



Summary of the 14th Annual Financial Innovations Roundtable
HEALTH-RELATED COMMUNITY INVESTING
March 24–25, 2014
Federal Reserve Bank in Washington, D.C.

Over the past fourteen years, the Financial Innovations Roundtable (FIR), located at the Carsey Institute at the University of New Hampshire, has worked with a range of community development and other types of financial institutions, government agencies, foundations, and trade associations to address and solve problems related to access to capital. The FIR does this by tapping the expertise of thought leaders from the institutional investment, banking, philanthropic, and community development industries. In 2014, after a long and productive relationship with the Federal Reserve Bank of Boston, the FIR moved to Washington, D.C., in a new partnership with the Federal Reserve Board of Governors. The FIR also created a formal Advisory Board after years of informal advice from industry leaders. (See Appendix.)

The 2014 Financial Innovations Roundtable focused on new practices and new opportunities for health-related community investment. What are the most promising ideas? What type of capital and products are needed? How can we promote policies and practices to grow the field? The event was not for health-first Community Development Financial Institutions (CDFIs) working primarily with health-first funders to deliver health-first outcomes. Rather, it tapped those CDFIs, funders, and health partners that are looking holistically at communities and realize that health is both an input and an outcome of other aspects of community development, including housing, transportation, jobs, and education.

As background, many funders have recently begun to focus on health care delivery to marginalized communities as a developmental goal. Community investments in this sector include investment in health care clinics, healthier housing, and other service provisions to underserved communities under its broader umbrella. Despite this recent activity, health and health outcomes have generally not been organizing principles for community investment. Two recent trends that suggest the sector is ripe for development are: (1) New federal programs and legislation have expanded the demand and increased the public funding available for health care in underserved communities, particularly through federally qualified community health clinics; and (2) Community investors have begun to argue that achieving positive health outcomes is an appropriate goal, as it captures a holistic measure of positive social benefits from targeted investing.

As a result, health-related community investment is emerging and has the potential to bring in new sources of capital. For example, investors have designed new products for health-related community investing including:

- Debt or equity products that help support federally qualified health care clinics in low-income areas
- Loan funds that target health care service providers, offering loans for real estate development and business expansion, to take advantage of the emerging market in the wake of the Affordable Care Act (ACA)
- Venture capital investments in medical supplies and equipment that serve hard-to-reach communities, for example, investments in remote diagnostic technology that reach rural communities
- Investment by insurance companies or hospitals in healthier foods, housing, or recreational facilities that will ultimately produce a healthier local population

Each of these strategies builds on traditional community investment practice while offering the potential to either expand the community investment portfolios of existing investors or bring in new investors who have a particular interest in the health sector but have not been active community investors. To date, the health sector has appealed particularly to large private foundations, but it also has the potential, depending on the product, to attract capital from a range of financial institutions, impact investors, CDFIs, and others.

This report summarizes key points that arose from the FIR presentations and discussions. It also foreshadows strategic next steps over the year ahead. At this point, participants are most interested in: (1) Developing investment principles and metrics to guide the most “impactful” type of health-related community; and, (2) Convening smaller follow-on meetings with focused outcome goals to bring CDFIs, banks, and health care providers closer together and to support their collective impact toward a holistic vision for community health.

All PowerPoint presentations are available online at www.carseyinstitute.unh.edu/csif/financial-innovations-roundtable/annual-meeting.

SETTING THE STAGE

At the March 24 evening session, **Joseph Firschein** of the **Federal Reserve Board of Governors** and **Michael Swack** of the **Carsey Institute** welcomed participants to the 14th annual Financial Innovations Roundtable. Firschein said the Federal Reserve Board of Governors was pleased to partner with the Carsey Institute to host the FIR because of its model for engaging senior leaders to drill down on specific topics in a way that leads to action. Swack acknowledged the financiers, funders, and health partners who are looking holistically at the topic of health-related community investment. He cited **David Erickson’s** and the San Francisco Federal Reserve Bank’s pivotal work in health over the past five years and challenged FIR participants to go further with innovation in health-related community development, to meet the growing needs.

Introductory speaker, **Kevin Barnett**, said that the **Public Health Institute** operates at the nexus of health care and community development. Barnett started as a community organizer thirty years ago and quickly discovered a disconnect between people who professed to be about health and those who professed to be about development. He observed that hospitals would come to the table for the first few community meetings, then leave, and he wondered how to engage hospitals more effectively and over a longer period of time.

Barnett observed we are in a unique moment in our history. After decades of what psychologists would call “parallel play,” we have the immense opportunity to work together.

Similar to the Community Reinvestment Act (CRA) for traditional banks, hospitals’ Community Benefit statutes require that they make investments to promote health for “class of beneficiaries sufficiently large enough to constitute benefit for the community as a whole.” This IRS definition broadened the definition of charity for hospitals beyond charity care and gave them flexibility to pursue a broader set of activities. Currently, however, Community Benefit is viewed as compliance issue, rather than an engine for transformation. Hospitals’ challenge and opportunity becomes to invest where health needs are concentrated and do in way that leads to measurable improvement.

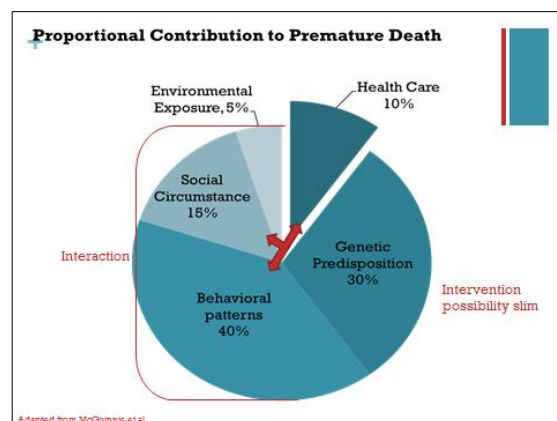
With the ACA, as well as the *Times Magazine* exposé, “Bitter Pill,” hospitals are obligated to target their investments in their communities more than ever before. The most significant issue is a radical increase in transparency. For example, Community Health Needs Assessment (CHNA)’s [Vulnerable Populations Footprint](#) tool locates areas of concern for vulnerable populations and health disparities in a community based on spatial visualization of two indicators—poverty rate and educational attainment. Because one can also see hospital and health center locations, one can identify individual hospitals that have systemically defined their community to exclude poverty areas. Overall, less than 25 percent of hospitals focus on poverty areas. Two other issues are that hospitals focus more on service coordination than other strategies (for example, prevention), and there is a lack of alignment with other players.

With 15 percent of hospitals likely to close in ten years, the industry is in crisis mode. Barnett offered four key recommendations:

1. **Harmonize disparate, but similar Community Health Investment (CHI) practices among community stakeholders.** Many different groups are conducting needs assessment, which squanders resources. Local Health Departments, Community Action Agencies, United Ways, Community Health Centers, and other institutions should share post-assessment findings. In addition, stakeholders should develop proactive strategies to align schedules for assessment and planning processes. The question is how to invest in support infrastructure—what David Erickson calls a “quarterback” and others call “backbone.”

