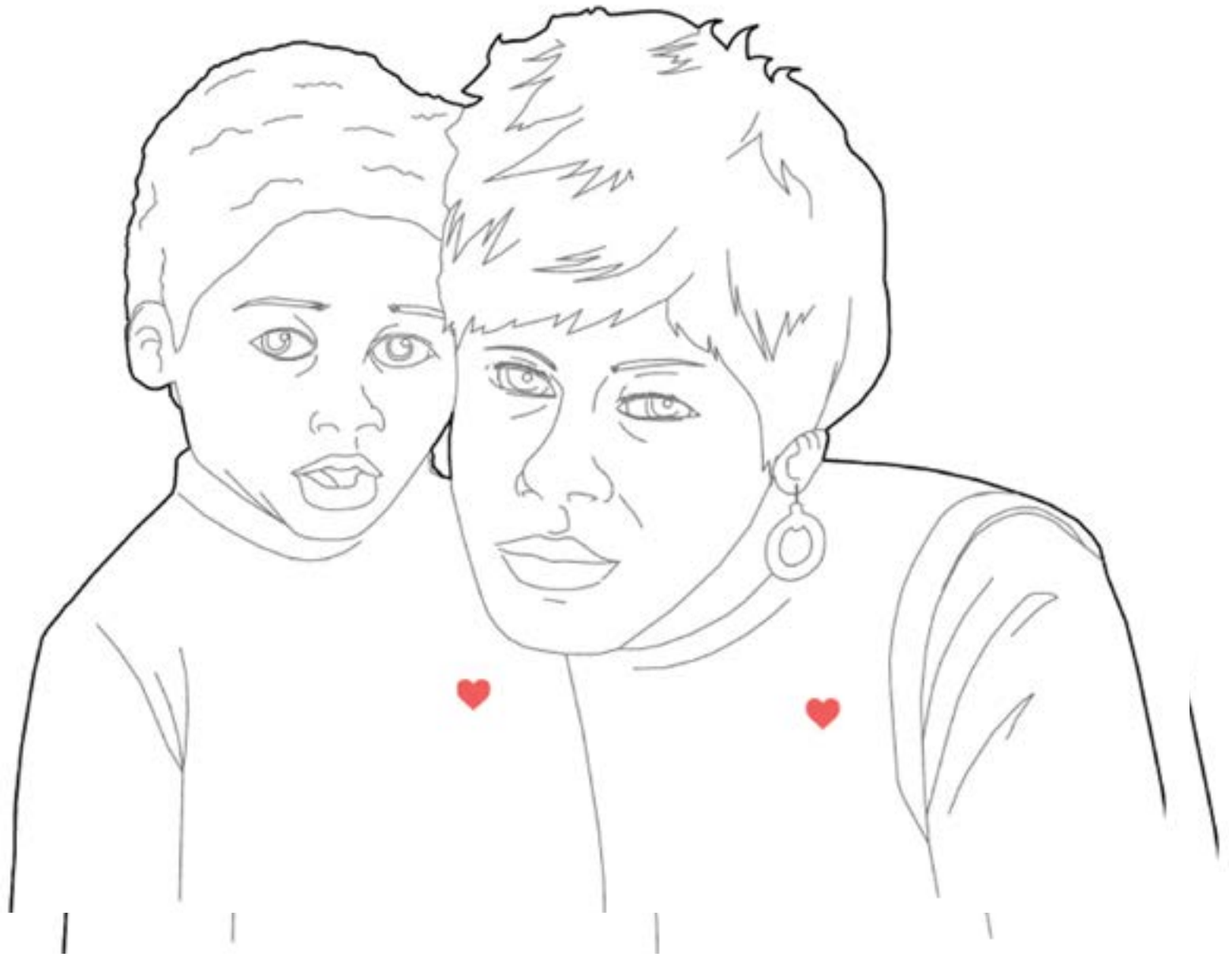
COMMUNITY ACHIEVEMENT RACIAL EQUITY

(C.A.R.E.) FRAMEWORK



01
PREFACE

As a child in Detroit, I experienced asthma attacks. My mother and I would leave the neighborhood hospital and go to expensive neighborhood grocery stores that reeked from food spoilage. The other choice was a dollar meal from a fast-food restaurant consisting of a greasy burger and fries accompanied by a high calorie beverage. This is commonplace in poverty-stricken communities.

Millions of poor families are discharged from healthcare facilities and exit those doors hungry, and not 100 feet away they access FAST food chains, gas stations, and liquor and convenient stores that carry products loaded with fat, sugar, salt and other non-nutritious ingredients. These communities are experiencing food apartheid, a term coined by food justice advocate Karen Washington that correlates to a lack of affordable, fresh groceries with perpetual and structural racial injustices, geographic disparities, and economic inequalities. As a result of this, generations of people revolve in and out of hospitals with obesity, diabetes, hypertension, kidney disease, heart disease and cancer.[1]

As a healthcare planner, I personally understand how urban planning and design impacts health equity. I considered this a matter of life and death, and so I designed the Community Achievement Racial Equity framework known as C.A.R.E.

1 Brones, "Food Apartheid."

02
EXECUTIVE SUMMARY

Health inequity is a matter of life and death! Historically, hospitals in under-served communities are surrounded by social inequalities and food apartheid. For almost two years, the COVID-19 pandemic has exacerbated the barriers to racial health disproportionately amongst the Black community. A Brookings Institution report took a deep dive into how COVID-19 affected Detroit, a predominantly Black city. Not only were Blacks more likely to contract and die from COVID-19, but the COVID-19 spillovers further exposed structurally embedded racial inequities.[1]

An estimated 20% of a person's health status is predicted by one's accessibility into a healthcare environment and the other 80% is determined by what happens in one's life outside of the hospital. Instead of focusing on the typical 20% of clinical care within hospitals, we will radically fuse historically disenfranchised neighborhoods surrounding the healthcare facilities of Detroit's Henry Ford and Sinai Hospitals with the 80% factors and map the existing ecosystem of health and wellness resources within each radius as a means of evaluating and reducing disparity gaps in disadvantaged communities. The 80% determinants consist of socioeconomic issues such as food apartheid and health behaviors.

To balance the 80%, we must engage both public and private sectors to care and service the community with dignity. By underscoring the highest racial disparities in our cities, we will incorporate justice and equity in our practice to vitalize and ensure a sustainable future that empowers the entire community.

The local food environment influences dietary patterns and food choices. The lack of access to healthy food within this environment may result in unhealthy food choices which could lead to obesity, hypertension, diabetes, kidney disease and most cancers.

Evidence suggests these outcomes are the result of limited food choices and the proximity of the overabundance of gas stations, liquor convenient stores and fast-food restaurants to DMC Sinai Grace and Henry Ford Hospital respectively. Research shows there is a link between food insecurity, chronic diseases, transportation options, graduation rates and lack of open spaces.

1 Ray and Gostin, "What Are the Health Consequences of Systemic Racism."

As a result, communities surrounding hospitals may have unhealthy food environments, therefore, preventing residents from making healthy food choices and finding themselves back in the hospital for chronic diseases

The C.A.R.E. framework will identify existing conditions; offer recommendations based on my research and engagement efforts; create a food justice ecosystem of stakeholders to develop their own rating systems to close the gap on racial health equity found in apartheid and collaborate with hospital goals and mission to be good neighbors to the community they serve.

