

2023 Financial Innovations Roundtable Summary

Climate, Equity, & Social Drivers of Health

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About the 2023 Financial Innovations Roundtable

Now in its 25th year, the Financial Innovations Roundtable (FIR), located at the Carsey School of Public Policy at the University of New Hampshire, has worked to address problems related to access to capital for low- and moderate-income consumers and communities. The FIR works with a range of financial institutions, government agencies, foundations, and trade associations to access their expertise for problem-solving discussions.

This year’s FIR (June 15–16, 2023) was hosted by the Federal Reserve Bank of New York and explored the connections among climate, equity, and the social drivers of health. The overlapping disasters of the COVID-19 pandemic, racial injustice, and the climate crisis call for integrated solutions and investments that address the complexity of interconnected burdens on disadvantaged communities. Innovative partnerships and investments at the intersection of climate, health, and community development hold promise for prosperity, wellbeing, and resilience for these communities. Through the Roundtable, we strove to better align those interests by bringing together key players from both the health and climate/environment sides to look at ways they might sharpen their investment strategies to more clearly achieve positive health, equity, and environmental outcomes.

The event had 110 participants from a variety of sectors including community financial institutions, healthcare organizations, government agencies, banks, and impact investment professionals.

Introduction and Framing

Claire Kramer Mills, Assistant Vice President and Director of Community Development

Analysis at the Federal Reserve Bank of New York, opened the FIR with a welcome and introduction. She noted that East Coasters got a wake-up call last week, as our cities and towns turned strange shades of yellow, the result of Canadian wildfires triggered by a warming planet. How do we mitigate the effects of climate change, invest in adaptation, and build resilience in frontline communities—communities that have long contended with pollution and disinvestment? What is working, and what new partners need to be engaged? The stakes for LMI families are profound: Continue on a path of dirty, unhealthy, and increasingly expensive poverty *or* transition to healthier and more opportunity-rich communities where genius can thrive. The Fed's community development team, borne out of the Community Reinvestment Act, has a mission to increase transparency about community needs and to bring together stakeholders who can address those needs, through technical assistance and investment. They have focused their work on access to safe credit and wealth-building financial services, neighborhoods that foster healthy people, and resources for equitable adaptation and resilience in the face of a changing climate—essentially, the topics of this year's FIR.

Michael Swack, Director of the Center for Impact Finance at the University of New Hampshire's

Carsey School of Public Policy, welcomed participants and thanked Kramer Mills and her colleagues at the Federal Reserve Bank of New York: Javier Silva, Julien Macrone, Kellye Jackson, and David Ericson. He also thanked this year's FIR sponsors: Robert Wood Johnson Foundation, MacArthur Foundation, Schmidt Family Foundation, Wells Fargo Foundation, Goldman Sachs, and Deutschebank.

Swack reflected that, back in 2014, the Roundtable looked at how to promote hospital investment in community development. Several excellent projects came out of that meeting. As he was preparing for this Roundtable, he came across a statement: '*History does not repeat itself, but it does rhyme*' (attributed to Mark Twain). Over 20 years ago, Kirsten Moy of the Aspen Institute wrote a piece on scaling in which she identified successful models of scaling in the business world and looked at CDFI opportunities. In a prescient observation that 'rhymes' with what we see today, she observed that, in the hundreds of CDFI applications she had reviewed during her time at the CDFI Fund, despite the fact that achieving scale was an aspiration for many of them, there was a lack of focus on infrastructure. We didn't know it at the time; that wasn't a word that people were using in community development. Foundations and government funded short-term programs. They rarely funded infrastructure. That seemed strange—like building cars with no roads or trains without tracks. Kirsten and Dan Liebsohn (Low Income Investment Fund) talked about building a system that would support affordable housing. Today, we often refer to that system as an *ecosystem*: developers, attorneys, architects, appraisers, city and state government, community-based organizations, property management people.

The point is that, if you don't have all the pieces, you don't have a vibrant system and you can't build at scale. And, if localities would work in this systems fashion instead of just focusing on individual projects and programs, they could have developed a lot more housing. This is the same issue we face now when we think about the climate crisis. How do we go beyond just financing individual projects? This session is in many ways a recurring theme—how to promote sector collaboration when so much of life is in silos? Since the first FIR, the CDFI field has emerged as a major force in financing people and projects mainly ignored by the world of mainstream finance. But collaboration for the purposes of achieving scaled operations is hard for CDFIs for many reasons, ranging from competition for funds, to frequently a hyper-local focus (often a good thing!), to business models that don't really accommodate scaled responses. At this year's FIR, we'll look at the health sector and the community finance sector with a focus on opportunities for collaboration around the climate crisis—and how these two sectors can serve communities most at risk, both health risk and climate risk—and the connections between the two.

