evidence-based. This approach not only strengthens the business case but also builds credibility and relevance for decision-makers.

ACCESS TOOL HERE

5D. Critical Success Factor #7: Communication and Storytelling

Making 'noise' about success is essential for maximizing impact and for driving change. This final step of the strategic framework provides guidance on how to make noise locally and how to effectively advocate for policy change.

Actions

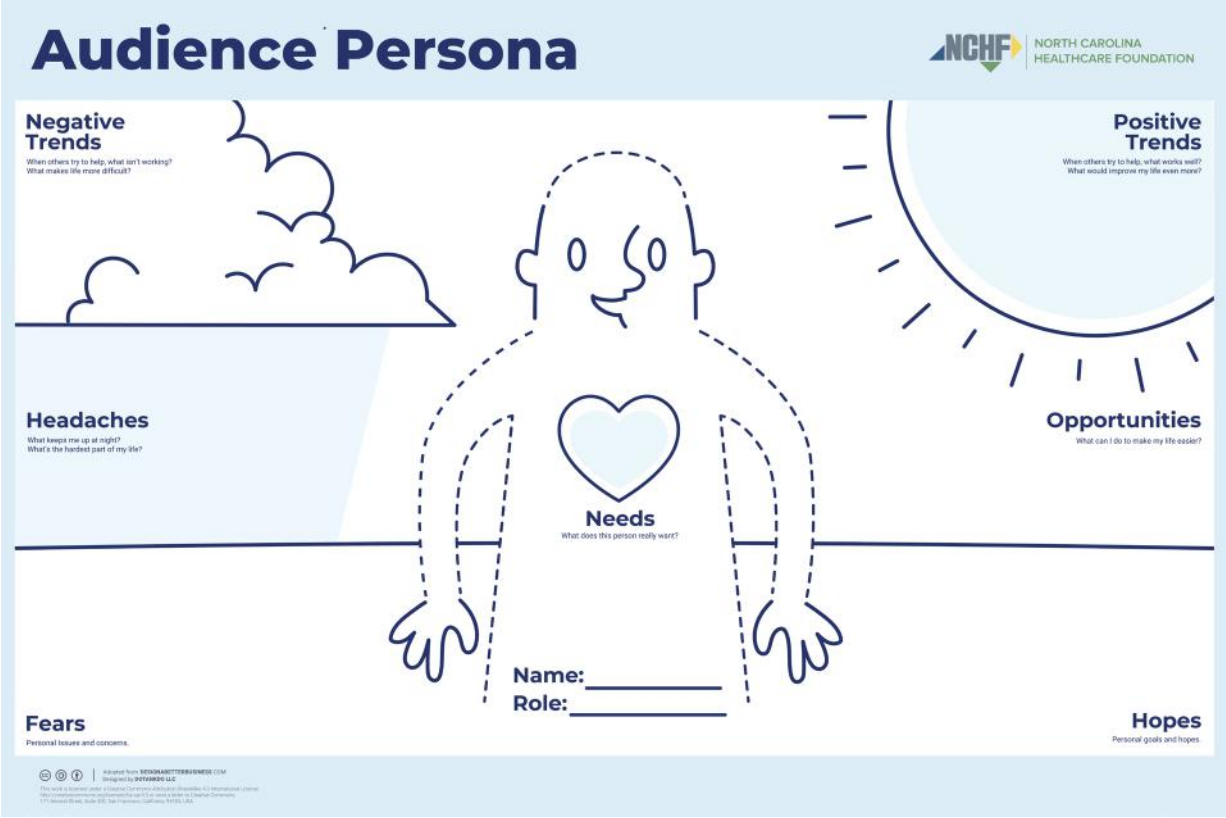
- Tell the pilot impact story.
- Tell the 'big picture narrative' on the portfolio of pilot initiatives and their collective impact.

Tools

- **Audience Persona Canvas:** to aid with audience understanding.
- **Storytelling Canvas:** to aid with empathetic communication.

