

Improving Community Health by Strengthening Community Investment

Roles for Hospitals and Health Systems



Robin Hacke, Executive Director, Center for Community Investment
Katie Grace Deane, Assistant Director, Initiative for Responsible Investment

Preface by Donald Schwarz, MD, MPH, MBA, Vice President, Program,
Robert Wood Johnson Foundation





Reader comments, ideas and suggestions for additional case studies are welcome.

Please direct correspondence to:

Robin Hacke, Executive Director, Center for Community Investment
rhacke@centerforcommunityinvestment.org
www.centerforcommunityinvestment.org

Acknowledgments

Preparing this paper has been an 18-month journey from the world of community investment into the rapidly evolving landscape of health institutions. We have been supported and encouraged on this journey by Donald Schwarz, Abbey Cofsky and numerous colleagues at the Robert Wood Johnson Foundation who made this work possible and took the time to read and comment on multiple drafts. Their passion and commitment to building a culture of health is inspiring.

We are particularly grateful to Erin Shackelford of IRI for her assistance in the research for this paper, and to our external reviewers, including: Will Snyder of Presence Health, Sara Rosenbaum of George Washington University, Karen Minyard of the Georgia Health Policy Center, Tim Lowe of Premier, Blair Childs of Premier, and Jean Flatley McGuire of Northeastern University. Any remaining errors are ours.

We have benefited considerably from the wisdom, clarity and patience of our partner in capital absorption, Marian Urquilla, who has been instrumental to our progress since the very beginning. The Kresge Foundation, with its unwavering dedication to urban opportunity, has been Robin's institutional home for two and a half years. It is through their support that our understanding of the community investment system has been tested and stretched. David Wood of IRI has been our thought partner in developing and refining the capital absorption framework; his humility and skepticism have kept us grounded.

We are deeply grateful to all of the individuals we interviewed for this paper for their time, candor and courage in taking on such important work. We have tried to represent their efforts faithfully, and we take responsibility for whatever we have failed to convey accurately. We also appreciate the efforts of all the partners and colleagues who have invited us to their conferences, shared their insights and pushed the boundaries of the field so that people have the opportunity to lead healthier lives.

Preface

By Donald Schwarz, MD, MPH, MBA, Vice President, Program, Robert Wood Johnson Foundation

Hospitals and health systems have a tradition of serving their communities—of not only improving community health by providing health care services, but of bolstering the local economy and quality of life by hiring local workers and contractors, buying locally through their procurement strategies, and building new clinical facilities in neighboring communities. These activities often lead these hospitals to be called “anchor institutions.” These increasingly frequent forms of community investment by health care organizations typically flow either from their charitable purpose or from their long-term mission of providing community benefit.

But, as this report shows, there are other, less traditional ways that hospitals and health systems can invest in their communities, if they broaden their thinking. Hospitals and health systems have an array of non-clinical assets—from their ability to make loans to expertise in real estate, financial, and project management to significant property holdings—that can be leveraged not only for the benefit of the community but for their own benefit as well.

Consider a health care organization that makes a loan to benefit its community, especially a community with high levels of poverty that might not otherwise be able to get such a loan. If the project financed by that loan is successful, the hospital or health system as the lending organization will get a financial return on its investment. And if the “lender” is an accountable care organization and the investment leads to health improvement in the community, the lender will see a bottom-line return on its investment. And if the community health improvement is sizeable, that means a healthier workforce, less crime in the community, and better relationships with the people they serve. The community becomes a more desirable place to live and work, and property values increase accordingly.

By thinking broadly and investing strategically, hospitals and health systems can be better partners in solving the most pressing issues in their community. This report offers examples of health care organizations that are experimenting with this new approach to community investment, and lessons they have learned. These lessons are then incorporated into a framework for community improvement that we’re calling capital absorption. This framework, and the lessons shared here, can help cultivate common ground between those who have long participated in community development *outside* health care institutions, and those *within* health care institutions who are now discovering the potential impact of community improvements on health.

At the Robert Wood Johnson Foundation, we are committed to building a Culture of Health in the United States—where every person, in every community, has the best possible chance to thrive. In many places, hospitals and health systems want to make the sort of upstream impacts on community health that also help to reach that goal. A range of opportunities are available. Investment strategies like those detailed in this paper offer a cascade of benefits—both to the investor and to the community.

By thinking broadly and investing strategically, hospitals and health systems can be better partners in solving the most pressing issues in their community.

Executive Summary

How can communities impacted by deep and entrenched poverty become healthier places? How can they overcome a legacy of disinvestment to create the basic living conditions—clean air and water; safe places to walk, bike, and play; access to fresh food and stable, affordable housing—and the opportunities for education, work, and social connections that people need to thrive?

Research has demonstrated that where people live, work, and play affects their life expectancy, stress levels, and incidence of chronic diseases. Yet in disadvantaged communities, structural racism and conventional market activity have created barriers and perceived risks that impede the very flow of capital that could transform these environments into places of opportunity. The community investment field has developed as a way to overcome the failure of markets to deliver the goods and services that disadvantaged communities need.

For the past six years, a team has been exploring how underserved communities can achieve more of their goals and objectives through the use of community investments that generate financial as well as social and/or environmental returns. Such investments can help overcome market failures and meet community-identified needs by financing affordable housing, community centers, grocery stores, childcare facilities, and other infrastructure improvements that make people—and neighborhoods—healthier.

Through our applied research efforts, which have involved hundreds of interviews, more than a dozen local workshops with dozens of stakeholders, and extended support and learning from cross-sector partnerships in several regions, we have seen that places vary in their capacity to absorb investment capital and use it to deliver public benefit. At the same time, potential investors searching for impact investments often report that they struggle to find investment opportunities that meet their social goals as well as their expectations for financial return. There is a clear disconnect here. As a result, our central question has been: what can communities do to make it easier to attract and deploy capital and leverage other assets to achieve their social goals?

In places with relatively high-functioning systems, stakeholders from community organizations, government agencies, foundations, banks, and nonprofits collaborate to articulate clear community priorities, develop a pipeline of investable opportunities that advance those priorities, and shape the context of policies and processes so that investments can move forward.

But in many places, communities lack a systematic approach to organizing demand for capital, producing the investable opportunities that could put willing capital to work, and creating the conditions to facilitate its deployment. Often this results from a failure to engage key stakeholders—be they public agencies, employers, or anchor institutions—whose mission is in fact aligned with community objectives. As we have seen, one of the primary ways to increase the “capital absorption capacity” of a place is to expand the boundaries of the set

of stakeholders who participate in the community investment system and engage these new actors. In the Bay Area and Los Angeles, for example, community investment leaders have been able to engage transit agencies, whose ownership of land makes them valuable additions to the effort to develop affordable housing.

Hospitals and health systems have a variety of assets—such as financial resources, land, and expertise—that would make them valuable participants in the community investment system; a small, but significant cohort of institutions have taken bold steps and engaged in investment discussions or transactions. For this paper, we sought to identify and interview these leading health institutions that have been playing pioneering roles in community investment to understand what they are doing, what they hope to accomplish, and what their experience has been.

Investment turned out to be a confusing term. Many interviewees referred to “investing in the community” or “investing in programs” to improve health outcomes without expecting an identifiable financial return. In other words, they had made grants or paid for programs. Sometimes they thought the project might result in future savings to the institution, and sometimes they did not expect measurable cost savings. Although grantmaking clearly is a valuable contribution, for the purposes of this paper, we were particularly interested in examples of something much narrower: deployment of capital that was intended to advance social determinants of health while producing at least a return of the amount invested.

What we found is that the hospitals that have engaged in community investment were exceptional—to the extent that there is a trend in this direction, it is at an early stage. Movement from volume to value, which could drive such a trend, is still too nascent to command action, and metrics are not yet available or proven. Yet those institutions that have undertaken community investment are convinced that their early efforts have important strategic value and are very much worth doing. They advance the institutions’ mission of fostering health. They promote the institutions’ self-interest because they create goodwill and improve the communities of which the institutions are a part. And they provide invaluable opportunities to gain experience outside clinic walls to inform future decisions about how the institutions might evolve along with a changing health care environment.

This paper is the result of interviews with a dozen such institutions, as well as a literature review that looked more broadly at social determinants of health, how hospitals were fulfilling their anchor mission through procurement and recruitment, as well as investment, and how population health initiatives were engaging hospitals in the communities outside their clinic walls. We found that health institutions utilized a wide variety of strategies to invest in improving social determinants of health in their communities. They used a range of resources, selected a variety of types of investment vehicles, targeted diverse interventions, and partnered with a range of other organizations, from community groups and nonprofits to other anchors, foundations, and local government. By looking systematically at the early examples of hospitals that are making community investments, we hope to ease the way for other institutions to tread this path, ultimately to arrive at healthier communities.

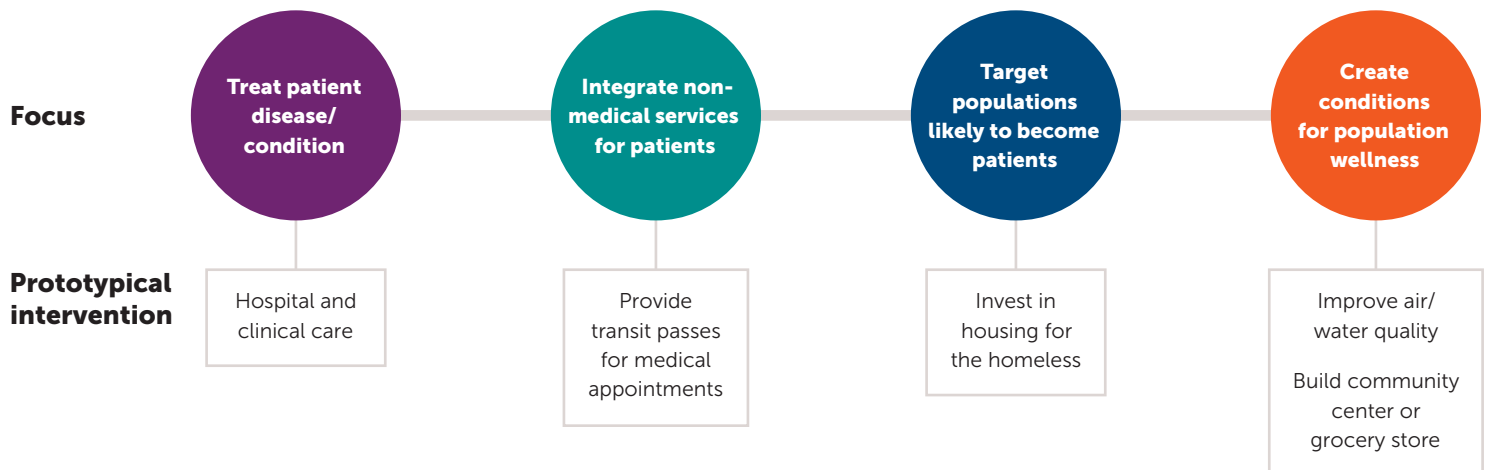
Institutions that have undertaken community investment are convinced that their early efforts have important strategic value and are very much worth doing.

Introduction

The American healthcare sector is experiencing a time of great uncertainty. Despite the highest per capita health care spending in the world, health outcomes are worse than those in other developed nations on more than 100 measures, including infant mortality and life expectancy.¹ Pressure is mounting to find ways to improve health outcomes while reducing costs; how our society will organize and pay for health is the subject of intense debate. At the same time, research from well-respected organizations ranging from the World Health Organization to the Centers for Disease Control and others demonstrates that health is powerfully affected by where people live, learn, work, and play. In poor communities, barriers such as the absence of parks, bike paths, and nearby outlets to purchase healthy food; housing instability; poor indoor air quality; exposure to lead and other contaminants, as well as limited public transportation, and safety issues negatively affect the health and wellness of residents (Trinity Health, 2015).

Health institutions have traditionally viewed their role as providing or paying for clinical services. Their focus has been on patients and procedures. But today, **some hospitals are experimenting with a much broader range of strategies to advance health and wellness and considering what role they should play in addressing the social determinants of health**—upstream factors like stable housing and employment that have such a powerful effect on health outcomes such as life expectancy, stress levels, and incidence of chronic diseases.

Hospital Approaches to Health and Wellness



Some health systems have focused on integrating non-medical services into patient care (e.g., by referring patients to social service agencies or providing transportation passes to help patients keep appointments). Some have gone beyond a focus on individual patients by initiating or supporting community efforts that target a specific population, such as homeless people, children with asthma, or high-cost users of health care services, who are likely to

¹ See Squires & Anderson (2015) cited in Rosenbaum (2016), p.2. See also Institute of Medicine and National Research Council (2013) and Schroeder (2007).

visit a hospital's emergency room or spend many days in hospital beds as a result of chronic health conditions. Others have widened their lens to encompass the health and wellness of the community as a whole and have begun to think through how they can apply "the long-term, place-based economic power of the institution, in combination with its human and intellectual resources, to better the long-term welfare of the community in which the institution is anchored" (Norris & Howard, 2015, p.7).

Hospitals with this mindset seek to leverage the nonclinical aspects of their operations to improve their community's health. This direction yields a wide variety of possible opportunities. As institutions that "employ large workforces, occupy and manage big pieces of real estate, purchase vast quantities of goods and services, attract investment through capital projects and research activities, and provide local constituents access to food, retail, and other amenities," hospitals can look for ways to conduct these activities so that they create shared value for the community and the institution (Dever, Blaik, Smith, & McCarthy, 2015, p.5). A number of articles and studies have chronicled how "eds and meds" create shared value through their recruitment and procurement practices, for example.²

This paper examines a small group of health institutions that have pioneered the use of investment strategies to advance the social determinants of health. As the paper describes, these investments have taken a variety of forms and targeted a range of issues. While interviews with the leaders of these institutions revealed different motivations for undertaking the investments, they have all found ways to deploy capital to improve health. In many cases, they also have leveraged other institutional assets, such as their land, reputation, and expertise, to contribute to the capacity of the system—the policies and practices, relationships, sources of capital—that generates and executes community investments.