Call to Action: Climate, Equity, and the Social Drivers of Health from a Policy and Philanthropic Perspective

Moderator: **Michael Swack**, Director, Center for Impact Finance, UNH Carsey School of Public Policy

Panelists:

- **John Balbus**, MD, Director of the Office of Climate Change and Health Equity, Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services
- **Ebony Perkins**, Director of Impact Investments, UnitedHealthCare
- **Laurie Schoeman**, White House Senior Climate Advisor, Executive Office of the President at Council for Environmental Quality

John Balbus, MD, Director of the Office of Climate Change and Health Equity, Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services, noted that—at the federal level—often the greatest opportunities come from the worst crises. We are in a cascading and compounded crisis. Globally, the U.S. pays the most for its health sector but achieves worse outcomes. Among the OECD, we pay twice what others pay, but our outcomes are 20th among the 38 countries. Community drivers, social determinants of health, and health equity all combined could be our biggest opportunity. However, the system is not ready for this. Many players are deeply involved in a fee-for-service paradigm, which is not the paradigm that will bring us out of this crisis.

Some individual health sector leaders (Kaiser, Gunderson) are becoming climate leaders, transforming their systems such as installing microgrids and renewable generators. Many are also making direct investments in communities in terms of reliance, housing, and sustainable food production. However, it's harder for hospitals to demand models that they aren't experts in. One way to solve this is for

community organizations to approach them and ask them to partner, as funds flow post-COVID and through the Inflation Reduction Act. Also look at how the insurance sector can participate in this work, reinvesting institutional funds into climate-related opportunities. Mold-reduction investments, for example, increase the health of people and of buildings *and* lead to positive returns.

Ebony Perkins, Director of Impact Investments, UnitedHealthCare, pointed to huge opportunity but also acknowledged the language barrier between various silos. She acts as a translator to help understand the barriers that people in communities are facing, especially overlaid with the climate component. In this role, she might have to reframe terms, tell a story, and/or code-switch—generally, meet folks where they are. UnitedHealthCare and others have buckets for their impact investments—affordable housing, mental health, maternal health, environmental equity—but why are these four separate buckets? For example, housing investments have a huge environmental component. On a recent site visit, she saw air conditioning that was moldy and dripping. We view that as a housing investment, but it clearly stretches across the buckets. A recent UnitedHealthCare success was a \$10 million investment to Andrew Crosson of Invest Appalachia that will address multiple issue areas; it’s a well-rounded fund. Advanced Research Projects Agency for Health (ARPA-H) has \$100 million to fund health systems resilience, but significantly greater focus is on supply chain resilience (such as COVID) than on environmental resilience.

Perkins emphasized the business case of addressing social drivers of health. If these SDOH are causing vulnerable groups to have more and more hospital visits and stays, that affects our line of business. The reality is, it hurts us. UnitedHealthCare chose to be proactive to all these issues, including climate and environmental components. We make the business case internally. The growing ESG movement is also a huge factor, especially for publicly traded organizations, whose investors are demanding them to be responsible with their business practices.

Laurie Schoeman, White House Senior Climate Advisor, Executive Office of the President at Council for Environmental Quality, agreed with the need to adapt language for different audiences and to code-switch. The Biden administration has committed \$370 billion in climate-related improvements around the nation. HHS, EPA, DOT, SBA, HUD, every federal agency has an allocation. These allocations will be moving into communities to support health, access to transportation, roads and bridges, electric grid, and more. If communities are immune systems, these investments bolster the system to reduce and manage climate risk. The goal is to fortify our nation and our most disadvantaged communities that have legacy and disproportionate health conditions, resulting from a legacy of disinvestments in tribal, rural, and communities of color. Government needs to have a holistic approach, with multiple streams of funding to deal with the cascading impacts of climate change. There’s not one magic bullet. We need a whole-of-society systems approach to get where we need to be. So much is locally led, block by block, neighborhood by neighborhood; it’s not bright and shiny, but it’s done through love of community by people who have been working there for decades.

