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PUBLIC HEALTH INSTITUTE

Community Development and Health: Alignment Opportunities for CDFIs and Hospitals

Summary of Boston Convening: December 14-15, 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 Boston Federal Reserve Bank on December 14-15, 2015, CDFI leaders and health system leaders from across the Northeast 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,
- build common knowledge and understanding of opportunities to address the social determinants of health,
- develop strategies to align hospital and health sector services and programs with community development investments, 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 hospitals, other local health sector leaders, and CDFIs to discuss approaches in particular communities during the convening.

The 1.5 day meeting opened with presentations about the evolution of community benefit practices and policies, changing dynamics for hospitals associated with national health reform, the history of community development, and the emergence of CDFIs, their purpose, mission, and practices.

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 Boston 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 traditional community health assessments and poorly aligned services and programs 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 Boston meeting has begun to develop its partnership-based community health improvement approach:

- **UMass Memorial Health Care / Worcester, MA**

  Team members from Worcester, MA focused conversations around two issues: pediatric asthma and opiate addiction.

  UMass Memorial is halfway through a funded project working with a task force that includes the City Health Department and other partners to do pediatric

asthma prevention work. The task force is looking at how to sustain this work. Measurable outcomes being sought include reducing ER visits and hospitalization, reducing absenteeism among children from school, and reducing asthma rates that are currently twice the state rate. Investable opportunities identified through this discussion included remediating childcare facilities and charter schools. A potential role was seen for CDFIs to finance remediation and housing improvement work tied to home visits and coordinated services; discussions envisioned CDFIs securing real estate-based loans and including a consideration of asthma triggers in underwriting guidelines. In addition, the group is looking to learn more about Health Impact Bonds and whether they could function as a good funding vehicle.

A community health needs assessment identified opiates as a critical issue. While prevention-oriented work to address issues "upstream" from this problem is seen as important, participants also want to do something to address the immediate needs of opiate-addicted women and their families. The group explored the possibilities for developing family sober housing for women and their children. The group reviewed issues around site identification, capital and operating financing, and complementary programming (such as wraparound services and job training) for such a program. The group explored who bears the costs of the current system, in which children are separated from their families when a mother goes into a detox unit. They discussed other groups who should be brought to the table to discuss the issue, data needs to understand the impacts of the issue, and investment feasibility.

- **UVM Medical Center / Burlington, VT**

The Burlington Team has been working to address chronic homelessness in the community and has regular meetings around the continuum of care. In addition to UVM Medical Center, team members participating in the Boston event included the Champlain Housing Trust, the Champlain Valley Office of Economic Opportunity, the United Way of Chittenden County, and the North Country Federal Credit Union. Last year, the group implemented a homeless registry, using a tool called the VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool) to identify the most vulnerable populations. The team helped 45 of the 90 vulnerable individuals they identified to find Permanent Supportive Housing (PSH) within 9 months. Champlain Housing Trust, one of the partners in the group, has just purchased a motel and rehabilitated it to provide 19 additional units of PSH, coming online in January 2016; the United Way and UVM Medical Center have funded the Federally Qualified Health Center to provide wraparound services to those 19 people. The team hopes to produce another 100 units of PSH in the next two years, and is looking at how that development might be financed through capturing cost avoidance for the hospital, corrections, law enforcement, education, etc. The team hopes to engage in advocacy work around inclusionary zoning, so that when a development project is proposed it must set some housing units aside for affordable housing.

As a part of this initiative, the group is looking at the question of data and impact measurement. For example, they are looking to collect law enforcement data to evaluate whether the initiative is achieving a decrease in police interventions. They are getting waivers from clients to be able to share information across systems. Hopefully, data will support an evaluation of results that allows social cost savings to be monetized so that efforts can be scaled up.

- **Rutland Regional Medical Center / Rutland, VT**

Rutland Regional Medical Center's team included NeighborWorks of Western Vermont (a local CDC/CDFI), the Rutland Police Department, and a collective impact organization called Project Vision that is working on opiate addiction and neighborhood revitalization issues for low-income areas of Rutland. The team is invested in looking past provision of health care services to the creation of a healthier Rutland, and is seeking to engage community residents to be agents of change in controlling their own health outcomes. Investable opportunities the team identified to address social determinants of health included:

  - Rehabilitating an existing building to serve as a Head Start / early learning center
  - Supporting housing rehabilitation and weatherization activity to reduce asthma triggers
  - Looking at other opportunities to address housing stability for low-income residents in order to reduce hospital readmissions and ER utilization
  - Creating re-entry opportunities to reduce recidivism for residents involved in opiates.