2. **Increase focus of CHI resource allocations in communities where health disparities are concentrated.**
3. **Move from compliance to transformation.** Hospitals should use tools to implement a Quality Improvement approach, consistent with a commitment to shared ownership and community transformation.
4. **Move beyond parallel play to clarify roles of stakeholders in setting priorities, planning, implementation, evaluation, and oversight of CHI practices.** Hospitals can't do it alone. Hospitals are in the bull's eye; they're being questioned, they have financial constraints in the immediate term, but they also have a lot of tools to bring to bear.

Our communities are stressed out, and we are seeing the health impacts (allostatic load) of chronic stress. Asthma, cardiovascular disease, and diabetes are three of the most costly diseases. An individual admitted for asthma will show a broad array of factors, and most of these health inequalities—unhealthy housing, exposure to environmental hazards, limited access to healthy food sources and basic services, unsafe neighborhoods, and so on—have nothing to do with the delivery of health.



Preventable admissions are more than twice as likely to occur in high-need areas. Kaiser is trying to partner to limit diabetes and, between 2006 and 2008, saved \$50 million through preventions.

In concluding, Barnett pointed to opportunities for alignment. First, to focus resources and model convergence, we should “stop casting bread on the water.” Hospitals are accustomed to funding specific small-scale programs, all between \$2,000 and \$20,000. This is not a good investment strategy. To have impact, we need to reduce the number and increase the scale and comprehensivity. Second, health institutions should utilize their advocacy potential. Typically, hospitals are the largest employers in a region. They should be saying to local, regional, and federal policy makers, “We need healthy food, decent housing, and broader employment in our neighborhoods...or we’re *all* going to be bankrupt.” Barnett’s slides (23 to 25) feature a useful and detailed matrix of how various community stakeholders can define community, list accountability mechanisms, and identify opportunities for alignment.

For CDFIs in particular, Barnett recommends working more closely with local hospitals to identify convergence investment opportunities. They should engage United Way, Community Action Committees, Community Health Centers, Local Public Health Agencies, and local foundations on opportunities for convergence, as well as engage hospital/health system leaders on opportunities to leverage influence with financial institutions for targeted investments. This will help multiple players scale up and diversify investment strategies, for example, food, retail,

housing, support services, education, and job development. Health institutions are looking to invest and have large portfolios. CDFIs, hospitals, and other stakeholders should jointly develop a small number of shared metrics and work to put the pieces together.

ROUNDTABLE DISCUSSION

Respondent **Elyse Cherry** from **Boston Community Capital** observed that hospitals have taken a long time to move to the concept of holistic community investing, while CDFIs have moved dramatically in this direction. Boston Community Capital focuses on “transformation zones,” for example, on grocery, health clinic, other commercial space, and housing within the city of Brockton, Massachusetts. From her personal experience, the notion that the health and community development worlds need to work together is both really important and really hard. One challenge she has faced is reaching people in health institutions who not only understand but have the decision-making ability to get things done. There’s a “gnat-elephant problem,” with enormous health institutions and small CDFIs.

Cherry noted that, because the financial benefits of improved health accrue to health insurers and government, we need to bring *insurers* to the table—including government, since so much is paid for through Medicare/Medicaid. Some of their savings need to be invested back in. Insurance companies could help certain demographics with important services such as shag carpet removal, lead clean-up, lead care, and nutrition. But do insurers even want to cover low-income, high-needs people?

Respondent **James Bosscher**, treasurer of **CHE Trinity Health**, observed that hospitals and CDFIs have similar missions and objectives but different strategies. CHE Trinity Health has \$832 million in Community Benefit funds each year. A lot of it goes to things like Medicaid that they’re not reimbursed for, but CHE Trinity Health has also become more active in socially responsible investing through two avenues. First, it influences corporations to act in a socially responsible manner. Second, it directs \$35 million in community investing—for example, investing in loans to universities to provide scholarships and low-interest loans to CDFIs, 80 percent of which are in the hospital’s geographic footprint. It can be hard to connect the dots, but Treasurers are often in a great position to facilitate partnerships because they work with their own hospitals, CDFIs, and banks.

Other attendees were eager to join the conversation.

- **Robin Hacke** of **Living Cities** said that people need to respond to incentives and sanctions. Why wouldn’t hospitals redline out high-poverty areas? ... Barnett replied that the real accountability is at the local level. How do we equip elected officials and their constituents to ask hard questions? With full transparency, hospitals and health institutions should have every opportunity to do the right thing. At the federal level, the

IRS imposes a token \$50,000 fine for not conducting a needs assessment; it's hard to know whether the IRS has the competencies or desire for oversight.

- **Don Hinkle-Brown of The Reinvestment Fund** noted that, in contrast to the CRA, we miss a huge segment with the Community Benefit statues because they only focus on nonprofits; others escape because they don't have to file a Schedule H. So, in a lighter regulatory environment, how do you tease out affirmative behavior if there's no hammer? Community organizing, shame, or share best practices? What promotes effective use of money and collaboration? ... Barnett responded that we need investment in sharing best practices. Flip it around to be competitive; look at peer institutions and say, "We've got to get on our horse." Location means more than articles of incorporation; it's payer mix and how you serve those populations. There are investor-owned hospitals in these areas that provide community services also. Even for-profits should do assessments. It's not a business proposition now, but it will be in five to ten years. Hospital leaders must live in both the current world and the future world.

Bruce Vladeck from Nexera, Inc. **Bruce Vladeck from Nexera, Inc.** noted that most hospitals serve relatively socioeconomically homogenous populations, and that 70 percent have no endowments to speak of. If basing urban development strategies on hospitals was ineffective, focusing on hospitals as anything other than sources of cash is probably the *least* efficient approach to alleviating poverty. Vladeck wondered if poverty is a social determinant of health, shouldn't we be focusing more directly on raising the minimum wage and other poverty alleviation strategies? "We're looking for keys under the lamppost...."

... Barnett responded that we're not talking about hospitals doing this work alone. Rather, they would partner with others, dialogue on alignment, and partner in targeted investments. Hospitals can apply the strengths that they do have, such as in the political arena and in spending Community Benefit resources more efficiently.

Michael Swack ended the first evening by asking **James Bosscher** from **CHE Trinity Health** to model how a CDFI should instigate a conversation with a hospital, under the premise that CDFIs and hospitals both want better services for better outcomes to those who need it at lower cost. Bosscher said that CHE Trinity Health hasn't had enough CDFIs approach them so far. Especially now that Trinity is focusing more on health determinants, it would be a "triple win" to work with a CDFI focused on health care. "They'd receive a positive reception. Most of our \$35 million is in housing, and not nearly enough of it is in health care. Frankly, we're desperate to find more CDFIs."

CURRENT PRACTICE AND EMERGING OPPORTUNITIES

The second day of the Financial Innovations Roundtable examined current and emerging opportunities for health-related community investing and led to the group's determination of next steps. Swack commented that, with the Community Benefit requirements, "There's a CRA for hospitals!" He also noted emerging opportunities to focus on community transformation where there are health inequities. He reiterated Barnett's observation that it's important to build institutional leadership if we want action and that we need more transparency in pricing,

public expectations, and outcomes measurement. What are the opportunities for alignment, if our missions are currently aligned but our strategies are not? How do we grow and diversify investment strategies to improve health outcomes, and what is the role of financial intermediaries?