Realities on the Ground: Climate, Equity, and Health

Moderator: **Doug Sims**, Senior Director, Resilient Communities at the Natural Resources Defense Council (NRDC)

Panelists:

- **Pete Upton**, Executive Director, Native360 Loan Fund, and Acting Director, Native CDFI Network
- **Sarah Norman**, Chief of Community Development, Sheppard Pratt Health System
- **Jason Vargo**, Senior Researcher, Community Development, San Francisco Federal Reserve Bank

Doug Sims, Senior Director, Resilient Communities at NRDC, framed this ‘on the ground’ session by noting a variety of impacts on human health due to the overlapping crises of climate change and inequity. The CDC notes the following exacerbated phenomena and their impacts:

1. Severe weather:
 - Injuries, fatalities, human health impacts
2. Air pollution:
 - Asthma, cardiovascular disease
3. Changes in vector ecology:
 - Malaria, dengue, encephalitis, Lyme disease
4. Increasing allergens:
 - Respiratory allergies, asthma
5. Water quality impacts:
 - Cholera, algal blooms
6. Water and food supply impacts:
 - Malnutrition, diarrheal disease
7. Environmental degradation:
 - Forced migration, civil conflict, mental health impacts
8. Extreme heat:
 - Heat-related illness and death, cardiovascular failure

Our panelists work in and serve communities that have high vulnerability to these impacts. Often, these individuals, families, and communities have the deck stacked against them health-wise already, in some or all of five key areas of SDOH as identified by the CDC: (1) Economic Stability; (2) Education Access and Quality; (3) Health Care Access and Quality; (4) Neighborhood and Built Environment; and (5) Social and Community Context (i.e., culture).

Pete Upton, Executive Director, Native360 Loan Fund, and Acting Director, Native CDFI Network, has a unique view on the ground. The Native CDFI Network has roughly 72 members (and 25 emerging) in many different states. Tens of thousands of Navajo residents were without water, many others were displaced after the Spencer Dam broke in Nebraska... climate change has huge impact on Native communities. Native communities need to come up with unique solutions to our problems, with wide guardrails because we need flexibility. For example, why does 90% of the HUD Section 184 Indian Home Loan Guarantee Program funding go to residents who do not live on reservations? The reason is that lenders are finding and selling to residents who do not live on reservations. Proposal: make Native CDFIs lenders. We know the communities better than anyone, have boots on the ground, understand the people and the solutions (which are often offered by stakeholders)—but we don't have the capital.

Don't give us cookie-cutter funding. For Native lands, we have to be innovative with different loan products to be successful. For example, we rely heavily on interest-only loans, but the CDFI Fund wants to prohibit this popular product. We must find the pieces of the puzzle in our community; they have to give us leeway. Invest money in Native CDFIs, hold us accountable; we have low delinquency rates and we know how to meet our geographic challenges. Overall, we fear that the Greenhouse Gas Reduction Fund (GGRF) will be similar to HUD; if the organizations who receive the money aren't in our communities, we fear we will be excluded. We took it upon ourselves to lead a coalition so that we can flow money into Native communities.

Sarah Norman, Chief of Community Development, Sheppard Pratt Health System, said that Sheppard Pratt's focus is individuals with disabilities and unhoused veterans. They have 70,000 clients across Maryland, with two psychiatric hospitals and with community services that give folks with disabilities an opportunity to live in communities and neighborhoods—not in institutions or prison. Norman also runs a social enterprise that provides meaningful employment for individuals with disabilities, making a place for individuals with disabilities to fit in our economy and thrive in our communities.

Norman noted that the Community Development, Climate Change, and Health communities don't just speak different languages, they have different cultures. The culture in public health is deeply data-oriented, deeply solution-oriented, focused on its own solutions. Community development's roots are in resident engagement; health has a lot to learn in this area. Yet, if you aren't thinking about people with disabilities in your climate work, you aren't doing the work right. (For example, during a recent heat wave in Canada, researchers found that schizophrenia increased risk of death by 200%.)

Jason Vargo, Senior Researcher, Community Development, San Francisco Federal Reserve Bank, focuses on climate change and racial and health equity. Formerly, he worked for California's Department of Public Health as a scientist in charge of researching climate change and health; during

the COVID-19 pandemic, he led the modeling team and advised the Governor's office about health equity reporting. At the San Francisco Federal Reserve Bank, he represents nine western states and Pacific territories and sovereign tribal nations. We have a lot of climate hazards that affect our communities. We try to drive our focus to impact (beyond exposure). You see the difference in the suffering and impact in LMI communities. For climate change, as we did with COVID, we want to center LMI populations in this work, stressing the relationship between climate risk and disadvantage. During COVID, scientists knew a lot about testing, cases, transmission, and communicable diseases but, in order to protect most vulnerable, we needed know more about social science.

Vargo read *The New York Times* opinion piece, '[Social Distancing is a Privilege](#),' and started to frame the pandemic along the lines of privilege, advantages, and opportunities. We found that those more vulnerable communities didn't have the opportunity to work from home; they had reduced agency to make choices that protect their health. Our place-based index found large disparities; place really matters. Looking at individual indicators contributing to these indices (e.g., housing, academic attainment, etc.), we found that wealthier and more educated communities had fewer COVID cases. The intersectionality of factors in these places compounded the impact of COVID on people. This became an important lens for designing the COVID reaction; for example, leaders focused on how many of the people with the lowest 25% of resources had been vaccinated.

