Connecting Resources & Driving Equity: Opportunities to Build and Spread Sustainable Community Referral Networks

RESEARCH TO PURSUE AND ADVANCE RACIAL EQUITY (RePARE)

JUNE 2024

Health Leads

CommonSpirit

blue california

California Health Care Foundation

Contents

Executive Summary

Community Referral Networks (CRNs) act as community care planning systems that facilitate connections between community stakeholders to help community members access essential resources like food, heat, housing, and other services. CRNs are enabled by a data architecture that facilitates coordinated referral, tracking, reporting, and measurement.

Unfortunately, CRNs have been under threat in recent years due to the increasing investment of large technology companies and private hospital systems in separate health information navigation platforms, which only include connections with a few community-based service providers. In addition, while **more than $2 billion has been invested in technology** to help local organizations manage data around essential resources, those platforms see limited adoption as community members are typically omitted from selection and implementation.

Research to Pursue and Advance Racial Equity (RePARE) is a liberatory design project that aims to assess the operational structure, financial makeup, and community impact of CRNs. To understand some of the root causes related to the financial viability of CRNs, Health Leads, and partners CommonSpirit Health, Blue Shield of California, and California Healthcare Foundation identified topics that were most crucial to inform the process. The Health Leads RePARE project team then conducted rigorous research to understand how CRN staff, fund, and communicate their impact to stakeholders. The team made suggestions for the future of CRNs and the resources they need for financial sustainability to ensure their continued success. Key findings include:

- Managing networks presents opportunities for more efficient allocation of resources to enhance community partnership development.
- By addressing resource limitations, networks can reduce burnout risk and maximize their impact.
- There is potential to develop a more sustainable and secure CRN revenue strategy for long-term success.

We are hopeful the findings, goals and recommendations outlined in this report advance conversations around how we can collectively ensure the impact and financial sustainability of CRNs as they continue to play a critical role in the health of our communities and spur action towards a more equitable future.

The Challenge to the Future of Community Referral Networks

Community Referral Networks (CRNs) have played a key role in the United States in addressing long-standing health inequities. CRNs act as community care planning systems that facilitate connections between community stakeholders (e.g., healthcare, social services, faith-based organizations) to help community members access essential resources like food, heat, housing, and other services. CRNs are enabled by a data architecture that facilitates coordinated referral, tracking, reporting, and measurement.

Unfortunately, CRNs have been under threat in recent years due to the increasing investment of large technology companies and private hospital systems in separate health information navigation platforms, which only include connections with a few community-based service providers. In addition, **while more than $2 billion has been invested in technology** to help local organizations manage data around essential resources, those platforms see limited adoption as community members are typically omitted from selection and implementation.

This rush of technology companies investing in these new healthcare platforms is largely due to updated Medicaid managed care contract requirements. In May 2022, 15 Section 1115 Delivery System Reform investment payment waivers were either approved or under federal review by the Center for Medicaid and Medicare Innovation which explicitly mentioned addressing the essential resource needs as a strategy to improve the health of those eligible for Medicaid. Of those waivers, seven encouraged or required healthcare providers to engage with community-based organizations (CBOs) as a means to support the Social Determinants of Health (SDOH) programming, and three waivers included a focus on establishing data systems that capture members' medical and SDOH information across the state.

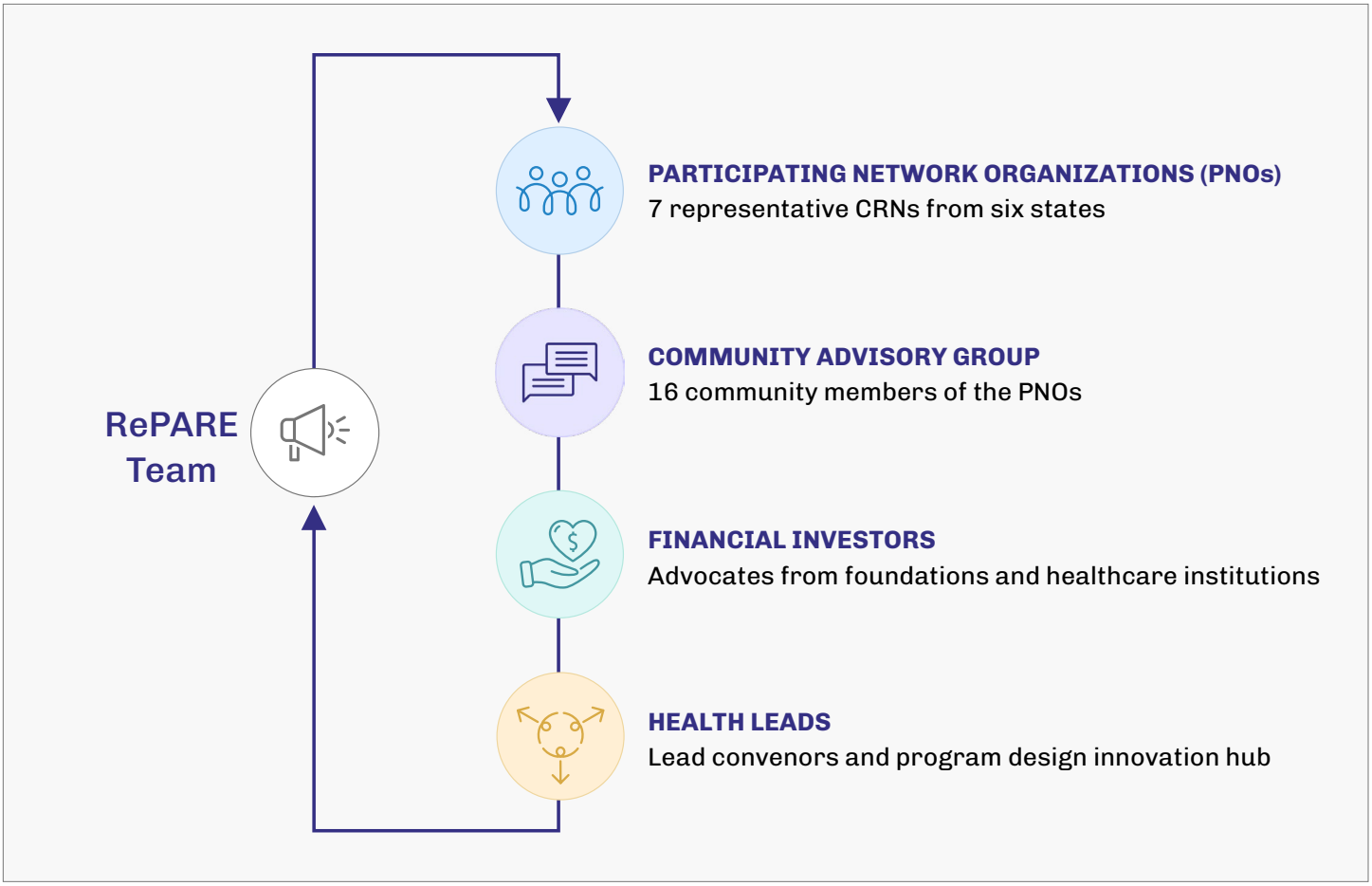
In addition to CMS efforts, the Biden-Harris Administration released **The U.S. Playbook to Address the Social Determinants of Health** in November of 2023. The document provides a "...set of structural actions federal agencies are undertaking to break down these silos and to support equitable health outcomes by improving the social circumstances of individuals and communities." The Playbook outlines three core pillars for investment: expanding data gathering and sharing, supporting flexible funding for social needs, and investing in backbone agencies.

While these initiatives represent positive steps forward, the risk remains that even well-intentioned efforts **may fall short if they fail to engage communities** as partners in the process . Meaningful progress requires moving beyond fast, short-term solutions to deep partnerships capable of yielding systemic change.

Research to Pursue and Advance Racial Equity (RePARE): A Collective Exploration of the Financial Sustainability of Community Referral Networks

Health Leads sponsored the Research to Pursue and Advance Racial Equity through Community Networks (RePARE) project, an endeavor to delve into the design and sustainable support of CRNs to enhance both community health and racial equity.

RePARE is a liberatory design project that aims to assess the operational structure, financial makeup, and community impact of CRNs. The goal of the RePARE findings is to help inform financial investors' ongoing commitments to CRNs and reinforce how their efforts can have a more equitable impact on the communities they serve.



From August 2022 through February 2024, the Health Leads RePARE team worked to gain a holistic understanding of the operations and finances involved in managing CRNs, and the experiences of those who utilize their services to maintain their health and well-being.

To conduct this research, the RePARE team brought together three key stakeholder groups:

Participating Network Organizations (PNOs)
The PNOs represented a broad spectrum of stakeholders from six different states that varied in terms of network models, geographical locations, operational tenure, organizational frameworks, and funding avenues. Their main function within CRNs is to oversee the operations, fundraise, and track service provision for their community.

