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BY

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DISSEPTION

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ABSTRACT

This study proposes that nonprofit healthcare organizations can function as social entrepreneurs, using the designed environment as a critical resource to address health and wellness issues within the community beyond their usual medical services. By taking this approach, organizations would not only help mitigate social problems within the community but also create incentives for themselves. Operating under a resource-based lens, this study explores whether the designed environment can help in the creation of social value as a means by which nonprofit healthcare organizations (called clinics) can become community resources, offering more than just sources of medical care.

Acknowledging the inseparability of space and activity, this practical and exploratory study incorporates principles from environment behavior, strategy management, and social entrepreneurship. The ideologies of Social Design (Sommer R., 1983) and Social Bricolage (Di Domenico, Haugh, & Tracey, 2010) are used as the basic framework, including areas such as stakeholder participation, a local approach, gender and spatial navigation, theories on everydayness, organizational mission, and resource-based theories.

Using pre-determined criteria from literature and preliminary research, two sets of social programs, actively supported by clinics, were chosen for a multiple case study methodology. The case studies were grouped into two themes addressing basic issues of food and shelter. The first theme, healthy eating, was addressed by farmers’ markets; the second theme, programs for low income women, was addressed through homeless shelters, transition homes, and community resource centers. The idea of social value creation was also examined from a cross-cultural perspective, examining one case in detail and several smaller cases from India. Each site was visited in the summer of 2013 through winter of 2014. Data were in the form of interviews with program and clinic personnel, observations, note taking, photographs, and official reports and documents procured from each clinic.
QDA Miner 4.1.12 was used as a means for verbal content analysis and visual analysis. Further, a Social Return on Investment (SROI) was conducted on some of the cases using the SROI Network’s Impact Map assessment technique. Findings showed enmeshed environmental and entrepreneurial factors. Visibility, access and seclusion (often at the same time), the location (at micro and city level) incorporated into program planning and structure, importance of organizational mission and partnering with community organizations were some of the major outcomes. Contributions of stakeholders stood out prominently in both content and monetary analysis. The SROI study results showed positive returns to the dollar on every analysis done. The clinics in this study realized several additional benefits in supporting the space-based social programs—low or no cost of building procurement, reduction in emergency room / ambulance services and unnecessary hospitalization, safeguarding tax status, brand recognition, awards, increase in volunteer network (thereby reducing staff cost), and avoiding replication of services available in the community.

There is a growing awareness of the unsustainability of the current operational model that most nonprofit clinics adopt. Clinics are constantly struggling with resource deficits along with high costs of uncompensated care and pressure from competing health systems. With increasing federal mandates in the form of laws and income tax regulations for clinics to address the larger wellness issue within the community, this study though exploratory, provides an insight into how adopting a physical resource-based view can be a huge incentive for a clinic to address a pressing social need in its community, in a manner that is not only beneficial to the community but to the clinic as well.
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Chapter 1.0: Introduction

It is one of the most beautiful compensations of this life that you cannot sincerely try to help another without helping yourself.

—Ralph Waldo Emerson

In the new millennium there has been an emergence of an interesting new ideology of wealth sharing where organizations and corporations are seeking to address social problems with innovative solutions in such a manner that it benefits both giver and receiver. This is a clear departure from earlier, more traditional thinking where social problems were considered the prerogative of governmental agencies and nonprofits solely dedicated to addressing these issues. Some organizations are now seeking to integrate social issues into their core strategy so that they can offer a multitude of benefits to the organization and community. They are using the wealth thus created to their advantage—from leveraging goodwill for future business endeavors, to boosting organizational profile and brand equity, to using the thus mitigated social problem to advance their own everyday business. Companies are also known to have used these kinds of communally beneficial programs to create a distinct competitive advantage over their peers.

Within the nonprofit sector, the idea of social programs actively benefiting program givers has yet to catch on. Resource constraints and pressure from regulatory agencies could be reasons for this. However, there are some organization-types within the nonprofit sector that are not only ideally suited for supporting social programs but also stand to gain significantly from doing so. When planned and implemented, these innovative programs could help reduce burden on an organization’s everyday activities, help satisfy federal and other regulatory agencies, act as brand ambassadors, and at the same time not affect their operational bottom-line.

A prime candidate for realizing such benefits is the nonprofit healthcare organization. These organizations have skills that other organization types lack. They have knowledge of
working with people directly, the ability to handle grief and other sensitive issues, and they are equipped to deal with a diverse range of population subsets and demographics. They also have a strong business model, strategies for finance, and various avenues for resource procurement and allotment. As nonprofits, they work under a constant resource paucity which helps them to understand the importance of planning, allotting, and economizing resources. This is important since social programs take longer to gain momentum than other types of interventions.

Healthcare organizations, are also highly visible and influential entities in their communities. Chances of other organizations within the community wanting to partner with a healthcare system to deliver programs and projects are much higher than with other nonprofit organizations.

Social issues and problems do not submit to direct market conditions; they are not goods that can be traded, so profit and loss cannot be established in monetary terms. These issues are also vague and intangible in nature which means the same problem can be addressed in many ways. It becomes important, therefore, for the healthcare organization to focus on programs it has the ability to address and execute. This will in turn enable smoother planning, resource allocation and leveling, implementation, and most importantly sustenance; together these ultimately create value for the parent company. Therefore, organizations must identify key resources that are required to structure, plan, and deliver the social program in such a way that it does not cause a deficit to the organization’s own operational bottom-line.

Resources could be physical, financial, labor, or intellectual; what resources need to be used for program implementation and in what proportion must be predetermined by the parent organization at the program-planning level. In fact, scholarship in this field of resource management, as applied to social entrepreneurship, says adopting a resource-based view would be a good way to ensure both program sustenance and prominence. Valuable resources that are central to program delivery, whether real or virtual, are considered essential ingredients
for program success. This study chooses to focus on physical resources, particularly the designed environment for further exploration of the value-creation process.

This study explores overt and covert factors of the designed environment which, when used as a prime resource central to a social program, actively support the creation and sustenance of social value. Social value, in this study, is defined as two-way wealth sharing where beneficiaries are both community and the parent organization offering the program. The community benefits from the program and the organization benefits in several ways from that association. Further, this study focuses on the incentives to the organization for offering a social program.

1.1 New Approaches to Social Value Creation - Help them but help yourself too

Over the last several decades, and particularly after 2000, there has been a shift in thinking—how can an organization work toward social betterment without feeling pressure on its own resources so that there is a prolonged commitment from the industry towards the community. Recent scholarship (Austin, Gutiérrez, Ogliastri, & Reficco, 2006; Orlitzky, Schmidt, & Rynes, 2003) has shown that companies that are working toward social betterment are viewed positively by society at large, providing the companies with greater incentives to conduct their everyday businesses. This two-way value exchange shows not only the interdependent nature of industry and society but also shows that while organizations have a certain agenda and everyday business to run, they need not be standalone entities that only seek profit from their surroundings (environment and people) in return for goods and services.

However, creating a socially sustainable network also means recognizing the organization as an integral member of society, (because of the benefit sharing) and not just as provider of goods and services. This status gives the organization rights and responsibilities like other members of society. In understanding its impact on society and vice versa, the organization can address social needs in a way that creates a meaningful benefit to society and
contributes positively to the company’s bottom-line (Porter & Kramer, 2006). By incorporating social good into its operational agenda, using nontraditional and traditional tools at its disposal to mitigate a social ill, an organization can become a driver of social change, albeit at a scale where it can be in complete control of structuring, implementing, succeeding, and accounting. This could lead to a program ultimately becoming self-sustaining.

This study approaches the idea of value creation from the organization’s viewpoint. It explores whether social programs can be created and offered in a manner that, in the long term, does not affect the parent organization’s operational bottom-line. Furthermore, it investigates whether such programs can create a sustaining advantage for the organization. It focuses on how programs for social good, when structured and implemented in an innovative manner using appropriate resources, can become self-sustaining over a period of time, thus creating a pool of advantages for the parent organization.

1.2 The Clinic and Social Value

A healthcare organization exists in a visible and scrutinized environment (Walshe & Smith, 2006). Nonprofit clinics essentially operate on patient payments, public funds and grants, insurance reimbursement, and governmental aid. Given the critical nature of their work, healthcare organizations are consistently under pressure from many sectors. For example, in the United States, clinics do not get reimbursed by the government, insurance companies, or related regulatory agencies for providing social programs of a non-medical nature. This creates a substantial lack of incentive for clinics, especially smaller, standalone nonprofit entities which are already resource strapped and competing against larger health systems and for-profit entities.

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1 For this study, any nonprofit organization that is directly involved with medical care (e.g., a hospital, an ambulatory care center, or an entire health system would be defined as a clinic).
A shortage of medical resources, the rise of chronic conditions, and the increase in life expectancy globally, combined with a change in perception of how community members view the clinic are beginning to create a change in thinking among healthcare organizations in the new millennium. This shift is toward thinking how to be of better service to the community, beyond medical care provision, while not overburdening their own resources. In the United States, a 2010 Institute of Medicine report on what constitutes value in healthcare resulted in some interesting outcomes. The report recognized that not all community members were patients actively receiving medical treatment at any given point in time. Further, members of a community were not just future patients but consumers. The community, therefore, is comprised of members who “acquire goods and services over a lifetime but not actively in treatment” (Young, Olsen, & McGinnis, 2010, p. 32).

Even though nonprofits, the clinics feel pressure to compete with other clinics in surrounding communities or other clinics offering comparable services within their own community. Research has shown that some demographics (especially women) are willing to travel outside their community if they perceive another clinic offers better quality of service (Dearing, 1987). Further, some clinics have a for-profit model², causing other nonprofits to want to create a competitive advantage that makes them stand out from the rest (McDonald, 2007). Additionally, clinics also seek to reduce uncompensated care expenses they incur, something that directly affects their sustenance as an organization. Exploring whether there are social programs that in the long term will reduce those expenses is a huge motivation for clinics (S. Seiler, former CEO of a large specialty hospital in central USA, personal communication, 2013).

While the basic nature of the clinic (critical service to mankind) creates little incentive for clinics to do more than immediate disease management, clinics are beginning to recognize that

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² For-profit clinics have significantly fewer governmental obligations (e.g., they are not mandated to provide Community Benefit), and are known to have more resources at their disposal than their nonprofit counterparts.
they are creating an unsustainable framework for themselves by not doing more. The pressure of survival in the face of resource shortage and competition is very real. However, clinics enjoy some advantages that are beyond the reach of other larger organizations, even other nonprofits. One such advantage is that they have greater economic impact on society than many other industries, including for-profit, mainstream businesses. The Illinois Medical District in Chicago, for example, employs close to 30,000 people, generating $3.4 billion annually (Illinois Medical District, January 2015). Other advantages enjoyed by health clinics include: working with cutting edge technologies, embracing a variety of business models, and having several stakeholder groups. The influential status and financial impact they have within a community (and beyond) makes possible partnerships with other sectors, be they real estate, finance, education, or even local governments.

That a clinic can look beyond disease management and aim toward becoming a true community resource by offering innovatively programmed, socially beneficial ventures is a nascent but steadily growing concept. In the United States, for example, the American Hospital Association in its Community Care Reports highlight those organizations that have developed community-related initiatives. What these reports do not indicate, however, is the longevity of these programs; nor do they mention in subsequent reports how these programs are faring or how organizations themselves are coping if not benefitting. This lack of long-term evaluation makes it difficult for other organizations of comparable stature to understand the true value of these programs and how, if at all, such programs can be adapted to other communities.

The Patient Protection and Affordable Care Act (as of 2014) and the expectation of clearer guidelines from the Internal Revenue Service (IRS, the income-tax department), as to what sorts of socially beneficial activities are tax exempt, could further create a positive incentive base. Clearer guidelines would enable clinics to more accurately project which activities and programs would be helpful in mitigating their tax liabilities. As part of the clinic’s
organizational plan, these projections could then expose the long-term benefits of implementing a socially advantageous program.

1.3 The Social Entrepreneur Outlook

Entrepreneurial leanings underpin the idea of leveraging social programs in a manner that enables the parent clinic to gain an edge over its peers and to maintain better leverage within the community. Social programs do not lend themselves to a profit and loss model and clinics do not get government financial support for offering these programs. Hence, there has to be a unique and innovative approach for clinics to offer these programs. It begins with establishing how these programs themselves can create a positive influence for the clinic and exploring how offering these programs will not negatively impact the operational framework of any clinic, financially or otherwise.

A good place to start is by understanding a few key elements of programs that deploy socially entrepreneurial ventures. They leverage organizational mission to their advantage; they channel the activist ideology strategically; most importantly, they operate under a resource-based model (Haugh, 2009), where the more unique (or hard to replicate) the resource (be it in content or application), the better the chance of success.

In order to do this, social enterprises use resources, both tangible (like physical, financial, and labor) as well as intangible (skills, etc.) to create a strategy for developing and implementing programs that accrue value (Wernerfelt, 1984). A resource-based view also suggests that it is the nature and quality of the resource that leads to long-term success. A resource that is either rare or inimitable, combined with an innovative use of that resource, provides a sustainable advantage in ensuring program success (Barney, 1991; Dollinger, 2008 among others).

Physical resources (buildings, furniture, IT equipment, etc.) can be among the most visible elements available for social programs to use as the central resource. These are also
among the harder resources to incorporate in a core strategy since they are easy to procure and replicate. Creating a unique and distinct advantage over peers with physical resources entails understanding the nature of the resource, harnessing its various overt and covert elements to turn it from resource to asset. This study explores whether the designed environment could be the physical resource base that clinics need, helping them to offer social programs such that the seen and unseen factors of our physical environment (from the practical to the philosophical) can be leveraged to their advantage. The fact that the physical environment (buildings, etc.) is easier to procure could be an advantage to these resource-deprived clinics, thereby increasing the chances that they would implement a social program.

In order to understand the positive influence of the built environment on the success of social programs, this study aims to elicit those individual factors of the designed environment that actively support and impact program usage. From tangible issues like process, costs of procurement and maintenance to more intangible issues like relationships between spatial layouts and social information, this study attempts to capture the various qualitative aspects of the designed environment that contribute positively to the social program. More importantly, this study seeks to identify factors that a clinic can utilize with innovative thinking and minimal investment so that the programs pay for themselves over a period of time and may also help the clinic to achieve distinctiveness among its peers.

1.4 A Design–Environment-Based Resource View

A social program’s success is largely dependent on opportunity and need recognition followed by an innovative, proactive, or risk-taking solution. (Sullivan Mort, Weerawardena, & Carnegie, 2003). A main difference between the way mainstream, for-profit businesses and nonprofit or grassroots organizations operate is that for the latter, service and program mission is the ultimate goal and not necessarily profitability and financial gain (as it is for the former). Since social programs do not always have a definable commercial value, they depend heavily
on resources in the form of grants, donations, and volunteers. However, in poor economic climates, organizations that intend to launch and persist with social ventures are urged to develop profit-based ventures to become more self-sustained (Zietlow, 2001).

It is generally acknowledged that our surrounding environment influences our behavior, and that activity is considered in relation to space. Space is used by humans as a means for orientation, association, and as a tool for identification (Amedeo, Golledge, & Stimson, 2009). Designed environments are closely tied to social meaning (Peponis & Wineman, 2002). Physical environments are nonverbal communicators of norms and expectations associated with social roles and affinities whether in relation to privacy (Altman, 1976), personal spaces (Sommer R., 1969), or invisible boundary markers (Barker, 1968).

Space, while not determining, can certainly be used as a facilitating factor. Environments can be inhibiting or facilitating and it is not inconceivable for new behaviors and actions to follow environmental changes (Rapoport, 2005). The physical environment can also be a facilitator of verbal or nonverbal communication among the program and its users. As has been acknowledged in the field of environment behavior, social implication or meaning arises from spatial configuration (Peponis & Wineman, 2002). For this study, how the space is organized—how the physical resource is configured—plays a crucial role in understanding the social program. The interpretation and subsequent understanding of space and social program, therefore, are intertwined and perceived in conjunction to extract appropriate meaning leading to optimum user experience.

Despite a large and continually growing body of literature, rarely is a physical resource harnessed for purposes other than to house a predefined activity for which it was created. One reason might be that building design is often conceived as largely deterministic. Requirements and problems are many times defined and invented rather than allowed to be discovered and identified (Rapoport, 2005). Yet another reason could be that for a physical environment to be an all-round success, problem definition must be accurate. This is rarely the case in the creation
of physical environments where users of any one environment at any given point are diverse (Carpman, Grant, & Simmons, 1985). Given that a requirement can be interpreted in several ways, all of which might be acceptable solutions at face value, and that each solution can bring with it distinctly different kinds of behavior, the creation, adaptation, and interpretation of designed environments is always a challenge.

While it is not the aim of this study to examine behavioral changes brought about by the designed environment, the study uses human activities in space as an important element in establishing the criticality of the environment in the existence and success of social ventures. In other words, the study examines the environmental factors that lead to the desired human activity. This study explores whether the various dimensions of the designed environment can contribute actively to the benefit of both the program provider and recipient thereby aiding the creation of a socially sustainable environment.

1.5 Target Recipients

There is a partial focus in this study on a critical part of the existence and sustenance of a social program, the subset community for whom the social program is created. Combining the general neglect faced by women in the public realm with the consumer potential women bring, the study looks at potential benefits when a program and space are tailored to the women in the community.

In addition to issues of equality, access, and safety in everyday life, sensitive situations like substance abuse, homelessness, and inadequate nutrition add a layer of complexity when tailoring programs for women. More often than not, women are accompanied by their children and, therefore, child care becomes a nested issue. It is not quite possible to conceive of programs for women and not make provisions for their children. Hence, any organization undertaking a social venture for women must make provisions for their children too, a reason many organizations hesitate to offer women-oriented programs (Beveridge, personal
communication, June, 2013). Furthermore women prioritize safety (Mozingo, 1989) adding further constraints toward the physical location, access, and arrangement of the program.

However, from the clinic’s point of view, it must be noted that women are greater consumers of healthcare than men (Dearing, 1987). Women are good at creating word-of-mouth publicity and are very loyal to programs and products in which they believe (Silverstein & Sayre, 2009). Consequently, appealing to women of the community, irrespective of which strata of women the programs target would in essence make good business sense. This study in part examines programs that are tailored to women as recipients, the nature and structure of those programs, and the role of physical space therein.

1.6 Significance of the Study

Whatever the sector of business and business model, it is difficult to conceive of any organization that would not consider creation of value for its clients to be of paramount importance (Austin et al., 2006). It is the word ‘client’ however that has changed over the decades. There has been a significant move from the 1950s model where organizations considered only direct consumers of their products and services as clients. The debate remains even today about whether the ultimate loyalty of an organization is to its end consumers alone and whether it creates value simply by discharging its everyday activities. However, this idea is slowly fading. While doing social good has long been considered the job of governments, nonprofits, and charitable foundations, social enterprises have emerged as a significant sector, where socially beneficial programs are being run on models not unlike regular businesses. At the same time, mainstream organizations are now looking for means to create a competitive

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3 This line of thinking often termed Shareholder Value Theory was made popular by such scholars like Milton Friedman (most popularly in the classic work *Capitalism and Freedom*, first published in 1962 with several editions as recently as 2002), who argued that the only social responsibility that a form has is to use resources to engage in activities designed to increase its profits . . . staying within rules of the game and without deception and fraud.
edge for themselves by offering social programs because they realize the added advantage of having the community think of them in favorable terms outside of their everyday business.

Given the various stakeholders an organization typically has, prioritizing whom to satisfy and how becomes yet another issue the organization has to contend. A line of thinking that supports prioritization based on organizational identity (Brickson, 2007) and organizational mission has meant that corporations think of satisfying societal needs as part of their own identity. This helps translate their mission in the form of communally beneficial programs, creating yet another incentive for ensuring program continuation.

Historically, the complex nature of healthcare delivery has meant that clinics have not been questioned about their own role in the community beyond satisfying medical needs (Young et al., 2010). While limited attention has been paid to increasing clinics’ value-base and moving more toward communal models of operation (Miller & Swensson, 1995), clinics have remained traditional in their outlook, citing resource constraints and reliance on charity as the main lifelines for offering social programs (or the lack of them). Clinics have not attempted to look toward unique and innovative ways of offering social programs that may accrue additional benefits. In other words, a socially entrepreneurial outlook has often been missing.

In today's world, a decade and half into the new millennium, the traditional model of clinic operation is increasingly questioned as inadequate and unsustainable. Paucity of resources to address social ventures, while acknowledged as a huge problem, is not enough for a clinic to isolate itself from the community it sits in. Moreover, competition and advent of technology has meant that clinics have to be increasingly conscious about their role in society. Furthermore, legislations and regulations are mandating that clinics increase their contributions to their community.

Given that mainstream organizations and nonprofits alike are striving to offer more programs and services, there is a growing base of scholarship as well as models of operation and measurement that clinics could learn from. While efforts are being made by organizations to
be more available to the community, in the field of healthcare there is neither sufficient cases to analyze nor adequate scholarship to effectively understand this two-way value process.

While this study does not attempt to examine and measure impact of the space-based program on the community, it addresses the symbiotic relationship between the social program and the environment and how the environment ultimately affects overall program delivery and outcome. This study challenges the traditionally understood role of a healthcare center in the community as a provider of medical care and nothing more. It also challenges the traditional outlook held by many organizations toward social programs (i.e., they are add-ons for which the parent organization must find funds and expect nothing in return). The significance of this study lies in its attempt to explore whether a socially entrepreneurial approach to social good, when tied to organizational strategy and the use of the designed environment, can help create a sustaining edge for clinics.

1.7 Purpose of the Study

An examination of how social programs can be used to the advantage of a parent organization is a new and nascent area even for mainstream commercial business organizations. Thus very few studies shed light on the topic. While there are some studies that measure the impact of social programs and how the programs are a cost saving feature to the state (Larimer, et al., 2009), there are no studies that illuminate the potential resulting benefits to a healthcare center from offering social programs.

There are also no studies of a qualitative nature that highlight the unique aspects of resources that have been turned into assets while simultaneously cost-saving. Individual hospitals, health systems, and medical boards may commission internal studies and reports but

\( \text{(Larimer, et al., 2009), a comparative study of two sets of homeless individuals in Seattle, Washington found a 53\% cost reduction for the set provided with supportive housing than the wait-list control participants over a 12-month period.} \)
these are not generally publicly available. While healthcare laws and regulations might require clinics to offer programs beneficial to the community, there is not adequate information to determine whether clinics approach these programs in a manner that could benefit them. Furthermore, exploration of this phenomenon from a resource-based perspective, where the physical environment could play a positive role in value creation, has not been attempted thus far.

All of this makes this study groundbreaking yet exploratory in nature. The potential of the designed environment remains mostly untapped to this day, with its role being primarily limited to traditional conceptions of a place of residence or work (i.e., a place of shelter or refuge). However as the ensuing chapters will show, the physical environment has more to offer to these ventures than what conventional understanding would suggest. The study explores whether the various factors of the designed environment, in supporting social programs, can help in the value creation process, which advances clinics toward being community resources. This exploration is grounded by three main research questions.

Primary question: What factors of the designed environment in supporting social programs enable the creation of value such that there are significant incentives for the program giver?

Secondary question: What factors of the designed environments could be unique to women as the target recipients of the social programs?

Tertiary question: Would there be an extensive investment (environmental, financial, physical, labor, resources, etc.) for a women-focused social program?

1.8 How this Dissertation is Organized (Chapter Definitions)

Chapter 2.0: A Review of Relevant Scholarship: Organization, Operation, Environment and Target related issues.
In this chapter, literature (scholarly works and popular press) is sourced from areas of environment behavior, healthcare design, healthcare management, social entrepreneurship, nonprofit management, marketing and gender studies, broadly speaking. Further, articles regarding the above topics are also sourced from the popular press to enable a better understanding of the popular perception of the topic. The literature review has two purposes. First, to create a scholarly base for the study to draw upon and to which relevant connections can be made, thus situating the study and its contribution relative to the appropriate body of knowledge. Second, the background literature helps to create a criteria matrix for case study selection.

Chapter 3.0: A Dual Concept Framework for operation: Social Design and Social Bricolage.

The chapter explains the theoretical framework the study is based upon. Given the exploratory nature of the study and the paucity of previous works of similar nature, the study combines two areas of inquiry, one from environment behavior and one from social entrepreneurship. The concepts of Social Design (Sommer R., 1983) and Social Bricolage (Di Domenico et al., 2010) and associated theories within create a comprehensive guide within which the study can be conducted.

Chapter 4.0: Research Design: A Multi-Case Study Mixed-Method Approach.

The chapter outlines the specific research methods chosen for this study and substantiates the choices. Data collection methods, criteria for case study selection and themes for studies identified, along with actual logistics of case studies, are also discussed.

Chapter 5.0: Theme 1- A Food and Nutrition Based Solution, Farmers’ Markets.

Chapter five describes, analyzes, and briefly presents the findings from the three farmers’ markets case studies in Northern California.

Chapter 6.0: Theme 2- Shelter Based Solutions. Programs of a Sensitive Nature for Low Income Women.
This chapter describes, analyzes, and briefly presents the findings from the four cases which address such issues as homelessness and substance recovery. These cases are spread across the country.

Chapter 7.0: Impact Measurement through a Social Return on Investment Analysis.

The chapter examines the quantitative social accounting method, the Social Return on Investment (SROI) analysis. Starting with an introduction of what an SROI entails, its positives and negatives, this section then details the SROI analysis for three cases.

Chapter 8.0: The Clinic and Community from a Cross Cultural Perspective: An Essay and Case Study in India.

This chapter gives a cross-cultural perspective from India. It details one case, examining the role of space in terms of being a social wealth creator and how this shapes the meaning of social value itself. Several smaller cases are included in a general discussion of the role of space in social programs supported by clinics and how that engineers the creation of social value.

Chapter 9.0: A Discussion of Major Findings of the Research.

This chapter brings together all the findings from the case studies. The chapter looks not just at actual findings but also at what they mean and how these factors impact the clinic and grouping elements to show the interdependence of seemingly unrelated areas. This is necessary to effectively comprehend whether the designed environment can, in fact, play a tangible role in social value creation. Diagrams are created to show outcomes and the interconnectedness of environmental and entrepreneurial or strategy management related areas that impact the findings.

Chapter 10.0: Conclusion, Implications of this Study and Areas for Future Research.

This concluding chapter gives a brief summary of the findings from the study, and then discusses the contribution the study makes to various areas of scholarship, including contributions to literature and methodology as well as implications to both the design and
healthcare industry. This is followed by a brief mention of limitations of the study and areas of future research that the findings from this study make possible.
Chapter 2.0: A Review of Relevant Literature: Operation, Organization, Environment, and Target related issues

Don’t reinvent the wheel, just realign it.

—Anthony J. D’Angelo, The College Blue Book

This chapter outlines the existing sources of scholarship that are relevant to the study. The purpose of this study is to explore factors of the designed environment that positively impact social programs supported by a clinic. In addition to looking for sources that will help answer this, some other areas of focus of this chapter include identifying which factors make a clinic unique from other nonprofits, what constraints or advantages fall upon clinics, and how these factors influence the nature of the social program adopted by the clinic. Emphasis is on the designed environment and entrepreneurial/strategy management-related factors that are critical for both program planning and delivery.

For better understanding, this chapter has been split into four categories. Each category has pertinent topics of inquiry that help further exploration of the research question:

1) Organization related
2) Operation related
3) Environment related
4) Target related
2.1 Organization related

2.1.1 The Nonprofit Organization

A not-for-profit organization can be defined as “An organization, corporation, etc., which does not operate for the purpose of making a profit” (Oxford English Dictionary, 2013). Called the individual sector, the charitable sector, independent sector, or voluntary sector, depending on the country, the nonprofit sector is vast, covering everything “from tiny soup kitchens to symphony orchestras, from garden clubs to environmental groups” (Salamon & Anheier, 1997, p. 2). Essentially, the nonprofit sector evolves in every society to fill the gap that neither government nor private industry can fill. Sargeant (2004) mentions that starting from the early
1980s, governments began to withdraw progressively from many facets of social life, leaving the burden to the independent sector. This led the nonprofit sector to evolve faster than it should have, which has resulted in the sector being largely disorganized whichever the country.

Nonprofit organizations can be broadly classified as either donative or commercial, (Hansmann, 1980) depending on an organization’s source of income and the way in which it is controlled. Hansmann further states that this classification helps from a strategic point of view because the nature of the organization is largely dependent on how the money comes in and how it is used. To date, this classification has been accepted as the standard by-and-large. Gruber and Mohr (1982) state that benefits from a nonprofit are primarily societal. The programs serve a social need and can be considered a benefit only if it contributes to the overall mission of the organization.

2.1.2 The Healthcare Organization

Traditionally, clinics have not been known for catering to communal needs beyond medical care. Foucault (2003) in the Birth of the Clinic says this is because healthcare organizations, by the very nature of their work, are so intrinsically valuable to society that they see no further incentive to do more for society. The value of a clinic does not submit to a collective decision, he says, as they relate directly to the human individual about whom any error can prove fatal. This has allowed clinics to get away without much questioning from the public. Clinics tend to forget they are not just les machines à guérir (curing machines) but also institutions that represent social and cultural values (Wagenaar, 2006).

Historically, clinics were alms houses and places where the poor and infirm could rest. They were places of shelter and refuge where one was not turned away on account of being ill or simply an ill-fit in society. With the advent of technology starting from the late 18th-century, clinics, as Wagenaar argues, have become powerful institutions and, because of their unique expertise in medical science and technology, they have come to dominate everything related to
healthcare, including public health. He further goes on to say that this medicalization has integrated with bureaucracies so that the clinics have become isolated and self-regulated. This has created a situation that is thoroughly unsustainable where disconnect between the clinic and the community, the very people for whom they exist is pronounced.

While most healthcare systems globally still operate under these notions—even into the second decade of the new millennium—a slow but steady shift is occurring. The shift, given a voice by the public—the community—is toward a more communal model. In a report published in 2010 by the Institute of Medicine in the United States on what constitutes value in healthcare, one of the outcomes was the change in perception of the public toward healthcare institutions, toward wanting more value, and a focus on communal betterment rather than just medical treatment.

The “history of a healthcare system is intertwined with the development of communities and social structures” (Walshe & Smith, 2006, p. 2). Clinics also, the authors continue, exist in social environments where given their sheer presence and visibility within a community, their actions and behaviors highly scrutinized. These include everyone from regulatory agencies and religious and charitable trusts, to trade unions, to local businesses and local governments. So it is only understandable that a community feels a sense of ownership toward the clinic in their midst. Clinics need, in many ways to keep their community happy and in many a case what matters is usually not what works but what people want.

Peter Drucker, often called ‘the man who invented management’ owing to his practical yet often philosophical analyses of corporations and industry typologies, says, in his classic work Managing the Nonprofit Organization (2006), that whatever their business model (nonprofit, for-profit, government owned, privately owned, etc.), healthcare centers have a social mission at their core; they are ultimately concerned with the public good. They often do things that might go against accepted business norms but do it anyway if it reflects their social mission. While the day-to-day operation of the clinics, (i.e., one of disease management) often means
that the social mission takes a back seat, Drucker argues that healthcare organizations can actually benefit greatly by exhibiting a thorough understanding of their social mission.

2.1.3 Community Benefit and Benefits to the Community

In the United States, in order to maintain their tax free status, nonprofit, clinics are expected to show to regulatory authorities (especially the Internal Revenue Service—the federal tax collection agency) that they are performing deeds beyond just caring for paying patients. In other words, they are providing Community Benefit. Hitherto (until 2009), there was no minimum or maximum amount the clinics were required to spend on the community and there was also no mandate on what constituted Community Benefit. As a result a significant chunk of whatever the clinic claimed as Community Benefit was direct medical care such as charity care and unpaid bills. Starting in 2009, the IRS revised a section of tax filing (Schedule H of form 990, that all nonprofit clinics are required to file annually) and mandated specific criteria as to what constituted community benefit. A section called Community Building now includes physical improvements, housing, environmental improvements, and community support. In other words, they enable clinics to report as community benefit building expenses for which the intent of improving community health and safety can be clearly established.

However, Young, Chou, Alexander, Lee, and Raver (2013) in a path-breaking meta-analysis showed that the title Community Benefit might be misleading as in reality most nonprofits claim direct patient care as Community Benefit—they consider caring for uninsured patients and bad debt write offs (patients who could not pay their bills) as community benefit. They further found that clinics spend roughly 7.5% of their annual revenue on community benefit of which more than 85% was direct medical care and less than 10% was spent on community development.

Burke et al., (2014) argue that while the new Affordable Care Act mandates a Community Health Needs Assessment every three years, the indicators are input based (like
expenditures on programs) and do not include outcomes as part of assessment. This, the authors predict, could lead to poor documentation and poor reporting of these programs, indicating a stronger need for impact measurement. Ainsworth, Diaz, and Schmidtlein (2013) and Jackson (2012) emphasize the need for clinics to partner with other clinics and other community members (organizations and individuals) for skill and knowledge sharing as well as better strategic management of the program, in order to ensure program longevity and meet its own incentive criteria.

Kabel (2013) says that nonprofit hospitals in the US collectively claim $13 billion annually as community benefit of which over $11 billion is uncompensated, direct medical care. He argues that shifting as little as 20% of each clinic’s Community Benefit upstream into community building activities like safer streets and better schools would be more preventative and yield a more sustained and equitable improvement in America’s health than any set of clinical procedures (p. 2). His line of thinking concurs with the findings of the Institute of Medicine’s 2010 report on what constitutes value in healthcare today—that communities are asking clinics what they are doing to keeping communities healthy, beyond providing medical care for paying patients.

This line of thinking looks at the health and wellness of communities in the broad sense, prevention as something that is not just applicable to a disease but to anything that affects a community, a society, and ultimately the country from reaching its optimum potential. This can also be termed as thinking about collective value and collective impact, in which every member of the community gains in some way and the gains are sustained over a period of time. This is a solution to a primary need-based problem, where everyone has a role, outcomes lend themselves to measurement, and it leads to an overall, equitable situation.
2.2 Operation Related

This brings about the idea of social value. Wood and Leighton (2010) define it as following: “‘social value’ refers to the wider non-financial impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment” (p. 20). While this definition gives a broad idea of social value, it is also vague and open to interpretation on so many levels. Therefore, most scholars choose to understand social value by borrowing concepts and ideas from allied fields of social entrepreneurship and social responsibility. Scholarship from these fields helps to distinguish social programs that have an entrepreneurial intent, that move toward self-sustenance as their end goal from the more traditional, philanthropy-based programs. Accordingly, this section has been further subdivided into areas of social responsibility, social entrepreneurship and innovation, and social impact and assessment.

2.2.1 Social Responsibility

The main question is why. Why should organizations, whether for-profit or nonprofit, address societal needs? Why should organizations undertake programs of such a nature in addition to their daily activities? After all, every organization has its own operational constraints.

There have been a number of studies that indicate that the public is more sympathetic toward organizations that are socially conscious. Austin, Herman, Reficco and Wei-Skillern (2008) say that “[T]he public is neither passive nor without power to affect corporate results” (p. 170). Research group Globescan conducted a massive poll in 1999–2000 of 25,000 consumers in 23 countries (samples include a vast range of consumers from developed countries like Australia, Canada, UK, and USA, as well as developing nations like Poland, South Africa, and India). Of that, over 49% of respondents said social responsibility was the factor that most influenced their impression and decision making about a company. Yet another meta-analysis of
52 studies on social responsibility by Orlitzky et al., (2003) shows that the public is more sympathetic toward companies that are committed to being socially responsible; interestingly, this study also highlighted that, to a smaller extent, companies perceived as environmentally conscious were also viewed favorably.

However, the concept of Corporate Social Responsibility has been severely criticized from within the field of organizational and strategy management itself. It has been called indifferent and ineffective (Porter & Kramer, 2006); while Strike, Gao, and Bansal (2006) contend that firms can be responsible and at the same time highly irresponsible using international diversification as the key factor, using many different markets, the opportunities and imperfections to its advantage (p. 574).

This line of scholarship that examines responsibility versus irresponsibility has plenty of support. An article in which Ormitson and Wong (2013) conduct archival study of Fortune 500 companies concludes that being champions of CSR actually create incentive for organizational leaders, especially the CEOs (Chief Executive Officer), to use that goodwill toward irresponsible behavior more so with company funds and resources. Asymmetry of information and non-transparency of CSR initiatives and products to stakeholders, end users and, the community the firm sits in is cited as a downside of this ideology (Crane, McWilliams, Matten, Moon, & Siegel, 2009). They further propound that the way in which firms incorporate social responsibility into their operational strategies can help to mitigate these negatives so that of the idea of corporate social responsibility is seen more positively by the public and, therefore, is more likely to become more commonplace.

2.2.2 Social Entrepreneurship

As a grassroots organization with an all-pervading stature within a community, a clinic is in an ideal position to support social ventures. As Brooks (2009) puts it, “grassroots organizations can be ideally-suited to exploit social opportunities quickly and effectively,
particularly when the resources needs are rather modest” (p. 16). Emphasis must be on program longevity, ultimately leading to self-sustaining program so that the burden on the clinic is reduced. Otherwise, the program would end up in the realm of charity, with the clinic seeking nothing in return, and where a slight change in economic stability, political climate, or even a change in leadership might lead to termination of funds to the program.

There is no one, set way to define a social enterprise. The European Commission defines it as follows: “Social enterprises devote their activities and reinvest their surpluses to achieving a wider social or community objective either in their members’ or a wider interest” (European Commission, October 2014). Phillips Jr, Deiglmeier and Miller (2008) expand the concept of social entrepreneurship to include social innovation which they define as “A novel solution to a social problem that is more effective, efficient, sustainable for which the value accrues primarily to society as a whole and not just to individuals” (p. 34).

Robinson (2006) takes a more holistic and broad-based view of social entrepreneurship, defining it as “a process that includes: the identification of a specific social problem and specific solution [or set of solutions] to address it” (p. 95). The evaluation of this impact is essential. They argue that social entrepreneurship cannot be a type of organization; instead, it could be anything from a nonprofit organization working dedicatedly toward a social mission, to social venture capital, to any organization that has a defined social purpose. This study adopts the above approach as it allows for a broader inclusion of organizations and allows for the understanding of social programs as aligned with the parent organization’s goal-set, either as subsidiaries of the parent organization or in partnership (and not as stand-alone entities).

While socially entrepreneurial ventures are generally respected for their innovative approach toward societal problems, they are particularly useful during poorer economic times because, these ventures could lead to social revival in addition to economic redevelopment (Thompson, Alvy, & Lees, 2000). It is, however, the identification of opportunities that garners the most attention. Dees (1998) identifies socially entrepreneurial ventures as those that “adopt
a mission to create and sustain social value” (p. 4). Social mission as a tangible contribution to social good is the central criterion where wealth (finances) is simply a means to an end. Further, he argues that markets do not do a good job of valuing or even recognizing social improvements and benefits for people who cannot afford to pay, making it difficult for a socially innovative venture to justify the consumption of resources toward this type of value creation.

2.2.3 Impact Measurement

Social entrepreneurs are under constant scrutiny regarding their ventures. They are questioned regularly whether the resources they consume justify the outcomes. Funders—people who have invested time, finances, and other resources—are particularly interested in how a clinic’s resources are used and the outcomes of their various programs. As Mulgan (2010) states “foundations want to direct their grants to the most effective programs; public officials, policymakers and government budget offices have to account for their spending, investors want hard data regarding their investments and organizations especially nonprofits need to demonstrate their impact to funders, partners and beneficiaries” (p. 38). And therein lies the problem—if social value is hard to define it is even harder to measure.

Some qualitative models include the triple bottom-line, social auditing, and balanced scorecard techniques. Triple bottom-line, as proposed by Elkington (1999), requires organizations to present social and environmental outcomes of activities that company has been involved in addition to financial measures. The drawback of such models is that the social and environmental reports are descriptive and subjective as they are conducted by internal assessors. Social audits deliver annual social accounts that compare progress against set objectives (Zadek, 1998). It does not, however, quantify the value added from these actions.

Some quantitative methods include social impact assessment, cost-benefit model, and social return on investment analysis. These quantitative tools, however, are not evolved through
rigorous scholarship and iterative model building tested at each level over time; instead, they are used by corporations as practical tools tailored to suit their requirements.

The SROI, or Social Return on Investment, method has been the most popular method for social-value measurement. First proposed by Emerson (2003), the process is relatively complex and intensive to carry out as it ascribes monetary values to soft, intangible outcomes. The New Economic Foundation, one of the pioneers of this method, concluded that “if organizations do not have the time or resources to commit to the SROI process, there is a danger that the process will not be robust” (Lawlor et al., 2008, p. 16). The most important aspect of the SROI method is that the outcome is only as good as the inputs. Lingane and Olsen (2004) argue that the SROI is more a practical tool than anything else for managers to maximize social and financial profits and a tool to enable informed decision making. Emerson, Wachowicz and Chun (2000) caution that the SROI is not a tool that definitively quantifies benefits and value that result from a program but is more an attempt to identify tangible and demonstrable savings that result from a particular intervention. For this study, the SROI can be a useful tool in helping assess the role of the designed environment (a particular intervention) in the successful delivery of a social program.

2.2.4 Social Identity and Mission Related Ideologies

Social programs have social good at heart; but when a program goes above and beyond the firm’s daily activities, it requires initiation and planning. It also requires additional drive and motivation from the decision makers of the firm. An activist-entrepreneurial mentality, aligning the program with organizational mission and self-identity, are two of the elements scholars suggest as ways to deliver social good for mutual beneficence and program sustainability.

