

**2020 Integrator Learning Lab  
NETWORK OVERVIEWS**

<b>Bridgeport Prospers at the United Way of Coastal Fairfield County</b>	
Region (City, Town, County)	Bridgeport, CT
Network Website/URL	<a href="https://www.unitedwaycfc.org/bridgeportprospers">https://www.unitedwaycfc.org/bridgeportprospers</a>
Primary Contact(s)	❖ Allison Logan (Executive Director): Bridgeport Prospers
Network Focus	Comprehensive care (prenatal through age 3) for children, and their families in Bridgeport, CT
Population-Level Health Goal(s)	❖ Healthy births for all women and babies, universal and targeted family supports anchored in the Protective Factors framework; and early childhood supports leading to age-expected milestones measured at three years of age for all Bridgeport children
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Integration of goals, strategies and tools for the network’s Health Enhancement Community’s (HEC) aim (improved child development prenatal through age eight) with CT’s evolving Medicaid transformation design (improving young child and family health) and Bridgeport Prospers' young child goal</li> <li>❖ Create a data-sharing process between Bridgeport Hospital, St. Vincent’s Hospital, SWCHC and Optimus Health that enables (a) the early identification of families and children at risk of trauma and chronic adversity, (b) family involvement in information sharing, and (c) a process to track family outcomes and system responses</li> <li>❖ To reach alignment, which will result in better client and population outcomes, identification of extant resources and opportunities for innovative new and realigned resources (money, people, skills and practice)</li> </ul>

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<b>DC Health Matters Collaborative</b>	
Region (City, Town, County)	Washington, DC
Network Website/URL	<a href="http://www.dchealthmatters.org">www.dchealthmatters.org</a>
Primary Contact(s)	❖ Julia DeAngelo (Program Manager of School Strategies): Children’s National Hospital
Network Focus	Improved population health for all residents of Washington, DC, by addressing community-identified needs with a health equity lens: mental health, care coordination, health literacy, place-based care. To date, we have completed three joint Community Health Needs Assessments in 2013, 2016 and 2019, with companion implementation strategies called Community Health Improvement Plan. The Collaborative maintains <a href="http://DCHealthMatters.org">DCHealthMatters.org</a> web portal and the DC Health Matters Connect social resource tool ( <a href="http://DCHealthMattersConnect.org">DCHealthMattersConnect.org</a> ).
Population-Level Health Goal(s)	❖ One healthy and thriving capital city that holds the same promise for all residents regardless of where they live
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Improve the monitoring, evaluation and documentation of measurable successes on local policy and system-level actions that are meaningful and sustainable</li> <li>❖ Incorporate successful models for sustainable community engagement</li> <li>❖ Increase participation &amp; leadership buy-in within the collaborative’s member organizations</li> </ul>

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<b>First 1000 Days Sarasota County</b>	
Region (City, Town, County)	Sarasota County, FL
Network Website/URL	<a href="https://barancikfoundation.org/campaigns/first-1000-days/">https://barancikfoundation.org/campaigns/first-1000-days/</a>
Primary contact(s)	❖ Dr. Chelsea Arnold (Program Coordinator): First 1000 Days Sarasota County
Network Focus	Improve coordination of services and increase access to care for pregnant women and families with children up to age 3
Population-Level Health Goal(s)	<p>Launch a targeted marketing campaign, and use an electronic referral database with an extensive navigator network, to:</p> <ul style="list-style-type: none"> <li>▪ improve family and child health and well-being</li> <li>▪ expand and improve collaboration between community healthcare and service organizations</li> <li>▪ increase parent knowledge about the importance of brain development in the early years</li> <li>▪ develop creative solutions to address systemic barriers in receiving medical care or social services</li> <li>▪ reduce healthcare costs and hospital re-admissions/ER visits</li> </ul>
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Fine-tune a strategic plan for the roll-out of a cross-sector data sharing system</li> <li>❖ Develop a plan to capture short-term impact and value of the initiative on the community and individual health (funding is over a 3-year period)</li> </ul>