TOOL Audience Persona Canvas

USE CASE(S): AUDIENCE UNDERSTANDING

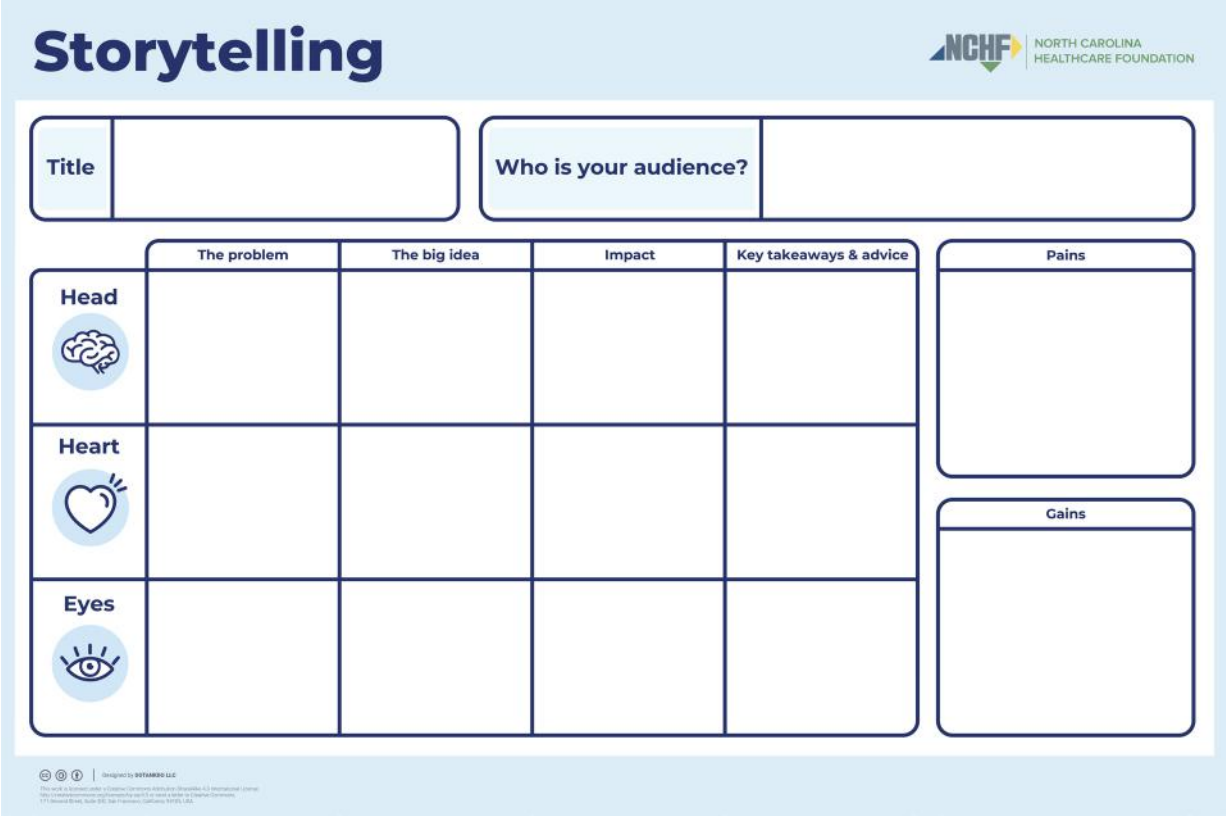


The Audience Persona Canvas will provide the knowledge needed from pilot partners to craft a compelling story of impact using the Storytelling Canvas at the community development team level.

ACCESS TOOL HERE

TOOL Storytelling Canvas

USE CASE(S): EMPATHETIC COMMUNICATION



The Storytelling Canvas tells the 'big picture narrative' of the portfolio of pilot initiatives and their collective impact. The Storytelling Canvas offers a pitch framework that embraces a 'head, heart, and eyes' approach. This tool helps community development teams AND pilot partners focus their narrative into an effective story arc to community partners and future funders.

ACCESS TOOL HERE

Section 6:

Playbook in Action: Robeson County and Their Focus on Addressing Transportation Challenges

6A. Robeson County as Testbed for Social Impact

In 2022, the Kate B. Reynolds Charitable Trust (KBR) granted funding to five organizations, including the North Carolina Healthcare Foundation (NCHF), to work within Robeson County, North Carolina, to address social drivers of health. Though there have been several initiatives to improve health in Robeson County, none of them have sufficiently addressed longstanding policy and practice that continue to exacerbate disparities. As such, Robeson County frequently ranks among the state's least healthy communities.

Leveraging funds from KBR, NCHF's social impact initiative aims to empower Robeson County residents to:

- Increase authentic collaboration between health systems and community.
- Re-imagine and redesign social systems.
- Advocate for future sustainable investments in community-led, systems-level solutions to disparate health outcomes.

Much of the program's funding has been regranted in the form of mini-grants. Investing these resources has empowered community partners to pilot systems-level interventions that aim to mitigate root causes of challenges around transportation, one social driver of health that the community identified as a priority.

The grants will inform future investment models while increasing access to resources that empower communities to define, design, and drive desirable change. Our strategy is informed by the knowledge that effective systems change requires cross-sector collaboration, inclusion of community voice, and a shared vision of success.

2024 Pilot Partners:

BRAVES Behavioral Health Workforce Transportation (UNC Pembroke): helping students overcome transit hurdles to access behavioral-health education and careers.