Practitioners Committed to the Complexity and Opportunity at the Intersection of Health, Climate, and Justice

Moderator: **Hannah Vargason**, Research Fellow, Center for Impact Finance, UNH Carsey School of Public Policy

Panelists:

- **Ruth Ann Norton**, President and CEO, Green & Healthy Homes Initiative
- **Jim Baek**, Executive Director, Community Investment Guarantee Pool (CIGP), VCC Social Enterprises
- **Duanne Andrade**, President, SELF

Hannah Vargason, Research Fellow, Center for Impact Finance, UNH Carsey School of Public Policy, observed that health is integrated into the mission or strategic plan of each panelist's organization, though the organizations' initially centered community finance and/or green building. She invited panelists to talk through the thorny issues they face, such as extreme weather, insurance costs, and instability, and investors who pick and choose what they are interested in when an organization is trying to be more holistic.

Ruth Ann Norton, President and CEO, Green & Healthy Homes Initiative, traced GHHI's roots to nine children in intensive care, poisoned by lead. Over time, the resulting Coalition to End Childhood Lead Poisoning (CECLP) grew to understand that we needed to look beyond lead, to the whole house. We were spending millions to retrofit homes but, if we didn't look at energy, people were still going to move. In 2008, GHHI received climate dollars for restorative justice and the development of a health measure. As a nonprofit, we became a high-trust audit agency, which means we can do patient analysis. We tracked a 99.4% reduction in lead poisoning, returning \$44.5 million to the Maryland economy—but these savings didn't necessarily funnel back into the community. By tracking measures such as days missed from school, work attendance, housing turnover, Medicaid costs, and reduced hospitalization, our goal is to track those dollars back and build a tangible pathway to equity. Health dollars are bankable. GHHI quantifies energy savings and health savings. This was a very new approach that has since become the common approach.

Jim Baek, Executive Director, Community Investment Guarantee Pool (CIGP), VCC Social Enterprises, told of a recent strategic planning process in which they realized/confirmed that everything they do is intersectional. One reason we organizations are designed in silos is because investors think about things in silos. How do we lean into the (un-siloed) reality of how people live? Social determinants of health (SDOH) has become the organizing frame for how VCC Social Enterprises will move forward. Regarding measurement, however, we collectively haven't nailed the metrics of that connectivity between climate investments and health. Right now, we are doing it through stories, which is how humans make sense of reality.

Duanne Andrade, President, Solar Energy Loan Fund (SELF), said SELF launched in 2009 with a mission to address climate change and the climate industry. SELF has three programs: consumer loans for low/no credit scores to access energy efficiency and upgrades, loans for landlords, and gap funding for BIPOC developers. Of our borrowers, 74% are LMI. We actually do very little solar financing. When we pursued solar installations, we learned that LMI households had other priorities/needs. How can you put solar panel on a roof that's leaking? They're going to switch their A/C when it no longer works, not because of cost savings or environmental benefits. Now most of our lending addresses climate resilience that has to do with health.

In contrast to GHHI, SELF didn't have capacity to do that level of measurement. We measured energy savings and captured the stories. We convinced our board by asking, "What is a home? It's the base from which society thrives. It supports social ROI, the health of your child with epilepsy, the mom who can't afford A/C and has very low credit..." We're going to listen to people sharing from their lives, e.g., after an unsecured personal loan, the family is thriving and can access insurance and other mainstream financial products. Ten years later, we want to partner with an impact measurement expert. We're going to do the work anyway. For each federal dollar, we raise \$16 in private capital.

Health organizations and hospitals collect an amazing amount of data. Community financial institutions have collected little data beyond federal funding requirements. Now everybody wants to understand climate, health, and their intersection—and money is coming. UNH/Carsey should provide impact measurement templates and tools for CDFIs to address a current void in tracking.

Hospital-Aligned Investments in Community Development

Moderator: **Kevin Barnett**, Executive Director, Center to Advance Community Health and Equity, Public Health Institute

Panelists:

- **Mark Schaefer**, Vice President, System Innovation and Financing, Connecticut Hospital Association
- **John Vu**, VP Strategy, Community Health, Kaiser Foundation Health Plan
- **Joe Betancourt**, President/CEO, Commonwealth Fund

Kevin Barnett, Executive Director, Center to Advance Community Health and Equity, Public Health Institute, observed that the Covid-19 Pandemic has presented the health care sector with an array of financial challenges at a time of growing awareness of the social determinants of health. For hospitals and health systems that have provided leadership to date, what is needed, both internally and externally, to regain our stride and build momentum? A common tool is Community Health Needs Assessments, but we've spent a long time assessing communities to death and far too little time following through. What strategies ensure a focus in communities where health inequities are concentrated, aligning investments across competitive and sector lines, leveraging public sector assets, and producing institutional and societal returns on investment?