The exploration grant highlights the internal and external environments surrounding hospitals that can impact health outcomes for patients focused on healing and wellness. The framework is a tool to monitor health services, empower communities and improve the accountability of service providers and community stakeholders. It will encompass a framework, based on the DMC Sinai Grace and Henry Ford Hospital catchment areas and a 5 minute and 15-minute walkable radius surrounding two Detroit hospitals.

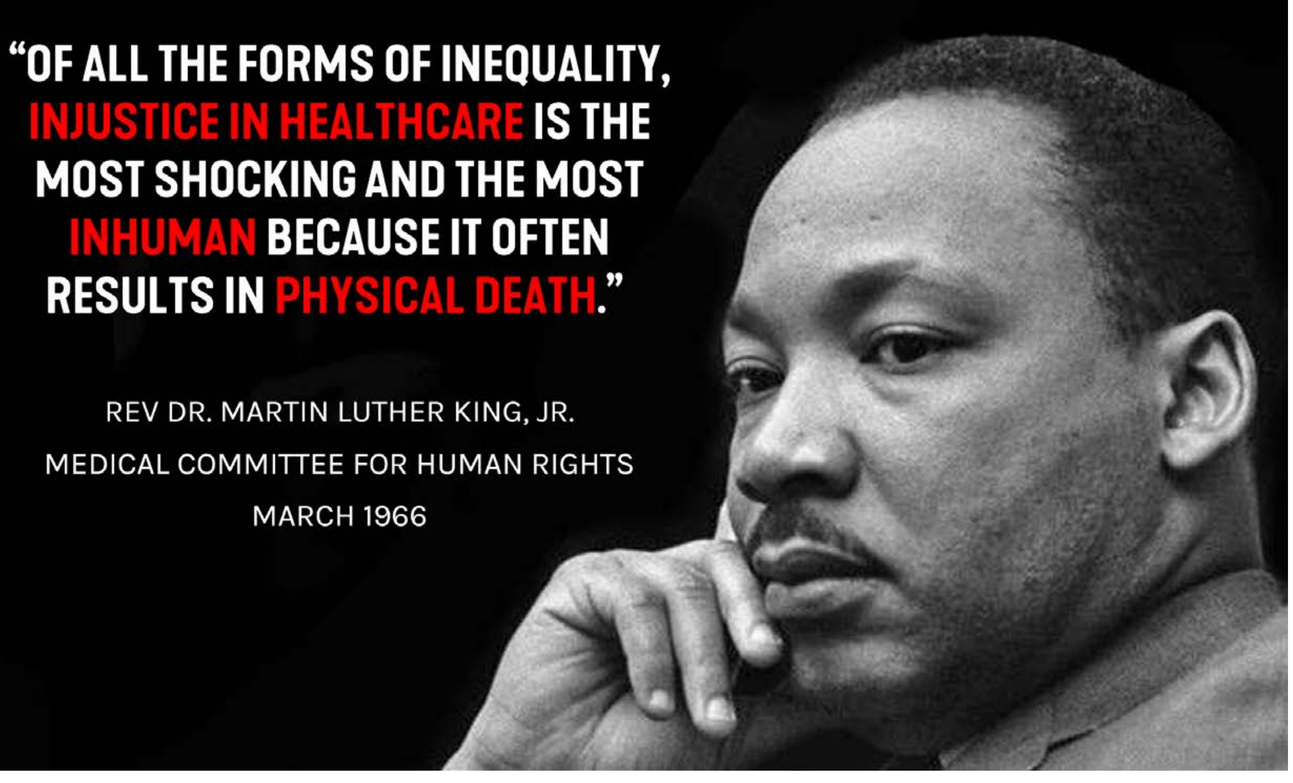
This document seeks to articulate an equitable vision for Detroit's future, and recommends specific actions for reaching that future. The vision resulted from a nine month-long process that drew upon interactions among Detroit residents and civic leaders from both the nonprofit and for-profit sectors.

Together, they formed an ecosystem for my research of experts in nutrition, food advocacy, community leadership of individuals from within Detroit. Their knowledge of civic engagement, nonprofit community work, and key areas such as food apartheid, land use, economic development, and the city itself were of deep value. I also shared my research publicly at the Detroit Food Policy Council annual October meeting and shaped my findings in response to evolving information and community feedback throughout the process.

Using the term "apartheid" focuses my examination on the intersectional root causes that created low-income and low food access areas less than a mile from hospitals, and importantly, creates a pathway towards working for structural change to address why there are higher rates of obesity and diabetes due to systemic limitation to healthy affordable food.[1]

To begin to root out and address all the unjust practices and structures within racial health disparities, it is my desire to focus first on the issue of food apartheid and system disparities in food access and availability.

1 Seligman, Laraia, and Kushel, "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants."



A DAY IN THE LIFE OF A FOOD APARTHEID COMMUNITY

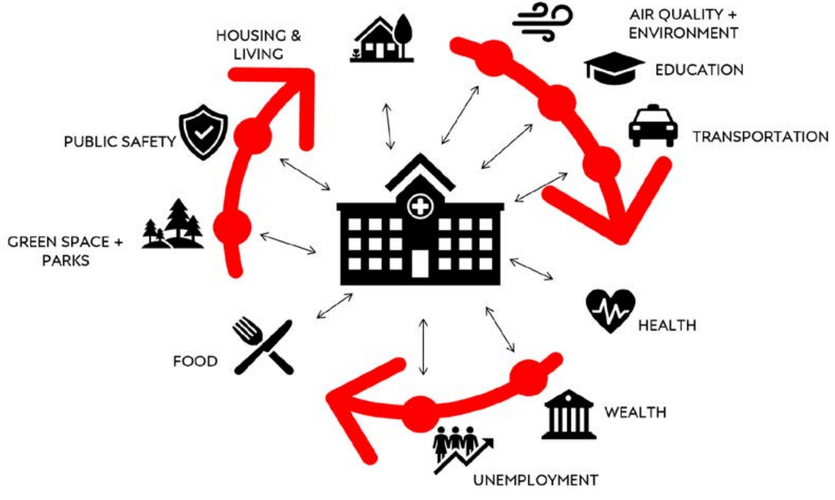
Racial health inequity is a matter of life and death! Dr. Martin Luther King Jr. , 56 years ago said, "injustices in health not just healthcare is the most shocking and the most inhuman because it often results in physical death." In other words Black lives end because of the injustice of poverty, racism, education and housing, now called social determinants of health.

For the purpose of this study, I used my personal story as a child growing up in Northwest Detroit with asthma attacks. My mother and I would leave the neighborhood hospital and go to expensive neighborhood grocery stores that reeked from food spoilage. The other choice was a dollar meal from a fast-food restaurant consisting of a greasy burger and fries accompanied by a high calorie beverage. This is commonplace in poverty-stricken communities.

Millions of poor families in similar households are discharged from healthcare facilities and exit those doors hungry, and not 100 feet away they access FAST food chains, gas stations, and liquor and convenient stores that carry products loaded with fat, sugar, salt and other non-nutritious ingredients.