Robeson Behavioral Health Transportation Network (PAWSS, Inc.): providing stigma-free rides for individuals with mental-health or substance-use recovery needs.

Robeson Fresh Moves Initiative (Southern Carolina Housing): a mobile market bringing fresh, affordable produce into food-desert areas.

Scotland@Home: Community Health Transportation (Scotland Memorial Foundation): using community health workers, paramedics, and rideshares to link patients with health services.

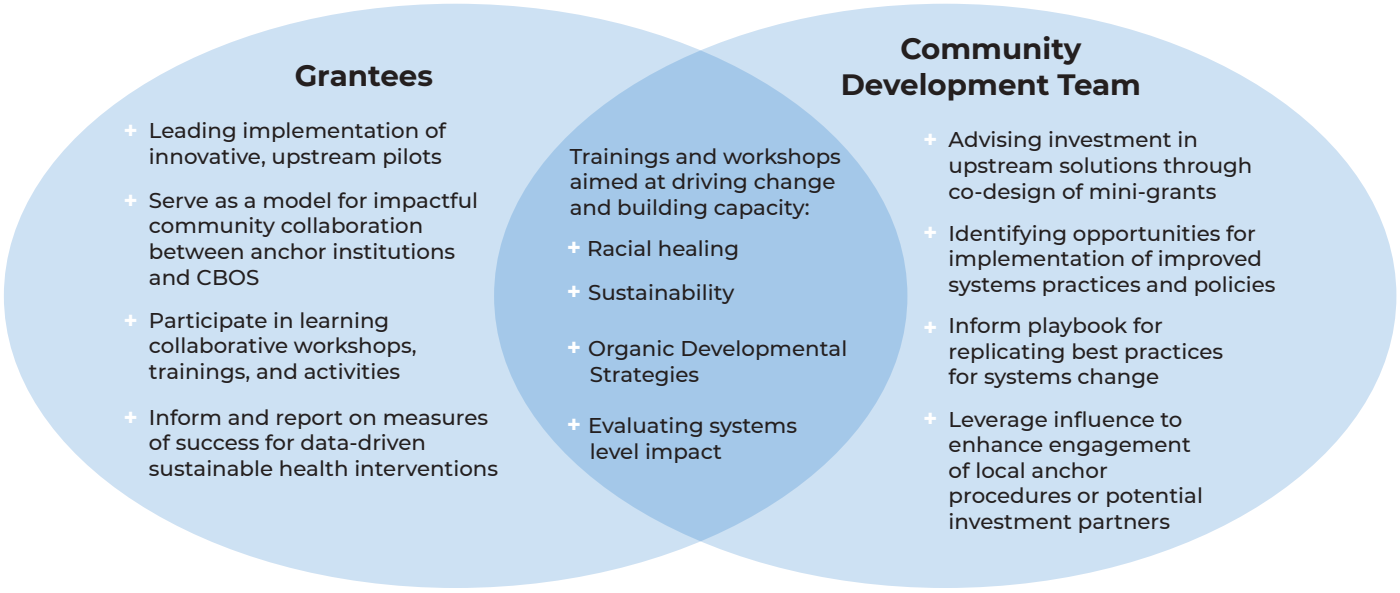
RHCC Mobile Unit Impact Project (Robeson Health Care Corporation): deploying a mobile health unit offering integrated care in rural communities.

6B. Development of the Robeson County Community Development Team

The Robeson County Community Development Team was developed to support community members as they pilot sustainable new solutions to long-standing practices and systems causing poor health in the community. It includes representatives from healthcare providers, major employers, and community-based organizations across Robeson County.

The Robeson County Community Development Team began by focusing on two objectives: (1) identifying opportunities for collaboration (e.g., data sharing) to advance community well-being, and (2) defining the scope and criteria for mini-grants to support community members with sustainable solutions addressing systems that hinder health and quality of life.

The connection between the CDT and grantees:



6C. A Focus on Transportation

Transportation was selected as the initial focus in Robeson County because it is a major barrier to health and well-being in this rural, underserved region. Robeson County faces limited public transit options, long travel distances, and high poverty rates—factors that make it difficult for residents to access essential services. Many community members struggle to get to medical appointments, pharmacies, behavioral health services, and even emergency care, contributing to poorer health outcomes and deepening health disparities.

Beyond direct healthcare access, transportation plays a critical role in shaping broader social determinants of health. Reliable transportation influences whether people can get to grocery stores with fresh food, maintain stable employment, attend job training, access childcare, or pursue education. By focusing on transportation, NCHF and its partners aim to remove a foundational obstacle that affects multiple aspects of daily life, particularly for those in poverty or isolated areas.