Social programs essentially operate on philanthropic efforts, donations, and grants. In poorer economic climates these ventures suffer. Zietlow (2001) opines that to remedy such a situation, social programs must develop ways to become self-sufficient—even if it means the
creation of profit-based ventures. In order to better understand this rather nontraditional and entrepreneurial way of thinking, it is first important to recognize that identifying, structuring, and planning a social venture is a reflection of the identities of the organization. There is sufficient scholarship in various fields from psychology to strategy management that says individuals possess several identities which are organized hierarchically salient to their personality (Stryker, 1980). Identification is, according to Robinson, Mair, and Hockerts (2009), the degree to which individuals see themselves as part of a larger subset. When we look at the individual within his role as decision maker, it follows that the individual will tend to match situational requirement with his most salient identity and behave accordingly.

Now, based on the nature of this topic, we examine the identity of the clinic’s decision makers within the context of social entrepreneurship. Here, scholars opine that of all the multiple identities, an activist mentality and entrepreneurial mentality become the most prominent, creating a situation wherein the organization has to make a decision as to which identity to prioritize or just separate these identities as far as the social venture planning is concerned (Ashforth & Mael, 1989). This becomes crucial given that the program giver’s identity influences his perception of opportunity identification and what is required to pursue that opportunity (Robinson et al., 2009).

Along with organizational and decision maker identity models, it is important to look at another driver of decision making—organizational mission. Every organizational mission is unique and tailored to its values and stakeholders. And for a clinic wanting to offer non-medical social programs, the organizational mission helps guide opportunity identification and choice of program offering. The mission acts as a reminder to the (social) program givers as to what the clinic stands for. A mission statement describes the organization’s fundamental, unique purpose (Ireland & Hitt, 1992). Bartkus, Glassman, and McAfee (2000) say that organizational mission helps focus allocation of organizational resources, which is of particular interest to this study as it deals with essentially a resource scarce situation.
As a counter criticism, there is scholarship that suggests that mission statements are sometimes just that—statements—and that they are either prescriptive or descriptive (Bartkus & Glassman, 2008). They also argue that oftentimes organizations include stakeholders in their mission, but this has no relationship to the firm’s actions, making the gesture more symbolic than anything else. McDonald (2007), in a study of two nonprofit clinics that examined the role of mission in the innovation process, found that a clear and motivating organizational mission helps organizations to focus attention on those innovations that support the accomplishment of the mission. And conversely, such a mission gives innovations a fair chance to succeed.

2.3 Environment Related

This study taps into the less explored world of the designed environment, seeking factors of the physical environment that can contribute tangibly toward social value creation. In order to better understand the impact of the physical environment on social programs, one needs to look at what is expected of the environment. The basic premise of social programs is behavior change, which is something that must be kept in mind whilst creating or using the physical environment for social programs. Space is not causal in determining human activity or bringing about a change in behavior, but it is known to exert significant influences on both given its own relationship with other aspects of the world around us, be it human or inanimate (Amedeo et al., 2009; Rapoport, 2005, p. 12). The following sections highlights scholarship on various aspects of the physical environment that lead to a better understanding of the potential of the physical environment.

2.3.1 Spatial Access and Information

Amedeo et al., (2009) say that there is “no standard and universally comprehensive definition of human activity” (p. 2), even though the study of the same has been undertaken widely in various fields. Space, they continue, is an integral part of communication in a society,
whatever the magnitude and “in fact [it is] difficult to think of movement and communications without thinking of them in terms of space. It is its extensiveness, its complexity, and the particular ways in which it enters into them that have significant consequences for the impacts it exerts on these processes [activities]” (p. 6).

According to Hillier and Hanson (1989), space has social logic. They argue that built environments are influenced by social prescripts, like traditions and customs, and that a familiarity with those societies leads to ease of spatial movement and activities within those forms of space. Furthermore, social logic brings to fore the importance of socially constructed meanings in spatial usage and experience. While one knows intuitively (or through past experience and learning) what certain areas are designated for, a string of those spaces simply put together do not make a building. Buildings are, in fact, a pattern of relationships which varies from one space to another.

Amedeo et al. (2009) put forth the notion of structuring and scale effects the comprehending of both of which is necessary by the user for optimum user experience. Structuring, as the name suggests, refers to the manner in which the external world appears, including the organization and arrangement of buildings, neighborhoods, etc. the scale of which affects the manner in which the same buildings, neighborhoods etc. are understood or interpreted by the user. Peponis and Wineman (2002) merge structuring and scaling with the sociophysical and opine that “built space is to be understood as a relational pattern of distinctions, separations, interfaces, and connections, a pattern that integrates, segregates, or differentiates its parts in relation to each other” (p. 271).

2.3.2 Elements of Spatial Perception and Control

One must remember that social programs often target marginalized populations and people who are in need of specific interventions. Some seek safety and refuge, while others seek help of a critical sort. Whether overt or not, each seeks from the program (and ergo the
space) a means to change. Some situations and programs might have a less emotional agenda. Nonetheless, it is imperative that the environment cater to the users’ needs—the more flexible it is to a variety of needs, the higher the chance of usage.

Lang (1987) says that the designed environment can be perceived to communicate many things, from utility to symbolism. A more direct, ecological approach toward environment perception is the concept of affordance. Gibson (1986) offers that the world is composed of substances, surfaces, and textures and the manner in which they are arranged provides affordances—or recognizable functions—which enable the user to understand what the environment (or element in question within the environment) is about and this, in turn, helps dictate how to use it.

Any discussion on perception is incomplete unless we address concepts of control, starting with privacy. Some define privacy in terms of exclusion and some in terms of freedom of choice. A definition accepted by most scholars is by Rapoport (1982): “privacy as the control of unwanted interaction” (p. 193). Archea (1977) takes a more practical approach and ties privacy with visual cues. According to his reasoning, the physical environment is finite and the location of edges, corners, and surfaces and the way they are arranged affect the distribution of visual information about the setting which in turn affects the individual’s definition of privacy.

2.3.3 The Role of Culture

The role of culture can be interpreted in many ways. It might be related to feeling and believing or related to behavior opines (Bliss, 1970), adding that for yet others, it is the meshing of values and behavior. A cultural approach should bring to fore underlying values, norms, and taboos that give meaning to the everyday lives of its members. Culture, according to Rapoport (2005), is what, in part, defines humans. It also divides us by language, religion, food habits, rules, and so on. This division creates a paradox which takes on particular significance with
respect to interpreting the designed environment since the same or similar environments can have different effects on people.

Whilst Rapoport too concedes the many ways in which culture as a concept can be defined, for the purposes of this study, an ecological approach to culture seems more appropriate where culture is viewed more as a tool for exploring and adapting to a particular environment. This outlook helps better explain human activities within a finite system (the physical environment in question) as it suggests the prominent role of the environment (the ecosystem) in influencing behavior particular or specific to that individual (or group) in that space.

2.3.4 The Meaning of Place

The study of meanings of place is an area of inquiry within the field of environment behavior with a vast and varying body of work ranging from qualitative, to empirical, to theoretical. Bearing in mind that this study focuses on what role space can play in actively contributing to value creation, it is essential to solidify a comprehensive, yet usable, parameter for the meaning of places and spaces.

In several works, Canter (2000) concludes that one must consider individual, social, and cultural aspects, as well as the scale of interaction (extent of involvement with the environment) in order to better understand and analyze what a place means to a person. Scannell and Gifford (2010) go a step further in understanding the meaning of place by examining the various definitions and levels of place attachment. A place could hold a personal, emotional connection to either an individual or groups. These could be based on common historical, regional, or even religious views. In an earlier work Stokols and Shumaker (1981), say that the physical attributes of a place provide a sense of attachment as they provide resources to support ones’ goals. This complements the goal-setting theory within scholarship on social identities. Having environments (and resources) that support one’s goals and ambitions takes the user one step closer to achieving the same.
A common critique that occurs in most of these works is that literature on place attachment (and its allied forms) mostly pertains to residential environments and neighborhoods; there is not sufficient research regarding attachment to other environments. There is also insufficient research regarding the reasons users feel attachment to a place other than for its social aspects (e.g., for physical attributes of the place). According to Lewicka (2011) who, after extensive research of methods and theory, concludes that the field needs to move beyond the aforementioned pitfalls since it has serious implications in the sociopolitical context. Nevertheless, this is an important area of scholarship that the study can benefit from as it provides valuable explanations for the reasons behind peoples' interpretation of space, convey a sense of the role of communities, and include social layers woven into the spatial fabric of user perception.

2.3.5 Participatory Planning and Stakeholder Involvement

The creation of a socially valuable system where benefits accrue to society as a whole (organizations included) is a task that can be best achieved by breaking down the task into small, achievable targets. While every stakeholder is important, only by identifying targets that the organization can realistically satisfy (Brickson, 2007) can an organization move toward value attainment. Griffith and White (2010), referencing healthcare organizations in particular, further extend this idea to say that stakeholders actually act as social controls on healthcare organizations. Stakeholders contribute viewpoints on everything from law and regulation to human rights and aesthetics.

Likewise, in the field of environment behavior, stakeholder involvement takes on various forms that can be categorized under the umbrella of participatory planning. Participatory Planning and its various allied forms basically call for autonomous participation rather than mobilized participation which is initiated by external factors (Horelli, 2002). It does not submit to the hierarchical, or top-down, planning principles that many organizations and planning
processes operate under. There are several layers to public participation that make it a compelling proposition. Churchman (1990) argues that while participants want to tackle tangible issues, the ones who participate the most benefit the most (p. 619). Wates (2014) says that public participation works when participants are considered partners with shared labor and decision making with authorities.

A strong critique leveled against participatory planning is that the whole process places too much prominence on the planner as decision maker, making him the central channel for all communication (Campbell & Marshall, 1999). While a participatory approach certainly brings forth the notion of a pluralistic society, there is still sufficient confusion as to whom constitutes the community—and invariably one group prevails over the other. Further, decision making even with public participation is a complex activity they say, which is likely to adversely affect some interests, giving rise to the question about the validity of involving a range of citizens and community groups.

With particular reference to this study where the focus is on the creation of a socially sustainable framework where benefits accrue to both clinic and community, special attention must be paid to the clinic’s status in the community. Everything from the types of programs chosen, who it is for, to where it is located will have far-reaching implications on the clinic’s sustenance. Griffith and White (2010) expand this idea to say that stakeholders actually act as social controls on healthcare organizations as they contribute viewpoints on everything from law and regulation to human rights and aesthetics.
2.4 Target Related

2.4.1 Women as Drivers of Economy

Women globally control over $20 trillion in consumer spending (Silverstein & Sayre, 2009) and is expected to increase by 50% over the next five years or so. They represent a growth market bigger than India and China combined.

From a consumer standpoint, women globally are known to make decisions regarding home and family issues to the tune of 90%. They are responsible for more than half of automobile purchases be it for the family or for themselves. Women are also very loyal to the brands and products they use (Popcorn & Marigold, 2000). They want a brand (or product) to extend into their lives in as many ways as possible. At the same time, women are also good at adapting products to obtain extra benefit. Given women’s brand loyalty, they are a great source of word-of-mouth publicity. North Jersey Community Bank is one such organization that has understood this. It has created a mentorship program wherein prominent women business owners from the community would help aspiring entrepreneurs with an eye on converting these relationship networks into prospective clients (The Entrepreneur, October 2011).

Mirta Crovetto, the Latin American regional head of Consumers International, the UK founded World Federation of various consumer groups that champions the rights of consumers insists that focus on women as consumers does not automatically mean westernized societies (Women Envision, 1997). She says, ”Women are not only homemakers and mothers. They are also, especially in poor rural sectors, producers, harvesters and traders. In those areas, about 70 percent of the production of basic food items depends on women” (p. 51), making it

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5 India and China have a combined GDP of 5.6 trillion whilst women have 13 trillion; this is expected to grow to 18 trillion by 2014 as opposed to 8.4 trillion of a combined India China according to Silverstein et al, (2009).
important for markets to appeal directly to women as consumers given the amount and extent of knowledge they possess in various fields.

Women are also known to make most decisions pertaining to healthcare. Women have a more value based agenda and this means they evaluate care in terms of non-technical criteria, a concept that is alien to healthcare providers. Public perception could change favorably and the reputation of a clinic could be enhanced with the offering of innovative programs that resonate with the community (Dearing, 1987). It is, however, in the identification of that one program that most clinics falter. Even discounting childbirth and related issues, women outnumber men in using healthcare services by 15%, continues Dearing, and that they (women), rely more on the perception of the hospital’s status in decision making than men. Furthermore, women are more likely (28 to 16) to take part and be involved in community related activities than men (Dearing, 1987). All of which makes good business sense for clinics to create programs that appeal to women.

In the United States women spend two out of every three healthcare dollars (About Women and Marketing, 1996). This has made some healthcare organizations take note and offer programs and services catering exclusively to women, even programs beyond maternity-related issues. For example, according to About Women and Marketing (a trade magazine that caters to women’s issues), the Spence Center in Boston has extended their services beyond the traditional full range of primary care; they offer nutrition, podiatry, acupuncture, herbalism, and chiropractor services—all services women favor. Other clinics, like the Arkansas Children Hospital, having identified nurse (mostly women) attrition as a problem became the only hospital in the state to offer onsite daycare for children, not only reducing attrition rate by over 80% but also earning a place in the “Forbes top 100 companies to work for” (Fortune, 2011).
2.4.2 Everydayness of Women’s Lives

In alignment with earlier mentioned works of Popcorn and Marigold (2000) and Flax and Kagan (2000) are the works of Michelson (1985) and Horelli and Vespa (1994) who put forth the notion that in order for women’s lives to improve in all spheres, it is important to understand the everyday life of women rather than just one aspect. Franck (2002) says that women have much less discretionary time than men and are more likely to be engaged in all kinds of daily caretaking activities. Jones, Holmes, and Espey (2008) look at the UN’s Millennium development goals from a gender perspective and say that current women empowerment programs reinforce their traditional caregiving role and underestimate their time constraints. Thus, they call for more transformative social protection for women that requires an institutional approach with concrete policy and program measures.

McDowell (1993) says that a hallmark of a woman’s life is the interconnectedness among everything she does and in order to understand how she processed her everyday life, one must look at her responsibilities. For Horelli and Vespa (1994), this everydayness is a process, not a concept, and it is defined by activities and the relations by which it is created. Focusing on tangibility, they say the physical environment can be seen as the bodily and sensory context of individual activity and, therefore, as part of self-regulation. Horelli and Vespa also say that the physical environment is both a social construction and constructor; and while it can limit and impede everyday activities in certain ways, it can also be manipulated to bring about change (p. 206).

Churchman (2000) says social changes cannot happen unless women’s lives are understood in the multiple contexts embedded within their lives. Women cannot be detached from their social, cultural, political, and physical environmental contexts, understanding of which makes it clear that changes that address only one context or at the individual level is not sufficient. Changing the fabric of society therefore should include the built environment as well.
(Churchman & Altman, 1994), to have a tangible impact on women’s lives. This is of relevance to this study because the role of the designed environment is examined for its value quotient, which helps to show the importance of complementing or meshing the program and space for optimum user experience. It enables us to understand more fully the contributing role space can play with respect to the social program.

2.4.3 Women, Navigation and Social Construction of Space

Despite there not being sufficient data or evidence that men are significantly better as navigators than women, women continue to express higher signs of anxiety say Coluccia and Louse (2004). It can be argued that women’s prime concern of security (fear of crime) makes them rely more on artifacts (landmarks) and hence may perceive any unfamiliar space with trepidation. Mozingo (1989) says that there is little or no research when it comes to examining people’s behavior in public with gender as the differential. She concludes that women have smaller personal space than men but, given their instinct to seek safety, they feel less stressed in crowded situations. On the other hand, women’s space and privacy is intruded upon twice as often as those of men she says with the intrusion more often than not being one that is unwelcome. However, Mozingo’s research too shows that both genders cite their main reasons for use of space (or nonuse) are climate and affordance related. Together, these variables, yet again lead to inconclusive evidence about reasons behind gender differences in spatial navigation.

Where Peponis and Wineman (2002) take a person-activity based, gender neutral view of the built environment and define space as a series of interconnected and interrelated social relationships, concluding that spatial structure is a result of social structure, Weisman (1994) takes a feminist stand. Alluding to the idea that space is socially constructed and that spatial arrangements reflect social arrangements, Weisman says that these spaces “reflect and reinforce the nature of gender, race, and class relations in society” (p. 2).
Low (2006) says that while spaces are “conceived [ . . .] as processual, relationally ordered systems” when it comes to investigating cultural and behavioral dimensions of more than one type, observing how structures are ordered in space is no longer useful (p. 120). Instead, understanding how structures form spaces would be a better approach. Traditionally, says Low (2006), gender and space are “conceived as material substances and posited as immutable” (p. 129), which hampers any research in this field because viewing either or both as immutable would mean using one dimension as the secure basis from which the other phenomena can be understood. Gender and space are fluid and must be viewed in relation to one another, as an “effective reciprocally constructing structure” (p. 130). In other words, one must look first at the relational arrangements between humans and objects and then look at how structures support that. This is particularly important for women who tend to use space in a manner that is unique to their sense of self and security.

Whether one takes a feminist approach or a gender neutral approach, it is important to recognize that gender roles are essentially social constructions, a notion adhered to by scholars on women’s issues across topics—from sociology, to design, to economics (Churchman A. , 2000; Day, 2000; Flax & Kagan, 2000). It is not as if women are in competition with men or that men and women must somehow have identical needs that can be addressed uniformly by a rigid set of social mechanisms. In fact, a key factor to remember is that the everyday life of women is different from that of men. Once this is recognized, environments can be aligned so that each person can navigate through these socio-spatial settings and carry on with their day as unrestrictedly as possible (Churchman A. , 2000).

The areas of scholarship discussed in this chapter thus far are represented in matrix form (see Table 2-1) to give the reader a snapshot of areas of scholarship relevant to this study.
<table>
<thead>
<tr>
<th>Category</th>
<th>Concept</th>
<th>Areas of inquiry</th>
<th>Prominent Authors / year</th>
<th>How it is relevant to study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization related</td>
<td>The nonprofit Organization</td>
<td>History of, definitions, classifications</td>
<td>Salomon and Anheir, 1997, Sargeant 2003, Hansmann 1990, Gruber 1982</td>
<td>Study focuses on programs offered by nonprofit clinics and so understanding the basics of the nonprofit organizational model is helpful</td>
</tr>
<tr>
<td></td>
<td>The healthcare organization</td>
<td>History of, changing face of healthcare, clinic-community equation, Healthcare law and policy</td>
<td>Welshe and Smith, 2005, Drucker 2006, Wagenaar, 2005,</td>
<td>Helps understand unique disposition of a clinic within a community and the unique pressures a clinic faces and some advantages a clinic has that is different from other nonprofits</td>
</tr>
<tr>
<td></td>
<td>Community Benefit</td>
<td>What comprises community benefit, exclusions and controversies surrounding</td>
<td>Young 2009, Burke et al, 2013</td>
<td>Helps understand incentive base for clinics to offer social programs of a non-medical nature and what constraints clinics face in doing so with respect to IRS and other regulations</td>
</tr>
<tr>
<td>Operation related</td>
<td>Social Responsibility</td>
<td>History of, definitions, evolution, why be socially responsible</td>
<td>Crane et al, 2009, Caroll 2009, Austin 2008, Oritzky et al., 2003</td>
<td>Helps understand an organization's responsibility toward its community beyond economic bottom line, and also how being socially responsible can boost that same bottom line</td>
</tr>
<tr>
<td></td>
<td>Social Entrepreneurship</td>
<td>Definitions, typical characteristics, importance of social ventures</td>
<td>Brooks 2009, Dees 1998, Simms and Robinson 2009</td>
<td>Helps demarcate socially innovative ventures from charity based programs, helps understand how social programs need not necessarily be a burden on an organization</td>
</tr>
<tr>
<td></td>
<td>Impact Measurement</td>
<td>Problems in assessing social programs, Qualitative and quantitative approaches, positives and negatives of the same</td>
<td>Elkington 2007, Mulgan 2010, Barrow, 2000, Emerson 1999, Lingane and Olsen 2004</td>
<td>Helps create accountability for social programs. Also outlines various existing ways to measure social impact which is of particular interest to this study</td>
</tr>
<tr>
<td>Category</td>
<td>Concept</td>
<td>Areas of inquiry</td>
<td>Prominent Authors / year</td>
<td>How it is relevant to study</td>
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</tr>
<tr>
<td>Environment related</td>
<td>Spatial access and information</td>
<td>Interconnectedness between space and activity, scale and structuring, interconnectedness between spatial and social structures</td>
<td>Amedeo et al 2009, Peponis and Wineman 2002</td>
<td>Helps understand critical role of space in influencing activity</td>
</tr>
<tr>
<td>Perception and control</td>
<td>Ecological concepts of affordances, privacy territoriality</td>
<td></td>
<td>Gibson 1979, Kopec 2006, Archea 1977</td>
<td>Helps understand various factors that impact usage</td>
</tr>
<tr>
<td>The role of culture</td>
<td>Culture as means of adaptation</td>
<td></td>
<td>Rapoport 2005</td>
<td>Helps understand relevance of the program to the setting at micro and macro levels</td>
</tr>
<tr>
<td>Meaning of place</td>
<td>Examine the way a space communicates to a person, significance of a place to a person, identity issues, criticisms against</td>
<td></td>
<td>Canter 2000, Twigger-Ross et al 1996, Scanell et al 2010</td>
<td>Helps understand importance of the physical environment in terms of social, cultural and emotional contexts and how channeling these aspects could alter usage</td>
</tr>
<tr>
<td>Participatory Planning, stakeholder involvement</td>
<td>local/place/situational knowledge, participants as partners, stakeholders as agents of social control</td>
<td>Horelli 2002, Wates 2014, Griffith and White 2007</td>
<td></td>
<td>Helps understand the various roles community members and organizations can play in a social program</td>
</tr>
<tr>
<td>Target related</td>
<td>Importance of stakeholders</td>
<td>Role of stakeholders in value creation</td>
<td>Freeman 1984, 2004, Brickson 2007, Griffith and White 2007,</td>
<td>Helps understand how identifying a target recipient influences choice of program and subsequently the space</td>
</tr>
<tr>
<td>Women as target audience</td>
<td>Women as drivers of economy</td>
<td>Women and healthcare choices, disparaging statistics against women</td>
<td>Silverstein and Sayre 2002, Flax and Kagan 2001</td>
<td>Helps understand the powerful impact yet invisible role women play in society- helps understand latent issues to address when tailoring programs to women</td>
</tr>
<tr>
<td>Everyday life of women, safety</td>
<td>Multiple roles a woman plays simultaneously</td>
<td></td>
<td>Horelli and Vespa 1994, Franck 2002, Churchman 2000, Day 2006</td>
<td>Addresses the importance to look beyond issues as they manifest in plain sight and approach instead bearing in mind social, cultural and financial contexts Helps guide choice of data collection tools, acting picking those that help examine women in a multidimensional manner</td>
</tr>
<tr>
<td>Spatial navigation and women</td>
<td>Navigating space with a gender as the differential, space as a socially constructed phenomenon</td>
<td></td>
<td>Mozingo 1989, Weisman 1992, Low 2006, Coluccia 2003</td>
<td>Helps identify socio-spatial factors that are unique to women users so as to enhance program usage</td>
</tr>
</tbody>
</table>
Chapter 3.0: A Dual Concept Framework for Operation: Social Design and Social Bricolage

Without theory, practice must be a blind doing of what somebody else—tradition, authority or accident—has directed.

—Ernest C. Moore, *What Is Education?*

The main purpose of this study is to explore the role of the designed environment in supporting the creation of social value such that there are benefits to clinic and community. Toward that end, this study looks at communally beneficial programs actively supported by clinics where the designed environment has played a critical role in helping to mitigate a pressing social need within their respective communities. Additionally, the study also looks at how clinics could leverage the value from these space-based programs to their own advantage. In order to understand this, the conceptual framework must be constructed in such a way that it address both of these issues—the environment and the program itself.

Theory talks about the inseparability of space and activity. From the days of Barker’s Ecological Psychology to more recent times, (for example, Amedeo et al., 2009) scholars opine that societies are spatial, both in terms of physical space and organizational makeup. In order to understand activity, it is important to look at the activity within a spatial system. This implies that if one wants to understand the implications of spatial systems on an activity, one has to understand the activity as well.

6 In his now classic 1968 work titled *Ecological Psychology*, Roger Barker propounds human behavior cannot be understood or predicted unless one knows what the situation/context is. The fundamental unit of Barker’s study is called *behavior setting*, a finite area which consists of both a geographical boundary (visible or invisible but certainly existent) and an activity occurring within. The activity accrues meaning only within that boundary.
Given the focus of this study in wanting to elicit spatial factors that best support the creation of value such that both giver and receiver benefit a dual approach is proposed such that the space is grounded within the context of the program. Figure 3-1 explains the reasoning behind adopting an approach that looks at both space and activity in tandem.

<table>
<thead>
<tr>
<th>Main idea</th>
<th>Leads to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio spatial factors within a social program</td>
<td>Benefits to clinic and community</td>
</tr>
</tbody>
</table>

Theory says

<table>
<thead>
<tr>
<th>Space + Activity</th>
<th>Leads to</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Meaningful interpretation of the phenomena</td>
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</table>

From the viewpoint of conducting this research the above is interpreted as

<table>
<thead>
<tr>
<th>Considered in Tandem</th>
<th>Leads to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space that is used to deliver the program + Social program</td>
<td>Gives the clinic the best chance of creating benefits to the community and itself</td>
</tr>
</tbody>
</table>

The framework therefore adopts a dual approach

| The designed environment (space) examined from an environment behavior standpoint + The social program (activity) examined from strategy management/social entrepreneurial standpoint | Dual approach enhances chances of understanding the research question, generalizability. |

Figure 3-1 Thought process behind choosing a dual approach.

The conceptual framework draws upon two primary ideologies from the fields of environment behavior and strategy management/social entrepreneurship. The framework also incorporates concepts that influence planning and implementation of the program such as collective impact, local knowledge, resource impact, and innovation.

As an exploratory study with very little published information that directly impacts the understanding of the topic, the framework must be open enough to incorporate elements from various fields at every level of the research process. At the same time, it must be rigorous enough to be self-correcting so that the researcher can identify if the study were to veer off from its true purpose. The main questions of how space can play a key role in shaping usage of
social programs and how space-based programs create tangible benefits to the health
organizations offering them must be visible throughout the study.

This chapter first looks at various normative and analytical ideologies from social
entrepreneurship and strategy management as pertinent to this study and then moves on to
relevant theories and ideologies from environment behavior. Lastly, this chapter identifies
complementary areas of inquiry, one each from management and environment behavior, which
act as major sources for guidance for the entire study.

3.1 Socially-Driven Motives

There might not necessarily be an exchange of goods between the clinic and the
community, but the programs must exhibit some other vital characteristics of a socially
entrepreneurial venture if the clinic too seeks some returns from the program. Ideologies from
the growing field of social entrepreneurship, therefore, form one arm of this study. Concepts
pertaining to organizational vision and mission, resource management, and stakeholder
identification are used to identify organizational values and, thereby, program choice (and
subsequently, case study selection). A clinic operates neither like a commercial business (even
if it is a for-profit organization) nor like the average nonprofit or social enterprise. It is imperative,
therefore, that concepts from the field of social entrepreneurship are chosen such that they
incorporate this aspect.

3.1.1 The Mission Statement

It is important to recognize at the outset modes of satisfying the unmet need for there is
no one way or one perfect solution to a social problem. While opportunities exist everywhere
(Singh, 2001), practically speaking, there are significant constraints and influences that lead to
opportunity identification. Prominent among which are issues like self and organizational
identities, organizational mission, and the activist-entrepreneur dichotomy of organizational
leadership. For nonprofits, the organizational mission serves as a strong, guiding hand in identifying and explaining who they are and what they stand for.

There is no one clear sector from where mission-related concepts emerge. There is also no formal theory on organizational mission and vision. However, from business ethics to nonprofit organizational behavior and theory, mission-driven ideologies have been found in many areas of scholarship under the umbrella of strategy management.

A corporate mission statement was originally considered as a statement of purpose for an organization (Drucker, 1976). Over the course of decades, these missions “have evolved into public disclosures of organizations’ promises to external constituencies regarding firms’ commitments to stakeholders” (Bartkus & Glassman, 2008, p. 208). The mission statement reflects their values, their outlook, and their business practices. A mission statement assists an organization with everything from communicating organizational identity to the consumers, to creating competitive advantage, to serving as a moral guideline for employees, to employee retention (a nested concept called mission attachment). They are considered a foundation upon which decision makers can build strategic planning processes (Pearce, J. A. II & Roth, 1988, p. 39). Mission-related ideologies, therefore, form a component of the conceptual framework.

3.1.2 Stakeholder Theory

It is important for this study to identify concepts and theories that support the idea of social initiatives that add value to the parent organization. A key concept in this direction is that of the Stakeholder Theory from the field of strategy management as it pertains to business ethics. The concept itself has undergone several iterations since its inception in 1984. It suggests that for any business to succeed, it must strive to create as much value as possible for all the possible stakeholders, including end users and communities (Freeman E. R., 1984). A stakeholder is defined as “any individual or group who can affect or is affected by the achievement of the organization’s objectives” (pg. 46). This use of the phrase “affect or is
affected by” includes those persons and groups whether they are inside or outside of the organization. This definition is broad enough to incorporate end users and members of the community as stakeholders who have an impact on the organization.

While this theory in this and allied forms has been used as a staple in enabling tools to optimize organizational theory, it must be kept in mind that this theory takes a somewhat normative approach. It assumes that stakeholders have a legitimate interest in the organization and that appealing to their interests has intrinsic value (Donaldson & Preston, 1995, p. 67). This theory can be applied to all those areas where an organization, by creating returns for its stakeholders, seeks competitive advantage in one way or another. Social ventures, however, do not follow the economic laws of supply and demand. Several studies have pointed out the importance of involving and partnering with other organizations and groups for optimum outcomes, especially in the healthcare sector. So Stakeholder Theory, in its ever evolving and various allied forms, becomes a key input into the framework of operation for this study.

3.1.3 Resource-Based Theory (RBT)

Resource-Based Theory (RBT), also from the field of strategic management, looks at sources external and internal (to the organization) that create an advantage base for the program. The resource-based model refers to the idea that resources hold the key for superior organizational performance. RBT, broadly speaking, refers to the use of tangible and intangible resources as a strategic asset to create competitive and sustained advantage. The resources must be unique in nature or application so as to transform themselves into an asset for the company [ (Barney, 1991; Wernerfelt, 1984) among others]. RBT proposes that market returns are interlinked to the manner in which resources are acquired and managed creatively by an organization. Admittedly, this theory has not been explored fully in the field of social

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7 See (Ainsworth, Diaz , & Schmidtlein, 2013), (Jackson, 2012)
entrepreneurship or social value creation (Haugh, 2009) given that the expectation of returns and the definition of who the competition is are both rather blurry. However, what differentiates these ventures from other nonprofits is their aim of optimum resource allocation and leveling and self-sustenance (on the contrary, these traits are something they share in common with regular commercial firms). This makes social ventures compatible enough to be examined under the resource-based lens.

Resources are generally divided into financial, physical, reputational, organizational, intellectual, and technological for any entrepreneurial venture. RBT argues that resources themselves are not keys to success; rather, the nature and quality of the resources and the manner in which they are employed can lead to long-term success. Extending this logic, one can say that the resource base must be inseparable from the venture such that it cannot be easily replaced, substituted, or replicated by another resource. It should also not be easily replicable (by competitors). This way, whether it is a rare resource or an easily procurable one, instances of program failure or replication from competitors and other comparable organizations will be greatly reduced. In other words, the resource base which the program uses must not be an add-on; the resource must be central and critical to program delivery.

Figure 3-2 represents the various operational influences acting on a clinic that intends to support a social program.
3.1.4 Choosing a Resource: The Designed Environment

As nonprofit organizations, healthcare clinics face unique pressures. As an organization, a clinic cares for the medically ill and infirm in the community. As a result, it faces several resource constraints, including fund procurement methods and non-payment for services rendered. At the same time, it faces regulations and pressure from governments, allied organizations, and communities themselves who want the clinic to do more for the people-to
address the general wellness of the community itself. Adopting a resource-based view could be considered a logical way of addressing this conundrum. The various resource attributes enable the planning and delivery of a communally beneficial program so that the clinic itself does not experience significant resource deficits; rather, the clinic has incentive to do so.

For this study, it is vital to assess the critical role of the physical environment for both its untapped potential and ready availability. Much like commercial businesses, clinics have established business models of operation and target markets; yet they are not like mainstream, commercial businesses. Simultaneously, clinics have social good at their core; yet they are not like regular nonprofits or social enterprises. This unique predicament puts the clinic in an ideal position to pursue what is popularly called Corporate Social Entrepreneurship⁸ (Austin et al., 2008). While a nonprofit clinic is not free to operate like a mainstream, for-profit corporation and does not have profit as a motivating factor, it nonetheless can incorporate appropriate elements from such ideologies as Corporate Social Entrepreneurship to achieve social good beyond medical care. However, given the influential and rather visible position a clinic holds within its community, and its role as a provider of a critical service, it has to be mindful of the types of social needs it can address. The clinic has to be diligent about the nature of the program as well as the resources the program might need for long-term sustenance.

The physical environment, however, is a resource the clinic is oftentimes already in possession of—or it is easily procurable. Physical resources are considered valuable mostly because procurement is low cost. Hitherto there has not been an examination from a more qualitative perspective where the latent factors of the environment play a significant role in

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⁸ Corporate Social Entrepreneurship involves leveraging a mainstream corporation or organization’s core competency and corresponding opportunity for social and economic good. The key aspects of which is aligning the social program with its mission, using its own skills/competency, thinking beyond traditional charitable giving and partnering wherever necessary for skills and resources to achieve overall value accrual. Incorporating this into its strategy ensures both implementation and long term sustenance of the social venture. (Austin et al., 2008)
turning the said venture into a success, transforming the physical resource into a valuable asset.

**Figure 3-3** Driving forces that are specific to a clinic wanting to support a space-based social program.

### 3.2 Social Bricolage

Furthering this line of thinking, the emerging concept of Social Bricolage (Di Domenico et al., 2010) is chosen for its approach to social-value creation that incorporates both practical and theoretical perspectives. It addresses each of the above mentioned concepts and points of concern—resource constraints, limitations from regulatory agencies, importance of stakeholder involvement, organizational survival, and giving social causes mainstream legitimacy to name a few.

Bricolage, first mentioned by Levi-Strauss in his book the Savage Mind (1966), is a concept that bridges the mythical and scientific worlds. The *bricoleur* is a person who is
essentially an improviser, a person who makes do with what is there, improvising as the project goes on and using existing (or whatever is readily procurable) resources to reach the end goal. Conversely, the project is oftentimes influenced by whatever tools and resources are at hand. The concept of bricolage, being all about efficient resource management, when further expanded to address social ventures and programs is termed Social Bricolage. Resources, resourcefulness, and resource limitations have been hallmarks of any entrepreneurial venture, more so of the social kind. Elements like information networks, peer networks, and even personal networks (Johannisson, 2000) play an important role in gaining support, skills, and experience required to make the program a reality. Successful social ventures are about being resourceful and persistent (Miner, Bassof, & Moorman, 2001). In other words, successful social ventures require improvisation, a parallel of which can be found in the *bricoleur*.

The concept of Social Bricolage outlines all of the above, creating a comprehensive framework for a social venture to operate within. It lists the following as the six main concepts every socially entrepreneurial venture must be mindful of:

- The creation of social value
- Making do with available resources
- Improvisation to enable active pursuit of social purpose
- Refusal to be constrained by limitations
- Stakeholder involvement and participation
- Persuasion / negotiate leveraging of further resources and support

In order to ensure that the clinic does not end up with a deficit, but instead finds advantages, the clinic must be mindful of its everyday duty--saving lives. It also must be selective in the programs it chooses to support. Thus, the focus should never be taken off its day-to-day business; at the same time, the clinic must be mindful of its own organizational mission and the approval of regulatory agencies. While aligning the social programs with its mission enhances chances of addressing the social issue comprehensively, choosing programs
that meet with the approval of regulatory agencies helps with both resource sharing and financial benefits (e.g., if the clinic can show that the program meets with the IRS regulation of directly benefiting the wellness of the community, the program can be accounted for safeguarding the clinic’s tax status).

Resource-based views, mission-driven ideologies, stakeholder theories, and supporting concepts are all incorporated and reflected in the extended theory of Social Bricolage. This provides a good starting point for this study to pursue the exploration of space-based, socially entrepreneurial ventures contributing to the creation of value in a community.

3.3 An Environment Behavior Perspective

Social Bricolage informs this study on the importance of addressing various aspects of social entrepreneurship toward social value creation and helps mark the departure from charitable contributions or philanthropy. It addresses the critical role of resource management. Further, the resource-based view arm of the framework mentions a valuable resource as central to creating a competitive advantage, giving further validation to the critical role of resource procurement in program success. This study identifies the designed environment as that critical physical resource which, in the process of supporting the social program, also gives the clinic the optimum opportunity to create value for the community and for itself. While literature on the resource-based view mentions the built environment as a valuable resource, no attempt has been made to understand the many ways in which it can be valuable.

This study looks at those areas of environment that address both physical and sociocultural properties. Social programs, at their core, aim at social change, which manifests through behavior change. When these programs are of a more sensitive nature, such as when dealing with a vulnerable population, the program and space will also have to accommodate the target audiences’ emotions, safety, well-being, and even other people who are not direct recipients of the program but are very much an integral part of the target audience’s life (i.e.,
children and spouses). This study addresses these and other related areas in order to examine whether the physical environment can play a central role in aiding the creation of social value.

The social programs are offered to help a target population with problems that affect their everyday life, encourage people to embrace a new way of life, create a safe place of refuge, and so on. However, it is essential to keep in mind culture and local norms. The target population’s problems might be of a universal nature, but the manner in which they are delivered must be local, attuned to local preferences and norms. Thus, microculture is an important influence on design. This is an area where the designed environment can play a prominent role in shaping outcomes. It is important for the methodology to allow for examination of both latent and dormant characteristics of spaces so as to understand the various ways in which the designed environment can support value creation.

### 3.3.1 Context Relevant Settings

An ecological approach would tell us that users understand a space based on the how they interpret the spatial cues available within a setting. Meaning and subsequent understanding of a setting is therefore based on the context of that setting (Rapoport, 1982). The quality of space is, thereby, more a perceived quality based on how each user understands the space. There are several influences for this—age, gender, social, cultural, and physical aspects (Rapoport, 2005). For the exploration of the designed environment’s role as a viable element in creating social value, and given the resource crunch often faced by clinics, it is vital that this study allows for the inclusion of the influence of local culture on the program, thereby making the program more relevant for the user. Subsequently, whether the environment has had a hand in enhancing the user experience will need to be examined.
3.3.2 Access and Approach

The second ideology from the field of environment behavior is access and vision related. It is important for the target recipients to have easy access to the program. Some issues are more sensitive, carrying with them a certain social stigma. These sensitive issues can make the target population hesitant to approach a program for help. On the other hand, there are some issues that everyone can relate to and need to address. The common factor between a target person having a sensitive issue and a target person having a more universal issue is that they will need to feel comfortable communicating their problem. And so siting of the program becomes critical and must reflect both the program philosophy and user needs. Schools of thought that examine the importance of accessibility and visibility of a space form a good starting point in addressing this because space aids communication. Greater the access and visibility of a space, the greater the chances of usage (Peponis & Wineman, 2002) is a line of thinking that has particular appeal to this study.

However, there are several ways to interpret these theories and studies. Accessibility and visibility does not necessarily mean a central location or a prime piece of property. The location must not serve as a deterrent in accessing the program and its space. It must be visible to the intended population, and, for some programs, it may be desirable to keep the location away from a central location for the benefit of the users.

3.3.3 Social Identity Theories

These theories deal with how people identify with a program or concept (or brand) by associating it as a part of their own identity through cognitive and affective dimensions. In other words, individuals can both think and feel a sense of extended self when they identify with some programs. One version of social identity theory (Bhattacharya & Sen, 2003; Sen & Bhattacharya, 2001), suggests that embedded relationships arise when users engage with
organization-related routines, rites, and rituals (p. 82). Studies also have shown people giving favorable opinions of places they feel connected with, thus they are basing their opinions on more than just physical and visual aspects. It becomes important for both social programs and their environments to resonate with users as not just a solution to their problem but also call to a deeper part of their conscious minds. The meaning of place identity, which tells us about the various elements individuals connect with, might play a role in some cases, even those that go beyond physical-visual-material connections.

3.3.4 Women and Nested Issues Within

Any study that examines the role of the female gender must be clear on the parameters of the gender examination. It is completely conceivable for a study to take directions that do not really address the gender-related issue from the angle the study requires. In this case, the gender-related focus is on what factors of the environment make a difference in program usage when they are tailored to women. This study addresses gender as a socially-constructed element. Additionally, this study accepts that social problems essentially arise from various dissonances caused by human relationships, hierarchical structuration of various groups (societies) occurring from human judgment, and disproportionate distribution of resources over generations (by humans). Neither normative nor prescriptive but exploratory in nature, this study uses the aforementioned gender and social inputs to address the issue of women with specific reference to how women perceive space in real-time.

The dichotomy in perceived and actual behavior of women with regards to spatial navigation is examined through both interactionist and ecological theories (Coluccia & Louse, 2004). While an interactionist approach asserts that gender differences are caused by a continuous interaction between environmental factors (experience based) and biological factors (natural predispositions), personality theories tell us how women, given their limited opportunities to interact with various environments, display greater anxiety and stress levels that
impede their navigational senses, though not necessarily the accuracy of outcome (Coluccia & Louse, 2004, p. 335).

The importance of understanding context in a woman's life is given due credence. A woman assumes many roles in a day, often at the same time. So her actions are often tied to managing of her various lives, which can be fully understood only when one examines her everyday life. The study of theories on everyday life has many versions and approaches and has now become an accepted discipline within sociology and environment behavior. It brings together humanistic and structural integration from a sociological perspective. Everyday life studies provide legitimacy to what is often taken for granted (Crook, 1998).