We are not arguing here that investment is better than other strategies; different institutions will choose different approaches or mixes of strategies to attain their goals. But we are focusing on the investment approach in this paper because it has several important strengths:

- Investments not only can improve social determinants of health, producing better health outcomes, but they also can produce financial returns and savings, allowing funds to be recycled.
- Investments can tap pots of money (such as the endowment or capital budget) of the institution in service of mission in ways that other strategies cannot.
- Investments can harness the reputation, land, and skills of health institutions to benefit the community without necessarily requiring out-of-pocket spending.
- Investments can galvanize and leverage the resources of other partners, such as foundations, banks, private investors, government agencies, and employers, in ways that other approaches cannot. By investing their own funds, hospitals can signal the importance of particular projects and help "de-risk" investments for other parties, resulting in more dollars for important initiatives than the hospitals themselves commit.

² See Zuckerman (2013); Zuckerman & Parker (2016); Kleiman, Getzinger, Pindus, Poethig (2015); and Dever et al. (2015).



The paper aims to do three things:

- Share examples of hospital community investment practices that inspire others to consider a broader range of options for addressing the social determinants of health than they might have imagined;
- Lay out a way of looking at the community investment ecosystem in a place so that health institutions interested in participating can understand the opportunities and challenges, consider possible strategies, and develop an effective approach; and
- Help communities that wish to engage their health institutions understand the motivations, constraints, and approaches that their potential partners might bring to the table.

Health care workers with the St. Josephs Queen of the Valley Hospital in Napa, CA care for in and out patients in the hospital and in their homes.

Several caveats are in order. **Adoption of an investment strategy by health institutions is still at an early stage.** Only a relatively small number of institutions using such an approach were identified, although we welcome additional examples. As studies of innovation from fields other than health suggest, innovators and early adopters have to be willing to tolerate a certain degree of ambiguity and use their efforts as opportunities to learn and refine practice.³ Although much work remains to be done on the selection and relative effectiveness of different types of investments in producing desired health outcomes and cost savings, progress depends on institutions making the decision to dive in, learn as they go, and share their experience.

It is also worth noting that this paper looks at hospitals, not at all types of healthcare providers. Although some of the hospitals we profile are also payers, an in-depth survey of how payers such as Accountable Care Organizations and health plans are using investments would be worthwhile. In addition, although some of the hospitals are part of university systems or have partnered with local colleges and universities, we did not focus explicitly on university investment strategies. Professor Michael Porter, the Democracy Collaborative, U3 Advisors, Neil Kleiman, and other experts have published substantial literature including numerous analyses and cases on university anchor strategies.

³ See, for example, Moore (1991).

Investing in the Social Determinants of Health

We now turn to an examination of how hospitals can invest in ways that improve the social determinants of health.

What Is Community Investment?

Investments that generate both financial and social or environmental returns are sometimes referred to as “double bottom line” or “impact” investments. Some impact investments, such as venture capital investments in “clean tech” companies, may benefit the world at large (e.g., by reducing pollution). Other impact investments are targeted specifically at benefiting a particular disadvantaged place.

Although there are slight variations in how the term is generally used,⁴ community investment as defined here refers to financial investments intended to achieve social and environmental benefits in underserved places, where conventional market activity does not fully meet community needs. As the Commission to Build a Healthier America (2014) put it: “Nearly one-fifth of all Americans live in low-income neighborhoods that offer few opportunities for healthy living. In these neighborhoods, job opportunities are scarce; access to adequate housing and nutritious food is poor; and pollution and crimes are prevalent. These factors have a tremendous impact on health” (p.18). In other words, community investment is organized to make possible the jobs, built environment, stable housing, and services that people need to lead healthy lives. Such investments have an important multiplier effect. They not only can produce immediate financial returns, but they also yield positive indirect financial impacts by improving the health of communities.

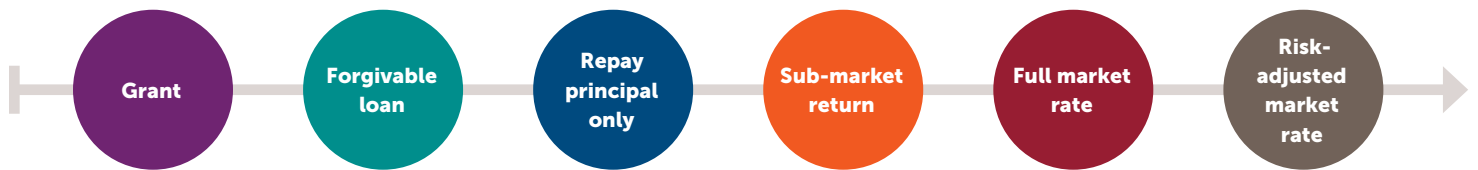
Community investment is often described as a practice that works around, or against, the conventional finance system. By targeting places, people, and issues where conventional markets are either absent or failing, community investment plays the role of filling gaps (where markets aren’t working), providing cushions (to absorb risk that others won’t bear) and taking haircuts (to adjust prices to “market” rates).

In this frame, community investment is viewed as the hard work it takes to do what the conventional finance system itself cannot or will not do (Hacke, Wood, & Urquilla, 2015). We sometimes refer to it as “making money roll uphill” to the communities where life expectancy can be 20 years less than in neighboring zip codes.

Community investment is designed to channel capital from public and private sources to areas such as affordable housing, child care, access to fresh food, green infrastructure, and small business development that make places more equitable, sustainable, and healthy.

⁴ See, for example, definitions provided by USSIF (2017) and Investopedia (2017).

Spectrum of Financial Return



Community investments come in different forms, including loans, bonds, equity, federal or state tax credits, credit guarantees, or pay for success arrangements, depending upon what is being financed. Investments may go directly into projects, for-profit or not-for-profit enterprises, such as developers or local businesses, intermediaries, or structured investment vehicles. They can have near-zero returns, return principal only, or offer the possibility of risk-adjusted market rate returns. As we will describe in more detail later in the paper, this means that health institutions interested in making community investments face a wide array of choices when deciding what resources they might deploy and what returns or other outcomes they might expect.

Investments like these take place through a complex network of actors—nonprofit and mission-oriented for-profit real estate developers; community development corporations (CDCs) and other neighborhood-based organizations; intermediaries like Community Development Financial Institutions (CDFIs);⁵ foundations whose mission interest in particular places or sectors drives their investment, often through the use of Program-Related Investments (PRIs)⁶; banks, many of which are motivated by regulations like those under the Community Reinvestment Act, which requires that they invest back into the communities they serve; and public sector agencies at the local, state, and federal levels.⁷

Forms of Community Investment

Type of Investment

- Loans
- Bonds
- Equity (e.g. venture capital)
- Tax credits
- Pay for success deals
- Guarantees
- Cash deposits in credit unions or mission-driven banks

Investment Target

- Project
- For-profit or not-for-profit enterprise
- Intermediary (e.g. CDFI)
- Fund or other structured vehicle

5 CDFIs are mission-oriented intermediaries, certified by the US Treasury Department, that provide credit and financial services to underserved markets and populations. For more information, see <http://ofn.org/what-cdfi>.

6 The IRS allows private foundations to make investments primarily to accomplish a charitable purpose and count them as part of their statutorily required 5% payout even if they produce financial gain. For details, see <https://www.irs.gov/charities-non-profits/private-foundations/program-related-investments>. PRIs are a powerful complement to grant-making in achieving a foundation's programmatic goals.

7 The Community Reinvestment Act (CRA) is intended to encourage depository institutions to help meet the credit needs of the communities in which they operate, including low- and moderate-income neighborhoods, consistent with safe and sound operations. It was enacted by the Congress in 1977 (12 U.S.C. 2901) and is implemented by Regulations 12 CFR 25, 195, 228, and 345. The CRA requires that each depository institution's record in helping meet the credit needs of its entire community be evaluated by the appropriate Federal financial supervisory agency periodically. A bank's CRA performance record is taken into account in considering an institution's application for mergers, acquisitions, and expansion. For details, see: <https://www.ffiec.gov/cra/>.

As we have learned from our previous work, the constellation of actors and institutions involved in community investment differs from place to place, depending upon the specific issues, priorities, leaders, and history that have shaped the local context. However, in our experience, **it is rare to have hospitals and health systems participating in community investment transactions, or even at the tables where such projects are discussed and come together. Yet engaging these institutions, with their significant resources and interest in place and increasing experience in community health planning, could expand the set of actors working to transform communities through investment.**

What Makes Community Investment Challenging?

As noted above, community investment is designed to overcome the failure of markets to deliver the goods and services that disadvantaged communities need. To accomplish this, community investments often are structured in ways that blend capital from multiple types of investors with varied constraints and requirements, and different appetites for risk and return.

Consider, for example, a transaction that finances development of multi-family rental housing for low-income people. Unlike a “typical” rental development, which would acquire land at market rates, take out a 30-year mortgage, and set rents at levels sufficient to cover the monthly mortgage payments, affordable housing developers cannot set rents at whatever level their costs dictate. They must target the level of rent that will be affordable to a household at a particular level of income and work backwards to make sure that all aspects of the deal lead to that result. What that means, in practice, is that developers of affordable housing must either receive a “break” on land acquisition costs, or they must find “gap funding”—public-sector subsidies and tax credits, philanthropic grants, or program-related investments that either do not need to be repaid or that carry less than market-rate interest charges. Gap funding makes deals financially viable by closing the gap between actual costs and the financial flows that a deal targeted at low-income people can produce. Given the relative scarcity and unpredictability of gap funding sources, community investment practitioners spend significant energy chasing the funding to make deals happen.

Hospitals tend not be participants in community investments; engaging them could help transform communities.

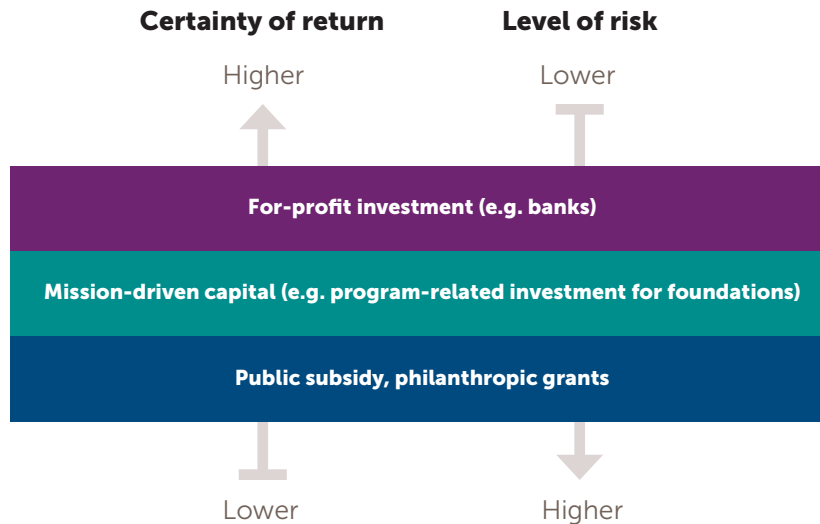
In addition to needing gap funding, affordable housing projects may be perceived as riskier than market rate deals. Gaining necessary approvals, finding gap funding, and managing the project to produce the desired results may involve more steps and take more time and specialized expertise than typical projects. Margins may be thinner, loan-to-value ratios higher, and time to pay off may be longer. Although there are decades of experience proving that these deals can be structured and executed successfully, some risk-averse investors will only participate if other parties—motivated by mission—provide credit enhancement or mitigate risks in other ways.

Community investment deals typically assemble a “capital stack”⁸ that includes for-profit investors such as banks; mission-driven individuals or foundations willing to provide below-market rate loans; Community Development Financial Institutions (CDFIs) that provide

⁸ A capital stack defines the varying risks and rewards assigned to different layers of financing in a particular deal. The composition and structure of the stack determines who gets paid when, and what happens to the various investors if expected returns fail to materialize.

pre-development funds and/or other types of flexible financing; as well as local government subsidies, which tend to be in short supply. Stakeholders willing to take a position further down in the stack make it possible for larger amounts of capital to flow to their priorities than would otherwise be possible.

Capital Stack



The need to blend capital means that community investment deals tend to be fairly complex. Balancing the interests of many stakeholders may require intense collaboration among community, commercial, philanthropic, and public-sector actors.

As a result of these challenges, in many places in the country, potential investors wishing to deploy their capital to achieve positive community outcomes, along with acceptable financial returns (sometimes called “double bottom line” or “impact” investments) do not find a ready pipeline of deals waiting for their capital. Although cities and towns are eager to increase the flow of capital that can help them achieve their social and environmental goals, they tend to lack a systematic way to produce and execute the opportunities that would balance “investability” with social impact.⁹

What Does It Take to Leverage Community Investment to Improve Health?

In order to leverage multiple sources of capital—public, private, and philanthropic—to improve the upstream social determinants of health, communities are well-advised to step back from individual transactions and focus as well on the system that produces—or fails to produce—such transactions. This system includes the actors, public policies, resource flows, institutional practices, culture, and relationships that influence how investment opportunities are developed and resources are allocated. In most places, this system is not particularly visible or well understood; it is no one’s day job to manage it. Yet the ability of communities to meet their goals depends on how effectively this system functions.

⁹ This work is first described in our March 2012 paper, “The Capital Absorption Capacity of Places: A Research Agenda and Framework” and is further elaborated in “Community Investment: Focusing on the System,” published in March 2015. Links to these and other publications on the topic may be found at <http://iri.hks.harvard.edu/capital-absorption>.