The decision to focus on transportation was also driven by strong input from the local community, health providers, and data showing transportation as one of the most pressing challenges residents face. Community feedback, public health assessments, and earlier county efforts highlighted transportation as a "linchpin" issue—where improvement could unlock access to many other services. This alignment between resident priorities and data-based evidence made transportation an ideal starting point for targeted pilot funding.

By investing in transportation solutions, the initiative also promotes cross-sector collaboration and systems-level change. These pilot projects are not just providing rides—they're building relationships between health systems, nonprofits, schools, and communities to rethink how services are delivered. The goal is to develop scalable, community-driven models that expand access and opportunity, while generating a playbook to guide similar efforts across North Carolina.

The Robeson County Process for Selecting Pilot Partners:

Open Call & Eligibility: Eligible applicants included 501(c)(3) nonprofits, fiscally sponsored groups, public agencies, faith-based organizations, and for-profit businesses operating in Robeson County. Collaborative proposals were especially encouraged to apply.

Application Submission: Requirements included a detailed project narrative and a budget template. Projects were expected to propose strategies that addressed transportation—either through new service models or by strengthening trust and collaboration around transportation systems.

Review & Award Notification: A committee, inclusive of NCHF, multi-sector partners, and local Robeson County members reviewed submissions and selected 5 pilot partners for a 12-month project period. The review process emphasized innovation, community-driven design, partnership potential, and feasibility.

Post-Award Support & Engagement: Once funded, pilot sites participated in regular check-ins with the Community Development Team. They were provided with evaluation and data-support services, peer-learning opportunities with other grantees, and assistance in tracking metrics. This support helped ensure projects were co-designed with the community and positioned for sustainability and replication.

6D. Case Study: Robeson Health Care Corporation's Mobile Unit and Community-Centric Healthcare

Executive Summary:
Robeson Health Care Corporation, facing significant transportation barriers and healthcare access issues in Robeson County, launched a mobile medical unit initiative. Initially conceived during the COVID-19 pandemic to facilitate testing and vaccinations, the project evolved into a comprehensive mobile health center providing primary and behavioral health services. This initiative, bolstered by a strong consortium of community partners and strategic grant funding, has successfully begun to expand healthcare access, build crucial community trust, and foster collaborative problem-solving among local agencies. The mobile unit serves as a visible community resource, addressing diverse health needs, from routine physicals to specialized care for vulnerable populations.

Project Vision & Goals:
The initial vision for the mobile medical unit emerged during the COVID-19 pandemic. Recognizing the challenges of transportation and the need to prevent congregation in brick-and-mortar facilities, Robeson Health Care Corporation's executive team aimed to create a **mobile health center, designed like a traditional clinic, but on wheels.** The primary goal was to **improve access to COVID-19 testing and vaccinations.** This vision later seamlessly integrated with existing efforts to address other health concerns such as the opioid epidemic, as the consortium of stakeholders identified **transportation as a major barrier to overall healthcare access.** The project's overarching goal **became breaking down barriers to healthcare and improving community well-being** by bringing services directly to residents.

Team Formation & Problem Identification:
Robeson Health Care Corporation leveraged its existing infrastructure and staff to establish the internal mobile unit team, initially cross-training personnel before hiring dedicated staff. The broader, more influential team consisted of a **consortium of community partners.** This consortium was formed through an HRSA planning grant (pre-COVID-19) aimed at addressing opioid issues in Robeson County. Key partners included UNC-Pembroke (UNCP), local hospitals, various agencies, family treatment courts, Robeson Health Care Corporation's internal SUD prevention and drug court programs, PAWSS, the Health Department, faith-based organizations, private businesses, school systems, treatment providers, HIV/AIDS organizations, food shelters/banks, the Lumbee Tribe, and the local community college.

The core problem identified by this diverse group was **significant transportation barriers** in Robeson County, where public transportation was nearly non-existent, and private options like taxis or ride-sharing services were unavailable. This proved a significant barrier to residents in receiving routine medical care. They also recognized the pervasive issue of **siloed efforts among community providers**, leading to duplicated services and inefficient resource utilization.

Community Engagement & Challenges:
Community engagement was central to the initiative, primarily through the **Consortium Leadership Team**, which comprised core providers. This leadership group planned agendas, analyzed data, and organized initiatives based on feedback from the broader stakeholder group.

They actively worked to **understand "who does what well**" among local agencies to foster collaboration and break down silos. The overarching aim of community engagement was to encourage shared resources and collaborative solutions for providing services and gauging the needs of the community to provide essential care.