For the purpose of this study however, concepts and ideas have been limited to those alluding to the material environment. Everyday life, according to scholars in the field, is more about the process than the outcome or action. By understanding the repetitive actions of everyday life, one can understand the structural conditions which form the basis for human action. What is common to all of these theories is that by understanding the everyday life of individuals (or groups), one can begin to get a sense of how women understand the world around them and simultaneously, how they (women) derive their own identity from that world (Horelli & Vepsä, 1994).

3.3.5 Participatory Planning

Lastly, a program of a social nature rarely has commercial value. Instead, social programs are driven by a social mission. Therefore, for these programs to be a success, it is important to arrive at solutions that not only fit each program but the users as well. This fit is critical for both program success and program sustenance. In a climate where accountability looms large and clinics feel pressure to show their usefulness to the community, it is imperative that their programs embrace the prime factors of success, including appropriateness to the community and conduciveness to usability.
The input of the community and stakeholders that the clinic serves—many of which have a vested interest in the success of the program—becomes vital to program outlay, implementation, and success. Also important for the design and implementation of a program are areas like place knowledge, local knowledge, and situational knowledge, all of which address a variety of issues, including material and historical, that pertain to that place and location (Schneekloth & Shibley, 1995). Participatory planning theories, therefore, form an integral part of this study’s framework.

Figure 3-4 Various environmental influences on the clinic’s decision to support a space-based social program.
3.4 Social Design

Bringing together all these ideologies under one comprehensive umbrella is the concept of Social Design (1983). First proposed by Robert Sommer, Social Design is aimed at humanizing the physical environment, making for optimum usage of the environments for the people for whom it is designed. The seemingly utopian nature of the ideology is backed by specific and viable environment-behavioral considerations to create conducive spaces which leads to enhanced user comfort. The ideology is particularly aimed at bringing out socio-cultural elements that have a direct impact on the operational (read financial) bottom-line of any organization. Social Design recognizes the unique features and individual nature of each community. It simultaneously acknowledges that customization of solutions does not mean a lack of generalizability. Social Design also stresses that solutions proposed and implemented elsewhere in comparable organizations and situations should not be neglected.

While not prescriptive, Social Design calls for a clear identification of the task on hand, asking what the space is supposed to achieve and then breaking down the requirements into several components. Social Design is very much a hands-on, action-oriented concept. At the same time, it emphasizes the importance of a good theoretical framework for project longevity. Overt factors like safety, privacy, and access—or more subtle, and often unnoticed, factors like user movement, patterns, and furniture placement—are all given their due place in this ideology. This concept recognizes the importance of every element of design, whether physical or socio-cultural, citing that “improving a single factor within a large system might not amount to a large percent (during evaluation) but is still worthwhile and necessary for those concerned with that particular aspect” (p. 68).
3.5 A Dual Framework of Operation

The ideologies of Social Design and Social Bricolage are broad and open ended, allowing for several allied concepts to be included for optimum understanding of the role of the designed environment in the creation of value. Both ideologies are practical in their approach, while emphasizing extensive planning and taking every available option into consideration in order to turn the program and environment into three-dimensional reality.

Further, a single, comprehensive arrangement has been created that merges the two ideologies and points out their common factors and allied areas which are important for this study (Figure 3-6). This arrangement helps to create a single set of guidelines to examine the role of the designed environment in the creation of social value as it actively supports the social program. The value accrued is beneficial to both the community and the clinic.
Given the exploratory nature of this study, this framework forms a source of guidance alone rather than a mandate from which the study should not diverge. The concepts of Social Design and Social Bricolage, along with the other allied theories, have been chosen for the degree of openness and flexibility they offer. Most of the theories used in this study are not normative in nature and ones that allude to a normative structure also have analytical approaches. There is no emphasis on prediction of outcomes (Lang, 1987). Each of these concepts is substantive and open to incorporating ideologies with the passage of time. They are concerned with describing and explaining of situations.

Figure 3-6 A combined representation of how both areas of social entrepreneurship and environment behavior come together to create a conceptual framework for this study to operate under.

This is also practical research of an exploratory nature, so substantive theories of the sort mentioned above help to identify similarities and differences across instances where they bear a common contextual reference (Adelman, 2010). They allow for a great deal of flexibility
to incorporate the essence of allied concepts into the evaluation process. Each of these concepts connects with one another to create an integrated approach allowing the study to proceed in a logical fashion.

There is a paucity of information pertaining to the particular area of inquiry, how a clinic can use the designed environment to create and sustain social value such that the benefits are for the community and for itself. A nonprofit clinic has a solid business model and yet is not a mainstream corporation. It is one of service and yet cannot adopt just about any social problem, it has its own restraints—resources, regulatory agencies, and the critical nature of its everyday work (catering to the sick and inform) to name just three. Given the right approach, clinics could be of greater service to their community without further resource depletion. And so for a topic that is so nascent (in idea and scholarship) the conceptual framework for this study has two strains of scholarship influencing it in order to get optimum guidance. It incorporates several allied areas and kept open enough to incorporate elements should they crop up as the study proceeds.
Chapter 4.0: Research Design: A Multi-Case Study, Mixed-Method Approach

If we knew what it was we were doing, it would not be called ‘research,’ would it?

―Albert Einstein

This chapter explains the research design the study has adopted. It starts by outlining the basic nature of this study, moves on to a reasoning of how and why a multiple case study methodology was adopted, and then outlines the criteria for the case studies, data collection tools, the actual cases chosen, and data analysis techniques.

An extensive search of published studies led to the conclusion that there is not enough scholarship that explores actual tools to help explore, examine, and understand whether a resource-based view, using space as a central resource, has any relevance in the creation of social value. The information dwindles further when healthcare environments and benefits to the program giver are additionally considered.

The literature review chapter creates a sufficient understanding of the existence and importance of adopting a resource-based outlook for programs of a social nature. However, there are significant gaps. For example, physical resources are stated as valuable and replicable (Dollinger, 2008), but the implications of employing such a resource on a long-term program are not discussed in either scholarly or popular discourse. It is also not clear what needs to be done by the parent organization in order to turn those resources into valuable assets that will enable long-term sustenance of the program. Using the dual-base framework of Social Bricolage and Social Design as guidance, this chapter explains the research design that

9 Section 3.1.3 for details on Resource-Based Theories
makes the study stand the rigors of scholarly research and at the same time be practical enough to help identify case studies already in existence.

4.1 Nature of the Study

Preliminary research in the form of internet searches, discussions with healthcare administrators, and the very fact that there was insufficient information in both scholarly studies and popular press established that a thorough assessment of the topic does not yet exist. This research, therefore, falls under the category of exploratory research (Black, 2005) as the basic question is one that looks for relationships between elements—the designed environment and social sustenance, socio-spatial networks and gender, the clinic as a community resource and the designed environment, etc.

In order for this topic to submit to the rigors of a scholarly research, the research design must allow for in-depth examination of the topic and be practical in its approach. Social programs need longevity to ascertain their impact and even then measurable data is hard to come by. This research instead examines tools that clinics can use in order to offer and persist with a social program in a manner that does not negatively affect the operational bottom line and at the same time create a pool of benefits for themselves in the process. To assess the program’s value quotient to the clinic from a resource viewpoint (the physical environment in this case) would require a design that is qualitative and innovative.

4.2 Choosing a Method

The study raises some questions that need addressing. Why is a resource-based view important for social sustenance? How can the designed environment play a positive role? And the topic was further explored, additional questions came up pertaining to both the designed
environment and the nature of the program. Why is a socially entrepreneurial outlook\textsuperscript{10} important for sustenance? Why are some spaces used more than others? How can spaces tailored for a particular population enhance impact? While appearing vague, these questions are critical to understanding the research topic. Therefore, it is imperative that the methodology be one that addresses these questions.

In order to assess what factors of the physical environment play an active role in enhancing the effectiveness of a social program, the space and program should already be in existence. This would enable the examination of the space and program from various angles including user modifications, space attachment etc. both internally and at a neighborhood level. This would however mean that the researcher would have no control over the program setting or user behavior. There will be no scope for modification to or adjusting of the sequence of actual human activity within the environment allowing for observation and analysis in an unobtrusive manner.

Given the vague nature of social value (Mulgan, 2010) and understanding that every community is unique as are its needs, the setting of the social program is vital. While behavior change is ultimately at the core of every social program (Lee & Kotler, 2012), it is also possible for similar programs in different communities to operate differently based on the micro-culture. In the field of environment behavior it is acknowledged that space influences behavior (Rapoport, 1982) and so there is a covert implication that such an approach, tracing human activity within a space will help us understand the true value of that space. There is also an overt implication that a topic of this nature will be best understood with a hands-on approach.

All of the above mentioned factors make a clear case for opting for a case study methodology. However, it is also clear that, given the exploratory nature of this study, one case

\textsuperscript{10} A social entrepreneurial outlook for this study is defined as that approach toward program planning delivery that exhibits the following characteristics: addresses a pressing social need, has an eye on self-sustenance, accountable and not averse to measuring impact, innovative in resource procurement and implementation.
study might not yield enough evidence to validate the topic. Hence, a multiple case study methodology (Yin, 2014) is proposed.

Figure 4-1 gives a diagrammatic illustration of the various factors that have led to the choice of a multi-site methodology.
Figure 4-1 Illustration of the various factors that have led to the choice of a multi-site methodology
4.3 The Multiple Case Study Approach

Gomm, Hammersley, & Foster, (2000) contend that a case-oriented approach is one that places cases, not individual variables, at center stage. This is particularly useful to this study since there is no particular interest in individual behavior. The aim is to understand the relevance of space to the program and the benefits that then accrue from the space-program dynamic.

According to some other scholars, notably Simmons (2009), a case study is one that essentially calls for the study of a phenomenon from various perspectives that bring out the complexity and uniqueness of that phenomenon in a setting that is real and uncontrolled. In other words, studying the phenomena as it occurs in its natural setting, undisturbed by the researcher. This definition brings out several elements to consider. One, the object to be studied must have a real-life context--it must already be in existence in the real world. Two, the object must lend itself to be examined from many different angles, which calls for different methods of examination. Third, being a particular project, policy, institution, etc., would mean it must be finite. That is, there must be a timeline and a definitive boundary wherein the researcher can differentiate which elements are within the case boundary and which are not.

Given the paucity of literature and established sources of information, one is unable to identify a particular case as critical or revelatory (Yin, 2014) from which to proceed as a single-case design. The study stands a better chance of yielding external validity through identifying several cases that lend themselves to replication design. In turn, this gives the researcher enough leeway to create a set of objective data-collection measures, the lack of which is a strong criticism levied against case studies as a methodology (operational measures are subjective and chosen to fit the researcher’s ideas thereby rendering the research weak (Ruddin, 2006)).
There are other advantages to doing multiple case studies. For one, evidence from multiple cases is considered to make the research thorough (Herriott & Firestone, 1983; Stake, 2006). A collective case-study methodology also allows for showing different perspectives on the same issue (Creswell, 2007). Also, given the gender quotient of this study, examining different programs and spaces for similar social causes could help to shed light onto factors specific to women as a target audience. Additionally, given the nature of the inquiry, the studies will be conducted in parallel (Thomas, 2011), meaning every program and space is already in existence and will be studied in concurrence.

![Figure 4-2](image)

**Figure 4-2** A modification of Thomas’ (2011) model, indicating appropriateness of a multiple case typology for the topic

### 4.4 Criteria for Case Selection

This research examines the role of the designed environment as a tool in enhancing social value. Boundary conditions indicating which factors need to be included in the research and, conversely, which need to be left out, was done prior to embarking on actual case-study selection. Criteria for choosing the case studies included looking at programs that were of a non-medical nature; space based with defined structure and target audience; and had proven
longevity (operational for at least five years). Special attention was given to see if programs reflected any or all factors of Social Bricolage and Social Design. Table 4-1 and Table 4-2 list the criteria used to identify viable cases.

From viewpoint of the topic

Table 4-1 Case Study criteria matrix

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Criteria: The Social Program/case study site must</th>
<th>Ideology</th>
<th>Scholarship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Be of non-medical nature (beyond immediate medical care) and support by clinics must be overtly evident</td>
<td>Has a clearly identifiable subject</td>
<td>Thomas 2011</td>
</tr>
<tr>
<td>2</td>
<td>Use space as central to program delivery</td>
<td>Clearly identifiable and tangible resource base, innovative response to social problem</td>
<td>Dollinger, 2003, De Domenico et al. 2010</td>
</tr>
<tr>
<td>3</td>
<td>Address an unmet societal need</td>
<td>Displays understanding of the community’s needs; exhibits local knowledge</td>
<td>Sommer, 1983, Schneckloth, 2002</td>
</tr>
<tr>
<td>4</td>
<td>Clinic exhibits interest in benefiting from program, does not view it as charity/philanthropy</td>
<td>Must show a two way value exchange socially entrepreneurial outlook</td>
<td>Austin, 2006</td>
</tr>
<tr>
<td>5</td>
<td>Have a defined audience</td>
<td>Has a clearly identifiable target recipient increases chances of execution and impact</td>
<td>Brickson, 2007</td>
</tr>
<tr>
<td>6</td>
<td>Has a focus on women as audience</td>
<td>Women are generally neglected in public realm, do not receive sufficient support from society at large</td>
<td>Weisman, 1992</td>
</tr>
<tr>
<td>7</td>
<td>Has been running for at least 5 years and / or has a definitive plan for future-</td>
<td>Exhibits persistence/longevity</td>
<td>De Domenico et al. 2010</td>
</tr>
<tr>
<td>8</td>
<td>Has gained recognition for its work (the clinic)</td>
<td>Public knowledge exists / public views the organization positively</td>
<td>Ortlizky, 2003</td>
</tr>
<tr>
<td>9</td>
<td>Can be identified as having value based or issue based dimensions</td>
<td>There should be a logically structured reasoning behind offering program irrespective of outcomes</td>
<td>Sirma and Robinson, 2009</td>
</tr>
<tr>
<td>10</td>
<td>Balance and variety</td>
<td>There must be opportunity to examine the topic from as many angles as possible at the same time not create huge disparity among cases</td>
<td>Stake, 1995</td>
</tr>
<tr>
<td>11</td>
<td>Have at least one unique feature that makes the program stand out from its peers</td>
<td>While built environment is not a rare resource, it can certainly have features that stand out from the rest/ the more outstanding the features of the resource, greater the chances of success</td>
<td>Dollinger, 1993, Haugh 2009</td>
</tr>
</tbody>
</table>
From viewpoint of conducting research

Table 4-2 Practical considerations

<table>
<thead>
<tr>
<th></th>
<th>Practical Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The sites must be geographically accessible and safe with no known extreme risks (for conducting case studies)</td>
</tr>
<tr>
<td>2</td>
<td>The program must be well documented</td>
</tr>
<tr>
<td>3</td>
<td>Contacts within the organization/program must be willing to share information; willing to allow researcher to visit the program site</td>
</tr>
</tbody>
</table>

4.5 A Thematic Exploration of Viable Cases

While preliminary research in the form of discussions with healthcare professionals led to various, interesting options, a more in-depth search was made before deciding on case studies. The search criteria as listed in Table 4-1 and Table 4-2 were used to guide the choice of case studies. It was also decided that the final choices must address programs that most affected American society and yet be generic enough for communities across the globe to relate to. These criteria and considerations resulted in choosing two themes that addressed two basic problems—those related to food and shelter.

4.5.1 Theme 1: Food and Nutrition

The first area chosen was that of food and nutrition. According to the CDC,\textsuperscript{11} nearly 35% (close to 80 million) of American adults\textsuperscript{12} are obese. The annual medical cost of obesity is estimated at $147 billion with medical costs of an obese person nearly $1,500 higher than that of a person with normal weight. Further, 18% of 6–11 year olds and 21% of 12–19 year olds in the United States are deemed obese. Over a third of all children\textsuperscript{13} under the age of 19 are considered either obese or overweight.

\textsuperscript{11} Centers for Disease Control and Prevention
\textsuperscript{12} An adult who has a BMI of 30 or higher is considered obese. (CDC 2014)
\textsuperscript{13} For children aged 2–19 years, obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex. (CDC 2014)
While the numbers alone call for attention in addressing and overcoming this problem, the new Affordable Care Act health law passed in 2010, mandates that employers and insurance companies take specific measures to help address this issue. While most countries around the globe do not have an obesity problem of this proportion, it is a problem everyone understands. Even a developing country like India has an impending obesity problem on its hands (Kelly, Yang, Chen, Reynolds, & He, 2008). Lifestyle disorders attributable to unhealthy eating habits, lack of exercise, and a lack of access to fresh food are important, contributing factors that often precede chronic medical issues associated with being overweight.

The idea of healthy living through healthy food offers a strong, viable option in the form of farmers’ markets. Offered on and around clinic premises, structured and supported by hospital staff, these markets were chosen as they stood for healthy eating as well as for furthering a clinic’s commitment to health and well-being of its entire community, not just its paying patients. The role of markets as public spaces, as harbingers of social interaction and communication among users, and the strong role of space as a facilitator in this endeavor were the factors that contributed to the choice of healthy eating, as represented by farmers’ markets, as one set of case studies.

4.5.2 Theme 2: Equitable Solutions for Low-Income Women

Homelessness is a serious issue with nearly two million people counted as homeless in the U.S. (National Law Center on Homelessness and Poverty, 2014). Thirteen percent of these are single women and 36% are families with children. The typical homeless family is a single mother with two children. According to a report published by the National Coalition for the Homeless in 2009, 66% of the homeless report either substance abuse and/or mental health problems.

At the same time, reports and literature show that with supportive housing, there is significant improvement in the lives of homeless people, including improved health and
wellness. Also, studies show significant cost savings in terms of emergency room, health care, police, and other public services (Modello, Gass, McLaughlin, & Shore, 2007; National Alliance to End Homelessness, 2010). People placed in supportive housing show an inclination not just to find better jobs but also to seek help for mental health, substance abuse, and other related problems. In particular, supportive housing allows women to keep their children with them, thereby reducing labor and service costs of foster care, and so on (M. Skahan, personal communication, 2013). Homelessness, especially for women with children, is not relegated to the United States, however. Rather, this is an issue that resonates globally.

With this information, this study sought programs and spaces tailored to this subset of women—low income, with or without substance abuse issues, who are making dedicated effort to turn their lives around. As a result, the study looked at homeless centers, substance abuse and transition homes, and community resource centers with women as the primary target.

### 4.6 Case Study Identification

The search for viable cases was two pronged. One, internet searches performed for information from regulatory agencies (like the American Hospital Association and its Community Connections Reports 2006–2012) and discussions with healthcare professionals were conducted to identify cases that fell into the realm of the aforementioned areas, food and nutrition and homelessness. Two, the cases thus identified were further examined to see if they answered to the case study criteria as derived from broader literature.

This led to the identification of the cases as seen in Table 4-3.
Table 4-3 Case Identification

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Supporting Clinic</th>
<th>Location</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating through farmers markets</td>
<td>Kaiser Permanente clinics</td>
<td>Fresno, Oakland, Santa Rosa, CA</td>
<td>3</td>
</tr>
<tr>
<td>Programs of a sensitive nature for low income women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House of Mercy Homeless Center</td>
<td>Mercy Hospital</td>
<td>Janesville, WI</td>
<td>1</td>
</tr>
<tr>
<td>House of Mercy (Home for women with Substance abuse issues)</td>
<td>Mercy Hospital, Des Moines, IA</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>McAuley Residence (Home for women with Substance abuse issues)</td>
<td>Mercy Maine Portland, ME</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Windsor Community Resource Center</td>
<td>Mt Ascutney Hospital and Health Center</td>
<td>Windsor VT</td>
<td>1</td>
</tr>
</tbody>
</table>

The programs of a sensitive nature can be considered as the most viable based on the search criteria (Table 4-1 & Table 4-2). While the presence of at least two programs similar to those listed above were known, sufficient information could not be gathered within a reasonable timeline, so these options were discarded. As for the farmers’ markets, the three chosen can be considered a sample from a larger pool. These three markets were chosen as typifying a unique market type based on discussions with key personnel at Kaiser Permanente involved closely in the farmers’ market initiative. And to give a cross-cultural perspective, one site was selected from India.

Table 4-4 Case Identification

<table>
<thead>
<tr>
<th>Wellness facilities for low income populations</th>
<th>Sambhaavana Trust Clinic Bhogal, India</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patios, verandahs, multipurpose hall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and a rustic hut as third spaces</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Sambhavana Clinic is the only viable case in this category of use of third spaces in the creation of social value as detailed in Chapter 8.
Two diverse sets were deliberately chosen to give the reader an idea of how clinics, by understanding the nature and needs of their communities, could address social programs that yield benefits to the community and the clinic. Also, the cases exhibit socially entrepreneurial motives with a well-structured operational strategy and deliberate use of the designed environment as central to program delivery.

4.7 Data Collection Tools

A practical, hands-on approach to data collection meant gathering information that helped answer the research question—what factors are essential in a physical environment so that it supports a successful social program? The data collection in this study addresses scholarship in areas of social entrepreneurship and environment behavior, both of which speak of the inseparability of space and activity.

Yin (2014) and Creswell (2007) concur that multiple sources of evidence as well as review of the research (including findings from that research) by key experts and informants lend a high degree of reliability to the study. Thus, interviews and discussions were an obvious choice. In order to understand what the program givers thought were pertinent issues to program success, talking to both program givers and personnel from the program’s clinic were contacted. Furthermore, as many onsite staff members as possible were contacted to get the views of people looking at the same program from different angles given their different roles. Documents, reports, and email correspondences with pertinent information were also used as part of the verbal data set. Visual data through the use of photographs was yet another source of data collection. Some issues pertaining to the built environment could be more accurately represented through the use of photographs. Additionally, observation of the spaces and how

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14 Any information that identified people directly through email address and phone numbers were either removed or their permission sought before collapsing it into the data set. While the interest of this study in people is limited to their professional opinion regarding the program, nonetheless any information that pertained to personal information was removed.
they were used was another data collecting tool used to get a firsthand idea of how some of the spatial issues worked at both micro and macro levels.

Interviews and discussions were kept focused on the role of space, how space impacted the program, and, subsequently, how it impacted the clinic. A wide range of issues were brought up at the discussions. Some of the program-related areas discussed include: origin of the program, reasons behind the program, role of the clinic, funding sources and other financial data, planning, implementing, and running the program. Furthermore, details on role of leadership, strategies and hardships for implementation and documentation of the program were also discussed. Clinics were asked about how they saw the program—as an investment or a charity, and whether they saw a difference between the two. It is conceivable that a clinic seeking returns on a program will structure and implement the program in a manner different from a program that is viewed as charity. Thus, every attempt was made to find out if socially entrepreneurial factors were in play.

Issues pertaining to the actual space itself were explored in the discussions. These issues include: the reasons for the clinic to offer the program in that particular space, the choice of location, building materials, access issues for the target recipient, the urban footprint, and the influence of local culture on both program and the space. Additional items discussed were heavily used spaces, unique aspects of the space that set it apart from other similar programs, etc.

Visual observation and photographs were used to examine such issues as use of particular spaces that program givers said were popular. These tools also helped in assessing other pertinent areas like the clinic’s association with the program, the visibility of the program within the community, the neighborhood in which the program sat, and so on. Since timelines for observation were severely restricted, systematic observation could not be conducted over a few days. However, casual observation of some areas as well as capturing still images helped to
corroborate verbal data and to expose other issues that were not mentioned in the interviews or discussions.

Topical questions, or information questions (Stake, 2006), used to lend structure to the data collection in order to best understand the research questions were broadly listed before going onsite. Table 4-5 lists some information research questions pertinent to this study, what the responses from those questions would help us understand, and what data collections tools were used to gather that information.
Table 4-5 Research questions pertinent to this study

<table>
<thead>
<tr>
<th>Information Questions</th>
<th>Understood Through</th>
<th>Tools Used in the Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there intent to create value</td>
<td>Program background and history</td>
<td>Interviews, document/report examination</td>
</tr>
<tr>
<td>Is there a way to determine commitment, persistence</td>
<td>Operational details - scale of operations (including staff numbers, financial outlay, and business model (partnering, direct offering etc.)</td>
<td>Interviews, document/report examination</td>
</tr>
<tr>
<td>Is there a defined target audience</td>
<td>Nature of the program, users of the program</td>
<td>Interviews, observation</td>
</tr>
<tr>
<td>Are there defined stakeholders/stakeholder involvement</td>
<td>Program structure</td>
<td>Interviews, document/report examination</td>
</tr>
<tr>
<td>Has the clinic opted for a resource based outlook</td>
<td>The space housing the program, square footage</td>
<td>Documentation of the physical environment. Observation, visual methods (photography, videos), interview/discussion</td>
</tr>
<tr>
<td>Does the resource exhibit elements critical to program delivery and usage</td>
<td>Whether the same program be offered through different mode of delivery, whether the space is tailored to the program and users (for example: access, lighting), whether the program reflects local culture (for example: building materials)</td>
<td>Documentation of the physical environment. Observation, visual methods (photography, videos), interview/discussion</td>
</tr>
<tr>
<td>Is the resource conducive for the program</td>
<td>Amount of usage, circulation patterns</td>
<td>Observation, interview/discussion</td>
</tr>
<tr>
<td>Is there an intent of long term sustenance</td>
<td>Program structure, longevity of program</td>
<td>Interview/discussion, document examination</td>
</tr>
</tbody>
</table>

4.8 Description Criteria

The two chapters addressing the two themes of food and shelter (chapters 6 & 7) and each case within those chapters follow the same pattern. This is the same pattern in which the interviews were conducted at each site, with each person, and in each discussion. Questions were open-ended enough to allow the interviewee to feel comfortable enough to discuss issues he or she felt were relevant. However, the conversation was primarily focused on the program
itself and the role of space within the program as it pertains to the creation of value (to clinic and community).

A systematic pattern of information gathering was executed to ease data analysis and to enable generalizability of the topic. Gathered information was analyzed and subsequently written up in the same order. In other words the information was examined under the same criteria, which gave the data a sense of uniformity. Each of the space-based programs was examined from organizational, operational, and environment-related areas to give an overall understanding of the program and the criticality of space to the program.

The two theme-based case study chapters hold the following order:

1. Operational model
2. Location and access
3. Role of space and space based challenges (if any)
4. Data analysis and discussion
5. Benefits to the supporting clinic from the program

4.9 Data Analysis: Triangulation of Methods

Triangulation of data sources, or information from multiple sources which is analyzed as one data set for comprehensive understanding of the research question (Patton, 2002), is an accepted process in qualitative studies in the social sciences. The data analyses techniques in this study were threefold. They address the visual, verbal, and monetary aspects of the program. They have been chosen so that each satisfies a crucial area of the research question, thereby allowing for a thorough understanding of the question.

The qualitative content analysis addresses the verbal and visual part of the research inquiry. Using data analysis software (QDA Miner 4.1.12), key elements from each case are elicited to form categories as they pertain to the designed environment, program structure, and gender. Other significant areas, should they emerge, will also be discussed.
The verbal part of the data set includes: notes from interviews, discussions and observation, documents and reports shared by the clinic, and. Location maps and images at both micro and macro levels\(^{15}\) (taken onsite during site visit) form the data set for the visual analysis. The idea of the visual analysis is to tell us what the categories (extracted from literature) and the data (and content analysis where relevant) mean within the physical setting of each case study; it also shows if there are other areas of the designed environment that might help to understand the relevance of the designed environment to the value-creation process.

Frequency distribution, co-occurrence analyses, and cross-case comparison were performed within each theme. Based on both literature and a first sweep of the data itself, codes and categories were created from the issues that were thought pertinent to the research question. These codes and categories were assigned to the verbal and visual data set for further data dissemination.

Co-occurrence analysis was done to see the similarity and diversity among data sets. Using QDA Miner 4.1.12, Jaccard’s co-occurrence co-efficient\(^{16}\) analysis was run to examine which of the codes occur in closer proximity to one another. Jaccard’s co-occurrence was used over other options available since this method is known to be rigorous for sorting non-parametric data (Real & Vargas, 1996). This form of data sorting was useful in bringing out the relevance of areas to one another and ultimately helped to better understand the research question. Additionally, cross-case frequency analysis was done to see how codes were

\[ J(A, B) = \frac{|A \cap B|}{|A \cup B|} \]

\(^{15}\)Micro level photographs include interior images and images eking out specific characteristics like a signage board. Macro level images include images from across the street, or images that captured a panorama of activities.

\(^{16}\)Jaccard’s similarity coefficient is a statistic measure used to compare the similarity and diversity of finite sample sets or codes. It is defined as the size of the intersection by the size of the union. The similarity co-efficient lies between 0 and 1 for a finite sample set, 1 showing greatest similarity between codes and 0 showing no similarity. Formulaic expression would be
distributed across the four cases, whether there were areas considered important by all, whether there was disparity among cases, and so on.

These forms of data analysis were chosen to give a better understanding of what factors made an impact from the program giver’s point of view, the relevance of the factors to one another, and how they fared across programs within the same theme. While statistical validity was not a primary aim of the study, and the data rich in qualitative content, statistical dissemination was considered necessary to give the reader a clear understanding of what issues made a showing when sorted into categories and frequency-wise, what issues were considered important by program givers. Textual analysis was also used to sort the data into logical clusters, further helping to explain the relevance of these factors to the research question.

In order to best understand the monetary impact of the social programs, to understand what kinds of investment are required to implement a social program, and what kinds of results could be expected over a finite timeline, a Social Return on Investment (SROI) analysis was performed. Running on the lines of a typical Return on Investment (output divided by input), the SROI enables monetization of all inputs and outcomes giving an estimate of what the return on a dollar might be for the clinic. Further, an SROI enables isolation of costs, allowing monetization of non-monetizable elements to help understand what the outcome would be if every element were to be monetized. It also allows for accounting for elements that are simply not monetizable yet have a role to play in the final outcome.

The outcomes from these qualitative and quantitative analyses were assessed in conjunction to give a better understanding of the role of the physical environment in supporting social programs thus offered by clinics.
4.10 Code-Categories

Based on literature and a cursory look at the data, categories were created to reflect the environment (space and behavior related), program related (operation, structure, entrepreneurial related), gender related (tangential to both environmental and program) as well as third spaces, which was a surprise outcome. A preliminary sweep of the interview and observation notes led to the conclusion that there was sufficient information pertaining to spaces that either did not have a defined function or were used for activities beyond what was envisioned for them. These spaces were used by some for social interaction, while others used the spaces for quiet solitude and introspection; sometimes the same space was used for both social interaction and solitude, depending on the users’ thought process at the time. It became impossible to ignore this aspect and further research in this area led to the creation of a separate category called Third-Space ideology.

The basic premise of third-space theories (Oldenburg, 1989) are that neutral spaces that are separate from home and work facilitate interaction and create social bonds. These are spaces where people can meet, share ideas, and just spend time without judgment or other prejudices. The ideology has been expanded over the decades to include any space that people use for respite and relaxation. In fact, there is scholarship that suggests places such as libraries are third spaces because students and the extended community can learn and interact there (Montgomery & Miller, 2011). There is even literature that suggests smaller areas within larger spaces could be considered as third spaces—seating, shelter, scope for personalization and permeability (Mehta & Bosson, 2009).

These four categories (environment related, program related, gender, and third space related) were used across both data sets and, whilst individual codes under these varied, the main categories were kept even in order to ascertain a level of logic and rigor for the study.
4.11 Primary Research Logistics

A map (Figure 4-3) and a matrix (Table 4-6) have been created summarizing the size, scale, timeline, and scope of the entire primary research process. The map tells the reader the exact location of each site while the matrix gives more specific information regarding number of interviews, etc., at each location.
Figure 4-3 Case study locations in the U.S.A. with time lines of visitation.
<table>
<thead>
<tr>
<th>Name of program</th>
<th>Where</th>
<th>What was studied/observed</th>
<th>When</th>
<th>How long (hours)</th>
<th>How many discussions</th>
<th>Discussion Details</th>
<th>Misc. information</th>
</tr>
</thead>
<tbody>
<tr>
<td>House of Marcy Homeless Center</td>
<td>Janesville WI</td>
<td>The entire center- public and private spaces</td>
<td>May 2013, Nov 2014</td>
<td>4</td>
<td>6</td>
<td>3 discussions in May 2013, 3 in November 2014</td>
<td>The lounge area as of the 2013 visit was remodeled to incorporate new offices and a volunteer rest/sleeping area and kitchenette</td>
</tr>
<tr>
<td>Kaiser Permanente Farmers markets</td>
<td>Santa Rosa CA</td>
<td>Farmstand in the covered boulevard connecting the two main blocks</td>
<td>June 2013</td>
<td>3</td>
<td>3</td>
<td>1 with market champion, 1 with vendor, 1 with landscape consultant on-site</td>
<td>Entire hospital complex (including indoors) was toured as interviewee wanted to explain the theme of healthy eating reflected everywhere</td>
</tr>
<tr>
<td>Oakland CA</td>
<td></td>
<td>Discussions only</td>
<td>June 2013</td>
<td>4</td>
<td>2</td>
<td>1 with the doctor who started the farmers market initiative, 1 with the food sustainability manager</td>
<td>Additional phone interviews were conducted with personnel from the Community Benefit department and information sought from the facilities management department regarding market layout requirements</td>
</tr>
<tr>
<td>Fresno CA</td>
<td></td>
<td>Entire market on the side patio, proximity to parking/loading/unloading of produce by vendors/setting up and taking down of booths</td>
<td>June 2013</td>
<td>4</td>
<td>7</td>
<td>1 with market champion, 6 with vendors</td>
<td></td>
</tr>
<tr>
<td>Oakland CA</td>
<td></td>
<td>Entire market on the sidewalk outside the Fabiola building</td>
<td>June 2013</td>
<td>3</td>
<td>2</td>
<td>1 with market champion and 1 with market manager</td>
<td></td>
</tr>
</tbody>
</table>
Table 4-6 Matrix showing case study details: Places visited, Time spent, Interview time and Observation hours (Continued)

<table>
<thead>
<tr>
<th>Name of program</th>
<th>Where</th>
<th>What was studied/observed</th>
<th>When</th>
<th>How long (hours)</th>
<th>How many discussions</th>
<th>Discussion Details</th>
<th>Misc. information</th>
</tr>
</thead>
<tbody>
<tr>
<td>House of Mercy Transition Home</td>
<td>Des Moines IA</td>
<td>Non-treatment and non-residential areas i.e. common lounges,</td>
<td>Sept 2013</td>
<td>3</td>
<td>4</td>
<td>1 with program director&lt;br&gt;3 program staff</td>
<td>No access was granted to the private residential quarters of the residents or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>corridors, niches, garden/ outdoors, dining space</td>
<td></td>
<td></td>
<td></td>
<td>hold areas, support center</td>
<td>treatment areas</td>
</tr>
<tr>
<td>Windsor Connection and Resource Center</td>
<td>Windsor VT</td>
<td>Entire center</td>
<td>Sept 2013</td>
<td>4</td>
<td>3</td>
<td>1 with clinic personnel in charge of community initiatives and&lt;br&gt;1 with day manager&lt;br&gt;2 program staff&lt;br&gt;1 program logistics consultant</td>
<td></td>
</tr>
<tr>
<td>McAuley Residence, transition home</td>
<td>Portland ME</td>
<td>Entire residence-common spaces and private apartments</td>
<td>Oct 2013</td>
<td>4</td>
<td>6</td>
<td>1 with clinic personnel in charge of community initiatives and&lt;br&gt;1 with day manager&lt;br&gt;2 program staff&lt;br&gt;2 with Housing Support agency</td>
<td></td>
</tr>
<tr>
<td>Sambhavana Trust Clinic</td>
<td>Bhopal, Machhia</td>
<td>Third spaces- patios, verandahs, courtyards, walls and garden</td>
<td>Dec 2013</td>
<td>7</td>
<td>6</td>
<td>1 with manager and librarian on site&lt;br&gt;6 discussions with support staff&lt;br&gt;1 volunteer on-site</td>
<td>The entire campus including treatment areas was toured as interviewees wanted to&lt;br&gt;show the influence of local culture and vernacular architecture</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>31</td>
<td>39</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.12 Measures to Ensure Research Quality

This topic does not fall into the category of theory testing. While the approach is descriptive and illustrative of how a physical resource can be utilized positively to create social value, this is a building block study (George & Bennett, 2005), the main purpose of which is exploration. The process of an explorative study is similar to an explanatory study wherein the data from the case study is examined within the analytical frame to build an explanation of the subject or phenomenon. However, in an exploratory study, the end product is often hypotheses generating, not concluding a study but generating ideas for further study (Yin, 2014).

The basic nature of an exploratory study is such that one does not really know the entire nature of the case setting (Miles & Huberman, 1994). Further, this is a nascent area of inquiry with a paucity of scholarly articles and other forms of published material. The absence of comparable studies makes it that much harder to establish credence to the work done in this study. This does not mean that the topic of inquiry cannot be explored with a set of measures across cases that highlight the significant elements of the subject (case) in a manner that lends credibility to the topic, leading to broad-based generalizability.

The study seeks validation with respect to the relevance of a resource-based strategy (utilizing the physical environment) wherein overt and covert factors of that resource could contribute positively in value creation so that the final value accrued benefits the community as well as the parent organization. The study aims for external validity (i.e., whether the findings could be generalized to other settings, other types of programs, other program givers, and even another resource base).

Several measures have been put in place to ensure the validity of the research. Data collection methods have been kept even across case studies. The same set of criteria has been used for selecting all cases (Table 4-1, Case study criteria matrix). Questions for interviews remain focused on a few core areas (Table 4-5) and have been kept even across
settings. Each case is disseminated following the same steps (Section 4.8). This has been done to ensure whether each case has sufficient elements that answer both space- and program-related issues. And finally, code categories have been kept broadly the same for both themes. The codes are an outcome of both literature and the data itself. Finally, both themes are being examined for the relevance of the designed environment in the creation of value.

In addition to answering the primary question, the idea of the study is also to give viable options to the healthcare facilities should they wish to pursue space–based, social programs. Each community, each case, and each supporting clinic is different and unique in its own way. However, each case in this study has been chosen owing to the centrality of space and their success in addressing a pressing social need, thereby creating benefits to their supporting clinic. Data measurement tools that are even across cases, analyzed under categories (and codes within), and that are close, if not the same, lends a great degree of generalizability of the topic.

Additionally several steps were taken to ensure the reliability of the data. This was particularly necessary because this is a nascent area of inquiry and the interviewees were unfamiliar with this study. Therefore, information outlining the study and broader questions were sent ahead of onsite visits so that interviewees could be better prepared. Further, similar sets of queries were posed to more than one program or clinic staff and to the same person at different times during onsite interviews as well as subsequently through emails. Any area that contrasted among interviewees was repeated and clarifications were sought. Finally, with issues that pertained to the built environment, wherever possible, in addition to words and images, a third form of inquiry (observation) was used to verify the responses.

Chapters 5 and 6 detail the case studies pertaining to the two themes of food and shelter, analyzing them, and briefly presenting the findings.
Chapter 5.0: Theme 1- A Food and Nutrition Based Solution, Farmers’ Markets

Let food be thy medicine, thy medicine shall be thy food

—Hippocrates

The farmers’ market initiative by the Kaiser Permanente group is a unique program through which the clinic creates access to fresh food for the community. These markets are offered on or adjacent to some of their clinics nationally across fifty (and counting) locations countrywide. Further, another fifty plus non-Kaiser hospitals are known to have replicated the model. Visible and with a clear association to the clinic, these markets offer fresh food choices in the form of fruits and vegetables, prepared food, and other items like flowers and dairy produce, locally sourced at most locations. The markets are open to the entire community, not just employees and patients.

The study identifies three different market types offered by three different Kaiser Hospitals in northern and central California. This chapter details the three case studies according to criteria that bring out both environmental and organizational issues (see section 4.8), which have been analyzed and the results presented toward the end.

Observation, interviews, and visual data were all focused on the physical environment so as to best answer the research question—can the designed environment positively support the creation of a socially sustainable framework as offered by a clinic to the community where both benefit? (Refer Figure 4-3 and Table 4-6 for location and logistic details of each case study.)

Description: The Kaiser Permanente (KP henceforth), a national (American) health system, chain of hospitals, and ambulatory care centers, that has the following as its organizational mission: “Kaiser Permanente exists to provide affordable, high quality healthcare
services, and to improve the health of our members and the communities we serve,” (Kaiser Permanente, 2014). KP has several health and wellness initiatives as part of its organizational and operational philosophy. As an HMO (Health Maintenance Organization), it is in KP’s self-interest to keep its members healthy, there are many ventures that KP undertakes that are open to the general community, whether they are KP members, patients, staff, or not. One such initiative is the farmers’ market that as many as fifty of the Kaiser hospitals have undertaken over the last decade, starting in 2003.

**Operational model of the markets:** Each market has a market champion, someone from within the Kaiser hospital (any position, not necessarily a nutritionist) who is passionate about the fresh local food movement. This person oversees the market from vendor and suppliers, to permits, to cost procurement, to safety regulations, to publicizing the markets. “This is not a top-down activity but something we do because we think it is right. And so anyone in any of our hospitals who have that discretionary energy and passion can become a market champion,” says Dr. Preston Maring, the OB-GYN who started the first market at the Oakland, California clinic in 2003. Maring provides strategic advice to any Kaiser hospital interested in setting up the markets. In addition, he has helped many non-Kaiser hospitals in understanding the nuances of setting up these markets.

Based on information and advice provided by Kathleen Reed, Food Sustainability Manager for the Kaiser Permanente system (at the time of writing this dissertation), three locations were chosen that answered to most of the selection criteria. In addition to criteria as listed in the previous chapter, availability of personnel on the market floor to explain market nuances, day of the week and time, character of the market and type of market (will be explained shortly) were some of the other criteria for selecting the markets.
5.1 Case Descriptions

5.1.1 Santa Rosa, northern California

The market here was started in 2003. This is more a farm stand than a market, which means that a single farmer displays his wares rather than a number of farmers or vendors with a number of stalls as would be expected in a full market.