Panel 1: Current Practice

Moderator: Joseph Firschein, Federal Reserve Board of Governors

What is happening now? What payments / grants / subsidies are forthcoming from the health care industry (government, insurance companies, etc.) and when and how do they work? What have we learned through early efforts such as fresh foods financing, clinic financing, and other early health-related investments?

Don Hinkle-Brown from **The Reinvestment Fund** said that many cities and states are focused on food access. In past years, \$90 million has been appropriated from federal sources to CDFIs and Community Development Corporations on food access, and local products and programs are bubbling up. Investments have evolved from singular focus on supermarkets to smaller grocery footprints, cooperatives, farmers' markets, food trucks, and connection to more classic development. Hinkle-Brown is particularly excited about fresh food prescriptions.

He observes improved access overall; there's a better definition of the need, evolved from anecdotal and "lightly drawn watercolors" of food deserts to more specified definitions from lots of different sources. However, one challenge lies in impact measurement. "It's not realistic to measure the BMI change in elderly women nine months after a grocery store opens, or a change in her hospital visits." Rather, how do we document perception and awareness, or use shopping data?

Another deeper challenge is that the community development sector is very transactional, mortar-and-brick focused. We're focused on the injustice of the now, not on fixing it in a systematic way. We drive a stake in the ground, declare success, and move on. That move-on approach is counter to long-term health outcomes. Since some of the work requires behavioral change (such as life skills), which we don't do, we need to partner. We still need to lengthen our attention span and broaden our coverage—"stay the course." Keep fresh food access as a goal; recent mission drift away from health and toward local agriculture and economic development will sap our efforts. Our work is not done. There's a new generation of CDFIs and still a need for seed capital, growth capital, and human capital. Communities of practice, such as those The Reinvestment Fund is building, are a promising way forward.

Many years ago, **Kimberlee Cornet** from **The Kresge Foundation** was struck by a "Housing is Healthier" bumper sticker. She then spent ten years financing housing without anyone asking her about health! If one looks at community development as a fiber optic cable, health is one cable that hasn't been strong enough. After a speed-dating "party," where CDFIs and health centers recognized they came from a common place and had explosive potential to bring sectors together, The Local Initiatives Support Corporation (LISC), Morgan Stanley, and The

Kresge Foundation launched the Healthy Futures Fund, an initiative to support development of Federally Qualified Health Centers in underserved areas as well as affordable housing that incorporates health programs for low-income residents.

Cornet reflected that more can be done if we can get information and funds to developers earlier in the process. They are trying to move “beyond the box,” that is, out of real estate, to affect what is going on *inside* the health center and where people are living. They are supporting services, technology, or products that decrease Medicaid, increase throughput, or achieve other goals. Immediate demand has shown a huge appetite and need for high-risk, early stage capital. Their next frontier is how to monetize health benefits and become an active investor in the pay-for-performance space. They want success to lead to a decrease in the cost of financing and require that states be at the table, even as an observer. In their performance-based loan to help Chicago homeless, Illinois made a \$500,000 grant to accelerate data management. Cornet thinks social impact bonds are another interesting pay-for-performance model, but she doubts this can go to scale because of the need for legislature approval.

Cornet noted Kresge’s “grand experiment” of creating an investment thesis around health. Kresge has a range of capital tools but is wondering how it can both invest in each one of these areas and also build the dynamic of feedback between program staff and investment staff. “How do we use both of those pieces of information more frequently and better?” Kresge’s \$10 million in mission-related investments next year will not only have local impact, but also more importantly will shape its behavior as an investor in the years ahead.

Allison Coleman from **Capital Link** suggests we are not done investing in boxes; there’s still a need for investing in health centers. Health centers then become a platform for community investment; for example, CVS’s divestment from tobacco product came as a teen project from Codman Square Health Center in Dorchester, Massachusetts, which Capital Link helped fund. Established through the community health center movement, Capital Link helps health centers grow by providing: (1) Industry vision and leadership in the development of capitalization strategies for facilities and operational expansion; (2) Metrics and analytical services for measuring health center impact, evaluating financial and operating trends and promoting performance improvement; and (3) Direct assistance to health centers and complementary nonprofit organizations in planning for and financing operational growth and capital needs.

Capital Links’ preliminary projections show 32 million patients by 2018 (up from 22 million in 2012); capital needs of ~\$10.3 billion; and an estimated funding gap for health center-owned space of \$4.8 billion, of which at least \$2.7 billion is needed in debt financing.

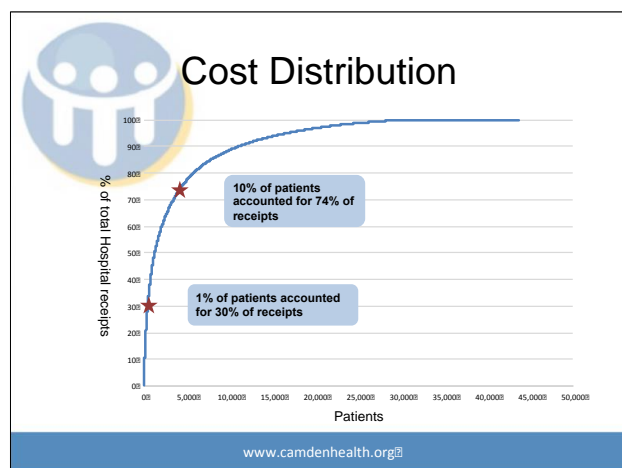
Tom Manning from **Primary Care Development Corporation (PCDC)**, a CDFI that invests solely in health care. Since 1993, PCDC has invested \$500 million in over 100 primary care projects in low-income communities serving over 700,000 individuals, leading to 4,600 jobs created or retained in these communities. PCDC’s mission is similar to that of the Federally Qualified Health Centers (FQHCs) that it serves; lending is a strategy to meet that mission. It also provides

consulting and advocacy work, with the belief that “Healthy kids stay in school; healthy adults stay on the job.”

Manning identified opportunities with: the Collaborative for Healthy Communities (a \$130-million national fund); in “expansion without construction” (operational improvements to improve efficiency, expanding services in existing footprint); and in pay-for-success financing. Referencing Kevin Barnett’s prediction that 30 percent of hospitals will close or transform into something else, he suggested strongly that FQHCs should step into the gap to save the primary and preventative services of bankrupt hospitals that are closing. This transition model would also include training for new doctors to work in low-income, urban areas for their careers. Manning acknowledged that hospital closures are “fairly unstoppable” since hospitals don’t provide the level of in-patient services to support their overhead, nor should they. But, when hospitals close, primary and preventative care services go out the door as well. Also, because hospitals tend to be major employers in low-income communities, closure is a major disaster in many low-income communities. To preserve hospital closings or move services to FQHCs, there are many allies; state and local government want to put in resources they have, although there will always be a gap between what they contribute and what is needed.