Three Functions of the Community Investment System

Strategic Priorities

Ensure there is a coherent, community-endorsed vision to shape investments

Pipeline

Generate deals and projects that add up to the realization of the community's strategic priorities

Enabling Environment

Shape the context that promotes or impedes the execution of the pipeline

As we have elaborated in our 2015 paper, *Community Investment: Focusing on the System*, an effective community investment system needs to perform three functions: articulate a clearly defined set of priorities; develop and execute a pipeline of “investable opportunities” that together help to achieve the priorities; and create an enabling environment that facilitates the creation and consummation of socially useful investments. These functions can be undertaken by different people or institutions in different places, and some activities can be performed by organizations whose headquarters are elsewhere. But unless these functions occur, getting capital deployed for impact is hard to do.

As health institutions consider engaging in community investment in a place, they may wish to keep this framework in mind. The following sections suggest how the framework might inform a hospital's exploration of opportunities.

Understanding Community Priorities

Understanding what priorities a community is trying to advance seems like a trivial first step—too obvious and/or vague to add much value. Yet we have found that being able to identify priorities with enough force and specificity to guide implementation is relatively rare for communities. This is true even in communities that have undergone rigorous, comprehensive, and well-regarded planning processes. For example, plans that identify 99 priority development areas, or fail to account realistically for the cost of what they propose and identify resources for implementation, do not fully do the job of helping communities operationalize their plans. On the other hand, communities that clearly articulate their priority (e.g., “We will develop solutions to food deserts that ensure that 100 percent of our people have access to fresh food at affordable prices within five years.”) know how to make choices about allocating time and resources that contribute to the realization of their goals. Without sharply defined priorities, decisions about resource allocation tend not to be well-aligned, critically needed attention and funding may be spread too thin to reach critical mass, and “wet cement moments”—the ripe opportunities that will be lost if not seized upon—may not be leveraged.

The community investment system includes the actors, policies, resource flows, practices, culture, and relationships that produce investment opportunities. These key functions can be undertaken by different people or institutions in different places. But unless the functions occur, getting capital deployed for impact is hard to do.

Health institutions can learn about community priorities through formal engagement and needs assessment processes like Community Health Needs Assessments for nonprofit hospitals; conversations with key stakeholders; review of local and regional plans; and analysis of how discretionary funding sources—such as Community Development Block Grants—are being used.

When engaging the community to discuss priorities, hospitals need to be mindful of the disparities in power between the institution and local residents, as well as the history and track record of the institution in its relationship with the surrounding community. Given the fact that most communities have competing needs and priorities, it is also critical to pay attention to how priorities were developed, who was or was not involved, and how widely a set of priorities are in fact shared.

Surfacing the Investable Pipeline

Translating priorities into concrete improvements in the community happens through development and financing of a series of projects and programs that promote health, neighborhood revitalization and economic opportunity. In most communities, no single initiative alone is transformative—it is only by moving a set of interventions that communities can achieve their goals. This is why we refer to a pipeline (i.e., multiple opportunities), rather than to the completion of a single project.

Investors interested in identifying potential opportunities to advance the social determinants of health may find it useful to consult with local foundations, city and regional officials, local housing agencies and economic development departments, Community Development Financial Institutions, credit unions, local nonprofit organizations and community development corporations, and the community development department of local banks to learn of projects underway. Unfortunately, in most communities, stakeholders tend not to have a clear line of sight to deals in which they themselves are not participants, so multiple conversations are likely to be necessary. This lack of transparency also results in lost opportunities to prioritize or integrate multiple deals to achieve community objectives, and to identify potential investors who would be interested in participating. One of the benefits of having a regular forum for discussion of community investment among leaders from multiple organizations is that it helps surface the pipeline and facilitate joint action.

An “investable” pipeline must include projects that produce financial returns. Although many projects could produce positive social impact, deploying capital that requires financial returns as well means structuring opportunities to yield identifiable monetary benefits. These benefits may come in a variety of forms—interest, capital appreciation, cost savings, etc. Sometimes the benefits are quite direct and obvious, and other times they are subtle or indirect. For example, real estate investment in the neighborhoods surrounding a hospital may generate rental income; reduce vandalism (and therefore facilities maintenance costs); increase property values; encourage employees to live closer to work, reducing commute times and potentially improving employee retention; contribute to the health of local residents, reducing costs for avoidable emergency care, etc.

Structuring deals to produce both financial and social returns requires the skill to balance what can sometimes be competing imperatives. This skill, which often resides in Community Development Financial Institutions (CDFIs) and other mission-driven financial intermediaries, is missing from many initiatives that seek to improve the social determinants of health. As a result, potential investors may find a lack of deal flow in the places they would wish to invest, which presents a missed opportunity for improving community conditions and health outcomes.

In many places, shaping a robust pipeline requires potential investors to pitch in, rather than wait for deals to come readymade to them. Potential investors can help deals come together by engaging in planning activities with the community, building the capacity of local organizations, tapping expertise from outside the existing system, and facilitating the creation of partnerships. Hospitals and health institutions can play a leadership and convening role by bringing together and fostering relationships between community leaders and CDFIs, banks, and other sources of financial expertise, to help structure appropriate deals, and by sharing information about how potential interventions could reduce health care costs. The case examples in the following sections of the paper provide many illustrations of different ways in which health institutions have done this successfully.

Shaping the Enabling Environment

How investable opportunities arise and are advanced in a community depends upon many place-specific factors: policies and regulations, resource flows, the presence or absence of needed skills and capacities, political realities, institutional practices, formal and informal relationships among key actors, the existence of platforms and incentives for collaboration, and cultural norms and behaviors. These factors—what we call the “enabling environment”—can promote or impede the translation of a community’s priorities into completed investments and constitute the context for community investment work.

Stakeholders with an interest in community investment can help to strengthen the system by initiating or participating in efforts to enhance the enabling environment.¹⁰ Again, the case studies that follow are replete with examples of how this can be achieved: from regularly convening relevant parties to work on common challenges, to helping gather or publish data (such as inventories of vacant parcels or neighborhood businesses) to inform decision-making, to joining in efforts to advocate for land use or other policies that advance community priorities.

¹⁰ For a detailed discussion of possible interventions, see Hacke et al. (2015, p. 12-20).

As the preceding sections suggest, hospitals and health systems seeking to invest in ways that improve the social determinants of health in their communities may find that in order to deploy their capital, they can—or must—become involved in strengthening the overall system that produces community investment opportunities. They can use their expertise and resources to:

- **Identify community priorities:** Health institutions can fund or organize engagement processes that enable residents, community organizations, local businesses, and other stakeholders to articulate their needs and priorities;
- **Enlarge the pipeline:** Hospitals and health systems have planning and development expertise that can help translate priorities into specific projects and investable propositions. They can provide grants and subsidies (i.e., money that does not have to be paid back) for use as gap financing or credit enhancement, thereby making more transactions “investable” by reducing risk to a level that more traditional investors are willing to bear. They can also contribute to making real estate developments financially feasible by providing master leases or guarantees, or by strategically locating offices and facilities off-campus so that they become “anchor tenants” for new mixed-use or commercial developments.
- **Improve the enabling environment:** Health institutions can contribute to creating an ecosystem that fosters investment in social determinants by using their government relations expertise and reputation to support advocacy efforts to change policies; gathering or supplying data that make the case for the positive health and economic effects of targeted interventions; paying for activities such as market studies, predevelopment costs, and business plans that are the precursor to successful transactions;¹¹ building the capacity of local nonprofits; helping to identify and engage organizations with the capacities (such as mixed use development, lending, operating grocery stores, providing technical support for immigrant, minority or neighborhood-serving businesses, etc.) that may be missing from the city or region.

As we have suggested, health institutions have important roles to play in each of the three functional areas described above. They have the staff expertise, financial resources, data, land, and institutional gravitas that can help the community investment system to perform at a higher level. The chart below enumerates these health system assets and explains how they can be translated into meaningful contributions to community investment. For more information on these examples, see Appendix A.

¹¹ For a fuller discussion, see Chung & Emerson (2013).

The following sections describe some hospitals that have taken up the challenge of participating in community investment and the approaches they have utilized. To read more, see Appendix A.

Health system resource	Significance	How to leverage	Example
Investment dollars and expertise	Underinvested communities need risk-tolerant, patient/flexible capital	<ul style="list-style-type: none"> • Take the lead in structuring transactions, especially in areas lacking partners • Supply gap-filling capital, with longer terms, higher loan-to-value ratios than commercially available funds 	Dignity Health
Grant money, from health system foundations, community benefit budgets or operational sources	Grant funding makes investment possible by boosting system/actor capacity; reducing risk in transactions; and preparing the ground for projects	<ul style="list-style-type: none"> • Pay directly for programs, infrastructure, or staff for cross-sector efforts • Provide loan loss reserves and other forms of credit enhancement or subordinated capital • Fund market studies, inventories of vacant properties or local businesses 	Trinity Health
Data	Expertise in data analytics can help improve community decision-making. Cost data can be valuable in assessing the potential for savings.	<ul style="list-style-type: none"> • Support collection and analysis of data • Coordinate on CHNAs 	Greater University Circle Initiative, Cleveland
Real estate expertise	Health institutions have internal capacity that can support development of community projects	<ul style="list-style-type: none"> • Participate in community planning • Help shape development RFPs to produce high quality results 	Gundersen Lutheran
Land	Health institutions occupy and manage key parcels and buildings	<ul style="list-style-type: none"> • Locate and develop facilities strategically, with an eye towards creating value/multiple benefits for the community • Orient and open the campus to the community 	Johns Hopkins
Reputation and relationships	As anchor institutions, hospitals and health systems have convening and coordination power that other community actors may not	<ul style="list-style-type: none"> • Utilize existing public, private, and nonprofit relationships to support community investment priorities • Leverage the institution brand in financial transactions 	Cooper Foundation

The Pioneers of Community Investment

For the purposes of this paper, the authors interviewed leaders from health institutions thought to have pioneered various forms of engagement in community investment. Sourced through referrals from the Robert Wood Johnson Foundation, consultants, and CDFIs, these institutions were reported to have invested in ways that advanced the social determinants of health in their communities while also generating financial returns. A list of institutions and individuals who were interviewed may be found in Appendix B.

Investment turned out to be a confusing term. Many interviewees referred to “investing in the community” or “investing in programs” without expecting an identifiable financial return. In other words, they had made grants or paid for programs. Sometimes they thought the project might result in future savings to the institution, and sometimes they did not expect measurable cost savings. Although grantmaking clearly is a valuable contribution, for the purposes of this paper, we were particularly interested in examples of something much narrower: deployment of capital that was intended to advance social determinants of health while producing at least a return of the amount invested.

As demonstrated in the previous section, there are a variety of ways that health institutions can contribute to the community investment system, in addition to providing return-seeking capital. Hospitals deploying their resources in ways described in the table above, for example by making grants for market studies or loss reserves, should be counted as participating in the community investment activities. Similarly, hospitals that provide land, or guarantees, or sign master leases that make real estate investments possible, might well be included as engaging in community investment, even though they may not have deployed capital in a transaction.

This section begins with a look at the motivations cited by the institutions we interviewed for engaging in community investment activities, and then turns to the choices they made when shaping their programs.

Motivations

The health institutions we interviewed cited several reasons for engaging in community investment activities as a way to improve upstream determinants of health. These reasons were not mutually exclusive, and sometimes different reasons were given by different people in the same institution.

We were particularly interested in deployment of capital that was intended to advance social determinants of health while producing at least a return of the amount invested.

Motivations for Engaging in Community Investment

“It’s our mission”: Some of the hospitals we interviewed were clear that community investment was simply another way to advance their mission of improving health by reducing health disparities, lowering the incidence of chronic disease, and improving life expectancy for disadvantaged populations. For institutions driven by mission, the question was not whether to invest in the community, but how much and in what ways to do so. The mission motivation was commonly cited by faith-based institutions, which spoke in terms of a moral imperative: “We stand with the poor.” But the mission motivation was also mentioned by other hospitals defining mission in terms of advancing health, rather than simply providing health care (e.g., “We distinguish ourselves through...improved health in the communities we serve”) (Gundersen Health System, 2017a).

Shared fate: Investing in the revitalization of communities surrounding a health institution’s campus not only can improve the wellbeing of local residents, but also can help institutions build trust, attract patients, recruit and retain staff, and increase property values for the institution and its neighbors. As institutions rooted in place, hospitals and health systems have an institutional interest in ensuring that the communities in which they are based are safe, stable, and vibrant (Norris & Howard, 2015; McGuire, 2016). Being viewed as a good neighbor fosters good relationships with local and state partners and community groups whose support may be required for facility zoning, capital investment plans, service approvals, or negotiation of Payments In Lieu of Taxes (PILOTs).¹² Several institutions we interviewed pointed to the fact that their institutions’ competitiveness depended upon the health and vitality of the city and neighborhood in which the institution was located. Participants in Cleveland’s Greater University Circle Initiative observed:

Institutions cannot thrive while their surrounding neighborhoods wither. A vibrant neighborhood contributes greatly to an institution’s competitiveness and viability. The combination of a successful institution within a vibrant neighborhood can help revitalize the economy of a city and a region because the institution and the neighborhood create an overall atmosphere of vitality that attracts investment, residents and visitors (Cleveland Foundation, 2014, p.19).

In the words of the Cooper Foundation, “we are an urban hospital in the heart of Camden. The future of our hospital is linked to the future of Camden” (S. Bass Levin, personal communication, November 18, 2015).

Strategic imperative: A few institutions viewed their investments as a way to “skate where the puck is going.” For these institutions, community investments were a way to gain experience in how the institution could affect the social determinants of health, in preparation for what they viewed as a coming shift in the healthcare industry towards paying for wellness rather than procedures.