Community Advisory Group (CAG)
The 16-member CAG is inclusive of four PNOs representing the communities the networks strive to assist, including individuals navigating local services, as well as managing health services. Their involvement steered the project towards racial equity by amplifying community voices and expertise.

Financial Investors Advocates
CommonSpirit Health, Blue Shield of California, and the California Health Care Foundation were critical to the exploration of CRNs, the shaping of the findings, and the amplification of RePARE's impact among fellow community network investors, including payors, providers, philanthropic organizations, and governmental bodies.

Through RePARE, the CRNs hoped to gain a deeper understanding of the impact of their services on community health and utilized tools and knowledge to make data-driven decisions that would ensure their sustainability and continued success. This project went beyond simply highlighting the challenges to operating CRNs, but took proactive steps, formulating enduring recommendations informed by the insights of those most affected.

To understand some of the root causes related to the financial viability of CRNs, the PNOs identified research questions they were most interested in exploring regarding the themes of costs and funding for CRNs. With the support of financial investors, the RePARE team then organized and narrows in on the following key areas of focus:

- Staffing makeup of CRNs
- Financing and funding of CRNs
- Measurement and communication of CRNs' success
- Experiences of CRN employees and their partners
- Experiences of community members that utilize CRN resources

The project team conducted research to understand gaps and opportunities in these core areas, to inform a set of recommendations around how CRNs staff, fund, and communicate their impact to stakeholders. Based on our findings, the RePARE team made suggestions for the future of CRNs, and the resources they need for financial sustainability to ensure their continued success.

Focus Area: Staffing

CRNs can take on many different structures, including:

1. Hotline
A community member can call a hotline if they need help finding a local service. For example, if they need food assistance, they can call the hotline, and they will be referred to a local food bank that can provide immediate food or help them sign up for benefits if they qualify.

2. Primary Care Provider Referrals
Often, a doctor's office within the CRN can provide referrals to non-medical services. For instance, during an intake appointment, they might ask if the patient or their family has missed more than two meals a day. If the answer is yes, they may ask for the patient's permission to follow up with a local community to help with this issue.

3. Local Agency
A local agency may work with multiple partners to refer clients to the services they need. For example, a local community-based organization or school may have walk-in and call-in options for community members in need, and they can refer patients that way.

The typical staffing model for a CRN

To better understand the specific responsibilities within the staffing structures, the RePARE team surveyed CRN members' top three responsibilities involved in the management of CRN sites. The research found that essential staffing components consisted of the following:

- Management and Oversight
- Community Engagement
- Accounting and Budgeting
- Technology Management & Oversight
- Direct Service referrals

Management and Oversight of CRNs

Strategy, Supervision & Staff Development

Strategy and staff supervision/development are essential staffing components that often oversee the management and oversight of a CRN. Job responsibilities such as strategic planning, financial projections, and staff development are key to their operations. Strategic planning includes financial projects, program creation, and execution while staff development includes planning and facilitating staff meetings, performance reviews, and supervising the day-to-day activities of the organization.

Community Marketing, Engagement & Communications

Internal & External Relationship Building & Collaboration

Community engagement, internal and external relationship building, and collaboration are also necessary staffing components. CRN staff reported that building partnerships with external organizations, engaging stakeholders, convening regular meetings, and developing champions are crucial for successful community partner engagement. Lastly, establishing suitable marketing strategies and objectives for community engagement and onboarding of health centers and community partners into the CRN is an essential task to ensure continued functionality.

Technology and Management Oversight

Data Infrastructure, Data Collection, & Analysis

A key ingredient to the referring, tracking, and administration of essential health services is the technology and data infrastructure of a CRN. Technology Implementation and Oversight are usually costly and involve several steps especially since many of our CRN participants engaged community members for the development of their platforms to ensure the platform is equity-focused, and community-driven.

Key job duties reported included building and maintaining the data platform, creating surveys for clients to complete, and completing evaluations of the program that would often be included in the reports to funders, investors and community members.

Direct Service

Development & Management of Community Partnerships, Service Referrals, Community Level Engagement, Data Entry

Direct service staff play a crucial role in connecting clients with the appropriate resources and services in their communities. Despite differences in specific responsibilities across organizations, a survey of 19 direct service staff members revealed that many shared common job duties such as calling and emailing clients and providers about referrals and programs, directing assistance requests and referrals to programs, and coordinating ride referrals and volunteer efforts. Other duties included emergency food and shelter work, resource navigation, and updating referral and outreach information. Regardless of budget constraints or job duty variations, the importance of direct service skills and capabilities was widely recognized across networks.

> ***"Having direct service staff is a very significant element of this work, and it doesn't work to have a resource referral network if you don't have those direct service staff, including navigators and Community Health Worker/ Promotores that someone important said and can make the reader get inspired."***
>
> – INTERIM DIRECTOR

Accounting & Budgeting

Fundraising & Financial Expenditures

The Accounting and Budget Department at most CRNs are responsible for a variety of financial tasks, including fundraising and expenditures, grant billing, payroll, reconciliations, and forecasting. These teams oversee organizational and departmental planning and budgeting, ensuring that all financial decisions align with goals and objectives. They meticulously review financials, grant billing, and payments to ensure accuracy and compliance with regulations. The Accounting and Budget Department plays a vital role in the CRN's financial success, ensuring that funds are allocated efficiently and effectively to support the organization's mission.

Focus Area: Financing and Funding

Part of our analysis included how CRNs manage and fund their networks. The RePARE team developed tools to support data collection against each financial research question:

- **Staff Survey:** 19 staff members who support their network project efforts in roles such as data analyst, program or project manager, and direct service provider completed an anonymous survey to measure the level of effort required to run a network.
- **Total Cost of Partnership Workbook:** A Microsoft Excel workbook created by the Nonprofit Finance Fund and Center for Health Care Strategies was provided to network leadership and finance staff who oversee and manage network budgets to help capture network operational costs and project funding. Network leadership and finance staff who oversee and manage the network's budget reported **$11.4M in costs, $8.5M in committed revenue from 26 sources**, and 314.17 full-time employees, across the seven CRNs analyzed.

The RePARE team analyzed several aspects of CRN staffing models to understand the **level of effort** across each PNO. The Level of Effort is identified as the amount of work needed to support the network's daily activities. Questions that were asked were: *What goes into a network? How much people power does it take, and what does effort look like on the part of network employees?*

Seven out of 19 staff survey respondents identified themselves as **direct service staff**. PNOs reported direct service staff comprise a smaller portion of the budget and there is a high degree of budget variability across PNOs.

The analysis showed that:

- 32% of funding goes towards the **management and oversight** of community referral networks and 21.5% goes toward the **development and management of community partnerships**, which house most of the **direct service** work and staffing.
- Four out of the seven participating networks have direct service staff, ranging from 15% to 77.5% of a budget.
- This represents a broad range of monetized investment among networks and the staffing flexibilities required to service the community.

FIGURE 1: Direct service staff represent an unexpected key segment of network staffing models.