Mark Humowiecki from **Camden Coalition of Health Care Providers (CCHP)**—a membership nonprofit of hospitals, primary care physicians, behavior health, home health, and social services—stated that Camden is one of the most dangerous and poorest cities of America. The CCHP board includes consumer organizations and patients. Care coordination means CCHP helps high-utilization patients engage with the health care system and manage their chronic conditions.

Camden hospitals have an interesting cost distribution, with 1 percent of patients accounting for 30 percent of receipts and 10 percent of patients accounting for 74 percent of receipts. Responding to a question about whether this was typical, Humowiecki said that Newark and Trenton have a similar curve, as does a rural population around Augusta, Maine, that they had examined. **Tom Manning** agreed that a small proportion of families account for a high percentage of the costs. In his experience, 5 percent of the people comprise 50 percent of the resources, since healthy people pay fewer bills. Humowiecki commented that generating savings among high users involves both social and medical complexity.



The United States is “off the charts” in an international comparison of the ratio of health care costs to social services costs. This is not surprising since many of the costs we see in the health care system are due to a lack of investment in social services and infrastructure.

CCHP is pursuing a unique Accountable Care Organization model in New Jersey: an independent nonprofit based around a particular geography with near-universal provider participation, including behavioral health and addiction support providers. Patients are also on the board. The requirement is that nearly all providers participate; “you’re responsible for those zip codes.” Hospitals think of how to keep patients out of beds instead of in to beds. The assumption is that shared savings comes with increased quality and reduced costs. But “the prospect of shared savings eighteen years down the road is a hard way to hire people,” so Humowiecki shared a few other financing ideas including a social impact bond and penny stock or venture capital. He also cited the need for health care information exchanges and services coordination.

Robert Jenkins from **NCB Capital Impact** discussed how the organization has a best-efforts mandate to keep 35 percent of its funds serving low-income people and in low-income communities. Its innovative Green House Project reinvented nursing homes by rebuilding them as small homes for ten people, on campuses, staffed by versatile/universal workers. Intended for very low-income people, the project was designed to improve long-term care ahead of the aging demographic surge. Multiple research projects show greater satisfaction, better clinical outcomes, Medicaid cost savings, cost neutral operations, and occupancy gains—which have influenced the nursing home industry at large.

The Green House Project required nursing homes to abandon the building they were in and go to an entirely new project. This was complicated, especially for lenders and equity investors. So they needed flexible and customized financing—but this was scarce. Nursing housing is a high-mission, low-return business. What approaches worked to spread The Green House innovation? First, go “under the radar,” tying the innovation to well-understood models (“it’s just a nursing home”). Second, bury a small-dollar innovation in large and strong financing (a “rounding error”). Third, use what you have by fitting existing subsidies where possible (for example, New Markets Tax Credits, Low Income Housing Tax Credit, Housing and Urban Development funding, Federal Home Loan Banks, and bonds). Fourth, pursue specialized loan funds, such as grant and Program Related Investment-supported programs. And fifth, frame for CRA lenders a “high-profile, high-benefit project” to receive attractive terms.

Looking forward, Jenkins cited the need for new sources of consistently available financing designed to:

- Fill in for declining public sector guarantees and subsidies
- Leverage ACA shared savings incentives
- Provide credit support for projects in low-income markets without large system and/or private pay markets
- Provide flexible structures with longer terms and affordable fixed rates
- Deliver significant and consistently available capacity

Respondents

Donna Gambrell, formerly of the **CDFI Fund at the U.S. Department of Treasury**, agreed the need remains, particularly in seed capital (how to work with smaller CDFIs to provide a way in) and finding sufficient high-quality resources, including ad hoc. Her question continues to be, “What is the role of government?” Is it as simple as providing funding in partnership with others, toward community development with health as one strand? Gambrell questioned where we are in terms of capacity. We’re clearly not at saturation point, but where is the capacity of the organizations already in that space? What resources do they need? She also questioned whether we really understand community needs. Even locally, with kidney disease, asthma, and sexually transmitted diseases—“how do we know we’ve got it right?” How do we get greater community engagement and ensure we’ve pinpointed the right issues and strategies?

Jim Galloway, a medical doctor formerly with the **Office of Health System Collaboration, Centers for Disease Control and Prevention**, worked with American Indians for many years and described their interesting perspective on community health, that is, that lack of harmony between individuals and other individuals (human or not) causes disharmony. This is truly the nexus of community and health. American Indians will go to providers to treat symptoms, but to medicine men for core treatment. Galloway also cited benefit corporations and low-profit limited liability companies (L3Cs) as exciting new models of care that have double- and triple-bottom-line goals.

Open Discussion. Other participants continued the conversation, including varying perspectives on how significant shifting incentives in the health care system will be for community development practitioners.

- **David Erickson** said we are at a unique moment, with the health industry shifting from doing procedures to managing population health. “Everything in community development has been practice leading up to this moment.” The notion of community capitalism held tremendous promise, but it never took over, so the CDFI industry has been constrained to subsidies and our conversation has been about making subsidies go further. We will miss something if we don’t pivot to meet this opportunity fully. We’ve seen great “green shoots,” but we need something deeper.
- **Robert Jenkins** agreed that changes in behavior due to new incentives offered through the ACA and Accountable Care Organizations has been the fastest system transformation he has seen. We should take advantage of that.
- **Don Hinkle-Brown** worries about the premise that we are in a resource-rich environment in terms of the health and community development worlds colliding. “Will we really be able to monetize unused cancer treatment and turn it into a daycare center?” Hospitals are allies, know things we don’t know, and have access beyond what we do. He sees no hammer to attract money, but sees a little hammer that we could use to attract attention. What hay can we make from this?

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- **Bruce Vladeck** said that banks lend to nursing homes because they have defined revenue streams. There's more capital available for community health care activities than there is revenue available for operations. Surpluses generated by the hospital sector (when they exist) cause payers to constrict those revenue streams. We need to identify recurring revenue sources for direct support of community health activities.
 - **Robert Jenkins** questioned if there was a different way to partner with commercial banks, especially around underwriting standards. This would unlock significant additional resources without having to utterly reinvent the system.
 - **Allison Clark** from the **MacArthur Foundation** said that the market is behind the curve in what's risky. What has made hospitals invest in nursing homes? Part of it is credit enhancements. We need this at federal levels too.
 - **Tom Manning** noted that federally qualified health centers are focused on health outcomes and also getting involved in accountable care organizations. "The most interesting ACO models don't include a hospital!" Those involved with preventative care manage care and negotiate with hospitals.
 - **Barb Stucki** from **NestCare** said that the "aging tsunami" has arrived. She cited a need in prevention and on the housing side, as more seniors age in place. Better infrastructure for seniors aging in place will drive jobs too, since we are currently relying on family care givers who can't take this on.
 - **Len Clay** from **Housing and Urban Development Public and Indian Housing (HUD PIH) / Office of Public Housing Investments** said we can't do social impact bonds because we don't have proof data. Where is the nexus from transaction to transformation? This occurs where you involve community. There aren't community organizers at this Financial Innovations Roundtable. **Don Hickle-Brown** agreed it was critical to involve residents (on Board, etc.).
 - **Laudy Aron** from the **Urban Institute** referred to data showing that the United States is at the bottom of the heap in morbidity and mortality, for all ages, all socioeconomic status, across sexes. There is a power in a cross-national lens. Other countries are beating us because of early intervention and prevention for the most part, rather than health care and medical care. Domestically, Yale research confirms that the states with greater services are doing better health-wise. We need to figure out where the money is flowing and why, since this is a major part of understanding the social determinants of health. Adolescent health is a critical manifestation period. When adolescents of communities are unwell, the entire community is unwell.
 - **Kevin Barnett** is excited to look beyond buildings to analytic capacity and operational efficiencies. In his prior project, clinics didn't have access to hospitalization data, so they couldn't calculate the total cost of care.