Struggling parents who have to make ends meet, despite hard work, find themselves on this endless merry-go-round of living in a physical environment with housing insecurity; little to no affordable healthy food; low graduation rates; limited resources to purchase a car or traveling over a mile to find an affordable grocery store; enormous medical bills; high wealth gaps compared to white families; high unemployment rates; high concentration of alcohol and fast food restaurants in a small area surround hospitals; no outdoor spaces to play or trees to reduce heat islands and public safety and health concerns for families with higher rates of diabetes, stress, obesity, and heart disease. This chronic lack of access to affordable healthy quality food produce generations of people who revolve in and out of hospitals with obesity, diabetes, hypertension, kidney disease, heart disease and cancer.

This study will ascertain the cause of food apartheid in the physical environment and develop solutions to help communities end food insecurity.



FOOD JUSTICE

To my surprise, the portrayal of the City of Detroit as a "food desert" is misleading, even as my research finds that Detroit has areas that lack food outlets.[1]

However,after conversations with food experts, they said food desert doesn't address the structural barriers the way food justice does. Food justice is more than looking at the available resources of nutritious foods; it also looks at land ownership and the connectedness with environmental justice.

"Food justice seeks to ensure that the benefits and risks of where, what and how food is grown, produced, transported, distributed, accessed and eaten are shared fairly. Food justice represents a transformation of the current food system, including but not limited to eliminating disparities and inequities."

This data will be shared with a food justice ecosystem composed of city leadership, advocacy groups, policy makers, community residents and stakeholders, urban planners, economic developers, and hospitals.

According to DMC Sinai Grace catchment areas in Detroit's District #2, there are 7 grocery stores; 132 Liquor Party Stores/Bar and Grills; 96 Fast food restaurants; 12 Urban farms; 10 dialysis centers and 43 gas stations. District #5 Henry Ford catchment area contains 13 grocery stores; 181 Liquor Party Stores/Bar and Grills; 183 fast food restaurants; 24 Urban farms; 3 dialysis centers and 9 gas stations.

After my consultation with the Detroit Food Policy Council, I was asked to compare the two Detroit hospitals with an affluent catchment area surrounding a hospital. I chose to analyze the catchment areas for West Bloomfield Henry Ford Hospital. My findings included 20 grocery stores; 15 Liquor Party Stores/ Bars and Grills; 64 fast food restaurants; 1 urban farm; 1 dialysis center and 12 gas stations. The DMC Sinai Grace and Henry Ford Catchment area is 1.6x larger than West Bloomfield Hospital catchment area and yet have the same number of grocery stores (20). In addition, there is a combined 20:1 ratio of fast-food restaurants in catchment areas surrounding DMC Sinai-Grace and Henry Ford compared to West Bloomfield. (See Figure Chart on page 55)

This chart illustrates health inequality is a matter of life and death! You can understand why the life expectancy rates are higher in West Bloomfield where as in this study, these communities have 18 less birthdays alone based on the access to quality affordable healthy foods.

1 Hill, "Critical Inquiry into Detroit's 'Food Desert' Metaphor."

FOOD METRIC COMPARISONS

Categories	District #2: DMC Sinai 48235, 48227, 48221	District #5 : Henry Ford 48202, 48204, 48203, 48228	West Bloomfield: WB Henry Ford 48322, 48331, 48334 48323
Population	105,748	97,279	65,610
Per Capital	22,495	19,287	44,885
18 & Over	80,135	76,497	13,778
Black	99,744	86,614	8,267
White	2,674	6,539	49,273
Hispanic	942	1,118	1,050
Square miles	17.1	26.1	27
Grocery Stores (includes the few major chain stores)*	7	13	20
Liquor_Party Stores/Bar & Grills/Liquor Licenses**	132	181	15
Fast Foods/Restaurants**	96	183	64
Parks	5	12	12
Gas Stations/Convenient Store**	43	9	12
Urban Farms/Food Distribution/Food Organizations*	12	24	1
Dialysis Centers	10	3	1
Drug Stores	2	3	11
General Stores/Family Dollar	11	8	2
Colleges/Universities	3	3	1

Healthy Foods* Processed Foods**

FOOD ACCESS

Studies show, most adults living in food-insecure households report being unable to afford balanced meals, worrying about the adequacy of their food supply, running out of food, and cutting the size of meals or skipping meals. The dietary changes associated with food insecurity may persist over extended periods, because food-insecure households often experience repeated food budget shortages. This is particularly challenging when families near DMC Sinai-Grace in District #2 and Henry Ford Hospital in District #5 have to travel more than a mile to a grocery store with healthy affordable food.

According to the 2020 Census, the main reasons for food insufficiency centered on stores that didn't have desired food items and families couldn't afford to buy more food. Almost 53% had enough food but not the always the types of food wanted because the stores didn't have them. 66% of families had just enough to eat and 77% didn't have enough to eat because they couldn't afford to buy more food.

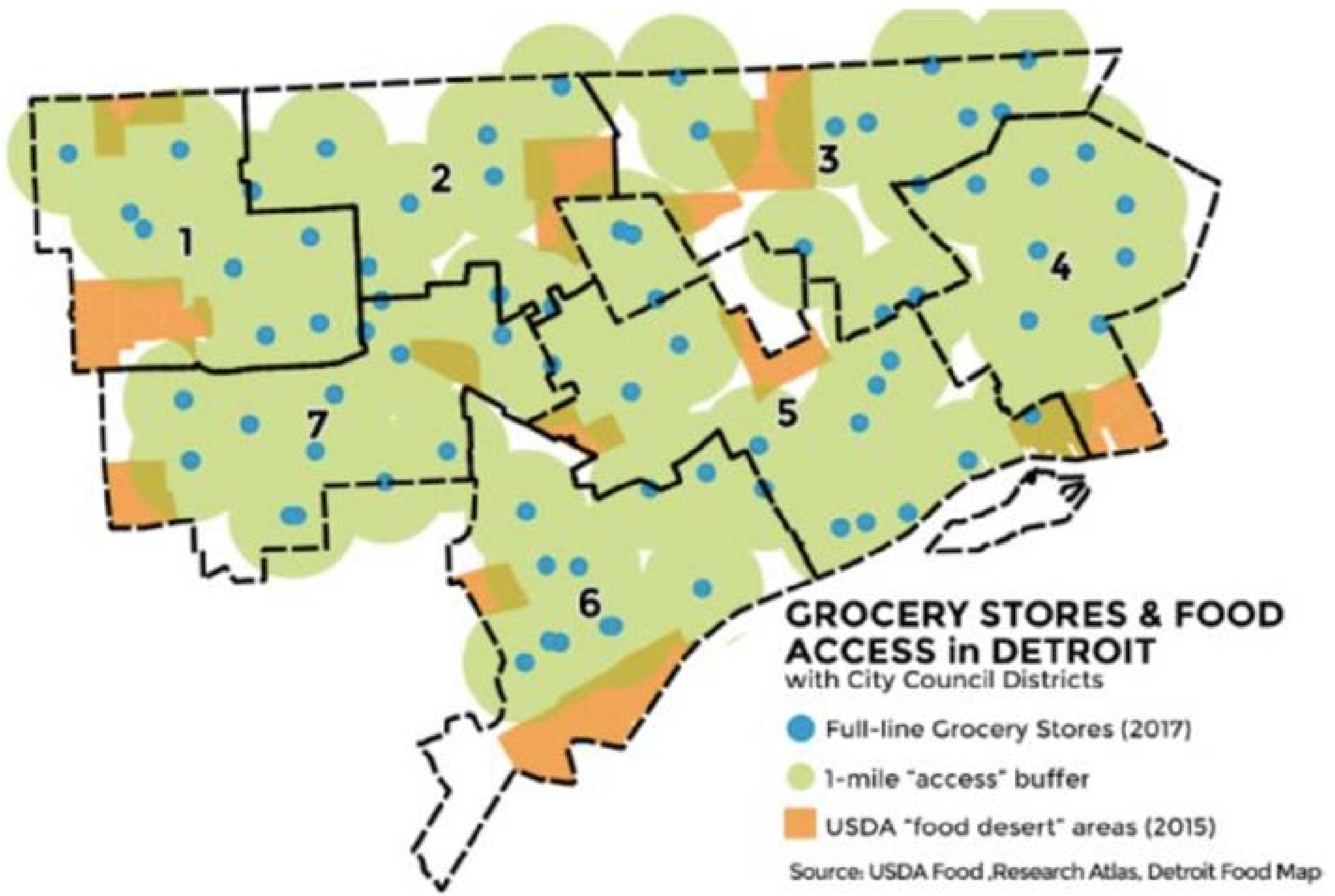
Families have to settle for high price unhealthy foods at liquor convenient stores and gas stations that are less than a mile near their hospital because they couldn't afford to buy more food. In addition, less than 25% of Detroiters own a car. This makes it even more inequitable for families to find healthy affordable food without taking multiple bus routes to various stores because they didn't have the desired food in one location.