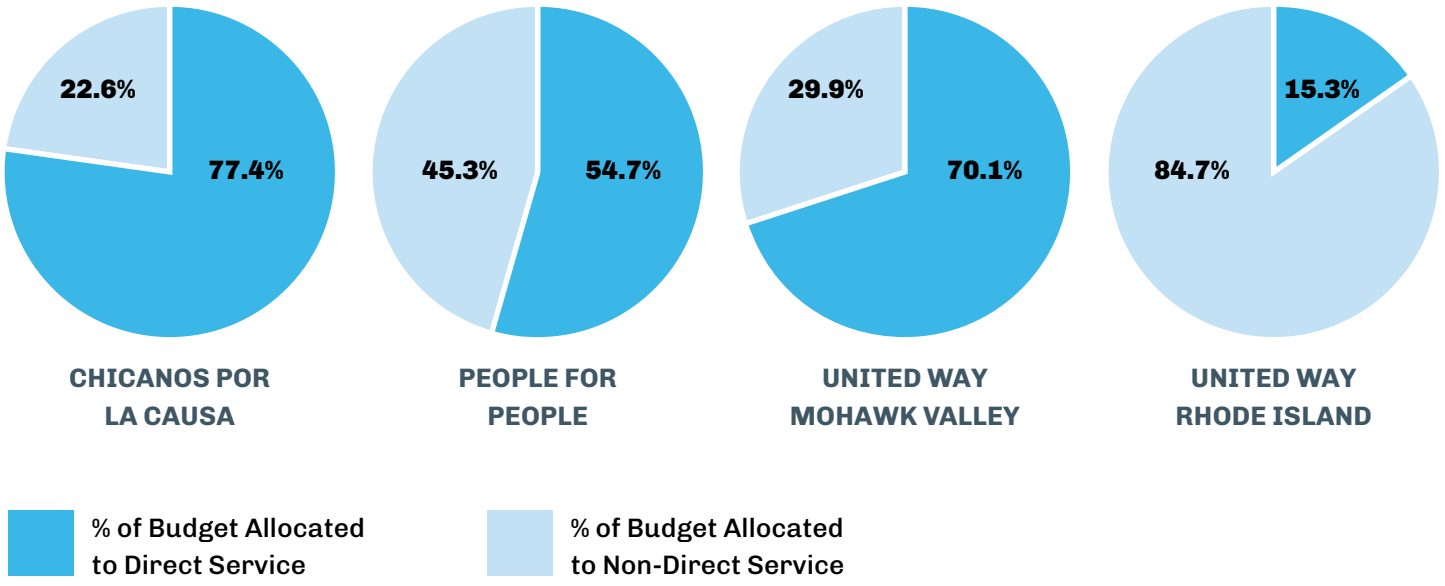
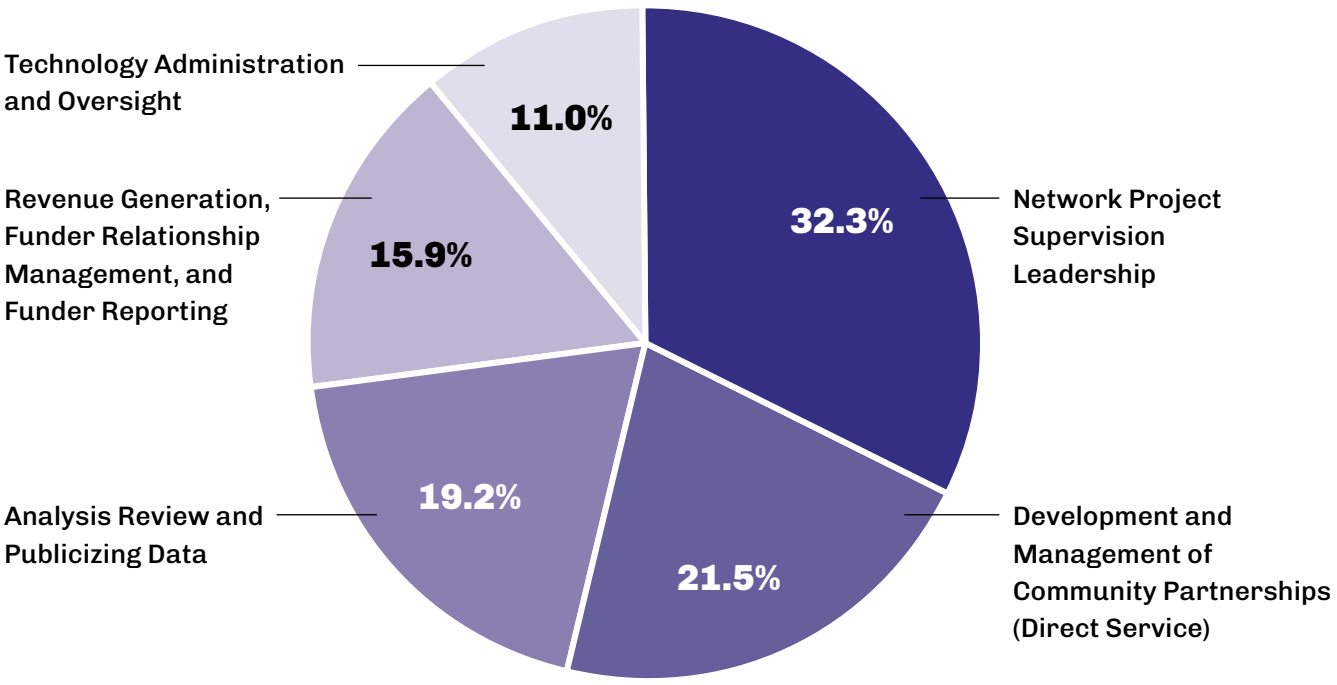


FIGURE 2: Reported Level of Effort it takes to run a network.



The RePARE team further examined the Level of Effort in CRN finances by examining the personnel monetization and coded non-personnel investments that were listed in the **Total Cost of Partnership Workbook**.

The team discovered that more funding is spent on the Management and Oversight (Network Supervision and Leadership) aspect of the CRN, and less is spent on Direct Services (Development and Management of Community Partnerships). Managing Networks presents substantial costs that fail to adequately support community partnership development.

FIGURE 3: Reported Level of Effort Across Network Aspects, Personnel and Non-Personnel

Operational budgets reveal competing narratives

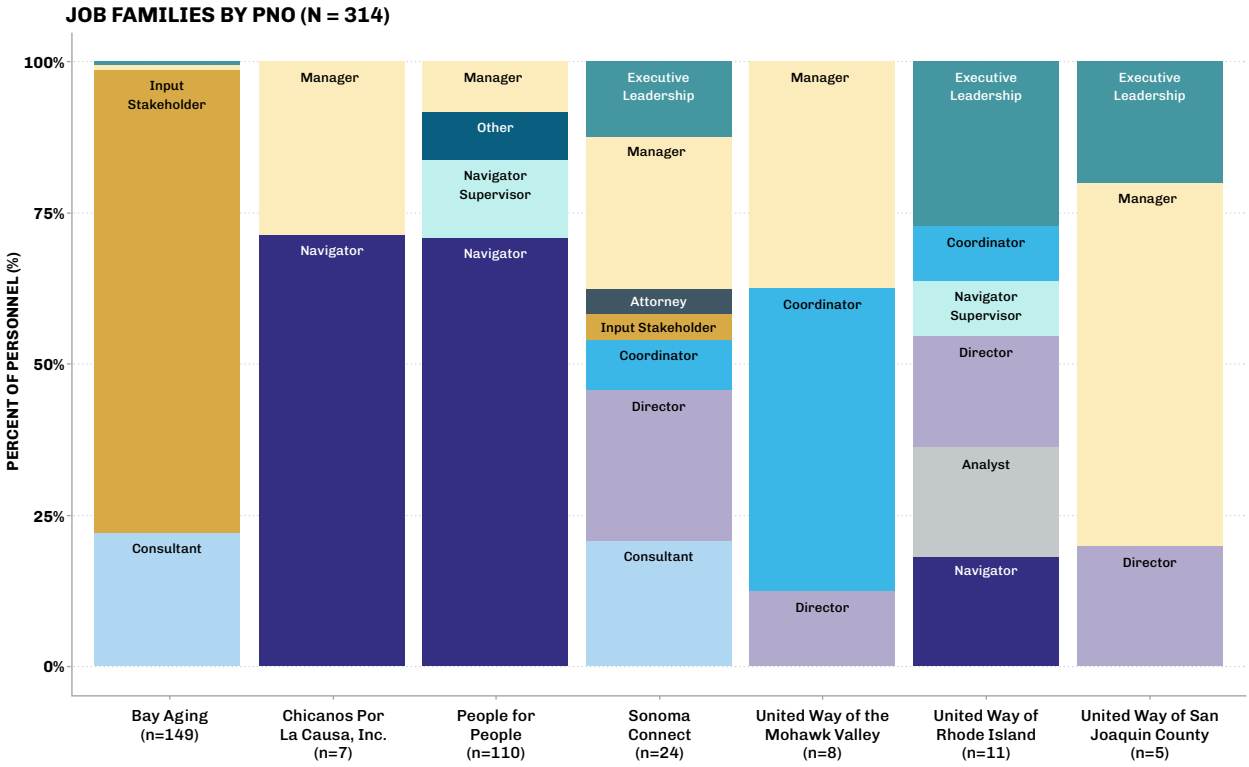
Furthermore, PNO operating budgets are skewed towards leadership roles, and while outreach and education are reported as significant staff duties, few roles are dedicated to these activities. Survey respondents report that this imbalance increases the risk of employee burnout as limited staff take on an outsized burden of owning stakeholder engagement.

However, this experience is also reflected among director-level employees (i.e. leadership) who report that their roles can or do feel unsustainable, that their tasks take longer than anticipated, and that their workload feels unmanageable.

The analysis of PNO budgets indicates a critical need for strategic investment in key roles to prevent employee burnout and enhance operational capacity. Input stakeholders, pivotal in engagement and feedback, are understaffed across PNOs, with only two organizations recognizing their importance through dedicated roles. This underrepresentation, as noted by a Senior Project Manager, limits the potential for outreach and community interaction, which are essential for the network's growth and effectiveness.

FIGURE 4: How are networks staffed? [capacity]

N= 314.17 FTEs, budget personnel



Similarly, the role of data analysts is scarcely acknowledged, with minimal allocation in personnel budgets, despite their crucial function in data management and reporting. Navigators, although unique in their community-focused responsibilities, are also a minority, suggesting a broader issue of insufficient staffing in roles that directly contribute to the network's sustainability and outreach capabilities. This situation underscores the necessity for PNOs to reassess their budgetary priorities to support and expand these vital positions, ensuring the longevity and health of the network and its employees.