Panel 2: Innovative Funding

Moderator: Yusi Turell, Carsey Institute, University of New Hampshire

Where are the opportunities for innovation and growth? What investments, partnerships, and financing vehicles are needed to move the needle? What is needed to jumpstart some of these innovations in order to promote greater adoption and scale? What projects, ideas, and research

might we advance over the next year? What are some emerging innovations that bring in new investors, address payment alignment/incentives, and capture important outcome data/metrics?

Doug Shoemaker from **Mercy Housing** said that Mercy has long provided “service-enriched” affordable housing that incorporates health services through a holistic, blended approach. The problem they are addressing is that a small percent of high-cost individuals drive our nation’s health care costs. For example, “high-cost” Medicaid enrollees (defined as over \$25,000 in annual spending) comprise 4 percent of all enrollees but 49 percent of all spending; of these, 49 percent are elderly and 43 percent are disabled. Nursing homes or other long-term care represent 77 percent of the cost attributable to elderly high-cost enrollees of Medicaid. Shoemaker offered a case study of the Mission Creek Senior Community in San Francisco to demonstrate that the cost savings from health care can create the revenue for a new model through: reduced hospitalizations, helping seniors avoid unnecessary nursing home stays, and more efficient delivery of community-based services.

Shoemaker pointed to remaining market inefficiencies that need to be resolved. For example, Medicaid will pay for skilled nursing or residential care facilities at three to four times the monthly cost of Mission Creek, and Medicare will pay twenty times the daily cost of Mission Creek for hospital beds for patients who lack a home to be discharged to. Once the patient’s medical needs have been met, hospitals pay the cost of “housing” in their \$1,000/night beds. One of the challenges in affordable housing is that it is hyper-regulated. Therefore, Mercy Housing tries not to use government funds.



Nirav Shah said that the mission of **Social Finance** is to mobilize investment capital to drive social progress. Social Finance structures and manages impact investments that will unlock capital to fund effective solutions and drive an outcomes-focused social sector. Social Finance US launched operations in 2011 after its sister firm, Social Finance UK, launched the world’s first Social Impact Bond in 2010. These two work closely together but are independently

funded, managed, and governed. They share a common mission, model, and knowledge platform.

Social Impact Bonds provide investment capital to fund evidence-based programs delivered by highly effective service providers. Through a Social Impact Bond:

- Government only pays for results, as the risk of paying for ineffective social programs is shifted from government to investors.
- Service providers receive upfront and reliable funding enabling them to grow proven interventions and serve a larger population.
- Communities and people in need receive best-in-class services that help them live healthier and more productive lives.
- Investors generate both a positive social impact and a potential return.

Shah offered four promising health care-related applications with one or more of the criteria for successful social impact bonds, including evidence-based intervention, sufficient net benefits within the time horizon, and replicable and scalable. (See Table, “Promising Healthcare-Related Applications.”)

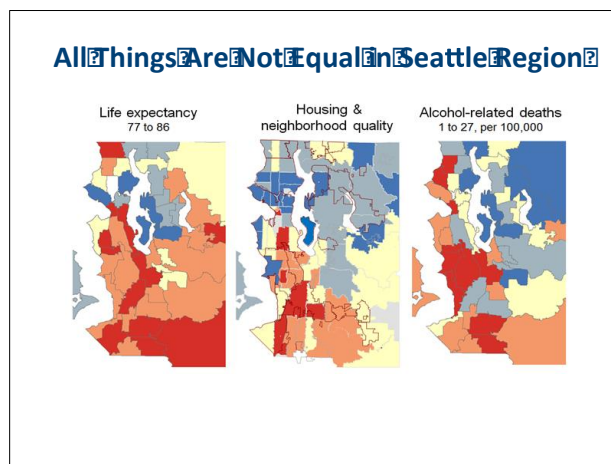
		Evidence-based Intervention	Sufficient Net Benefits within Time Horizon	Replicable and Scalable
<i>Vulnerable Population</i>	<i>Potential Intervention</i>			
Low-Income Mothers	Prenatal and early childhood support for first time, low-income mothers to improve family success	●	●	●
Low-Income Seniors	Supportive housing and care coordination to reduce out-of-home healthcare usage	○	○	●
Individuals with Chronic Conditions	Preventative care and management of chronic diseases, e.g. education and home retrofits to reduce asthma-related emergencies	○	●	●
Chronically Homeless Persons	“Housing first” supportive housing to reduce emergency healthcare and shelter usage	●	○	●

Shah described an asthma demonstration project in Fresno, California, designed to build a pipeline of “investment ready” health care interventions and providers. He noted it was important to create a feedback loop that focuses on outcomes, which is tricky currently when there is minimal data and evaluation, and he cited other potential opportunities tied to early childhood and to home and health.

Chrissy Rusillo noted that **Seattle and King County, Washington**, has the biggest economic disparities in the nation, with many very affluent residents but also many in poverty. This manifests in a ten-year difference in life expectancy between neighborhoods, as well as

major differences in housing and neighborhood quality. Inequities across race, income, and education all fundamentally align with place. The county's Transformation Plan is to increase equity in health and well-being for King County residents through: (1) Improving outcomes in communities with the most to gain; and (2) Improving outcomes for adults with high-risk, high-cost complex conditions.

King County seeks to achieve large-scale results through system change (not pilots) through cross-sector collective impact in which partners can hold each other accountable. Accordingly, the County funded a \$500,000 Catalyst Fund to jumpstart innovations and leverage other funds. It is not intended to pay for current, ongoing services that groups are providing now, or for services that would need ongoing support in the future.



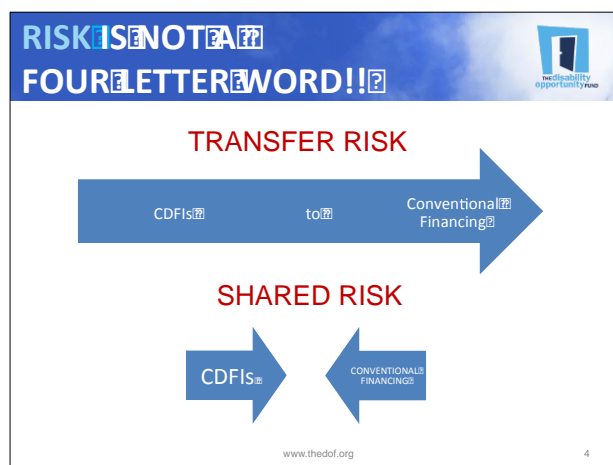
King County's public sector and capital innovations include overcoming outdated bureaucratic structures, better engaging residents, improving government performance, and leveraging private investments. Since this approach is not typical for government, they have faced a few challenges, including holding on to "innovation money" when funding for direct services is being cut. It is also difficult to agree how and where to spend the money, to leverage the money effectively, and to have impact while moving at "government speed."