**Location and access:** This market is located inside the hospital compound under a covered walkway connecting two buildings (Figure 5-10). The hospital is located mainly in a business area. At the time of visual observation (June 2013), there was construction activity inside the campus hampering full-fledged operation of the farm-stand, leading to a reduction in foot traffic from employees of neighboring businesses. The market runs one day a week (Monday at the time of writing) from 8 a.m. until 2 p.m. with fruits and vegetables grown less than ten miles away, picked that morning and on display. The entire length of the covered walkway is dotted with posters and samples of crops of vegetables and fruits with information on their nutrition as well. There are food and recipe demonstrations in the walkway and nurses use the market time to give out information about public health, blood drives, and so on. There is no overt mention of becoming a Kaiser member or anything that falls in the realm of attracting new members or patients.

The walkway is roughly 8 feet wide allowing for the stand to be set up along one side and for buyers to walk comfortably without impeding hospital activities. The entrance and exit of both wings that the walkway connects is kept clear of any market merchandise.
The activist: Samantha Reslock, the market champion at Santa Rosa, is also a fresh-food activist and takes personal responsibility in making sure the stand runs on time, has produce that is season, and so on. She creates food themes that run throughout the hospital and fun, food-related games for kids (and adults) inside the hospital that patients and visitors can browse as they wait (see Figure 5-8). The upper floor café has fresh fruit and vegetable plants in planters that employees can pick and add to their salad or meal (See Figure 5-9).

While this facility (i.e. the café) is open only to employees, patients, and visitors, Reslock says the café, just like the farm-stand is an extension of the fresh-food movement. “Northern California, especially the Santa Rosa area, grows a lot of fresh fruits and vegetables; and so I want everyone in the community to understand its importance. After all, employees are part of our community too,” she says.
She concedes that access is a bit of a problem to the Santa Rosa farm-stand, which is further impeded by parking problems. However, she believes that given the local culture in NCA revolves around fresh food, the stand goes a long way in ensuring fresh food is on people’s minds. Reslock also believes that the markets further the Kaiser mission. “Kaiser takes wellness seriously and the markets are a visible way of demonstrating this.” She added that the stand at Santa Rosa was not closed despite construction and inclement weather (at the time of on site visit).

5.1.2 Fresno, central California

The market was started in 2005. This market is among the larger markets with over 50 vendors. This is a direct market because the hospital deals directly with each individual vendor. The market champion in this case, therefore, has greater commitments in terms of time and effort as she has to maintain contracts, permits, etc. for every vendor.

Location and access: the market is located within the Fresno KP campus, on the entrance patio of the north entrance. The Fresno campus is located in a mixed neighborhood of homes and businesses. It is a large hospital campus with abundant parking and access to the market is prominent, highly visible, and easy to navigate. There are banners on the hospital compound overlooking the street on market days. The walkway space between stalls is adequate, measuring over 6 feet in average, allowing buyers to browse comfortably on both sides as they walk. The aisle leading to the main hospital entrance is approximately 12 feet and 6 inches wide.
Figure 5-2 Shows the map of Fresno Kaiser Campus with market indicated in purple, the patio at one of the side entrances to the clinic. Despite three bus stops, the typical buyer apart from employees and patients walks to the market rendering access to public transport a not an issue for consideration. Neighborhood is a mixture of residential and businesses. (Map courtesy: Google Maps)

According to the market champion (see below), there is plenty of seating, a gazebo with creepers above to provide shade, music from satellite radio, and electrical outlets for hot and cold foods has all been provided to give a real farmers’ market experience for the users (see Figure 5-11, Figure 5-12). Since the wares sold include prepared food, attendance is higher at this market, especially around lunch time. The presence of several places of employment within walking distance from the campus has added to the popularity of the market.

The strategist: Market champion Meredith Murillo has adopted a more strategic and entrepreneurial approach in running this market. “Despite fresh food being grown in central California, the irony is that farmers find it more profitable to travel 200 miles and sell it in the bay area,” she says. Murillo adds: “There are not many farmers’ markets in this area, and so this market has an added significance.” While emphasis remains on access to fresh food, she
has created a comprehensive market that includes prepared food, pet food, storable food (like honey), and so on. She has successfully found funds (from the public affairs department) to widen the market patio area by an additional ten feet, installed electrical outlets to increase the types of foods that the market can offer. She garners publicity for the market by tapping into contacts at the local television station to do food-related reports from the market premises now and then.

Murillo further says that the market adds value to the Kaiser brand, lending it legitimacy as a local clinic. When started in Fresno in 2005, Kaiser was seen as a big, Oakland corporate hospital that would not do much for the locals; but the market has helped break some barriers, letting the people know they care about wellness of the community—both by creating access to fresh food as well as with generating business for local farmers, which has helped to shorten the supply chain from grower to consumer. This initiative is clearly not just about patient and member procurement.

5.1.3 Oakland, northern California

The Oakland market was the first of the Kaiser farmers’ markets started in 2003. It is the country’s first hospital-based, organic, fresh food market says its founder Dr. Preston Maring. The market is run by the Pacific Coast Farmers’ Market Association (PCFMA), which provides strategic intelligence on location, choice of vendors based on buyer profile, and negotiates terms with the vendors on behalf of the hospital. The clinic provides the space (in this case, just the sidewalk outside the clinic, but the clinic worked with the local authorities to get the necessary permits) and the market champion works toward generating publicity and interest in the market within the community and clinic.

Location and access: The market is located along the sidewalk directly in front of the main building of the Oakland Medical Center, the Fabiola building. It is located in a mixed neighborhood of businesses and homes. At the time of writing, the market operates from 10
a.m.–2 p.m. on Fridays year round. Comprised of about 25 vendors, the market sells wholly organic and locally-grown produce. The sidewalk measures about 8 feet in width, allowing just enough space for vendor stalls, buyers, and regular commuters. There is a bus stop right in the middle of the market strip and a bench for seating which compounds the space issue further. There is plenty of publicity provided for the market with signs and banners on either end of the road reminding community members of the market (see Figure 5-13). Most community members walk to the market from nearby residences.

As with the Santa Rosa market, parking is a problem here as well. Despite there being a multi-tier parking lot directly across from the Fabiola building, observation revealed that lower-level spots were reserved for physicians, employees, and patients, while other community members have to park on the higher levels. Market manager on site suggests that given the time quotient in traversing all the levels to get to the market and small size of the market, the market suffers from less non-patient and non-employee traffic than some of the other hospitals. The market does not need electrical outlets for any of its vendors and, hence, setting up and dismantling stalls takes shorter time.
The role of space for the three markets

- According to Dr. Maring, the man who started these markets, location holds the key to a market’s success. This thought is echoed by the Food Sustainability manager as well as the market champions. They all emphasize that it is important for people to be able to see the market and its colorful produce as they drive or walk by in order to motivate them to stop and try it.

- There is a Kaiser policy that all markets should be ADA\textsuperscript{17} compliant. This means that there must be sufficient space for a wheelchair to move easily and to turn around at the end of each aisle if the space is not possible in the middle.

- There must be space to easily off-load and reload produce into the stalls and onto trucks or vendor vehicles with as little turnaround time as possible so as to not impede hospital activity.

- Vendor vehicles must be parked as far away from hospital parking as possible so that they do not take up patient spaces and so that their trailers and other such items do not impede patient movement.

- The clinic has streamlined these issues by creating a design guide booklet for individual hospitals that intends to set up a market.

Other challenges

- Kaiser personnel note that the majority of market buyers are employees and members (patients). Individual hospitals are trying harder to get more non-KP community members to use the market. An internal policy prevents any activity from being counted under the community benefit quota if the activity’s primary users are 50\% (or more) employees or

\textsuperscript{17} ADA = Americans with Disability Act. Signed into law in 1990, the law prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services. (Department of Labor, accessed January 2015)
staff—however beneficial the activity is to the community. This has meant that none of the KP hospitals use the markets toward the safeguarding of their tax-exempt status. Though, efforts are being made to encourage more community members to benefit from the market. Some of KP’s strategies to boost community involvement include bussing senior citizens from the senior citizen center to the market and back, getting school kids involved, and so on.

- General reasons attributed to fewer community members than employees, patients, and staff attending the market (based on discussions with various KP personnel involved in the market operations) include lack of on-site parking, neighborhood and location of the hospital itself, and timings of the market (the fact that the market runs on weekdays only).

- Oakland personnel gave an additional reason for lack of community attendance at the market: there is a farmers’ market every day of the week within a 10-square block area. Whilst this is advantageous in that local culture is amenable to farmers’ markets, it also means people have plenty choices and can choose one that is more convenient for them.

5.2 Research Findings

QDA Miner 4.1.12 was used for both verbal and visual analysis. Notes from interviews, discussions, documents, reports, and observation was uploaded into the software and various analyses were run to examine the role of the physical environment as it aided the creation of a value base to both clinic and community. In addition to interviews, etc., on-site and documents procured form the clinic, the verbal data included interviews with three key personnel within the Kaiser Health System who are actively responsible for the inception, structuring, and operation of the markets regionally and nationally.

Codes that that resulted from both literature and the data sets were assigned manually to sentences or phrases and assigned to four categories. This information is compiled in Table 5-1.
Table 5-1 Matrix shows various codes and categories for Theme 1: Healthy Eating

<table>
<thead>
<tr>
<th>Environmental factors</th>
<th>Program related factors</th>
<th>Third space ideology</th>
<th>Gender related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Program planning</td>
<td>Permeability onto street</td>
<td>Women as majority buyers</td>
</tr>
<tr>
<td>Visibility</td>
<td>Activist / strategist Identity</td>
<td>Neutral spaces</td>
<td></td>
</tr>
<tr>
<td>Pedestrian scale</td>
<td>Benefits all round</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-issue of public transport</td>
<td>Benefits to the clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Approach</td>
<td>Mission alignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power of space/place(^\text{18})</td>
<td>Partnering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social design(^\text{19})</td>
<td>Negligible costs</td>
<td>Social Bricolage(^\text{20})</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand association (visual analysis only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proximity of target catchment (visual analysis only)</td>
<td></td>
</tr>
</tbody>
</table>

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\(^\text{18}\) **Power of space and place** codes address those spaces that were described to include phrases such as ‘feeling of peace,’ ‘spaces allowing for communication and solitude,’ ‘the space brings a sense of equality’ and so on, that stood out during the interviews as poignant factors yet not falling under any predefined socio-spatial characteristic. (For example: the side aisles in the markets.)

\(^\text{19}\) **Social Design** codes include: local approach, small scale, and participatory planning

\(^\text{20}\) **Social Bricolage** codes include: making do with what you have, persistence, negotiation, innovative thinking, and stakeholder participation
Figure 5-3 Screen shot of a location map of the Kaiser Fresno clinic with code markups on QDA Miner 4.1.12 as part of visual analysis. (Image courtesy: A Saligrama)

Figure 5-4 Screen shot of an open interview notes document with code markups on QDA Miner 4.1.12 as part of the verbal content analysis. (Image courtesy: A Saligrama)
Figure 5-5 Sector graph above shows the frequency of all the codes across all cases.

Co-occurrence Analysis

After running several iterations and combinations, a five-cluster separation searching for code co-occurrences within a five-paragraph range yielded optimum results. The results were captured in a dendrogram, showing links of strength between the codes as shown in Figure 5-6.
Cross-Case Analysis

In a bid to create external validity, a cross-case frequency analysis was done to see how the same codes fared across the three markets. Figure 5-7 shows how the codes are distributed across the three cases. The sizes of the bubbles show frequency.
**Code frequency for FILE**

<table>
<thead>
<tr>
<th>Category</th>
<th>KP_Fresno</th>
<th>KP_Oakland</th>
<th>KP_Santa Rosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visibility</td>
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<td>Pedestrian Scale</td>
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<td>Non issue of pulic transportation</td>
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<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local culture/norm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power of space/place</td>
<td></td>
<td></td>
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<tr>
<td>Social Design</td>
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<td>Program planning</td>
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<tr>
<td>Activitv strategist</td>
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<tr>
<td>Benefits all around</td>
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<tr>
<td>Benefits to clinic</td>
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<td>Mission alignment</td>
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<td>Partnering</td>
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<td>Negligable costs</td>
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<td>Social Bricolage</td>
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<td>Permeability onto street</td>
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<tr>
<td>Neutral spaces</td>
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<tr>
<td>Women as majority buyers</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>women and income</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Colors legend:**

- **Red**: Environmental factors
- **Green**: Program related factors
- **Purple**: Gender related factors
- **Blue**: Third Space ideology

Figure 5-7 Bubble chart shows all the cases and codes, sorted by color and size for category and frequency. Larger the frequency, larger the bubble size.
5.3 The Outcomes of the Content Analyses

Social Design and Social Bricolage

The market that is at pedestrian scale, in the community’s eye line has the most chance (sic) of succeeding even if it is not the biggest or has the fanciest fare.

—Market manager, representative of Pacific Coast Farmers’ Market Association

Areas of Social Design and Social Bricolage rated high in frequency distribution and showed high similarity with one another. This analysis included issues such as inclusive design and importance of stakeholder involvement. A co-occurrence co-efficient of 0.7 in textual analysis meant elements pertaining to these two areas overlapped significantly. Given that the interviews, discussions, and documents were all from the program giver’s point of view, the high similarity also gives an insight into the priorities of the decision makers.

Further, if one were to examine the documents that contain interview notes of some key Kaiser personnel who are actively involved in the farmers’ market program across all locations (the food sustainability manager, the Community Benefit department personnel, the doctor responsible for starting the markets initiative), one sees a significant amount of their responses revolving around both Social Bricolage and Design factors.

Gender based codes

Women definitely are major buyers here.

—Market manager at Kaiser Oakland

I would say it is equal, I do not see one gender tipping more.

—Farm stand owner at Kaiser Santa Rosa
There was no conclusive evidence that the market was used mostly by women from the statistical analysis. Women did not fare high in terms of frequency, meaning they were not mentioned in the interview or discussions. Observation, however, showed women buyers outnumbered men; but since user interaction, counting, etc., was not permitted, this could not be corroborated.

**Third spaces**

If we had more space to sit around, there would be more people here; we are trying to incorporate seating somehow.

—Market champion, Kaiser Oakland

The gazebo and seating underneath provides the perfect backdrop for the market. Many take their lunch here, and just buy fruit from me. That is also good.

—Vendor at Kaiser Fresno

Third-space codes find mention in each case study. Third space factors of seating and shelter were also strong on the overall distribution, accounting for a combined 16% of all codes. Seating was quite visible at Fresno and Oakland where the markets are more colorful and have a larger number of vendors, thus encouraging people to stay longer as opposed to Santa Rosa, which has a single, farmer-owned farm stand. However, there was sufficient attendance at Santa Rosa too, where the market champion said employees often took lunch, especially when demonstrations were done at the market. A combination of times the markets run (during lunch time when buyers tend to stroll, sit down, and want to have a bite), the need to protect the produce, and the need to support other activities like demonstrations and informal talks can be considered as reasons for why seating and shelter were considered...
essential by the interviewees as well as the food sustainability manager who oversees all of the markets nationally.

**Local culture, Organizational legitimacy**

Farmers’ markets are part of our lives here in the bay area. In Oakland, there is one every day of the week, if not more. We are extending that thinking here as well.

—Market champion, Kaiser Oakland

The influence of local culture in contributing to program success was mentioned repeatedly in each case study and in each discussion. Farmers’ markets are something ingrained into the way food distribution and procurement is understood by communities in Northern California. Therefore, when the clinics began to offer the markets, there was no need for the clinic to educate the community about what a farmers’ market is, how it operates, etc. Instead of focusing on teaching the community about the benefits of farmers’ markets, they could focus on other things like popularizing the market, expanding the idea to include cooking demonstrations, and so on.

This is in line with literature from both environment behavior and organizational strategy management. While the former talks about the importance of local culture as reflected in the program environments to create a meaningful experience, the latter talks about the importance of the same in order to capitalize market share with as little opposition from the buyer segment as possible. If one is already familiar with the concept, offering it in a convenient manner to the community would make things much easier to the parent organization, as opposed to creating a new segment by starting with educating the community as to what the product is (the farmers’ market in this case) and then going about turning the community into prospective buyers. While this is not impossible, it takes considerable resources (time, money, labor, etc.) to get there.
Social programs are naturally resource strapped, thus offering a program that the target audience is already familiar with reflects innovative thinking, while still making do with an existing idea. The use of innovative thinking and capitalizing on an existing idea are both critical components of social bricolage.

Public Transportation

I have never seen anyone come specifically to the market by bus. I can’t say no one ever ever (sic) comes but I am quite sure that’s not the case. Most of our community buyers are foot traffic.

—Market champion, Kaiser Oakland

There was a prominent presence of public transportation across the three sites. Each of the markets has a bus stop within a block. In fact, the Oakland market has a BART (Bay Area Rapid Transport, tram system of the bay area) shuttle right in the middle of the market strip. However, every interviewee held the opinion that market buyers do not use the bus for the purpose of market shopping. Attendees are mostly foot-traffic from the community that makes up the non-patient and non-employee faction of the buyer demographic. They are either residents or office-goers from nearby businesses that walk to the market. While the interviewees could not rule out with a 100% certainty that no shopper at the market took the bus, their understanding of the buyer demographic combined with the local culture of the place led them to deem public transportation as a non-issue. Further, the market location (closer to the clinic) and timings (weekday mornings) were inconvenient for the community to arrive by bus (see section 9.4.3 for a full discussion on the role of public transportation in this study).
Brand Association

There is no direct clinic activity here. We do give out information about blood drives and so on. But this (the markets) is a Kaiser initiative and we are proud to be associated with this; our banner is up there at the markets in most places. Even our market publicity material has the Kaiser logo.

—Market champion, Kaiser Fresno

Brand association (13%) was yet another area that sits closely with benefits to the clinic. Images that showed the market activities in close physical proximity to the Kaiser brand (name, logo, the clinic building itself) were all marked under this code (see Figure 5-13, Figure 5-14). How closely and how visibly a clinic is associated with the social program it is supporting goes a long way in strengthening ties with the community. The Kaiser markets have become a national phenomenon and personnel say it has been nothing if not a positive, fruitful association for them. It is important for them to be seen as someone who does not just talk-the-talk but walk-the-talk as well.

Location, access and visibility

Whoever said location, location, location was so right. That is the most important thing about our markets. We want people, everyone in the community, to see it so they can then come in and benefit.

—Dr. Maring, OB/GYN who started the farmers’ market initiative at the Kaiser clinics

Visibility, both from street and within campus rated high (accruing a combined 16% of all codes) in corroboration with the verbal analysis. The same was true in the visual analysis, with visibility factors accruing a total of 15.4% of the frequency distribution. Access and visibility
showed the highest similarity with an index of 0.7. This concurs with the information from the interviews and discussions where each member spoken to insisted on the importance of location and being seen as critical factors for market success.

5.4 A Visual Representation of Outcomes

Figure 5-8 Consistency of mission, activist, and strategic maneuver: Kaiser Santa Rosa, California. The healthy living ideology of Kaiser is taken into the clinic as well; here we see information about lentils with samples displayed in the café and lobby area. (Image courtesy: A. Saligrama)
Figure 5-9 Consistency of mission/activist and strategic maneuver: Kaiser Santa Rosa, California. The healthy living ideology of Kaiser is taken into the clinic as well; here we see salad plants and herbs in the cafeteria. Despite being for employees only, the market champion believes this creates a consistency of mission. (Image courtesy: A. Saligrama)

Figure 5-10 Third spaces: Kaiser Santa Rosa California. Covered walkway doubles as a farm stand every Monday (Image courtesy: A. Saligrama)
Figure 5-11 Visibility, seating, and shelter in public spaces enhances usage: Kaiser Fresno. Wide patio allows for plenty of display space in a prominent location with ample space for circulation between aisles at Kaiser Fresno, California. (Image courtesy: A. Saligrama)

Figure 5-12 Visibility, seating, and shelter in public spaces enhances usage: Kaiser Fresno. Covered seating allows for users to sit and relax, have lunch or coffee from the market or simply just take a break as they take in the market at Kaiser Fresno, California. (Image courtesy: A. Saligrama)
Figure 5-13 Publicity to enhance usage: Kaiser Oakland. Information board indicating the market on either end of the road where the market is located at Kaiser Oakland, California. (Image courtesy: A. Saligrama)

Figure 5-14 Brand Association: Even though there is no direct clinic activity at the markets, there are several ways in which Kaiser ensures brand awareness. For example, hand fans given out at the markets have the Kaiser logo and market details printed on them. (Image courtesy: A. Saligrama)
Figure 5-15 Positive brand association and visibility: Kaiser Oakland. The market on the sidewalk allows for high visibility and easy access to the (mostly) foot traffic of buyers. Close proximity with the clinic makes the brand association with the market unmistakable. (Image courtesy: A. Saligrama)

Figure 5-16 Public transportation and access: A bus stop in the middle of the market hampers foot traffic even though it does not get in the actual way of market movement. Kaiser staff says despite the bus stop, the typical (non-employee/non-patient) buyer is not one who would take the bus just to get to the market, instead are those who live up the street and walk to the market, throwing light into the importance of understanding customer demographic. Location Kaiser Oakland, California. (Image courtesy: A. Saligrama)
5.5 Benefits from the Market

Community consumes more fresh food: The hospital system has conducted surveys to track the benefits from the market to the community. They are very candid and upfront in saying it is difficult to ascertain how the fresh food has directly benefitted the health of the buyers and, therefore, have not made that a parameter for impact study.

A survey conducted in 2012 about the impact of the market on the community produced some interesting outcomes. Market success was based on several other factors including those where over a third of members and visitor respondents said they schedule clinic visits on market days. Additionally, 74% claimed to eat more fruits and vegetables after being exposed to the farmers’ markets. Another 85% said Kaiser is helping to address the larger issue of wellness by hosting the markets\(^2\).

Local farmers/distributors benefit: Based on the success of the market at Oakland, Maring took the initiative inside the clinic in 2006. The Oakland Kaiser Permanente clinic worked with the local farmers and food distributors to ensure that a majority of the food used even within the clinic was locally sourced, taking less than 48 hours to get from the farm to the patient. This has given a boost to local farmers to grow more fresh food and, given that the Oakland clinic alone needs 250 tons of food every year, distributors have been ensured more business.

Less use of medical resources: Kaiser is a HMO (Health Maintenance Organization), they provide both patient care and insurance all under one umbrella. Kaiser has, therefore, a strong self-interest in keeping its members healthy. “It directly affects how we function as an organization,” says an officer of the Community Benefits department for Northern California. She concludes, “It’s in Kaiser’s advantage to keep our members and, by extension, our community out of the hospital and it also caters to their overall wellness.” This thought is

corroborated by Kathleen Reed, the Food Sustainability Manager for Kaiser nationally, who is responsible for overseeing all of the Kaiser farmers’ markets.

Further, nonmembers, non-patients, and the general community also benefit from access to fresh food. This reduces pressure on non-reimbursed care on a much broader level says the Community Benefit officer, concluding that every bit counts. "We take our community very seriously as it directly affects our tax status as a nonprofit organization," she clarifies. “We make sure we do everything we can beyond just charity care for uninsured and underinsured.”

In fact their initiatives for healthy eating stem from the intent to reduce the burden of charity care so that more revenue can be diverted to community building activities.

**Low cost (for the clinic):** In terms of money, it costs next to nothing to offer a market, says Samantha Reslock of Santa Rosa, but it makes a lot of difference to the image of Kaiser and to the community’s health. The maximum any clinic has had to pay nationally is $5,000 for a permit (at Fresno, incidentally). Some have invested more by procuring funds internally through some innovative as well as some old-fashioned tactics for market betterment (like raising an additional $10,000 for patio expansion at Fresno). Otherwise, the markets do not cost Kaiser any money. “The costs are next to none,” corroborates Reed, the food sustainability manager.

**Brand promotion:** Maring says the success of the market has even led to publicity images of Kaiser revolving around food from 2005 onward. “Our banners never say we have the best cardiothoracic surgeon or latest surgical equipment, our banners always talks about good health and [have] images of food” (see Figure 9-5).

All that is required of individual hospitals is to find the space--somewhere in a prominent location within or just outside the campus—and someone with the passion to start it, the rest follows. “In fact, even the size (of the market) does not matter, as long as there is enough space to offer a market regularly in a spot where people can see it,” Maring concludes.
Maring and the Oakland farmers’ market was featured in an HBO documentary “Weight of the Nation,”\textsuperscript{22} where he talks about the need to increase markets for fruits and vegetables as a means to reduce the obesity epidemic that is plaguing the United States. The documentary talks extensively about the Kaiser Markets and fresh-food procurement initiative, detailing how the markets have helped local food distribution plants. Since the markets phenomenon took off, Maring is regularly invited to lecture on the benefits of healthy eating at various events, including some for doctors. He even has his own channel on YouTube (“From Dr. Preston Maring’s kitchen”\textsuperscript{23}, where he shares recipes and other issues on healthy eating) sponsored by the clinic. All of these activities help to raise the clinic’s profile.

The Pacific Coast Farmers’ Market Association (PCFMA) that oversees many of the northern California Kaiser markets (in addition to several of their own) has increased its own profile and image after its association with the clinic. They are now seen as more responsible and involved in the procurement and distribution of fresh food and not just as food vendors. This was the general opinion of the Kaiser personnel interviewed as well as the PCFMA-appointed market managers on site at some of the markets.

Information about blood drives and so on is provided at the markets from time to time. Other promotional materials, including reusable bags and hand fans, are given out, all bearing the clinic’s name, thereby creating a link between the market and the clinic (see Figure 5-13).

**Strategies to safeguard tax status:** Kaiser is exploring various strategies to get more of the community to use the markets. The markets drive healthy eating; so, if the numbers were to rise, these markets could be accounted under Community Benefit by the health system. This would lead to a more tangible way of channeling the farmers’ market into Kaiser’s operational strategy.

\textsuperscript{22} http://theweightofthenation.hbo.com/watch/bonus-shorts/healthy-foods-and-obesity-prevention-increasing-markets-for-fruit-and-vegetable-farmers accessed January 2015

\textsuperscript{23} https://www.youtube.com/playlist?list=PLAB8E126B412F1A16 accessed November 2014
Currently, the markets make it into the Kaiser Permanente annual report as a Community Investment (Kaiser Permanente Annual Report 2013), clearly indicating Kaiser’s views on its association with the farmers’ markets.
Chapter 6.0: Theme 2- Shelter-Based Solutions, Programs of a Sensitive Nature for Low-Income Women

We're all human, aren't we? Every human life is worth the same, and worth saving.

—Kingsley Shacklebolt (author JK Rowling) in *Harry Potter and the Deathly Hallows*

This chapter describes and analyzes four social programs tailored to women facing low income and associated difficulties within a community. These are programs of a sensitive nature, catering to a specific subset of women who are in critical need of intervention to help improve their lives and, by association, the lives of their children. Ably supported by four clinics, these cases have been chosen from across the country as they display different characteristics from both environmental and organizational perspectives.

The chapter draws out similarities and unique aspects of the programs in order to understand the importance of both the designed environment and the operational structure. Due scrutiny is given to the role of the clinic as well. Each case follows the same structure for better understanding, the content of which is analyzed and briefly discussed at the end.

6.1 Case Descriptions

6.1.1 Windsor Connection Resource Center, Windsor, Vermont

The Windsor Connection Resource Center (WCRC henceforth) is a neighborhood resource center providing a range of social services to the people of Windsor Vermont and the surrounding area. It offers space for counselors (legal, mental, behavioral, occupational, etc.), meeting rooms, conference rooms, a free computer lab, phone, fax, and copier services (for
people—mostly women—looking for jobs). It also allows a free, local public-funded radio station to operate from a portion of the second floor.

### 6.1.1.1 History

The WCRC is a brainchild of the Mt. Ascutney Hospital and Health Center (MAHHC henceforth), which has had direct involvement in planning and setting up WCRC’s operations. Windsor lies between two social service networks, and, therefore is without certain social services within a 30-mile radius, such as DCSF (Department of Children, Schools and Families), Department of Corrections, and so on. A community needs assessment conducted by the hospital around 2000 showed several gaps in community welfare because community members did not have access to certain facilities and social services and traveling out-of-town was not feasible for these members.

### 6.1.1.2 Operational Model

WCRC is a part of MAPP (Mt. Ascutney Prevention Partnership), an affiliate of Mt. Ascutney Hospital and Health Center. WCRC runs as an independent organization for its day-to-day activities but is entirely reliant on MAPP (and, by extension, MAHHC) for funds and other operational strategies. Employees involved in the community wellness activities of the hospital find it part of their job to work with WCRC. Space procurement, program implementation, etc. required approximately $559,000. This was sourced through a series of community block grants and a town-revolving fund. The clinic has been able to negotiate a unique deal with the town and the Connecticut River Development Corporation (who owns the railroad and the WCRC building) that the loan only needs to be repaid if the clinic wants to purchase the title of the building for itself. Furthermore, annual operation costs come to $32,000, which the clinic foots, accounting it under their Community Benefit agenda.
Two part-time staff at the WCRC are currently paid through grant money which will run until the end of 2015. MAHHC says it is committed to keeping the place open, viewing this as a long-term investment. It was not revealed at the time of interviews, however, what measures were being taken to ensure continual procurement and disbursement of funds. Jill M. Lord, who is in charge of overseeing all community activities of the hospital, says WCRC is closely tied to MAHHC as they share a common mission—preventive and restorative care.

6.1.1.3 Location and Access

WCRC is located just off of Main Street on Railroad Plaza in Windsor, Vermont. The building is not visible from the main thoroughfare road (Main Street). There are plenty of parking spaces and easily accessible by foot from Main Street once the location is determined (which is important for returning visitors). However, the staff feels the building never runs to full capacity simply because many, even in this small town, don’t know about it. They consistently opined that a more comprehensive publicity campaign—not just signage—is required.
Figure 6-1 Shows a map of position of WCRC (in purple) relative to the main street. The hidden location means poor visibility. Staff at WCRC say the place is yet to reach full potential in terms of usage. (Map courtesy: Google Maps)

6.1.1.4 The Role of Space

- The L-shaped building has a simple layout with rooms laid out in a linear fashion following the footprint. The entire building is ADA\textsuperscript{24} compliant. A dedicated effort has been made to create efficient circulation. Services used more heavily are in the front and on ground floor, while services of a more sensitive nature are either toward the back or on the top floor.

- Efforts have been made “to make the place look comfortable and not like a charity place,” says Bissette, one of the two part-time managers on the site. Bright-colored walls and upholstery and placement of furniture that create niches for resting or reading are all part of

\textsuperscript{24} See footnote\textsuperscript{17} for details on ADA (Americans with Disability Act)
that effort. A strong, local flavor is also induced with tapestries, pictures of flowers, and fruits native to Vermont and Windsor adorning the walls (See Figure 6-13, Figure 6-14).

- WCRC is a converted, old railroad building on a budget and so finishing touches, including insulation, is not to the extent that staff and users would have liked. The manager explains that the exposed brick and concrete walls tend to get cold in the winter.

- Since structural changes could not be made, many private counseling rooms do not have windows. Some windows have been boarded up (it is not clear why). One mental health provider who was there to meet a client remarked on how the lack of direct sunlight and air could get stifling during long sessions (see Figure 6-11).

6.1.2 House of Mercy, Janesville, Wisconsin

6.1.2.1 Background

The House of Mercy Homeless Center (HOM henceforth), started in the late 1990s, and commonly known as House of Mercy, is a 25-bed homeless shelter for the general public (with preference given to women). While HOM is open to anyone with need, their clientele is mostly comprised of women and their children from southern Wisconsin and Northern Illinois. They are very particular about being called a center and not a shelter; in fact, for everyday purposes, it’s just called House of Mercy. “Even small things like what it’s called makes a lot of difference to the psyche of the residents,” says Richard Gruber, the vice president at Mercy Health Janesville who oversees this center. The on-site manager, Erin Loveland, reinforces the significance of the center’s name by explaining that the center offers several other types of assistance and not just a safe roof over their heads, thus making the word “center” more appropriate.
6.1.2.2 Operational Model

HOM is supported by the Mercy Health System in Janesville, Wisconsin. It is an independently registered nonprofit organization but considered a subsidiary of Mercy Janesville. It has two full-time and two part-time employees (all of whom are on the employee payroll of the hospital system). Rather than having a separate governing board, it is overseen by one of the vice presidents of the hospital. All financial reporting is done through the hospital’s accounts.

HOM operations amount to $200,000 each year. Administrators estimate costs at $25 per person, per day (including lodging, utilities, salaries of employees, etc.) excluding food expenses. The operational expenses are split among grants, donations, and fundraising done for specific projects. Volunteers are a critical part of running this center says HOM staff; with at least one volunteer staying the night, every night of the year. Volunteers put in a total of 7,000 hours annually. If HOM had to hire staff to do what the volunteers do annually, it would cost them an additional $61,000! The association with the center has been fruitful for Mercy Health System Janesville in many ways, including winning in 2007 the prestigious Malcolm Baldridge National Quality Award for their successful quality management systems.

In order to measure program effectiveness, the center has a 12-point self-sufficiency scale test that the residents have to complete, one when they arrive and one when they leave. This test is a point-based qualitative assessment tool. It includes such metrics as housing, income employment, mobility, physical health, mental health, and so on. The center says they have modest expectations from the test saying that an 11% increase across all 12 sectors would be a good target. “Currently we are at 13%, which is really good for a center our size,” says Loveland.
6.1.2.3 Location and Access

HOM is located in a lower- to middle-income neighborhood. It is a mixed-use neighborhood with mostly homes, a school, and smaller places of business. There is sufficient parking for the residents in an adjacent parking lot and with street parking. There is a bus stop a couple of blocks from the center. However, HOM staff members say that no one takes the bus to get around in Janesville. HOM is quick to clarify that this is not an issue since all residents over the years have owned cars. In fact, the origin of HOM is that in the mid-90s, the CEO of Mercy Health found that many women visiting the emergency room were listing their car as their address, which inspired him to start the HOM homeless center in 1996.

Being a program of a sensitive nature, the location works to their advantage say employees. Prospective residents, mostly women and children, apply over the phone, and come in for an interview only when HOM calls them—so there is no need for a main street presence. Furthermore, residents feel more assimilated into the community given that the center sits in a residential neighborhood and does not stand out as a charity home in a prominent location.
Figure 6-2. Location of HOM Janesville (in purple) relative to the main street. The not so prominent and primarily residential location works to the center’s advantage creating access to those who need it and not make them feel on display. The center has abundant parking for the residents. (Map courtesy: Google Maps)

6.1.2.4 The Role of Space

- The Center was built in the 1950s originally as a convent and prayer center for nuns. As a result, living spaces are small and narrow with one window at the end. According to HOM staff, this was the traditional design for living quarters at a nunnery. While every effort is made to accommodate families in larger spaces, sometimes space gets very tight they say. This results in families with older children being split between two rooms. The thick walls with brick and mortar construction and the column and beam structural positioning prevent any kind of large-scale remodeling.
- Even with the drawbacks of the building design, staff and administrators are quick to point out the criticality of actually having this building at hand at the time of program inception.
Had the building not already existed, starting the program would have been much harder and much more expensive. With this building in their possession, Mercy Health was able to start the program almost immediately once basic modifications were done.

- Through fundraising, approximately $60,000 was raised in 2013 to remodel a few areas of the center, including sleeping spaces for volunteers. Program staff and administrators emphasize that so strong is the community’s commitment to the center that all of the money was raised within the local community itself. The remodel and new addition includes sleeping space with two beds, a kitchenette area, bathroom facilities for volunteers, and some new office spaces.

- A large community lounge with comfortable sofas and television space is right at the entrance of the center, a space used heavily by residents. This space was created by moving some offices that were in that spot to a more interior location.

- Yet another heavily used space is the day center manager’s office. The office is kept very informal and comfortable so that residents feel calm enough to talk. Art and words of encouragement adorn the walls alongside art made by the kids.

- There are spaces allocated in the kitchen for residents to store their own food supplies (for which there are subsidy schemes) and to take turns for cleaning and other chores. The day manager, R. Deviana, points out the importance of residents’ children being able to see their parent(s) cook, to have regular meal times. These everyday activities give the children a semblance of family routine and structure, irrespective of where they are she says. All this helps establish a sense of ownership and feels less like charity, which is very important for the residents’ self-esteem says the day manager.

- The residents have a chore list which includes cleaning and maintenance of the kitchen, the dining area, and some public areas. "It helps retain normalcy for them and keep costs
down for us,” says Loveland, “otherwise we would have to hire someone to clean this and reduce some other services we provide.”

- This gives a new understanding of place attachment—as one that is linked more to the activity in space than the space itself; a place for goal support, further cementing the bond between space and activity.
- A large basement play area with toys, books, and a television is located next to the laundry and storage supply area, allowing mothers to carry out chores while the kids play nearby. This (the toy room), staff members say, is the most heavily used area in the center.

6.1.3 House of Mercy, Des Moines, Iowa

When it comes to women, providing the solution to their problem involves making it possible for them to overcome barriers that prevent them from getting closer to the solution.

—Todd Beveridge, director of House of Mercy Des Moines, Iowa

6.1.3.1 Background

The House of Mercy (HOM henceforth) in Des Moines, Iowa is committed to "providing vital housing, health, wellness, and human services to those for whom access to care/services is difficult" (House of Mercy, 2015). The location at 1409 Clark Street, Des Moines, Iowa offers several comprehensive treatment, recuperation, and residential facilities for qualifying clients on a number of issues ranging from substance abuse, to mental health issues, to homeless women, and women with children in need of transitional housing and permanent supportive housing. The case study was limited to non-treatment areas, common areas like lounges, dining areas, and outdoor spaces. Access was not granted to individual, residential spaces.
6.1.3.2 Operational Model

Offered under the banner of the Mercy Health System Iowa (no connection to other facilities covered in this research at Wisconsin or Maine), this facility accommodates nearly 200 women and teenage girls receiving help in the many areas mentioned above. The facility is funded from a variety of sources including federal grants and reimbursements, donations, foundation grants, and other forms of philanthropy as well as interest from investments. The overall operational budget (including treatment) for the center is approximately $16 million. The clinic contributes about 50% of operational expenses. The clinic uses its contributions to be accounted under the Community Benefit agenda for tax purposes. All financial reporting is done through the clinic.

6.1.3.3 Location and Access

Located on a six-acre plot in a medium- to low-income neighborhood, HOM is a three-wing structure that incorporates seven substance abuse and related treatment facilities, residential spaces for women with children, residential spaces for single women and teenage girls, dining facilities, and daycare facilities for residents and their children. There are no buses or other means of public transportation to the center. HOM personnel say that lack of public transportation is not an issue as everything the women would need is within the campus. Further, prospective residents come in after making a prior appointment for screening, etc., thus ruling out the possibility of foot traffic completely. Here too, having a less than prominent location was stressed as being advantageous for the program.

The three wings are connected by passages at the basement level. All treatment programs are contained in one wing, residential facilities in another, while the third houses dining facilities, daycare, library, meeting rooms, and so on. As mentioned earlier, the study excludes analysis of treatment areas as they fall outside the interest of the research topic.
Figure 6-3 Location of HOM Des Moines (in purple) relative to the main street. The not so prominent and primarily residential location works to the center’s advantage creating access to those who need it and not make them feel on display. The campus has abundant parking for the residents as well as plenty of open spaces and two play areas in addition to a licensed full time daycare for children (not visible in the map). (Map courtesy: Google Maps)

6.1.3.4 The Role of Space

- The structure dates back to the early 1950s and was built to be a hospital. Over the years, it has had many identities, such as being run as office space, a residential complex for low income residents, and a long term care center for senior citizens. Renovations over the years to suit the needs of the time have made the design footprint irrevocably complex which has made circulation and access overly complicated in some areas.
- The director of the facility, Todd Beveridge (TB henceforth), mentions that because the building was built as a hospital in the 1950s, when insulation and heating is not as good as today’s buildings. He also points out that the windows are much smaller than desired.
• Further, the entire campus (including the residential facilities) has an institutional feel, which is another drawback according to HOM personnel. “We want them to feel like it is home, but that’s just not possible here; it is not built for our purpose, but it’s still something,” said M.J., one of the support staff.

• The front lobby personnel sit behind glass barricades, which is necessary, they say, given the violent history some residents and visitors have. While done to protect safety of employees, it also enhances the feeling of an institution. HOM personnel say they have attempted various combinations to make the lobby more open and welcoming but have not found a good combination yet. The fact that they cannot make many modifications given the structural limitations and the age of the building is a major impediment.

• A building complex that is more than 70 years old also means regular maintenance. This costs 3–5% (roughly $20,000–$25,000) of annual operating expense. However, HOM is quick to add that, for specific repairs or additions, funds are raised separately either through donation or grants.

6.1.3.5 Other Space Related Features

• There are plenty of open spaces within the campus. Some of the spaces have been landscaped with flowering plants and seating benches while other spaces have been left vacant for residents to walk about.

• There are two outdoor, kids’ play areas and a dedicated children’s daycare to accommodate 88 children exclusively for resident children. Daycare staff members are trained to handle children with emotional difficulties (which staff members say almost all of the kids have).

• The library (including a computer area) and open spaces were cited as the most used spaces in the campus. Three smaller, informal niche spaces were chosen for casual
observation. During the 30-minute observation session, all three were in continual use. However, staff members say that since those areas are also used for counseling, discussion with sponsor, etc., they were not preferred by the residents when they were on their own time. This information gave a deeper insight into the concept of place association.

- Residents have made murals and other works of art that are placed along the corridors throughout the center. Many depict ideas of hope and freedom. Staff members note that these are very empowering and at the same time therapeutic while making the place more relatable (see Figure 6-18).