- With just two PNOs including the role "input stakeholders" tasked with engagement and feedback, these 147 full-time employees represent an operational component that is primed for investment, according to one Senior Project Manager. "There is so much more that we would like to do but we don't have the capacity to do more, more outreach, more touch points... We need way more capacity to make it run like we want it to."
- Only one network names an "analyst" as part of their staff capacity, and just one PNO lists two FTEs as "analysts" in their personnel budgets.
- While a unique role across all participating PNOs, "navigators" are a significant percentage of staff where they are deployed in the three PNOs that reported 83.15 FTE in their budget.

> ***"Overall, PNOs are faced with the challenge of doing more with less... especially when you work in small orgs or nonprofits, there are never enough people to do the work you want to do. Often there can be passion burnout and not enough people to carry them through."***
>
> – SENIOR PROGRAM MANAGER

PNOs must consider key factors for CRN financial sustainability

Collectively, PNOs reported that their monetized cost of Level of Effort is valued at $11.4 million; however, from the 26 funding sources analyzed, PNOs report year-to-date revenue of $8.5 million in committed funding. The resulting **$2.9 million deficit in operational costs** must be sourced by other parties. Of the $8.5 million in committed funding, networks reported local government as the leading source by a large margin, with a 62% share of revenue. The third most prominent source of funding was the federal government with a 10% share of revenue.

This positions CRNs in risky funding models that are heavily dependent on a few sources of income, and require supplemental sources that are not sustainable. Additionally, to meet the deficit, most networks are forced to draw down from funds that are not designated for network costs. For instance, four of the seven PNOs identified themselves as a network funder or backbone support. This was the second leading funding source at 18% of revenue, and not sustainable in the long-run, especially with shifts in national and local policies related to healthcare funding. Health systems are one of the smallest investor types at 1% of revenue, and the least desirable for the majority of participants.

FIGURE 5: RePARE PNO Network Funders

Budget Workbook, $8,591,617 in Committed Funding from 26 sources

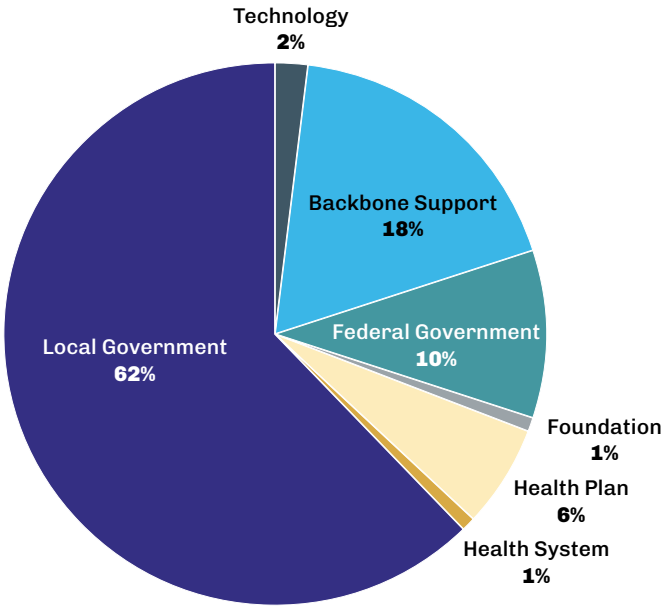
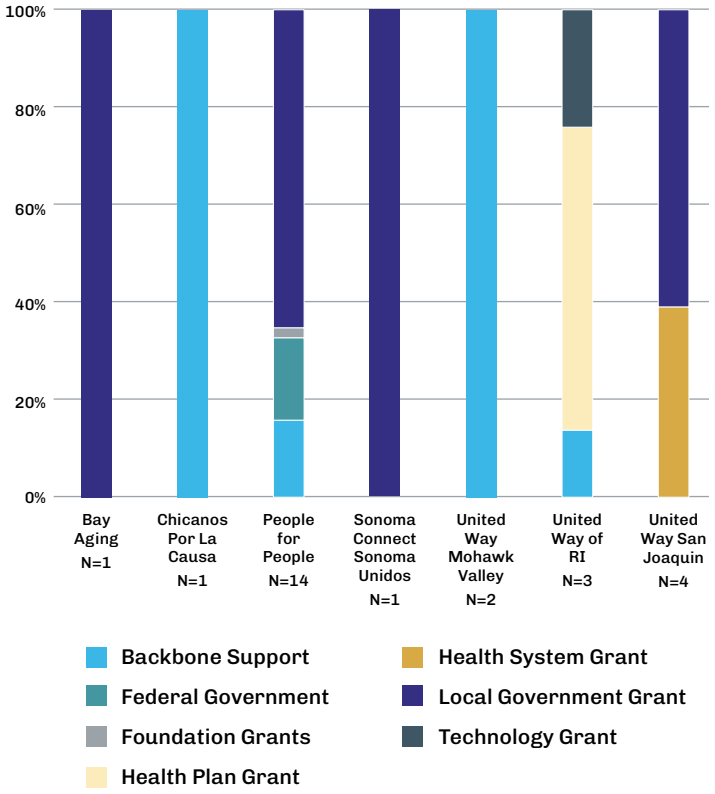


FIGURE 6: Network Funding Models: Overall breakdown of funding across the PNOs



The results of the financial sustainability efforts reveal that investors must more deeply engage with the networks they fund to better understand the strength and sustainability of network funding models and advocate for adequate support to deliver community impact. To examine this, the team took essential next steps, understanding their impact measures, surveying employees of communities, and surveying clients that CRNs serve.

Focus Area: Measurement & Communication of CRNs' Success

CRNs use a number of methods to communicate their success to funders, partners, and community members

RePARE sought to understand how networks communicate their impact to community stakeholders and investors by using the Impact Measurement Workbook. This workbook allowed leaders of each PNO to share how they communicate their stories to investors and the rest of the community. It breaks down what is funder-mandated and exactly what constituents can view and access the data. The Health Leads team coded 70 measures that are in use by the seven PNOs. (*These measures include assumptions that were not verified by participating networks.*) Analyzed research revealed a significant emphasis on process measures (63) vs outcome measures (7). Additionally, many networks have measures that are focused on delivering services rather than measuring other indicators, due to contractual obligations mandated by funders. Examples of reported measures that are not funder-mandated include the number of:

KEY FINDING

Differing interests in what gets measured often means PNOs are tracking two sets of measures: those that are required for funder reporting and those that improve the quality of services delivered.

- Community Health Workers/Promotores (CHW/P) who have completed the learning opportunity series for core competencies for CHW/P (by sector: schools, health centers, CBOs)
- Community partner organizations adopting trauma-informed policies
- SNAP applications completed
- ACE or SDOH screenings and referrals conducted by cross-sector organizations

Overall, RePARE's research revealed that PNOs prioritize process over outcome, with a focus on delivering services rather than meeting contractual obligations. Despite the lack of direct funding for service providers, the networks still consider direct service crucial and find it important to track these additional measures.

Opportunities exist to improve sharing impact data with community partners and stakeholders

Beyond tracking against the sheer number of measures, networks also dedicate substantial resources to managing various data-sharing processes with a majority reporting sharing network information with five or more different types of partners which include: education systems, government agencies, philanthropic entities, and community service organizations.

While PNOs report that "access to data" is most often accomplished through reporting that is managed by their staff, most do not have public or partner-facing dashboards. Closing this data gap is crucial in exploring equitable data-sharing practices. A popular saying amongst community health workers/promotores and activists is, "Nothing about us without us," meaning that the community should not just be the subject of research data, but also be the owner of their data.

KEY FINDING

The technology infrastructure to make CRN data public or more accessible is inadequate. PNOs dedicate substantial resources to manage various data-sharing processes with multiple stakeholders.

Five out of seven PNOs also reported taking steps to make data available to community members although the technology infrastructure to make real-time data-sharing is limited. According to one Senior Project Manager, "[We are] looking into something like a public dashboard that we can share out information more often. People still don't exactly know what [we] do, we are looking to use our data to spread the word about what we are doing in the community. It is important to share those success stories about how our members can successfully connect to services."

Focus Area: Effectiveness of Connecting Clients to Services

RePARE's Community Advisory Group (CAG) tapped their network of community members and their affiliated organizations to conduct a survey of 44 network partner employees followed by a focus group to capture and verify their perceived effectiveness in connecting network clients to their services and referral sources.

The survey results displayed that PNOs are successful in helping clients connect with services by utilizing numerous referral systems, such as 211 services and personalized introductions to services. The survey also revealed that CRN employees have certain skill sets that ensure successful service connections. Their specialized support in legal aid, language support, and care coordination help them effectively understand and build relationships with community members. These efforts are supported by creating a personal connection with clients and meeting them where they are, which effectively leads the clients to the services they need.

Community Advisory Group

The 16-member CAG is inclusive of four PNOs, representing the communities the networks strive to assist. These include individuals navigating as well as managing health services. Their involvement steered the project towards racial equity by amplifying voices from the communities.