Providing a framework to connect families with the ecosystem of nutritionists, food advocacy organizations and hospitals is the first step in creating a healthy community.

Reasons for Recent Food Insufficiency

	Enough Food, But Not Always the Types Wanted	Sometimes Not Enough to Eat	Often Not Enough to Eat
Couldn't afford to buy more food	25.2%	**66.2%**	**77.0%**
Couldn't get out to buy food	10.5%	16.5%	4.6%
Afraid to or didn't want to go out to buy food	18.4%	7.0%	0
Couldn't get food delivered to me	10.6%	7.9%	0
The stores didn't have desired food items	**52.9%**	35.1%	11.3%
Did not report	3.9%	0.3%	9.9%

SOURCE: Data from www.census.gov/householdpulsedata as of [illegible]



Source: Alex B. Hill; Detroit Food Policy Council

FOOD INSECURITY DURING COVID-19

Health inequality is a matter of life and death! There are longstanding systemic forces that have created health disparities throughout the history of our nation. Covid-19 and the senseless death of George Floyd, Breonna Taylor and Ahmaud Arbery in 2020 have served to highlight the impact of structural racism and its profound role in exacerbating the effects of chronic diseases on Black Americans resulting in shorter life expectancies and a compromised standard of life.

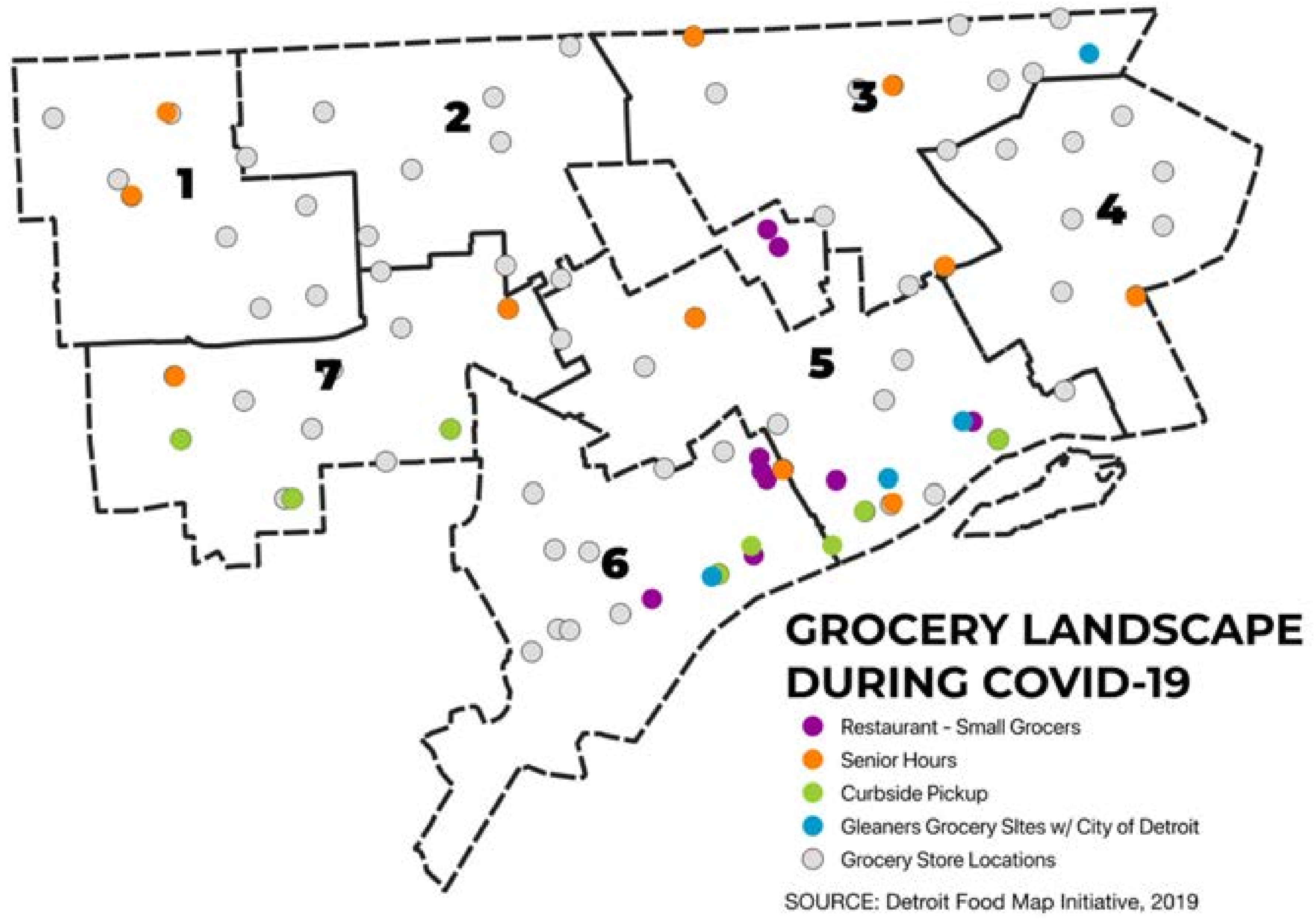
For almost two years, the COVID-19 pandemic has exacerbated the barriers to racial health disproportionately amongst the Black community. A Brookings Institution report took a deep dive into how COVID-19 affected Detroit, a predominantly Black city. Not only were Blacks more likely to contract and die from COVID-19, but the COVID-19 spillovers further exposed structurally embedded racial inequities.[1]

Detroit, one of the largest segregated cities in America, has a history of systemic racism that factors in the city's lack of access to healthy food. The City of Detroit's residents are predominately Black, (83%- Black and 14% White) and any effort to improve the health of the people of Detroit must also be an effort to improve the social determinants of health at play in communities overwhelmed with food insecurity.[2]

2020 Census data shows that 40% of families didn't have enough food because the stores didn't have desired food choices and 31% couldn't afford to buy more food. These reasons were intensified during Covid-19 in Detroit. Families living in within a 15 minute walkable distance to Henry Ford Hospital and DMC Sinai Grace didn't have access to restaurants-small grocers, senior hours, curbside pickup, grocery stores or Gleaners grocery sites.