Similar to the UVM team, this group also discussed needs to develop a data hub that would help to identify the best investment opportunities, enable evaluation, and support community-led planning efforts.

- **St. Francis Care / Hartford, CT**

St Francis hospital and Community Solutions, a community-based nonprofit in Hartford, are working to "integrate community health care and community development under one umbrella." Team members also included the Asylum Hill Neighborhood Association and the Hartford Community Loan Fund. They have formed a pilot initiative to understand factors driving health for the heaviest emergency department utilizers. Community Solutions employed a case manager to follow 12 of the 16 highest ER users for close to a year, in the North End of Hartford. Through this pilot initiative Community Solutions and St. Francis have determined the need to engage in a "systems change" approach to change how health care is used. This approach includes looking at housing, transportation, improving utilization of a Federally Qualified Health Center

(instead of the ER), community engagement, and food issues. Some specific next steps they are looking at include:

- revitalizing a 60,000-square-foot abandoned factory as a community hub that could include community health services;
- promoting urban farming including community gardens, a community-supported-agriculture (CSA) farm; and
- engaging residents in the North End of Hartford in the wake of the area's recent designation as a Promise Zone.

- **Baystate Health / Springfield, MA**

Baystate Health came to the meeting thinking about wealth creation strategies as a way of addressing social determinants of health, given that its service area includes the poorest county in Massachusetts, Hamden County. Team members included DevelopSpringfield, the Economic Development Council, HAP Housing (a CDC), and Wellspring, a collaborative developing green, worker-owned businesses. The group decided to focus on two health issues, asthma and diabetes. The team identified a range of potential investable opportunities to intervene upstream in these health issues. Those opportunities included affordable housing, workforce development (especially for community health workers), developing additional exercise facilities, and business and entrepreneurship development, including supporting worker co-ops. Discussion was also held around how to move an idea for developing a supermarket serving a low-income community "off of paper and into action." The group reported that it needs to develop a logic model to help narrow down these choices to the highest-impact strategies.

- **Northeastern Vermont Regional Hospital / Northeast Kingdom, VT**

Northeastern Vermont Regional Hospital's team included the Caledonia Accountable Health Community, Northeast Kingdom Human Services, the Northern Counties FQHC, and the Vermont Foodbank. The team discussed how "we need to be investing our money – not just our time and effort – in projects in the community." They are hoping to build on a recent success in starting a warming shelter in St. Johnsbury, VT. They are having conversations with experts about how to make direct investments in projects like affordable housing, and the risks and returns of those kinds of investments. Two questions the group explored, for example, was whether they could come up with a pool of funds to subsidize some housing vouchers, or provide predevelopment capital for affordable housing projects. Another conversation topic was how the hospital might use local purchasing to help the local economy.

Finally, the group discussed "who needs to be at the table" – the conversation identified the potential for a different type of partnership discussion with local

CDFIs, for example.

- **Codman Square / Boston, MA**

The Codman Square team is one of five sites nationally that are part of the Alignment for Health Equity and Development (AHEAD) initiative funded by the Kresge Foundation, and included the Dana Farber Cancer Institute, Codman Square Health Center, Boston Medical Center, Codman Square Neighborhood Development Corporation, Boston LISC, Health Resources in Action, the Boston Alliance for Community Health, and the Massachusetts Department of Health. The team has been focusing on the food system in its neighborhood of about 40,000 people. There are a variety of innovative efforts already in play, with a core challenge being how to align and leverage, and scale existing programs. Options under consideration include:

  - Oasis, a plan for a production garden including a teaching kitchen and employment opportunities targeted to men of color reentering the community from prison
  - Rehabilitating the Franklin Park Greenhouses
  - A food co-op currently developing in the neighborhood, the Dorchester Food Co-op
  - Supporting the continuation of an organization called the Daily Table that cooks and sells low-priced surplus food
  - Supporting group purchasing for small corner stores to get better pricing and install refrigeration for fresh foods
  - A senior housing project that is currently in predevelopment and could include a health care clinic along with supportive housing programming and staff
  - Health education programming from Codman Square Health Center including diabetes management, nutrition, weight control, and screening and referral for food insecurity