While reported successes are meaningful, internal network systems and structures hinder their overall impact. As one network employee indicated, meeting network community members' needs starts by reflecting the makeup of their service population. "[We] need [a] culturally responsive workforce (e.g. promotores/community health workers) and skill building for people with lived experience."

KEY FINDING

PNOs must overcome internal systemic challenges to better connect with clients and meet community demand.

Employees at PNOs report a series of system-wide challenges when connecting clients with healthcare and social services. These challenges align with our findings in the financing and funding focus area (*Figure 3*), which report the level of effort across Networks. Data showed that managing network costs fails to adequately support community partnership development.

PNOs caution that without additional investment and collaboration from cross-sector stakeholders, community needs will go unmet.

PNOs report the following racial health equity challenges are limiting their effectiveness:

- **Building a culturally responsive workforce** and investing in skill-building for staff, particularly for working with folks with lived experience. Staff capacity and resource availability within these systems also need to be addressed.
- **Investing time in education and engagement takes time.** Building trust is crucial for fostering cultural humility, enhancing community health, and practicing racial equity.
- **Funding and investment to build trust in community relationships are needed.** A network that intends to help community members access resources is limited in impact by the relationships between the network providers and those that provide resources.
- **Developing networks in rural areas can be especially challenging**, especially in places with significant racial variety, including large immigrant populations and non-English speaking populations.

Focus Area: Expressions of the Clients

RePARE's CAG surveyed community referral network clients to capture their experiences and attitudes to assess how effective the PNOs are in meeting community needs.

Surveys were given to 65 callers to 211 resource lines, and 156 network clients in Arizona, California, New York, and Washington between July 23 and September 23, 2023. Surveys were conducted by 211 operators and electronically by individual CRN clients. The survey data was verified through meetings with participants from the CAG and PNOs that explored the themes and captured related client experiences and insights.

RePARE findings show that **64% of respondents find referral services useful.** As a result, referral networks seem to be meeting the needs of clients effectively. While these services are useful to community members, systemic barriers like transportation and community access to service information persist in preventing access to essential resources. **Nearly 36% of respondents do not feel fully satisfied with these services,** which is significant. The referrals received by 22% of respondents do not meet their needs on occasion, while the remaining 14% expressed that their needs were consistently unmet. While these services are generally effective, a substantial segment of the population remains underserved by networks — despite their overall effectiveness.

PNOs saw room for improvement in CRN diversity

The survey also included questions related to the experiences of "diverse entities," which encompassed racial/ethnic groups, the annual income of individuals/families, and the varying needs of living locations (urban/suburban). Understanding the needs and experiences of these individuals is essential to the values of the Liberatory Design Model used in designing the engagement and research for Black Indigenous and People of Color (BIPOC).

The survey results indicated that **46% of respondents felt that organizations handled their diverse identities "very well,"** suggesting that almost half felt their identities were well recognized. Additionally, nearly 24% felt their identities were recognized "well," indicating a significant portion had a positive experience. However, 24% rated the handling of their identities as "average," suggesting room for improvement. Furthermore, smaller segments, each comprising 3%, expressed dissatisfaction with the recognition of their diverse identities, indicating that a minority felt under-recognized.

Report participants discussed the limitations of the client survey to address diverse needs. In reviewing RePARE's findings, the CAG was motivated to further explore and understand the diverse needs within their communities. The broad spectrum of experiences reported by Indigenous and multiracial groups indicates different levels of recognition and satisfaction, emphasizing the importance of addressing diverse identities effectively.

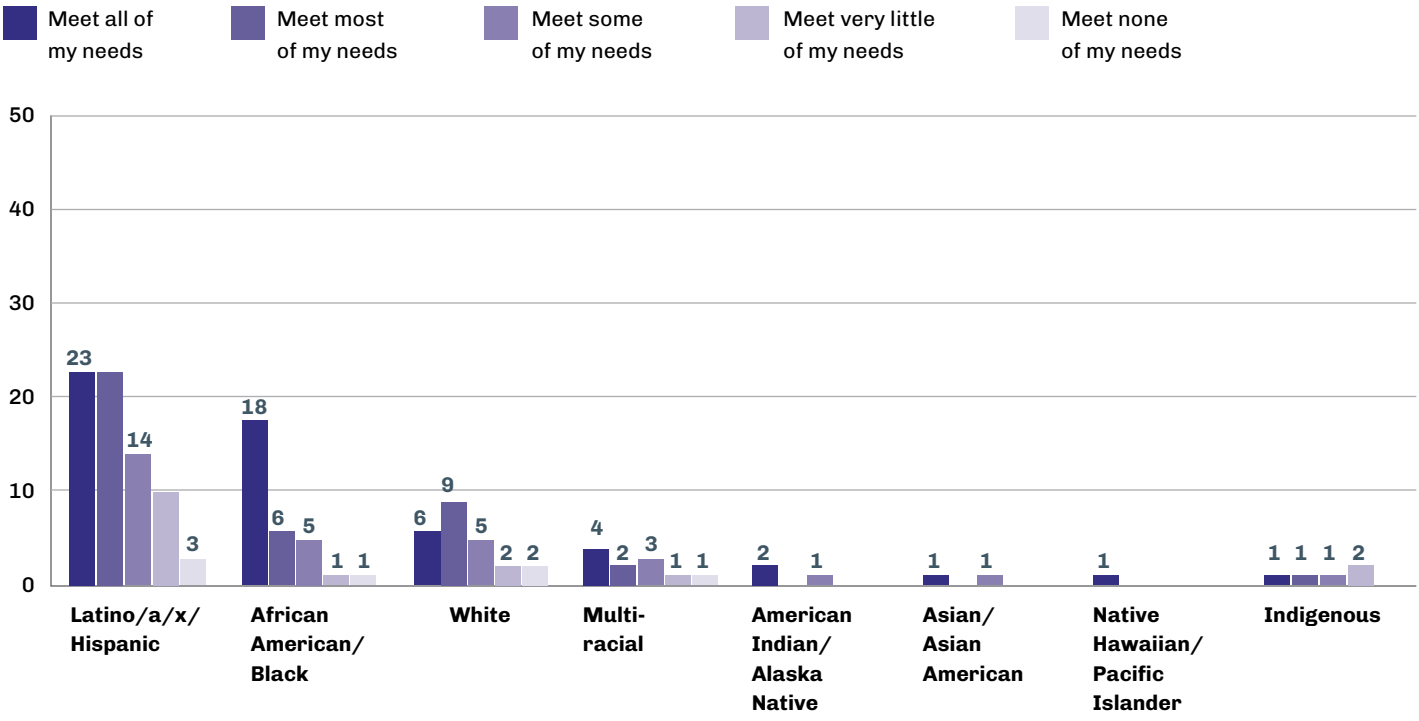
KEY FINDING

RePARE found a wide range of responses between Latino/a/x/Hispanic and African American/Black communities, suggesting a diversity of experiences using networks within these groups.

- Indigenous and Multi-racial groups have a wide spread of satisfaction, with 40% of respondents reporting very little of their needs being met while 20% report all/some/most of their needs are being met by networks.
- The Latino/a/x/Hispanic community comprised the highest number of respondents and reported a wide range of satisfaction, with nearly two-thirds indicating that their needs are either fully or mostly met, however, a substantial amount feel their needs are not being met.
- White respondents have a relatively balanced distribution of satisfaction, with some 80% leaning towards their needs being met to some degree.
- A majority of women and men report they are satisfied and that CRN systems meet their needs; one non-binary respondent reported most of their needs are met.
- **53 of 156 respondents across all racial and ethnic groups believe their needs are fully met** by the resource referrals they receive.

FIGURE 7: How would you rate the resource referrals (like housing, legal, and medical services, etc), you receive in terms of meeting your needs effectively?

Answered: 143 Skipped: 2



CRNs are key to identifying barriers to top local services needs

With a unique view into local resource landscapes, PNOs were able to easily identify what prevents community members from accessing services. This is critical to creating a path to remove systemic barriers to essential resources. Overall, respondents report the top five barriers to accessing network services are:

1. Transportation
2. Lack of information or awareness
3. Income or insurance limits
4. Interpersonal interactions with staff
5. Language differences or citizenship requirements

Relatedly, 45% of respondents say their income status has prevented them from accessing services. This is particularly relevant to network clients who have multiple jobs to make ends meet. As one client shared, "In my case I have to work double shifts to be able to pay my bills which affects me not being able to go or call to ask for information for certain resources."

Clients facing income challenges also report that they grapple with decisions to pay for food or gas for a personal vehicle or on public transportation. According to one client respondent, "If I don't have enough money for gasoline, I can't afford to pay for it."

NETWORK CLIENTS DESCRIBE BARRIERS TO SERVICE ACCESS

TRANSPORTATION

"I have no transportation and rely on my friends and family to get assistance."