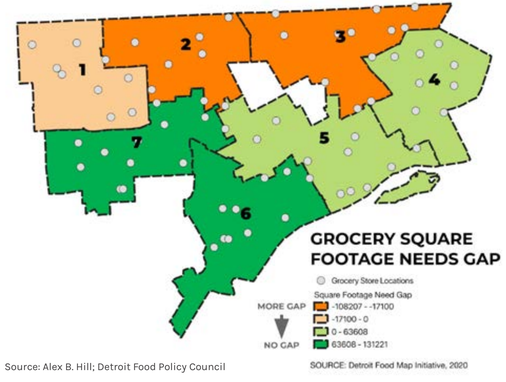
Physical environments in the places like District #2 and #5 where people live, learn, work, play, and worship affect a wide range of underlying conditions that affect access to healthy food and health care, and health risks and outcomes, such as COVID-19 infection, severe illness, and death. These conditions are known as social determinants of health. Long-standing systemic health and social inequities have caused Black families to die from COVID-19 at a rate 2.4 times greater than it is for white families.

1 Ray and Gostin, "What Are the Health Consequences of Systemic Racism."
2 Scott et al., "Structural Racism in the Built Environment."



Source: Alex B. Hill; Detroit Food Policy Council

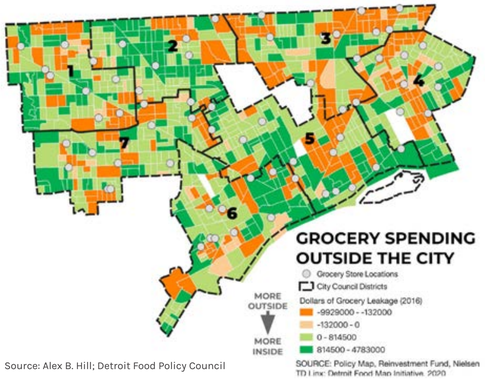
GROCERY STORE ASSESSMENTS



Source: Alex B. Hill; Detroit Food Policy Council

District #2 has the greatest grocery store square footage needs gap in all of Detroit. Black families and lower-income families have access to fewer supermarkets and other healthy food retail outlets that provide a wide selection of affordable, healthy foods. Studies show, families spend more on groceries inside the City of Detroit on the high concentration of liquor convenient stores, gas stations and overpriced single retail stores. Similarly, the limited healthy food choices near DMC Sinai-Grace Hospital is a risk to families who develop obesity, diabetes and heart disease.

District #5 has grocery store square footage needs. Families spend more on groceries outside of the City of Detroit. Due to the limited number of grocery stores in proximity of Henry Ford Hospital, many residents are forced to travel outside their community to find healthy, affordable food.



Source: Alex B. Hill; Detroit Food Policy Council

Residents living near DMC Sinai Grace in District #2 spend more on groceries inside the city. Data shows residents travel over one mile to purchase healthy food from grocery store. Most food purchased are found in liquor convenient stores, gas stations and ma & pa stores.

Residents living near Henry Ford Hospital in District #5 spend more on groceries outside of the city. Data shows residents travel over one mile to purchase healthy food from grocery store. 25% of residents don't own a car, so they travel on multiple buses to purchase affordable healthy food at various grocery stores based on what they like.

GROCERY STORE & HEALTHY FOOD PRIORITIES

The Detroit Food Policy Council 2019 report identifies grocery store and healthy food a priority for Detroit residents. According to the Detroit Health Department Community Health Assessment, every district prefer grocery stores over healthy foods.

District #2

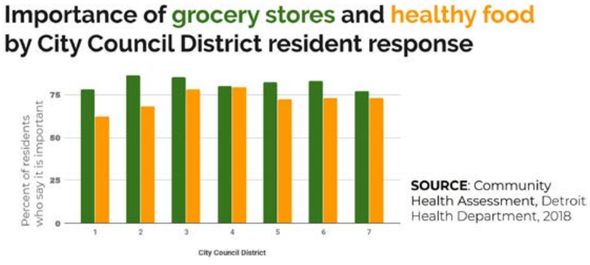
This over 80% of District #2 residents want grocery stores and 70% want healthy foods. Out of a scale of 1-10, grocery stores are ranked #1 and healthy food ranked #5.

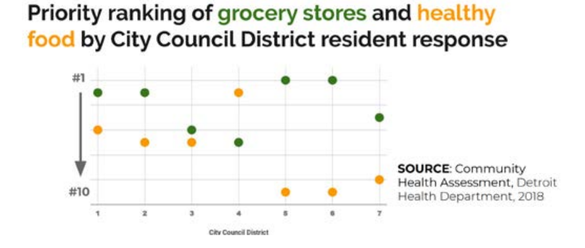
District #5

Over 75% of District #5 residents want grocery stores and 73% want healthy foods. Out of a scale of 1-10, grocery stores are ranked #1 and healthy food ranked #10.

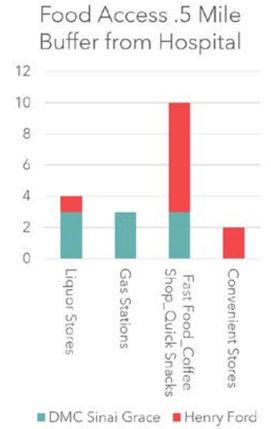
Although Detroiter's in District #2 and #5 desire grocery stores and access to healthy food, mapping data shows that there are no grocery stores and healthy food options within a 5-15 minute walking distance from hospital. Residents currently patronize liquor convenient stores, gas stations or fast food restaurants. Studies also show that families travel over a mile to grocery stores and for households without cars, travel on multiple bus lines just to find affordable healthy foods at different stores because there is no grocery store near their hospital.

This study introduces strategies and case studies that Detroit can implement to eliminate food apartheid.

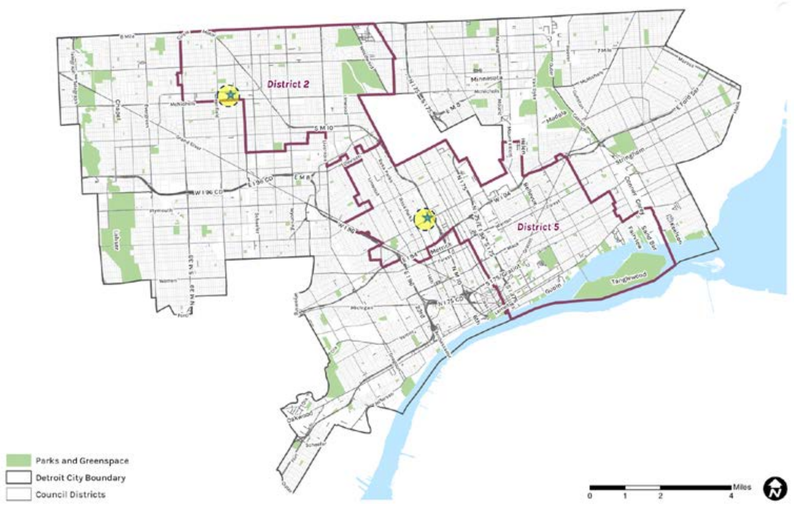




FOOD ACCESS RATE .5 MILE BUFFER NEAR HOSPITAL



Sinai Grace: 9 locations liquor stores, Gas Stations, Fast Food; 0 convenient stores
Henry Ford: 8 locations liquor stores, Gas Stations, Fast Food; 2 Convenient Stores