- Having a daycare on campus in addition to residential facilities is a main reason the program is a success says TB: “When it comes to women, providing the solution to their problem involves not just providing a solution but also making it possible for them to overcome other barriers that prevent them from getting closer to the solution—child care, transportation, insurance coverage, medication, references, and a roof over their head to name some. We should also find a way to fit our solution into their timeline, otherwise, they will simply not come in, more so in our case.” [Note that “our case” refers to substance abuse and related issues.]

- "This is a safe place” says the welcome personnel at the lobby who wished to remain anonymous. "It is in a location that is not too obvious; discretion is quite important for this type of program. Yet not so far out and hard to reach. The campus itself has everything the women and their kids would need. They only need to go out if they choose to.” He also added that many residents do not venture out for weeks.

6.1.4 McAuley Residence, Portland, Maine

We are like vitamin shots, we don’t do everything for our girls, but we do what is best for them to reintegrate into mainstream society. McAuley Residence here is
an extension of that thinking, we like to think of it as a step toward empowerment for our girls

—Laura Phillips, program manager at McAuley Residence, Portland

6.1.4.1 Background

The McAuley Residence in Portland, Maine is described as “a safe environment and a comprehensive transitional housing program—offering life skills, counseling, emotional support, and mentoring—to women and children in need” (Mercy Hospital Maine, July 2014). It is a residential facility for 15 women and their children. These are women with substance abuse issues who are either seeking treatment actively or have just finished treatment but still need support in terms of counseling, etc., in order to transition into mainstream society. This residential facility does not offer clinical treatment of any kind but offers counseling, parenting skills, and similar counseling whilst providing a place to stay for up to two years.

6.1.4.2 Operational Model

The McAuley program is part of Mercy Hospital Maine’s community initiatives. This clinic has a comprehensive substance abuse program and has extended that to support the women’s lives outside of medical treatment. The clinic provides the financing, counseling, and other related services where required. They coordinate with other professionals from housing support to life-skills coaching in order to best create a comprehensive recovery community for the women.

According to McAuley staff members, the women at McAuley Residence are allowed to live with their children as it has been reported that women who are allowed to live with their kids tend to stay in programs longer, have higher self-esteem, and lower levels of depression. In fact, child reunification is said to be the norm at McAuley (something that was mentioned at HOM Des Moines too). According to Mercy vice president, Melissa Skahan (MS henceforth),
many women come in without custody and work toward getting it. An additional point the staff members made about this initiative is that it also saves the state in foster care costs.

The clinic contributes approximately $180,000 annually and other sundry expenses (which it did not feel was substantial enough to account for) and subsequently uses these expenses under the Community Benefit agenda. The residents live rent-free for up to six months when they are not allowed to work and subsequently pay a nominal rent of around $600 per month for the remainder of their two-year stay. Residents receive this help in the form of subsidies and vouchers (in addition to vouchers for food and other living expenses). Rent is paid to the building management company of Elm Terrace, where McAuley Residence is housed, all of which is moderated and mediated by the Community Housing of Maine (CHOM henceforth). Cullen Ryan (CR henceforth), the director of CHOM, explained that some women start paying rent earlier and some later, but that the rental company does not make a hard and fast rule about this.

6.1.4.3 Location and Access

- McAuley Residence is located at 68 High Street, close to Portland’s downtown and business district. It is part of Elm Terrace, a historic building in the Portland area.
- Originally built as a children’s hospital (1909–1948), Elm Terrace was then used as a school of law and various administrative offices. Community Housing of Maine subsequently procured it and converted it into a 38-unit (including McAuley residences) apartment complex which formally opened in January 2013. (There are 15 McAuley units located in a new wing.)
- It is in a prominent location with the front door visible from the street, within minutes of all prominent business and shopping areas of Portland.
- There is a sidewalk throughout the area allowing for foot access. This is particularly beneficial as most of the women do not own a vehicle of their own. There is a school and
daycare center within a 5-minute walking distance allowing for many of the women to walk their kids to these places. Further, given that downtown is so close by, the women can walk to places of interest, even with strollers.

• Additionally, there are two bus stops within the block which takes the women to most places across town. The women are given free bus passes periodically to encourage them to go around town with their kids. The area is always relatively busy, making the residents feel safe and not so isolated.

• Many of the women seek help for substance abuse from Mercy Medical Hospital, which is less than 0.25 miles away. This enables the women to walk to the clinic even in winter. Other support services like AA meetings and similar sessions on drug abuse, etc. are all within a mile radius—within walking distance.
Figure 6-4 Shows a map relative locations of McAuley Residence (in purple) and Mercy Hospital, less than quarter of mile away. Also can be seen the proximity to public transport and main business district. (Map courtesy: Google Maps)

6.1.4.4 The Role of Space

- The McAuley section was built for its current purpose; it was not adapted or modified from an earlier use. Further, these premises have been in operation since January 2013 and the on-site visit conducted in October 2013. Therefore, not enough time had passed for space-based issues to evolve.
- The only problem staff seemed to have was the fact that residents smoke in the neighborhood because McAuley does not have its own grounds or open spaces for residents to walk around. While staff members are not supportive of smoking, and they are glad when neighbors complain as they feel social regulation beyond McAuley staff is good
for the women, they feel some amount of space around the building might have benefited the women more.

### 6.1.4.5 Other Space Related Features

- The philosophy of McAuley is one of empowering the women to reintegrate into mainstream society as seamlessly as possible. “There is a fear of doing too much in such cases,” says MS. “But once their two year period is up, they have to leave and suddenly they are on their own. We do not want them to be overwhelmed; we want to show them the real world is not an impossible place.” According to the staff members, that philosophy is extended to the physical environment also.

- Subtle environmental influences have been used to push the program philosophy. There is no signage outside Elm Terrace indicating the presence of a substance abuse transition home. During the course of conversation, a couple of residents mentioned they liked the fact that they enter the building with everyone else, not through a side entrance, or through heavily guarded doors with a security person checking them each time they enter. Program staff members explain that the women feel less of the social stigma this way.

- However, the McAuley section within Elm Terrace has its own additional entrance, accessed from the lobby, and requires a separate key. Knowing only other residents and staff can be there, gives the women a sense of security. Children can even be seen playing freely in the hallways.

- Further, the electronic fob keys automatically record each entry and exit so women do not have to physically clock in and out in a ledger—all of which is a conscious move toward self-empowerment and accountability.

- There are several common areas within the residence. These common areas include a sofa lounge, computer area, play and reading area (for kids), and a large, kitchen with
seating for at least 30 people. The women are required to have one common meal each week. Additionally, there are cooking demonstrations and nutrition sessions in the kitchen that are popular among the residents, says Laura Phillips (LP henceforth), day manager at McAuley. She also says that the community meals are well appreciated as many of these women have never had a proper sit-down meal their whole lives and very little (or no) family support.

6.2 Research Findings

A set of codes across four categories were created based on information from literature, preliminary discussions with healthcare professionals, and preliminary review of the notes and images.

Table 6-1 Matrix shows various codes and categories for Theme 2: Programs of a sensitive nature for low income women.

<table>
<thead>
<tr>
<th>Environmental factors</th>
<th>Program related factors</th>
<th>Third space ideology</th>
<th>Gender related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location and access</td>
<td>Program planning</td>
<td>Shelter</td>
<td>Everydayness</td>
</tr>
<tr>
<td>Visibility</td>
<td>Activist /strategist</td>
<td>Seating</td>
<td>Women as caregivers</td>
</tr>
<tr>
<td>Local Approach</td>
<td>Benefits (to clinic and all round)</td>
<td>Neutral Spaces</td>
<td>Women and income</td>
</tr>
<tr>
<td>Pedestrian scale</td>
<td>Mission alignment</td>
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<tr>
<td>Power of space and place</td>
<td>Partnering</td>
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<tr>
<td>Public transportation</td>
<td>Social Bricolage</td>
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<tr>
<td>Social Design</td>
<td>Brand association</td>
<td></td>
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<tr>
<td>Limitations due to modifications</td>
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<td></td>
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</tbody>
</table>

Note: Codes for Power of space and place, Social Design, and Social Bricolage are identical to that in the farmer’s market category.
Figure 6-5 Screen shot of an image with code markups on QDA Miner 4.1.12 as part of the visual analysis.

Figure 6-6 Screen shot of an interview document with code markups on QDA Miner 4.1.12 as part of the verbal content analysis.
Co-occurrence Analysis

Jaccard’s similarity index with five clusters and a five-paragraph boundary condition was used for analyzing the similarity and diversity among codes. As with the analysis on healthy eating, the document content was in the form of bullet points, often containing no more than one or two sentences. Each bullet was considered a paragraph by the software, which made a considerably tight boundary setting.
Figure 6-8 Dendrogram shows the Jaccard’s similarity index diagram for occurrence of all the codes, split into 5 clusters for optimum similarity and diversity results.

Cross Case Analysis

One of the aims of this study is to establish external validity (i.e., generalizability of this topic). Some codes might have had a big presence when all four codes were put together, but what was the distribution of each code in each case? For each case, all the codes were added up to represent 100% and then a frequency distribution analysis of those codes was performed per case and presented in a single matrix for easy comparison. Figure 6-9 shows how the codes are distributed across the four cases, with the sizes of the bubbles showing the size of the frequency.
Figure 6-9 Bubble chart shows all the cases and codes, sorted by color and size for category and frequency.
6.3 The Outcomes of the Content Analysis

**Social Design and Social Bricolage**

Having this ready space meant we could move in a lot more quickly than if we had to procure a new building from scratch.

—Program staff at HOM Janesville

We're a small program compared to some others. We want to stay that way to ensure we give the best to our residents and that there is no compromise on their living space as well. We don't want to cramp a family of four in one room; that will not do.

—Program staff at HOM Janesville

Social Design and Social Bricolage codes showed high frequency and strong similarity. A major reason for this was the *making do with what you have* aspect. Three out of four cases are housed in buildings remodeled for current use. While program givers concede to having building-related issues (mostly pertaining to heat and insulation), they were very candid in saying that readily available space made the program a reality much faster. There were fewer hoops to jump through and cost savings were huge, saving the clinics at least half a million dollars (US) in each case. The small-scale approach advocated by Social Design made a big impact in three cases where staff members and administrators said they would rather keep the program small so that quality of living could be maintained.

**Gender based codes**

Women as caregivers (5.6%) stood out as an important factor, finding mention in each of the four cases. However, one must remember that the women themselves were not questioned, greatly limiting a full elucidation of the gender-related usage patterns. Women as caregivers showed a relatively higher relevance with neutral spaces. This gives a deeper
insight into the everyday life movements of women (which, incidentally, fell in the same cluster as the other two). Most women in these programs have children and to see how these women morph spaces to fit into their activities was an interesting observation. This has been discussed in detail in several places in this study (Sections 9.3 and 9.4).

**Third Spaces**

Since the corridors are in lock down at either end, the kids are safe to play there while the moms work inside or hang out together.

—Program staff at McAuley Residence Portland, Maine

Termed neutral spaces for this segment, this code garnered sufficient interest across cases. These third spaces included such spaces as corridors, ends of corridors with a chair to sit in, common lounges, community kitchens, etc. These can be considered the closest thing the residents have that could be comparable to having personalized spaces in these programs. These areas have special meaning to the users, despite the absence of personal artifacts and long-term commitment to that space. Observation shows that the importance granted to these areas is a result of the activities conducted in these spaces (sitting down to have a quiet read, think, reflect, etc.) as the activities lend meaning to the experience. This had a marked presence in the visual analysis as well. Program givers across all cases emphasized that just having a chair to sit down and relax or to momentarily have the kids off their minds since they were safely playing is a luxury for these women. Systematic observation was not allowed to enable further corroboration. However, casual observation did show these kinds of spaces were continually occupied.
Program Planning and Mission alignment

Our program is very closely aligned our (the clinic's) organizational mission. And these resonate with several community organizations. This has led to some very fruitful associations.

—Vice president, Mercy Maine on the McAuley Residence’s Association with the Community Housing of Maine

When our CEO challenged us to find ways to help our community we first looked at what areas could be best served under our organizational mission. A community center (referring to WCRC) was definitely one of them.

—Mt. Ascutney Hospital and Health Center’s Chief Nursing Officer and Director of Patient Care Services, in-charge of community initiatives

Program givers placed a lot of emphasis on program planning and on programs aligning with their organizational mission. From deciding on the nature of the program to partnering with appropriate organizations, program givers emphasized that these two areas played a critical role in shaping the final product. Each case stressed how the program was an outcome of wanting to do community good in alignment with their own organizational mission. This was seen as a way of continuing the organization’s work in a different way while enhancing partnering options. This was also, according to some, a way of ensuring program longevity. The more connected the program was to their mission, the more clinic leadership and decision makers would be willing to continue with the program. Displaying a strong, socially entrepreneurial nature, most program givers said a strong business plan was a must for such programs, especially for procuring resources and winning over critics.
Visibility access and location

This is the perfect place for this program. It is within the city limits and easy enough to locate. But is it not on a main road that the women will feel hesitant to come in. There is no foot traffic, women need to make appointments and at that time we explain how to get here. Once here we provide everything for them including onsite children’s daycare. It takes a lot of courage to enroll in a program like ours. We want to make the rest easy for them.

—Program director at HOM, Des Moines

Location and access was yet another area that yielded a high frequency in both verbal (6.5%) and visual analysis (12%). These codes showed a high relevance of 0.5 as well. While this re-emphasizes the importance of these areas in both segments of the case studies, they tend to mean different things, having different connotations both environmentally and from the program’s point of view. Regardless of the benefits of such programs to society in general and to the women who need them in particular, there is a certain social stigma in being associated with such programs. This adds to the pressure and stress these women already carry with them. And so the location, how the space is accessed, and how it is viewed at the micro and macro levels, becomes very important. Please see section 9.4 for a full discussion.

6.4 A Visual Representation of Outcomes

Some areas that did not make an impact in the content analysis stood out in the observation notes and in the visual data. Along with content analysis, some images corroborate some of these areas like safety and goal support.
Figure 6-10 WCRC Windsor, Vermont: A large conference room that can comfortably seat over 20 with plenty of windows / natural light is one of the more used facilities in WCRC. It is used by everyone from small nonprofits to other groups as a meeting place. (Image courtesy: A. Saligrama)

Figure 6-11 Limitations in inheriting an existing building: WCRC Windsor Vermont. Converting an old railroad warehouse for a different use has its limitations—inability to make structural changes has left many private counseling rooms windowless. (Image courtesy: A. Saligrama)
Figure 6-12  Third spaces: WCRC Windsor, Vermont. Brightly colored furniture line the corridor to allow users (mostly women) to have a quiet read, relax or wait for an appointment. (Image courtesy: A. Saligrama)

Figure 6-13  Emphasis on the local: WCRC Windsor, Vermont. Brightly colored walls lined with photographs of flowers that grow locally, taken and framed by a local photographer. This exhibits both parochial pride and making the entire setting ‘local’ to make users more comfortable. (Image courtesy: A. Saligrama)
Figure 6-14 Emphasis on the local: WCRC Windsor, Vermont. Tapestry depicts points of interest in Windsor, Vermont. Tapestry weaving incidentally is a local tradition. (Image courtesy: A. Saligrama)

Figure 6-15 Emphasis on the local: WCRC Windsor, Vermont. The address of WCRC reads “No. 1 FOR THE COMMUNITY.” Such subtle elements have been used throughout WCRC as a message to the community that every service at WCRC is for every member of the community. The clinic’s involvement is not overt. (Image courtesy: A. Saligrama)
Figure 6-16  Brand association, Access and Seclusion, and Reduction of stigma through environmental elements: HOM Janesville, Wisconsin. The Center’s name along with the Health System’s name in smaller size is put up right at the front entrance establishing the association between clinic and program. Note that the signage shows the name and associated clinic but not the function (a homeless center). This coupled with a not so prominent location reduces the stigma associated with such places. (Image courtesy: A. Saligrama)

Figure 6-17 Access and Seclusion and Reduction of stigma through environmental elements: McAuley Residence Portland, Maine. There is no signage outside Elm Terrace indicating the presence of McAuley residences within. A prestigious building in the Portland area, the absence of signage, a common entrance for everyone and several such environmental elements have been used to boost the program philosophy of empowerment of women and their seamless reintegration in mainstream society. (Image courtesy: A. Saligrama)
Figure 6-18 Reducing stigma, boosting morale, and goal support: HOM Des Moines Iowa. Hope filled messages written on residents’ palms on one of the walls at the facility. (Image courtesy: A. Saligrama)

Figure 6-19 Safety measures for physical and psychological wellbeing: HOM Des Moines, Iowa. The welcome lobby with glass panel separating the HOM welcome staff from visitors and residents, a necessity for the safety of the staff says HOM. (Image courtesy: A. Saligrama)
Safety measures for physical and psychological wellbeing: McAuley Residence Portland, Maine. McAuley residents have a separate entrance nested within Elm Terrace which can be accessed with a special fob key which McAuley staff say is for resident safety, a notion confirmed by some of the residents. (Image courtesy: A. Saligrama)

Third spaces/ goal support: McAuley Residence Portland, Maine Community Kitchen that doubles as workshop and demonstration space. (Image courtesy: A. Saligrama)
Figure 6-22  Goal support: McAuley Residence Portland, Maine. View of the harbor and bay from one of the water facing apartments of the McAuley Residence. Being in a very prominent and prestigious location has meant easy access to a number of Portland amenities, from banks to potential job opportunities. Each apartment has plenty of windows with good views and letting in plenty of breeze and sunshine, a factor well cherished by residents. (Image courtesy: A. Saligrama)

6.5 Benefits to the Clinic

Benefits to the clinics offering these programs are multifold, though not all monetizable. Three of the four clinics list the social programs as Community Benefit. This means each of these programs is accounted under the clinic’s rationalization for safeguarding their tax-free status. While the amounts are relatively small compared to their overall Community Benefit dollars, it must be mentioned here that most Community Benefit dollars, to the tune of over 85% goes toward direct medical care. It can also be argued that by spending as little as less than one percent of their Community Benefit budget, these programs yield several benefits to the clinic beyond just monetary gains. For example, reduction in emergency room usage is a huge benefit to clinics that offering women sensitive programs.

McAuley Residence/Mercy Maine: A 2007 study on supportive housing for the Greater Portland area shows that by providing housing for homeless, healthcare costs were cut by almost 60% and ER costs by another 62%, both of which directly impact Mercy Medical
This is in concurrence with what Cullen Ryan of Community Housing of Maine (CHOM) has to say: "This program is saving Greater Portland at least $1,000 per resident and this is not even counting what is saved on foster care for the children." The same study also showed that once a clinic provided supportive housing was provided, the number of people seeking substance abuse treatment increased by 22%.

**House of Mercy/Mercy Health Janesville:** The clinic does not contribute monetarily to the center and, therefore, cannot claim tax credits under Community Benefit. However, the clinic gains in many other ways. For one, the center contributed substantially to the clinic winning the Malcolm Baldridge National Quality Award in 2007—the only national award recognizing both quality and performance excellence, awarded across all industries and sectors including businesses and nonprofits, and recognized by the President of the United States. The clinic is very strong in its conviction that the center does benefit them, showing their association strongly even on the front signage of the center. Further, given that provision of stable housing is the aim of HOM, this center, like the McAuley Residence, helps to reduce emergency room usage as well as unnecessary use of medical services at the clinic. The clinic also feels that associating with HOM increases its profile locally, increasing goodwill, which makes it relatively easier to procure donations. Also, at a time when healthcare systems are competing for procurement of additional business, associating with a socially compassionate project can only help public perception of the clinic. Particularly because it costs them nothing—barring sharing of skills they already possess—the clinic sees nothing but positives coming out of its association with HOM.

**WCRC /Mt. Ascotney Health Center, Windsor:** At WCRC, the city of Windsor’s location has left many, especially the low-income women, with no direct access to social services and other facilities. For a nominal fee (which is usually waived) of $15 an hour, the center brings all those facilities to Windsor. While this certainly benefits the community, the clinic benefits by sorting
out problems at an early stage, not letting them escalate into a medical situation. This early intervention helps to reduce pressure on both medical resources and emergency room usage.

WCRC also coordinates directly on behalf of the community with the agency, thus freeing the clinic of this responsibility and saving staff time. While the clinic is not sure whether at all a metric to measure this is possible, they say the clear demarcation of roles allows for staff members to focus on their work, which is of great importance in a medical environment.

For its work and involvement with WCRC (in addition to several other programs), Mt. Ascutney Hospital and Health Center was awarded the Foster McGaw Prize for Excellence in Community Service by the American Hospital Association, the most prestigious and sought after recognition by clinics nationally.

Common to all the cases, clinics generally have larger resources for financial accounting, budgeting and auditing, fundraising, public relations and marketing. The program, by associating with the clinic, can take advantage of all these resources. Employees are all under clinic payroll and enjoy benefits and perks the clinic has to offer. This helps to attract better-quality staff with lower attrition rates. The clinic does not see a dent in its day-to-day operations by contributing to these areas, thus making for a two-way, sustainable agenda between the clinic and the program.

6.5.1 Benefits because of the Built Environment

This program is visible, tangible, physical evidence that Mercy Medical can demonstrate to justify its nonprofit status, its commitment beyond medical care, and a very specific way to show the federal government and taxpayers its commitment to serve the community.

—T. Beveridge, HOM Des Moines
According to the clinics, using the existing physical environment keeps overhead and maintenance low. For routine maintenance, small repairs, etc., the clinic’s resources are used. These expenses get absorbed into the clinic’s budget and cost the program nothing. This way, operating costs for the programs can be kept low. Any major repairs, additions, or renovations are done by raising separate funds or grants. Either way, the clinic does not have to make substantial investments for the physical environment.

Clinics routinely come into possession of buildings by means of donations from former patients or other community organizations. Clinics, as nonprofits, can also procure land and buildings at rates much lower than market rate provided they have a plan that does not clash with local zoning laws. Converting or adapting them at minimal cost allows clinics to offer social programs at a cost much lower than if they had to offer them through a new build. As has happened with House of Mercy in Janesville and Des Moines, the clinics could do away with the initial investment, which is invariably the biggest cost. While this has meant limitations in other ways, it nonetheless gives the clinic a chance to start the program right away and to manipulate the environment to better suit the program and user needs.

At other times, a clinic’s influential status within a community puts it in a better position to attract donations and grants, town funds, and so on. For example, at WCRC Windsor, the supporting clinic was able to locate a building, get a town-rolling loan, and negotiate an agreement that did not involve repayment of the funds—all of which ultimately benefit the clinic. They invest very little and use whatever is invested for Community Benefit as well.

By creating a single meeting point, there is a reduction in duplication of services (i.e., different agencies offering the same support on an individual basis). WCRC allows for agencies and services to be monitored and while allocating services based on each agency’s core competency. According to J. Lord, having this central point has been essential to their success. Once the space was procured, it was simply a matter of time and program structuring before the WCRC became a ‘one stop shop’ for all community’s wellness needs.
The biggest advantage of the physical environment is its visibility. Visibility makes it easier to establish the program’s connection to the clinic (such as at HOM Janesville). This connection shows the clinic’s commitment to the community beyond just medical care and paying patients.

Adding to the prestige of their program, the McAuley Residence in Portland was the recipient of the National Housing and Rehabilitation Association “Timmy Award” in 2013 for their restoration of a historic building. Table 6-2 presents in a matrix the various benefits to the clinic discussed.
Table 6-2 Matrix showing benefits to the clinic

<table>
<thead>
<tr>
<th>Benefits</th>
<th>WCRC Windsor</th>
<th>HOM Janesville</th>
<th>HOM Des Moines</th>
<th>McAuley Residence, Portland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounted under Community Benefit</td>
<td>Yes. Approximately 0.68%</td>
<td>Not applicable</td>
<td>Yes. Approximately 19%</td>
<td>Yes. Approximately 1%</td>
</tr>
<tr>
<td>Reduction in ER usage</td>
<td>No, but clinic opines reduced pressure on clinic regarding queries that are now handled by WCRC</td>
<td>Yes. Exact data unavailable</td>
<td>Yes. Exact data unavailable</td>
<td>Yes. Exact data unavailable</td>
</tr>
<tr>
<td>Reduction in consumption of other medical resources</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Awards</td>
<td>Yes, Foster McGaw Prize by the AHA for outstanding service to the community</td>
<td>Yes, Malcolm Baldrige award for quality in 2007, a nationally recognized award across all industry types</td>
<td>No</td>
<td>Yes. National Housing and Rehabilitation Association &quot;Timmy Award&quot; for 2013 for restoration of historic building</td>
</tr>
<tr>
<td>Press recognition /Prestige</td>
<td>No</td>
<td>No</td>
<td>Yes. Several prominent personalities including US presidents and Vice Presidents have visited the center</td>
<td>Yes. Portland Press Herald, Novogradac Journal of tax credits</td>
</tr>
<tr>
<td>Increase in local donation /volunteering for the clinic and clinic related activities</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>SROI</td>
<td>1.2</td>
<td>1.6</td>
<td>Insufficient data</td>
<td>1.7</td>
</tr>
<tr>
<td>Low investment / maintenance costs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: The table above shows the various ways in which the clinics are benefiting from being associated with the social programs. The benefits (on the first column on the left) have been arrived at based on both literature and what clinics themselves have said are the benefits they are getting from the program. Further, see Chapter 7.0: for SROI analyses.
Chapter 7.0: Impact Measurement through a Social Return on Investment Analysis

Anything that just costs money is cheap.

—John Steinbeck

Valid impact measurement is among the harder things to achieve in any social program. This is because accurate and measurable user data is hard to come by, so it is even harder to isolate impact of the program on the user for a particular intervention. Social accounting is a useful option in such cases since it estimates the monetary impact of the program over a finite timeline. This chapter details a monetary impact analysis for three cases discussed in this study—the House of Mercy Homeless Center, Janesville; the McAuley Residence, Portland; and the Windsor Connection Resource Center, Windsor Vermont.

7.1 About the SROI Method used in this Study

There are several ways to do a Social Return on Investment (SROI) analysis. The most popular tool on the market is the SROI guide made popular by the SROI network, an international social enterprise which helps both organizations and individuals interested in social enterprise management and analysis.

Made most popular by the Roberts Enterprise Development Fund (REDF) and then taken over by the New Economic Foundation in the UK, the SROI tool used in this study, looks into several aspects of a social program before arriving at the actual accounting part. The

25 The data for the SROI (monetary, percent values & proxies as well as parameters for outcomes) is a result of interviews with program personnel, national reports and scholarly studies and are true to the best of the researcher’s knowledge at the time of writing. The analysis has followed the SROI Network’s Impact Map guidelines closely. The numbers and outcomes however should not be treated as absolutes. These are for information and academic purposes only.
analysis is in a systematic, step-by-step fashion that identifies stakeholders, parameters for measuring outcome, procuring financial data for those parameters, and, where not available, it uses proxies and estimates from reliable sources (national reports, scholarly studies, etc.). Finally, over a finite timeline, the outputs are divided by the investments to give the SROI.

The SROI method adopted in this study follows the guidelines and Impact Map method set by the SROI network\textsuperscript{26}. As a first step, prior to actual analysis, a comprehensive checklist was created that detailed all inputs, stakeholders and their roles, type of SROI being conducted, sources for data and proxies where direct data is unavailable, and the timeline for the SROI with space for additional comments to report adjustments and special accommodations made for the SROI analyses being conducted\textsuperscript{27}. Once these parameters were set, the actual SROI analyses were conducted.

7.2 Windsor Connection Resource Center (WCRC), Windsor Vermont

The SROI was conducted for the WCRC located at No. 1 Railroad Plaza, Windsor Vermont, for the (projected) years 2014–16. For this period, with an annual investment of $54,000, the SROI analysis yielded a positive result of 1.2 over two years.

WCRC has been in operation since February 2002, 12 years at the time of writing (2014) and growing in number of residents served at a rate of more than 25% each year. The 12 years indicates longevity or sustenance, while the growing number of users indicates popularity.

The SROI is focused on how the center affects the stakeholders rather than on how the center impacts the community. While community members are considered stakeholders, their role is limited in examining the collective impact in terms of return to the dollar. The individual


\textsuperscript{27} See Appendix C for checklist and additional comments explaining reasoning for some of the choices made in the SROI analyses for the three cases: Substance abuse recovery and transition homes in Portland, Maine and Des Moines, Iowa and the homeless center in Janesville, Wisconsin.
benefit gained by community members and the subsequent ripple effect is not addressed (since that is not the focus of the study).

7.2.1 Role of space in the SROI

The clinic says the center has helped to focus all required services to the community in one place, under one roof, thus reducing underutilization and duplication of services by more than one agency.

The clinic has procured the current location from the Connecticut River Development Corporation (CRDC). Actual costs total close to $560,000, which was obtained through community block grants and a rolling town council fund. The clinic has entered an agreement with both the town council and CRDC that loan repayment need be made only if the clinic wishes to hold the title. This effectively brings the clinic’s building procurement costs to nil.

Program staff members say it is impossible to monetize the value of such things as residents having access to a guidance counselor in a private office, being able to just sit down and read or reflect, or even just being able to use the phone. In other words, it is impossible to quantify such value additions as dignity—a vital, yet intangible benefit.
### Table 7-1 Table of inputs for SROI WCRC Vermont

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended changes</th>
<th>Inputs Description</th>
<th>Value ($) annually</th>
<th>Additional comments</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an effect on/who has an effect on us</td>
<td>What do you think will change for them</td>
<td>What do they invest</td>
<td></td>
<td></td>
<td>Summary of activity</td>
<td>How would you describe the change</td>
</tr>
<tr>
<td>The Windsor community residents, mostly the low income</td>
<td>Better connected and informed</td>
<td>Time, money</td>
<td>$17,000</td>
<td>Approximately 1500 members meet with counselors, for at least an hour. Hourly</td>
<td>Women have a resources for finding jobs,</td>
<td>Makes women more empowered; get jobs; rely less on state and health</td>
</tr>
<tr>
<td>women of the community, annual footfall is approximately</td>
<td></td>
<td></td>
<td></td>
<td>meeting room rate = $15</td>
<td>getting legal, mental, behavioral help</td>
<td>services</td>
</tr>
<tr>
<td>3500</td>
<td></td>
<td></td>
<td></td>
<td>1500 X 15 = $22,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Estimating that quarter of those cannot pay, 16,785 ~ 17,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Clinic- MAHHC</td>
<td>Provide critical services under one roof for this remote rural town. Reduction</td>
<td>Time, money</td>
<td>$37,000</td>
<td>Provide admin, fundraising, accounting skills; train staff</td>
<td>Smooth operations of WCRC, enabling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>on hospital resources and staff spend</td>
<td></td>
<td></td>
<td></td>
<td>connectivity of WCRC users with extended</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>local/state/federal services</td>
<td></td>
</tr>
</tbody>
</table>
Table 7-1 Table of inputs for SROI WCRC Vermont (Continued)

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended changes</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees of WCRC</td>
<td>Heightened awareness of community problems</td>
<td>Time, Money</td>
<td>Annualy 15,000 (included in the $37,000 operating expenses and Community block grant income);</td>
<td>Ensure smooth running of the center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td></td>
<td>Enable better coordination between community members and counselors; help with job searches etc.</td>
</tr>
<tr>
<td>Department of mental health, corrections and other regulatory agencies (see appendix for all stakeholders list)</td>
<td>Easy access to members of Windsor and surrounding community within a 44 mile radius</td>
<td>Time</td>
<td>Any expense is incurred by them is part of their job agenda, absorbed by the respective agencies</td>
<td>Meet with relevant population subset, sort out their legal, mental health etc. issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td></td>
<td>More members are reached this way, tangibly moving toward a healthier community</td>
</tr>
<tr>
<td>Other inputs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building procurement and remodeling costs</td>
<td>Town revolving fund and Vermont Community block grant</td>
<td>Money</td>
<td>$560,000 town rolling fun loan in 2002. However as part of agreement with the town, the loan need not be repaid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td><strong>$54,000</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7-2 Table of inputs for indicators and proxies for assessment WCRC Vermont

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Quantity</th>
<th>Duration</th>
<th>Financial proxy</th>
<th>Value</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you measure program success</td>
<td>Where will you get information for that from</td>
<td>How many people does it serve</td>
<td>For how long are we assessing the outcomes</td>
<td>Against what are we going to assess the outcomes</td>
<td>What is the monetary value of that/ is it monetizable? ($)</td>
<td>Where is the proxy information coming from</td>
<td>Other non monetizable issues</td>
</tr>
<tr>
<td>Number of people visited and counseling room time occupation; Track increase in number of users; track whether all types of services provided are made use of</td>
<td>WCRC record keeping; discussion with program staff</td>
<td>3,500 annually</td>
<td>1 year</td>
<td>Cost of reliance on services for substance abuse, mental health and taxes.</td>
<td>100,000</td>
<td>American Mental Health Association rates as of 2013 National Society of Accountants fee prices as of 2013</td>
<td>Several other agencies not included (refer appendices for list and reason for exclusion)</td>
</tr>
</tbody>
</table>

Refer to Appendix C.1 for details of all proxies and financial calculations.
7.2.2 The Outputs

**Deadweight:** The SROI in this study is being done in the present and projected for two years (2014 being considered present). When staff was asked what would have happened if WCRC did not exist as it does today, the response was that the previous arrangement would have continued—clinic staff would pick up some of the work and relevant social agencies would do the rest, albeit with much greater impediments. Therefore, deadweight is 100% and does not come into play.

**Attribution:** Clinic and program staff members credit crisis hotlines and helplines as well as websites as contributors to the program’s success. The annual number of people who come into the center to use the phone or fax and (over a 1,000) and computer (over 750) is quite high. Staff members attribute a large portion of calls to those seeking employment; they attribute another large portion of calls to recommendation by some of the counselors whom the callers have met at WCRC. This indicates that phone and internet usage on personal equipment by target audience is not high; this information also shows a trend of what the phone and internet are used for. As a result of this, a best estimate of 10% is made and attributed to crisis and other helplines.

Financial value therefore reduces to $100,000 - 10% = $90,000

**Drop off**

The WCRC users are only there for a very short period of time. No effort is made or can be made to track individual clients to see how the help obtained at WCRC has helped them over the years. Given the critical help WCRC provides in being a one-stop center for several issues—from mental health, to coordinating with prison and family services, to providing phone and faxes—it is expected that the benefits stay with them for at least a couple of years.

However, one also needs to be realistic and steep drop offs are made to compensate for the lack of availability of metrics to measure benefits or even to track users. A 50% drop off
is estimated at the end of each of the two years (that is how long interventions obtained at WCRC are expected to last).

**Year 1:**

(Collective) **Impact year 1 = $90,000 - 50% = $45,000**

**Year 2:** At the end of the second year, the impact is again reduced by half.

(Collective) **Impact year 2 = $45,000 - 50% = $22,500**

Table 7-3 Outcomes WCRC Vermont

<table>
<thead>
<tr>
<th>Description</th>
<th>Deadweight</th>
<th>Attribution</th>
<th>Drop off</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe the change</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>What would happen without the activity (if WCRC did not exist)</td>
<td></td>
<td>Who else contributed to the change</td>
<td>Does the outcome drop off in future years</td>
<td>Quantity x financial proxy less deadweight, displacement and attribution (5)</td>
</tr>
<tr>
<td>Community members had better access to many social services</td>
<td>Not Applicable</td>
<td>10% Phone helplines - hotlines independent of WCRC</td>
<td>Yes, 50% each year</td>
<td>45,000 (Y1) 22,500 (Y2)</td>
</tr>
</tbody>
</table>
7.2.3 SROI Calculation

Given that this is a social program, a discount rate of 3.5% is assumed. In turn, this is used to calculate the Present Value of the entire program timeline (2104–16 in this case).

Table 7-4 SROI Calculation WCRC Vermont

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Year 1 Impact</th>
<th>Year 2 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discounted Value</td>
<td>45,000 / 1.035</td>
<td>22,500 / 1.035</td>
</tr>
<tr>
<td>Present Value</td>
<td>64,482.25 ~ 65,000</td>
<td></td>
</tr>
</tbody>
</table>

Total Present Value = $65,000

\[
\text{SROI} = \frac{\text{Total Present Value}}{\text{Total Value of Inputs}}
\]

- This implies that over a period of two years, for every dollar invested in WCRC the ROI for the program is 1.2 (assuming starting year as 2014). One must remember that this number does not reflect those served over the phone.
- And several other agencies like the department of corrections that renders critical service is not included as financial data from such sensitive areas is not readily procurable.
- Again it must be remembered the SROI is to gauge how the investment is impacting the clinic including stakeholder contribution and not on welfare impact of the users or the community at large.

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28 Discounting allows for understanding the future value of an entity today. Estimation of discount rates is subjective and open to debate with opinions ranging from a high of 5% to as little as 0%. For the public sector, the UK Treasury recommends a rate of 3.5%. Rates in this range (3%–5%) are considered descriptive while lower rates are typically considered prescriptive (Roberts, 2012). For this study, one must remember no access was granted to perform contingent evaluations of any sort and information limited to the opinions of the program givers. Further, there are no published comparable American studies or mandates for such programs. All this, coupled with the exploratory nature of this study has led to the assumption of a rate of 3.5% is used for this study. The same rate is also endorsed by the SROI network, whose methodology is used in this study.
7.3 SROI House of Mercy Janesville WI

The SROI was conducted for 25 women who stayed at the HOM center for 30 days. For a total investment of $25,000 (for 30 days), an SROI analysis yielded a return of 1.6 over a period of two years. This means, for every dollar invested over a period of two years, the program yields 1 dollar and 60 cents. A positive return on any social investment is always considered to be significant.

The analysis looks at the various inputs and stakeholders from the viewpoint of operating the center from the clinic’s perspective. This includes direct costs toward operational expenses, made available for this study by the center’s staff as well as other costs estimated from national reports of comparable scale. Outcomes are estimated from data available, including deadweight, attribution and drop off rates, as well as impact timelines as discussed with the clinic and HOM staff.

Food, day-to-day sundry expenses, and child care costs are not included in this analysis as those are expenses the residents would have incurred anyway. The clinic staff members and administrators cited shorter duration of stays as well as lack of support staff from their own end as the biggest inhibitors to continue to offer support for the women after they have left the center. They consider moving to a newer, evidence-based recruitment system that prioritizes safety and need over simple chronology of application as well as their 12-point qualitative assessment scale when residents leave as two of their biggest developments in the last 18 months (2013 onward) that have made a significant impact in how they run the program.

7.3.1 Role of Space in the SROI

Having a building that was ready from the outset has been cited as a distinct plus to the program. This alone has saved the clinic at least $500,000, which it would have had to find
outset sources for in order to procure and run the center at this level. Cost of building procurement is $0.

Further, staff members say that procuring close to $65,000 for a remodel of some areas in the summer of 2013 was done with community outreach alone. People in the community are aware of this large space nestled in a residential area, aware of the good it is doing to the community, leading to positive returns in donations and fundraising efforts.

An annual building maintenance cost of nearly 17% of their operational budget was cited as a downside of inheriting and operating out of an old nunnery from the 1960s.

The savings per person per month to the community amounts to $2,400 because of the center. This is in corroboration with other studies, especially ones acknowledged by the National Alliance to End Homelessness and US Department of Housing and Urban Development (HUD) which put monthly savings per month at approximately $2,449 (Larimer, et al., 2009).
### Table 7-5 Table of inputs for SROI HOM Janesville

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended changes</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an effect on/who has an effect on us</td>
<td>What do you think will change for them</td>
<td></td>
<td>Summary of activity</td>
<td>How would you describe the change</td>
</tr>
<tr>
<td>Homeless women and their children in Southern Wisconsin and Northern Illinois mostly but anyone with a need, including men (25 adults and 12 children)</td>
<td>Safe place to stay Less use ER services Reduced use of homeless centers</td>
<td>Time</td>
<td>Women are off the streets</td>
<td>Makes women more empowered; get jobs; rely less on state and health services Safely placed in some form of permanent housing</td>
</tr>
<tr>
<td>Donors, HUD and state grants, pledges etc. (who contribute to operating expenses)</td>
<td></td>
<td>Money</td>
<td>Provide resources to enable the activities for women</td>
<td>Reduction of homelessness in the community</td>
</tr>
<tr>
<td>Mercy health system, Janesville</td>
<td>Reduce homelessness in Southern Wisconsin/northern Illinois</td>
<td>Time</td>
<td>Provide admin, fundraising, accounting skills; train staff</td>
<td>Women are less reliant on ER and other medical services Smooth operations of HOM</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Intended changes</td>
<td>Inputs</td>
<td>Outputs</td>
<td>Outcomes</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------</td>
<td>--------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td>Keep active, enhance awareness of social problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time, 700 hours a month</td>
<td>$5,100</td>
<td>700 hours X 7.25 (min wage in Wisconsin)</td>
<td>Residents have help around the center</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5075 ~ $5,100</td>
<td></td>
</tr>
<tr>
<td>Other inputs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The building</td>
<td>Provide safe shelter for residents; give a sense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>of home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>Included in operational $20,000 budget</td>
<td>Actual expenses $3,400; 5% of operational budget; included in operational expenses of $20,000 per month from donor pledges, HUD and state grants</td>
<td>Houses the residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The new building</td>
<td>Enhance usage of common spaces; better space for</td>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>remodeling</td>
<td>volunteers and staff</td>
<td>$0</td>
<td>Actual expenses = $65,000/. This is a onetime expense for which separate fundraising was done and need not be repaid, input is assumed at $0</td>
<td>Makes residents feel less stigmatized than when living out of shelters; reduces risk of disease, sexual abuse and by extension hospital use. Healthcare savings is estimated at 60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$25,100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7-6 Table of inputs for indicators and proxies for assessment HOM Janesville

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Quantity</th>
<th>Duration</th>
<th>Financial proxy</th>
<th>Value</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you measure program success</td>
<td>Where will you get information for that from</td>
<td>How many women were there</td>
<td>For how long are we assessing the outcomes</td>
<td>Against what are we going to assess the outcomes</td>
<td>What is the monitory value of that/ is it monetizable? (in $ for 25 women)</td>
<td>Where is the proxy information coming from</td>
<td>Other non monetizable issues</td>
</tr>
<tr>
<td>Reduced costs of ER healthcare &amp; mental health after entering supportive housing.</td>
<td>Hospital / ER records / national reports or state commissioned studies</td>
<td>25 women and 12 children = 37 in all. Analysis is limited to the 25 women</td>
<td>30 days</td>
<td>Reduced costs of ER, hospital use, mental health and police / jail costs</td>
<td>Annual Reduction / savings See** TOTAL 708,475 ~ 710,000 year OR $59,166 ~ $60,000 per month</td>
<td>Estimated from data available at the HUD, National Alliance to end Homelessness website and other scholarly articles</td>
<td>All costs are estimated under the assumption that women are insured / under government assisted programs (as gathered from interview data)</td>
</tr>
</tbody>
</table>

** ER – $22,500; Office based healthcare-$27,500; Hospital care -$37,500; Mental health-$60,000; Emergency shelter use- $60,975; Jail and police costs- $500,000

See Appendix C.2 for full calculation details of how savings costs were arrived at.
7.3.2 The Outputs

**Deadweight:** The SROI for HOM Janesville is done for the present and projected for two years (2014 being considered present). If the center did not exist, of the 25 women receiving assistance, approximately five could be accommodated within the community in comparable programs, say HOM staff members. Therefore, if we consider five as the 100% benchmark (that is, safe housing for five women), HOM allows for another 20 to be cared for, or a 400% increase in activity. Therefore, deadweight is \( \frac{100}{100+400} = \frac{100}{500} = 20\% \)

This brings down the total proxy value to \( 60,000 - 20\% = $48,000 \) at the end of one month.

