



Community Development and Health: Alignment Opportunities for CDFIs and Hospitals

**Summary of Chicago Convening:
October 21 - 22, 2015**

Overview

Expansion in coverage and a shift in payment models from volume to value in the implementation of the Affordable Care Act is driving a fundamental transformation in the health care delivery system. Hospital leaders increasingly recognize the need to engage stakeholders who can help address social and physical conditions that contribute to poor health.

This new reality has led to an increasing awareness of the substantial contributions of Community Development Financial Institutions (CDFIs) in facilitating investment in areas ranging from improved housing to grocery stores, child care centers, and small business development. These CDFIs focus their work in the same disadvantaged communities that generate substantial costs for hospitals, suggesting that hospitals might be able to not only achieve their missions but also improve health outcomes and their bottom lines over time by understanding and working with CDFIs.

In a convening hosted by the American Medical Association in Chicago on October 21-22, 2015, CDFI leaders and health system leaders from across the Midwest region of the United States met to explore how they could work together to implement comprehensive, place-based approaches to community health improvement. Through a series of presentations and discussions participants sought to:

- learn about each other's history and practices, as well as challenges and opportunities in the fulfillment of their missions,
- identify investable opportunities to address the social determinants of health, and
- explore the roles of hospitals as investors in community development and the roles of CDFIs in promoting community health improvement.

Participants formed teams that included hospital systems and CDFIs to discuss approaches in particular communities during the convening.

The meeting began with presentations about the evolution of community benefit practices and policies, as well as the history of the CDFI industry, its overall purpose and mission.

How Hospitals and CDFIs are working towards comprehensive, place based approaches to community health improvement

As noted by presenter Kevin Barnett, communities with high concentrations of poverty also experience higher prevalence and acuity for a wide range of health problems. Physical and social conditions (e.g., poor housing quality, lack of jobs, dysfunctional schools, a lack of access to affordable fresh food, unsafe neighborhoods, and other factors) all contribute substantially to the development and exacerbation of these health problems. As health care providers and payers assume more financial risk to keep people healthy and out of inpatient settings, addressing these drivers of poor health in communities will become an increasing priority. While the IRS requires nonprofit hospitals to conduct community health needs assessments, there is a clear need to expand the scope of partners that will support a more comprehensive approach to health improvement.

Teams at the Chicago convening are working to build partnerships that are both broad and deep enough to effectively address the social determinants of health in disadvantaged neighborhoods. These partnerships go beyond hospitals and CDFIs to include local philanthropic funders, local and state government (including planning, health, community development, and criminal justice agencies), nonprofit human service agencies and community development corporations, and grassroots leaders and organizations. Moreover, hospitals and CDFIs recognize that they do not need to be the lead convening organization (or the “backbone” or “quarterback” organization) of such efforts, although they can certainly play that role in some communities. These efforts go well beyond the basic Community Health Needs Assessment to a proactive, deliberate consideration of how best to strategically leverage a broad spectrum of local assets.

Below we summarize how each of the teams present in the Chicago meeting has begun to develop its partnership-based community health improvement approach:

- **Aurora Health Care** and CDFIs, CDCs, and government partners (including the District Attorney’s office) are looking at how to support economic development, improve access to fresh food, reduce crime, and address other determinants of health in Milwaukee’s Near West Side – where Aurora operates the last of seven hospitals that had been in the community 30 years ago. Several specific projects are in the planning stage, with specific land and business partners. Team participants discussed the need to better understand the economic impact of poor health in the community in order to obtain foundation support. Also included was a discussion about a financial investment from the hospital into partner CDFIs.

- **St Vincent Hospital** (part of the Ascension Health System) is working with the Indianapolis Neighborhood Housing Partnership (a CDFI), the area United Way, LISC (a community development intermediary) and other health providers to address quality of life in the Crooked Creek community of Indianapolis. The challenge these partners are facing is a lack of capacity among community development corporations and other grassroots organizations serving the neighborhood. St. Vincent is considering increasing its involvement to play a role as the “community quarterback” or backbone organization helping to convene and orchestrate community development efforts in the community.
- **St Joseph Mercy Health System** (part of Trinity Health) is supporting a comprehensive strategy in Washentaw County, Michigan. The hospital is considering joining six other partners (including public funders, foundations, and the area United Way) to invest in a Coordinated Funding Effort addressing five thematic areas in the community: education, food access, safety, housing, and seniors. In addition, the team discussion unearthed several specific opportunities including structuring Medicaid reimbursements for a local supportive housing provider (Avalon Housing); expansion of an existing Frequent Users Systems Engagement (FUSE) program to include frequent users of the criminal justice system and homeless shelters; and potential for CDFI investment in improving food access to build upon an existing “Prescription for Health” program for patients with chronic diseases.
- **Presence Health** has engaged in a community visioning process to reinvent its campus on the near northwest side of Chicago. With assistance from a planning and architecture firm, Presence held 15 community stakeholder sessions and is exploring whether and how to transform several blocks of parking into affordable housing, a grocery store, a fitness center, and possibly other retail options. Team members at the convening – including IFF, the Chicago Community Loan Fund, and the Chicago Department of Public Health – discussed how such a project could be funded and implemented and other community partners that should be involved. Presence Health Care has also invested in Mercy Housing, a nonprofit provider of service-enriched housing, to finance the development of affordable housing with resident services, and will operate a health and wellness center in one of Mercy’s developments.
- **Advocate Health Care** began to explore possibilities with CDFI partners to create a transitional home in Lake County, IL for children with traumatic brain injury or very early prematurity. Specifically, the hospital may cover the difference between Medicaid reimbursements and operating costs of the home, which would create a savings compared to in-hospital care. Convening team participants also discussed the development of a detox facility. These specific project opportunities may serve as a starting point for more comprehensive work going forward, as team participants also discussed the need for additional projects to address unemployment and low educational attainment in the