Courtesy of Caeley Harris

FOOD ACCESS RATE NEAR DMC SINAI GRACE

1.8

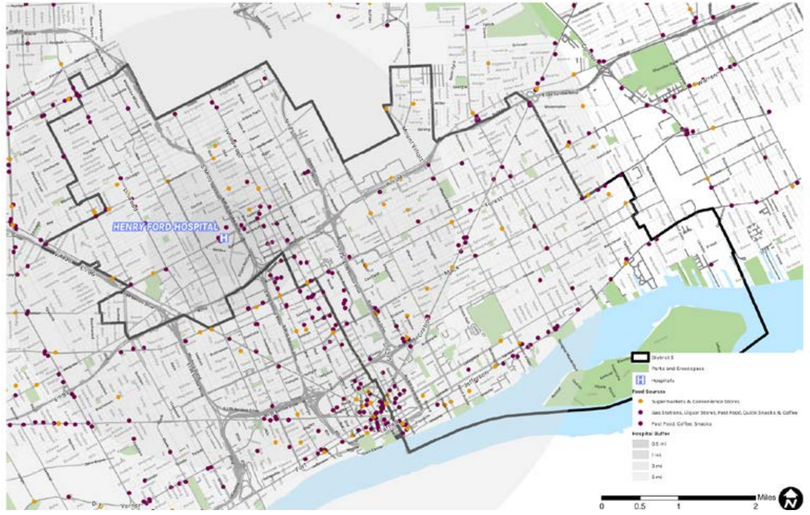
For every 4 convenient stores, there is a total of 31 (liquor stores, fast food and gas stations) for residents to chose quality, affordable and healthy food

Courtesy of Caeley Harris

FOOD ACCESS RATE NEAR HENRY FORD

1.6

For every 4 convenient stores, there is a total of 24 (liquor stores, fast food and gas stations) for residents to chose quality, affordable and healthy food



Courtesy of Caeley Harris

FOOD ACCESS RATE SUMMARY

The 13th Congressional District in Detroit, where Henry Ford Hospital is located, has the highest project food insecurity rate in the nation at 29.3%

The maps found on pages 62-64, illustrate that for every convenient store (CVS, etc.), there are 6-8 liquor stores in a 5 minute walking distance from the hospital. Not only families are impacted by food apartheid, but so are the hospital staff who can't find quality affordable healthy food for lunch.

The food insecurity is compounded by high number of liquor stores and fast food restaurants, and the lack of public open green spaces has greatly interrupted many households access to quality food. This also increases their risk of severe illness and disease such as obesity, kidney disease and heart disease.

The C.A.R.E. Framework will influence legislatures and policymakers to improve laws and regulations and help protect food apartheid communities surrounding hospitals.

Highest Projected:	State		County		Congressional District	
	Overall	Children	Overall	Children	Overall	Children
Food insecurity rate	Mississippi (22.6%)	Nevada/ Louisiana (32.3%)	Jefferson County, MS (36.8%)	Kusilvak Census Area, Alaska (56.9%)	Michigan's 13th District (29.3%)	New York's 15th District (43.9%)
Increase to the number of people in food insecure households	California (1.9 million)	California (864,100)	Los Angeles County, CA (614,760)	Los Angeles County, CA (271,290)	Nevada's 3rd District (61,720)	Nevada's 4th District (26,890)
Total number of people in food insecure households	California (6.2 million)	California (2.2 million)	Los Angeles County, CA (1.8 million)	Los Angeles County, CA (613,540)	New York's 15th District (215,690)	New York's 15th District (88,270)
Percent increase in the food insecurity rate	Massachusetts (59%)	Massachusetts (102%)	Kendall County, IL (93%)	Norfolk County, MA (163%)	New York's 3rd District (96%)	Michigan's 11th District (183%)

Feeding America: The Impact of the Coronavirus on Food Insecurity in 2020

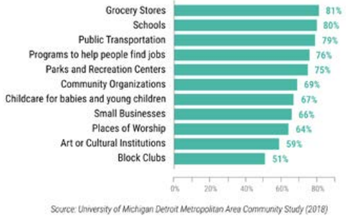
WHY IS THERE SO MUCH FAST FOOD NEAR HOSPITALS IN POOR URBAN AREAS?

Studies show fast food restaurants near schools is associated with higher obesity risk among students in urban schools and increased fast food purchases and obesity rates among teenagers are associated with fast food proximity to schools. If this is true with schools, why is there so much fast food in and near hospitals?

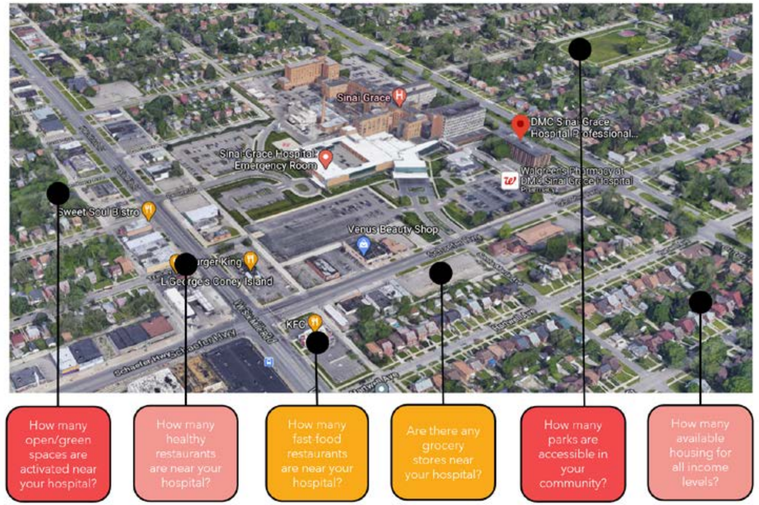
In cases near DMC Sinai- Grace and Henry Ford Hospital, liquor convenient stores and fast food are within walking distance from the front door. Some hospitals still serve greasy food and fast food and yet, patients are discharged only to find themselves back in the hospital with obesity and high-fat diet which causes cancer. DMC Sinai Grace has prevention programs and Henry Ford Hospital recently opened their cancer pavilion to address various forms of cancer.

"There's strong evidence to show that high consumption of fast food increases the risk of obesity and chronic disease, such as heart disease, diabetes and range of cancers."

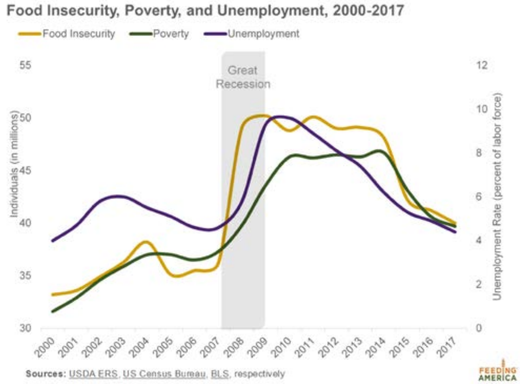
This study will provide strategies to reduce food apartheid and mention other drivers such as housing insecurity, more open parks and greenways, grocery stores, healthy affordable food options, and less fast food restaurants.