Mark Schaefer, Vice President, System Innovation and Financing, Connecticut Hospital Association (CHA), said that his work falls in two areas: (1) Medicare and Medicaid reimbursement and how this affects hospital finances; and (2) Community investments focused on root causes of health inequity, our focus today. Formerly Medicaid director in Connecticut, he joined CHA because they were explicitly looking to achieve sustainable means to finance community health. Transforming communities is good for business interests and the right thing to do. What role can we play in driving improvements in healthcare and equity, beyond the acute care space? How do you engage the community in a meaningful way to direct and drive change, so decisions aren't divorced from wishes of community in a way that's disempowering? Every hospital has Community Benefit obligations; they must conduct a Community Health Needs Assessment and develop Improvement Plans. We have the opportunity to capitalize on a role that hospitals already are required to do. CHA began to formulate a roadmap for working with communities to drive a

change agenda. Our greatest challenge to doing work as an organizer/aggregator of action is that the actions we're trying to organize around are an unnatural act in the healthcare marketplace.

John Vu, VP Strategy, Community Health, Kaiser Foundation Health Plan, noted that Kaiser was founded on a model that financially incentivized the organization to keep people healthy. As a nonprofit, we talk about improving the health of members *and* communities; it's baked into who we are. For our first 60 years, despite efforts to look upstream, Kaiser followed a sickcare model. In the last 17 years, more attention has gone to SDOH in a growing understanding that 'Health is beyond what healthcare is.' How does this translate to strategies and tactics? The existential question: What is our responsibility? We can't solve everything, but we can't ignore them either. It's been a bit of awakening from leadership and others that we should deliver health, not just healthcare. Turn over every stone—how would we affect/fix climate/air/forest fires, food security, housing? We came to it with great humility; we needed to find our rightful space. There are already a ton of experts out there. We must find where we bring our assets and resources to the highest and best value. How can those resources be catalytic? We can't fund our way through the housing crisis, but can we generate 5x, 10x, 50x in other markets.

Joe Betancourt, President/CEO, Commonwealth Fund, noted that, when we look at epidemiology and public health data, we see significant disparities in health outcomes among communities of color and vulnerable communities. He firmly believes that health equity accrues benefits to entire system. Health outcomes are rooted in social drivers; it's Maslow's hierarchy of needs, not rocket science. If you're underinsured, you're going to do less well. If two patients present in a hospital all being equal, the person of color receives worse care in a variety of clinical conditions. Change within will come from two sources: (1) The next generation of healthcare providers. Coming out of the pandemic, people are starting to talk about demoralization and moral harm, saying "this is unacceptable, we need to be more attentive to climate and social drivers." The provider community is an appropriate catalyst to engage. (2) People—discontented patients. No one feels they are getting what they could or deserve (even those *with* insurance).

Overall, we are limited by our perception of structures. Hospitals and healthcare organizations cannot address needs alone. We must access funding from other community goals such as workforce development. Real investments with tax incentives at city and state level allow for rejuvenation of many communities. Anchor institutions that leverage community spending towards health is another strategy, in partnership with developers. While this approach can create win-win opportunities, a concern is that it leads to gentrification.

Models for Optimizing Investments in Health Infrastructure

Moderator: **Tina Poole Johnson**, Deputy Director, Center for Impact Finance, UNH Carsey School of Public Policy

Panel Speakers:

- **Maggie Super Church**, Visiting Scholar, Federal Reserve Bank of NY
- **Becky Regan**, CEO, Capital Link
- **William O'Brien**, Managing Director, PCDC

Tina Poole Johnson, Deputy Director, Center for Impact Finance, UNH Carsey School of Public Policy, said that, in this session, we want to zero in on the realities and opportunities of specific projects and businesses. What is health infrastructure—and, for those in housing, finance, etc., what is in our sphere of influence? How do we make the pitch, both the *impact case* to funders, staff, and community partners and also the *business case* to funders, investors, and insurers?