**Attribution:** HOM and clinic staff members give the larger recovery community with as much as 30% credit for helping the cause of the residents.

This brings down the total proxy value to \( 48,000 - 30\% = $33,600 \sim $35,000 \) at the end of one month.

**Drop off**

The impact of the intervention is calculated for two years. Given that the women stay for only 30 days, the center does not have high estimates for impact and outcomes.

Year 1: at the end of one year, the women are expected to stay in stable housing, benefiting from help with training, job search and placement, medical assistance, and financial planning that they receive from HOM. They estimate the impact to drop off by roughly 20% at the end of year 1 (11 months after they leave the center).

(Collective) Impact year 1 = \( 35,000 - 20\% = 35,000 \times 0.8 = $28,000 \)

Year 2: At the end of the second year, the impact is expected to reduce by half, meaning a drop off rate of 50%.

Impact at the end of year 2: \( 28,000 - 50\% = $14,000 \)
Table 7-7 Outcomes HOM Janesville

<table>
<thead>
<tr>
<th>Stage 2; Table of Outcomes-1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The outcomes Description</strong></td>
</tr>
<tr>
<td>How would you describe the change</td>
</tr>
<tr>
<td>Women were healthier, used emergency services less, were actively employed / seeking employment</td>
</tr>
</tbody>
</table>

### 7.3.3 SROI Calculation

A discount rate of 3.5% is assumed\(^{28}\). In turn, this is used to calculate the Present Value of the entire program timeline (2014–16 in this case).

Table 7-8 SROI Calculation HOM Janesville

<table>
<thead>
<tr>
<th>Year 1 Impact</th>
<th>Year 2 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>28,000</td>
</tr>
<tr>
<td>Discounted Value</td>
<td>28,000 / 1.035</td>
</tr>
<tr>
<td>Present Value</td>
<td>40,122.29 ~ 40,000</td>
</tr>
</tbody>
</table>

### Calculation:

\[
\text{SROI} = \frac{\text{Total Present Value}}{\text{Total Value of Inputs}} = \frac{40,000}{25,000} = 1.60
\]

- This implies that over a period of two years, for every dollar invested in HOM, the ROI for the program is 1.6 (assuming starting year as 2014). Of this, a substantial portion (close to 60%) is put toward healthcare, mental health, and emergency room services, which relieves pressure on resources to Mercy.
- Further, these women can keep their children with them, thus avoiding foster care and such issues. Foster care alone is estimated by the US Government to cost nearly $30,000 per
child per year depending on the state. This program is for both men and women, basically anyone who qualifies, whether or not they have children. Traditionally, however, as interviews have revealed, women are the overwhelming majority in that more than 70% of them have kids—and, it should be noted, oftentimes it is because they have children that these women seek help to straighten out their lives.

7.4 SROI McAuley Residence Portland Maine

The SROI was conducted for the McAuley Residence, including the 15 women who stay for two years. A total investment of $850,000 for two years (all stakeholders put together) yielded a SROI of 1.56 over a period of three years.

This analysis focused on how associating with a transition home or supportive housing program for women with substance abuse issues impacts the stakeholders’ investments over a period of three years. The SROI attempts to show a return on the dollar for the stakeholders as a collective.

Residents are considered stakeholders in the program and, therefore, are responsible for the collective impact; but their role (in this analysis) is limited to their financial contributions alone. The analysis does not include such things as food costs since those are costs residents would have incurred whether or not they were residing at the center.

While regaining custody of children is something women work on at McAuley, thereby reducing the state’s burden on foster care, child welfare is not the main aim of this program. Additionally, there is no mandate for women to have children as a criterion of eligibility. Therefore, children are not accounted for in this exercise.

While the clinic itself has not attempted such an analysis, it nevertheless calls its involvement in the McAuley program something that makes good business sense and something that is evidence based with a proven track record of helping women in a
constructive manner. It credits their program structure, which is actively supported by the physical environment, for the kind of success it has yielded.

7.4.1 Role of space in the SROI

The clinic entered an agreement with the Community Housing of Maine (CHOM henceforth) to trade in the older set of apartments where the McAuley program was in operation for the newer accommodations at Elm Terrace. From information gathered in this study, it is understood that there was no additional monetary payment made by the clinic to CHOM, bringing total procurement cost for larger spaces in a busier location to $0.

Cost savings from private transport and gas usage over two years are used to create a tangible metric to understand the importance of a pedestrian-scale location. Savings from car maintenance costs alone contribute to 7% of the total value of the financial outcomes.

Program staff members admit that it is impossible to pin down value from other qualitative factors, such as the weekly sit down meal that the community kitchen allows, or the bonding that takes place across the safe hallways often leading to long term friendships, where women become each other’s support system lasting beyond the residents’ tenure at McAuley.
Table 7-9 Inputs for SROI McAuley Residence Maine

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended changes</th>
<th>Inputs</th>
<th>Additional comments</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an effect on/who has an effect on us</td>
<td>What do you think will change for them</td>
<td>What do they invest</td>
<td>For a period of 2 years</td>
<td>Summary of activity</td>
<td>How would you describe the change</td>
</tr>
<tr>
<td>Women with substance abuse problems (15 nos.)</td>
<td>Better health</td>
<td>Time, rent</td>
<td>$120,000</td>
<td>Counseling sessions, 3 step meetings, AA meetings, job, life skills, finance workshops, attending</td>
<td>Makes women more empowered, get jobs; rely less on state and health services</td>
</tr>
<tr>
<td>Mercy Medical</td>
<td></td>
<td></td>
<td>$400,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHOM</td>
<td>Coordinate housing</td>
<td>Time</td>
<td>$0</td>
<td>Safe shelter for women and their children</td>
<td>Reduction in homelessness in Portland ME</td>
</tr>
<tr>
<td>Local authority</td>
<td>Provide housing vouchers, other support services</td>
<td>Money</td>
<td>$280,000</td>
<td>Government subsidies, grants, etc.</td>
<td>Reduction in homelessness in Portland ME</td>
</tr>
</tbody>
</table>
Table 7-9 Inputs for SROI McAuley Residence Maine (Continued)

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended changes</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other inputs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The building/Elm Terrace</td>
<td>House the residents in independent apartments, common lounge and community kitchen</td>
<td>Money</td>
<td>15 women and 17 children have a safe place to stay, communicate, attend support group meetings have common meals at the community kitchen etc.</td>
<td>Women feel empowered, feel able to make decisions on their own, reintegrate better into mainstream society</td>
</tr>
<tr>
<td>Building location</td>
<td>Increase mobility and connectivity for the residents</td>
<td>Money</td>
<td>Supports the program’s mission of empowering women and helping them reintegration with mainstream society. Pedestrian scale setting that allows for extensive walkability to city center, a bus stop within a block that provides access to the entire city greatly increases both mobility and connectivity to the women, as does the presence of daycare centers and schools within walking distance.</td>
<td>Women are less reliant on private transport, cost effective solution</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$800,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refer to Appendix C.3 for full calculation details on proxies and sources.
Table 7-10 Indicators and Proxies for SROI McAuley Residence Portland, Maine.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Quantity</th>
<th>Duration</th>
<th>Financial proxy</th>
<th>Value ($, for 2 years)</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you measure program success</td>
<td>Where will you get information for that from</td>
<td></td>
<td></td>
<td>For how long are we assessing</td>
<td></td>
<td>Where is the proxy information coming from</td>
<td>Other non monetizable issues</td>
</tr>
<tr>
<td>Reduced costs of ER healthcare &amp; mental health</td>
<td>National reports, State commissioned studies</td>
<td>15</td>
<td>2 years</td>
<td>Savings on ER, hospital use and mental health services, emergency shelter use, police and jail costs</td>
<td>$306,885 per year or $613,770 ~$615,000 for 2 years</td>
<td>National alliance to end homelessness, Wang &amp; Henderson 2010, State of Maine report, 2007</td>
<td>All costs are estimated under the assumption that women are insured / under government assisted programs (as gathered from interview data) Financial values do no include shelter for 17 children</td>
</tr>
<tr>
<td>Reduced cost of reliance on private transport</td>
<td>Used car rates, gas prices in Portland ME /consumption for 2 years</td>
<td>10</td>
<td>2 Years</td>
<td>Annual cost maintenance costs</td>
<td>2,200 per person = 33,000 for 15 women/year, $66,000 for 2 years</td>
<td>Rates for the state of Maine as ranked by Bankrate.com, the go-to website factsheet for auto issues</td>
<td>Car cost not included. Operating under the assumption that women would already have cars (akin to the other cases in this study).</td>
</tr>
</tbody>
</table>

** $13,500; Office based healthcare-$16,500; Hospital care -$22,500; Mental health-$36,000; Emergency shelter use-$36,000; Jail and Legal costs- $180,000; Police savings - $2,385

Refer to Appendix C.3 for full calculation details on proxies and sources.
7.4.2 The Outputs

**Deadweight:** The SROI in this study is being done in the present and projected for three years (2014 being considered present). However, the McAuley program has been in existence for a much longer time (since the late 1980s) at a different address. And so when staff members were asked what would have happened if McAuley did not exist as it does today, the general response was that the previous arrangement would continue. Thereby, deadweight is 100% and does not come into play.

**Attribution:** Clinic and program staff members credit the location and barrier-free access it provides as active contributors to program success as they aid in women empowerment. They further credit the larger recovery community (AA meetings, Life Coach Social Workers, and so on) for having a role in the program’s success. A 15% attribution rate is tagged to the role of space and recovery community, respectively, giving a total of 15%.

Financial value therefore reduces to $680,000 - 15% = $578,000

**Drop off**

The women stay at McAuley Residence for a period of two years. They get a high degree of support and counseling in their first year. From the second year onward, they are encouraged to be more independent, so that by the end of their second year, they are confident enough to move into mainstream society.

For our SROI, a period of three years is chosen as it is deemed most realistic in terms of program impact. Year 1 is the last year of the women’s stay.

**Year 1:** At the end of their last year of stay, the women are expected to have found jobs, stable housing, and be free from substance abuse issues to the extent that it enables them to live independently. Drop off is, therefore, considered 0.

(Collective) Impact year 1 = $578,000
Year 2: At the end of the second year, the impact is expected to reduce by a quarter, meaning a drop off rate of 25%.

578,850 - 25% or 578,000- x .75 = $433,500

Year 3: At the end of the third year, the impact is reduced by another third, meaning a drop off rate of 33.33%.

433,500 - 33.3% OR 434,137 x 0.67 = $290,445

Table 7-11 Outcomes for SROI McAuley Residence Portland, Maine

<table>
<thead>
<tr>
<th>Description</th>
<th>Deadweight</th>
<th>Attribution</th>
<th>Drop off</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe the change</td>
<td>What would happen without the activity (if McAuley did not exist)</td>
<td>Who else contributed to the change</td>
<td>Does the outcome drop off in future years</td>
<td>Quantity X financial proxy less deadweight, displacement and attribution ($)</td>
</tr>
<tr>
<td>Women were healthier, used emergency services less, were actively employed / seeking employment</td>
<td>The program would have continued to operate from the previous address and operational model. Therefore deadweight is not Applicable</td>
<td>15% (LCSW recovery community etc.)</td>
<td>0% year 1 25% year 2 33.33% year 3</td>
<td>578,000 (Y1) 433,500 (Y2) 290,445 (Y3)</td>
</tr>
</tbody>
</table>

7.4.3 SROI Calculation

A discount rate of 3.5% is assumed. In turn, this is used to calculate the Present Value of the entire program timeline of three years (2014-17 in this case).
• This implies that over a period of three years, for the $800,000, Mercy and other stakeholders invested in the McAuley program, the ROI for the program is 1.56, which means for every dollar, there is a gain of one dollar and 56 cents. Of this, a substantial portion is put toward healthcare, mental health, and emergency room services, which relieves pressure on resources to Mercy.

• According to a study commissioned by the state of Maine regarding costs of homelessness, once in permanent housing, there was a 22% increase in the number of people who sought substance abuse treatment. This directly impacts Mercy because it has an extensive substance abuse treatment program.

• Furthermore, these women can keep their children with them, thus avoiding foster care, and such issues. Foster care alone is estimated by the US government to cost anywhere from $19,000 to $26,000 per child per year. This program is for women and is offered to women who qualify whether or not they have children. However, as interviews revealed, on average more than 70% of the McAuley women have kids—and, it should be noted, oftentimes it is because they have children that these women seek help to straighten out their lives. Child reunification is the norm at McAuley and Mercy raises funds for paying the Life Coach Social Workers (which is included in the attribution). This study does not include children in the

### Table 7-12 SROI Calculation for McAuley Residence Portland, Maine

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Year 1 Impact</th>
<th>Year 2 Impact</th>
<th>Year 3 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discounted Value</td>
<td>$578,000</td>
<td>$433,500</td>
<td>$290,445</td>
</tr>
<tr>
<td>Present Value</td>
<td>$1,225,096 / 1.035</td>
<td>$433,500 / 1.035</td>
<td>$290,445 / 1.035</td>
</tr>
<tr>
<td>Total Present Value</td>
<td>$1,250,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SROI = Total Present Value / Total Value of Inputs

= $1,250,000 / $800,000

= 1.56
SROI, but the value this program provides to not just women but entire families in both qualitative emotional ways and in costs saved for the state is substantial.

7.5 Conclusion

As is evident from the above analyses, the SROI in yielding a positive return to the dollar on all three cases makes a strong case in supporting the area of inquiry—that using the designed environment as central to social program delivery does not impede clinic resources. Furthermore, when sustained over a period of time, these programs lead to positive outcomes, including monetary. Additionally, cost of procurement and maintenance for the built environment is negligible. The returns, one must remember, are calculated considering the inputs just once and then projected for 2–3 years. The clinics, in being realistic about their expectations, limit the impact to that amount of time for each intervention. Such information makes the SROI a useful tool. It is practical and shows results in real-time, provided the program givers and stakeholders (or anyone wanting to analyze the returns on the social investment) are realistic in their expectations.

An SROI is not an all-encompassing, decisive tool but it certainly helps to shed light on most of these issues because it shows the importance of relationships among peers and stakeholders; it exposes other attributors to program success; and most importantly, it helps organizations to think in terms of what their expectations should be, what should be adjusted for the future, and what they can do better at each stage to improve outcomes. This sort of analysis helps make social programs more accountable to program givers, decision makers, and stakeholders who can determine further steps based on present outcomes, and who can review their own roles and contributions in those outcomes. For this study, the SROI enables us to see how space-based social programs fare over a finite timeline, what kinds of returns can be expected, and most importantly, what the active role of the designed environment is in monetary terms.
Chapter 8.0: The Clinic and Community from a Cross-Cultural Perspective: An Essay and Case Study in India

To be different is not necessarily to be ugly. To have a different idea is not necessarily to be wrong. The worst that could possibly happen is for all of us to look and think and act alike.

—Gene Roddenberry, at Shore Leave 14, in Hunt Valley, MD, July 11-12, 1992

This chapter examines the issue of the clinic and its role in a community within a country and culture that is vastly different from the United States—India. Healthcare delivery is deemed global in presence yet local in delivery. And so it was an intriguing idea to examine whether a country like India, with a culture so vastly different from the United States, would support the notion that clinics could be of service to the community beyond direct medical care. The basic focus remained on the designed environment, or how the physical resource has been used to satisfy a pressing social need.

Preliminary research in the form of internet searches and phone interviews with healthcare professionals in India revealed that the topic of inquiry is at an even more nascent stage than it is in the USA. Another difference made obvious in the preliminary research is that in India social value is understood and interpreted rather differently from the United States.

Since the intent of this study is to look at a two-way value exchange, as in whether the clinic also actively sought a benefit from the space-based social program, finding viable cases turned out to be much more complicated. This chapter, therefore, is visualized more as a descriptive, qualitative essay on the idea of clinics in India reaching out to communities in a manner that is beyond just medical care, with one viable case examined in detail.

**Background:** India and the United States have several things in common. They are large countries and democracies with a diverse population set. But there are several differences too.

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India is a developing country and broadly identified as a high-context culture with literacy and life expectancy rates far behind the United States. It is also a country where clinics see a big divide in business models, with most private (non-government) ventures being for-profit outfits. A fundamental criterion for this study was for the clinic to be nonprofit, so this greatly limited the search pool. The selection criteria for clinics in India were the same as that for the United States (see Table 4-1 and Table 4-2 for criteria matrix).

The stereotypical perception that anything pertaining to social problems is the burden of either the government or nonprofit outfits is prevalent in India too. Most non-government hospitals are for-profit and, like in the United States, these clinics are under no mandates or obligation to address social issues. It is considered the job of the government to collaborate with nonprofits, other social regulatory agencies, and international agencies like the U.N. Further, pressure for basic medical care is so high that government and nonprofit clinics are overburdened doing just that.

This is not to say that there is no attempt toward addressing a larger social good. Preliminary research in the form of internet searches and phone and email discussions with healthcare professionals in India led to the conclusion that if one were to look for spaces aiding social good beyond medical care, a broader definition of social value would have to be put in place. The idea of a clinic providing a space-based venture to enhance a socially sustainable framework would need to be examined in a holistic sense, looking at how provision of certain spaces (that was not catering to direct medical care) was adding value to the community’s experience. Additionally, whether or not clinics benefitted from this interaction would need to be examined.

A broader definition for a socially valuable venture also led to a reexamination of the role of space within the clinics. Included were spaces supported by the clinic and used for purposes beyond medical care in such a way that the clinic was addressing a social need. This meant looking at the third spaces, spaces that are neutral in nature, and inclusive, but with no political,
religious, etc. agenda of its own. From a physical characteristic standpoint, third places are neutral spaces that allow for personalization, seating, and shelter (Mehta et al, 2010, p. 783). The basic premise of the third space ideology is that these spaces support the social wellbeing of the users.

Once this characteristic of space was included in addition to the other search criteria, one viable case manifested—third spaces at the Sambhavana Trust Clinic Bhopal.

**8.1 The Sambhavana Trust Clinic, Bhopal, India**

**8.1.1 Background**

A methyl isocyanate gas leak in the early hours of December 3, 1984 in the city of Bhopal, in the state of Madhya Pradesh (central India), left hundreds dead. Over the years, ground water contamination resulting from the gas leak has left thousands permanently disabled with a range of gas-afflicted problems. The aftereffects of the gas tragedy continues with children (as of 2014) being born with physical and mental deformities. Several social problems have arisen from this as well. At a forum on International Women’s day in 2015 in the city of Bengaluru, it was reported that girls from the part of Bhopal where the tragedy occurred find it harder to get married since the fear of gas affliction runs high among the public. Known as the worst man-made tragedy on earth to this day, this tragedy and the fallouts from it are never far away from the minds of Indians and receives regular coverage in popular press and media.
Figure 8.1 shows several images from popular press regarding the Bhopal gas tragedy over the decades.

Started in the 1990s to care for the largely low-income population that was most affected by this tragedy, the Sambhavana Trust Clinic in Bhopal has since become the go-to place for all things related to the gas tragedy—medical treatment, health education, research (they have an extensive library on all gas related issues), and general wellness.
The clinic is built entirely from locally available materials. It uses vernacular design principles (high ceilings, light wells, tiled roofs, mud paths, etc.) to create a more casual atmosphere. To reduce the use of electricity, the clinic has no air conditioning and harnesses solar power to supplement day-to-day electricity requirements. There is a one-acre herb garden with 125 indigenous, medicinal plants which are used to produce ayurvedic medicines.

8.1.2 Operational Model

The clinic is a nonprofit ambulatory care center that implements a holistic approach to the delivery of care. Its mission, as communicated during on-site study, is “to empower the community to lead a better life.” A combination of allopathic (western) medicine and Ayurveda (traditional Indian medicine) is rendered in varying degrees depending on the patient’s condition. Operating costs are roughly rupees 1.5 crores a year (approximately $240,000 as of March 2015 exchange rates), which is raised primarily through donations and charity. The clinic takes no monetary help from the government, whether local, state, or central. They also reject corporate sponsorships on principle.

The social issues that the clinic addresses are different from the other categories mentioned thus far in this research. Given that a high percentage of people in the surrounding community are affected by gas inhalation and suffer from related diseases, every program the clinic offers is geared toward helping to alleviate their conditions: physiological, psychological, or socio-physical.

Third spaces at the clinic have been chosen for two main reasons:
- They do not pertain to delivery of direct medical care.
- Third spaces help to mitigate a pressing social need for that community.

The spaces being studied include open patios and verandahs, a multipurpose hall, and a rustic hut.
8.1.3 Location and Access

The clinic is set on a two-acre campus, in the heart of the community that was most affected by the gas leak and adjacent to the now defunct Union Carbide factory (which was responsible for the leak). This was done to ensure that community members can have direct access to the clinic as most residents are low income and do not have a means of transportation. Residents either walk to the clinic or use a two wheeler. The clinic is particularly proud that by locating the clinic within walking distance of the community, it has ensured that women in the community can still come in. (The clinic does not charge anyone for service rendered.)

Clinic staff members point out that an added advantage to the ease of location is that once they (community members) arrive, they learn that with no added cost they can stay for other programs like yoga, meditation, the afternoon tea service, and so on. The nearest public transportation is over a third of a mile on the main Berasia road. This is the closest point to get private transportation as well (taxis, auto-rickshaws etc.). Roads that lead to the clinic from thereon are narrow, winding, and insufficient for navigation, making them difficult to access. However, word-of-mouth publicity for the place is high and directions to the clinic are clearly given on their website, even though on-site research found actual navigation to be very poor in terms of signage.
Figure 8-2 Location map of the Sambhavana Trust Clinic Bhopal. Set amid a densely packed small business but mostly residential low income neighborhood. Also seen are relative positions of Union Carbide plant, responsible for the gas leak and nearest bus stop. Despite the actual distance being approximately 0.3 miles, the streets are narrow and labyrinthine making access confusing, which is further hampered by poor navigation signs. Most clinic users access the place either by foot or private transportation, usually a 2 wheeler. Entire community is the target recipient zone. Clinic says that given that it is located within everyday movement radius of the catchment area, signage, nested location, and visibility issues are not impediments. (Map courtesy: Google Maps)

Interviews, discussions with staff on premises (including a couple of volunteers), extensive images, and observation of the third spaces were conducted. Further, a walk around the neighborhood was done to understand the condition of the neighborhood, access roads, and transportation issues. Major findings from the data set are presented briefly sections 8.1.4 and 8.1.5.
8.1.4 Third Places

The people found uses for these; we were just going by traditional principles.

—Staff member at front reception on the extensive use of third spaces

We never ask anyone to leave; 15 minutes of rest can improve ones’ day by a big margin.

—S. Ansari, librarian and manager-in-charge

- **The patios and open verandahs:** These are scattered all over the clinic. Semi-open verandahs, porches, and light-wells serve as spaces for rest and rejuvenation for the community members. People rest there, have quiet talks with one another, or have discussions with a social worker. The clinic staff members say that this was an unintended benefit of the vernacular design. Most residents of the community live in cramped living quarters and having these open spaces surrounded by greenery is a huge bonus for them.

Four different locations were chosen for five minute observations at three different times in a work day. Of the total 12 sessions, the spaces were occupied 11 times.

- **The multipurpose hall:** The semi-open circular hall with three-foot high parapet wall all round serves many purposes—discussion, health education, yoga, cooking demonstrations, and when the space is without a designated use, it is used for rest and relaxation. Located centrally within the campus, this hall has a thatched roof which makes it cool during summer and traps heat in the winter, thus making it an ideal place for many activities. The clinic is firm in its belief that a mind-and-body holistic approach that includes a combination of health education, mental wellness, and physical fitness is essential for a person’s wellbeing.

- The hall is not part of the main clinic building and the semi-open structure gives a feeling of casual informality. Women particularly use this space in large numbers for rest and relaxation, or just to take a nap. The space was observed for three minutes at four different
times and observations indicate a 100% occupation of the space. During the observations, the space was used once for a demonstration and lecture and three times for resting.

- **The Rustic Hut:** a hut has been created at the bottom of the one-acre herb garden behind the clinic. Built of timber poles and a thatched roof, it is open on all four sides with the exception of a low wall which also serves as a ledge for seating. Like the other space, the hut has been created for rest and rejuvenation amid the greenery. There is a clay hearth for making tea which adds to the local, rustic charm. Staff members say that this space is mostly used by women, usually to relax after a yoga session or after an ayurvedic treatment. Women can also be seen chatting with one another, they say, adding that it is good to listen to others in the same situation because it makes them feel less isolated.

- Given the highly conservative families these women come from, it is notable that they are talking and listening to others while understanding that what they are going through is not a moral failure on their part. S. Ansari says of the women: “We want them to come back, get whatever treatment is required, and learn that they can manage their situation and live a full life. All these efforts (meaning the yoga, meditation, the hut etc.) are toward encouraging and empowering these women.”
8.1.5 Visual Data

Figure 8-3 Images show various patios and open verandahs on the clinic campus. These are heavily used spaces according to clinic staff, which was corroborated during observation at various times during the day. The clinic has extended its mind-body philosophy to the designed environment, creating these third spaces on intent to create spaces for quiet reflection, discussion, rest, and respite. (Image courtesy A. Saligram)
Figure 8-4 The multipurpose hall—created for meetings, discussions and demonstrations, a space which users have made their own and used for rest and relaxation. (Image courtesy: A. Saligrama)

Figure 8-5 The rustic hut at the bottom of the herb garden, used for an afternoon tea service and also as a space for some peace and quiet. (Image courtesy: A. Saligrama)
8.1.6 Benefits to the Clinic

The Sambhavana clinic renders a critical service to this very large community (the clinic had, as of December, 2013, close to 30,000 registered members with various gas-afflicted issues). The services the clinic offers are free of charge and so every bit of help in terms of mitigating the community’s suffering directly benefits the clinic, including reduced pressure on medical resources, doctor hours, and so on.

Spaces for rest and rejuvenation, which house programs like yoga and meditation, not only aid patient health but they also benefit the clinic by allowing it to offer medical attention only to those who need it rather than to everyone who comes in with a gas-afflicted situation.

For its unique health model, the clinic has received national and international recognition and awards, including the International Regenerative Health Care Award in 2009 at the Clean Med Global Conference on environmentally sustainable health care.

Clinic staff members also say that the holistic approach of addressing the mind and body as one has been adhered to very stringently, which she says is a reason why community members are seeing so much relief in their everyday lives from their chronic diseases. The success of this model has led to a steady flow of donations and philanthropy which helps keep the place afloat.

Having this space to offer all these programs have helped the community recuperate better. We are glad we have this campus so that the community can benefit in every way.

—S.J. Ansari, librarian

8.1.7 The Everyday Life of Women as a Strategy

Access and visibility took on new meaning when the Sambhavana Trust Clinic was studied. At face value, one could conclude that both were low and complex. However, from the
Clinic’s point of view, the fact that the clinic is nestled in the midst of narrow, winding streets is not an issue because their focus is mostly on providing relief for those most affected. And this population subset resides in and around those narrow and labyrinthine streets, so they know exactly how to access the clinic. Additionally, the fact that staff members say that the location is particularly ideal for the women sheds further light on the importance everyday lives of women as well as on the socio-cultural qualities of spatial arrangements for meaningful interpretation. This also gives a better understanding of the inseparable connection between spatial and social networks.

The clinic does not keep track of what modes of transportation are used by patients. While it is imaginable that a portion of patients would come by public bus, clinic staff members say that percentage is negligible, adding that the location was chosen to ensure women and children could have the greatest amount of access. Places of rest and relaxation, a playground for kids while their female caregivers see a doctor, tea service, and so on, are all features that are targeted to ensure that the women in the community feel comfortable enough to come to the clinic. The large numbers of women who attend the clinic is testimony to how much the clinic has understood their everyday lives (Horelli & Vepsä, 1994; Michelson W., 1994). This successful use of the designed environment was a deliberate and strategic move by the clinic.

8.1.8 The Role of Third Spaces

It can be fairly argued that third places play a critical role in the socio-spatial dynamic in the Sambhavana Trust. There is sufficient literature, more recently by Hickman (2013), that argues for the importance of third places in civil society (nonprofit organizations), and deprived neighborhoods in particular. Spaces are created to fulfill a functional role, but when spaces are created (by design or default) to harbor social roles as well, the place tends to have more meaning to the users. While it strives to appeal to women, the Sambhavana Trust clinic is neutral ground. Characteristics such as gender, religion, caste, economic status, or age of the
users do not matter. For a low-income community that is severely afflicted by a poisonous gas leak, a community where most live in packed tenements, where solitude and privacy are essentially nonexistent concepts, having spaces that allow them to relax, reflect, and rejuvenate makes a definitive difference in their day-to-day lives.

8.2 Libraries as Third Spaces

Yet another interesting case for third spaces in the Indian context is that of a library within clinic premises. A large, nonprofit government teaching hospital that specializes in cardiac care in Bengaluru has opened a public library and reading room for patients, visitors, and the general public on its premises. Having identified that a lack of reading facilities was a problem in the community, combined with a desire to reduce the noise levels of patients and visiting relatives or friends within hospital premises, a visitor expressed the idea of starting a library on the clinic premises.

In an interview with the popular press (Praja Vani29, April, 2012), the hospital director says that he liked the suggestion so much that he started a library in a large, vacant storage room across from the food court. This central location is ideal as many who come to the food court also have direct access to the library, he says. Since its inception in November 2011, the library has become so popular that it exceeds 300 visitors each day with the collection now including advanced medical education books per requests from students (it is also a teaching hospital).

Clinic staff members say that community interest in the library has increased to a point where they are running out of space. They want to start a separate reading room for newspapers, magazines, and fiction, thereby separating the serious readers from the more

29 Praja Vani (Voice of the People), published in Kannada language is a widely circulated newspaper in the state of Karnataka and is published across four locations, with a reported circulation of over half a million to one and a half million each day.
casual readers. This concurs with Montgomery and Miller (2011) who argue that the new normal is the role of the library as a third space for both learning and community interaction (p. 229). The clinic says that monetary benefit is not something they seek. They say they are happy that they are in a position to offer this much-needed service to the community and that the reduced visitor traffic and noise in the hospital corridors is a huge plus.

In the Indian context, discussions and on-site visits lead to the understanding that third spaces play a vital role in generating social wellbeing. If one were to consider Mehta and Bosson’s (2009) spatial conditions to support human use as a guide, these spaces seem to answer at least three out of the four characteristics. Leanings into a vernacular style of design and human scale were two additional elements that stood out in the Indian context. The nature of these neutral spaces allows the user respite from their everyday activities, allowing them to spend time relaxing, reading, reflecting, or resting. A clinic, by definition, is neutral ground, where service is not denied to anyone. By extension, offering third spaces that help to mitigate a pressing social need in order to benefit its community can be construed as an extension of the clinic’s basic mission.

8.3 The Importance of Program Structure

However, when we narrow the Indian context down to the basic research question as to whether or not there is a two-way value exchange being sought where beneficiaries are both clinic and community, the idea of value to the clinic must be evaluated in the holistic sense. Clinics do not seek monetary or even monetizable benefits. Rather, reduction of pressure on providing medical resources is a prominent concern for clinic staff members and administrators. While socially entrepreneurial elements do exist (as can be seen from both the Sambhavana

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30 The four characteristics being personalization, permeability, seating, and shelter.
Trust case and the library case mentioned above), a clear identification of need, opportunity, and a business-minded approach are lacking.

This is a reflection of how things work in India, says Dr. Sita Subba Rao, former chief of operations at a specialty hospital in Bengaluru. As someone who specializes in setting up hospitals, Subba Rao says that demand in India for health care is so high that private hospitals do not have an incentive to do anything beyond medical care for social good. She doesn’t believe that this is a healthy approach, adding that it will be a long time before the private health sector opens its door for more than medical care. Furthermore, most private hospitals are for-profit and see no incentive in doing anything extra for the community. Government and charity trust hospitals do their part, but the burden of subsidized and free medical care is so high that taking on social programs becomes an ad hoc effort.

An activist mentality from someone in a senior position is what usually works, Subba Rao says. Even getting help from the corporate sector to adopt social issues as part of their (the corporation’s) CSR initiative needs an activist within the clinic, someone willing to take it upon themselves to contact the corporation, make them aware of the issue, and to make the issue appealing to the corporation. Dr. Subba Rao concludes: “It is a pity we see some very good programs folding once the concerned person leaves. It’s unfair to expect their successor to be as passionate about the same project especially since most times these programs will be running on personal contacts and goodwill garnered by the person who set it up. Usually there is no system in place which would make it easy for the next person to carry on.”

Target identification is less complex in a community like the one where Sambhavana is located, since most members are gas afflicted. Simultaneously, however, when one is faced with an entire community (upwards of 150,000 people) that is sick, innovative thinking is not an option but a must. The idea that an open verandah or tea hut can attract people to the clinic certainly helps the clinic in the long run—patients come in for treatment, they rest, relax, and
then they go back to their daily lives refreshed. This beneficial outcome increases the chance that patients will come back to the clinic and that they will tell others about their experience.

While the clinic does not charge anything for medical services, its aim of bettering the community’s health so as to reduce the burden on its own medical resources seems to be working. The designed environment has actively contributed to the delivery of care (medical and beyond), garnering national and international awards, and mentions in books. But in the library case mentioned above, it remains to be seen how the program sustains over time since an overtly entrepreneurial program structure dedicated to that social venture seems absent.

8.4 Similarities across Cultures

Like their US counterparts, social programs in India are not offered with a monetary profit in mind. Each of the programs has social good at the core. Different countries and different communities mean different problems and different ways to address them. Reduction on medical resources is definitely a larger aim in the Indian context, overtly expressed or not. Programs and details are not well documented and it appears that the activist identity dominates over the strategist.

A committed, socially entrepreneurial outlook is not evident, in program structure or operational strategy, where there is an almost complete reliance on philanthropy. This puts into question the longevity, or long-term sustenance, of such program(s). A departure from this seems to be the Canara Bank Relief and Welfare Society (CBR & WS henceforth), which is more business-oriented with emphasis on program structure and planning. Operational since the 1960s, this trust offers various, communally beneficial programs, including a large specialty hospital, out of its welfare complex in Bengaluru. On the same campus is an elder home and geriatric center. All operational practices are generated through the trust, while the clinic offers its expertise only where medical care is required. While this model is highly successful, CBR & WS must work full-time to procure funds since its operations are mostly reliant on charitable
contributions (rent from the elder homes and payments from patients for medical care are among its few income streams). The role of space is limited to providing housing at the elder home and to providing advantages due to the clinic’s proximity to other amenities like banking and shopping.

That space can be used as an active and valuable resource, modified and tailored to support social good is a nascent idea in the Indian context, even more nascent than in the United States. Staff members at CBR & WS acknowledge that pressure on land in India is greater than in the US, so using space for anything other than designated uses seems to be unthinkable, particularly when the new use would be a social cause wherein the returns are not readily measurable. Some clinics (like the Sambhavana Trust) understand the benefit that lies in it for them, so they are taking strategic steps to address social problems; while others (like the cardiac care hospital and library case) have the right intent and are offering a space-based solution to a social problem whilst not having worked out the details.

Despite the mixed bag of ideas that have come out of the Indian context, it is nonetheless an encouraging sign that clinics are not averse to addressing social problems. The idea that the “haves” must help the “have-nots” is still very much in play. Several volunteer organizations have been established in which doctors donate their time to community-building in an organized manner, though it is not through their clinic. This activist mentality could well be channeled into creating alliances between clinics and the corporate sector which has started addressing social initiatives in a serious way. This association could lead to fruitful three-way partnerships between clinics, their communities, and the corporate sector, making for some interesting times ahead.
Chapter 9.0: A Discussion of Major Findings of the Research

It is better to debate a question without settling it than to settle a question without debating it.

—Joseph Joubert

The findings from the analyses showed the various environmental and program-related factors that contributed to program existence and output. They also revealed degrees of relevance of the various factors to one another that ultimately contribute to program success. Additionally, the results highlighted how not all factors are uniform across case study themes, or even across similar programs. This chapter discusses some of the major findings from the research. It looks at several issues in-depth, makes a broad mention of other issues, discusses similarities across cases, and finally looks at the connotations the outcomes have in both environmental and socially entrepreneurial areas.

Common to all cases was the importance of intent, planning ahead, and using the environment to support the program—even though the actual manner in which the environments were used to support the programs differed from one case to another. The clinics in each of the cases displayed innovative thinking to varying degrees in using the main resource, the built environment, to its advantage in order to enhance program output and to create advantages for the clinic. From using the urban footprint, to furthering their message of empowerment, to using the physical environment, to creating positive brand awareness, the clinics in this study have displayed a clever understanding of the potential of the designed environment to benefit both the community and themselves. As is often said of **bricoleurs**, “the tools not only shape their end purpose, but the purpose is also shaped by the resources available” (Di Domenico et al., 2010, p. 685).
The following sections highlight some major outcomes of the analyses, including factors that had an impact on program outcome, and factors that help to create an advantage-base for the clinics to support space-based social programs.

9.1 The Activist / Strategist Dilemma and Program Planning

There has to be an activist streak, absolutely. But he/she must be resourceful enough to back it up with a plan that actually works.

—Dr. Maring on the role of the market champion

A nonprofit clinic shares common ground with other socially entrepreneurial nonprofits in some areas—self-reliance, a reserve of voluntary effort, and, most importantly, the absence of profit motivation. While there is a certain level of dependency on philanthropy and grants, they aim for financial stability through revenue generation (e.g., paying patients, insurance and government reimbursements, etc.). However, when a clinic decides to address social problems that may be tangential to its motto but above and beyond its everyday business, it needs resources and planning that do not affect its operational bottom-line. And for these social ventures to be fully operational and sustainable over a longer period of time, these programs must exhibit tendencies that are both innovative and entrepreneurial.

Most social ventures start from activism. The farmers’ market phenomenon at Kaiser Permanente started from exactly that. Dr. Maring, a proponent of healthy eating and fresh food, started the first market on the sidewalk adjacent to the Oakland clinic because he believed that it was not enough to just ask people to eat healthy. He wanted to make it easy for people to do so as well. However, Maring is very clear in saying that for every good thought, the so-called activist must be in a position to back it up with a plan for action. Having been with the organization for a number of years, with several leadership positions under his belt, he says he knew whom to approach and how to go about planning the market. He is candid in saying the
market champion has to be someone in middle management who has been with the clinic long enough to know people and be known in return.

The same can be said of the segment of programs with a sensitive nature. The House of Mercy at Janesville was started by the CEO of Mercy Health System, who felt strongly about the homeless women in the community. As noble as the thought was, it was just as important that, as the CEO, he had access to the information and resources necessary to plan and implement the program. At House of Mercy, Des Moines, the initial idea for a substance abuse and transition home was mooted by a senior nurse, but was subsequently adapted into the system’s core strategy and a senior Vice President of the clinic was appointed to oversee the venture.

When we examine the identity model of nonprofits, especially those nonprofits that are socially entrepreneurial, one sees that their identities are comprised of both activist and entrepreneur mentalities, and the salience of one mentality over the other influences the type of social venture implemented. As noted by Simms and Robinson (2009), it is the ability to innovatively use resources to create a valuable output that sets an entrepreneur apart from an activist.

Opportunities exist everywhere. It is, however, in the identification and interpretation of opportunities based on the founder(s) salient value set and how those values are incorporated into program planning that we see the social venture taking on its final form. While the personnel within the clinic responsible for the social venture might have both activist and entrepreneurial identities, when it comes to the actual planning and implementation of the program, they must deal with both identities simultaneously and resolve this by either prioritizing one identity over the other or separate them altogether (Ashforth & Mael, 1989).

31 A socially entrepreneurial model is defined as one that has a social mission at its heart, moves toward self-sustenance through innovative means, moving away from traditional funding and strategic planning with intent to create value collective to society.
The social ventures in this study started with an activist mentality but were backed by a strategic and professional approach that incorporated strong entrepreneurial overtures. This, though over time in some cases, has become part of their organizational strategies. In the programs of a sensitive nature, full-time employees are on the clinic’s payroll. In the farmers’ markets segment, the market champions are people who know and are known within the clinic’s leadership, and who have enough influence to deal with the expected and unexpected issues that are involved in continuing to offer the market. The program staff, market champions, etc. are passionate about what they do and it comes across in the interviews and discussions. However, what also comes across is the strong desire to have a plan of operation so that the program can continue to run smoothly. This was common to all cases.

