Partnering for Prevention: Hospital Community Benefit Investments for Community Development
About the Low Income Investment Fund

The Low Income Investment Fund (LIIF) is dedicated to creating pathways of opportunity for low income people and communities. Serving the poorest of the poor, LIIF is a steward for capital invested in community-building initiatives. In so doing, LIIF provides a bridge between private capital markets and low income neighborhoods.

Acknowledgements
Matthew Singh and Rachel Bluestein, Low Income Investment Fund
Martha Somerville, Somerville Consulting

Special Thanks
Jason Battista and Adam Kopp, Mercy Housing
Pablo Bravo and Michael Bilton, Dignity Health
Sue Kaplan, JD, New York University School of Medicine
George Kleb, Bon Secours Baltimore Health System
Shari Nethersole, MD and John Riordan, Boston Children’s Hospital
A. Jonathan Porteus, PhD, WellSpace Health

© 2016 by Low Income Investment Fund
Disclaimer: This paper is for informational purposes only and not for the purpose of providing legal or tax advice. You should contact your attorney or tax professional to obtain advice with respect to any particular issue or problem.
Executive Summary

A novel and sizeable funding source is available today to advance the trend toward increasing collaboration between the health care and community development fields. Nonprofit hospitals have both a financial incentive and a legal requirement to provide community benefits in exchange for exemption from taxes. To preserve their tax-exempt status—worth an estimated $24.6 billion to hospitals annually—nonprofit hospitals must either directly provide or financially support health-related benefits for the communities they serve. These resources can contribute funding to a broad range of community development initiatives, including affordable housing development and neighborhood revitalization.

Hospital community benefit spending is a novel and sizeable funding source available today to advance collaboration between the health care and community development fields.

Healthcare reform and an increasingly strong evidence base support this collaboration. Nonprofit hospitals’ growing work in population health has coincided with the Affordable Care Act’s value-based payment reforms, which have encouraged hospitals to embrace care delivery on the basis of patient outcomes as opposed to the volume of services provided. As a result, they are focusing increasingly on evidence-based prevention initiatives that affect the social determinants of health: non-medical, social, economic, and environmental factors that impact health. Meanwhile, the community development field is drawing on the same evidence base to align its antipoverty work with positive health-related outcomes, inspired by increasing awareness of the health implications of improvements in housing, infrastructure, and the economic vitality of communities. Key actors include nonprofit lenders, such as community development financial institutions (CDFIs), and community development corporations. Community development corporations are community-based organizations that focus on revitalizing low-income neighborhoods, typically by developing affordable housing and often also by providing social services such as job training.

However, practical starting points for collaboration are less clear. Through a discussion of the work of organizations including Dignity Health, Bon Secours Health System, Asian Americans for Equality, and Mercy Loan Fund, this paper offers examples of effective collaboration between the health care and community development fields and concludes with five practical recommendations to guide best practices:

1. Nonprofit hospitals could engage in strategic partnerships with community development corporations and CDFIs to inform their community health needs assessments (CHNAs) and otherwise guide implementation of community benefit investments.

2. Community development corporations and nonprofit hospitals could collaborate to create and preserve affordable housing, along with other programs that draw on the partners’ respective strengths.

3. Hospitals could support legislation and fund programs to prevent, reverse, and end homelessness, following the example of Boston Children’s Hospital.

4. CDFIs could seek, and nonprofit hospitals could provide, funding to support the origination of loans for affordable housing, health clinics, and other health-related real estate investments—while additionally supporting research and documentation of best practices.

5. Beyond community benefit funding, future research should examine the potential for using additional funding sources, such as the Delivery System Reform Incentive Payment (DSRIP) program, to align the work of the community development and health care fields.
A novel and sizeable funding source is available today to advance the trend toward increasing collaboration between the health care and community development fields. Distinct from other 501c3 organizations under the tax code, nonprofit hospitals have both a financial incentive and a legal requirement to provide what the Internal Revenue Service (IRS) calls community benefits in exchange for exemption from taxes. To preserve their federal and state tax exemptions—worth an estimated $24.6 billion to hospitals annually—nonprofit hospitals must either directly provide or financially support health-related benefits for the communities they serve. These resources can contribute funding to a broad range of community development initiatives, including affordable housing development and neighborhood revitalization.

Federal policy and an increasingly strong evidence base support the collaboration between the fields. In health care, nonprofit hospitals’ growing work in supporting healthy lifestyles and healthy communities has coincided with federal healthcare reform. The Affordable Care Act’s value-based payment reforms, such as shared savings arrangements, have encouraged hospitals in recent years to embrace population health strategies. These reforms provide hospitals with an incentive to deliver care on the basis of patient outcomes as opposed to the volume of services provided, and as a result, hospitals are focusing increasingly on social determinants of health: non-medical, social, economic, and environmental factors that affect health. Evidence-based prevention initiatives addressing those upstream causes of poor health have gained traction as cost-effective approaches to reducing health care costs and improving health at the community level.

