University of New Hampshire
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PUBLIC HEALTH INSTITUTE

Community Development and Health: Alignment Opportunities for CDFIs and Hospitals

Summary of Charleston Convening:
May 25-26, 2015

DRAFT

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 Appalachian Regional Commission on May 25-26, 2016, CDFI leaders and health system leaders from across the Appalachian 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 – a theme that was echoed by most of the hospital teams in attendance. 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 Charleston convening are working to build partnerships that are both broad and deep enough to effectively address the social determinants of health in disadvantaged neighborhoods. Although many of these teams are still in the early stages, these partnerships ultimately will go beyond hospitals and CDFIs to include local philanthropic funders, local and state government (including planning, health, community development, and criminal justice agencies), local businesses, 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 Charleston meeting has begun to develop its partnership-based community health improvement approach:

- **Charleston Area Medical Center (CAMC) / Charleston, WV**

  CAMC is a teaching hospital serving southern and central West Virginia. CAMC defined two core issues that it seeks to address. One is obesity and its links to diabetes, or "diabesity" as the team termed it. Beyond metabolic risk, the team

identified nutrition density, physical activity, and environmental factors as drivers of this problem. Around this issue, team conversation identified the need to retrain health care professionals to spend time with patients, engage in prevention, and identify how social determinants may be impacting patient health. Other potential strategies discussed included various options to improve access to healthy food, access to green space, improving walkability and bikeability, and AHC navigation assistance.

The other key issue identified by the CAMC team is substance abuse disorders including prescription drugs, illicit drugs, and alcohol. Strategic responses discussed included workforce development, "justice reinvestment act" changes to sentencing and corrections, and family and peer recovery support.

The team also identified a wide variety of players who need to be at the table in order to effectively address the team's top two health issues, including payors, government leaders, workforce development organizations, faith based organizations, and many others.

- **Manchester Memorial Hospital / Clay County, KY**

The Manchester Memorial team identified diabetes, obesity, tobacco, behavioral health, and mental health as key issues. Social determinants that contribute to these health problems include persistent poverty in many communities in the county, as well as the "sense of hopelessness and fatalism that comes with that." The team identified food insecurity / healthy food access, as well as housing and housing-related health issues (such as asthma and indoor air quality), and substance abuse and mental health programs as opportunity areas for program development. Ideas for food access strategies included engagement with farmers markets, farm-to-school programs, mobile food markets, and the "Farmacy" program (which provides "prescriptions" for healthy food). Health homes strategies discussed included indoor air quality improvement, accessibility improvements, and supports for aging in place. Substance abuse and mental health ideas included engaging with / supporting the Chad's Hope program, faith community efforts, and support groups, as well as establishing a mental health clinic. Partnerships with two area CDFIs were discussed as well as a number of other nonprofit organizations, funders, government agencies, and other stakeholders. The team committed to organizing additional meetings upon returning home, and seeks to form a group with the right skill sets from a long list of potential partners to assemble data, design interventions, and monitor progress.

- **Mercy Pittsburgh / Pittsburgh, PA**

The Pittsburgh team focused on the challenge of opiate-dependent patients with related health problems such as epidural abscesses and organ infections. These

patients have been kept in the hospital with intravenous antibiotics but no other services, and that many of the patients are homeless or have unsafe housing. The team discussed the development of a medical respite facility where such patients could recover after hospitalization; a pilot program had some initial successes. Unfortunately, the team is concerned that a highly competitive environment among the major hospitals in the city may prevent collaborative investment in developing a facility.

- **Salem Regional Medical Center / Salem, OH**

The Salem team looked at the issue of "frequent flyers" (health care super-utilizers) and emergency department readmission, with the goal of better managing patient issues with high costs and high risks. Sharing data on this patient population is a barrier the team currently faces – new information technology infrastructure of some sort will be needed, as health providers in the area do not have integrated e-health records. In Columbiana County, the team noted that "our strength is our collaboration" between partners including 2 hospitals, a CAP agency, and a FQHC. That said, they are looking to bring other players to the table including payers and primary care physicians. The team discussed partnerships with CDFIs but is still in the process of identifying specific investable opportunities.