9.2 Social Design and Social Bricolage

Albeit being separated in origin by nearly three decades (1983 for Social Design to 2010 for Social Bricolage), these two areas have several factors that are highly pertinent to this study. Starting from recognizing resource limitations, both areas talk about the importance of having the end user in mind at all times for maximum program and environment benefit. They each address several areas like cost, scale of operations, community and stakeholder participation, to name a few common strains. Social Design looks at issues like inclusive design, a bottoms-up approach, and the use of appropriate technology. Social Bricolage, on the other hand, places significance on the skills of personnel involved in structuring and planning the program. Skills emphasized include persistence, negotiation, innovative thinking, and improvisation.

When we look at the individual case types, the manner in which the farmers’ markets (healthy eating) initiative is offered by Kaiser stands out. The market initiative is overseen by the food and sustainability manager nationally. There are basic options for market structure and some design guidelines, but beyond that, it is up to the individual clinics and market champions as to how they run the market. Whether they offer a single-farmer farm-stand (Santa Rosa),
whether they partner with a farmers’ market association (Oakland), or whether they offer it themselves, directly working with each vendor individually (Fresno) is entirely up to the clinics. It was also mentioned that there was not a top-down mandate on how to set up a market; rather, the setup was left entirely to the market champion. This means innovation, persistence, negotiation, and using every tool at their disposal based on the needs of their own communities. So it follows that Social Bricolage components come into play in full force.

When it comes to programs that address issues such as homelessness, factors such as innovation and persistence take on a different meaning. The dynamics involved in setting up and running a homeless center or community center for a low-income population is infinitely complex. There are several regulatory agencies to be satisfied, comprehensive community needs assessments to be conducted, and significantly larger pots of funds that need to be procured on a continual and sustained basis (e.g., the HOM in Des Moines, Iowa has an operational budget of $16 million, with an annual food budget alone exceeding $300,000). By necessity, the manner in which these program givers approach program and resource planning is different from the program givers at the farmers’ markets.

Each place has been strategic in utilizing its main resource, the building. Two of them inherited buildings already owned by the clinic (HOM at both Des Moines and Janesville), one found an abandoned railroad building and worked with the town council to obtain loans for remodeling (WCRC Vermont), and one (McAuley Residence Portland) traded an existing building for a larger space with a partner (Community Housing of Maine) who had the necessary skills to operate the housing. These strategic decisions exhibit strong intent on program implementation through innovative thinking, persistence, and a clever adoption of a resource-based view.

In Bhopal, Social Design elements like taking a human-scale approach, design features, and materials reflecting the local community have been used effectively to ensure that the community feels comfortable in that space, thus allowing the clinic to impart its mind-body
holistic treatment. Vernacular architectural elements and locally sourced building materials are used so that users of the space feel a sense of familiarity and are not overwhelmed by the building itself. As was revealed during on-site discussions, once people view the campus as a local offering and “the campus does not look threatening or like a hospital”, (S.J.Ansari, personal communication 2013) it becomes easier for clinic staff to introduce other programs like yoga and meditation. The campus, its location, layout, building materials, etc., have all helped to create a bond of trust between the clinic and the community. While spaces as tools for goal support is discussed elsewhere in this chapter (section 9.5), it is nonetheless important to point out the role Social Design and Social Bricolage elements played in making the Sambhavana Trust campus a success. Another benefit to using local design principles and materials is that they help to keep maintenance costs down for the clinic. All materials are locally sourced and so costs for transportation during construction and subsequent replacements are much lower says the facilities management personnel on-site.

These two areas (Social Design and Social Bricolage) exhibited strong frequency and a co-occurrence co-efficient with one another. This implies that not only are these issues important, they are also compatible, and, therefore, are the optimum program output when used in tandem. The practical implications of Social Design factors like human-scale and small scale approach were evident in the cases where these very factors were mentioned as critical to program quality and delivery, the space defining the nature of the program, and the nature of the program making space a central, critical requirement.

9.3 With Women as the Focus

When the study was proposed, the focus on women as a target audience was considered as a partial focus. As the research progressed, however, it became increasingly obvious that the social programs chosen had a certain gender bias, though some more than others. Even the farmers’ markets were said to be used by women more than men in some
places. When it comes to more serious issues like drug rehab, research says (Hodgins, El-Guebaly, & Addington, 1997) that women tend to do better in single gender programs that are long term and not overly structured. Women discuss their problems better amongst other women as opposed to mixed gender groups (NeSmith, Wilcoxson, & Satcher, 2000). On-site interview discussions concurred with all of these notions and so whilst the study does not exclude any population subset, women as the target recipient became the main focus, albeit an unexpected one. All the major outcomes of this study directly or indirectly reflect the usage patterns of women in the programs.

For example, in the segment devoted to programs for low-income women, the issue of women as caregivers stood out prominently. At all three residential programs studied, it came to light that it was not just the women but also their children that were a focus for the program givers. It was very clear to them that ignoring child-related needs was not an option.

From offering on-site day care (HOM Des Moines) to ensuring that families could be accommodated into one living space (HOM Janesville), the environments and programs were purposefully structured to incorporate children. Even the WCRC Vermont, where the women need come in for only a few hours or less, has created a play area with toys, etc., for kids to keep kids safe and busy while the parent (usually the mother) attends a session with a counselor (see Figure 9-1). Apart from catering to the psychological and emotional needs of mother-child bonding, there were several other benefits from this family-minded approach. For one, knowing their children were safe meant freeing up time and mind space for mothers to attend and benefit fully from the program. And for the residential programs, the clinics’ staff members emphasize that by keeping children with their mother, there are substantial savings for the foster care system—upwards of $26,000 annually, depending on the geographical location (Zill, 2011).
Many of the programs’ environmental appropriations revolve around the role of women as caregivers and making sure that as many barriers as possible were removed. In some cases, like WCRC Windsor and, particularly, McAuley Portland, spatial structure seems to follow the program’s motto—the empowerment of women. From a well-connected location to a pedestrian scale of operation (outside the residence, including bus stops), the environment supports the women in their endeavor to seamlessly merge into society. This certainly ties with various scholarship associated with everydayness (Michelson W. , 1994; Horelli & Vepsä , 1994).
9.4 Visibility, Access, and Location

These three factors combined make for the highest subset of codes in each case type and analysis type [both visual and verbal]. And one can also say the importance of these above three concepts for program success is fairly direct. In order for a program to be used, the space must be seen; it must be visible, accessible, and where it is located directly impacts both vision and access. As was seen when examining pertinent literature (Chapter 2.0), there is a strong connection between vision and access as well as activity and usage. Most relevant to this study, however, are the different ways the same factors are manipulated by the program to optimize output.

9.4.1 Location and All-Inclusive Access

Farmers’ markets with their intent of increasing access to fresh food for the entire community have more of a chance at success if they are visible and accessible to as much of the community as possible. Some markets are more successful than others in this regard. The Kaiser Farmers’ Markets at two of the locations, Fresno and Oakland, typify this. While some markets are restricted in certain ways (e.g., local councils barring them from putting up publicity material), the location, visibility, and accessibility it affords can make big difference in market popularity—something corroborated through both interviews and observation.
9.4.2 Access and Seclusion

Simultaneous access and seclusion (The Bletchley Circle, January, 2014) has been employed in some of the programs with a sensitive nature. Accessibility and visibility in these cases can be translated as something that can be approached by the target user without barriers. As long as the spatial characteristics make it accessible and visible to those who require it, there is increased probability of the program reaching optimum usage.

In these cases it is the relationship among the components, the manner in which these relationships are configured, and how the configuration agrees with the users’ movement patterns that gives the space (or building type) meaning. The importance of visibility, access, and location lies in what it is convenient and respectful to the user. In some cases, a location away from the main street was said to be advantageous to the program. Program givers say that a not-so-prominent location helps reduce the stigma of being associated with such
programs while simultaneously enabling the women to get help, recover, and to go about their lives without feeling scrutinized.

The location of the Sambhavana Clinic in Bhopal has a strong connection to the target audience. Located close to the factory that caused the gas affliction, the clinic is directly in the heart of the community that needs these medical and other wellness facilities. The location also encourages women in this community to access the clinic on their own, with minimal reliance on private transport or other family members. It is not a prominent location on a main road; it is nested inside a community with labyrinthine paths and winding streets; yet the clinic is accessible to those who need it the most.

In one particular case, a fairly prominent location with high visibility was handled innovatively. In fact, the high visibility was turned into an asset by program givers to support their philosophy of empowerment. Elm Terrace (Portland, Maine) is a 40-unit apartment building, with 15 of those units allotted to the McAuley Residence. Program givers have put no signage outside indicating the presence of a transition home. The entrance and lobby is common to all residents of the building. It is impossible to say which women are a part of the McAuley program and which women are just tenants. Once inside, there is a more discrete second door off the lobby that requires a separate fob key to enter. This door takes us into the McAuley Residence part of the building. There are apartments for the women, counseling spaces, a community kitchen space, common lounge, computer lounge, children’s play areas, and so on. It is as if they live in a world of their own, nested within the building, nested within the neighborhood--hidden in plain sight (see Figure 6-17).

Navigation does not always depend on direct visibility and requires a more abstract understanding of the many ways in which local parts are interrelated into a whole pattern (Chang, 2002, p. 429). And equally important for the parent organization offering the program is to structure the program in a manner that the environmental influences can be incorporated into it, thus turning the physical resource into a valuable asset.
9.4.3 Barrier Free Access and the Case of Public Transportation

The presence or absence of a particular element and its utility are different things, no matter what stereotypes say. This point was made abundantly clear with the issue of public transportation. When interviews were conducted for both case types (across seven settings), the issue of presence or absence of public transportation was raised. Bus stops were present in and around each of the farmers’ markets studied. As the visual analysis of the farmers’ markets show, public transportation had a huge presence within a block of the markets (see Figure 5-1, Figure 5-2). In fact, at the Oakland market, there is a BART\textsuperscript{32} Shuttle stop right in the middle of the market (see Figure 5-16). The outcome of the interviews and observation showed that reliance on buses for market buyers was next to none. Neither observation nor interviews conclusively could say none of the buyers at the market came by bus. However, there were several factors that lead one to believe in this case-type the presence of bus stops makes no difference to program usage or program impact.

As interview data revealed, most patrons who are non-KP staff or patients (roughly 25%, according to a 2010 KP farmer’s market survey) walk to the markets. Poor parking choices in most Kaiser clinics that offer markets was cited as a major problem for market champions who wish to increase the number of market goers. The timings of the markets are a contributing factor to the lack of public bus usage. Weekday daytimes are when most people are at work and this is when these markets are run. Finally, there is the question of choice. In Northern California, farmers’ markets are widely prevalent; and in cities like Oakland there are markets run every day of the week. Market consumers choose markets closest to them at times most suited to them, so they see no need to use public transportation to get to the markets (Jeanne O’ Reilly, market champion Kaiser Oakland, personal communication).

\textsuperscript{32} BART = Bay Area Rapid Transport
There is a line of scholarship that links income levels of women and reliance on public transportation. Prominent in this line of thinking, Churchman (2000), says that given the generally lower levels of wage earning, women tend to use public transportation more. However, in our case-types on programs for low-income women, it was shown quite strongly that in three of the four cases, reliance on buses was nil. Historically, the House of Mercy at Janesville was started when the CEO of Mercy Janesville noticed that many women visiting the emergency room were listing their car as their home address. Despite the presence of a bus stop a couple of blocks from the center, staff said none of the residents (or staff) had ever been seen using the bus. WCRC Windsor’s small, rural community does not own a public transit system at all. Residents have no choice except to own their own vehicle and, therefore, public transportation is not an issue for WCRC users.

This is not to say that public transportation played no role at all. In fact, for one program, it was a vital feature. In Portland, Maine, the McAuley Residence has an operational philosophy very different from the other three in this segment. The entire program has been structured as one of empowering the women to merge into society as seamlessly as possible. To this end, administrators chose a location that supports not only walking to the busier part of town (for jobs, shopping, etc.) but also has a bus stop within a block of the residence (see Figure 6-4). Given the robust public transportation system at Portland, residents can go all over town at relatively low cost. Furthermore, the program works with the transport authority to get free bus passes for the residents to encourage them to move around the city. This is particularly beneficial for those who have children. This move to a car-free situation for residents is a conscious one that creates savings from automobile maintenance, gas, etc. owing to the location is listed as a benefit in the SROI (see section 7.4, Table 7-10).

It is, therefore, not the prevalence or absence of an amenity but its relevance to the setting that ultimately makes a difference. While this concurs with scholarship that adheres to the importance of context to the ultimate meaning of a setting, it also lends helps to explain why
physical environments often face the criticism of being largely deterministic in nature. This is an important factor to bear in mind, especially when we use the physical environment as a critical source whilst the parent organization is under its own resource constraints.

9.4.4 Third Spaces

As the on-site research progressed, several elements during discussion and observation made it imperative that several codes pertaining to third spaces be included for data analysis. Neutral spaces came up as a factor to contend with in both segments of the study. Neutral spaces included such areas as common lounges, community kitchen, hallways, and laundry rooms. In a broader sense, markets as a whole can be considered as a neutral space. Markets are places where people interact for social exchange and commerce (Carr, Francis, Rivlin, & Stone, 1992), drawing people out for more than just trading goods. However, consumer social interactions are often short-lived and relationship building is more likely to occur with the vendors than anyone else. Oftentimes, people come to these markets with someone (Sommer, Herrick, & Sommer, 1981) or agree to meet with an acquaintance at the destination. Thus, in addition to the act of procuring produce, farmers’ markets can also be considered points of communication and relaxation.

Farmers’ markets are neutral spaces in principle, all inclusive, and open to all. In this study, the location and visibility made it clear that the markets were open to every member of the community and not for just clinic patients and employees. As Koohsari, Karakiewicz, and Kaczynski (2013) opine, neither proximity nor distance or even attractiveness of a space makes it more usable. It is where the space lies and how it can be accessed that makes the difference. People do not mind walking extra distance to get to a public space as long as it is in a familiar area or within their everyday route choices.

This concurs with the farmers’ markets location and visibility criteria that Kaiser Permanente demands from every clinic that intends to set up the market. Clinics themselves are
highly visible entities in communities that are usually well connected. Locating markets on clinic premises means greater access to the public and greater footfall for the markets. This location strategy could also help to counter the criticism faced by farmers’ markets in the western world (particularly in the United States)—that they are essentially white spaces, for the upper-middle to high-income population and, therefore, necessarily exclusionary (Slocum, 2007).

A location such as a hospital is essentially neutral ground, accessed by people of all race and income levels. Thus, by association, a market vending fresh food on clinic premises could be termed inclusionary. While from this study's point of view, neutral locations bring to fore the Social Design (inclusion, humanistic scale) and Social Bricolage elements (innovative thinking, making do with what is there); they also help answer the larger question of creating barrier-free access to those who need it the most, the low-income strata of society.

When it comes to programs of a sensitive nature, the women are often socially isolated, barring those who have children living with them. The residential complexes they live in become their homes and the people they interact with, for all practical purposes, become their families. Neutral spaces like laundry rooms, corridors, dining areas, and common lounges become points of interaction and communication. Acknowledging the everyday lives of women, these programs incorporate areas like laundry rooms in close physical proximity to play areas for kids, thus enabling ‘multi-tasking’ for the mothers as they work and keep an eye on the kids. Another example are corridors outside of apartments where children can play with one another whilst the mothers remains in the apartment, secure in the knowledge that the corridors are locked down (see Figure 10-4). Other neutral spaces, like chairs by the windows at the end of hallways, in many of the cases studied were cited as coveted spots by the women program participants who would use these spaces to catch up on the news, read a book, or reflect quietly (see Figure 9-3). This was certainly a surprise finding of the study, something that was not anticipated at the time of embarking upon the case studies.
Figure 9-3 Neutral or flexible spaces: Chairs at the end of corridors and by the windows enable women to sit down and have a quiet read, reflect, or just look out onto the views outside. Given the pressures these women face continually, such environmental features cost little but make a difference in the day-to-day living of these women. However, such interventions are possible when there is a thorough understanding of the program itself. (Image courtesy: A. Saligrama)

9.4.5 Visibility for Positive Brand Association and Competitive Advantage

A major outcome of the visual analysis was the very visible and unmistakable association of the clinics’ brand with the social program. Barring McAuley Residence in Portland, in all of the other six cases it is impossible to miss the connection between the program and the clinic. These associations were in the form of proximity between program and clinic locations, signage, banners, promotional material given, etc. Even virtually, on the clinic websites, it is easy to access information regarding the programs from the clinics’ main pages (see Figure 9-4 - Figure 9-6). This establishes not only the clinics’ commitment to the community but also helps create brand awareness for the clinics themselves.
As with mainstream businesses, clinics are not just about brand preference but brand relevance (Aaker, 2012). These social programs allow clinics to set up subcategories within their core competencies (one of health and wellbeing of the community) and to create benefits for community members such that competition from peers becomes irrelevant and monetary reimbursement from federal agencies (with respect to the program) becomes secondary. The clinics relying on their own inherent competencies (mission, resource capabilities, etc.) have addressed social problems and are garnering goodwill for itself by being visible in the community as a community resource, not just a medical service. At the House of Mercy Des Moines, the program was appropriately describes as a “visible way to show our (the clinic’s) commitment to the community, addressing complex social issues many shy away from.”

As was mentioned during an interview at House of Mercy, Janesville, there are three competing health systems in a small place like Janesville, which is not a major city, even for the state of Wisconsin. Additionally, there is competition from the bigger city of Madison, as well as health systems from northern Illinois. These places are within a 50-mile radius, giving members of Janesville a range of options. As the vice president from Mercy Health who oversees the HOM operations said: “[T]here is no guarantee that people will come to us if we support a homeless center, but it certainly shows the community that we are committed to the community’s welfare beyond just caring for paying patients. And we believe this has worked for us over the years. Our volunteer network is extensive33, the expenses to hire staff instead would have made it impossible for us to sustain as long as we have. People view us positively and this is certainly good for us as a health system.”

33 Volunteer hours annually at HOM clock 8,400 hours which at Wisconsin min wage rates (as of 2014) would amount to $61,000. This shows huge cost savings (considering the center has a total operational budget of $200,000) and positive brand reinforcement for the clinic to be in association with the social program.
Figure 9-4 Collage shows the clinic name, the clinic logo, and the clinic building itself in close proximity to the non-medical program. (Image courtesy: A. Saligrama, Kaiser Permanente website, M. Murillo)

Figure 9-5 Promotional posters of Kaiser Permanente health system; absent are images that claim to having the best doctors or surgical systems that most clinics have. Instead are shown fresh foods, interwoven with the message of health. (Image courtesy: M. Murillo)
Figure 9-6 A screenshot of the Kaiser Permanente website (November 2014) shows its strong association with the farmer’s market initiative.

9.5 Goal Support

In some cases, it is not so much about actual ownership but about the affordances—the access and convenience—an environment provides to solve a problem (Bass, 2014) that makes the difference. This seems particularly true in the case of the Windsor Connection and Resource Center, Windsor Vermont. A dedicated space that allows for everything from mental health and legal counseling to access to computers and faxes might not lead to users’ feeling a sense of ownership or attachment to the place. It does, however, provide resources that actively support the users’ goals in a non-obtrusive manner by providing access and privacy leading to repeated use of the space. Yet another example from this study is the Sambhavana Trust Clinic in Bhopal. The yoga hall and pockets of respite throughout the campus allow the women to follow a regimen of mind and body rejuvenation to help them cope with their medical situation which has no definite cure.

Another successful third space is HOM Janesville’s dining area where the families cook, eat, and clean up together. This space was cited as heavily used and a morale booster. The day manager says that in a situation where they own nothing, meal-time routines are a great way to
show the children they are still a family and that they still have rules to follow. At the McAuley Residence, the same was said of the community kitchen, where all the residents have a sit-down meal (see Figure 6-21). Such environmental provisions might not lead to emotional attachment to the place itself, but they play a big role in actively supporting user goals, thus agreeing with literature that discusses how the physical characteristics of a space that provide resources to support ones’ goals are used more (see section 2.3.4).

9.6 Context Relevant Settings

One outcome of this study was that each of the environmental features made sense only when understood within the context of the program or activity. Even a factor like location has meaning only when looked at in conjunction with the program. Where a farmers’ market should be highly visible, other programs, like a drug rehabilitation center or transition home, only require the amount of visibility necessary for potential program participants to be able to find the program.

For this study, advantages of using a space include monetary savings and a ready availability that allows for immediate implementation of the program. Opting to support a program that the community is already familiar with (farmers’ markets in northern California) lends a degree of credibility to the clinic because the program giver cares about issues beyond health needs; it also cares about continuing local traditions. Such context-relevant programs make it easier for both program giver and target recipient. With context-relevant programs, it is easier for the program giver to create legitimacy for the program; for the user, programs and environs they are familiar increase their chances of using these resources.

The McAuley Residence, for example, is a program and space that has high relevance to its setting. Mercy Maine has a comprehensive substance abuse treatment center. So a transition home for women with substance abuse issues is an extension of that thinking, an area within its core competencies that they have the ability to handle. The space and location are
used to channel the program philosophy of empowerment. The residence is located within a part of the city of Portland, Maine that is pedestrian friendly with sidewalks, bus stops, and is in close proximity to the center of the city as well as the harbor. The clinic has used the mobility the city offers to help residents get around town on their own, thereby learning basic life skills and reintegrating into mainstream society as slowly, yet as seamlessly as possible. The physical environment is, therefore, deployed as that critical resource which helps address the social problem, using its various physical and socio-cultural properties to optimize outputs from the program (See location map Figure 6-4). The various environmental and socially entrepreneurial elements acting simultaneously on the program are represented in a diagrammatic form (Figure 9-7) for ease of understanding.

Figure 9-7 Principles of Social Design and Social Bricolage reflected in the McAuley Residence program in Portland Maine.
9.7 A Local Approach and Organizational Legitimacy

Institutions aim to create a favorable reputation for themselves by creating products, projects, and environments that align with key stakeholders (Rao, 1994). This is another way to interpret some of the findings from this study. Further, gaining legitimacy, particularly for socially entrepreneurial ventures is considered a form of accountability or measurement metric in itself (Brown, 2005). Nicholls (2009) suggests that from a resource-based view, stakeholder perceptions directly impact the social venture’s legitimacy, thus combining accountability and impact.

In northern California where farmers’ markets are a regional norm, Kaiser Permanente’s initiatives were used to create legitimacy for the clinic because they tapped into a local practice, the provision of farmers’ markets. The farmers’ market initiative has given a boost to local fruit and vegetable farming with Kaiser’s added condition that produce sold in the markets should be fresh to the point that they should be picked from the fields on market day (in California). This has been mentioned in documentaries and books giving the health system a huge profile boost nationally.

Using space-based programs has added to prestige in the community. Kaiser Permanente at Fresno was initially seen as an outsider, a big Oakland chain hospital. The clinic, however, understood that Fresno farmers would travel 200 miles to the bay area to sell their produce. Thus, by establishing a highly visible, fresh food market right in Fresno, within Kaizer’s own campus, the clinic was able to appeal to the farmers as well as to the broader community by demonstrating that it cares in ways more than just providing medical care—fresh produce to citizens and a boost to local farming initiatives.

Further, supporting programs of a sensitive nature (like homeless centers) enable clinics to establish themselves as caring citizens of the community who think about community welfare and not just the financial bottom-line. These kinds of ventures that tap into familiar frames of
reference and are then applied to the organization’s own strategy helps to build legitimacy in the long run (Lounsbury & Glynn, 2001).

9.8 Stakeholder Involvement, Partnering and Mission Alignment

Partnering with CHOM was a natural choice. We share the same outlook, helping vulnerable sections of population and ensuring their safety and well-being.

—Vice president of Mercy Maine on their association with the Community Housing of Maine for the McAuley Residence

PCFMA knows things about farmers’ markets which we would never know. We defer to them for all the logistics. We provide the space here and supervise but the rest they take care. We don’t have to deploy personnel to do a job that PCFMA already does and does very well across the bay area.

—Kaiser personnel at Oakland on their partnership with Pacific Coast Farmers’ Market Association

Volunteers do such a good job here. From sweeping to testing chemicals they chip in with everything. They are here round the year, sometimes in large numbers and from around the world. We are very grateful to them.

—Staff at Sambhavana Trust, Bhopal, India

An added value that comes from involving stakeholders is the benefit of local and place knowledge (Sommer R., 1983; Horelli, 2002). Skills and contacts in their own, everyday work could be channeled for the betterment of the social program. Some community members and organizations, having been in the community longer than the clinic or program, might have insights into the working of various elements critical to program planning (e.g., working of the local government, types of permits required, and so on). Inputs and involvement from
stakeholders and community partners also help reduce the resource burden on the program giver.

This study stresses the importance of stakeholder participation and partnering over various sections of the study. Across the cases it was brought to light that involving stakeholders at various levels and partnering with other community organizations led to optimizing program output. While some practical implications of not involving stakeholders in decision making are highlighted in section 10.4 (Participatory Planning, Fresno patio expansion issue), there are positive examples as well. The partnership between Pacific Coast Farmers’ Market Association (PCFMA) and Kaiser Permanente has proven fruitful for both organizations. The clinic saves on resources it would have otherwise had to employ for intelligence, vendor procurement, etc. while the PCFMA benefits in its own way, raising its own profile as a preferred partner of a nationally recognized healthy system. Additionally, farmers, by coming in a few hours early to a Kaiser market and then go to a destination market in the evenings earn enough to cover gas money through the Kaiser markets, says Maring. “This way they don’t make a huge profit but it doesn’t really hurt them either” he says. This can be considered a positive example for healthcare leadership at the time of decision making in choice of a social program—partnering with an organization that already has relevant skills.

Social programs are resource-tight operations. Involving the community in this regard helps reduce the resource burden to some extent. Volunteering, for example, can help the program givers in ensuring higher quality and smoother operation of the program. At HOM Janesville, there is a volunteer each night of the year, thereby eliminating the need to employ someone to do that job. As has been mentioned elsewhere in the study, collective volunteer effort saves the program over $60,000 annually. The Sambhavana Clinic in Bhopal also has strong volunteer support. They come from all over the world, year round. The participation of volunteers helps reduce manpower required to run the clinic, while simultaneously bringing in the volunteers’ significant skills which the clinic does not have to pay for. From groundwater
quality testing to landscaping the herb garden, volunteers have contributed significantly to better the program.

The study also highlights how organizational mission can play a vital role in optimum program output. Some community organizations (Community Housing of Maine in its association with Mercy Maine for the McAuley Residence) partner with the clinic if they feel they share a common mission or have strong belief in the organizational mission of the clinic. This has led to a profitable partnership between the clinic and that organization, once again reducing the resource burden on the clinic. These partnerships also contribute unique skills leading to a more effective execution of the social program. While there is scholarship that talks about the importance of partnering and the importance of organizational mission, this study highlights these issues through its case studies.

9.9 Low-Cost Solutions

The clinics incur minimal financial outflow because of the social programs. Kaiser clinics invest no money toward the markets, they use space already existing. While a few clinics have incurred some expenses for expansion of space, etc., the money has been raised internally using funds already allocated for a community-related purpose. Vendors bring in their equipment, set up, and dismantle their stalls. Existing parking spaces are used for vendor trucks, etc. So there are no expenses that are attributable to the markets says the food sustainability manager who oversees all the Kaiser markets nationally.

In the programs for women segment, each case mentioned little or no investment for building procurement. Both of the HOM cases mentioned that the respective clinics (both incidentally called Mercy Health, no connection to one another) were already in possession of the building and so initial investment for space procurement was $0. This allowed for starting the program with minimal remodeling as soon as required permits came through. For the Windsor community center, the clinic (MAHHC) coordinated the procurement of the building as
well as a loan from town council so that they invested nothing upfront. The clinic, as per the agreement with the town council, is not required to repay the loan. It does however invest approximately $32,000 annually toward the WCRC, which is accounted for under Community Benefit, thereby not causing much of a dent in the clinic’s operational bottom-line.

McAuley Residence was created at the new address by trading in an older, existing building they had. Mercy Maine (no connection to any of the other Mercy Systems in the study) like MAHHC contributes a certain amount ($180,000 annually) but accounts it under Community Benefit, thus causing no overt expenditure to the clinic. Further, at Mercy Janesville, which does not use the HOM Janesville for Community Benefit, it must be noted that the clinic does not incur direct expenses from the program in any way. Expenses are limited to areas like HR and payroll, making it a low-cost solution from the clinic’s point of view.

The Social return on Investment (SROI) analysis gave a clear indication of the expenses and benefits from the built environment from a monetary point of view, which are negligible when considered in comparison with the program cost (see Table 9-1).

This is not a qualitative tool and yet it points to some interesting facets of the physical resource and the benefits resulting from them. For example, owing to its location, McAuley Residence in Portland, Maine could become a car-free program, saving automobile-related expenses (e.g., gas, insurance, and maintenance) which are listed as a savings for the program.
Table 9-1 shows program vs. built environment costs

<table>
<thead>
<tr>
<th>Case</th>
<th>Annual program cost ($)</th>
<th>Built environment cost</th>
<th>% of built environment cost with respect to the program</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCRC, Windsor Vermont</td>
<td>$32,000</td>
<td>$560,000 – block grants and town revolving fund, No Need for Payback</td>
<td>$1,500</td>
</tr>
<tr>
<td>HOM Janesville WI</td>
<td>$260,000</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>McAuley residence Portland ME</td>
<td>$200,000</td>
<td>0</td>
<td>$0</td>
</tr>
</tbody>
</table>

9.10 Outcomes with Connotations in Two Areas

What has been established through data analyses is the interconnectedness and interdependence of the various layers of environmental, entrepreneurial, and allied factors along with gender-based ideologies that are common or complementary (one leading to the other). The application of these factors in tandem has contributed to the space-based social programs in this study becoming the kind of long-sustaining successes they are today. A diagram has been created to bring together the major outcomes of the study and the connotations each has in both environmental and socially entrepreneurial as well as in supporting areas.
Figure 9-8 Common and complementary ideologies from the fields of environment behavior and strategy management + social entrepreneurship as they affect the social venture.
9.11 Tying the Outcomes to the Benefits

This research question is best answered when the environmental factors are examined in tandem with the program itself (i.e., space and activity). Meshing of appropriate scholarship and theoretical concepts allowed for the creation of a dual-concept framework to guide the study. Then the research design was kept open and practical, which led to the emergence of a new area (third spaces) as well as the emergence of women-centric issues as the focus. When data was analyzed, it became clear that in order to examine the role of the designed environment in value creation—even in an exploratory manner—one had to look at it in conjunction with the other driving factors that influenced the program. Thus, the study looked at entrepreneurial and strategic factors that were related to the physical environment related. As shown in Figure 9-8, the outcomes have strong connotations in both areas (environmental and socially entrepreneurial factors), the assimilation of which ultimately lend meaning to the outcomes.

A final attempt has been made to show how the various contributing factors (major findings of the research) relate to value creation and what benefits (to the clinic) can be attributed to those factors. Figure 9-9 shows the interconnectedness of the contributing factors and the resulting accrual of social value. This effectively brings to a conclusion the question of what factors contribute to the creation of a socially sustainable framework between clinic and community and what benefits incorporating each of these factors could mean for the clinic.
Admittedly, benefits to the community will be significantly larger than what is indicated; but since that was not the focus of the study, they were neither examined nor measured.
Chapter 10.0: Conclusion

You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.

—Buckminster Fuller

This chapter brings the entire study to a logical end. Starting with a brief summary of findings, the chapter then discusses contributions this study makes to different areas, and what implications it holds for the design and healthcare industries. The chapter ends with future directions this area of inquiry could take and its broader appeal, beyond both the designed environment and healthcare.

10.1 Summary of Findings

The basic research question was one of exploration: Could the designed environment have an active role in the creation of a socially sustainable system between a clinic and its community? A secondary question was to look at what kinds of environmental factors (if at all) were required to positively impact usage of programs tailored with women as the major target.

To begin with, a logical diagram has been created to show the various forces acting on a clinic that wants to implement a social program and the resource-based thinking that leads to the designed environment as the optimum choice.
Figure 10-1 shows the various aspects a clinic has to bear in mind when wanting to offer a social program, and forces acting on it that leads to the designed environment as the optimum resource to help mitigate that social need.

Further, a table has been created summarizing all of the findings and the support offered by literature and the conceptual framework in conducting the study and arriving at the conclusions (Refer Table 10-1).
Table 10-1 Lessons learned

<table>
<thead>
<tr>
<th>Research question</th>
<th>Literature support</th>
<th>Framework support</th>
<th>Research outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Can the designed environment play a positive role in the creation of a socially sustainable framework, through the offering of non-medical programs between a clinic and its community? What factors contribute to this?</td>
<td>Social Design</td>
<td>Environmental factors</td>
</tr>
<tr>
<td></td>
<td>Socio-spatial relationships as they impact physical layouts - Access and its impact on usage - Generative &amp; reproductive qualities of space - Third spaces, neutral spaces as aides in creating social bonds &amp; positively impact program usage</td>
<td>- Designing with users in mind - Practical / implementable - Financial feasibility - Local in approach / humanize the process</td>
<td>Direct access including</td>
</tr>
<tr>
<td></td>
<td>Stakeholder involvement/participatory planning -- local, situational &amp; place knowledge as it impacts both physical layout and program structure</td>
<td>Social Erigolage</td>
<td>High visibility (to the target user)</td>
</tr>
<tr>
<td></td>
<td>Resource Based Theories, Social Identity ideologies Mission statements, activism &amp; operational strategy</td>
<td>- Make do with what you have / acknowledge resource crunch - Innovative thinking - Negotiate / persist - Self-sustenance</td>
<td>Location appropriate to the program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Places of quiet and respite</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Places that facilitate interaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Local in approach -- users familiar with program offerings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Small scale/ within target's travel route - larger the layout, harder for users to comprehend, people will not travel well out of their comfort zones, whatever the program is offering</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nil / negligible initial and maintenance costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spatial layout follows program structure/ program structure modified by the available environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community/stakeholder involvement / partnering - stakeholders share/impart skills enabling smoother operations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resource based perspective allows for turning the physical environment into an asset, using the environmental and entrepreneurial factors as listed in the two left columns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visibility enhances brand image/ brand communication spaces reflecting the clinic’s name/logo etc. on program site has a positive impact of program-clinic association</td>
</tr>
</tbody>
</table>
Table 10-1 Lessons learned (Continued)

<table>
<thead>
<tr>
<th>Sub question</th>
<th>Literature support</th>
<th>Framework support</th>
<th>Environmental factors</th>
<th>Entrepreneurial factors</th>
<th>Overlapping / intertwined elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>If such programs are tailored for women as target recipients, what kinds of environmental factors impact usage?</td>
<td>Everyday life theories An understanding of the everyday movement patterns of women in order to create environments that enable them to get the most (of that endeavor) - Women have less time at their disposal to accommodate events and activities that are out of the way - Women and decision making - Women are bigger decision makers and spenders of healthcare dollars in the US - Nearly 90% of homeless families are female headed - Women are loyal to the brands they endorse and very good at word of mouth publicity.</td>
<td>Incorporating concepts that allow for examining environmental and program based affordances for barrier free access</td>
<td>For certain programs simultaneous access and seclusion very important for women Connectivity within campus and to other parts of the town Accommodations for children Co-locating of spaces such that it enables the women to work and keep children safe (despite looking unrelated at face value) Neutral spaces that enables communication and solitude</td>
<td>Program structure dedicated to target population enhances usage Women are time conscious. Importance of program to be accommodative of their needs when the target audience is on site/ make an effort to inquire about the program.</td>
<td>Program structure incorporating target user enables tailoring environment to suit the target, enabling greater program usage Empowerment of women through a combination of program structure and environment complementing one another to reflect the same</td>
</tr>
</tbody>
</table>
While the framework and scholarly literature guided this study helping to decide research methods and analysis tools, several lessons manifested from the outcomes of the study itself. The following sections detail the contributions of this study to various areas, with implications to both academic scholarship and industry.

10.2 Contributions to Literature

The idea of program givers actively benefitting from social programs is an emerging area of inquiry (ca. 2000 onward). While there is sufficient information with respect to Corporate Social Responsibility and related areas, there is not much when we narrow the search to social initiatives which are part of organizational and operational strategy. The amount of published literature reduces further if we include the healthcare context, focusing on clinics as program providers. Finally, when we add the resource-based approach—more particularly the designed environment—the amount of published information available is nearly non-existent. Although this study is practical in nature, it could be considered as a contribution to literature in social entrepreneurship and nonprofit management that involves exploring social wealth from a resource-based viewpoint.

From an environment behavior standpoint, this study enables better understanding of the potential of the designed environment in hitherto unexplored areas such as brand association, context relevant settings based on prevailing cultural practices, organizational mission, and organizational legitimacy. Also, most literature in environment behavior pertaining to people’s association with spaces and places revolve around the idea of place attachment—sentiments and emotional bonds owing to personal experiences in that space or place. Spaces in both segments (farmers’ markets and programs of a more sensitive nature), whilst not causing any lasting emotional attachments with the place itself, create incentives and support for their goals and objectives. This study contributes to growing literature into the idea of spaces for goal support.
There are but a handful of studies in recent times (Mehta & Bosson, 2009; Montgomery & Miller, 2011) that talk about the important role that third spaces can play in enhancing user experience of space. This study contributes to a more rounded understanding of third spaces in different place types, from markets to homeless centers. The link between neutral spaces and women is of particular interest. Overall, the study furthers our understanding of areas like socio-spatial navigation and everydayness with the added layer of how these ideologies could be harnessed for optimizing program output.

10.3 Contributions to Theory and Methodology Techniques

The approach to this study was practical and hands-on. Literature and theories were used as a source of guidance. Resource-based theories (RBT) played a key part in shaping this study and identifying case studies. Given that the parent organization in this study is a nonprofit clinic, the use of RBT as one of the foundations of the study proved beneficial for both interview structuring and financial data collection. RBT also proved infinitely useful in identifying the built environment as a critical resource and allowed for examining the various socio-cultural and financial of that resource. There are no studies in the field of environment behavior and allied areas that have used RBT to explain various phenomena pertaining to the built environment. It can be argued that since the studies pertain to the built environment itself, there is no need to explicitly mention the validity of the physical environment. However, RBT helps explain the importance of the physical environment in crossover studies such as this, showing how the environment can be assessed in many ways to create an advantage base for the program it houses.

From a methodological viewpoint, social accounting in the form of the Social Return on Investment (SROI) was a unique find. Assessing social programs is a common enough endeavor in academic studies and finding measureable user data is often the hardest task. Some information is too sensitive to be given out and in some cases the information is simply
not available or measurable. While it cannot be ruled out that no academic study has to date used the SROI method, one can safely conclude that is it not a common type of quantification analysis in academic circles. As a practical tool, SROI needs inputs from the parent organization for certain estimates and attributes. These can be acquired from either individuals with expertise in such assessment techniques or from individuals closely involved with running the program. This is particularly important given the lack of comparable studies.

This makes the process long and drawn out since it requires contacting the parent organization, getting the information, and sometimes steering the organization to think along lines they have not before. Nonetheless, this process is useful in not only giving a monetary assessment of the social program but also in understanding the role of each stakeholder and their contributions. The SROI is also useful in isolating certain costs. For example in this study, the expenses and savings owing to the built environment are shown clearly as well as the impact they have on the final outcome. This study can be considered a building block in this area, bringing a practical tool envisioned for industry into an academic research project.

10.4 Implications to the Design Industry

Participatory Planning

This is a classic example of a square peg in a round hole.

—Vendor at the Fresno farmers’ market

Participatory planning has been advocated by environment behavior scholars for a long time. A number of works spanning several decades cover everything from the planning level to post-occupancy evaluation, including several strata of people involved with the program and environment at varying stages of planning and construction. This study can be considered a practical tool in furthering this idea of participatory planning. Across the case studies and
interviews, the importance of involving a varied set of people in making the program an ultimate success emerged.

The Kaiser Permanente farmers’ markets are an excellent example in user-ownership. The market champion, who sets up and oversees the market, is someone who takes the initiative to start the market since the program not mandated by the clinic. They decide on the type and size of the market based on details like permits and vendor-procurement processes. They borrow expertise from various sources like farmers’ market associations and vendors themselves. However, situations arise that point out the importance of continual input from stakeholders.

At the farmers’ market in Fresno, California, a patio expansion was sought to enhance market space for the vendors. This led to the patio being expanded in a curved fashion to make it aesthetically appealing. However, the vendor stalls are all rectangular or square shaped. This resulted in an unsatisfactory situation wherein the vendors could not make use of the expanded space (see Figure 10-2). Given that the patio expansion was specifically for vendor convenience, the vendors felt that their opinion should have been sought by the designers. Such situations cause an everyday nuisance for the user-group, yet it could have been avoided had there been communication between the stakeholders at various planning levels.

Kaiser Permanente has created a design guidance booklet that any clinic intending to start a farmers’ market can use. This shows great initiative and forethought. However, when significant resources are at stake and reversing the situation is not always an option, such illustrations could serve as a guiding source for designers to involve user groups at relevant junctions. Thus, while informative and well-intended, the guidance booklet missed an opportunity to include communication with user groups as one of its recommendations.
Figure 10-2 Yellow markup indicates space wasted owing to mismatch between design intent and outcome. A curved patio thought to be more soft and artistic by designers has resulted in space wasted when pitching the rectangular tents. Given that the patio was widened to accommodate the market, significant space wastage behind several vendor booths is considered unacceptable by vendors. Such elements throw more light on the importance of participative planning, including users, clients, and designers. (Image courtesy: A. Saligrama)

Third spaces as tools for supporting everydayness

We are glad to have these spaces, if women can rest for even a few minutes in this cool, calm shade before getting back to the tensions of their life—that is good.