Source: University of Michigan Detroit Metropolitan Area Community Study (2018)



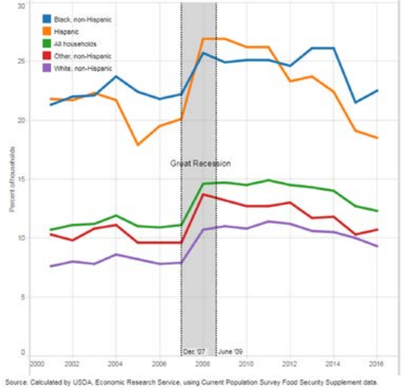
FOOD INSECURITY AND THE GREAT RECESSION



Both poverty and unemployment are driving factors of this induced food insecurity. According to Feeding America, food insecurity, poverty and unemployment rates are at there lowest since the Great Recession.

Though food insecurity, which increased sharply during the Great Recession, has declined, it still hasn't returned to pre-recession levels. One can argue that cities with high levels of food insecurity, almost 1/3 of children live in a food-insecure household.

For Black families living in Detroit it was worst because many lost their homes and employment during the Great Recession. This chart shows that food insecurity has impacted all races. However, Black families are the most impacted with the highest rates of food insecurity.



Source: Calculated by USDA, Economic Research Service, using Current Population Survey Food Security Supplement data.

Food insecurity and hunger have long-lasting health and development consequences, particularly for children. Hunger impairs emotional and intellectual development. For Detroiters, this makes sense when unemployment for African Americans is 1.5x that of white people; 17% of residents have a bachelor's degree or higher and the average household travels over a mile to purchase healthy food from a grocery store and the median income in Detroit is half that of the region.

There are evidence-based solutions to food insecurity: SNAP, supplemental summer nutrition benefits, food pantries, hospital programs with Easter Market and other urban farms and school meal programs. However, many of the food advocates I interviewed said it's time for Detroit leadership to take food apartheid and food justice serious as a new industry and as a pathway to feed thousand of struggling families.

PARTNERING WITH INTENTIONALITY

It is my goal that this first attempt at assessing hospital contributions as good neighbors with a focus on racial health equity in food apartheid will advance conversations to compassion in action that partners with the entire community.

One way to achieve this is to partner with intentionality. Dr. Kimberlydawn Wisdom, Sr. VP of Community Health & Equity and Chief Wellness & Diversity Officer at Henry Ford Health System said, "we need to partner in a very deliberate, intentional, and systematic way with public health [departments], with our urban planners, and with our economic developers. We need to partner in ways that traditionally we haven't if we're truly going to address social determinants of health.

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ECOSYSTEM

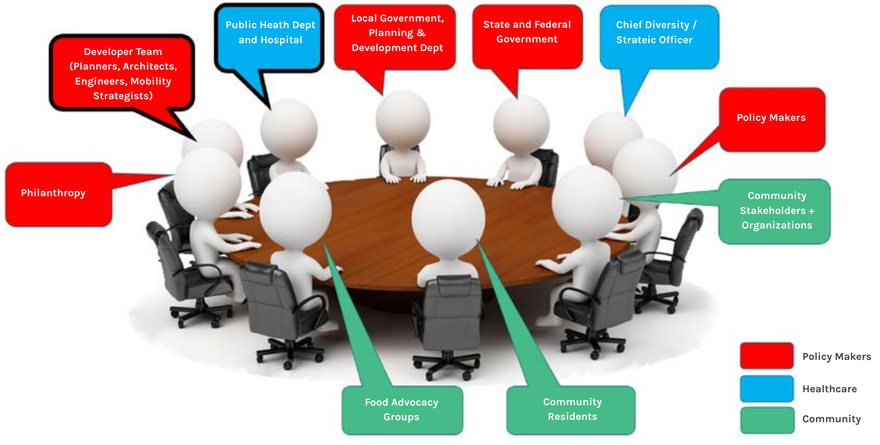
The C.A.R.E. Framework will create an ecosystem of stakeholders committed to addressing a racial health disparity found in food apartheid. Detroiter's have voiced their concerns that food insecurity, housing instability and wealth inequality. Detroit has a history of great organizations, churches and food advocacy groups working toward food justice. However, many are working in silos and C.A.R.E. strives to bring everyone together in a structured way to achieve racial health equity in food apartheid.

This framework will be used in collaboration of community partners, human service agencies, economic developers, urban planners, policy makers, health care systems and local governmental education to set priorities, common goals and target resources.

Developing policies and defining actions to target efforts solve food apartheid is crucial!! My interviews with college professors, healthcare institutions and nutritionists all said that policies are the key to promoting health.

"Food justice seeks to ensure that the benefits and risks of where, what and how food is grown, produced, transported, distributed, accessed and eaten are shared fairly. Food justice represents a transformation of the current food system, including but not limited to eliminating disparities and inequities."

This data will be shared with a food justice ecosystem composed of city leadership, advocacy groups, policy makers, community residents and stakeholders, urban planners, economic developers, and hospitals..



COLLECTIVE IMPACT MODEL

The collective impact model was first described in an article published in the Stanford Social Innovation Review (Winter 2011) by John Kania and Mark Kramer. The model was used to describe cross-sector collaborations that were already taking place in the U.S. to solve seemingly intractable problems by creating a centralized infrastructure with a structured process and dedicated staff. [1]

Because so many organizations are working in isolation from one another, Collective impact brings people together in a structured way to achieve social change.

It starts with a common agenda, then establishes a shared measurement to foster mutually reinforcing activities.. Afterwards, the team builds trust with continuous communication and participating as a team.

This model is used all over the world. For example, the leading organization in Canada that is working on ending poverty from a holistic perspective is the Tamarack Institute.

This is a good case study for the C.A.R.E. Framework that is working to close the racial disparity gaps found in food apartheid

1 Collective Impact Forum | What Is Collective Impact?"

Collective Impact Graphic courtesy of Clear Impact

WHERE DO WE GO FROM HERE?

The C.A.R.E. Framework's ecosystem of collective leaders will collaborate together to solve the same issue of food insecurity surrounding DMC Sinai Grace and Henry Ford Hospital. They will also discuss benefits for the community and beneficiary groups throughout the process.

This is the starting point to track the success of bringing everyone together using tools such as the collective impact collaboration. Establishing an agreement with hospitals, business, government, researchers, investors, economic developers, policymakers, non-profits and community stakeholders can give a credibility boost in the eyes of the general public and the overall community.

Each organization will be able to discuss and agree on standard metrics that will address food insecurity. The partners under the framework will gain leverage to increase opportunities for government and funding.

My interviews with food experts addressed the power to lobbying for beneficiary legislation (Certificate of Need and other programs) by demonstrating hospitals, businesses and nonprofits working together to improve racial health disparities and food insecurity.

As a result of these organizations working together under the C.A.R.E. Framework can best demonstrate meaningful and effective measures to track the progress of food apartheid and related disparities such as education, housing insecurity, employment, access to outdoor green spaces and access to healthy food.

Leveraging the C.A.R.E. Framework as a way to take a hospital's existing internal leapfrog surveying/feedback process outside the institution is a new holistic approach that focuses on continuous learning and improvement of key outcomes.