Resourcing & Project Aim Determination:
The mobile unit's initial funding and resourcing stemmed from **COVID-19 grant dollars,** allowing Robeson Health Care Corporation to design and outfit the unit. The ongoing support for addressing transportation barriers and expanding the mobile unit's reach was primarily achieved through **strategic grant writing.** The consortium consistently wrote transportation support into every grant application, including HRSA's implementation grants, psychostimulant grants, and neonatal abstinence grants, securing anywhere from $15,000 to $75,000 per grant for transportation efforts.

The project's specific aim evolved from addressing COVID-19 to a broader focus on **bringing healthcare appointments directly to people,** rather than just providing transportation to existing clinics. This decision was a result of internal discussions within Robeson Health Care Corporation and the broader stakeholder team, recognizing that "taking the appointment to them" was a more impactful solution to the transportation barrier.

Action Plan & Data Utilization:
The action plan involved designing the mobile unit to mimic a brick-and-mortar health center, including exam rooms, a behavioral health room, and Telehealth capabilities with Wi-Fi. Staffing mirrored a clinic setup, with providers, nurses, and administrative personnel. Initial efforts focused on **visits to schools,** gradually expanding the scope of services.

Regarding data utilization, early on, there were struggles due to a transition in electronic medical records and challenges in getting a dedicated data analyst. However, the system has significantly improved. Robeson Health Care Corporation now has access to **robust patient data,** including age, gender, diagnoses, and specific service utilization (e.g., COVID shots, immunizations) and are able to generate detailed reports. **They now have the capability to extract any data point needed to demonstrate impact.** This data can be used to track patient demographics, types of services provided, and the overall volume of patients served by the mobile unit.

Storytelling & Funding Support:
Storytelling has been a crucial element in advancing the work. Internally, Robeson Health Care Corporation reports on the initiative's progress and staff actively participate in foundation meetings. The consortium meetings serve as a platform to share information about the mobile unit and consistently highlight transportation as a barrier to care, generating interest, and encouraging other stakeholders to apply for similar grants. The initiative's impact has also been shared with **county commissioners and other counties** (like Scotland and Cumberland County) facing similar transportation challenges.

Sharing the story has directly aided in gaining external funding support by:

- **Demonstrating impact:** While specific data points were initially hard to pull, the narrative of reaching underserved populations and breaking down access barriers resonated with funders.
- **Highlighting a unique solution:** The mobile unit presented an innovative approach beyond traditional transportation solutions, appealing to grant providers.
- **Fostering collaboration:** The consortium's collective approach and shared mission, as told through their collaborative efforts, likely made grant applications more compelling. The ability to articulate a clear problem (transportation) and a tangible solution (mobile unit) helped secure continuous funding.

Biggest Obstacle & Overcoming It:
The biggest obstacle has been consistently **deploying the mobile unit to different places** due to communication breakdowns and bureaucratic hurdles, particularly with large organizations like school systems. This led to "sputtering" efforts and difficulty maintaining a consistent schedule.

Overcoming this involved:

- **Perseverance and flexibility:** Despite setbacks, they continued efforts, even using the unit for outreach at parades to raise awareness.
- **Internal advocacy:** Individuals within Robeson Health Care Corporation actively pushed for the unit's utilization and connected with its coordinator to understand needs and share ideas.
- **Leveraging relationships:** The established trust and relationships within the consortium helped navigate some of these challenges, even if direct bureaucratic issues remained. The increased visibility and recognition of the mobile unit across the county also helped in generating interest and opportunities.

Moment of Pride & Key Accomplishments:
A significant moment of pride for the team is the **transformation of the mobile unit into an effective tool for increasing access to care and reducing reliance on traditional transportation.** This internal shift in thinking led to discussions about acquiring additional, smaller, more agile units for specialized services like sports physicals or flu shots.

Key accomplishments include:

- **Expanded access to care:** Providing essential services like immunizations and sports physicals to children who otherwise wouldn't have received them, allowing them to attend school or play sports.
- **Addressing unmet needs:** Diagnosing and treating conditions like COVID-19 for individuals who lacked transportation, preventing untreated illnesses.
- **Community recognition:** The mobile unit has become more recognized across the county than individual health centers, highlighting its significant presence and impact.
- **Building trust and breaking silos:** The consortium's success in fostering collaboration among diverse agencies, leading to joint grant applications (e.g., bringing medication-assisted treatment to the detention center) and a unified approach to community problems.
- **Impacting special needs populations:** Successfully providing care for unhoused children, enabling them to stay in school, and planning to provide sports physicals for Special Olympics participants.

Conclusion:
Robeson Health Care Corporation's mobile unit initiative stands as a testament to the power of collaborative community engagement and adaptive problem-solving in addressing critical healthcare access issues. What began as a response to a pandemic evolved into a vital, recognized community resource, effectively bringing essential healthcare services directly to underserved populations.

