Health Equity Investments
Tracking to Success Plan
TABLE OF CONTENTS

I. KEY TERMS .................................................................................................................. 2

II. PROGRAM DESCRIPTION ............................................................................................... 2

PROGRAM OVERVIEW ...................................................................................................... 2
PARTICIPANT DESCRIPTION ............................................................................................... 4
GEOGRAPHIC AREA AND DESCRIPTION ......................................................................... 4

III. PROGRAM TARGETS ..................................................................................................... 4

RESULTS ............................................................................................................................. 4
BROADER IMPACT(S) ........................................................................................................ 4
EVALUATION STRATEGY ..................................................................................................... 4

IV. PROGRAM MILESTONES ............................................................................................... 5

PARTICIPANT MILESTONES ............................................................................................. 5
MILESTONE VERIFICATION .............................................................................................. 5
KEY STEPS ........................................................................................................................ 5
QUARTERLY PROJECTS ...................................................................................................... 6

V. QUESTIONS & ASSUMPTIONS .................................................................................... 7

VI. POTENTIAL RISK AND CRITICAL PROGRAM FACTORS ........................................ 8

VII. COSTS & GAINS ........................................................................................................ 9
Organization: Healthy BR  
Project name: Geaux Get Healthy  
Focus Area(s): 1) Food Security and 2) Social Connection  
Humana Market: Baton Rouge  
Investment Amount: $700,000  
Investment Award Period: November 1, 2018 – October 31, 2019

I. Key Terms

- **Investor and investing**: We are investors in results, not funders of programs. Partner nonprofits receive investments that have an expectation of return on investment through improved health and well-being of those served.

- **Focus areas**: These are the areas in which the Humana Foundation intends to direct its investments – 1) postsecondary success and sustaining employment, 2) asset security, 3) social connection and 4) food security.

- **Results**: The specific intended accomplishment to be made by individuals or groups served by a program. They are the gains and outcomes that come from services. The Humana Foundation does not equate the delivery of services or the availability of services as results.

- **Targets**: The number of participants and specific geography to receive a minimal level of a result in a project.

- **Milestones**: The indicators that must be accomplished on a set timeline to forecast that a program will hit its results with the time and money remaining.

- **Impacts**: These are broader gains (or losses) which come from achieving a result. Some happen simultaneously in other areas of gain while others come later. Impacts increase return on investment when a result keeps on giving.

- **Evaluation**: This is what nonprofits do to measure and show evidence of success and what the Humana Foundation uses to show return on investment. We are not measuring program outputs; we are measuring accomplishments within programs.

- **Learning and pivoting**: These are changes in behavior and approach by both investor and nonprofits based on experience and new knowledge. It is not about only what we know—it is what we do with what we know to improve investing in and implementing programs.
II. Program Description

Program Overview

This program will address the social determinants of food insecurity and social isolation for many more people than the number of "program participants" for whom we anticipated being able to report final outcomes. By providing program access points in a variety of ways - a mobile market that will be regularly available throughout the zip code, a food ordering service (Top Box) that will be available through local churches, and incentives for a grocery retailer to open an additional store in the zip code - we will be able to ensure access to residents with a full spectrum of barriers. By providing an opportunity for social connection at each of these access points, as well as through a shared community space and urban farm that will help supply food, we anticipate that we will be able to increase access and improve opportunities for social connection for the population. In terms of measurable outcomes, we realistically expect to collect ongoing data and be able to accurately report outcomes for people who utilize the Geaux Get Healthy Program.

The overarching goals of this program are to:

- Heavily saturate a well-defined, highly food insecure geographic area with multiple ways to access fresh food (mobile market, Top Box, retail grocery)
- Provide mechanisms for sustaining that access (urban farm and community garden)
- Provide education and food experience (mobile teaching kitchen and cooking demos/tastings)
- Offer multiple opportunities for social interaction as well as multigenerational collaboration and volunteerism (partnering Senior Center with local high school on community garden project, outdoor community event space and garden).

This approach is necessary to ensure that a large percentage of residents, 20% of the total population of the zip code, are offered drastically increased access to fresh food, information about making changes to food consumption presented in a way that they are able to easily understand and assimilate into their daily lives, and numerous, regular opportunities for positive, multigenerational social interaction throughout the program structure.