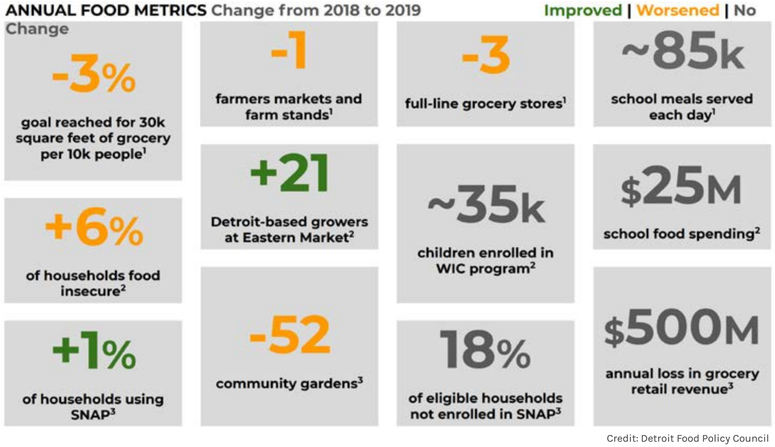
ANNUAL FOOD METRICS

One example of custom metrics is the food metric system developed by the Detroit Food Policy Council (DFPC). Every year, the Detroit Food Policy Council produces and disseminates City of Detroit food system reports that assess the state of the city's food system. This includes activities in production, distribution, consumption, waste generation and composting, nutrition and food assistance program participation and innovative food system programs. They also collaborate with other non-profits, urban farmers, planners, community garden organizations on programs, reports and conferences to reduce food apartheid.

This chart illustrates the various metrics such as household food insecure, Detroit based growers at Eastern Market, farmers markets and farm stands, full line grocery stores and a host of nutrition programs.

The DFPC tracks these metrics to see if there are any improvements. Metrics that worsened over the year period will become priorities to engage partners for the following year and beyond.

As a result, metrics like this are designed around ending food apartheid and improving access to healthy affordable food.



Credit: Detroit Food Policy Council

EVALUATING METRICS

After establishing the collective leadership and developing standard meaningful and effective measures to solve food apartheid, the team can focus on evaluating the metrics to identify priorities based on community needs and hospital assessment reports.

Using tools such as Power BI, the team can evaluate data and mapping to determine locations for healthy affordable food and reinvestment opportunities.

This evaluation process include tools such as collective impact forums to complement the C.A.R.E. Framework and give leverage to the holistic community to fight food insecurity with equitable policies and laws that will reduce racial health disparities.

This chart could be an example for each participant to identify metrics that are important to food insecurity from their perspective and knowledge. A nutritionist, researcher and food policy council metric will be different than a hospital or developer, but reviewing shared common goals and data will offer strategies that could link metrics and racial health disparities..

Becoming trusted partners that hold each other accountable to one another is the key to bringing everyone together by listening and evaluating metrics based on a common goal and vision.

	NOT MEETING 1	APPROACHING 2	MEETING 3	EXCEEDING 4
Access to healthy affordable and nutritious foods		x		
Partnership with local food advocates, non-profit organizations and anchor institutions in catchment areas				x
Reduce racial wealth gap (recruiting & upward mobility opportunities)	x			
Support Black owned business and Black farmers			x	
Partner with stakeholders to build a grocery store near campus		x		
Farmers markets and farm stands on campus			x	
Open green space & Community gardens		x		
Monitor Community Health Needs Assessment goals and outcome/process	x			
Reduce household food insecurity		x		
Increase purchasing power to minority owned businesses with programs like (1 product, 1 %, 1 contract) to address food apartheid	x			
Readmission Rates		x		
Include community benefit requirements in their hospital licensing programs	x			
Onsite food pantry		x		

C.A.R.E. FRAMEWORK SWOT ANALYSIS

S STRENGTHS	W WEAKNESSES	O OPPORTUNITIES	T THREATS
• Hospitals provide a Community Health Needs Assessment once every three years according to the Affordable Care Act • Organizations are doing great work • Existing food advocacy in Detroit • Hospitals have outreach programs and community assessments to address social determinants of health and needs of community • We have access to lots of data on food apartheid; social determinants of health and racial health disparities to assist organizations	• Not enough healthy food outlets • Health inequities are killing people • Lack of access to health, affordable foods • High levels of stress, anxiety and depression • More liquor store, fast food and gas station concentrations than grocery stores • Obesity, cancer, kidney disease, diabetes impact community • Fewer opportunities for physical activity • Lack of parks and open green spaces	• Vacant city parcels and existing buildings with infrastructure can be used to close racial health disparities in food apartheid • Create more open space for physical activity • To partner with planners, economic developers, food advocacy groups, stakeholders, community residents, hospitals and local government • Influence policy makers at all levels of government to address hospital certificate of need based on health disparities and connect the dots	• Wealth inequalities • Lack of affordable and fresh produce • Inadequate access to transportation • Community disinvestment • Limited access to health care • Disconnect between food advocacy, hospitals and community • Hospitals perceived not a "good neighbor" based on high numbers of fast food, liquor convenient stores and gas stations near hospital • Patients revolve in and out of hospitals with obesity, diabetes, kidney disease, heart disease and cancer due to lack of food options

SWOT Analysis

LENS OF JUSTICE

The food justice metrics within the framework will be decided in a collaborative process by the community partners and identify SWOT (strengths, weaknesses, opportunities and threats) analysis that exist in the community to improve the health equity and food justice surrounding hospitals.

This framework will provide the holistic community with tools such as the SWOT analysis to highlight such strengths for collective leadership impacts based on hospital programs and community health needs assessments. Weaknesses include but are not limited to lack of healthy food options in proximity to the hospital, high health inequities and healthy food ratios to liquor stores, fast food and gas stations within a 5-15 minute walk from the hospital. Opportunities include hospitals becoming a trusted advisor for community health, partnering with planners and other stakeholders to reduce food insecurity and influence lawmakers to create healthy communities. Threats include wealth gaps, patients revolving in and out of hospital doors with chronic diseases due to food insecurities.

Each collective leader will be charged with developing a rating score that will educate and help hospitals be a better neighbor by reducing food insecurity in their community.

This lens of justice begins with legislatures, designers, planners, economic developers, hospital leadership, non profits, community stakeholders and residents impacted by policies and systemic forces that perpetuates food apartheid.

Furthermore, this study suggests the need to re-examine urban food inequalities through the lens of justice, racism, capital, and policy, and to reimagine the role of government in protecting the rights of citizens, especially in food insecure communities known as food apartheid in hospital catchment areas.

While food desert addresses the need for supermarkets in neighborhoods where people have limited access to healthy affordable food, it begs the question are we solving the right problem when we ignore the historical injustices that plague Black communities with liquor stores, fast food restaurants and no access to healthy foods near their neighborhood hospital.

The "food desert" decline narrative is used to promote supermarket reinvestment policies aimed at improving health and spurring urban economic development; such a policy ignores the role of racism in creating inequalities and therefore cannot address root causes of unequal food access.[1]

The C.A.R.E. Framework creates an ecosystem that brings the collective leadership together that addresses the structural barriers, while advocating and designing for the health and wellbeing of the community through the lens of justice.

Lastly, the data can and should change how we plan and design for equity and justice. This can be accomplished by using the following metrics: Detroit life expectancy by zip code, food desert data, GIS data layers to support your research on social determinants of health, etc..

1 Lakhani, ""The Food System Is Racist.""