As Jean McGuire (2016) of the Northeastern University Institute on Urban Health Research and Practice has written, “public and private payers have been shifting reimbursement approaches, even before additional incentives emerged from the Affordable Care Act. These arrangements are increasingly value-based and emphasize outcome-focused provision of care, increased quality, and risk assumption” (p. 20). She adds: “Current and future costs are pushing plans and providers upstream” (McGuire, 2016, p. 21). Particularly for institutions that are beginning to serve newly insured Medicaid beneficiaries or that were engaged in Accountable Care Organizations (ACOs), finding ways to address non-clinical aspects of their patients’ lives holds the potential to reduce costs and improve results.

¹² Charitable nonprofit organizations, including private universities, nonprofit hospitals, museums, soup kitchens, churches, and retirement homes, are exempt from property taxation in all 50 states. At the same time, these nonprofits impose a cost on municipalities by consuming public services, such as police protection and roads. Payments in lieu of taxes (PILOTs) are payments made voluntarily by these nonprofits as a substitute for property taxes. See Kenyon & Langley (2010).

Although a move from volume to value in healthcare is still a nascent trend and considerable uncertainty exists about how the field will evolve, some leaders believe that now is the time to experiment and learn from new approaches. The strategic imperative tended to be cited by hospitals focused on innovation; community investment was one of multiple experiments that could help the institution learn and evolve in an uncertain environment. As one interviewee put it:

Increasing innovative access points to care and making investments of this nature is part of our larger strategic plan to transform ourselves into an integrated health system (P. Perialas, personal communication, February 18, 2016).

Even at a time when the health sector is bracing for significant shifts resulting from changes in federal and state policy, the pioneer organizations were forging ahead with their investments in social determinants of health.

Institutions were interested in two types of metrics: improvements in health outcomes and financial returns. In general, this was viewed as an area where substantial additional work would be needed. A few institutions were tracking whether any of their investments might produce operational savings (e.g., reducing unreimbursed health costs). However, at present, this was viewed as largely uncharted territory: hospitals mentioned they were still uncertain what to look for, whether they were capturing the data that would indicate changes, were there to be any, and what timeframe would be required to see changes.

One institution that had a unique approach to achieving operational savings through community investment was Gundersen Lutheran Health System in La Crosse, Wisconsin. Gundersen made a commitment to sustainability in and around their headquarters, participating in regional energy partnerships with public and for-profit partners to operate dairy digesters, wind turbines, and a landfill gas-to-energy initiative. Local projects also include geothermal energy and a biomass boiler. Gundersen set out to make the air better for its patients to breathe, control rising energy costs and help the local economy. Gundersen is the first health system in the country to offset its fossil fuel use with locally-produced energy and conservation, a move that generates \$3 million in annual cost savings to the health system (Gundersen Health System, 2014).

Compliance: A few institutions mentioned that community investment might help them comply with payer requirements. For example, investing in service-enriched housing for homeless patients could reduce the likelihood of frequent readmission to hospital emergency rooms.

“Bang for the buck”: In addition to the reasons cited above, some interviewees mentioned that the direct and indirect financial returns generated by community investing made the programs sustainable, creating a greater impact (“bang for the buck”) than a one-time grant could achieve. For example, hospitals that had made loans to nonprofit organizations or CDFIs tended to reinvest the proceeds of those loans when they were repaid. As a result, they were able to develop more units of affordable housing or support the expansion of more small businesses. An example of this approach was the Cooper Foundation’s program to acquire and renovate properties in the 10-square block area around the campus, sell them to local residents who have undergone financial training, and recycle the proceeds from home sales into future acquisitions.

Investment Program Choices

Health institutions that decide to use financial investments as a way to strengthen their communities and improve social determinants of health face an enormous array of choices about how to proceed:

- **Programmatic focus:** They can focus on a single social determinant of health, such as access to nutritious food, or work on multiple determinants through a portfolio of investments in food, education, housing, and job development.
- **Direct investments vs. investments through intermediary structures:** They can invest directly in individual projects, for-profit enterprises or not-for-profit organizations. They can also invest in multiple projects through intermediaries like banks and CDFIs, funds, or structured investment pools.
- **Source of funds and expected returns:** Depending on the source of their investment funds, health institutions will have different expectations for financial return and social impact, tolerance for risk, and procedures for decisionmaking.
- **Financial instrument:** They can choose to invest in loans, bonds, equity, tax credits, guarantees, cash deposits or, theoretically, in pay for performance structures.
- **Degree/type of collaboration:** They can work on their own, in concert with other “eds and meds,” and/or with community partners and residents.

The following sections chronicle and compare the experience of some of the institutions we interviewed on these dimensions.

Programmatic focus

Some health institutions we interviewed selected a focus based on their understanding of community needs or their read of evidence regarding the efficacy of particular upstream interventions. A website called *What Works for Health* provides information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors that are known to affect health.¹³

Other institutions relied on the communities they served to identify their priorities or areas of highest need. For some nonprofit hospitals, the process of preparing a formal Community Health Needs Assessment influenced this choice. Two examples from multi-site systems suggest how the choice of focus can play out:

Trinity Health, a large Catholic health care system which operates across the U.S., with 93 hospitals and over 120 long-term and continuing care locations in 22 states had a history of investing in affordable housing and healthy food. When it unveiled its “Transforming Communities Initiative,” a competition which invited hospitals in

¹³ A collection of materials distilling the evidence for various interventions can be found in the County Health Rankings & Roadmaps Action Center, University of Wisconsin Population Health Institute (2016).

its system to undertake community collaborations aimed at improving health and well-being, it chose to concentrate on reducing smoking and obesity as well as pursuing other unmet health needs identified by CHNAs (Trinity Health, 2017b).

Dignity Health, the fifth largest health system in the country, with 39 hospitals in California, Nevada and Arizona, as well as other facilities in 21 states, targets its investments broadly to revitalize low-income communities, empower low-income people to create, manage and own enterprises, demonstrate a commitment to healthy communities and safeguard the environment (Dignity Health, 2016a).

Affordable housing tends to be the best developed sector of the community investment arena, with experienced developers and lenders active in many parts of the country. Hence, hospitals are more likely to find affordable housing transactions underway in their communities than other types of community investments. However, community investment encompasses a much wider set of possibilities than just housing, and health institutions interested in small business development, access to nutritious food, early childhood education, community facilities, and other components of a healthy community can find willing partners in these areas as well.

Direct vs. intermediated investments

Some hospitals deploy their capital by selecting the individual projects, enterprises or organizations that best match their geographic and impact area objectives. The most common type of individual projects that health institutions mentioned investing in directly were affordable housing developments. But they were not the only type. For example:

Johns Hopkins partnered with Walgreens to locate a “Well Experience” store near its medical campus, bringing new health and wellness services to the community and serving Hopkins staff and students. In addition to offering a selection of healthy food, the store is partnering with the Johns Hopkins Medical faculty to offer student health services, a Take Care clinic for the community, and smoking cessation programs. According to John Rothman, MD, dean of JHU School of Medicine, the “collaboration with Walgreens creates the opportunity to offer innovative, locally-based health care services while further weaving Johns Hopkins Medicine into the fabric of East Baltimore” (Walgreens Co. Corporate Communications, 2013). Hopkins mitigated risk for Walgreens, which would not otherwise have opened a store in that location, investing \$500,000 and agreeing to bear a share of losses in exchange for a split of revenues. This example also demonstrates the risk-absorbing characteristic of some health institution investments; Hopkins’ willingness to share losses made Walgreens’ investment possible.

Another example of a direct investment came from Children’s HealthSM, the leading pediatric health care system in North Texas and the eighth-largest pediatric health care provider in the nation.

Community investment encompasses a much wider set of possibilities than just housing, and health institutions interested in small business development, access to nutritious food, early childhood education, community facilities, and other components of a healthy community can find willing partners in these areas as well.

In December 2015, Children’s Health made a \$5 million strategic investment in GoNoodle, the “leading provider of online movement videos and games helping teachers and parents get kids moving” (GoNoodle, 2015). GoNoodle encourages children to avoid the sedentary lifestyles that are a risk factor for chronic disease, generating 3 billion minutes of physical activity in the past year. The sponsorship brings GoNoodle to elementary schools in multiple school districts in Texas, where Children’s Health is based. It also enables GoNoodle to expand its sales and marketing efforts and accelerate product innovation.

This investment was of particular interest because, unlike most of the investments discussed in this paper, the investment targeted social determinants of health but was not specifically place-based.

Rather than making direct investments, many health institutions chose to work through funds or intermediaries (such as CDFIs) that aggregate and deploy capital across multiple projects. For example, Dignity Health has been an active investor in CDFIs and loan funds, such as the Healthy Futures Fund¹⁴ and the California FreshWorks Fund,¹⁵ which bring together multiple investors and projects. Working through intermediaries enables health institutions to diversify their portfolio, reducing the risk that any one project or company might fail. It also reduces the need to source and review individual projects, which can be burdensome and time-consuming for institutions with limited investment staff.

Source of funds and expected returns

Funds for investment may come from a variety of sources within the health institution, including endowments or pension plans, affiliated foundations, community benefits programs or operating budgets. **The source of funds affects the institution’s risk tolerance and target returns, which can range from zero to return of principal to risk-adjusted market rates.** For example, investments coming from an endowment or pension fund typically are deployed at or near market rates of return, while investments made with operating or community investment dollars may prioritize social over financial returns. What elements “count” as part of those financial returns is a decision each institution makes. The return might be calculated narrowly, based only on payments of interest and dividends or capital gains, or it might also factor in savings or avoided costs in the provision of care or non-clinical expenses, or elements such as property appreciation.

Financial instruments

Although many hospitals we interviewed, when speaking about their investments in social determinants, actually meant they made grants with no expectation of financial returns, the most common form of investment as we define it in this paper appears to be loans. But loans are certainly not the only form that investments take. Dignity Health, with one of the larger community investment programs in the field, has employed a variety of financial instruments. In addition to providing secured and unsecured loans, guarantees and lines of credit for terms up to seven years, Dignity Health also makes below-market rate deposits in

¹⁴ The Healthy Futures Fund supports the colocation of primary care health services with affordable housing. For more information, see www.healthyfuturesfund.org.

¹⁵ FreshWorks invests in healthy food projects in California. See www.cafreshworks.com for more information.

credit unions and Community Development Financial Institutions to enable them to make small business and affordable housing loans to particular projects. It also purchases stock in community development banks.

Other financial arrangements are also possible. As noted above, Dallas Children's has made equity investments in companies whose products benefit children. In Cleveland, University Hospitals and the Cleveland Clinic helped establish and capitalize employee-owned companies that supply solar energy, lettuce and other greens and herbs, and laundry services.

As a for-profit company, UnitedHealth Group has used its ability to leverage tax credits to advance the social determinants of health.

UnitedHealthcare, the business that provides health benefits to nearly 5.7 million Medicaid beneficiaries through programs in 24 states and the District of Columbia, covers 27.6 million individuals through individual and employer-sponsored health plans and provides healthcare to nearly one in five seniors eligible for Medicare, invested \$50 million each in Low Income Housing Tax Credit (LIHTC) funds managed by Greater Minnesota Housing and Enterprise Community Investment, resulting in development of multi-family rental units for very low-income and special needs households (UnitedHealth Group, 2016; Crosby, 2013; UnitedHealth Group, 2011).

Although we found no examples of health institutions having completed investments, some hospitals are exploring "pay for performance" or "Social Impact Bond" structures that are being created to foster the adoption of evidence-based strategies that improve social outcomes while reducing costs. Strategies like these are being used to reduce homelessness and extend quality early childhood education to more youngsters, among other goals.

Degree/type of collaboration

The Cooper Foundation's work in Camden, cited above, is an example of how a single health institution can move a community towards investment readiness.

There also are multiple examples of health institutions collaborating with other health institutions and/or with public, private, and non-profit partners on community-focused initiatives. Some prominent examples include:

- **Cleveland**, where University Hospitals, the Cleveland Clinic, the Cleveland Community Foundation, Case Western Reserve University, and the city have joined together in an effort called the Greater University Circle Initiative (GUCI) to rebuild some of the most disinvested neighborhoods in Cleveland. GUCI has charted a redevelopment plan for seven adjacent low-income neighborhoods. It combines extensive planning and physical redevelopment with an economic development effort that invests in creating jobs at employee-owned cooperative businesses such as a laundry, greenhouse, and solar installation firm (Cleveland Foundation, 2014).

- **Detroit**, where the Henry Ford Health System and Detroit Medical Center joined with Wayne State University as funders and investors in Midtown Detroit Inc. (MDI), a nonprofit planning and development organization that supports the physical maintenance and revitalization of the neighborhood through new mixed income housing, commercial activity, and infrastructure investments. MDI is viewed in Detroit as being a critical force in the success of the neighborhood, having facilitated funding for over 40 residential developments resulting in over 1,000 new units of housing and having provided technical assistance and financing to 30 local businesses (S. Mosey, personal communication, June 1, 2016; Midtown Detroit, 2017).
- **Baltimore**, where Johns Hopkins catalyzed formation of the Homewood Community Partners Initiative (HCPI), an effort focused on the ten neighborhoods around the Homewood campus that involves the health system as well as the university. HCPI has worked with the Central Baltimore Partnership, 15 community and neighborhood organizations, and other stakeholders such as foundations and anchor institutions to develop an overlay plan for the area; identify 29 priority projects including blight removal, housing and commercial development; and invest and raise funds for project implementation (Reiner, 2014).

Beyond the places mentioned here, more than 70 communities are participating in philanthropically funded initiatives such as the BUILD Health Challenge, Invest Health, and Bridging for Health, which encourage partnerships between hospitals and other institutions to improve the social determinants of health.¹⁶

Construction of houses in the area of the Jackson Medical Mall in Jackson, MS.