We are trying a promising new approach, but one that is backed by a history of relationship building and programming success. By providing many ways to access fresh food at an affordable price (mobile market, Top Box, and retail stores), combined with a mechanism for sustainability that empowers local residents to grow locally (youth farm and community gardens) and knowledge/food experience (mobile teaching kitchen, educational materials that are culturally relevant and engaging) this area will realize a significant improvement in health behaviors.

1) Food Security

In the first year of implementing the Geaux Get Healthy Program approximately 750 people will:

- Be able to purchase fresh food within one mile of where they live or work;
- Demonstrate that they understand what constitutes a balanced meal;
- Increase the number of balanced meals they prepare at home;
- Increased the number of servings of fruits and vegetables they consume;
- Measure; and engaged in community events or cooking demonstrations.
2) Social Connection
100% of those over the age of 50 will receive an individual assessment of their social connectedness, information on how to reduce loneliness and/or depression; increase their social network; improve the quality of supports and increase their frequency of social contacts. Grant administrators and community collaborators will conduct to participants in program activities and community events. Following individual surveys of participants to gauge their social connectedness, participants will be encouraged to participate in building an action plan to better understand their risk factors and steps to improve or strengthen protective factors.

**Participant Description**
Low-income, food insecure, socially isolated community members in the 70805 zip code, a high need, high vulnerable area.

**Geographic Description**
We are focusing on the zip code 70805
III. Program Targets

1) Food Security
750 participants who were food insecure at baseline will experience increased food security as measured by the USDA 10-Question Adult Food Security Survey at least one level of improvement, i.e. moving from low food security to marginal food security) and the food consumption survey and dietary change survey at the post-intervention data collection period. This will enable them to lead a healthy lifestyle because they have weekly access to enough affordable, nutritious food and are empowered with the resources and knowledge to select and prepare it. This will include fresh fruits and vegetable consumption.

2) Social Connection
58 participants experience improved social connection and a low risk of social isolation and loneliness as measured by the Campaign to End Loneliness Measurement Tool, enabling them to have a sense of purpose and belonging because they have a satisfying social network of quality relationships and frequent contact with members in that network.

Broader Impacts
We will work with our partner agencies to promote hiring people who live in the 70805 into jobs that are created as a result of this project. We will also encourage our partner agencies to purchase and utilize business that are currently in the 70805 community. For that reason, one broader result will be an increase in economic stability for some program participants and for the larger community. The community gathering space, farm and garden will improve the quality of the built environment for neighborhood residents and offer greater opportunities for participation in health promoting outdoor activities. In addition, the farm and garden components of the program will provide youth leadership skills and soft skills training. Finally, we expect to see a measurable increase in the number of healthy days as measured by the CDC’s Healthy Days

Evaluation Strategy
The evaluation plan will measure outcomes through two broad aspects: program implementation and program impact. Program implementation assessment outcomes will focus on overall participation rates, access to information and resources, utilization rates of resources, and overall satisfaction. Program impact assessment outcomes will focus on short term goals such as built knowledge, degree of awareness, changed behavior, development of healthy food choice skills, and food insecurity. We will use the CDC Healthy Days questionnaire, USDA food security measure, and validated food access intervention surveys. We will also generate a survey directly related to our desired outcomes of increased access to fresh produce, increased meal preparations at home; increased daily consumption of fresh produce; and increase community engagement/participation. This survey will be created through participatory research based on community partners and community members. We will track progress through a series of activities, apps and community partner surveys.

For social connection, the program will use the Campaign to End Loneliness measurement tool to demonstrate achievement of social connection. Healthy BR will work with AARP Louisiana and AARP Foundation to create a measuring tool to gauge participants social isolation/connectedness at the first engagement and will survey them at certain intervals throughout the grant period. Each of these tools will be used as pre-tests, quarterly, and at the end of the first project year.
IV. Milestones