Maggie Super Church, Visiting Scholar, Federal Reserve Bank of NY, has spent most of her career looking at the intersection of housing, health, environment, and climate. Now this intersection is prevailing wisdom, but how do we manifest it in our work? How do we advance an agenda for health equity in a way that embeds community priorities and voice? All infrastructure should be health infrastructure. Through that lens, there are more possibilities. Climate equity is the same for health purposes; 50% of emissions come from buildings, transportation, and agriculture, which also drive health outcomes. Climate infrastructure and health infrastructure have dual aims. One area where we can make significant gains in decarbonization, resilience, and health is building infrastructure—specifically, care infrastructure, which includes eldercare, hospitals, schools, and youth centers. State departments of insurance also have a serious interest of what's happening in their markets, as parts of the country become uninsurable, e.g., the Gulf Coast, California. State insurance commissioners have strong incentive to get capital aligned, to get more resilient and more insurable. Two examples: Connecticut is exploring how to get more stable power to affordable housing residents who rely on home medical devices and refrigerated medication; and Alabama is the nation's leader in fortified roofs for tornado- and hurricane-strength winds.

Becky Regan, CEO, Capital Link, provides advisory services to Federally Qualified Health Center (FQHC). FQHCs started over 50 years ago as part of the civil rights movement to provide access to care for people who didn't have it. Access to care is a human right. FQHC practitioners are committed to serving patients with dignity, regardless of ability to pay. Environmental justice language has been part of FQHCs from the start. Without electrical power, FQHCs lose revenue and lose lives, their refrigerated medications spoil, and they can't access digital medical records. The goal of our Community Health Access to Resilient Green Energy (CHARGE) Partnership is solar panels plus battery back-up at every FQHC. At 9,000 sites, we potentially could have solar on 9,000

rooftops; this is a major carbon reduction! We are bridging from very, very local, to the cumulative need of \$3.6 billion.

William O'Brien, Managing Director, Primary Care Development Corporation (PCDC), said that PCDC is a CDFI that expands access to general care through three programs: (1) a policy advocacy group; (2) a technical assistance program towards optimization at the primary care provider level; and (3) a finance program that has made over \$1.5 million in investments in PCPs over 30 years. FQHCs comprise 85–90% of PCDC's investment platform; all typically have narrow operating margins. FQHCs are arguably the largest network in the healthcare system, because of how many people are served. There's the joke, "If you've seen one, you've seen one" because of the varied services FQHCs provide. But on the revenue side, they are very similar. They are notoriously risk-averse and depend heavily on grants for operations. What could move the needle on incentivizing FQHCs to make a move? Clear and reasonable economic incentive. FQHC decisions must always result in an increase in revenue stream and net surpluses, through grants and innovative financing such as New Markets Tax Credits.

Emerging Opportunities at the Intersection of Health and Climate

Moderator: **Tyler Norris**, Founding CEO of Well Being Trust, Visiting Scholar at Federal Reserve Bank of NY

Panelists:

- **Sima Thakkar**, Sr. Director of Health & Climate Equity, Raza Development Fund
- **Andrew Crosson**, CEO, Invest Appalachia
- **Keith Bergthold**, CEO, Better Blackstone CDC, Fresno Investment Corridor
- **Steve Saltzman**, CEO, NH Community Loan Fund

Tyler Norris, Founding CEO of Well Being Trust, Visiting Scholar at Federal Reserve Bank of NY, pointed to three goals discussed at a recent event at the Fed:

1. Reimaging: what is opportunity and how do we ensure all kids and people have a shot at equitable opportunity.
2. Accountability for outcomes. It may be time for oversight of our big healthcare organizations. Hospitals' total Community Benefit investments of \$14 billion have fallen short of delivering. Our healthcare system is the leading driver of personal debt and bankruptcy. There is a lack of transparency in billing. Are we getting what we need to get from this major tax break to hospitals? Consumers and taxpayers say No.
3. Leadership towards an inclusive economy for all people. It's a distribution problem. We must look at all the forms of capital—social as well as economic—including trust, reciprocity, and cohesion. With trillions of dollars about to move in the coming decade,

what are the co-benefits to the community? How do we ensure they return to community? A good solution solves multiple problems. If we're working at these intersections, how do we move beyond capital needed and units delivered, to an ecosystem that is actually capable of affecting health outcomes? We must make it possible for communities to capture the value of their work, versus building a system that is fundamentally extractive.

Sima Thakkar, Sr. Director of Health & Climate Equity, Raza Development Fund, said Raza was created as the capital arm of UnidosUS, the Latino civil rights organization. Putting health and climate together is relatively new for us, but not for our community-based partners since those communities are hit first and worse. If we want to finance justice for our partners and bring capital investments and resources to them, we need to listen, learn, and amplify. Raza focuses on affiliates. For example, San Ysidro, California, is a community dissected by three highways and a busy land port. Residents experienced air pollution and its effects for many years. Raza conducted research then worked with affiliate Casa Familiar and a community advisory board to make sure the information collected was presented back to community in a bilingual manner. Casa didn't stop there; they started another program, Casa Verde, training their residents in environmental justice principles and organizing. How should Raza finance efforts like this? We need to listen and learn before applying (financial) solutions.