The success comes not only from the tangible services provided but also from strengthened relationships, dismantled barriers, and a unified mission among community stakeholders from various backgrounds. This ongoing dedication to innovation and collaboration promises continued positive impact on the overall health and well-being of Robeson County.

Case Study: Southern Carolina Housing's Mobile Grocery Store Initiative

Executive Summary:
Southern Carolina Housing embarked on an innovative initiative to launch a **mobile grocery store** in Robeson County. This project directly addresses critical issues of food insecurity and transportation barriers in rural food deserts. The concept emerged from discussions within the Kiwanis Club and was validated through extensive **community cafés**, which gathered resident input on everything from product selection to payment methods. Despite facing significant supply chain disruptions and some governance challenges, the project has fostered strong community partnerships and aims to provide dignified access to healthy food and essential household items for residents, ultimately improving their quality of life.

Project Vision & Goals:
The vision for the mobile grocery store was born from a recognized need to address **transportation issues** in Robeson County, specifically concerning access to grocery stores. While the existing public transportation system (SEATs) prioritized medical appointments, it lacked the capacity for regular grocery runs. The project's vision, inspired by a similar initiative in Kentucky seen by Lumberton Housing Authority members, was to **bring a full-fledged grocery store on wheels directly to residents** in food deserts.

The primary goals include:

- **Improving access to healthy and fresh food** for residents in rural areas.
- **Reducing transportation burdens** for individuals, particularly the elderly and disabled.
- **Enhancing the dignity and quality of life** for community members by providing convenient access to essential goods.
- **Challenging existing policies** that contribute to food deserts (e.g., dollar store proliferation without fresh food requirements).

Team Formation & Problem Identification:
The initial team coalesced from individuals already concerned with community challenges. A grant facilitator from UNC Health Southeastern, was actively researching transportation issues as part of a Kate B. Reynolds Charitable Trust grant focused on social determinants of health. Concurrently, the Lumberton Housing Authority had observed a successful mobile grocery store model. Their shared concern for transportation barriers, particularly for housing authority residents, brought them together.

The core problem identified was the **lack of accessible and reliable transportation to grocery stores** in Robeson County's rural areas, leading to significant food insecurity. They also pinpointed the proliferation of dollar stores in these areas, which, while accessible on foot, offered limited healthy food options and posed challenges for obtaining heavier household items.

Community Engagement & Challenges:
Community engagement was foundational to the project from its inception. The team hosted **"community cafés" (following the World Café model)**, essentially community forums, to validate the need for a mobile grocery store and gather detailed input from residents. This feedback informed crucial aspects like desired food items, product types (including unexpected requests for cleaning supplies), operating schedules, bus design, and preferred payment methods.

Post-launch, engagement continues through:

- **Southern Carolina Housing's newsletter** to all residents.
- Ongoing discussions within the **Healthy Robeson Coalition.**
- Inclusion as a **"chip" (community health improvement plan)** in the county's community health needs assessment, ensuring continued visibility and data collection once operational.

The biggest challenge encountered has not been community engagement itself, but rather **supply chain disruptions.** Specifically, delays from contractors selected by the housing authority to complete work on the bus.

Resourcing & Project Aim Determination:
The initial focus on transportation was aligned with grant funding from **Kate B. Reynolds Charitable Trust** to UNC Health Southeastern for addressing social determinants of health, an issue identified by both the health system and community members.

Upon meeting the Lumberton Housing Authority members, the specific intervention—**a mobile grocery store**—crystallized. This decision was informed by:

- Research into SEAT's capacity limitations for grocery transport.
- Awareness of Duke Endowment grants focusing on obesity and nutrition, and the prevalence of dollar stores in rural areas.
- The Lumberton Housing Authority's observation of a successful mobile grocery store.

Action Plan & Data Utilization:
The plan of action involved extensive research into mobile grocery store models, including connecting with existing mobile produce initiatives, securing grants to fund the endeavor, and acquiring and outfitting a bus as a mobile grocery store. Key aspects included:

- **Designing the store based on community feedback** gathered during the community cafés.
- **Addressing logistics** for stocking healthy food, local produce (when available), and essential household items.
- **Developing a schedule** to reach various food deserts in the county.

While the bus isn't fully operational yet, the team plans to collect specific data once launched:

- **Types of items purchased:** Tracking healthy food purchases versus other items and demand for local produce.
- **Frequency of use:** How often residents utilize the service.
- **Impact on travel:** Assessing reductions in travel for groceries.
- **Anecdotal evidence:** Continuing to collect stories from residents about how the service improves their lives.

Storytelling & Funding Support:
The story of the mobile grocery store is being proactively shared through:

- **Newsletters** from Southern Carolina Housing.
- Discussions within the **Healthy Robeson Coalition.**
- Inclusion in the **county's community health needs assessment** presented to the hospital board.