Chuck J. Milligan, Jr., from the **State of Maryland**, also spoke about the public sector as a key community health partner, but also about public policy and legal impediments to innovation. For example, Medicare is barred from paying for food and clothing unless the person is in a nursing home, yet it costs more than \$70,000 per year for each nursing home resident. Teeing up the next panelist, Charlie Hammerman from The Disability Opportunity Fund, Milligan cited the Supreme Court's 1990 Olmstead Ruling stating that keeping people in institutions is a form of segregation and violates the Americans with Disability Act. Therefore states and other programs are trying to get people out of institutions and into communities—at the same time that certain group interventions are on the rise and showing good outcomes, such as Hammerman's model for housing and residential support for adults with autism.

Charlie Hammerman from **The Disability Opportunity Fund (DOF)** also noted the irony that the whole industry is de-scaling, just as DOF is trying to bring its models to scale. DOF makes mission-driven investments that yield double-bottom-line results, providing financial returns through opportunities that address pressing social concerns. DOF finances high-impact projects via co-lending, direct lending, bridge and term loans, as well as gap,

predevelopment, acquisition, and rehabilitation financing. It also provides sophisticated, customized advisory services and acts as a liaison for investors, banks, insurance companies, non-profit organizations, and other financial institutions. DOF is not trying to be an island unto itself and is trying to bring its ideas to others.

Hammerman encouraged participants to not be scared of risk and to find creative ways to transfer and share risk, as DOF did with a cooperative single family home in Massachusetts. In closing, he called our attention to the [ABLE Act](#), a bill introduced to amend Section 529 of the Internal Revenue Service Code of 1986 to create tax-free savings accounts for individuals with disabilities. The ABLE ACT has bi-partisan support and (as of March 26, 2014) just received its 68th sponsor in the Senate.



Respondents

Tina Castro from **Avivar Capital** heard a running theme of Equity, with disparities adding up over a life course to impact health outcomes. She wondered how to invest over a life course, including earlier to get better outcomes. Castro called for more and better data, as well as bringing other current players to the table and new players into the field.

Dan Nissenbaum from **Goldman Sachs' Urban Investment Group** also questioned, "Who are we missing from the conversation? Who are the payers? How do we get them to the table?" In mapping types of subsidies and types of revenue streams, he observed that the biggest opportunities for savings come through "big needle movers" that change behaviors.

Talking about financing businesses harkens back to CDFIs getting into charter schools. With savings models (versus revenue models), how do you finance enough of these and where is the return? The CDFI Bond Guarantee Program has potential, as do pay-for-performance approaches, which are supported by the White House. How can we use the advances in "housing and services" models as a point of departure?

Open Discussion. Participants were interested in monetizing outcomes and community care models, as well as how important 'jobs' should be as an outcome goal.

- **Nirav Shah** noted that monetizing outcomes is critical.

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- **Doug Shoemaker** recommended trying to secure a revenue stream or a payer that cares if they are producing the outcome; switching from fee-for-service to managed care is critical.
 - **Chuck Mulligan** said the opportunities are the strongest where there is a capitated model. Some hospitals will get a fixed amount of money per person in the entire community.
 - **Morris Michael** from the **National Disability Institute** noted a profound shift in the expectations of families. The disability population is the fastest growing ‘minority’ population. There will be built-up pressure with aging parents and people not being satisfied with the current system of elder care.
 - **Barbara Stucki** said seniors who need long-term care primarily use their own resources. When they need funds, it is often a crisis situation, possibly leading them to sell their homes. The question is how to tap money from their home without causing the person to move out. Requiring an 85-year-old to manage money from the proceeds of a home is not a good idea. A “shared ownership” type of model is needed.
 - **Doug Shoemaker** agreed we need new communities that are not in an institutional setting.
 - **Chuck Mulligan** said, if we allow payments to family members (or people in the community), it will allow people to age in place.
 - **John Hamilton** from **City First Enterprises** observed that ‘jobs’ have been missing from the discussion so far.
 - **Charlie Hammerman** said that, in his world, the priority is saving jobs, that is, not increasing jobs but maintaining jobs and not losing them. Twenty jobs resulted when the Disability Opportunity Fund created one house in Massachusetts.

Panel 3: Enhancing New Opportunities

Moderator: Michael Swack, The Carsey Institute at the University of New Hampshire

Looking forward, where do we go from here and how do we build from what we have done and enhance these emerging models? What do we need to do to bring in health-oriented investors? What is the role for social enterprise and venture capital? What policy-related actions should we support?

Eileen Fitzgerald from **NeighborWorks America** is focusing on the supply of quality housing and then the incorporation of resident services (such as mold removal, accessibility, and pest management). Insurance providers are aggressively looking at how to manage down costs, which could be a way to pay for broader resident services if you have a level of concentration for the model to be worthwhile.

In the Lowell Healthy Homes project (a pilot HUD program), 170 kids with asthma reduced emergency room visits by more than 80 percent. This impact is measurable with huge impact on school districts and others, although it’s often hard to get data. Other opportunities lie in financial capability/counseling (since stress causes health issues *and* health care bills get people

in financial problems), urban reinvestment, and employer-assisted housing. Scale is doing it more efficiently, not just doing more of it.

Pablo Bravo from **Dignity Health**, the fifth largest health care system in country, said that Dignity's community health department has several legs: shareholder advocacy; community benefit; and community investment, which makes \$80 million in direct loans to nonprofits and intermediaries each year. In the new world of the ACA where hospital walls are expanded to community, we need to expand how we operate—not just mobile services, etc., but also investments in community. Investing in our community improves overall community health. Dignity looks at housing, access to fresh foods, job creation, homeless issues, and more in order to tackle issues holistically. Its community investments aim to: 1) Stabilize communities by identifying and helping distressed communities; and, 2) Connect health care with services. For example, if a homeless person needs aftercare, Dignity will partner with a shelter and offer capital to expand the shelter to include a recuperative care center and buy beds throughout the year, so that homeless people will not use the emergency room for shelter. The recuperative care center can also give access to transitional housing. They receive a revenue stream by partnering with hospitals.

Community benefit reporting requires us to give back the equivalent of tax breaks we receive. In some communities, most benefits go to charity care. On the community investment side, the hospital does not get credit since there presumably is a return, even if just two percent or even zero percent. Bravo would like this group to think about providing that incentive to get hospitals to the table, for example, saying, "If you invest for five to seven years, we will give you credit for your investment for every year you keep money in the community."

Bravo also suggested integrating community benefit into the community needs assessment. Hospitals should have a conversation with the city and county to see what they are doing and how they can integrate, such as bringing a supermarket instead of a fast food establishment into the area. Regarding health centers, we should also think about regular (not federally qualified) clinics; some are primed to move into the FQHC world but lack working capital to get there. We can help with equipment capital by working with CDFIs, investing directly, or investing through the NCB Capital pool.