The team also discussed potential impact measures including measures of neighborhood social cohesion, stress reduction and stable employment for families, shifts in family expenditures (e.g. not having to choose between healthy food and meeting other basic needs), and reduced health care expenditures. The team identified some local players that need to be involved at the table, including two health systems and local businesses including a food market and several restaurants. Payers, including the two primary Medicaid managed care organizations in Boston, were also seen as a key stakeholder group to bring to the table.

- **Valley Regional Hospital / Claremont, NH**

Team members included Valley Regional Hospital, ReThink Health: Upper Connecticut River Valley, the City of Claremont NH, the NH Citizens Health Initiative, and The Dartmouth Institute for Health Policy and Clinical Practice. This team faces the challenging dynamic that nonprofit community hospitals have been losing money in their region. The investable opportunities the group discussed therefore arose not only from addressing social determinants but helping to financially sustain the hospital. The first opportunity discussed was for energy efficiency upgrades that would generate substantial cost savings for the hospital. The upgrades would require nontraditional financing with a payment plan based on the savings achieved. The second opportunity discussed was for the hospital to offer opiate treatment – a service where a private sector provider in the area is currently realizing a profit. The group's idea was that the hospital could earn revenues and provide a more comprehensive intervention that could include workforce development and early childhood learning for families, for example, alongside opiate treatment.

Other ideas discussed by the Claremont team included creating affordable housing downtown, transitional housing, IDA programs, and connecting businesses to a skilled workforce.

Issues to be Addressed

This section on issues to be addressed in order to effectively align the health and community development sectors draws from emerging ideas in the wake of our Boston convening on December 14/15 and convening in Chicago on October 21/22. Participants at both events identified a variety of issues for discussion that merit further examination.

- **Compliance mentality and comprehensive approaches** - Most nonprofit health providers have met their IRS community benefit requirements predominantly through provision of charity care services in emergency room settings and public pay shortfalls. The IRS has become more open to including more proactive services and activities to address social determinants such as youth development, healthy food access, job creation, housing improvements, and child care to meet their community benefit requirement. Some hospitals, however, may view such approaches as at risk for being viewed as out of 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.

- **Making the business case for hospital investment –** There is a near term question 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. While there is recognition that we are moving towards a system of health care

financing that incentivizes keeping people healthy, in the near term hospitals are faced with declining revenues and other more immediate demands for resources (e.g., data systems, physicians practices). It should also be noted that some of the impediments to hospital investment capital 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. That having been said, there are a growing number of health systems that have invested financial assets in CDFIs as part of a socially responsible investment strategy.[1] Some hospitals are beginning to look at ways to align those investments with community benefit programming, as well as with core business strategies such as population health management. In this way, they are better positioned to build the capacity to more proactively reduce preventable utilization and improve health status in communities where health disparities are concentrated.

- **Outputs, outcomes, and attribution –** Collection and analysis of data to establish how community development investments are contributing to savings in health care costs is essential. Establishing data collection and sharing protocols, determining who should manage a data hub, and how to pay for data collection are all important issues. Moreover, even once data is in place, 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. Further complicating matters is the question of "attribution," or assigning impact to particular components of a comprehensive effort.

- [1] It is important to note that health systems do not report these investments as community benefits, since they are loans, rather than grants, nor do they report the difference between interest rates charged (typically between 1 and 2 %) for these social investments and market level interest rates. Trinity Health System and Dignity Health are two systems that have allocated substantial resources for community investment ($80 million by Trinity, $100 million by Dignity) Trinity Health has just announced a new program of grants and investments that will bring communities together – including CDFIs – to complete specific projects that will receive grants, loans, and technical assistance that operationalize the alignment of services and programs with investments in physical infrastructure.