Meanwhile, the community development field is drawing on the same evidence base to align its antipoverty work with positive health-related outcomes, inspired by increasing awareness of the health implications of improvements in housing, infrastructure, and the economic vitality of communities. Key actors include nonprofit lenders, such as community development financial institutions (CDFIs), and community development corporations. Community development corporations are community-based organizations that focus on revitalizing low-income neighborhoods, typically by developing affordable housing and often also by providing social services such as job training.

Through five case studies, this paper offers examples of effective collaboration between health care and community development practitioners, and concludes with recommendations to guide best practices.

While hospitals’ financial and mission-based incentives to improve population health provide a basis for collaboration with community development groups, practical starting points are less clear. Through a discussion of the work of organizations including Dignity Health, Bon Secours Health System, Asian Americans for Equality, and Mercy Loan Fund, this paper offers examples of effective collaboration between the health care and community development fields and concludes with a set of practical recommendations to guide best practices.
In recent years, the health care and community development fields have evolved toward an understanding that poverty and poor health are inextricably linked, and that improving a population’s health requires understanding and addressing the social determinants of health. An extensive and rigorous evidence base illustrates the importance of this shift. For example, the Robert Wood Johnson Foundation has reported that, on average, college graduates at age 25 have life expectancies that are eight to nine years longer than those who have not completed high school, and two to four years longer than their counterparts who have attended some college but not received a degree. In addition, adults without a high school diploma are over six times more likely to report having poor or fair health than adults with college degrees. At the macroeconomic level, studies have demonstrated that health outcomes improve as the ratio of social service spending to health service spending increases. This finding holds true both between countries and domestically between states.

Social determinants of health influence these differences in life expectancies and health outcomes. According to the County Health Rankings and Roadmaps program, only 20 percent of the responsibility for overall health can be attributed to the clinical health care services a person receives. Other important factors include one’s environment, such as access to transportation and quality affordable housing; social and economic factors such as education, employment, and family support; and health behaviors including diet, exercise, and use of alcohol, drugs, and tobacco. For low-income people, geography is especially important. People with high incomes tend to live longer no matter where they live, but life expectancies vary with location for low-income people. The life expectancy of low-income women living in Little Rock, Arkansas, for example, is 3.5 years shorter than for low-income women who live in Miami, Florida.

For their part, community development organizations have been working nationally for decades to improve what are now recognized as social determinants of health, with a focus on the physical and social fabric of housing and neighborhoods. The Low Income Investment Fund (LIIF), for instance, is committed to providing capital for healthy families and communities. Since 1984, LIIF has invested $2 billion dollars for the benefit of 1.9 million people, creating or preserving 69,000 affordable housing units and 82,000 seats in high-quality schools. LIIF is also a lender in the Collaborative for Healthy Communities, which is a three-year, $130 million initiative launched in 2014 that provides capital for community health centers. Partners in the Collaborative include the Primary Care Development Corporation and Reinvestment Fund, both CDFIs, as well as Goldman Sachs, The Kresge Foundation, and Rockefeller Foundation. Investment possibilities will continue to evolve as the regulatory landscape changes to promote new forms of partnership across the health care and community development fields, including partnerships between community development organizations and nonprofit hospitals.
The hospital community benefit requirement is a critical part of the regulatory landscape at the federal level (and, albeit to a lesser extent, at the state level).\textsuperscript{10} Historically, nonprofit hospitals could justify their federal tax exemption only by providing free care to the poor, also known as charity care.\textsuperscript{11} This changed in 1969, when the IRS established the more flexible community benefit standard, which recognizes “the promotion of health” at the community level as a means for hospitals to justify their tax exemptions.\textsuperscript{12} The provision of free and reduced-cost care to those in need continues to be an important—but no longer exclusive—component of hospitals’ community benefit spending.\textsuperscript{13} Since 2009, the IRS has required nonprofit hospitals to report community benefit spending by newly defined categories on Schedule H of the 990 tax form, which includes categories in addition to charity care, such as research, health professional education, and expenditures for community health improvement.

Subject to specific qualifying criteria,\textsuperscript{15} hospitals can count as community benefit investments their contributions to initiatives such as 1) physical improvements and housing; 2) economic development; 3) community support; 4) environmental improvements; 5) leadership development and training for community members; 6) coalition building; 7) community health improvement advocacy; and 8) workforce development.\textsuperscript{16} Grants are a common means of making such investments. Loans, because they are expected to be repaid, do not qualify as community benefit spending even if they are offered at no-interest or below-market rates.\textsuperscript{17} As discussed below, however, a hospital may choose to originate loans—regardless of such investments’ community benefit status—in order to complement its community benefit spending and potentially improve its long-term financial position by reducing need in the community for unreimbursed care.