Kevin Barnett from **Public Health Institute** said that, in his earlier remarks, he had stressed the importance of hospitals looking to transformation, where hospitals see themselves acting in the community space. CDFIs are also moving from a transactional/project mindset to one that is longitudinal and transformational. These two sides need to collaborate. Yet, "collective impact is like Christopher Columbus discovering America; there were already a lot of people there when he arrived!" Along the collaboration spectrum (networking, coordination, cooperation, collaboration), how do we share risk toward a greater objective?

We need to get practical in the near term and take incremental steps to spark interest, for example, trumpeting current best practices to spur competitive urges. We need more hospital

representatives on CDFI boards. Hospitals are posting implementation strategies on their websites; responding to these trends in transparency, CDFIs should look at the strategies and explore intersections. Barnett offered to broker connections.

Paul Stange from **Centers for Disease Control and Prevention (CDC)** spoke from his diverse experiences with the CDC, in real estate, and as a public official. Enabling infrastructure at a community level is required before we can think about financial wizardry. A small group of core organizations (philanthropy, hospitals, CDC) should consider multi-jurisdictional or regional approaches to population health improvement.

Stange pointed to structures around collective impact and also to Elinor Ostrom's valuable-but-often-overlooked work on 'the commons.' Philanthropy and hospital CEOs have very different ideas of risk, return, and time horizon preferences. We need a backbone or quarterback organization that stands above the fray. We also need to enlarge the circle of *owners* tackling the problem with long-term solutions.

For his paper, "[A Sustainable Financial Model for Community Health System](#)," Stange and co-author James Hester used an investment perspective that was collaboratively based and had a twenty-eight-year planning horizon. They wanted to create a stable financial model with constant investment into common fund, in order to: (1) Permit significant social and economic returns to a hypothetical region; (2) Improve the health status of region; and (3) Be self-sustaining. This involved appropriate governance and community oversight and managing a population health budget with many different time horizons and returns. The resulting approach was similar to finding a balanced mix within a mutual fund, optimized for financial, health, and social returns. (See Table, "Sample Balanced Portfolio for Community Health System.")

TABLE 1 Sample Balanced Portfolio for Community Health System

Intervention	Target population	Implementation partners	Financing vehicle	Time frame	Risk/evidence	Savings sharing vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing–based services	Medicaid eligible, multiple chronic illness	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illness	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA diabetes prevention program	Commercial insured and self insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium	Performance contract
Asthma medical management	School-aged children	Commercial and Medicaid health plan	Shared savings	Medium	Medium	Performance contract
Asthma environmental hot spots	Children with asthma	Public health agency	1115 Medicaid waiver	Medium	Medium	Savings sharing
Expand early childhood education	Reduce adverse childhood events	Preschool educators	Pay for Success, Social Impact Bonds	Long	Medium	Investing in Social Impact Bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium	
New grocery store	Residents of U.S. Department of Agriculture food deserts	Community Development Financial Institution	Community reinvestment	Long	Medium	None

Respondent **Bruce Vladeck** from **Nexera, Inc.** was formerly Administrator of the Health Care Financing Administration (now Centers for Medicare and Medicaid Services). He pointed out that all health care is local; the variation in health care markets means some generalizations make him very uneasy. Vladeck said that the focus should be less on “how do we get affluent parts of health care to pay for other parts of health care,” and more on “how do we get additional resources into the preventive sector.” Otherwise, we’re just “rearranging deck chairs on the Titanic” and will not get to where we need to go. “Given that shared savings programs, for example, comprise an eight-digit number in a country with a \$2 trillion health care system, I have a feeling we haven’t really put our fingers on real sources of capital, other than to say we should spend on X rather than Y.” The most rational (therefore least likely!) avenue to more effective prevention is to spend less on health care and to spend more *outside* health care, for example, universal pre-kindergarten or raising the incomes of low-income workers.

Open Discussion. **Michael Swack** noted that this is large, complex field, evinced by the fact that most speakers prefaced their comments with “*I’m not really a... ‘health person’/‘community development person,’ BUT....*” These are uncharted waters and we benefit from each other’s diverse perspectives.

Participants chimed in:

- [CDFI participant] Everyone wants you to spend someone else’s money. But the political reality is, it’s hard to re-budget once money comes back into a budget. So, the reason that health care is an organizing target is that you have a defined set of money that you can figure out how to use in a silo. This is easier than returning to the source and trying to reallocate. Hospital employees shouldn’t do affordable housing, “just like you don’t want me to do a tracheotomy.”
- **Bruce Vladek** strongly disagreed. In his experience, Medicare or Medicaid savings have been hard to access for other purposes and, as budgets continue to shrink, there’s a real possibility that they will disappear altogether or become tax cuts. Further, “the notion that health organizations will invest in anything with uncertain long-term payback is confusing investing with public relations.”
- **Laudy Aron** echoed Vladek’s comments. She noted that there’s a political dimension to this whole conversation about how to spend health care dollars versus other social services, both at the national and local levels. She suggested moving forward in a complex landscape by developing broad principles to guide investment, which would play out differently in different communities. Principles could include:
 1. All else being equal, invest earlier in a life course.
 2. Prioritize public health (preventative) investments over acute/sick care health. Be on the preventative side of the continuum.
 3. Prioritize projects that have the opportunity to drive major changes in national public systems, such as social insurance programs. (There are many financially driven *disincentives* to things we know are right. We could be driving reform in these systems, changing broad understanding of the return on investment. Until we get these systems right, we’re not going to solve many problems.)
 4. Prioritize solid data-driven projects with a long-term perspective. Regarding Stange’s model, “twenty-eight years is a single generation!”
 5. Consider innovative models within formal institutions. Maternity and child health system, behavioral health, mental health, substance abuse—these have been starved of funding and have had to innovate too.
- **Bob Schall** from **Self-Help**, one of the largest CDFIs and with a deliberate place-based strategy across the country, observed that there are lots of opportunities but the opportunities are very confusing. There are opportunities in housing, job creation, and education, for example, but each has different risk assessment and industry knowledge. Furthermore, there are all these different revenue streams that are constantly changing. It becomes confusing to know where to jump in and be successful. It’s our role now to figure it out. From a hospital’s community benefit perspective, success means to raise

the bar on health outcomes in a community, which means you have to be in all of these sectors at the same time. However, if you're the only CDFI in a community, it's difficult trying to play in all of these. Schall predicts CDFIs are going to have to pick a few projects in a few sectors—but these might not be concentrated in a community, so “we'll have to see if health care partners will play.”