Milestones & Verification Strategy

<table>
<thead>
<tr>
<th>Result Area: Food Security</th>
<th>Organization Key Step</th>
<th>Verification Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> – 2,000 community residents and leaders will participate in the planning and implementation strategy to address food insecurity within communities of the 70805 zip code</td>
<td>Host meetings - Faith based (TogetherBR) - Community Conversation - MLK Day of Service - Plank Corridor Meetings</td>
<td>Track attendance at meetings in Geaux Get Healthy Database</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> – 1,500 community resident at-risk of food insecurity will enroll in the program based on need and have access to nutritious food</td>
<td>Ask residents to fill out survey and enroll in program at - community conversations - Food Pantries - Canvassing</td>
<td>Track in Geaux Get Healthy Database</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> – As a result of participating in the program, at least 1,000 community residents will report they’ve tried a new nutritious food or meal</td>
<td>- Ingredients for HOPE - Dinner with a Doc - Mobile Teaching Kitchen - Top Box - Mobile Market - Urban Farm - Community Gardens</td>
<td>Community Conversations and Geaux Get Health database</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> – At least 800 community residents will access the Geaux Get Healthy nutritious foods resources at least twice during the program period (top box, mobile markets, and/or gardening)</td>
<td>- Ingredients for HOPE - Dinner with a Doc - Mobile Teaching Kitchen - Top Box - Mobile Market - Urban Farm - Community Gardens</td>
<td>Geaux Get Health database</td>
</tr>
</tbody>
</table>

**Target:** 750 community residents of the 70805 zip code who were food insecure at baseline will experience increased food security as measured by the USDA 10-Question Adult Food Security Survey at least one level of improvement, i.e. moving from low food security to marginal food security) and the food consumption survey and dietary change survey at the post-intervention data collection period. This will enable them to lead a healthy lifestyle because they have weekly access to enough affordable, nutritious food and are empowered with the resources and knowledge to select and prepare it. This will include fresh fruits and vegetable consumption.

### Quarterly Projections

<table>
<thead>
<tr>
<th>Participant Milestone</th>
<th>Qtr.1</th>
<th>Qtr.2</th>
<th>Qtr.3</th>
<th>Qtr.4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,000 community residents and leaders will participate in the planning and implementation strategy to address food insecurity within communities of the 70805 zip code</td>
<td>800</td>
<td>500</td>
<td>500</td>
<td>200</td>
<td>2,000</td>
</tr>
<tr>
<td>1,500 community resident at-risk of food insecurity will enroll in the program based on need and have access to nutritious food</td>
<td>500</td>
<td>350</td>
<td>300</td>
<td>100</td>
<td>1,500</td>
</tr>
<tr>
<td>As a result of participating in the program, at least 1,000 community residents will report they’ve tried a new nutritious food or meal</td>
<td>0</td>
<td>250</td>
<td>500</td>
<td>250</td>
<td>1,000</td>
</tr>
</tbody>
</table>
At least 800 community residents will access the Geaux Get Healthy nutritious foods resources at least twice during the program period (top box, mobile markets and/or gardening)  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>200</th>
<th>300</th>
<th>300</th>
<th>800</th>
</tr>
</thead>
</table>

**Target:** 750 community residents of the 70805 zip code who were food insecure at baseline will experience increased food security  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>750</th>
<th>750</th>
</tr>
</thead>
</table>

### Result Area: Social Connection

<table>
<thead>
<tr>
<th>Participate Milestones</th>
<th>Organization Key Step</th>
<th>Verification Strategy</th>
</tr>
</thead>
</table>
| **Milestone 1** – 200 people who live or work in the 70805 participate in planning and implementation of a strategy to enhance social enhancement in their community | Create survey to identify socially isolated people in 70805  
- Senior Council Meetings  
- Senior engagement in Urban farm  
- Community Gardens  
- Community Conversations  
- Food pantries | Track attendance at meetings in Geaux Get Healthy Database |
| **Milestone 2** - 125 socially isolated people have enrolled in the Geaux Get Healthy program and have access to at least one community resource that promotes social connectedness weekly. | Ask residents to fill out survey and enroll in program at  
- Community conversations  
- Food Pantries  
- Canvassing  
Create a calendar of events  
- Geaux get healthy monthly event  
- Senior council  
- Urban farm  
- Community gardens  
- Charles r kelly center | Track in Geaux Get Healthy Database  
Updated Calendar of events |
| **Milestone 3** - As a result a personal invitation via a phone or in person visit, 75 participants will have utilized Geaux Get Healthy community resources or event at least two times. | 100 participants report that they have received a personal invitation to a community event or to engage with a community resource quarterly.  
- AARP senior volunteers  
- Senior council  
- Community center  
- Geaux Get Healthy Ambassadors | Geaux Get Health database |
**Target:** 58 participants experience improved social connection and a low risk of social isolation and loneliness as measured by the Campaign to End Loneliness Measurement Tool.