Andrew Crosson, CEO, Invest Appalachia, described Invest Appalachia as a community development organization that happens to use the tools of investment. We build vehicles to serve community needs. There are Appalachian counties in six states, facing persistent poverty, health disparities, and a chronic lack of community investment. Unique about us is that: (1) We are purpose-built. Through a six-year collaborative design process, service providers came to identify gaps and what new tools they need. (2) We are embedded in our system, with community control and governance at all levels and with accountability for products and services continuing to meet need. (3) We are multi-sector. Our impact goals are in community wealth, climate resilience, and equity. (4) We offer blended capital. Market-rate capital is not going to get us to our goals; new capital tools bring investment-ready and shovel-ready CDFI-adjacent financing plus grant pool.

A transaction mindset is not sufficient. We think about ecosystems, including capital absorption / capacity on the ground and the ability to move projects from idea to investment. A sector like clean energy has different gaps and opportunities. We have the ecosystem—developers, lenders, commercial entities, public schools, etc.—then we have a sector quarterback to see across the system and identify gaps and opportunities. Sometimes the gap isn't financing; it could be predevelopment, technical assistance, soft costs, roof repair, workforce development, and so on.

Keith Bergthold, CEO, Better Blackstone CDC, Fresno Investment Corridor, operates in the heart of California's most robust farming corridor—nevertheless, there is high food insecurity. We are in a red area of a blue state; the language of 'justice' wouldn't unite people. Instead, we focused

on food with Food to Share, a food recovery and distribution program which is uniting people and also reducing costs for the hospital network. To avoid creating an extractive industry like agriculture, we *defer* to the community (rather than lesser verbs such as ‘listen to,’ ‘collaborate with’); we hire organizers to do thousands of 1:1s in eight counties, and we develop individual community benefit agreements with communities that are organized.

Steve Saltzman, CEO, New Hampshire Community Loan Fund, focuses on home ownership with responsible mortgages to people living in manufactured housing communities. We help them form cooperatives so they can buy the parks themselves. With 80% of residents low-income and 25% with a disability, any work in environmental sustainability must focus on the people and lowering their costs. We’ve installed solar at 4 Resident-Owned Communities (ROCs) and have 142 left. There are creative approaches to passing along energy savings; for example, Mascoma Meadows ROC chose a sliding scale of rent reduction from their community solar project. In a closing remark, Saltzman emphasized that community organizing should be as much part of the budget as are solar arrays or anything tangible. If we invest in community organizing over multiple projects, this capacity-building is exponential.

IRA Implementation: Opportunities to Integrate Health and Climate

Moderator: **Eric Hangen**, Center for Impact Finance, UNH Carsey School of Public Policy

Panelists:

- **Ashok Gupta**, Senior Energy Economist, NRDC
- **Nicole Steele**, U.S. Department of Energy and U.S. Environmental Protection Agency
- **Bert Hunter**, EVP, CIO, Connecticut Green Bank

Eric Hangen, Center for Impact Finance, UNH Carsey School of Public Policy, recalled innovative forms of customer acquisition in Vermont, e.g., Rutland Hospital, where providers can prescribe home improvements to their patients, and the HEAT Squad, a service of NeighborWorks of Western Vermont that originally centered energy efficiency and now identifies just as much as a health fund. What are other granular suggestions on how the health sector could partner with community financial institutions and green banks, to drive demand for IRA deployment?

Ashok Gupta, Senior Energy Economist, NRDC, observed from his time in Kansas that red states are also interested in IRA funds. A lot can be done in the intermediary space to help build coalitions. One FIR takeaway is to get in touch with hospitals to be sure they are a full partner. One of the questions on a hospital intake form could be, ‘Are you having trouble with your energy bills?’ Connecting with existing energy programs is a simple but effective role for hospitals.

Nicole Steele, U.S. Department of Energy and U.S. Environmental Protection Agency, cautioned that, while \$27 billion seems like an incredible amount of money, it's still just a little bit of a lot of money. This is the seeding of market transformation. We're investing in, but need the whole ecosystem to invest in, this space. Health, safety, and wellness of people! Save money on utilities, have a resilient community center, build asset ownership. One co-benefit we need to discuss more are careers in the clean energy industry; people need to see themselves belonging in this space, feel supported and mentored in, get the skills they need, and have the opportunity to join a union if they want.