Sharing the story, especially through anecdotal evidence, is crucial for gaining support, though the team notes a challenge in resonating with policymakers and potential donors who may lack an understanding of food insecurity without direct experience. To overcome this, future plans include:

- **Advocacy training for residents** in food deserts to empower them to vocalize their needs to elected officials.
- **"Walk a mile in their shoes" simulations** for elected officials and stakeholders to foster empathy for the challenges faced by residents.
- The potential for **short-form digital storytelling videos** featuring community members sharing their experiences.

For sustainable funding beyond the current grant, discussions are ongoing with:

- The **county government** (which runs SEATs) for potential support with maintenance and fuel costs.
- Grocery chains like **Food Lion** (which supports food banks) and other local grocery stores.
- **Cold storage companies** for food donations.
- **Local farmers** for "grow a row" programs to donate produce. Anticipating that **direct purchases** by residents will cover some operational costs.
- Seeking additional **grants focused on food insecurity.**

Biggest Obstacle & Overcoming It:
The biggest obstacle has been **supply chain disruptions and delays from selected contractors,** particularly a vendor responsible for wrapping the bus. Overcoming this involves:

- **Persistent advocacy and intervention,** leveraging experience and relationships to push for progress.
- **Continued internal communication** and keeping the project's momentum alive through various engagement efforts, even while the physical asset faces delays.

Moment of Pride & Key Accomplishments:
The team's perseverance in **bringing the project to the brink of completion,** despite the numerous hurdles was a moment of pride. The bus is nearly ready to be deployed, awaiting only its final wrap.

Key accomplishments include:

- **Successfully identifying and validating a critical community need** (transportation to groceries) through direct resident engagement.
- **Building strong partnerships** among various community organizations, including UNC Health Southeastern, Lumberton Housing Authority, Kiwanis, and the Healthy Robeson Coalition.
- **Designing a responsive intervention** that addresses not only food access but also the dignity and practical needs (like carrying heavy cleaning supplies) of residents.
- **Influencing policy discussions** by highlighting the impact of dollar store proliferation and advocating for changes that provide healthier food options.
- **Maintaining enthusiasm and support** for the project within the community and among stakeholders despite significant delays.

Conclusion:
The mobile grocery store initiative in Robeson County exemplifies a dedicated, grassroots effort to tackle deeply rooted social determinants of health. Led by proactive individuals and propelled by robust community engagement, the project demonstrates a profound understanding of local needs, extending beyond basic food access to encompass the dignity and practical realities of residents.

While supply chain and governance issues have presented challenges, the project's resilience, strategic partnerships, and clear vision for improving quality of life in food deserts underscore its potential for significant, long-term impact once fully operational. It serves as a powerful illustration of how community-driven solutions, even in the face of adversity, can strive to meet fundamental human needs and promote a fairer society.

Case Study: Scotland Health Care System – Bridging the Transportation Gap in Robeson County

Executive Summary:
Scotland Health Care System launched a crucial initiative to address transportation barriers for patients in Robeson County, North Carolina. The project emerged from clear community feedback and internal data highlighting transportation as a significant impediment to accessing healthcare. The **team successfully implemented a transportation service,** demonstrating a positive impact on patient access, appointment adherence, and ultimately, health outcomes. This case study details the project's inception, execution, challenges, and successes, offering valuable insights for similar community-focused health interventions.

Project Vision & Goals:
Before embarking on the initiative, the team aligned on a vision centered around removing transportation barriers to ensure patients could access necessary care. Initial goals were to:

- Provide reliable transportation for patients, especially those at risk of missing appointments.
- Reduce Primary Care Provider (PCP) no-show rates.
- Decrease unnecessary Emergency Room (ER) visits and hospital admissions.
- Lessen patient stress related to transportation.
- Improve overall patient access to care.

Team Formation & Problem Identification:
Upon receiving grant funding, a multidisciplinary team was assembled, comprising individuals from care coordination, social work, community health, and administration. This diverse expertise facilitated a holistic approach to patient needs and community engagement.

The problem was identified through robust community feedback and internal data:

- **Community Health Needs Survey:** Transportation consistently emerged as a top barrier to care.
- **System-wide Social Determinants of Health Screenings:** Transportation was the highest-scoring reported need among patients.

This strong evidence base clarified that transportation was a critical and solvable issue directly impacting patient health.

Community Engagement & Challenges:
Community engagement was a cornerstone of the initiative from its inception. The team maintained connections with local partners, gathered patient feedback on transportation services, and utilized community outreach events to foster open communication.