¹⁶ See www.buildhealthchallenge.org, www.investhealth.org, and <http://ghpc.gsu.edu/about-us/> for more information about these initiatives.

Health systems interviewed for this paper offered many insights about how health institutions can help communities formulate and develop investments that improve health.

They emphasized that many hands are required for this work, and that health systems should plan to collaborate with philanthropy, state and local government agencies (including those in planning, public health, education, community development, and criminal justice), nonprofit human service agencies, neighborhood-based organizations, community development corporations and CDFIs. As Trinity Health recently put it:

Because the roots of complex health issues often originate in community environments, solutions are likely to require a collaborative approach that engages, for example, government agencies or public school districts, a variety of community- or faith-based organizations, and/or businesses/employers (Trinity Health, 2015).

Interviewees urged health systems to convene these partnerships when others will not, but to be ready simply to join in when other stakeholders step up to lead. They urged patience and commitment to trust-building processes that could take time to bear fruit.

Leveraging Non-Financial Assets

Although the preceding sections focused on ways that health institutions can deploy their financial resources, hospitals and health systems participating in the community investment system can leverage other assets as well. Health institutions are important anchor institutions—they are often one of the largest employers in cities, they spend billions of dollars procuring goods and services for their operations, and they are significant landowners, investing in and around their campuses in a variety of facilities (Norris & Howard, 2015; Zuckerman, 2013). By making recruitment, procurement, and real estate decisions strategically, considering not only internal institutional needs but also the interests of the surrounding communities, health institutions can create “win-win” outcomes that improve property values, facilitate the flow of capital to strengthen neighborhoods, and create better health outcomes for local residents.

Consider land, for example:

...anchor institutions are prime real estate developers. Virtually every month, the *New York Times*’ “Square Feet” section chronicles a hospital...development project that has transformed large swaths of abandoned or under-used land and breathed new life into downtown areas. Oft cited examples include University Circle in Cleveland or Midtown Detroit, where...medical facilities have proven to be critical long-term partners for urban revitalization and economic growth (Kleiman et al., 2015, p. 4).

Health institutions sometimes find creative ways to use the land they own to benefit their communities:

Health institutions sometimes find creative ways to use the land they own to benefit their communities.

When the 305-bed Stamford Hospital began planning a major expansion, it hoped to build a large new state-of-the-art addition to its facility. The hospital owned various pieces of real estate in the nearby neighborhood, but none were contiguous with its existing campus. Meanwhile, Charter Oak Communities (COC), a public-private entity that evolved out of the Stamford Housing Authority, was exploring ways to replace its outdated public housing complexes on the West Side, building several lower density complexes of mixed-income housing without displacing tenants in good standing. Because the anticipated project would reduce density and add market-rate and middle-income affordable housing, one-for-one replacement would require more land than COC owned at the time. Leaders of the two institutions came up with a novel plan: a land swap. As a result of the swap, COC exchanged the public housing site adjacent to the hospital for hospital-owned property elsewhere in the neighborhood (Miller, 2016).

Institutions can obtain needed **goods and services**, from office space to catering services, in ways that contribute to the viability of local businesses or commercial developments.

To spur local development, Johns Hopkins decided to move certain functions off campus and sign leases strategically so that developers of projects considered important could secure financing and speed their lease-up. This approach has yielded significant benefits for surrounding neighborhoods. “The real estate office at Johns Hopkins thinks explicitly about how their decisions can serve not only the institution, but the community as well. We ask: what do we have in our control that we can leverage?” (A. Frank, personal communication, December 2, 2015)

Hopkins has also used its **name and its purchasing power** to help create local jobs and amenities:

- When Marriott was considering building a hotel in the area, Hopkins agreed to permit the use of its name. As a result, the “Marriott Residence Inn at Johns Hopkins Medical Campus” was able to secure financing for an \$80 million, 194-room property, creating jobs for the community (A. Frank, personal communication, December 2, 2015).
- In a similar vein, the community near the East Baltimore campus of Hopkins was interested in attracting a restaurant. When a restaurant identified as desirable by the community hesitated due to concerns about the level of business, Hopkins gave the restaurant a three-year guarantee of catering contracts to offset potential early losses. The restaurant hired locally and is doing well, and Hopkins had no incremental cost from the deal (A. Frank, personal communication, December 2, 2015).

Another strategy to stimulate the local economy in neighborhoods with high levels of vacancy and poorly maintained housing stock is to offer incentives to hospital employees to live near their work, sometimes termed as **“live local”** initiatives. Such incentives can contribute to employee satisfaction, reduce housing and transportation costs for workers, help remediate blight, and create mixed income neighborhoods, with greater opportunities for residents.

Health institutions in Cleveland and Detroit have sponsored successful “Live Local” programs for employees. Through the Greater University Circle Initiative, for example, hospital employees are eligible for a forgivable \$20,000 loan to purchase a home, an additional \$10,000 forgivable loan for families with incomes under \$150,000, one month’s rental payment for employees signing a lease, and up to \$8,000 in matching funds for employees making exterior improvements to homes in the neighborhood. As of 2013, 48 employees had purchased and 87 employees had rented homes in the targeted neighborhoods (Cleveland Foundation, 2014, p. 51-53).

Health institutions have a unique contribution to make with regards to **data**, an important aspect of collective impact initiatives. Given their IT capabilities, their patient and claims data, and their obligation to evaluate community health every three years, health systems are well-positioned to play the role of data provider in the community ecosystem. Health institutions can help galvanize community action by collecting and disseminating information on threats to health and wellness, including pollution, crime, lack of access to clean water, healthy food, and green space. As part of their CHNA process, they may sponsor community asset maps or analyze data to identify populations and hot spots most at risk. They may forge data sharing agreements with public agencies or with school districts to create a more comprehensive picture of community wellness.

Finally, health institutions may bring particular credibility and skill to organizing and advocating for **policy and practice changes** that facilitate investment and improve social determinants of health. Such advocacy helps to improve the “enabling environment” in which community investments take place. For example, some health institutions have participated in coalitions working to strengthen public transit options to facilitate access for patients and employees. Others have used their fundraising capacity and relationships to help raise money for projects from city and state government or from foundations.

As a major employer in Maryland and a key anchor institution in Baltimore, Johns Hopkins is an important source of strength and influence. According to Andy Frank, Special Advisor to the President on Economic Development, “We’re leveraging all the institution’s resources—real estate staff, IT staff, government relations—we’ve pressed people into service on behalf of the neighborhood” (A. Frank, personal communication, December 2, 2015). The institution has used its expertise to assist with fund-raising for important projects in the community and has gone to the legislature to request acquisition and predevelopment money from the state.

Health institutions may bring particular credibility and skill to organizing and advocating for policy and practice changes that facilitate investment and improve social determinants of health.

Key Success Factors for Health Institution Efforts

Getting beyond clinical practice to focus on investments in the social determinants of health represents a major change for institutions that have long viewed their role more narrowly. As one expert put it, "...the focus and cultural change needed within their institutions is significant....it's hand-to-hand combat. It's not a policy issue; it's breaking bureaucracy down" (Omar Blaik as cited in Kleiman, 2015, p. 15).

Earlier in the paper, we described the various motivations that institutions cited for embarking on this work at all. Based on our interviews and review of the literature, we have identified several factors that appear to be critical in getting health systems to start and succeed with interventions in the community investment system. These include:

- High level institutional champion and support;
- Understanding the range of possible interventions and investment approaches;
- Staff with non-traditional experience;
- Leveraging staff interest and capacity where it exists;
- Narrative that ties efforts to mission/goals;
- Finding partners in the community and taking time to build trust;
- Engaging the community in defining priorities; and
- Patience, modesty, and willingness to listen.

It is easiest for institutions to make such significant changes when strong leadership comes from the top. We heard again and again in our interviews with Catholic health systems about the important role played by nuns on their boards, who insisted that community health was at the very core of the institutional mission. In other cases, this vision came from leaders who believed that the evolution of the health sector created a strategic imperative for institutions to change their focus. Regardless of the animating force, a well-placed institutional champion was a common denominator among the organizations we interviewed.

Understanding what is possible—how community investment could influence social determinants of health, how such investments would benefit the health institution, and what roles health institutions could play—was essential to moving efforts from vision to implementation. Many of the institutions we interviewed have fielded numerous calls from peers interested in learning what they had done, how they had approached the work, and what they had learned. Organizations like the Build Healthy Places Network and the Democracy Collaborative, among others, have published cases and tools and fostered formal and informal information sharing.¹⁷ Numerous multi-site initiatives are supporting

¹⁷ See Appendix C for a list of relevant references.

hospitals and communities as they explore the possibilities. The appetite for opportunities to learn together appears considerable, both among institutions already engaged in the work, as well as those wondering where to begin.

One surprising finding was the number of health institutions at the forefront of community investment that had recruited staff with backgrounds from outside health care delivery fields to lead the work. Some of these individuals had served in public sector roles such as economic development, public health, or planning. In particular, having someone on the core team with deal experience seemed to be helpful.

In many cases, hospitals found that staff members were eager to participate in community investment activities. Starting from staff who demonstrated interest and drawing on the skills that exist across the organization—from IT to real estate to finance to executive leadership—enabled health institutions to contribute to the community investment system in ways that supported and went beyond financial resources.

Telling the story of the effort to invest in community health in ways that link it closely to the mission of the institution was important both in gaining support internally and in explaining it to external audiences. Highlighting and celebrating small victories on an ongoing basis helped fuel and sustain momentum.

Interestingly, starting with a clear goal or set of metrics for the intervention did not appear to be a critical success factor. Many interviewees commented that this work is emergent, and defining the right indicators for measuring these efforts is a work in progress. Although they are monitoring their initiatives carefully to assess outcomes in multiple dimensions—improved health, operational savings, financial returns—it was still too early to know what the appropriate metrics would be. This is an important area for continued work.

Finding strong local partners enables health institutions to extend and embed their work into the community. Intermediaries, such as a properly funded community development corporation or CDFI “are more nimble than large anchor institutions and thus able to negotiate among numerous partners,” while community foundations or other place-based philanthropies can be steady and neutral conveners (Dever et al., 2015, p.6).

The adage that “change proceeds at the speed of trust” appeared to be true in the case of health institutions investing in building community health. Building relationships between the institutions and community organizations and residents took time and commitment. Getting the right people from government, philanthropy, and other institutions to the table was also critical. As one interviewee explained:

We also started a quarterly meeting of everyone involved in housing and community development in our neighborhood as well as city, state, county officials, so every quarter our nonprofit partners have the ear of government. The meetings are purposely informal; developers report on what they're doing and what their barriers are. Right in the room are the people who can help. We all have common problems and this is a great place to discuss and solve them (S. Bass Levin, personal communication, November 18, 2015).

The adage that “change proceeds at the speed of trust” appeared to be true in the case of health institutions investing in building community health.

One interesting finding concerned the presence of multiple hospitals in the same geography. Although some observers suggested that hospitals would be more motivated to invest in community health when they are the only health provider in the area, and therefore would be the sole beneficiaries of improved outcomes, we found robust examples (such as Cleveland and Detroit) where institutions that were putatively competing for patients cooperated on ambitious plans to revitalize neighborhoods and invest in community health. As one expert put it:

The Greater University Circle Initiative has national significance...[because] it shows how large institutions can overcome decades of isolation and work together on matters of common concern and interest in a way that creates shared value for all stakeholders...The role played by the Cleveland Foundation...shows that the most important contribution that foundations can make to community change is not just providing money, but in brokering and strengthening connections and relationships between and among other important civic actors (Charles Rutheiser cited in Cleveland Foundation, 2014, p.90).

Many interviewees emphasized the importance of listening to community voices when defining priorities. As one interviewee put it, "You can't just come in with your good idea." Another quoted a motto of community organizing: "Nothing about us without us." Others emphasized the importance of being mindful of context and building from strength, using an asset-based model rather than a "cookie cutter" approach imported from elsewhere. Some interviewees pointed out that overcoming the legacy of past disappointments and what have sometimes been contentious relationships between health institutions and communities requires openness, commitment, and follow through.

The Truman Medical Center has the busiest adult emergency room in Kansas City, MO with over 60,000 visits annually. A notable number of these visits are the direct result of violence and as such, the hospital works with community organizations to mitigate violent responses while friends and family are gathered at the hospital.



For the Community: Engaging Health Institutions

Many communities view hospitals and health institutions as important stakeholders in efforts to improve the social determinants of health. Yet in most places, these actors have remained outside of community development networks and community investment transactions. According to our research on community investment, one of the best ways to grow the capacity of the community system to deliver projects with social benefit is to expand the complement of institutions and actors who are engaged as potential partners or resources. This section is meant to provide guidance to practitioners who seek to engage health institutions in community development and investment activities. More detailed information tailored to different types of stakeholders, including residents, community development professionals, government, and philanthropy is available at the County Health Rankings and Roadmaps Action Center website (<http://www.countyhealthrankings.org/roadmaps/action-center>).

Informing the Discussion

An excellent starting point for anyone seeking to engage a health institution is to obtain and review its Community Health Needs Assessment (CHNA), which the two-thirds of hospitals that operate as tax-exempt charitable organizations are required by the Affordable Care Act to conduct and publicize at least once every three years (Rosenbaum, 2016). The CHNA must assess the health condition of the local community for each nonprofit health facility. It is meant to consider:

[N]ot merely the need for health care, but the “requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community.” This must include the need to “prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community” (Rosenbaum, 2016, p.5).

The CHNA, which is generally available on a hospital’s website, identifies the community that a facility serves, and prioritizes the most pressing health challenges facing that community. Hospitals are also responsible for producing a plan to address the health challenges. Implementation strategies, which must be updated annually, must either be attached to Schedule H of the hospital’s 990 filing with the IRS or made available through a web link (St. Luke’s Health Initiatives, 2015, p.6). These documents can inform and shape the “ask” of a hospital’s staff by clarifying the hospital’s perspective on community challenges and institutional priorities. In the words of one guide for communities, “If a hospital has identified obesity and injury prevention as priorities, a discussion about childcare facilities or air quality may not be fruitful” (St. Luke’s Health Initiatives, 2015, p.10).