- **Collaboration and competition** – Addressing the social determinants of health is a challenging endeavor that requires a comprehensive mindset and sustained effort. The complex interactions between human behavior, culture, and social and physical environments are not easily impacted by unidimensional interventions. In this context, hospital leaders seeking near term reductions in health care costs may lack the patience, commitment, and vision to work on an ongoing basis with others, including competitors, in order to make a difference Structures are needed that support collaborative investment, help hospitals get past competitive instincts, and help hospitals to see themselves as one set of players in a larger partnership that shares ownership for community health.

- **Infrastructure and integration** – Recent literature on "collective impact" suggests that successful partnerships to address complex social problems require a "backbone" or "integrator" organization. A series of critical questions thus emerges around which organization or organizations in the community should play this role, how they will be governed, how funding flows will be directed through or by this organization, how health care and other cost savings will be recaptured to support the initiative, how results will be measured, how the organization will maintain responsiveness to community input, and how accountability will be enforced – in short, "how to do this collective impact thing," as one of the Boston participants put it.[2]

  Both hospitals and CDFIs should be circumspect about "volunteering" to serve as the leaders of a comprehensive community health-development initiative. Hospitals are often viewed as the "800 pound gorilla" in a community that tends to do things with limited community input and engagement. In an environment where the goal is to build shared ownership for health across a broad spectrum of stakeholders, and given the limited expertise in comprehensive community health improvement in most hospitals, it may be advantageous for hospitals to seek out and foster leadership development among other stakeholders. This does not suggest that hospitals should withhold resources and limit the engagement of its leadership, but rather that they find ways to encourage others and optimally leverage their own limited resources. CDFIs, on the other hand, must grapple with impatience about deliberations to build shared understanding of the drivers of poor health and limit their focus to specific transactions. 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, many CDFIs lack experience in

[2] A helpful article was recently published by the Prevention Institute on the question of how to structure the integrator or backbone entity for Accountable Communities for Health. See: http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html

engaging in planning work with specific low-income neighborhoods or communities.

- **Broader alignment** – The successful planning and implementation of comprehensive initiatives 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, not at the table, or not well aligned around shared goals, progress will be slow. At the Boston convening, several groups developed substantial lists of local players who were critical to the success of their efforts but not currently a part of their discussions. Health care payers (insurers) were commonly cited, but far from the only stakeholder group needed at the table.
- **Where's the money?** – Monetizing outcomes in order to fund work addressing social determinants of health will be increasingly critical in an era where essential government funding for basic social services has been cut back. In many cases not only hospitals, but a wide range of other players stand to realize substantial cost savings from initiatives that successfully address poverty and its impacts – these institutions include health care payers, law enforcement, corrections, and education, to name a few. They are thus potential funders of implementation efforts, alongside hospitals, if the benefits can be monetized and the right financing vehicles can be created for these stakeholders to participate. The structuring of social impact bonds (pay for success programs) may have particular relevance for these efforts.

- **A quality improvement approach** – As one of the Boston team members remarked, strong logic models need to be developed to direct investments to the most effective ways of addressing social determinants of health. Better data is needed to understand at a more granular level the forces that adversely impact the health and health care consumption of low-income people. Strategies must be selected based on evidence of efficacy and not simply by copying "best practices."[3] Teams must also be supported to develop appropriate portfolios of interventions, balancing between improving clinical care, addressing health behaviors, and intervening in the physical environment and social determinants at work in low-income communities. Outcomes need to be tracked, and stakeholders need to be willing to change strategies to improve outcomes, including dropping

[3] One resource for evidence-based strategies is the CDC Community Health Navigator database of interventions, online at: http://www.cdc.gov/chinav/ Another resource is "What Works for Health," online at: http://www.countyhealthrankings.org/roadmaps/what-works-for-health

ineffective programs from funding.

- **Policy and the big picture** – 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.

Additional reading resources

In addition to several resources already cited in this summary, we recommend that participants examine:

- "Making the Case for Linking Community Development and Health," available at: http://www.buildhealthyplaces.org/resources/making-the-case-for-linking-community-development-and-health/

- "Can Hospitals Heal America's Communities?" available at: http://democracycollaborative.org/publications

- "Hospital-based Strategies for Creating a Culture of Health," available at: http://www.rwjf.org/en/library/research/2014/10/hospital-based-strategies-for-creating-a-culture-of-health.html

Next Steps

The projects discussed at the Boston 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 measurements that are developed by CDFIs and hospital systems working together.

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