The primary challenge encountered was **building awareness and overcoming trust barriers.** Many patients were unaware of the service or hesitant to accept help due to past negative experiences. The team addressed this by:

- Working closely with front-line staff to inform patients during screenings and follow-ups.
- Creating clear and simple program materials.
- Leveraging positive word-of-mouth as patients experienced the service.

Resourcing & Project Aim Determination:
Team responsibilities were assigned based on individual strengths and expertise, with care coordinators leading patient identification and the community health team focusing on outreach. Regular check-ins and flexible task adjustments ensured efficient workflow and prevented team member burnout.

The specific aim of the project – **to help patients in Robeson County get to and from appointments to stay on track with their care** – was determined by:

- **Consistent Data:** Overwhelming evidence from social determinants of health screenings and the Community Health Needs Survey highlighted transportation as the critical barrier.
- **Feasibility:** Recognizing that transportation was a realistic intervention given the grant funding.
- **Impact Focus:** Shifting from a general access concern to a targeted intervention to reduce missed appointments and improve health outcomes.

Action Plan & Data Utilization:
The plan of action involved leveraging team strengths for patient identification, outreach, ride coordination, and scheduling. Crucially, the team integrated data tracking from the outset to measure impact.

Pre-initiative data access:

- Hospital system's regular social determinants of health screenings (transportation as most frequent need).
- Community Health Needs Survey results (transportation as a major barrier).

Data collected during the initiative:

- PCP no-show rates (before and after service use).
- Hospitalizations (before and after service use).
- ER visits (before and after service use).
- Patient feedback on service experience.

Data utilization for impact measurement:
The collected data was used to assess whether patients were making appointments more consistently and if this led to fewer hospitalizations or ER visits. This data was vital for demonstrating the program's value to internal leadership, external partners, and potential funders.

Storytelling & Funding Support:
The story of the initiative was shared internally with hospital leadership and staff through updates and presentations, and externally with community partners. Patient feedback and success stories were highlighted to illustrate the human impact of the program.

Sharing the story and leveraging pilot data proved instrumental in securing external funding. By demonstrating a clear correlation between transportation access and improved health outcomes (e.g., reduced no-show rates, fewer ER visits), the team presented a compelling case for the program's effectiveness and long-term value, attracting further financial support.

Biggest Obstacle & Overcoming It:
The most significant obstacle was **building awareness and ensuring patients knew the transportation service was available.** This was overcome through:

- Direct communication by care coordinators and front-line staff during patient interactions.
- Development of clear, accessible program materials.
- Organic word-of-mouth as satisfied patients shared their positive experiences.

Message to North Carolina & Key Accomplishments:
Scotland Health Care System urges the state of North Carolina to recognize that **transportation is a healthcare issue, not just a logistical one.** Lack of transportation leads to missed care, poorer health outcomes, and increased healthcare costs. The initiative demonstrates that investing in transportation support directly improves health outcomes, reduces no-show rates, and decreases ER visits. This type of program is effective, scalable, and crucial for healthier communities across rural and underserved areas in the state.
The team is most proud of:

- **Meeting patients where they are:** Ensuring consistent access to care for those who previously struggled.
- **Team collaboration:** Departments working cohesively towards a shared community goal.
- **Demonstrable impact:** Showing tangible, positive results through data and patient stories as a means to describe long-term value and attract further financial support.

Conclusion:
This initiative underscores the profound impact of listening to community needs and implementing targeted, data-driven interventions. By focusing on transportation as a critical social determinant of health, Scotland Health Care System has enhanced individual patient outcomes and provided a model for fostering healthier communities statewide and beyond. The commitment to continuous improvement and sharing learned lessons will undoubtedly inspire similar vital efforts.

Appendix

Appendix

Key Terms and Definitions

Distinct stakeholder groups are required for effective social impact initiatives. These include:

Funding Organization(s) - provides funding for the pilot or established program aiming to initiate or sustain change in social impact initiatives. Funding organizations may be internal or external to a community development team (see below).

Community Development Team - A group of (1) established businesses, charitable organizations, and other influencers who have a vested interest in social impact; (2) grass roots organizations who are embedded within community, and (3) community members themselves.

Backbone - An entity or entities within a community development team that are responsible for organizing the infrastructure, governance, and activities of the multi-sector efforts needed to advance systems-level change.

Pilot Partner(s)- an organization provided funding to serve as a change catalyst within the community.

Upstream Interventions - Address the root causes of social issues by focusing on macro-level factors such as social structures, economic systems, and policies. The goal is to prevent problems before they arise by creating better structures and greater opportunities.

Downstream Interventions - Provide direct assistance to address the immediate impacts of social problems, with a focus on micro-level solutions. Their goal is to lessen the burden of disadvantage and guarantee accessible care and resources for all.

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