An excellent starting point for anyone seeking to engage a health institution is to obtain and review its Community Health Needs Assessment (CHNA).

In preparing the CHNA, hospitals are required to solicit input from community residents and public health experts. By noticing when the CHNA was conducted, community leaders may identify opportunities to participate in dialogue and build relationships with the hospital.

Starting from the Top

Many practitioners naturally turn to community benefits officers or community affairs departments when contacting hospitals. These can be important resources. However, as hospitals grapple with the changing context in the healthcare sector, taking on the challenge of improving social determinants of health is becoming a strategic imperative for many. Leadership from top executives and from the board is an important accelerant of these strategic shifts. Unless a hospital has already authorized a particular executive to play an active role in community development and investment activities (as some institutions at the leading edge of practice have done), it may be best to leverage whatever relationships already exist in the community to reach out to the CEO or another senior executive. Even if these executives do not themselves become involved in a partnership or project, they can help community leaders navigate through the health institution to the right party.

One way to assess how strategically a health institution is using its community benefits function is to examine Schedule H of the hospital's IRS Form 990, available online. Tax-exempt health institutions are required to specify the types of activities they have supported in the past. Two parts of Schedule H have particular relevance to leaders for healthy community design, implementation and policy: Part I: Financial Assistance and Certain Other Community Benefits at Cost, line 7e is where hospitals list community benefit investments and activities that are not medical care; Part II: Community Building Activities provides more specific information about investments and activities that are outside the medical care industry, such as affordable housing development and coalition building (St. Luke's Health Initiatives, 2015, p.12).

Although a health institution's strategy will be determined by many factors, understanding what "counts" for the purposes of calculating community benefit and comparing it to a specific institution's history can be instructive. Hospitals are permitted to recognize "community building activities," including physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development as eligible community benefit expenses if they submit evidence documenting the relationship between such investments and health improvement (IRS Schedule H [Form 990], Hospitals cited in Rosenbaum, 2016, p.3). On the form for reporting community-building activities, a hospital's 990 Schedule H Part II, the following lines are itemized (St. Luke's Health Initiatives, 2015, p.14):

As hospitals grapple with the changing context in the healthcare sector, taking on the challenge of improving social determinants of health is becoming a strategic imperative for many.

Physical improvements and housing: The provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors, and the development or maintenance of parks and playgrounds to promote physical activity.

Economic development: Assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.

Community support: Child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs and disaster readiness, and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

Environmental improvements: Activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.

Leadership development and training for community members: Training in conflict resolution; civic, cultural or language skills; and medical interpreter skills for community residents.

Coalition building: Participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

Community health improvement advocacy: Efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.

Community leaders may wish to consider these categories, as well as some of the examples provided in this paper, when framing their approaches to health institutions.

Knowing What to Ask For

In the words of a recent New York University report, “We are recommending... [an] approach...based on identifying shared interests, and on co-creating ambitious goals and working together to achieve them” (Kleiman et al., 2015, p.5). There is a spectrum of what to ask for, ranging from “please invest in this already cooked transaction” to “please join our partnership and come to all of our meetings forever.” Although there is no single right answer about where to land on this spectrum, a few points are worth considering:

- As this paper suggests, **a health institution’s money is not its only valuable resource.** Access to the institution’s campus and other land, its development expertise, its data, relationships and reputation, as well as its purchasing and other operational capacities may significantly expand the capacity of the community investment system to deliver transactions that improve the social determinants of health. Research, listen, and explore what the possibilities are before narrowing too firmly on a single “ask.”
- **Consider the priorities** of the health institution and frame “the ask” in terms of what benefits it will have both for the institution and the community. Will engagement in a partnership help the institution develop or deepen important relationships? Will it contribute to reducing costs? Will it enhance the institution’s reputation or public profile?
- **Ask about process.** Who is making the decisions that are most relevant to your effort? What are the factors that are shaping those decisions?
- **Probe what is possible.** Prepare several options and if the preferred alternative does not seem to be a good fit, explore alternatives. Understand the pressures and limitations that the institution is facing and see how the “ask” can be tailored to address them.

As relationships evolve, it may be possible to engage more broadly and deeply with the health institution, putting more of its assets to work for community health. Getting started is key!

As relationships evolve, it may be possible to engage more broadly and deeply with the health institution, putting more of its assets to work for community health. Getting started is key!

Conclusion

For people to lead healthy lives and thrive, they must have access to clean air and water; safe places to walk, bike and play; fresh food; stable, affordable housing; good education; economic opportunity; and social connections. Yet in so many communities, a legacy of discrimination and disinvestment leaves people without the ability to make healthy choices. The community investment system takes on the challenge of transforming these places.

Health institutions have the potential to be hugely valuable actors in the community investment system, bringing their investment dollars and leveraging their operations and expertise to improve community health. If we as a society are to confront what has been called the “triple threat”: the highest per-capita health spending in the world, relatively poor health outcomes; and significant racial, ethnic, and socioeconomic disparities in health and health care that leave burdened populations and communities vulnerable to preventable mortality and morbidity,” health institutions can lead the way to a greater focus on the upstream social determinants of health (Rosenbaum, 2016, p.2). The pioneers are already at work, deepening and expanding their own institutions’ practices, and they are eager to share lessons learned with their peers. We hope this paper has stimulated your appetite to build institutional knowledge, data, capacity, and relationships, and explore how you can contribute to moving this work forward. We invite you to share your feedback.

Appendices

Appendix A: Examples of Pioneering Health Institutions Engaging in Community Investment

Throughout the paper, we have included examples of health institutions that have engaged in community investment activities, deploying capital, leveraging relationships, lending real estate expertise, or contributing in other ways as described in the table on pages 11-12. Below, we have included short case studies on a number of the institutions we interviewed, providing additional context for their activities and decision-making in one place.

In addition to the material we have included below, more useful information on community investment activities by other health institutions may be found through the Build Healthy Places Network, which has a set of “Community Close Ups” including Stamford Hospital (CT) on the Vita Health & Wellness District (Miller, 2016) and Children’s Hospital of Philadelphia (PA) on the Community Health and Literacy Center, (Miller, 2015) as well as relevant articles in their Crosswalk Magazine, such as the work of Nationwide and Cincinnati Children’s Hospitals to invest in housing in surrounding neighborhoods (Ray, 2017).

The Democracy Collaborative’s anchor work on hospitals is also available at <http://hospitaltoolkits.org/> and includes cases on Bon Secours Health System’s (multi-state) system-level Community Investments program, as well as Henry Ford Health System and Detroit Medical Center (MI) on coordinated investment in Midtown Detroit (Zuckerman & Parker, 2016).

Children’s Health (Dallas, TX)

Children’s Health is a private, not-for-profit pediatric health care system in Texas that includes two flagship hospitals, Children’s Medical Center Dallas and Children’s Medical Center Plano, as well as the Children’s Medical Center Research Institute at UT Southwestern, a telemedicine network, multiple specialty and primary care practices, and home health and physician services. As of 2015, the system, with nearly 7,000 employees, including 1,100 medical staff, cared for more than 280,000 patients (Children’s Health, 2016a). The mission for Children’s is: “To make life better for children” (Children’s Health, 2016b).

In December 2015, Children’s Health made a \$5 million strategic investment in [GoNoodle](#), the “leading provider of online movement videos and games helping teachers and parents get kids moving” (GoNoodle, 2015). GoNoodle encourages children to avoid the sedentary lifestyles that are a risk factor for chronic disease, and use of its videos generated 3 billion minutes of physical activity in 2015. The sponsorship brings GoNoodle to elementary schools in multiple school districts in Texas, where Children’s Health is based. It also enables GoNoodle to expand its sales and marketing efforts and accelerate product innovation.

Appendix Content

Appendix A: Examples of Pioneering Health Institutions Engaging in Community Investment

Appendix B: Interviews

Appendix C: References

According to a Children's Health executive, "Increasing innovative access points to care and making investments of this nature is part of our larger strategic plan to transform ourselves into an integrated health system" (P. Perialas, personal communication, February 18, 2016).

The Cooper Foundation

The Cooper Foundation, based in Camden, New Jersey, is the philanthropic arm of Cooper University Health Care, which offers health services in New Jersey, Pennsylvania, and Delaware. Cooper operates an academic specialist hospital, Cooper University Hospital, in addition to three urgent care centers, a surgery center, and more than 100 outpatient offices with more than 2,000 nurses and physicians (Cooper Foundation, 2017). Cooper's main location, the Health Science Campus in Camden, is located in a neighborhood suffering from high levels of disinvestment and poverty.

Starting with an initial effort with one of its nonprofit housing partners in Camden to acquire and rehab six homes on a historic block directly across from the hospital, the Cooper Foundation has led a variety of efforts to revitalize the surrounding community. It helped the community create a vision plan for redevelopment. It raised and invested more than \$4 million for neighborhood revitalization activities, including partnerships with local nonprofit organizations to acquire and renovate over 40 properties in the 10-square block area around the campus, and then sell them to local residents who have undergone financial training. Proceeds from home sales are recycled into future acquisitions. In addition, this has leveraged the construction or rehabilitation of another 75 homes or condos by Cooper's housing partners to improve the neighborhood. Cooper has taken advantage of a New Jersey program called the Neighborhood Revitalization Tax Credit Program to raise portions of these funds to complete revitalization projects in the neighborhood. The Foundation has been active in park design and maintenance, as well as in efforts to improve safety and create a new school for the neighborhood (S. Bass Levin, personal communication, November 18, 2015).

Cooper also hosts a quarterly meeting of all stakeholders involved in housing and community development in their neighborhood, as well as city, state, and county officials, so "every quarter, our nonprofit partners have the ear of government" (S. Bass Levin, personal communication, November 18, 2015). In the words of a Cooper Foundation executive, "We are an urban hospital in the heart of Camden. The future of our hospital is linked to the future of Camden" (S. Bass Levin, personal communication, November 18, 2015).

Dignity Health¹⁸

Dignity Health, formerly Catholic Healthcare West, is the fifth largest health system in the country, with 39 hospitals in California, Nevada, and Arizona, as well as other facilities in 21 states and 60,000 caregivers and staff (Dignity Health, 2017). It serves many communities in disinvested places. With a commitment to "making a positive impact on the social determinants of health, particularly on the health of those economically-disadvantaged communities served by Dignity Health hospitals," Dignity Health invests directly and indirectly in nonprofit organizations running community development programs benefiting underserved populations, including the economically poor, women and children, mentally or physically disabled, or other disenfranchised populations (Dignity Health, 2016a).

¹⁸ See also: <http://hospitaltoolkits.org/investment/case-studies/dignity-health/>.

Dignity encourages investments that target resources to low-income communities; revitalize urban or rural areas; empower low-income people to create, manage, and own enterprises; demonstrate a commitment to healthy communities; and safeguard the environment (Dignity Health, 2016a).

Dignity provides secured and/or unsecured loans, guarantees, and lines of credit at or below market rate to nonprofit borrowers and intermediaries for terms up to seven years. It participates in loan funds such as the Healthy Futures Fund,¹⁹ the Living Cities Catalyst Fund,²⁰ and FreshWorks,²¹ which bring together multiple investors and projects. It makes below-market rate deposits in credit unions and Community Development Financial Institutions to enable them to make small business and affordable housing loans to particular projects, and can also purchase stock in community development banks (Dignity Health, 2016a).

Since its inception in 1990, the Dignity Health Community Investment Program has had a total loan volume of \$164 million, resulting in affordable housing and assisted living facilities for seniors, access to shelters for the homeless discharged from hospitals, access to capital for more than 55 small businesses, and healthy food projects (Trust for America's Health, 2015 and P. Bravo, personal communication, October 13, 2016). The investment policy set by Dignity's board allows up to 5 percent of assets from funded depreciation to be used for community investments, of which \$100 million is presently being allocated. Dignity has found that sourcing and reviewing projects that fit the institution's guidelines can be staff-intensive; additional funds could be deployed if staff capacity increased (P. Bravo, personal communication, December 16, 2015). Although community health staff at Dignity facilities help source investments, the investment program is in addition to Dignity's traditional community health activities.

Dignity's Community Investment Program fits squarely in its mission as a health institution to "dedicate our resources to...partner with others in the community to improve the quality of life" (Dignity Health, 2016b).

Gundersen Lutheran Health System²²

Gundersen Lutheran Health System is a not-for-profit healthcare system in La Crosse, Wisconsin, that serves patients in three states and 19 counties with a teaching hospital in La Crosse, four regional hospitals, and over 25 regional medical clinics. In 2014, Gundersen Lutheran became the first healthcare system in the U.S. to become energy independent (Gundersen Health System, 2017c).

In 2008, Gundersen "made the commitment to improve the health of the communities [they] serve and control energy costs through improving efficiency and creating cleaner energy" (Gundersen Health System, 2014). This has resulted in work in and around their La Crosse headquarters on locally produced energy and conservation projects, including regional energy partnerships with public and for-profit partners to operate dairy digesters, wind turbines, and a

19 The Healthy Futures Fund finances projects that promote primary care access and improve community health by co-locating health services with services that impact a social determinant of health, like housing, grocery stores, or job training centers. See: <http://www.healthyfuturesfund.org/>

20 The Living Cities Catalyst Fund invests concessionary, flexible debt to improve the lives of low-income people and the communities where they live. See: <https://www.livingcities.org/work/catalyst-fund/about>

21 FreshWorks invests in healthy food projects in California. See <http://cafreshworks.com/>.

22 See also: <http://hospitaltoolkits.org/investment/case-studies/gundersen-health-system/>.

landfill gas-to-energy initiative, as well as geothermal energy and a biomass boiler on campus. Gundersen set out to make the air better for its patients to breathe, control rising energy costs, and help the local economy, generating \$3 million in annual cost savings for the health system in the process (Gundersen Health System, 2014). For Gundersen's executive leadership, activities on environmental sustainability came from a combination of "reality and a broader view of our responsibility...our job is to keep people healthy, not make them sick" (Gundersen Health System senior staff, personal communication, November 24, 2015).