community.

- **Mercy Muskegon** is part of the Trinity Health System, and serves the people of Muskegon County (173k population) and surrounding areas of Western Michigan. They have recently completed a three year Center for Medicare and Medicaid Innovation grant focusing on the engagement of community health workers, and were also selected as one of five communities across the country to participate in the Way to Wellville initiative, which focuses on the development of financial innovations to support sustainable health improvement. Their team is focusing on the neighborhoods of Muskegon Heights, an area of concentrated poverty in the city of Muskegon. Key challenges are housing instability, substance abuse, and violence. Like a number of other smaller cities across the country, Muskegon is dealing with an influx of gang members from larger cities such as Chicago and Cincinnati for the sale of methamphetamines and heroin. They are building a partnership with a local Federally Qualified Health Center, local schools, and law enforcement to establish an adolescent health center that provides mental health, job training and other life skills development for youth in Muskegon Heights. These community and youth development activities will be linked to small business development that is being supported by the Way to Wellville initiative.
- **Genesys Health System**, part of Ascension Health in Genesee County, Michigan, has reached out to a local CDFI to discuss a Veteran's program that would help to identify, assess, educate and refer Vietnam-era veterans to access health and financial benefits through the Veterans Administration. They are also exploring other opportunities to work with CDFIs and community development intermediaries.

Challenges and Barriers

Convening participants identified various barriers to the development of deeper partnerships between hospitals and CDFIs. A different set of challenges was also discussed that has to do more broadly with securing the ingredients that are necessary for comprehensive, place-based community health approaches to succeed. We discuss each set of barriers in turn.

Barriers to the development of Hospital / CDFI Partnerships

These barriers relate to whether and how CDFIs can make the business case to hospitals that they should make large, long-term investments in community development as a way of improving their own financial performance.

- Many nonprofit health providers have met their IRS community benefit requirements simply through the provision of charity care. The IRS has become more open to including broader activities that are not clinical in nature, such as job creation, investment in affordable housing, child care, and access to fresh food as meeting the community benefit requirement. However, some hospitals may still perceive risk in using such approaches for compliance with the community benefit requirements. In the words of one presenter, “we need to have institutions that are courageous enough” to make this shift.
- As mentioned above, many hospital systems have invested financial assets in CDFIs as part of a socially responsible investment strategy. More recently, hospitals are thinking about aligning those investments with community benefit plans. These hospitals will need to work internally to achieve this alignment between the finance department and the community benefit leaders. Hospitals will have to review their own economic models and achieve agreement on overall goals. Initially investments will be made for specific projects in targeted communities, to increase the ability to determine measures of success. For example, Trinity, a leader among hospital systems investing in CDFIs, allocates 1 percent of its investment portfolio for such investments. Trinity has just announced a new program of grants and investments that will bring communities together – including CDFIs – to complete specific projects that will receive investments from Trinity. Trinity will select the targeted communities based on internal knowledge about health indicators and hospital use.
- Some of the barriers that prevent hospitals from directing a larger portion of their investment capital towards investments in CDFIs may be similar to those that other investors face, such as a lack of liquidity, limited understanding of investment performance, and lack of a similar “look and feel” to the more conventional options that hospital investment committees typically consider.
- Evaluation methods and standards of evidence differ substantially across the two fields of health and community development. Randomized trials of specific interventions are common in medicine, while in community development most program evaluation is limited to turnstile measures of program activity, such as the number of housing units created or businesses financed. Neither set of practices is likely to be effective at the intersection between health and community development. A longer term approach to using community development to reduce overall health costs for a hospital system will require a new approach to measurement. Adding amenities to communities, improving access to healthy food and education on nutrition, helping community residents find jobs and housing – these are long term efforts.