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<b>Get Ready Guilford Initiative</b>	
Region (City, Town, County)	Guilford County, NC
Network Website/URL	<a href="https://www.getreadyguilford.org/get-ready-guilford-initiative/">https://www.getreadyguilford.org/get-ready-guilford-initiative/</a>
Primary Contact(s)	❖ Mary Herbenick (Executive Director): Get Ready Guilford Initiative
Network Focus	Improving the health and well-being of children through 3rd grade in Guilford County, N.C.
Population-Level Health Goal(s)	To improve outcomes and reduce disparities in five outcome areas for children (0-8) and families in Guilford County, with a focus on: <ol style="list-style-type: none"> <li>1) Planned and well-timed pregnancies;</li> <li>2) Healthy births;</li> <li>3) Healthy development at ages 1, 2 and 3;</li> <li>4) Kindergarten readiness; and</li> <li>5) On-track for success by the end of third grade.</li> </ol>
Near-Term Network Goal(s)	The Get Ready Guilford Initiative has five priorities focused on building the system of care, each with a set of milestones: <ol style="list-style-type: none"> <li>1) Building a system of navigation to ensure families get connected to high-quality programs/services starting prenatally through age three;</li> <li>2) Expanding evidence-based programs, which serve at the heart of navigation;</li> <li>3) Building a culture of continuous quality improvement focused on 13 programs that serve 23,000 families (duplicated) prenatally through age five;</li> <li>4) Building supporting technology to improve data collection and connections to services; and</li> <li>5) Evaluating the effort for learning and impact on children/families. In addition, we are working on strategies to reduce persistent disparities and to sustain our efforts through policy change and building public will.</li> </ol>

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<b>Los Angeles Collaborative</b>	
Region (City, Town, County)	Los Angeles, CA
Network Website/URL	<a href="https://www.downtownwomenscenter.org/">https://www.downtownwomenscenter.org/</a> <a href="https://www.jwchinstitute.org">https://www.jwchinstitute.org</a>
Primary Contact(s)	<ul style="list-style-type: none"> <li>❖ Spencer Coats (Director of Health &amp; Wellness): Downtown Women’s Center</li> <li>❖ Jill Lubin (Program Director): JWCH Wesley Health Centers</li> </ul>
Network Focus	Comprehensive healthcare services for women living on Skid Row in Los Angeles, CA
Population-Level Health Goal(s)	To continuously serve an increased number of clients and to retain those clients in order for the client to eventually obtain sustainable health goals while also being linked to other serves/resources, such as housing and workforce development
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Increase the number of women seen at the JWCH Wesley Health Centers clinic</li> <li>❖ Increase client engagement and ownership of collaborative efforts</li> <li>❖ Increase care coordination between agencies in order to better serve clients</li> <li>❖ Strengthen the overall functioning of partners and sustainability of the collaborative</li> </ul>

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<b>Maternal Mental Health Coalition</b>	
Region (City, Town, County)	Flathead County, MT
Network Website/URL	<a href="http://www.flatheadforward.com/groups/flathead-maternal-mental-health-coalition/">http://www.flatheadforward.com/groups/flathead-maternal-mental-health-coalition/</a>
Primary Contact(s)	<ul style="list-style-type: none"> <li>❖ Molly Neu (Health Promotion Specialist): Flathead City-County Health Department</li> <li>❖ Kayme Backstrom (Early Childhood Collaboration Specialist): Flathead City-County Health Department</li> </ul>
Network Focus	Comprehensive perinatal mental health services for parents in Flathead County, MT
Population-Level Health Goal(s)	<ul style="list-style-type: none"> <li>❖ Create referral resources for service providers and improve referral coordination process</li> <li>❖ Provide opportunity for co-facilitators with lived experience and create a network where we value voices of people with different kinds of expertise and knowledge</li> <li>❖ Develop a three year implementation plan for future projects and goals</li> <li>❖ Support training and certifications for service providers to identify and support people with perinatal mood disorders</li> </ul>
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Stabilize existing Maternal Mental Health Coalition, re-focus, and energize the coalition</li> <li>❖ Develop a clear vision and mission and start to plan for long term projects</li> <li>❖ Create expectations around consistent meetings, regular attendance from key stakeholders, and active participation of members</li> </ul>