LIMITED KNOWLEDGE OF RESOURCES

"The lack of advertising makes it difficult to find the organizations that offer the services."

INCOME/INSURANCE LIMITS

"...Some resources will not help because I make too much income with my SSI. I have been denied due to having too much income and just gave up trying..."

INTERPERSONAL ACTIONS/ UNWELCOMING STAFF

"I have experienced racial profiling or lack of experiences of job duties at service locations."

Recommendations

RePARE analysis participants have achieved some success in promoting racial health equity by effectively connecting clients with healthcare and social services in their local areas. However, the networks have emphasized the imbalance of power and influence between funders and organizational leadership as a significant challenge.

Members highlighted the need to strengthen trust between service providers and community members to ensure the effective delivery of services and belief in the network's mission. Additionally, the lack of diversity in the composition of boards of directors and leadership teams has been identified as an obstacle, along with the failure of current leaders to continue to prioritize racial health equity initiatives.

Below are several successful approaches to implementing racial health equity across a variety of spectrums within CRNs.

Relationship Building & Trust

- Building relationships and trust with community members is key to uncovering which services they find beneficial. PNOs seek to meet people where they are and consult with their clients, and people with lived experiences (promotoras/ community health workers) on how to improve efforts.
- PNOs leverage referral systems such as 211 services to facilitate warm hand-offs. These approaches, coupled with strong relationships with service providers, are key to ensuring that the services are appropriate and accessible to community members. PNOs do this through Building essential relationships and fostering collaborative efforts across various sectors.

> ***"It is hard to find healthcare providers that look like our community...[There is] lack of trust in the health care system from the community."***
>
> – OUTREACH SPECIALIST

Feedback & Communication

- PNOs should prioritize creating channels of trust, paths for open feedback and sincerely listening to the needs of the community through a human-centered approach.

Specialized Resources Support

- PNOs leverage technology platforms and their social media to promote specialized support such as legal aid, language support, and care coordination.

CRN Equity Initiatives

- Hiring a workforce to create an organizational staff that matches the demographics of their service communities.
- Developing and implementing racial health equity strategies, including anti-racist **liberatory design-based frameworks**.
- Developing clear collective impact statements with roles and understanding of partnerships.
- Providing racial health equity training to individuals overseen by specific departments, such as human resources, and tracking participation in various events, including diversity office initiatives.
- Creating groups and committees such as a health equity council or social determinants of health committee.

Key Performance Indicators & Metrics

- **Demographics:** Tracking of demographic information including race, ethnicity, gender identity, household size, and socioeconomic parameters.
- **Health Outcomes:** Metrics based on health outcomes and service satisfaction rates of patients from the medical clinics involved in the study.
- **Employment Metrics:** Monitoring placements after exit, median earnings, and skill gains, specifically in state-led programs following WIOA requirements.
- **Referral Metrics:** Tracking the number and effectiveness of referrals made to different services.

CRN Sustainability: The Path Forward

The recent increase in public and private investments in efforts to address the essential resource gaps in our communities is encouraging. Connecting community-based organizations through CRNs, and fueling them with the capacity and funding to succeed, can strongly influence and create critical pathways to enabling families and individuals to access the resources we all need to thrive. Yet unless we rethink the systems that govern who and what we value, we risk replicating past harms and drawing attention and resources from critical areas tackling the root causes of health inequities.

Strengthening CRNs to improve the health of communities requires a concerted effort of multiple actors across the health and social services ecosystem. Investors, legislators, network organizations, and more all have a role to play in creating communities nourished and supported by the resources they need to support the health and well-being of their people. Overall, investors must broaden how they define, quantify, and qualify impact and evaluate associate measures or reporting requirements asked of sites. They must also partner with CRN technology providers to ensure communities are decision-makers about how data is shared and accessed to eliminate harm. CRNs must use their voices, engage allies, and advocate for mediums that more accurately convey the realized impact of their networks on their communities.

We are hopeful the findings, goals and recommendations outlined in this report advance conversations around how we can collectively ensure the impact and financial sustainability of CRNs as they continue to play a critical role in the health of our communities, and spur action towards a more equitable future.

About Health Leads

An innovator in community-led health equity initiatives and advocacy for over 25 years, Health Leads drives toward a vision of “health, well-being and dignity, for every person, in every community.” Health Leads has a proven track record of working collaboratively with local and national partners to unearth and address the root causes of some of the most pressing and complex health equity challenges of today. From maternal health to vaccine access to housing and food security, our collaborative initiatives are focused on removing systemic barriers to health and building a future where communities have the essential resources they need to thrive. **www.healthleadsusa.org**

Acknowledgements

This endeavor was made possible through the generous backing of CommonSpirit Health, Blue Shield of California, and the California Health Care Foundation, all of whom were instrumental in shaping the project's foundation, participant recruitment, and research direction.

We are thankful to our team and partners for their dedication and expertise to RePARE.

Health Leads RePARE Team

Artrese Morrison, Project Lead
Daniel Chau, Project Manager
Cristina Zuniga, Community Engagement SME
Lauren Pennachio, Financial Workstream Lead
Hannah DuVivier, Financial Workstream Support

KEY CONTRIBUTORS

Sean Yoo, Chief of Staff, Health Leads
LeAndra Padgett, Director, Program and Learning, Health Leads
Juanito Jose Duran Terrobias, University of California Berkeley MPH Student
Hiba Ali, Dartmouth University Undergrad Student
Heather Krause, We all Count
Javier H. Morrone, M.A. UCLA Adjunct Instructor – Legal/Medical Translation & Interpretation
Vidya Lakshminarayanan, Connxus (Integrated Care Collaboration)

Partner Network Organizations & Representatives

NAME	ORGANIZATION	STATE
Saskia Garcia	Sonoma Connect | Sonoma Unidos	California
Fran Anderson	Bay Aging	Virginia
Stacy Kellogg	People For People	Washington
Courtney Smith	United Way of Rhode Island	Rhode Island
Najja Haynes	United Way of San Joaquin County	California
Elliott Sharrow	United Way of the Mohawk Valley	New York
Veronica Rivas	Chicanos Por La Causa, Inc.	Arizona

Community Advisory Group Members & Affiliated Partner Network Organizations

NAME	ORGANIZATION	STATE
Nubia Padilla	Sonoma Connect | Sonoma Unidos	California
Mariana Raschke	Sonoma Connect | Sonoma Unidos	California
Mel Oriolo	United Way of the Mohawk Valley	New York
Emma Rasmussen	United Way of the Mohawk Valley	New York
Garry Bliss	United Way of Rhode Island	Rhode Island
Courtney Smith*	United Way of Rhode Island	Rhode Island
Dianne Franck	Bay Aging	Virginia
Fran Anderson*	Bay Aging	Virginia
Karla Caraveo	Chicanos Por La Causa	Arizona
Veronica Rivas*	Chicanos Por La Causa	Arizona
Renee Stewart	United Way of San Joaquin County, CA	California
Charles Stewart	United Way of San Joaquin County, CA	California
Douglas Dalton	Connxus (Integrated Care Collaboration)	Texas
Lilian Bravo	People for People	Washington
Stacy Kellogg*	People for People	Washington

**Denotes PNO representative*

Appendix

1. Resource Guide

- **Health Leads Data Equity Framework**: The CIE Data Equity Framework, created in partnership with Dr. Rhea Boyd, 211/CIE San Diego and Health Leads, is an innovative framework that guides individuals and institutions towards building anti-racist systems that create more equitable and inclusive systems.
- **National Equity Project**: The National Equity Project is a nonprofit, social impact organization committed to increasing the capacity of people to achieve thriving, self-determining, educated and just communities.
- **We All Count**: We All Count continually develops tools, case studies, practices, and systems to improve equity in data science.
- **Racial Equity Tools**: Designed to support individuals and groups working to achieve racial equity. It offers tools, research, tips, curricula, and ideas for people who want to increase their understanding and to help those working for racial justice at every level.
- Suggested Reading: *Design For Belonging: How to Build Inclusion and Collaboration in Your Communities* by Susie Wise

2. RePARE Literature Review

The intricate web of CRNs plays a pivotal role in shaping health disparities among diverse racial and ethnic groups. An emerging body of research sheds light on the nuanced interactions within healthcare referral networks that form a series of entanglements individuals may experience. Four themes reveal systemic challenges and emerging best practices for improving user experiences, operations, management, and government investments in CRNs.

Accessing services through CRNs presents a myriad of challenges for individuals from racial and ethnic minority groups.
Brener et al[1] identified three phases and related challenges that individuals experience before, during, and after an appointment. Prior to appointments, individuals grapple with structural inequalities, cultural beliefs, documentation hurdles, scheduling conflicts, and transportation issues. During the appointment, they often face provider biases, a lack of cultural understanding, and inadequate interpretation services. The post-appointment phase is fraught with challenges related to payment, medication adherence, securing indigent care, and navigating follow-up appointments.