A decade ago, doctors started to prescribe Nature. Beyond asking about energy bills, ask if clients have the information that they need to get solar efficiency, storage, etc. Do you have resiliency if there's a power outlet, e.g., for cooling refrigeration or for medical devices? We need to utilize the trusted messenger of the healthcare system. Everyone in healthcare workforce can play that trusted messenger role.

Bert Hunter, EVP, CIO, Connecticut Green Bank, said the Connecticut Green Bank has roots in the Connecticut Clean Energy Fund, handing out rebates for solar panels and offering loans for innovative technology. Now as a green bank, we focus on getting our money back! Our premise is access to capital at affordable rates and the duration that people and businesses need it for, so the investments will pencil. The IRA is bringing new and enhanced tax credits. Healthcare systems have a big role to play in customer acquisition. They can conduct community health assessments, figure out where the needs are, then step up as partners in transforming neighborhoods to be safer, healthier places to live.

Closing

David Erickson, Senior Vice President and Head of Outreach and Education at the Federal Reserve Bank of New York, observed a need for mental calisthenics about what paradigms we will use. The truth of what we're looking at is much bigger than anything we've talked about in the past 1.5 days. In the Federalist Papers, James Madison tried to convince readers that democracy could work at a large scale. At the small scale it works, at the middle scale it doesn't work, and at the very large scale it works again. The countervailing forces give it a stability.

What produces health? Traditional wisdom says: (1) Good medical care; (2) Good genes; and (3) Good behavior. All of these are wrong! Even where there are good care providers, we now know there are huge disparities with respect to class and race. Epigenetics get overwhelmed by the environment. Lamarck overwhelms Darwin. In a good environment, good genes turn on. In a bad environment, bad genes turn on. Behavior is always a loser; we never could change that (with the exception of smoking, which took moving mountains).

Sir Michael Marmot's Whitehall study classified male British civil servants into four job levels: janitors etc., middle managers, professional class, and senior management. Everyone had a job and medical care. Yet, the risk of death, measured by life expectancy, doubled at each stage! Why? Because a sense of control, or hope, affects us to the molecular level. Likewise, Dr. Elizabeth Blackburn at UCSF researched dozens of mothers of chronically ill children over time; she found that chronic psychological stress dramatically increases the rate of cellular aging, by hastening the shortening of DNA-protein complexes called telomeres. As Tracy Chapman sang, "body's too young to look like his." Premature aging makes people more expensive to the health system. Remember, community development is in the hope business, helping build individuals' and communities' sense of control. That's the bigger picture we have to keep in mind.

In 2010, the Federal Board of Governors convened 50 meetings at Federal Reserve Banks across the country on the topic of 'community development and health.' We drew from these findings in *Investing in What Works for America's Communities: Essays on People, Place, and Purpose* (2012), including the quote: "In the near future, we'll look back and wonder why health and healthcare was ever a different industry than community development." Remarkably, heat maps showing overcrowding in housing, poverty, prevalence of obesity, and violence were essentially the same maps. Community development and health organizations were working side by side and didn't know each other. Now, how might we think about climate in relation to access to capital? Which communities don't have access to a bank branch? Or were flooded most from Hurricane Sandy? Where did Covid-19 land first and spread the fastest? Again, these are all the same neighborhoods. Our new book, *What's Possible: Investing Now for Prosperous Community Neighborhoods*, will be out in six months and focuses on climate resilience and opportunity-rich communities.

Any marketplace has buyers, producers, and connectors. There are a lot of buyers in the health and wellbeing category. We used to think we needed more funding, but now there's just so much money, e.g., environmental funding mechanisms, \$500 billion in social welfare spending (which is more than any country except for France), and insurance companies, who will come around. The buyer category is not complicated. The producer category is not complicated. It's a big tent, but it's not organized well enough for buyers to buy from the producers. Why can I buy stock in a company that reduces blood pressure, but not invest in a community action that does the same thing? There are lots of examples of connectors, but we need to get better organized. We don't lack money, but we do lack imagination on what we need to do to get to a better future.

Swack said that community financial institutions are the capillaries to communities that light up on heat maps, no matter what variable the maps measure (e.g., poverty, prevalence of obesity, etc.). Rather than infighting or a mad scramble, he is hopeful for better collaboration and cooperation towards the influx of IRA funding. Community finance professionals are inherently optimists. The Carsey Center for Impact Finance stands ready to think through, write, research, and design collaborations in a way to do this critical work.

Swack then closed out the formal part of the FIR, thanking panelists and those who made the event possible.

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