- **Doug Jutte**, executive director of the **National Partnership of Community Development and Health** and a faculty member at Berkley's School of Public Health, observed that longtime public health leaders have never heard of community development. We are underinvesting in early life and people are dying early, so we have a moral imperative to figure this out. With a “sick care” system of \$2.9 trillion per year, even 1 percent of that would make a difference. The new National Partnership of Community Development and Health is looking at metrics, policy change, and financial innovation. If there's a property available downtown, public health professionals should be able to answer the question of what should be built there, based on multiple social determinants of health, for example, consider a school, government services, and grocery store in one place.
- **Michael Swack** said that the Carsey Institute's forthcoming CDFI Impact Study shows that most CDFIs just measure outputs. “If you can't measure what happens to people, you're not measuring anything at all.”
- **Kerwin Tesdell** from **Community Development Venture Capital Alliance (CDVCA)** relates to this topic through CDVCA's job creation activities, as well as its financing of innovative companies including health and wellness business services. CDVCA has been working with smaller employers to adopt high-road employment services, such as providing insurance or creating wellness programs.
- **Pam Porter** from **Opportunity Finance Network (OFN)** directed participants to free tools and resources through OFN's Capacity-Building Initiative, which helps CDFIs successfully finance community health centers. There are webinars, curriculum, and best practices on a wide range of topics, including how to underwrite community health centers as community businesses.
- **Julie Eades** from the **New Hampshire Community Loan Fund** wondered if we have a public relations issue about the factual causality of low-income people bankrupting the health care system (just like we had tried to convince people that low-income people didn't cause the financial crisis). Blaming the victim is bad enough without making the victim do it all. How do we approach this? A lot of things are happening at the basic community organizing level. NeighborWorks America will begin to focus on health care and wellness in its resident community sessions, harkening back to environmental justice.
- **David Erickson** encouraged participants to continue the conversation at [SOCAP Health](#), June 25 to 26, 2014, in New York City. There will be a broad cross-section of partners, including buyers, sellers, and tool-makers, engaging in a similar conversation to what we've had today.
- **Robin Hacke** pointed to transit as a huge opportunity. A North Carolina program using transit as a diet strategy led to an eight-pound average weight loss. As a former venture capitalist, she noted that the conversation follows the model of new market

organization. Look at who's making the most money or the most concentrated money. Find the opportunities that affect a large percentage of the population, including where the most pain is; this encourages action. Or, if we look at market failure, we're where President Obama invites us to make administrative changes, such as in IRS definitions. Big flows of non-market dollars is a promising place to be.

- **Susan Harper** from **Bank of America** said, at the top of the list is to get better and smarter with data, including how to communicate data.
- **Ellen Seidman** noted that HIPPA issues are big, for example, childhood asthma. Can we get to self-reporting at the level, quality, and consistency that funders will accept?
- **Michael Swack** pointed to the Progress out of Poverty Index (PPI) and wondered if we could develop a handful of methods that are offered by CDFIs and other community lenders that tell us something meaningful about quality of life improvements of borrowers.

Tasked with wrapping up and summarizing the roundtable, **Ellen Seidman** first agreed that transportation is a critical issue affecting the elderly in rural areas, especially as gas prices rise. She then shared overall Goals, Tools, and Needs that she had heard emerge from the past day.

- Goals
 - Improvements in community health for the long-term—"not that it should take a long time to get there, but that it should last."
 - Equity across communities, reducing disparities.
 - Intervention in the right time and place—including occurring earlier and changing behaviors.
 - Community involvement. Integrate community stakeholders into conversation through collective impact or other system and make sure we know how the community defines the outcomes.
- Tools
 - Aligning strategies; this is precursor to a lot of other things.
 - Community Benefit obligation. Can we get even more dollars into the community, perhaps by changing definitions to include community investments?
 - Accountable Care Organizations. How much money is there really? Is the only right answer 'absolute reduction' or is there room for redirection? Seidman believes ACOs give opportunity for both, but there is the challenge of appropriately capturing and using the savings, versus directing them to tax reduction or into someone's pocket.
 - Federally Qualified Health Centers.
 - Community Health Needs Assessment. These exist and are publically available. CDFIs can probably think of multiple ways to connect.
 - Current subsidy streams. These are peanuts compared to Supplemental Security Income and Medicaid. Can we move these toward the aforementioned goals?
 - Expansion without construction, for example, technology, coordination, and alternative mechanisms for care.

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- Needs
 - Realigning funding streams. This goes back to the political question. Policies need to focus on prevention, community benefit, and community integration.
 - Involve insurers. This need is a subset of a more general category of needs: if there are savings, how do we make sure the community gets the benefit?
 - Prove the benefit. Try to figure out proxies for long-term results. Adolescents are “canaries in the mine” and bring opportunities for proxy development.
 - Share risks together. One way to do this is through integrating boards of directors; when people are on both sides of a transaction, they have opportunity to think through the risks and benefits together.
 - Consider both the positives and negatives of a “job’s” focus. Reform strategies threaten a lot of jobs, including those for both physicians and low-income workers. Can we create new jobs as old jobs are being destroyed?
 - Develop new capital structures and capital streams. We all know how to layer capital, but first we have to find it. How do we bring in risk capital, large capital (capital markets), different underwriting concepts for banks, and really experiment—not stopping with pay-for-performance, pools, and funds? At best, can we make it possible to go forward without any subsidy at all?

Michael Swack and **Joseph Firschein** closed the session by noting the tremendous amount of thoughtful experimentation in the field and inviting participants to share additional suggestions and offers to get involved.

NEXT STEPS

At and immediately after the Roundtable, participants suggested that the FIR conveners and broader network could be helpful to the emerging area of health-related community investing in two primary ways:

- **Develop investment principles and metrics.** Building on Laudy Aron’s comments, we could develop principles and metrics to guide most “impactful” type of lending. These would be based on studies that demonstrate maximum impact. For example:
 - Invest earlier in a life course
 - Invest in public health, instead of acute care
 - Invest in projects with stronger community engagement and participation
 - Invest in projects with data driven metrics that have a long-term perspective
 - Invest in projects that drive changes in national systems

As part of refining the principles, we should engage health economists to get additional perspectives on the future of health care economics.

- **Convene smaller follow-on meetings with focused outcome goals.** Strategic stakeholders groups could include:

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- CDFIs with other health care providers (clinics, hospitals, insurance, primary care associations, etc.) so they can be introduced to the CDFI network and potential products and services.
 - CDFIs, banks, and health care providers to identify ways to record impact and to identify new areas in health care that need funding.
 - Health care providers and financial institutions to provide an overview of the lending terms and practices of CDFI and banks—and of how these lending terms and practices support or impede lending to health care providers. Create a webinar from the findings of this meeting and disseminate it more widely to interested parties.

APPENDIX: Advisory Board of the Financial Innovations Roundtable

Frank Altman – Community Reinvestment Fund
Elyse Cherry – Boston Community Capital
Allison Clark – MacArthur Foundation
Lisa Davis – Ford Foundation
Cathy Dolan – Opportunity Finance Network
Julie Eades – New Hampshire Community Loan Fund
David Erickson – Federal Reserve Bank of San Francisco
Joseph Firschein – Federal Reserve Board of Governors
Eileen Fitzgerald – NeighborWorks America
Jeannine Jacokes – Partners for the Common Good
Dan Letendre – Bank of America
Cathie Mahon – National Federation of Community Development Credit Unions
Saurabh Narain – National Community Investment Fund
Dan Nissenbaum – Goldman Sachs
Luther Ragin – The Global Impact Investment Network
Bob Schall – Self Help in North Carolina
Dan Sheehy – Impact Community Capital
Kate Starr – The F.B. Heron Foundation
Charles Tansey – Export-Import Bank
Kerwin Tesdell – Community Development Venture Capital Association