In addition to the energy work, Gundersen has thought expansively about its relationship with the neighborhoods surrounding its main campus. In 2006, Gundersen negotiated a TIF district for its surrounding neighborhood, and has upgraded street lighting, cleaned up and redesigned local green space, co-founded a local food co-op, and developed and invested in affordable and medical resident housing (Gundersen Health System senior staff, personal communication, November 24, 2015). In 2013, they partnered with city and council members to create the "Powell-Hood-Hamilton Gundersen Lutheran Medical Center Joint Neighborhood and Campus Plan," which leveraged community charrettes to develop a set of priority needs and next steps for revitalizing the community (Powell-Hood-Hamilton, 2013). Leadership has interpreted Gundersen's mission—"Distinguishing ourselves through... improved health in the communities we serve"—to broadly include improved health across physical, mental, economic, political, and environmental impacts (Gundersen Health System senior staff, personal communication, November 24, 2015).

Johns Hopkins

Johns Hopkins Medicine (JHM), headquartered in Baltimore, Maryland, is an \$8 billion integrated global health enterprise that operates a medical school, six academic and community hospitals, four suburban health care and surgery centers, and 40 primary and specialty care outpatient sites with over 40,000 full-time faculty and staff (Johns Hopkins Medicine, 2016). It is the largest employer in Baltimore, and its flagship institution—The Johns Hopkins Hospital—is located in a disinvested neighborhood.

Johns Hopkins is a member of the East Baltimore Development Initiative (EBDI), a multi-stakeholder coalition to revitalize the neighborhood (Johns Hopkins University, 2017a). The University has also engaged with the community through the Homewood Community Partners Initiative (HCPI) a neighborhood located three miles away near its main campus (Reiner, 2014). HCPI has worked with the Central Baltimore Partnership, 15 community and neighborhood organizations, and other stakeholders, such as foundations and anchor institutions, to develop an overlay plan for the area; identify 29 priority projects including blight removal, housing and commercial development; and invest and raise funds for project implementation (Johns Hopkins University, 2017b).

As part of its work in East Baltimore, Johns Hopkins partnered with Walgreens to place a "Well Experience" store in Baltimore near its medical campus, bringing new health and wellness services to the community and serving Hopkins' staff and students. In addition to offering a selection of healthy food, the store is partnering with the Johns Hopkins Medical faculty to offer student health services, a Take Care clinic for the community, and smoking cessation programs. According to John Rothman, MD, dean of JHU School of Medicine, the "collaboration with Walgreens creates the opportunity to offer innovative, locally-based

health care services while further weaving Johns Hopkins Medicine into the fabric of East Baltimore” (Walgreens Co. Corporate Communications, 2013). Hopkins mitigated risk for Walgreens, which would not otherwise have opened a store in that location, investing \$500,000 and agreeing to bear a share of losses in exchange for a split of revenues.

Beyond this role as an investor, Johns Hopkins has been particularly creative in leveraging its non-monetary assets—its name, its purchasing power, and its staff—to strengthen the local community. To spur local development, Johns Hopkins decided to move certain functions off campus and sign leases strategically so that developers of projects considered important could secure financing and speed their lease-up. This approach has yielded significant benefits for surrounding neighborhoods. “The real estate office at Johns Hopkins thinks explicitly about how their decisions can serve not only the institution, but the community as well. We ask: what do we have in our control that we can leverage?” (A. Frank, personal communication, December 2, 2015).

Hopkins has also used its name and its purchasing power to help create local jobs and amenities. When Marriott was considering building a hotel in the area, Hopkins agreed to permit the use of its name. As a result, the “Marriott Residence Inn at Johns Hopkins Medical Campus” was able to secure financing for an \$80 million, 194-room property, creating jobs for the community. In a similar vein, the community near the East Baltimore campus of Hopkins was interested in attracting a restaurant. When a restaurant identified as desirable by the community hesitated due to concerns about the level of business, Hopkins gave the restaurant a three-year guarantee of catering contracts to offset potential early losses. The restaurant hired locally and is doing well, and Hopkins had no incremental cost from the deal (A. Frank, personal communication, December 2, 2015).

As a major employer in Maryland and a key anchor institution in Baltimore, Johns Hopkins is an important source of strength and influence. The institution has used its expertise to assist with fundraising for important projects in the community and has gone to the legislature to request acquisition and predevelopment money from the state. According to Andy Frank, Special Advisor to the President on Economic Development, “We’re leveraging all the institution’s resources—real estate staff, IT staff, government relations—we’ve pressed people into service on behalf of the neighborhood” (A. Frank, personal communication, December 2, 2015).

Trinity Health²³

Based in Livonia, Michigan, Trinity Health is a large Catholic health care system that operates across the U.S., with 93 hospitals, as well as over 120 long-term and continuing care locations in 22 states (Trinity Health, 2017a). Trinity’s efforts are informed by its mission, which calls for it “to serve those who are poor, especially those who are most vulnerable.” Trinity has maintained a robust Community Investing Program that lends capital to CDFIs in underserved communities, with a particular regard to affordable and special needs housing, childcare for low-income families, revitalizing urban and rural areas, safeguarding the environment, and supporting healthy communities. 90 percent of available funds are targeted to states where Trinity has a presence (Trinity Health, 2017b).

²³ See also: <http://hospitaltoolkits.org/investment/case-studies/trinity-health/>

Late in 2015, Trinity Health unveiled its “Transforming Communities Initiative” (TCI), a competition that invited hospitals in its system to undertake community collaborations aimed at improving community health and well-being by reducing smoking and obesity, as well as other drivers of preventable chronic diseases and high health care costs (Trinity Health, November 2015). TCI is an \$80 million, five-year program which will provide annual grants of up to \$500,000 as well as \$40 million in low-interest loans to partnerships in six communities.

In partnership with two CDFIs and leading national health transformation agencies, TCI is assisting communities to address resource and infrastructure disparities and policy gaps that prevent children and low-income adults from adopting healthy diets, engaging in physical activity, living without tobacco, and pursuing other unmet health needs identified by Community Health Needs Assessments. The communities (Trenton, NJ; Springfield, MA; Maywood, IL; Montgomery County, MD; Boise, ID; and Syracuse, NY) are all sites served by Trinity that were selected in a competitive process that included a requirement to provide at least 25 percent in matching funds (Taylor, 2016).

Grant funds for TCI are coming from the approximately \$1 billion that Trinity spends annually on community benefit programs. The flexible capital for the CDFI loans was allocated by the board specifically for this program (B. Choucair, personal communication, December 7, 2015; Q. Moore, personal communication, November 10, 2015; Trinity Health, 2015).

As Trinity put it in a recent program announcement:

...[The initiative] is not intended to support...improved access to, or quality within, Trinity Health ... or other healthcare institutions. Rather, this opportunity focuses on community transformation that enables priority populations (i.e., low income adults, children) to incorporate healthy behaviors in their daily lives. In other words, Trinity Health seeks to invest outside the walls of healthcare institutions, at the community or neighborhood level (Trinity Health, November 2015, p. 6).

UnitedHealth Group

UnitedHealth Group, a publicly traded company (NYSE:UNH), has two businesses: UnitedHealthcare and Optum. UnitedHealthcare provides health insurance and benefits to nearly 5.8 million Medicaid beneficiaries through programs in 24 states and the District of Columbia, covers 27.6 million individuals through individual and employer-sponsored health plans, and provides healthcare to nearly one in five seniors eligible for Medicare. Optum is a health services business that focuses on tools and technology around population health management, health information, and pharmacy benefits, serving 115 million individuals across the country (UnitedHealth Group, 2016).

UnitedHealth Group invested \$50 million each in LIHTC funds managed by the Greater Minnesota Housing Fund and Enterprise Community Investment, resulting in development of multi-family rental units for very low-income and special needs households (UnitedHealth Group, 2016; Crosby, 2013; UnitedHealth Group, 2011). Having gained experience in the housing market, United has identified additional opportunities to use regulated capital from its

85 insurance subsidiaries to make loans secured by real estate projects to organizations with strong balance sheets and track records of developing and managing affordable housing with supportive services for residents (T. McGlinch, personal communication, February 22, 2016).

In the words of UnitedHealth leadership: “Unsafe or unhealthy living conditions, educational barriers and financial constraints can prevent many people from living healthier lives. By removing these barriers, we can help people improve their health [and] strengthen communities” (T. McGlinch, personal communication, February 22, 2016).

University Hospitals

University Hospitals is a health care system in Northeast Ohio that includes its Cleveland-based headquarters; children’s, cancer, and women’s hospitals; a network of outpatient centers and home care services; and 24,000 employees and physicians. University Hospitals is the second largest private sector employer in the region (University Hospitals, 2017). Located in University Circle—an area dense in educational, medical, and cultural institutions—University Hospitals is adjacent to some of the most disinvested neighborhoods in Cleveland (Cleveland Foundation, 2014).

In 2005, University Hospitals joined the Cleveland Clinic, the Cleveland Community Foundation, Case Western Reserve University, and the City of Cleveland in creating the Greater University Circle Initiative (GUCI), a partnership of locally based organizations focused on rebuilding the University Circle area. GUCI addresses both physical development and economic inclusion, with programs including support for employees to live nearby; investment in worker-owned cooperatives which grow lettuce, provide laundry services, and install solar panels; planning support for transit expansion; and creation of a Health Tech Corridor that provides convenient space for related businesses (Cleveland Foundation, 2014).

According to University Hospitals executive staff, the motivation for engaging in GUCI and these activities is that “for University Hospitals, job creation leads to neighborhood stabilization, which leads to better community health” (S. Standley & D. Skriba, personal communication, November 18, 2015).

Appendix B: Interviews

Institution	Name
Association for Community Health Improvement	Julia Resnick
Ascension Health	Marcy Buren
Buffalo Niagara Medical Campus	Matt Enstice
Bon Secours	Samuel Ross
Build Healthy Places Network	Colby Dailey
Cooper Foundation	Susan Bass Levin
Dallas Children's Hospital	Stephanie Farquhar and Pete Perialas
Dignity Health	Pablo Bravo
Gundersen Lutheran Health System	Jeff Thompson, Mark Platt, Jerry Arent, Mike Richards
Healthcare Without Harm	Gary Cohen
HICCup	Rick Brush
Johns Hopkins	Andy Frank
Kaiser Permanente	Tyler Norris
Midtown Detroit Inc.	Sue Mosey
Mt. Auburn Associates	Devon Winey and Beth Siegel
PATH	David Fleming
Pew Charitable Trust	Rebecca Morley
Public Health Institute	Kevin Barnett
Trinity Health	Bechara Choucair
Trust for America's Health	Jeff Levi and Anne DiBiasi
UnitedHealth Group	Jenny Ismert, Catherine Anderson, and Tom McGlinch
University Hospitals	Debra Skriba and Steve Standley

Appendix C: References

Sources Cited:

- Children's Health. (2016a). *Facts and figures*. <https://www.childrens.com/footer/aboutsection/about/facts-and-figures>
- Children's Health. (2016b). *Mission and values*. <https://www.childrens.com/footer/aboutsection/about/mission-and-values>
- Chung, A. & Emerson, J. (2013). From grants to groundbreaking: Unlocking impact investments. *ImpactAssets, Issue Brief 10*. <https://www.livingcities.org/resources/139-from-grants-to-groundbreaking-unlocking-impact-investments>
- Cooper Foundation. (2017). *About us*. <http://www.cooperhealth.org/about-us>
- Cooper Foundation. (2016). *Housing and neighborhood revitalization*. <https://foundation.cooperhealth.org/new-pages/who-we-are/transforming-our-community/housing-and-neighborhood-revitalization>
- Crosby, J. (2013, November 14). UnitedHealth invests \$50 million in low-income rental housing. *Star Tribune*. <http://www.startribune.com/unitedhealth-invests-50-million-in-low-income-rental-housing/231933561/>
- Dever, B., Blaik, O., Smith, G., McCarthy, G.W. (2015, February). Anchors lift all boats: Eds & meds engaging with communities. *Land Lines*, Winter 2016. <https://www.lincolnst.edu/publications/articles/anchors-lift-all-boats>
- Dignity Health. (2017). *About us*. <https://www.dignityhealth.org/about-us>
- Dignity Health. (2016a). *Increasing capital for underserved communities*. <https://www.dignityhealth.org/about-us/community-health/increasing-capital-for-underserved-communities>
- Dignity Health. (2016b). *Mission vision and values*. <https://www.dignityhealth.org/about-us/our-organization/mission-vision-and-values>
- Cleveland Foundation. (2014). Cleveland's Greater University Circle Initiative: Building a 21st century city through the power of anchor institution collaboration. <https://www.clevelandfoundation.org/wp-content/uploads/2014/01/Cleveland-Foundation-Greater-University-Circle-Initiative-Case-Study-2014.pdf>
- FreshWorks. (2017). *About us*. <http://cafreshworks.com/about/>
- GoNoodle. (2015, December 8). GoNoodle now engages 10 million kids per month; Company receives \$5 million investment to support growth. *Marketwired*. <http://www.marketwired.com/press-release/gonoodle-now-engages-10-million-kids-per-month-company-receives-5-million-investment-2079996.htm>
- Gundersen Health System. (2017a). *Community contributions*. <https://www.gundersenhealth.org/community-assessment/contributions/>
- Gundersen Health System. (2017b). *Gundersen envision*. <http://www.gundersenenvision.org/envision/>
- Gundersen Health System. (2017c). *Our system*. <http://www.gundersenhealth.org/our-system/>
- Gundersen Health System. (2014, November 6). *Gundersen reaches first days of energy independence*. <https://www.gundersenenvision.org/gundersen-envision/resources/videos/gundersen-reaches-first-days-of-energy-independence/>
- Hacke, R., Grace, K., & Wood, D. (2012, March). The capital absorption capacity of places: A research agenda and framework. *Initiative for Responsible Investment and Living Cities*. http://iri.hks.harvard.edu/files/iri/files/the_capital_absorption_capacity_of_places_2012.pdf
- Hacke, R., Wood, D., & Urquilla, M. (2015, March). Community investment: focusing on the system. Initiative for Responsible Investment and Kresge Foundation. <http://iri.hks.harvard.edu/files/iri/files/community-investment-focusing-on-the-system-march-2015.pdf>
- Healthy Futures Fund. (2017). *About us*. <http://www.healthyfuturesfund.org/section/aboutus>
- Institute of Medicine & National Research Council. (2013). *U.S. health in international perspective: Shorter lives, poorer health*. Washington, D.C.: The National Academies Press.
- Investopedia. (2017). *Community investing*. http://www.investopedia.com/terms/c/community_investing.asp
- IRS. (2017) *Program-related investments*. <https://www.irs.gov/charities-non-profits/private-foundations/program-related-investments>
- Johns Hopkins Medicine. (2016, November 10). *Fast facts*. <http://www.hopkinsmedicine.org/about/downloads/jhm-fast-facts.pdf>
- Johns Hopkins University. (2017a) *East Baltimore development initiative*. <http://president.jhu.edu/anchor-initiatives/east-baltimore-development-initiative/>
- Johns Hopkins University. (2017b) *Homewood community partners initiative*. <http://president.jhu.edu/anchor-initiatives/homewood-community-partners-initiative/>
- Kenyon, D.A. & Langley A.H. (2010, November). Payments in lieu of taxes: Balancing municipal and nonprofit interests. *Lincoln Institute of Land Policy*. <http://www.lincolnst.edu/publications/policy-focus-reports/payments-lieu-taxes>
- Kleiman, N., Getzinger, L., Pindus, N., & Poethig, E. (2015, September). Striking a grand (local) bargain. *National Resource Network*. <https://wagner.nyu.edu/files/faculty/publications/strikingbargain.pdf>
- McCormick, K. (2016, July). Gentle infill: Boomtowns are making room for skinny homes, granny flats, and other affordable housing. *Land Lines*, Summer 2016. <https://law.wustl.edu/landuselaw/Articles/Gentle%20Infill.pdf>
- McGuire, J. (2016, March). Population health investments by health plans and large provider organizations: Exploring the business case. *Northeastern University Institute on Urban Health Research and Practice*. <http://www.northeastern.edu/iuhrp/wp-content/uploads/2016/05/PopHealthBusinessCaseFullRpt-5-1.pdf>
- Miller, J. (2016, February 16). Vita health & wellness district, Stamford, Connecticut. *Build Healthy Places Network*. <http://buildhealthyplaces.org/whats-new/vita-health-wellness-district-stamford-connecticut/>
- Miller, J. (2015, November 6). Community health and literacy center, Philadelphia, Pennsylvania. *Build Healthy Places Network*. <http://www.buildhealthyplaces.org/whats-new/community-health-and-literacy-center-south-philadelphia-pa/>
- Midtown Detroit Inc. (2017). *Organization history*. <http://midtowndetroitinc.org/who-we-are/history>
- Moore, G. A. (1991). *Crossing the chasm: Marketing and selling high-tech products to mainstream consumers*. New York, N.Y.: HarperBusiness.
- Norris, T. & Howard, T. (2015, December). Can hospitals heal America's communities? *Democracy Collaborative*. <http://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/CanHospitalsHealAmericasCommunities.pdf>
- Opportunity Finance Network. (2017) *What is a CDFI?* <http://ofn.org/what-cdfi>
- Powell-Hood-Hamilton/Gundersen Lutheran Medical Center joint neighborhood and campus plan*. (2013, April). https://www.cityoflacrosse.org/filestorage/593/844/3606/5145/PPH_Gundersen_Plan.pdf

Ray, B. (2017, February 23). A new responsibility for children's hospitals: The health of neighborhoods. Build Healthy Places Network Crosswalk Magazine. <https://medium.com/bhpn-crosswalk/a-new-responsibility-for-childrens-hospitals-the-health-of-neighborhoods-257107d6051f#.ipnoqm1zu>

Reiner, S. (2014, May 13). *The Johns Hopkins University Homewood Community Partners Initiative*. Presentation, Federal Reserve Bank of Philadelphia Bridging Growth and Opportunity: Reinventing Older Communities. <https://www.philadelphiafed.org/-/media/community-development/events/2014/reinventing-older-communities/resources/salem%20reiner%20-%20reinventing%20older%20communities%20conference.pdf?la=en>

Rosenbaum, S. (2016, March). Hospitals as community hubs: Integrating community benefit spending, community health needs assessment, and community health improvement. *Economic Studies at Brookings, Discussion Papers on Building Healthy Neighborhoods*, No. 5. Retrieved from: <https://www.brookings.edu/wp-content/uploads/2016/07/Rosenbaum-PDF-Layout-FINAL-1.pdf>

RWJF Commission to Build a Healthier America. (2014, January 13). Time to act: Investing in the health of our children and communities. <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf409002>

Schroeder, S. A. (2007). We can do better – Improving the health of the American people. *New England Journal of Medicine*, 357, 1221-1228.

Sobel Blum, E. (2014, March). Healthy communities: a framework for meeting CRA obligations. *Federal Reserve Bank of Dallas*. <https://www.dallasfed.org/~/media/documents/cd/healthy/CRAframework.pdf>

Squires, D., & Anderson, C. (2015, October 8). U.S. health care from a global perspective: spending, use of services, prices and health in 13 countries. *The Commonwealth Fund*.

St. Luke's Health Initiatives. (2015, July). Connecting the dots: A healthy community leader's guide to understanding the nonprofit hospital community benefit requirements. *Arizona Health Futures Policy Primers*. <http://vitalysthealth.org/wp-content/uploads/2015/07/Primer-Connecting-Dots-Community-Benefit-July2015.pdf>

Taylor, B. (2016, March 15). Trinity Health grant initiative seeks community transformations. *Catholic Health Association of the United States*. <https://www.chausa.org/publications/catholic-health-world/article/march-15-2016/trinity-health-grant-initiative-seeks-community-transformations>

Trinity Health. (2017a). *About us*. <http://www.trinity-health.org/about-us>

Trinity Health. (2017b). *Community investing*. <http://www.trinity-health.org/community-investing>

Trinity Health. (2015, November). *Grant application guide: Trinity Health Transforming Communities Initiative (TCI) FY 2016*.

Trinity Health. (2015, November 19). *Trinity Health to invest in partnerships that address the root causes of poor health*. <http://www.trinity-health.org/body.cfm?id=196&action=detail&ref=80>

Trust for America's Health. (2015, November 24). *Dignity Health's community health investments*. http://healthyamericans.org/health-issues/prevention_story/dignity-healths-community-health-investments/

UnitedHealth Group. (2016). Facts 2016 Q3. <https://www.uhc.com/content/dam/uhc.com/AboutUs/PDF/Q3-2016-Fact-Book.pdf>

UnitedHealth Group. (2011, December 8). UnitedHealth Group and Enterprise Community Investment launch \$50 million affordable housing investment program. <http://www.unitedhealthgroup.com/newsroom/articles/news/unitedhealth%20group/2011/1208affordablehousing.aspx>

University Hospitals. (2017). *About*. <http://www.uhhospitals.org/about>

University of Wisconsin Population Health Institute. (2016). *County Health Rankings & Roadmaps Action Center*. <http://www.countyhealthrankings.org/roadmaps/action-center>

University of Wisconsin Population Health Institute. (2016). *Exploring the data for community investment*. <http://www.countyhealthrankings.org/roadmaps/action-center/community-development/assess-exploring-data-community-development>

USSIF. (2017). *What is community investing?* <http://www.ussif.org/communityinvesting>

Walgreens Co. Corporate Communications. (2013, June 27). Johns Hopkins Medicine and Walgreens expand collaboration to bring first-of-its-kind Walgreens to Johns Hopkins medical campus. http://www.hopkinsmedicine.org/business/business_development/_docs/jhm_walgreens_joint_venture.pdf

Zuckerman, D., & Parker, K. (2016, September). Hospitals aligned for healthy communities. *Democracy Collaborative*. <http://hospitaltoolkits.org/>

Zuckerman, D. (2013, March). Hospitals building healthier communities: Embracing the anchor mission. *Democracy Collaborative*. <http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/Zuckerman-HBHC-2013.pdf>

Sources consulted:

Axelrod, R., & Dubb, S. (2010, December). The road half traveled: University engagement at a crossroads. *Democracy Collaborative*. <http://www.iupui.edu/~solctr/wp-content/uploads/2013/02/University-Engagement-at-a-Crossroads-2010.pdf>

California Health Care Foundation Health Innovation Fund. (2014, March 21). Pablo Bravo on mission investing. *California Health Care Foundation*. <http://www.chcf.org/innovation-fund/mission-investing/bravo>

Corrigan, J. (2013, June). Developing a balanced investment strategy. *Rethink Health*. <https://www.rethinkhealth.org/wp-content/uploads/2015/11/FIN-Balanced-Investment-11-05.pdf>

Dubb, S., McKinley, S., & Howard, T. (2013, August). The anchor dashboard: Aligning institutional practice to meet low-income community needs. *The Democracy Collaborative*. <http://www.aecf.org/m/resourcedoc/AECF-TheAnchorDashboard-2013.pdf>

Folkemer, D.C. et al. (2011, April). Hospital community benefits after the ACA: Building on state experience. *The Hilltop Institute*. <http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf70570>

Fraze, T., Lewis, V.A., Rodriguez, H.P., & Fisher, E.S. (2016). Housing, transportation, and food: How ACOs seek to improve population health by addressing nonmedical needs of patients. *Health Affairs*, 35:11, 2109-2115.

Glover Blackwell, A. (2017, Winter). The curb-cut effect. *Stanford Social Innovation Review*, 28-33. https://ssir.org/articles/entry/the_curb_cut_effect

Gregg, H. & Herman, B. (2013, July 31). How investments in community health pay off. *Becker's Hospital Review*. <http://www.beckershospitalreview.com/finance/how-investments-in-community-health-pay-off.html>

Harkavy, I. & Zuckerman, H. (1999, August). Eds and meds: Cities' hidden assets. *The Brookings Institution Center on Urban & Metropolitan Policy*. https://www.brookings.edu/wp-content/uploads/2016/06/09_community_development_report.pdf

Katz, B., & Wagner, J. (2014, May). The rise of innovations districts: a new geography of innovation in America. *Metropolitan Policy Program at Brookings*. <https://www.brookings.edu/wp-content/uploads/2016/07/InnovationDistricts1.pdf>

Kauper-Brown, J. & Seifer, S.D. (2006). Health institutions as anchors in communities: profiles of engaged institutions. *Community-Campus Partnerships for Health*. <http://community-wealth.org/content/health-institutions-anchors-communities-profiles-engaged-institutions>

Martinez-Vidal, E., Kennedy, S., & Kennedy, S. (2016, November 21). Payment reform for population health. *AcademyHealth*. <http://www.academyhealth.org/publications/2016-11/payment-reform-population-health>

Mt. Auburn Associates & Kim Burnett Consulting. (2016, February 18). *Integrating community development and the culture of health: initial findings*.

Mt. Auburn Associates. (2014, October). The integration initiative final outcome report. <https://livingcities.s3.amazonaws.com/resource/282/download.pdf>

Ross, T. (2014, October). Eds, meds, and the feds: How the federal government can foster the role of anchor institutions in community revitalization. *Center for American Progress*. <https://cdn.americanprogress.org/wp-content/uploads/2014/10/EdsMedsFeds-Oct.pdf>

Serang, F., Thompson, J.P., & T. Howard. (2013, February 2). The anchor mission: Leveraging the power of anchor institutions to build community wealth. *Democracy Collaborative*. <http://community-wealth.org/content/anchor-mission-leveraging-power-anchor-institutions-build-community-wealth>

Singh, M., Bluestein, R., & M. Somerville. (2016). Partnering for prevention: Hospital community benefits investments for community development. *Low Income Investment Fund*. <http://www.liifund.org/wp-content/uploads/2016/12/Community-Benefits-LIIF.pdf>

Singh, P., & Butler, S.M. (2015, November). Intermediaries in integrated approaches to health and economic mobility. *Economic Studies at Brookings, Discussion Papers on Building Healthy Neighborhoods*, No. 4. Retrieved from: https://www.brookings.edu/wp-content/uploads/2016/07/intermediaries_in_integrated_approaches_to_health_and_econ_mobility.pdf

Skinner, D., Gardner, W., & Kelleher, K. (2016). When hospitals join the community: practical considerations and ethical frameworks. *Journal of Health Care for the Poor and Underserved*, 27, 1171-1182.

Stateline. (2015, October 12). Urban hospitals reach out to poor neighborhoods. *Governing Magazine*. <http://www.governing.com/topics/health-human-services/many-urban-hospitals-reaching-out-to-poor-neighborhoods.html>

Taylor, H.L., & Luter, G. (2013). Anchor institutions: An interpretive review essay. *Anchor Institutions Task Force and Marga, Inc*. http://www.margainc.com/files_images/general/Literature_Review_2013.pdf