Referrals do not guarantee access to service or specialized care.
Give et al[2] highlighted the inefficacy of referral slips, noting that possessing one doesn't guarantee access to services. Landon et al[3] found Black patients had a narrower range of specialists within their primary care physician referral networks compared to their white counterparts. Compounding this concern, Ghomrawi (2018)[4] revealed that areas with a higher concentration of Black residents were encompassed by physician

1 Brener, S., Jiang, S., Hazenberg, E., & Herrera, D. (2023). A Cyclical Model of Barriers to Healthcare for the Hispanic/Latinx Population. *Journal of racial and ethnic health disparities*, 10.1007/s40615-023-01587-5. Advance online publication. https://doi.org/10.1007/s40615-023-01587-5
2 Give, C., Ndima, S., Steege, R., Ormel, H., McCollum, R., Theobald, S., Taegtmeyer, M., Kok, M., & Sidat, M. (2019). Strengthening referral systems in community health programs: a qualitative study in two rural districts of Maputo Province, Mozambique. *BMC health services research*, 19(1), 263. https://doi.org/10.1186/s12913-019-4076-3
3 Landon, B. E., Onnela, J. P., Meneades, L., O'Malley, A. J., & Keating, N. L. (2021). Assessment of Racial Disparities in Primary Care Physician Specialty Referrals. *JAMA network open*, *4*(1), e2029238. https://doi.org/10.1001/jamanetworkopen.2020.29238
4 Ghomrawi, H. M. K., Funk, R. J., Parks, M. L., Owen-Smith, J., & Hollingsworth, J. M. (2018). Physician referral patterns and racial disparities in total hip replacement: A network analysis approach. *PloS one*, *13*(2), e0193014. https://doi.org/10.1371/journal.pone.0193014

referral networks that were tightly knit internally but had limited external connections. This potentially restricts Black residents from accessing specialized care beyond their immediate surroundings, underscoring a pressing need to address these systemic disparities in healthcare access and outcomes.

State-level leadership is critical to dismantling barriers and championing equitable data-sharing.
The Center for Health Care Strategies and Data Across Sectors for Health[5] notes Pennsylvania's Allegheny County witnessed the fruits of a collaborative governance process. Diverse stakeholders including health plan representatives and the state health department director converged to establish a robust data-sharing project. Their collective efforts set the stage for subsequent collaborative endeavors. Such collaboration was effective in Maine where leaders in the department of health and human services and the governor's office partnered to catalyze legislative changes by streamlining data-sharing for public health and emergency responses.

Electronic referral systems act as catalysts for enhanced patient care, streamlined treatment access, and heightened patient satisfaction (Seyed-Nezhad)[6]
These systems foster coordination across healthcare tiers, generate cost savings, and deliver superior care quality. The continued investment in operational systems including ongoing training for general practitioners, consistent policy implementation, and adherence to standard guidelines are instrumental in optimizing the referral system's efficacy. Organizational aspects across robust management, policy-making, and strategic planning units further bolster the network's foundation.

The RePARE study of community resource networks is informed by the literature and directed our inquiry of the funding, staffing and communication of network impact.

3. Data Biography for RePARE Contributor and Partner Data

NAME OF DATASET: RePARE Contributor and Partner Data
Dataset Collection Period: July 23rd to September 23rd, 2023

DATA SOURCES

Who created the data?: Development by the PNO and CAG RePARE teams and compiled by the Health Leads RePARE team
Who contributed to the data?: People who are navigating and/or managing community referral networks in California, Washington, Arizona and New York
Why was it collected?: To understand the success and challenges of Community Referral networks
How was it collected?: Through surveys, 211 calls, and listening sessions

Survey Contributers: 211, Partner Network Organizations, Network Partners, and Community Members

DATA PROCESSING

Cleaning: The Health Leads team removed data corrupted by bots.
Tools/Software Used: Survey and listening session information was collected using SurveyMonkey

DATA ANALYSIS

Methods: Quantitative data analyzed via SurveyMonkey and Qualitative data was categorized by emerging themes. The information was then validated by the PNO and CAG team members who are closer to the work.

5 Beers, A., Hoffmaster, A., & Cavanagh, A. (2020, November). Advancing Health, Equity, and Well-Being through Community-State Data-Sharing Partnerships: Thought Leader Insights. https://www.chcs.org/media/Report-Advancing-Health-Equity-and-WellBeing-through-Community-State-Data-Sharing-Partnerships.pdf
6 Seyed-Nezhad, M., Ahmadi, B., & Akbari-Sari, A. (2021). Factors affecting the successful implementation of the referral system: A scoping review. Journal of family medicine and primary care, 10(12), 4364–4375. https://doi.org/10.4103/jfmpc.jfmpc_514_21

DATA STORAGE

Location and Backup Strategy: Stored on SurveyMonkey's password-protected site
Accessibility and Sharing Policies: Anonymous data is available to the partners and contributors of the project and the public in the research report

ETHICAL CONSIDERATIONS

Privacy and Consent Issues: Data shared without personal identifiers

FUTURE USE

Guidelines for Use: To support the development, management, and sustainability of Community referral networks

4. Research Survey Questions

4.1 RePARE Financial Research Network Survey Questions

- Q1: Which network organization do you support?
- Q2: What is your job title?
- Q3: List the top 3 things you spend your time doing in your role overall (open text field)
- Q4: What percent of your time do you spend supporting your organization's community anchored referral network?
  - 0-10% [0-4 hours/week]
  - 11-25% [4-10 hours/week]
  - 26-50% [10-20 hours/week]
  - 51-75% [20-30 hours/week]
  - 76-100% [30-40 hours/week]
- Q5: Number of hours worked weekly tied to this network project (open text field)
- Q6: At the end of most weeks, do you feel like you have been able to complete all of your necessary network tasks in a way that feels sustainable?
- Q7: Does the network project require more time than you initially planned?
- Q8: Please indicate how many hours per week you spend supporting each of the following tasks (0-4 hours; 5-10 hours; 11-20 hours; 21-30 hours; 31-40 hours):
  - Network project supervision or leadership (i.e. project oversight, program or project management)
  - Development and management of community partnerships (i.e. managing governance structure, hosting network engagements)
  - Analysis, review, and publicizing data
  - Revenue generation, funder relationship management, and funder reporting
  - Technology administration and oversight (i.e. IT support, managing data security)
  - Other

4.2 RePARE Contributor Survey Questions

- Q1: How would you rate the resource referrals (like housing, legal, and medical services, etc.) you receive in terms of meeting your needs effectively?
- Q2: How would you rate access to receiving these services you need?
- Q3: What are the top three services that you access? (for example: childcare, housing, food, etc.)
- Q4: How frequently are you accessing referral resources that benefit your health and well-being?

- Q5: Have there been instances where your income status has prevented you from accessing the resources you need?
- Q6: Have there been instances where your health insurance status has prevented you from accessing the resources you need?
- Q7: Have there been instances where your health insurance status was not clear or not explained well to you?
- Q8: How do organizations welcome the multiple identities you bring (race, cultural, religious practices, refugee, sexual orientation, etc....)?
- Q9: Please explain how organizations have welcomed the multiple identities you bring (race, cultural, religious practices, refugee, sexual orientation, etc....)?
- Q10: Is there anything that prevents you from going to an organization for services?
- Q11: What if any, changes would you like to see resource providers/organizations make to improve your experiences?
- Q12: How do you racially identify? (Race=Based on similar physical and biological attributes)
- Q13: Which ethnicity best describes you? (Ethnicity = cultural expression and place of origin)
- Q14: What is your gender identity?
- Q15: How old are you?
- Q16: What is your sexual orientation?
- Q17: Do you identify as a person with disabilities or a disabling health condition?
- Q18: Do you have health insurance?
- Q19: What is your income status?
- Q20: Which county and state do you live in?
- Q21: Please enter email for gift card distribution
- Q22: Physical address (physical gift cards will not be provided in all counties, please be sure to enter your email address as well)

4.3 RePARE Contributor Questions (Spanish)
Preguntas de los colaboradores de RePARE

- Q1: ¿Cómo calificaría las remisiones/referencias de recursos (como vivienda, servicios jurídicos y médicos, etc.) que recibe en términos de satisfacción efectiva de sus necesidades?
- Q2: ¿Cómo calificaría el acceso a recibir estos servicios que necesita?
- Q3: Cuáles son los tres principales servicios a los que accede? (por ejemplo: cuidado de niños, vivienda, alimentación, etc.)
- Q4: ¿Con qué frecuencia accede a recursos de referencia que beneficien su salud y bienestar?
- Q5: ¿Ha habido casos en los que su situación económica le haya impedido acceder a los recursos que necesita?
- Q6: ¿Ha habido casos en los que la situación de su seguro médico le haya impedido acceder a los recursos que necesita?
- Q7: ¿Ha habido casos en los que la situación de su seguro médico no haya quedado clara o no se le haya explicado bien?
- Q8: Las organizaciones ¿Cómo recopilan las múltiples identidades que usted aporta (raza, cultura, prácticas religiosas, refugiado, orientación sexual, etc....)?
- Q9: Explique cómo han acogido las organizaciones las múltiples identidades que usted aporta (raza, cultura, prácticas religiosas, refugiado, orientación sexual, etc....).
- Q10: ¿Hay algo que le impida acudir a una organización en busca de servicios?
- Q11: ¿Qué cambios, si los hubiera, le gustaría que hicieran los proveedores de recursos/organizaciones para mejorar sus experiencias?