### Quarterly Projections

<table>
<thead>
<tr>
<th>Participate Milestone</th>
<th>Qtr.1</th>
<th>Qtr.2</th>
<th>Qtr.3</th>
<th>Qtr.4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 people who live or work in the 70805 participate in planning and implementation of a strategy to enhance social enhancement in their community</td>
<td>50</td>
<td>75</td>
<td>75</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>125 socially isolated people have enrolled in the Geaux Get Healthy program and have access to at least one community resource that promotes social connectedness weekly</td>
<td>0</td>
<td>50</td>
<td>50</td>
<td>25</td>
<td>125</td>
</tr>
<tr>
<td>75 participants will have utilized Geaux Get Healthy community resources or event at least two times</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td><strong>Target:</strong> 58 participants experience improved social connection and a low risk of social isolation and loneliness</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>
V. Questions & Assumptions

**Questions:**
1) Is the food access and support in changing behaviors strong influencers in sustaining the food security after the program end?
2) What role will increased access to healthy food have as a preventable social determinant of health?
3) What outreach strategies are most effective in enrolling participants committed to food security or social engagement success?
4) What level of support and guidance will be required for partner agencies to ensure their effectiveness and success?
5) Are there local, state, or national policies influencing the ability to achieve and sustain social connection? If so, what are they?
6) What have we learned regarding our demographic and ability to influence change for a significant number (50% or more) of community residents?
7) Where are the opportunities to reduce costs, leverage resources, or expand services (within existing or new communities)?

**Assumptions:**
1. **If** fresh food, education, and support services are made available simultaneously, **then** participant food security will increase.
2. **If** opportunities are created for seniors to engage in meaningful, volunteerism and multigenerational events, **then** their social connections will improve.
3. **If** the distance to fresh food is reduced, **then** will improve participant food security
4. **If** the collaboration and partnerships with well-qualified organizations in a collective impact model is effective, **then** it will magnify program effectiveness and result in increased participant successes.
5. **If** we saturate a limited geographic area with programs that fully address the causes of food insecurity and social isolation through access to nutritious foods (fruits and vegetables) at an affordable price point within one mile of where program participants live **then** program participants will show measurable improvement in food security and social connection.
VI. Potential Risk and Critical Program Factors

Risk Factors:
There are a number of potential program risks in which our leadership team will monitor and plan for as necessary. The current known program risks are as follows:
1. Limited community engagement
2. Unanticipated partner challenges
3. Overly optimistic schedule

Key Program Elements:
The success of Geaux Get Healthy as a sustainable, comprehensive, and replicable model is dependent of the following key program elements:
• Community ownership, participation and support
• Identifying and engaging with key decision makers in the community
• Clear goals and scopes of work in engaging partners and other stakeholders
• Effective leadership and management of partner relationship
• Properly planning for dependencies that are not directly controllable

VII. Costs & Gains
The Geaux Get Healthy program hopes to achieve food security for 750 residents and social connectedness for 58 residents of 70805. We believe the 58 residents who experience social isolation will also be food insecure. As a result, our cost per resident is for the 750 residents we will serve, knowing that 58 of them will also be socially isolated. This project is unique in that we are partnering with over six different community organizations to create and implement brand new programs and initiatives. Currently, none of the proposed programs exists in the East Baton Rouge Parish.

Humana will be co funding this project with Blue Cross Blue Shield of Louisiana Foundation. We also received funding for this project from Robert Wood Johnsons, with the potential of additional grants. As a result, this is our best analysis of the cost per resident from Humana’s investment.

A $700,000 investment will produce the following cost per gain by level of challenge:
• Few Barriers: $635.83
• Mid-Range Barriers: $953.25
• Many Barriers: $988.05