—Ground staff at Sambhavana Trust Clinic Bhopal

It doesn’t cost much extra really, just need to think a bit.

—Program staff at HOM Janesville about environmental interventions that convenience women

Carving out spaces within spaces for a new use and using spaces for different activities (e.g., corridors for circulation and play space for kids; community kitchen for dining and educational workshops) had significant impact on the program usage in this study. Seating enhanced usage in one market (Fresno, Figure 5-11, Figure 5-12), while a wide-covered walkway
connecting two buildings served as market space for another clinic (Santa Rosa, Figure 5-10). At the Sambhavana Trust Clinic in Bhopal, third spaces in the form of verandahs, patios, courtyards, and multipurpose halls are scattered throughout the campus, giving users several options for rest and respite. Such design elements, when understood in conjunction with the program itself, lead to optimum program output, the space supporting the program intent, and the program benefiting from the comfort provided by the spatial intervention.

![Campus map of the Sambhavana Trust marked up with third spaces in yellow.](Figure 10-3)

Third spaces have implications on both design and translating the theory of everydayness into three-dimensional realities. The woman’s role as a caregiver has been
examined in the case studies with a sensitive nature and design solutions have incorporated it as well.

Creating adjacencies in terms of activities could make a significant qualitative difference to the women’s lives. Laundry rooms next to play areas so that women can do laundry and keep an eye on their kids while the kids play safely in a controlled environment (HOM Janesville) and a play area within consulting spaces (WCRC Vermont) are two examples in this study where everydayness has been translated successfully into three-dimensional reality.

Figure 10-4 At the McAuley Residence, the corridors double as play areas for kids while the mothers spend time with one another or in their apartments. It is a safe option requiring minimal supervision as the doors at the end of the corridor are locked at all times and need fob keys which only residents and staff have access to. Chairs at the end of the corridor by the window allow women to relax or read while overlooking the Casco Bay (Also see Figure 9-3). Environmental interventions like these support the social program ably and bringing a sense of ‘normalcy’ into the lives of the women, allowing them to carry out their everyday, routine activities without having to compromise on other caregiving activities.

This is a significant implication to building design where a little extra thought could make a difference in program usage, thereby allowing the users to manipulate the spatial affordances to their needs.
Figure 10-5 Adjacencies and everyday lives of women: in one of the case studies. The laundry room has been placed adjacent to the children's play area. This enables the mothers to do the laundry while keeping an eye on their kids. Environmental interventions like these support the social program ably and bring a sense of normalcy into the lives of the women, allowing them to carry out their everyday, routine activities without having to compromise on other caregiving activities.

**Taking advantage of microculture**

This study shows how context-relevant settings make a difference in program usage and how design can positively impact that. From using the urban footprint, to support program philosophy (see section 9.6), to the use of vernacular architectural elements in order to enhance user comfort (section 8.1, Figure 8-3 - Figure 8-5, The Sambhavana Trust Clinic), each of the spaces in this study show how the spaces are relevant to the setting and, therefore, actively support optimization of the program philosophy.
Flexible spaces

Spaces that allow more than one function made a significant impact in this study. Community kitchens used as workshop spaces, corridors for farm-stands (see Figure 5-10) and as play areas (see Figure 10-4), a semi-open hall for yoga, lectures, and resting (see Figure 8-4) are a few of the multifaceted spaces cited as being heavily used by program participants. Depending on the context of the setting, incorporating spaces that allow different uses to support the program can make a significant difference in user experience. These spaces, at times, allowed for activities that would not have been possible otherwise. This efficient and innovative use of spaces for multiple functions is also a cost-saving feature since these spaces remove the need to use significant resources (e.g., space, money, building materials, etc.) incorporating the multiple requirements elsewhere in the design footprint.

10.5 Implications to the healthcare industry

The study has several implications to the healthcare industry as well. As a practical study, there were several outcomes that have broader implications to any clinic that intends to support a social program. Starting with cost advantages in using space as the central resource for the program, to tax benefits, to press recognition, there are several benefits for the clinic.

Two things were made clear in the course of this study. First, the clinics have to be committed to accomplishing social good; they need to believe in the program. Secondly, the clinics have to exhibit a clear understanding of the community’s needs and then to identify which of those needs it can satisfy. This is where aligning the programs with organizational mission helps. Each of the case study programs was well-structured to start with, had clearly defined target audience, and had a plan for resource procurement. In turn, this led to seeking appropriate partners, reducing the resource burden, and so on.
Table 10-2 details all of the benefits to the clinic in supporting space-based programs. The benefits listed are an outcome of the study and can be considered as informative to any clinic intending to support a social program.
Table 10-2 Contributions to the healthcare industry

<table>
<thead>
<tr>
<th>Tangible Benefits</th>
<th>Type of benefit</th>
<th>Leads to</th>
<th>Exhibited in program</th>
<th>Supported by findings from this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monetary</td>
<td>Zero cost / Low cost for resource procurement</td>
<td>Cost savings, resource advantage, allows procurement and allocation of resources to other areas</td>
<td>Each of the 7 case studies</td>
<td>See section 9.9</td>
</tr>
<tr>
<td>Positive return to the dollar</td>
<td>A systematic SROI shows positive return to the dollar in three cases, showing tangible savings as regards the building</td>
<td>McAuley Residence, transition home for women with substance issues (1.56)</td>
<td>House Of Mercy Homeless Center (1.6)</td>
<td>See chapter 7.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Windsor Connection Resource Center (1.2)</td>
<td></td>
</tr>
<tr>
<td>Safeguard tax status</td>
<td>Community Benefit</td>
<td>Some clinics use investments towards the programs under community benefit agenda to the IRS, helping protect tax status</td>
<td>1. McAuley Residence, transition home for women with substance issues</td>
<td>Since IRS allows 'community benefit' to be accounted as Community Benefit, space based social programs could be used toward safeguarding tax status</td>
</tr>
<tr>
<td>Reduction in seeking of medical care</td>
<td>Reduction in insurance payouts</td>
<td>For HMOs, keeping the members healthy is a way of ensuring they do not have to pay for doctor fees</td>
<td>Farmers markets at Santa Rosa, Fresno and Oakland CA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in use of ER, hospitalization and ambulance services</td>
<td>Over 50% cut in unnecessary use of emergency services by the homeless</td>
<td>1. McAuley Residence transition home</td>
<td>This study corroborated with other studies in showing that safe housing reduces reliance on medical services like ER and ambulance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. HOM Homeless Center</td>
<td>Aligning program with clinic’s core competency additionally benefits the clinic. For ex: Research shows people seek treatment for substance abuse once in supportive housing. Mercy has a comprehensive substance abuse program; providing a transition home with substance abuse is tangentially beneficial to them</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. HOM Substance abuse transition home</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Windsor Connection Resource Center</td>
<td></td>
</tr>
</tbody>
</table>
Table 10-2 Contributions to the healthcare industry (continued)

<table>
<thead>
<tr>
<th>Tangible Benefits</th>
<th>Type of benefit</th>
<th>Leads to</th>
<th>Exhibited in program</th>
<th>Supported by findings from this study</th>
</tr>
</thead>
</table>
| Commitment to the social program leads to increase in help for program, reducing resource burden on the clinic | Increase in volunteering, in local donations (for both program and the clinic) | Smoother operations of the program at little to no extra cost        | 1. McAuley Residence transition home  
2. HOM Homeless Center  
3. Windsor Connection Resource Center | Mercy Janesville credits in part the positive image the social program generates for its extensive volunteer network and ability to raise donations locally. See Sections 9.4.5 & 6.1.2.4 |
| Awards, press recognition | Enhanced brand image | Customer preference, favorable stakeholder opinions, better partnering options (for the program and the clinic) | EACH OF THE 7 CASE STUDIES | Study shows the cases have acquired national recognition for their work: Foster McGaw Award, Malcolm Baldrige Award for Quality, National Housing and Rehabilitation Award, mention in journals, HBO documentaries etc. |
Table 10-2 Contributions to the healthcare industry (continued)

<table>
<thead>
<tr>
<th>Inangible Benefits</th>
<th>Type of benefit</th>
<th>Leads to</th>
<th>Exhibited in program</th>
<th>Supported by findings from this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive association with the program as recognized by the community, especially</td>
<td>Long term benefits; favorable opinion of the clinic</td>
<td>Increase in everyday business</td>
<td>Farmers Markets, Programs of a sensitive nature</td>
<td>Programs that are beneficial to women or programs that save women time/effort earn the loyalty of that population subset. Women are known to be loyal to brands they believe in and could lead to long term favorable outlook of the clinic. Further, in the US 2/3 healthcare dollars spent by women, makes good business sense for clinics to cater to them. Even if the program is for a specific subset of women (ex. homeless center), women in the community tend to be more positive of the clinic for supporting such initiatives. This was indicated directly and indirectly in some interviews.</td>
</tr>
<tr>
<td>the women</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Programs aligned to organizational mission enhances chances of partnering</td>
<td>Smoother program delivery; clinic saves on resources, knowledge/skills brought in by the partnerin organization</td>
<td>Increase in everyday business, enables accreditation to several initiatives, strategic partnering with similar minded organizations</td>
<td>McAuley Residence / Mercy Maine + Community Housing of Maine Kaiser Oakland Market / Kaiser Permanente Oakland + Pacific Coast Farmers Market Association</td>
<td>Organizations within the community tend to partner with the program/clinic if the organizational missions are aligned</td>
</tr>
<tr>
<td>Enhanced reputation, Organizational legitimacy</td>
<td>Organizational accountability</td>
<td>Taking the clinic closer to becoming a community resource; Customer preference, favorable stakeholder opinions, better partnering options (for the program and the clinic)</td>
<td>Kaiser Permanente Fresno, CA</td>
<td>Seen as a big Oakland chain, offering farmers market softened public’s perception of the clinic. Community recognized the support the clinic was offering not just to the clinic but also to local farming</td>
</tr>
</tbody>
</table>
10.6 Limitations and Strengths of the Study

The study has several limitations. Not having direct access to program users hampered any chance of getting user-feedback on the role space played in that context for them. Permission to speak to users was denied in some cases, though, for the most part, restricted resources and timelines prevented the incorporation of user opinions as part of the data set. Also, for the SROI, user data was not available, which led to the use of estimates and proxies from national reports and scholarly studies34. Data consisted of interviews and discussions with program staff, the researcher's own observation notes, and photographic and video images. Therefore, three different data synthesis methods were proposed; simultaneously, input and critique were sought from program givers to make for a rigorous triangulation of methods.

Timeline and access within campuses: observation studies could not be conducted for as long as one would have liked. At each site, access was granted to observe for a few hours only. This prevented focused and systematic observation as had been originally envisioned. Permissions from the program director (or equivalent) and anyone who might be within the image frame were sought before any images were taken. This also resulted in permission being denied in some cases. Also, restricted timelines meant some spaces were occupied during observation, thus images (of those spaces) could not be captured.

The biggest strength of this study is that it is both a scholarly piece of research submitting to rigors of theory and methodical elucidation of data through a series of established methods as well as a practical tool that has relevance to both the healthcare and design industries. The study brings concepts like Resource Based Theory (RBT), traditionally used in strategy and organizational management, into the field of environment behavior. This is the first study of its kind, exploring how healthcare organizations can move beyond medical care to

34 In many cases, user data is not tracked, not possible to track. While the use of proxies is a perfectly acceptable form of data dissemination, outcomes would have been more authentic if user data from the programs itself was available.
become community resources. It is backed by first-hand studies of several institutions that are implementing this idea successfully. Incentives to clinics derived from their space-based, social programs, including safeguarding tax-status to generating goodwill within the community, have been shown methodically, with the diverse sets of cases showcasing varied options for clinics to pursue. The study also highlights the use of social accounting, which elucidates the numerous aspects involved in running a social program, while helping to isolate costs and benefits of the critical resource—the physical environment.

10.7 Looking Beyond the Clinic

The study has implications well beyond the clinic. There is nothing in this study that implies the use of designed environment to be limited to clinics alone. The study examines harnessing the power of the designed environment for optimum usage in social programs. This could just as easily be adapted to industries as well. As has been seen within this study itself, each community and its needs are different. Even programs with similar intent (e.g., transition homes for women with substance or drug abuse issues) are treated in very different ways (HOM Des Moines, Iowa versus McAuley Residence Portland, Maine), despite both supporting clinics that have comparable core competencies in substance abuse issues. The final offering is largely dependent on the community and the parent organization’s vision of the outcomes. This dictates program structure, environment modifications and so on. It is ultimately the Social Design-Social Bricolage approach in good proportion that has worked for these programs and clinics.

As an analogous example, the Prototypes Second Chance Women’s Re-entry Court program in southern California has become a cost-saving alternative to the Department of Correction with respect to women who plead guilty for nonviolent crimes. The women are given a place to stay (often with their kids), have to attend a tough rehabilitation program, and, if they pass, they are then free to leave (finishing whatever sentencing they have outside of prison). Program organizers explain that the program costs $18,000 per year, per woman, thus saving
the state millions of dollars in prison and foster care costs. While the benefits of supportive housing has been discussed at length elsewhere in this research, this example is analogous to this study even though the housing program is supported by the Department of Corrections rather than a clinic, because the program and its use of space benefits both the women and the Department of Corrections in very tangible ways.

There is much scope for a topic such as this, where every type of industry can create a socially sustainable framework for itself and the community it sits in by using one critical resource. Given its focus on finding out the relevance of the physical environment to the creation of value, this study uses both qualitative and accounting measures to assess program output. The qualitative measures (both verbal and visual) show the overt and covert areas of the designed environment as unique to each program and community. The accounting measure gives the monetary impact of the program. It allows for the listing of all inputs, even the built environment. From this, one can monetize and recognize the individual roles and contributions of everyone who has a hand in the program output. The methods complement one another, making for a more comprehensive understanding of what happens when a clinic adopts a physical resource-based view and uses the designed environment to offer social programs.

All of the cases in this study have been in existence for at least 10 years, have grown in stature, while some have moved into newer, more spacious premises (WCRC Vermont), and some clinics are planning to replicate the model (Mercy Maine is planning a program similar to McAuley Residence at Bangor, Maine). Some have even become a nationally recognized phenomenon (the Kaiser Permanente farmers’ markets are offered in at least 50 Kaiser and another 50 non-Kaiser clinics nationally). This shows sustenance and success with minimal cost to the supporting clinic.
10.7.1 Areas for Further Research

This study opens the door to several areas for further research. As mentioned earlier, exploring the idea of social value for other organization types using a resource-based approach would be an obvious choice for further research. For-profit organizations do not have the same kinds of regulatory and resource issues as clinics, but they face pressure from other areas like investor-shareholder dynamics. However, it is foreseeable that other areas (e.g., organizational mission, organizational identity, and resource allocation) would be just as important for them as it is for clinics—even if the manner in which these areas affect each type of organization varies. Such research will be able to borrow several insights from this study whilst breaking new ground in the area of corporate social good.

This study makes the case for the relevance of the designed environment to social-value creation. Looking at more tangible connections between space and activity as it creates advantages to both program giver and receiver; both in the form of case studies and methodological tools, will make for interesting research. Exploring various ways to understand the links between women, everydayness, and third spaces is yet another area that could be explored further.

A tool such as the SROI (Social Return on Investment) that looks at program input as a whole whilst eking out the individual contributions of stakeholders could be modified to look at the monetary impact of smaller yet critical aspects within each program or case. For example, is there is a way to estimate the value from third spaces? Such research would be beneficial to both academic circles and social enterprises that routinely struggle to prove the value of certain interventions.

This study is admittedly exploratory, basing its views and results on interviews, observation, and photographic evidence collected on-site. At this time, there is not sufficient information to conduct more case studies, to conduct an even more exhaustive SROI, or to tie
all the benefits gained by the clinic from the program to accountability measures like, for example, the Community Benefit agenda (to safeguard tax status). There is increasing demand from governments, agencies like the IRS, and the public for clinics to do more for their communities. However, there is also increasing recognition from regulatory agencies (like the American Hospital Association's Foster McGaw Prize) for clinics that care about the social and economic wellbeing of their communities.

The IRS, in its Schedule H[^35] form, includes an additional group of activities called “Community Building,” which incentivizes improvements to community health. Among this, “environmental improvements” to the community is listed as one such activity. While this does not mean that all environmental appropriations could be automatically counted as Community Benefit, as we have seen in this study itself, many clinics are using their social programs as Community Benefit so long as they can explain how these programs promote the health and wellness of the community.

The clinics in this study are committed to their social programs, structuring and delivering them using space as a central resource such that there are benefits in it for them too. They have been doing it successfully for a long time now, even before there were mandates from regulatory agencies. As more clinics realize the benefits for themselves from offering such social programs, these interventions could become more commonplace. Given time, this form of social value, where social programs adopting a resource-based view are structured and offered such that they are beneficial to both program recipients and clinics, might well become a major player in turning clinics into true community resources.

[^35]: Schedule H form is an IRS special tax filing supplement that all US nonprofit clinics have to file (along with the annual tax form 990). This defines which activities constitute Community Benefit, which clinics use to safeguard their tax-free status.
Bibliography


Jones, N., Holmes, R., & Espey, J. (2008). Gender and the millennium development goals: A gender lens is vital for pro-poor results". *Overseas Development Institute, 42.*


doi:http://dx.doi.org/10.1016/S0140-6736(14)60460-8


Appendix A. IRB Document Samples

This appendix includes sample documentation for the Institutional review Board (IRB) approval used for the interviews in the case studies.
1. Recruitment Script Sent to Program Personnel (As First Communication)

From:

Dr. Kathryn Anthony, Professor, School of Architecture,

117 Temple Hoyne Buell Hall,

611 Lorado Taft Drive MC-621,

University of Illinois at Urbana Champaign, Champaign IL 61820

Email: kanthony@illinois.edu ;

Phone: 217-244-5520

And

Aparna Saligrama Ramachandra, Doctoral Candidate,

School of Architecture, University of Illinois at Urbana Champaign, Champaign IL 61820

Email: aparna.saligrama@outlook.com, saligra2@illinois.edu

SUBJECT: Social value creation in healthcare organizations

To: whom it may concern (name of person and designation with contact details).

Hello,

We are conducting a study about the social initiatives offered by healthcare organizations within their premises that are targeted to the community and that are over and above direct medical care. We think your expertise in the area of healthcare administration / facilities management / communications and operation would be very beneficial for this study. We would like to conduct an interview that would pertain to the same. This study is academic in
nature and informs the dissertation research of Aparna Saligram, Doctoral Candidate and an Investigator of this project and primarily for her dissertation report, scholarly and professional journals.

Questions will be regarding the nature of the communally beneficial program, when it came into existence, usage and cost patterns. Current and expected outcomes of the program, impact of the program on both the public and the organization will be discussed. We seek your professional opinion based on your expertise and experience as healthcare administrators, running and operating healthcare organizations. We would, should you give permission like to mention the name of your organization as a model for social value creation in the final report. Should you not consent; the name of your organization will remain anonymous.

This interview will take no more than 35-45 minutes of your time. As mentioned earlier, this is for academic research and while may not benefit you personally in any way, it will be very useful for us to have your opinions.

Please do not hesitate to contact us for any clarification and / or more information before you decide.

Kind regards,

Dr. Kathryn Anthony

Aparna Saligram
2. Information Sheet for Program Personnel (Handed on Site During Interview / Discussion)

You are invited to take part in a research study about the kinds of programs that are provided by healthcare organizations that are beyond medical care.

This is for study purposes and for research purposes. We wish to interview you for your professional opinion regarding the program (give name here….this will be unique to each case), including the role of the built environment in providing communal and organizational benefits.

You must be 18 years or older to take part in this study.

This interview will take approximately 35-45 minutes of your time

RPI: Dr. Kathryn Anthony

Study conducted by: Aparna Saligrama Ramachandra, Investigator, PhD candidate, School of Architecture.

Your decision to participate or decline participation in this study is completely voluntary and you have the right to terminate your participation at any time without penalty.

You do not have to answer any of the questions you do not want to.

Extensive notes will be made based on your replies from the interview. The notes will be destroyed once the study period is over. Your responses will be stored in a confidentially marked folder to which only the RPI and Investigator (Aparna Saligrama) will have access to. This too will be destroyed once the study period is over.

Your participation in this research will be completely confidential. Information and organizations will not be identifiable directly unless you specifically give us permission to mention your organization, name and designation.
Although your participation in this research may not benefit you personally, it will help us understand what kinds of activities that are beyond medical care are provided by healthcare organizations for communal benefit.

There are no risks to individuals participating in this survey beyond those that exist in daily life. If you have any questions about the project you may contact Dr Kathryn Anthony at 217-244-5520 or kanthony@illinois.edu

If you have any questions about your rights as a research participant in the study, please contact the University of Illinois Institutional Review Board at 217-333-2670 (collect calls accepted if you identify yourself as a research participant) or via email at irb@illinois.edu.

You can keep this sheet for your reference should you so choose.
3) Consent Form for Clinic for Program Personnel (Handed on-site During Interview / Discussion)

You are invited to take part in a University of Illinois research study. This study looks at the role of the built environment in the creation of social value.

The Responsible Primary Investigator in this study is Dr. Kathryn Anthony, professor, School of Architecture, University of Illinois at Urbana Champaign

The other investigator is Aparna Saligramra Ramachandra, Doctoral Candidate, School of Architecture, University of Illinois at Urbana Champaign

This research primarily informs the doctoral dissertation research of Aparna Saligramra. It is also envisioned to be used in professional conferences and publications. It involves a thorough study of communally beneficial programs such as (name the one being offered by this organization). If you take part in this interview, the discussion will be recorded and extensive notes will be taken. The goal is to then analyze these recordings / notes along with other observation notes of the space itself to elicit the importance of the built environment in the creation of a socially valuable network for the parent organization.

Should you concede to take part the discussion will take about 35-45 minutes of your time. The recording device shall be turned off at any point you request. Should you feel uncomfortable having an audio recording, notes alone will be taken instead. No comments outside of the topic matter will be recorded or noted and any anomaly will be deleted. You can withdraw consent at any time during the discussion or in the future. Should you withdraw, all notes and recordings pertaining to your participation will be deleted and destroyed.
Limited Risk in Participation

There are no known risks to participate in this study than what exists in everyday life. You are however free to terminate the discussion at any point. You also do not have to answer any question you do not want to.

Privacy and Confidentiality

It will be beneficial to this study were we to mention your name / designation etc. should you not be comfortable doing so, your identity will not be revealed at any time nor will there be a way of directly identifying you if the report is read. Any information that is obtained which could identify you will be kept confidential with access only to the RPI and Investigator. The notes and recordings will be stored on a password protected computer to which once again access is limited to the RPI and Investigator alone.

Accept / decline / withdraw from study

You are not obligated in any way to take part in this study. This study will not affect your status within the organization in any way and there will be no personal gain for you from this discussion. Your inputs will however greatly improve the quality of this research.

You are free to:

1. Stop participating in the discussion at any point
2. Ask for the recorder and note taking to be stopped at any point
3. Ask the entire session destroyed and excluded from the study
Questions and Contacts

If you have any questions at this time please ask the Investigator Aparna Saligrama who is present here. Should you have any additional questions, please address them to

Dr. Kathryn Anthony
412 Architecture Building,
School of Architecture, Lorado Taft Drive,
University of Illinois at Urbana Champaign
Champaign 61820
Phone 271-244-5220
Email: kanthony@illinois.edu

If you have any questions about your rights as a research subject you should contact

Institutional Review Board for the protection of Human Subjects at the University of Illinois
Urbana Champaign
Suite 203, MC_419
518 E Green Street
Champaign, IL 61820
Ph: 217-333-2670
Fax: 217-333-0405
Email: irb@illinois.edu
Authorization

You are making this decision whether or not to take part in this interview discussion. You must be at least 18 years or older to sign this form and take part in this research. Your signature means you have read and understood the above information and have decided to participate. You may withdraw at any time after signing this form. You are at this point in possession of an information sheet explaining the same. You will be given a participant’s copy of this form.

I, _______________________________ have read the information in this consent form. I voluntarily agree to participate in this study. My signature also means that I have been given a copy of this consent form.

_________________________________  ________________________________
Signature of research subject                  Date

_________________________________  ________________________________
Signature of Person obtaining consent                  Date
Permission to use these recordings and notes

Please put your initials next to yes or no in response to the below

1. The researchers may use the recordings / notes obtained from this discussion for professional conferences and publications
   ________________ Initials Yes  ________________ initials No

2. The researchers may use your name and designation in their research
   ________________ initials Yes  ________________ initials No

________________________________________________________________________
Signature of Research subject  Date
Appendix B. SROI Checklist

An SROI was conducted for three cases in Theme 2: Programs of a sensitive nature for low-income women to examine what returns could be expected, and also the role of the physical environment- how much it cost in terms of initial investment and what kinds of returns could be attributed to it. Three cases that held most promise in terms of documentation and information availability were chosen- the Windsor Connection Resource Center, Windsor Vermont (supported by Mt Ascutney Hospital and Health Center, for the years 2014-16), House of Mercy Homeless Center Janesville WI (supported by Mercy Health System, for the years 2014-16) and the McAuley Residence Portland Maine (supported by Mercy Medical, for the years 2014-17).

As per the methodology followed, a detailed checklist was compiled with information pertaining to stakeholders, scope of the project, timeline and so on. This was done prior to the actual analysis to ascertain the scope of information gathered, to see if anything was missing and if there were areas of potential problems. Table B - 1 details this.

While every effort has been made to gather firsthand information from the 3 cases for which the SROI was proposed in certain areas, financial 'proxies' had to be used for estimating financial values. And some areas required detailed calculation a cumulative of which then made for a single input. Appendix C.1, Appendix C.2 and Appendix C.3 detail this.
Table B - 1 with checklist with stakeholder information, scope of project and timelines

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: Establish scope and identify stakeholders</strong></td>
<td></td>
</tr>
<tr>
<td>Gather background information about the parent organization</td>
<td></td>
</tr>
<tr>
<td>Explain reason for doing the SROI</td>
<td>This is a way of understanding the monetary value of the social program to assess program status and inform future resource planning and allocation; this also allows us to understand what the contribution of the built environment is and how much it impacts the cost of the program.</td>
</tr>
<tr>
<td>Decide whether SROI is for a specific source of income or for all streams of income from various sources</td>
<td>This is contingent on financial information available; for this project the SROI is performed keeping in mind all income streams.</td>
</tr>
<tr>
<td>Decide whether this SROI is for the past, present or future…set a timeline</td>
<td>All SROI in this study is for the present, estimated for the next 2-3 years (2014-2017).</td>
</tr>
<tr>
<td>Identify resources one needs to do this analysis</td>
<td>Time, financial and services data pertaining to operating the program.</td>
</tr>
<tr>
<td>Examine program details closely enough to identify all stakeholders and then decide who are important enough to target (based on the scope of your study)</td>
<td>For this study, this will include the clinic, the users, the local authority and all support services used by homeless and substance abuse programs as well as larger social services like child services, legal counseling etc.</td>
</tr>
<tr>
<td><strong>Stage 2: Documenting Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Identify contribution of stakeholders</td>
<td>In terms of time or money</td>
</tr>
<tr>
<td>Identify values (or financial proxies) for stakeholder inputs</td>
<td>National reports, state/city commissioned studies as well as information gathered during onsite visit is used.</td>
</tr>
<tr>
<td><strong>Stage 3: Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Identify indicators for outcomes</td>
<td>This is part of the interview discussion- getting information about what the clinic using as benchmarks for each input- different for each clinic; it is listed in the individual SROI.</td>
</tr>
<tr>
<td>Identify duration of outcomes-long term or short term programs</td>
<td>Each clinic studied is looking at these programs long term; for this study a five year projection is used (2014-2019).</td>
</tr>
<tr>
<td>Identify financial proxies for outcomes if data not available</td>
<td>National reports, state/city commissioned studies as well as information gathered during onsite visit is used.</td>
</tr>
<tr>
<td>Identify credible sources for financial proxies</td>
<td>Relevant city/ state/ national reports and websites are used. This provides credibility.</td>
</tr>
<tr>
<td>Mention clearly if there are outcomes for which there is no data and financial proxy</td>
<td>This is mentioned in an Additional Comments column within the matrices wherever relevant.</td>
</tr>
</tbody>
</table>
Table B - 1 with checklist with stakeholder information, scope of project and timelines (Continued)

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 4: Impact</strong></td>
<td>Information for this entire impact section is elicited from interviews, discussions with clinic and program staff</td>
</tr>
<tr>
<td>Establish estimates for deadweight and attribution- run estimates by exports, refer from comparable analyses etc.</td>
<td></td>
</tr>
<tr>
<td>If there is attribution, check again if there are other stakeholders whose inputs might have been missed</td>
<td></td>
</tr>
<tr>
<td>Record clearly how attribution was made</td>
<td></td>
</tr>
<tr>
<td>Does the program have a drop off over the years- mention why if answer is no. if answer is yes, show how drop off rate was arrived at</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 5: Calculate SROI</strong></td>
<td></td>
</tr>
<tr>
<td>Make sure all indicators have financial values</td>
<td></td>
</tr>
<tr>
<td>Decide on discount rate- explain how the rate was chosen</td>
<td>A flat discount rate of 3.5% is assumed for all the programs. While this is highly subjective and left to the individual researcher, globally, for social and environmental issues, discount rates between 3-5% are accepted as the standard. Given the small scale of the project as well as the 3 year timeline, 3.5% was decided as a reasonable rate. A higher discount rate is more descriptive than prescriptive (Grist 2012), which fits well with the theme of this study- one of exploration and understanding.</td>
</tr>
<tr>
<td>Decide whether you want an SROI, a net SROI or payback period- explain reason for choice</td>
<td>An SROI is done for the programs because the SROI is used as an estimate to see what the program is worth today (discounted over five years). Given that these are social programs, that too of a sensitive nature, it is impossible to ‘demand’ a return of certain percent on these investments. Therefore a Net SROI is rejected. Long term sustenance is a larger aim but none of the clinics had the specific aim of wanting to earn back the money they are investing. And so payback period calculation is also rejected.</td>
</tr>
<tr>
<td>Check sensitivity of result- make sure deadweight and attribution are realistic.</td>
<td>Information regarding contribution of others has been cross checked with clinic personnel and with comparable studies (which are listed in the bibliography section under a separate heading)</td>
</tr>
<tr>
<td><strong>Stage 6: Reporting</strong></td>
<td></td>
</tr>
<tr>
<td>Summarize entire analysis succinctly, emphasizing on what the SROI means to the parent organization</td>
<td>The conclusion part of this chapter answers to this.</td>
</tr>
</tbody>
</table>
Appendix C. SROI Details of Proxies and Calculations

Appendix C.1 SROI Appendix, WCRC Windsor, Vermont

Table C - 1 Financial proxy calculation

<table>
<thead>
<tr>
<th>Type of service sought</th>
<th>Number served annually</th>
<th>Rate per hour ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health help</td>
<td>1,337</td>
<td>$63</td>
<td>$84,231</td>
</tr>
<tr>
<td>Alcohol and drug</td>
<td>77</td>
<td>$63</td>
<td>$4,851</td>
</tr>
<tr>
<td>Taxes</td>
<td>113</td>
<td>$152</td>
<td>$17,176</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$106,258 ~ $100,000</td>
</tr>
</tbody>
</table>

Agencies not included in calculating financial value/proxy

- Does not include those served over the phone
- Department of correction costs not included since we operate under the assumption of ‘innocent until guilt’ (legal fees need not be paid if defendant wins)
- Housing, vocational rehab guidance etc. Costs absorbed under either operation costs, MAPP (Mt Ascutney Prevention Partnership) or other relevant agencies

Explanation of proxies

- Numbers served annually data taken from MAHHC’s (Mt Ascutney Hospital and Health Center) Community Outreach Details Report and MAHHC Annual Report for 2012
- Substance Abuse and Mental Health: the American Mental Health Counselors Association, an organization of and for mental health counselors puts the median cost per session for clinical mental health counselors is $63 and $60 for clinical social workers. Since both forms of ailment need the same type of counselor skills, the same rate is applied for both drug abuse and mental health related users. (Source: http://www.amhca.org/about/facts.aspx accessed Nov 26, 2014)
- The National Society for Accountants, a nonprofit set up with the sole purpose of catering to the welfare of public accountants, in their 2013 study on fees state that the average 1040
with state tax return (and no itemized deductions; the simplest tax return there is in an IRS transaction) costs $152 per filing.

Appendix C.2 SROI, House of Mercy, Janesville, Wisconsin

Details of Calculation:

Total number of residents (women) at HOM = 25

Table C - 2 Financial proxy calculation

<table>
<thead>
<tr>
<th>Type of usage</th>
<th>Annual Cost per homeless person</th>
<th>Percent saving</th>
<th>Calculation Cost – percent saving</th>
<th>Final cost per person after PSH*.</th>
<th>What you save per person annually with PSH*.</th>
<th>Cost For 25 residents after PSH*.</th>
<th>Cost saving for 25 residents after PSH*.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>$1,600</td>
<td>60%</td>
<td>$1500<em>60% or $1500</em>0.4</td>
<td>$600</td>
<td>$900</td>
<td>$15,000</td>
<td>$22,500</td>
</tr>
<tr>
<td>Office based care</td>
<td>$1,815</td>
<td>60%</td>
<td>$1815<em>60% or $1815</em>0.4</td>
<td>$726</td>
<td>$1,089</td>
<td>$18,150</td>
<td>$27,225</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$2,448</td>
<td>60%</td>
<td>$2448<em>60% or $2448</em>0.4</td>
<td>$979</td>
<td>$1,469</td>
<td>$24,480</td>
<td>$36,720</td>
</tr>
<tr>
<td>Mental health</td>
<td>$5,761</td>
<td>41%</td>
<td>$5761<em>41% or $5761</em>0.49</td>
<td>$3,393</td>
<td>$2,368</td>
<td>$84,827</td>
<td>$58,948</td>
</tr>
<tr>
<td>Emergency shelter use</td>
<td>$2,439</td>
<td>96%</td>
<td>$2439<em>96% or $2439</em>0.92</td>
<td>$49</td>
<td>$2,390</td>
<td>$1,220</td>
<td>$59,756</td>
</tr>
<tr>
<td>Jail Costs</td>
<td>$20,000</td>
<td>100%</td>
<td>$20,000 <em>100% or $20,000</em>0.4</td>
<td>$0</td>
<td>$20,000</td>
<td>$0</td>
<td>$500,000</td>
</tr>
<tr>
<td>TOTAL ANNUAL</td>
<td></td>
<td></td>
<td></td>
<td>$143,677</td>
<td></td>
<td>$705,148</td>
<td></td>
</tr>
<tr>
<td>TOTAL MONTHLY VALUE</td>
<td></td>
<td></td>
<td></td>
<td>$58,762</td>
<td></td>
<td>~ $60,000</td>
<td></td>
</tr>
</tbody>
</table>

*PSH: Permanent Supportive Housing

Explanation of proxies

- Mental Health, ER, Office based care, Hospitalization, emergency shelter and jail use proxies and savings proxies are from the same sources as the McAuley program. The data reflects national averages and since no data is available specific to Janesville WI, the same proxies were used.
- Financial data for ER, Hospitalization, and Office based care was taken from Hwang et al., 2010, while financial data for mental health, emergency shelter was taken from Modello et al., (2007). Jail costs were taken from the National Alliance to End Homelessness (2014) at the recommendation from staff at the case study sites as most accurate.

- Program staff says that they do not track resident movements during their stay at HOM. They however opine that overnight jail stays might not be relevant since the stay period is only 30 days. Therefore, jail savings is put at a 100% or assume that none of the residents spend jail time during their tenure at HOM.

- The total monthly savings because of the center comes to $60,000 for the 25 women or $2400 per person per month. This concurs with the landmark study by Larimer et al (2009) that puts monthly savings for the homeless after housing at $2449 per person per month.
Appendix C.3 SROI, McAuley Residence Portland, Maine

Table C - 3 Financial proxy calculation

<table>
<thead>
<tr>
<th>Type of usage</th>
<th>Annual Cost per homeless person</th>
<th>Percent saving after PSH*</th>
<th>Final cost per person after PSH* / What you save per person annually with PSH*</th>
<th>Cost For 15 residents after PSH</th>
<th>Cost saving for 15 residents after PSH*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>$1,500</td>
<td>60%</td>
<td>$726</td>
<td>$1,389</td>
<td>$11,224</td>
</tr>
<tr>
<td>Office based care</td>
<td>$1,815</td>
<td>60%</td>
<td>$979</td>
<td>$1,458</td>
<td>$14,688</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$2,448</td>
<td>60%</td>
<td>$1,402</td>
<td>$1,908</td>
<td>$16,535</td>
</tr>
<tr>
<td>Mental health</td>
<td>$5,751</td>
<td>41%</td>
<td>$2,386</td>
<td>$3,000</td>
<td>$22,000</td>
</tr>
<tr>
<td>Emergency shelter use</td>
<td>$2,439</td>
<td>98%</td>
<td>$49</td>
<td>$59</td>
<td>$359</td>
</tr>
<tr>
<td>Jail Costs</td>
<td>$20,000</td>
<td>60%</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$180,000</td>
</tr>
<tr>
<td>Police Costs</td>
<td>$240</td>
<td>66%</td>
<td>$156</td>
<td>$222</td>
<td>$3,276</td>
</tr>
<tr>
<td>TOTAL ANNUAL</td>
<td>$240</td>
<td>66%</td>
<td>$300</td>
<td>$306</td>
<td>$369</td>
</tr>
<tr>
<td>TOTAL 2 years</td>
<td></td>
<td></td>
<td>$606,178</td>
<td>$606,178</td>
<td>$33,000 per year $66,000 for 2 years</td>
</tr>
<tr>
<td>Car Maintenance</td>
<td>$2,200</td>
<td>100%</td>
<td>$0</td>
<td>$2,200</td>
<td>$0</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td></td>
<td></td>
<td>$682,412</td>
<td>$672,178</td>
<td>$680,000</td>
</tr>
</tbody>
</table>

* PSH: Permanent Supportive Housing

Explanation of proxies

- **Car Maintenance**: Assuming the women already have cars (akin to the other three case studies in the Programs for Women silo), annual car maintenance costs would amount to $2,200 per person. For a period of two years, that would be $4,400 per person, totaling $66,000 for 15 women. This is the amount of money saved because of the location, which allows for walking and bus connectivity to all part of town. (Source for annual car maintenance cost for state of ME: Bankrate.com, December 2014)

- **Mental Health and Emergency Shelter**: numbers were taken from a cost of analysis of permanent supportive housing (PSH) study commissioned by the state of Maine in 2007.
• **Mental Health** Cost per person before PSH = $5751. Savings after PSH = 41%. That is a saving of $2400 per person or $36,000 for 15

• **Emergency shelter** Cost before PSH per person = $2439. Savings after PSH = 98%. that is a savings of $2400 per person or $36,000 for 15

• **ER costs** ($1436), office based care costs ($1815) and hospitalizations ($2448) (Hwang & Henderson, October 2010) for homeless people with insurance was cut by approximately 60% with PSH (data taken from a study commissioned specifically for the Greater Portland area, Maine).

• Savings = $900, $1100, and $1500 respectively, or $13,500, $16,500, and $22,500 for 15 women.

• **Prison and police costs**: The report on PSH commissioned by the state of Maine shows 60% savings on prison and 66% on police costs. The National Alliance to end homelessness, a nationally recognized prominent nonprofit working on this cause puts annual prison costs at $20,000 per person or $300,000 for 15 women annually.

• Prison savings after PSH = 60% or 180,000 (for 15 women)

• Police and law enforcement costs - $240 per year without PSH. A 66% savings brings it to $159 per person or $2385 for 15 women annually.

• Financial data for ER, Hospitalization, and Office based care was taken from Hwang et al., 2010, while financial data for mental health, emergency shelter was taken from Mondelo et al., 2007. Jail costs were taken from the National Alliance to End Homelessness (2014) at the recommendation from staff at the case study sites as most accurate.
How we arrived at $140,000 for the local authority and $60,000 for the women, as value of inputs in STAGE 1 TABLE 1 (annually)

- The women pay a rent of approximately $600 a month, of which they do not (as an estimate) do not pay anything in the first 6 months.
- Therefore annual rent per resident will be 600 X 6 months = $3600.
- For 15 women, the amount comes to $54,000 which is rounded to $60,000 mainly because some women start working earlier in their stay and may start paying rent sooner.

Table C - 4 Calculation of input values of the residents contribution.

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A rent of $600 per person per month</td>
<td>$7200 annually</td>
</tr>
<tr>
<td>Women do not pay rent for first 6 months</td>
<td>$3600 annually</td>
</tr>
<tr>
<td>For 15 women</td>
<td>15 X 3600</td>
</tr>
<tr>
<td>Cost of Permanent Housing according to report commissioned by state of Maine</td>
<td>$13,000</td>
</tr>
<tr>
<td>Local authority provides housing for 15 women therefore</td>
<td>13,000 X 15</td>
</tr>
<tr>
<td>Therefore local authority gains 60,000 from its contribution</td>
<td>$195,000 - $60,000</td>
</tr>
</tbody>
</table>

Given that the women stay for a period of 2 years, the amounts are doubled in the inputs table, Stage 1 Table 1 (Table 7-9)

How we arrived at 15% as attribution rate for larger recovery community

Discussions with hospital staff at Mercy regarding relative roles of all sources they deemed as attributors for program success

- Mercy staff involved in the running of McAuley was very vocal in crediting the larger recovery community for attributing to program success. From AA and 12 step meetings to various religious organizations that provide both spiritual and more practical guidance (like warm clothes procurement and winter survival advice), there are several outfits, staff opines that help the women.
Another big attributor was the local bank (declined to name the institution). Program staff said that financial recovery for the women was just as important as anything else in this program. Women are typically put in touch with a financial adviser from the bank who works with them in how to manage and plan their finances.

Program staff gives a best estimate of 25% as external attributors of program success.