- Q12: ¿Cómo se identifica racialmente? (Raza=Basada en atributos físicos y biológicos similares)
- Q13: ¿Qué etnia le describe mejor? (Etnia = expresión cultural y lugar de origen)
- Q14: ¿Cuál es su identidad de género?
- Q15: ¿Cuántos años de edad tiene?
- Q16: ¿Cuál es su orientación sexual?
- Q17: ¿Se identifica como persona con discapacidad o con una enfermedad discapacitante?
- Q18: ¿Tiene seguro médico?
- Q19: ¿Cuál es su nivel de ingresos?
- Q20: ¿En qué condado y estado vive? (ej. Condado de Alameda, California)
- Q21: Ingrese el correo electrónico para la distribución de la tarjeta de regalo (requerido)
- Q22: Dirección física (no se proporcionarán tarjetas de regalo físicas en todos los condados, asegúrese de ingresar también su dirección de correo electrónico)

4.4 RePARE 211 Contributor Survey Questions

- Q1: Is there anything that prevents you from going to an organization for services?
- Q2: What ideas can you share to help us make our referral system better, so you can trust that the resources we recommend will really help you?
- Q3: Please enter current zip code

4.5 RePARE PNO (Partner Network Organizations) Survey Questions

- Q1: The name of your organization
- Q2: Please share your title and your department
- Q3: Please list the ways your organization has been successful when connecting clients with appropriate healthcare and social services via your resource referral network.
- Q4: Please list the ways your organization has been challenged when connecting clients with appropriate healthcare and social services via your resource referral network.
- Q5: Please identify any challenges your organization has encountered during the development and or implementation of initiatives aimed at enhancing community health and racial equity.
- Q6: Please list key performance indicators or metrics used to monitor and measure the progress of racial equity initiatives.
- Q7: Does your organization conduct training sessions for staff focused on cultural humility and racial and social equity? If so, how often?
- Q8: How do you assess the readiness of your staff members to apply the learnings from these equity training sessions?
- Q9: Do the results of that assessment show that staff feel prepared to apply the learnings from the equity training?
- Q10: To what extent does the diversity of your staff represent the populations and communities you serve?
- Q11: What referral network technology software does your organization utilize? Please check all relevant answers
- Q12: Do clients have the ability to access their personal data within your technology system?
- Q13: What innovative initiatives have you witnessed within your organization and or network that have been effective in supporting your client needs?
- Q14: Any additional thoughts you would like to share?

4.6 RePARE Network Partner Survey Questions

- Q1: Please share your title and department
- Q2: Please share your email address
- Q3: Which county and state are you located in? (ex. Alameda County, California)
- Q4: Please share which network partner category represents your organization
- Q5: Please list the ways your organization has been successful when connecting clients with appropriate healthcare and social services via your referral network.
- Q6: Please list the ways your organization has been challenged when connecting clients with appropriate healthcare and social services via your referral network.
- Q7: Please list any initiatives that your organization has undertaken or continued to promote community health and racial equity since 2020.
- Q8: Please identify any challenges your organization has encountered during the development and/or implementation of initiatives aimed at enhancing community health and racial equity
- Q9: Are your clients aware of these initiatives?
- Q10: Please list key performance indicators or metrics used to monitor and measure the progress of these community health and racial equity initiatives.
- Q11: Does your organization conduct training sessions for staff focused on cultural humility and racial and social equity? If so, how often?
- Q12: How do you assess the readiness of your staff members to apply the learnings from these equity training sessions?
- Q13: How do the results of that assessment show that staff feel prepared to apply the learnings from the equity trainings?
- Q14: To what extent does the diversity of your staff represent the populations and communities you serve?
- Q15: What referral network technology software does your organization utilize? Please check all relevant answers.
- Q16: Do clients have the ability to access their personal data within your technology system?
- Q17: What have been innovative initiatives you have witnessed within your organization or within the network that has been effective in supporting client needs?
- Q18: Any additional thoughts you would like to share?
- Q19: Please enter email for gift card distribution (required)
- Q20: Physical address (physical gift cards will not be provided in all counties, please be sure to enter your email address as well)

4.7 RePARE Listening Session Questions

- Q1: Listening Session date
- Q2: Name and Location (city) of group
- Q3: Name of group facilitators
- Q4: Number of Contributors
- Q5: Share an experience where you felt welcomed receiving services (mental health, physical health, housing, etc.).
- Q6: How do you know you and your family are better off receiving these services?
- Q7: How do organizations welcome the multiple identities you bring (cultural, religious practices, refugee, sexual orientation, etc.)?
- Q8: Is there anything that prevents you from going to an organization for services? If so, can you share these experiences?

- Q9: What changes, if any, would you like to see made to improve your experience?
- Q10: From the findings and information shared at today's session, what information resonated with you as the group facilitator?
- Q11: Are there any additional comments/insights that you would like to raise after hearing the information shared today?

5. Partner Network Organization Overview

Bay Aging

Bay Aging is a 501(c) nonprofit organization serving as an area agency for the Middle Peninsula and Northern Neck area of Virginia. Bay Aging is also designated as the Community Care Hub for the state of Virginia, under the name of VAAACares®, managing contracts with health care entities by coordinating services through a network of community-based organizations. Bay Aging is governed by a volunteer board of directors consisting of members of the community, consumers, and family members. The priority populations for Bay Aging are minorities, older adults, persons with disabilities, veterans, and those living in poverty. The organization has established strong relationships within the community over the past 44 years. Bay Aging regularly collaborates with other community-based organizations, faith-based organizations, governmental organizations, and health care providers.

Chicanos Por La Causa

CPLC is a nonprofit organization that looks to combat structural inequities and set up individuals to be economically and politically empowered. CPLC is recognized for their special service to Latinos, although they help people from any background. CPLC has five main areas of impact: Health and Human Services, Housing, Education, Economic Development, and Advocacy. Their goal is to "treat the whole human" and their five areas of impact reflect this.

People For People - Greater Columbia 211

With a strong emphasis on empowerment and sustainable change, People for People operates across various sectors to address diverse societal challenges. Their comprehensive approach encompasses areas such as education, healthcare, poverty alleviation, and community development. Through a range of programs and initiatives, they seek to uplift individuals and families, particularly those facing adversity or marginalized circumstances. By collaborating with local partners, volunteers, and stakeholders, they build a network that is dedicated to fostering well-being.

Sonoma Connect | Sonoma Unidos

Sonoma Connect | Sonoma Unidos (SC|SU) is a coalition of community leaders and partner organizations in Sonoma County working together to increase access to healing centered resources to prevent and heal Adverse Childhood Experiences (ACEs) and trauma caused by Structural Drivers of Health (SDOH). Specifically, SC|SU supports cross-sector partner relationships, shared frameworks, and shared technology, to connect people to the resources they need. SC|SU focuses on organizational capacity building and systems integration, so families and individuals receive appropriate care, regardless of the level of need, within a broader community healing context.

United Way of Mohawk Valley

United Way of Mohawk Valley focuses on more than one issue facing the community, taking a comprehensive approach to creating solutions to the community's toughest challenges. They aim to build stronger communities by advancing health, enhancing education, growing economic mobility, and addressing urgent needs — the building blocks for a good quality of life.

United Way of Rhode Island

United Way of Rhode Island is home to 211 in Rhode Island, which is the statewide front door to social services. They connect individuals with food, housing, job training, and much more. Their main goal is to "go deep rather than wide" on the root systemic inequity for Black and Brown individuals. They have four main areas of impact: building economic security through services like affordable housing and job training, advancing childhood learning through building literacy and advocating for more extracurriculars, increasing philanthropy across Rhode Island and driving for policy and public participation. They rely on public donations from their communities. They also support local nonprofits by offering grants, raising money, running a Volunteer Center, and running professional development sessions. They recently launched the Alliance for Non-Profit Impact, which will be offering programs and practical tools and resources for community-based organizations across the Ocean State, but especially focused on supporting organizations led by people of color and smaller organizations.

United Way of San Joaquin County

UWSJC is focused on addressing education needs and homelessness in their county. They have been active since 1926 and have put an estimated $100 million into their communities, raising about $2–3 million annually. They support local nonprofits through annual workplace giving campaigns which allow employees to make an impact by donating a portion of their paycheck. In addition, they help local nonprofits enhance their capacity and sustainability.