- The social determinants of health are long term and comprehensive in nature, such that the benefits of addressing them will be broadly dispersed throughout a community over a long timeframe. Thus, a hospital investing in community development might hesitate to include the project in a community benefit plan because it cannot capture reductions in health care costs within a certain timeframe, and because such reductions will be shared with other hospitals in the community. This dynamic further suggests that some structures for collaborative investment are needed, which in turn requires that hospitals get past competitive instincts.
- Last but not least, the revenue model under which a given hospital operates will directly impact the strength of the business case that community developers can make for investment. Hospitals operating under a fee-for-service model will not have incentives to reduce utilization for services where costs are fully reimbursed. Hospitals that are part of Accountable Care Organizations or that operate under a capitation revenue model will have stronger incentives.

Challenges to developing successful comprehensive, place-based approaches for community health improvement

A second set of barriers exists that will also require long term thinking about how leaders across a given community can succeed in implementing comprehensive, place-based approaches.

- First, in many cases neither hospitals nor CDFIs will be the strongest leaders of a comprehensive community initiative:
 - Hospital community benefit staff may be focused merely on compliance with IRS requirements. They may want to conduct comprehensive assessments but lack experience in actually implementing plans that address physical and social determinants of health.
 - CDFIs, meanwhile, may be impatient and seek to identify specific transactions before developing a full understanding of health drivers seen by the hospital. As one CDFI Executive Director noted, “we are transaction oriented and want to avoid sitting on committees that could create a conflict of interest for the transaction.” Many CDFIs work source their deals across multiple neighborhoods or even multiple cities and states, and focus their efforts on running a financial institution. As a result, only some CDFIs have extensive experience engaging in planning work with specific low-income neighborhoods or communities.
- Second, overall planning of comprehensive initiatives, as opposed to moving on specific projects, will require not only a strong partnership between the

hospital and CDFI, but the active commitment – and in many cases the leadership – of other entities including local and state government, funders, community development corporations, human service providers, environmental groups, neighborhood leaders, local businesses and institutions, grassroots organizations, and advocates for the low-income. To the extent these players are not strong or not well aligned around shared goals, progress will be slow.

- Finally, macro forces are beyond the control of disadvantaged communities and purely neighborhood-level planning efforts cannot address them except through well-organized advocacy. Broader policy advocacy work may therefore also be required around issues that include but are not limited to growing income inequality and the decline of living-wage jobs; increasing income segregation and continued racial segregation; fair housing; urban sprawl; and environmental protection. Both hospitals and CDFIs may be asked to take on challenges they cannot lead at the neighborhood level. The involvement of system leaders from large health systems in broader advocacy and policy work could therefore be an important ingredient in supporting the success of community-based initiatives. For example, Trinity Health has been working with community coalitions on policy efforts to curb tobacco use, including state “Clean Indoor Air” acts and a “Tobacco 21” advocacy campaign to raise the minimum age for tobacco purchases to 21.

Opportunities and Drivers Discussed for Hospital / CDFI Partnerships

Nonetheless, there are many reasons for optimism. In spite of the barriers above, Hospital-CDFI partnerships will bring change, both short and long term.

- Hospitals are increasingly motivated to address social and physical determinants of health as they move along the continuum from fee-for-service towards capitation.
- Hospitals have the capacity to bring significant financial resources to comprehensive community initiatives, and could sustain this level of investment for a long time, if they begin to see such investment as a core part of their business model. Large health systems can bring the ability to invest across multiple locales, as evidenced by Trinity Health’s recent announcement of \$80 million in funding to improve health across six communities. Moreover, they could be joined by other health industry players, such as insurance companies, if these other players have the right incentive structure.
- Many core financing activities of CDFIs directly address physical and social determinants of health, and in some cases there is strong evidence from

evaluations that these activities have achieved measurable change in the overall health of community residents. For example, the MacArthur Foundation has synthesized research about the benefits of stable housing on a low income family. (See <https://www.macfound.org/programs/how-housing-matters/>).

- Sectors in which CDFIs routinely provide financing that changes the course and stability of lives include:
 - Affordable housing
 - Supportive housing
 - Healthy food access
 - Small business development
 - Education and child care
 - Community health centers

- CDFIs offer hospitals a way of deploying their resources that does not require the hospital to develop new skills as a lender or investor. CDFIs can leverage hospital resources with other capital, and can provide a degree of risk protection for hospitals by absorbing any defaults or losses. They also bring skills at assembling all necessary financing and underwriting transactions to keep all costs down, improving the potential for success of each project.

Next Steps

The projects discussed at the Chicago convening will be tracked, and the results of the convening will be documented. As mentioned above, several projects discussed at the convening were already underway.

The convening team looks forward to connecting with participants to:

- Offer assistance as they develop strategies to work together,
- Learn from project teams about the successes and challenge they are experiencing, and identify their keys to success.
- Disseminate lessons learned among all of the teams, including knowledge garnered from future convenings to be held in other regions of the US.
- Specifically track changes in the approach to the community benefit requirement by hospital systems and the IRS.
- Document models of measurement that are developed by CDFIs and hospital systems working together.

For further information contact:

Michael Swack, Carsey School of Public Policy

Michael.swack@unh.edu

603 862-3201