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<b>Partners for a Healthier Paterson</b>	
Region (City, Town, County)	Paterson, NJ
Primary Contact(s)	<ul style="list-style-type: none"> <li>❖ Hanaa Hamdi (Director Health Impact Strategies and Partnerships): New Jersey Community Capital</li> <li>❖ Oshin Castillo (Director, Health and Human Services): City of Paterson</li> <li>❖ Ken Morris (Vice President of External Affairs): St. Joseph Health</li> </ul>
Network Focus	Housing equity and its related health and economic benefits for residents of Paterson, NJ
Population-Level Health Goal(s)	<ul style="list-style-type: none"> <li>❖ To ensure the health and stability of Paterson’s households by planning and creating the infrastructure for systemic changes via policy shifts and the provision of programs, services, and healthy housing that will satisfy people’s most fundamental needs while enabling and encouraging an upward socioeconomic trajectory</li> </ul>
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ To address housing-related illnesses and vulnerabilities (HRIVs) (i.e. asthma, lead exposure, as well as housing the vulnerabilities that lead to eviction and displacement- which have measurable negative health outcomes in children and adults alike) by targeting three core housing vulnerabilities:               <ul style="list-style-type: none"> <li>▪ Substandard Housing to address indoor health risk factors (i.e. mold, lead, fire hazards and structural deficiencies)</li> <li>▪ Housing-Cost Burden (subsidized housing, supportive and assisted living housing, and affordable housing)</li> <li>▪ Gentrification and Displacement</li> </ul> </li> </ul>

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<b>Sharswood THRIVE: Community by Design</b>	
Region (City, Town, County)	Philadelphia, PA
Primary Contact(s)	❖ Melanie Cataldi (Chief Impact Officer): Philabundance
Network Focus	Increase stability of Sharswood residents through collaborative community engagement
Population-Level Health Goal(s)	<ul style="list-style-type: none"> <li>❖ Build community engagement &amp; capacity</li> <li>❖ Increase utilization of existing community assets</li> <li>❖ Develop and implement programming to fill gaps in service</li> <li>❖ Increase overall resident physical and mental well-being</li> </ul>
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Residents, community associations, and partners identify with the neighborhood, feel connected, and support one another</li> <li>❖ The willingness and competency of residents, community associations, and partners to work cooperatively</li> <li>❖ Residents, community associations and partners have completed projects or advocacy that will drive ongoing work in the neighborhood</li> <li>❖ Residents have access to the amenities needed for healthy daily life within a reasonable distance</li> </ul>



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<b>Ventura County Children Thrive</b>	
Region (City, Town, County)	Ventura County, CA
Initiative Website/URL	<a href="http://www.first5ventura.org/">http://www.first5ventura.org/</a>
Primary Contact(s)	❖ Elizabeth Majestic (Director + Pritzker Fellow): First 5 Ventura County
Network Description	System of care for families and children birth to age 5 in Ventura County, CA
Population-Level Health Goal(s)	Ensure all families have the support they need to give their children birth to age 5 a strong foundation in school and life
Near-Term Network Goal(s)	<ul style="list-style-type: none"> <li>❖ Jointly develop a pilot that would leverage Medi-Cal/Medicaid and CHIP               <ul style="list-style-type: none"> <li>○ A continuum of screening to identify needs in areas that affect children’s health and development including physical, social-emotional and behavioral development, adverse childhood experiences, and social determinants</li> <li>○ Differentiated levels of care coordination/case management that responds to risks identified at levels of intensity reflecting child and family needs</li> <li>○ Other population health responses that address children’s developmental risks and needs (e.g. Parent and Child Together Classes, parent engagement and empowerment activities)</li> </ul> </li> </ul>