- **St. Mary's / Athens, GA**

The St. Mary's team highlighted a number of pressing health issues in Clark County including chronic disease, obesity, tobacco use and lack of access to care (there is a 25 percent uninsured rate in the county). The team looked at whole person care as a response to these challenges. Specific ideas explored included purchasing a building for wellness services including nutrition, health education, smoking cessation, exercise programs, and a produce stand with double SNAP benefits. The team discussed how University pharmacy and nursing students who are interested in community service projects could serve as a resource. The team intends to engage in planning sessions, including meetings with personnel from the hospital and clinics in addition to other stakeholders, to map a path forward.

- **St. Thomas Health / Grundy County, TN**

The St. Thomas Health team noted significant poverty-related health challenges including substance abuse, food insecurity, mental health, dental health, diabetes and chronic disease. The team focused discussion on strategies to respond on the issue of access to care – specifically, a lack of centralized resources in the county. An investable opportunity exists to convert a former high school in Tracy City to a multi-service center. St. Thomas has received $1 million of grants to put into the building, but needs additional financing to retrofit it. The team

needs help assembling a business plan as well as a financing plan for the facility. The team will seek to work with a variety of players including the City government (which currently owns the former high school), area universities, the South Cumberland Community Fund, and tourism industry stakeholders, among others.

- **Whitesburg ARH / Whitesburg, KY**

The Whitesburg Appalachian Regional Hospital team identified diabetes, heart disease, and chronic respiratory problems as major health issues. The team believes that these health issues are related to both substandard homes (1 in every 3 homes in the area is substandard) and a lack of active lifestyles. In turn, these problems are driven by issues around unemployment, poverty, and education. Opportunities the group discussed to respond to this challenge included expanding on remote patient monitoring, developing a community kitchen, school programs, and expanding the "Farmacy" program to prescribe local food. The group discussed the need to improve connections to the area health department, schools, and state and local government. The team began discussions with FAHE, a regional CDFI, around programming to address housing needs. The hospital intends to serve as a central hub to gather players to the table, seeking to work with other healthcare providers. Data collection needs were discussed including the need to develop a HIPPA secure platform with uniform data collection parameters.

- **WVU Health System / Morganton, WV**

The WVU team described itself as an "aspirational" team in that it had not met before the conference began. The team initial worked simply to choose a community on which to focus, settling on Morgantown, and identified needs to conduct asset mapping, bring competitors to the table, and capitalize on the assets and expertise of the university. The team ultimately decided to look at high-user populations, working with FQHC and community partners to track and share information about social determinants that are gleaned from patient encounters. The team plans to convene groups to discuss the role of the hospital and the university as anchor organizations and investors, beginning in June.

- **Wake Forest Baptist / Winston-Salem, NC**

The Wake Forest team zeroed in on diabetes as a top health issue, but discussion quickly developed into a review of how the hospital has engaged the local community and how to "bring people back together to solve this problem together." For example, while the community health assessment process has been collaborative with the other major hospital in the area, implementation has been siloed, without a collaborative funding strategy. Other opportunities to build relationships and "invite people in" were discussed, including the

possibility for the hospital to source more of its business from the local community and from minority-owned businesses. The team built on this community engagement discussion to develop a framework for tackling the diabetes challenge. In this framework, solving the problem is at the hub, with a variety of stakeholders (influencers, connectors, promoters, institutions) around that hub. A key role for the hospital is to better identify and understand the different perspectives and interests in solving this problem that different stakeholders bring. Afternoon discussion focused on measurement issues, particularly on linking data with Wake Forest Baptist's competitor hospital system and creating a longitudinal view of patients across the two health systems.

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 three events: the Charleston convening on May 25-26, 2016; the Boston convening on December 14-15, 2015; and the Chicago convening October 21-22, 2016. Participants at these 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.

- **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

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- [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.

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 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,

[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

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 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

[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

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 all three convenings 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.

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