Despite increasing evidence that addressing the social determinants of health is an effective means of improving the public’s health, some hospitals may avoid these kinds of investments. Hospitals may make this decision partly based on the outdated perception that the IRS views more favorably those investments directly related to clinical health care services, such as free and discounted care, unreimbursed costs from participating in Medicaid and other means-tested government programs, subsidized health services, and clinical research.\textsuperscript{18} However, since 2009, the agency’s view has expanded to recognize “the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”\textsuperscript{19}

In addition to charity care, community benefit spending can support housing development, neighborhood revitalization, and economic development initiatives.

In conjunction with IRS regulations, a community health needs assessment (CHNA) requirement under the Affordable Care Act of 2010 (ACA) gives communities a voice in how hospitals direct their community benefits. Every three years, a nonprofit hospital must use a data- and community input-driven process to conduct and document a CHNA, prioritize the significant health needs the CHNA identifies, and develop an implementation plan to address those needs.\textsuperscript{14} For any significant need that will not be addressed, the hospital must explain why it will not address the need. Together, a hospital’s CHNA and implementation plan memorialize the hospital’s intended community benefit investments, guide IRS evaluation of the hospital’s continuing qualification for tax exemption, and provide advocacy levers for the community that the hospital serves.
The following five case studies highlight three types of opportunities for collaboration between nonprofit hospitals and community development organizations: 1) informing the community health needs assessment; 2) implementing programs with community development corporations; and 3) structuring and originating mission-driven financing with CDFIs.

### Informing the Community Health Needs Assessment

#### Community Benefit Advising: Boston Children's Hospital and Fenway CDC

In Boston, Massachusetts, the relationship between the Fenway Community Development Corporation (Fenway CDC) and Boston Children’s Hospital has nurtured the growth of a job-training program for low-income individuals and has created opportunities for Boston Children’s to address issues of affordable housing and homelessness—areas in which the hospital had not historically been involved. Going forward, it is conceivable that Boston Children’s may choose to address housing in its next CHNA and implementation plan.

In Boston, Massachusetts, the relationship between the Fenway Community Development Corporation and Boston Children’s Hospital has nurtured the growth of a job-training program for low-income individuals and has created opportunities for Boston Children’s to address issues of affordable housing and homelessness.

Boston Children’s is a 404-bed, comprehensive pediatric care center with the mission to “provide the highest quality health care, be the leading source of research and discovery, educate the next generation of leaders in child health, and enhance the health and well-being of the children and families in our local community.”

Within Boston, the hospital is located in the Longwood Medical Area together with other nationally distinguished institutions and schools such as Harvard Medical School, Brigham and Women’s Hospital, and Beth Israel Deaconess Medical Center. It serves the 4.5 million person metropolitan Boston region and receives referrals from across New England, but its community benefit spending on geographically specific programs and partnerships includes city-wide work and a focus on four neighborhoods adjacent to the Longwood Medical Area—Fenway, Roxbury, Mission Hill and Jamaica Plain. Total community benefit spending, which also covers categories such as charity care and research, was $127 million in fiscal year 2014. Boston Children’s “concentrates its community programs in areas for which it has the expertise, resources and community partnerships to improve health outcomes and address the community’s significant health needs,” focusing on wellness and prevention, access to care, and partnering with other community organizations to address upstream health determinants such as violence, employment, and education.

Among its community partners, Boston Children’s has partnered with Fenway CDC to support Fenway CDC’s programs for low-income residents in the Fenway neighborhood. Boston Children’s provides Fenway CDC with modest general operating funding while supporting, for example, the CDC’s Walk to Work pre-employment training program and health care workshops in the CDC’s affordable housing. This support of Walk to Work is especially important because the neighborhood’s low-income residents face barriers to accessing employment even though the job-rich Longwood Medical Area is within walking distance. In total, institutions in the Longwood Medical Area employ over 45,000 people, create an average of 1,100 new jobs annually, and post 7,500 jobs per year. Since inception, Walk to Work has placed over 550 Fenway residents in jobs, and it has provided “skill training, career counseling, job placement and career counseling services to hundreds of others.” One resident, Angela Ayala, completed a 20 week intensive in medical administration at YMCA Training Inc., which provided her with the credentials she needed to obtain an internship and eventually a part-time job at Beth Israel Deaconess Medical Center.
This partnership has also created opportunities for Boston Children’s to expand its community efforts into housing and homelessness. The Director of Community Programs at Fenway CDC, Kris Anderson, joined Boston Children’s Community Advisory Board in 2013 and was recently selected to be its Chair. The Community Advisory Board advises the hospital on its community benefit plan and its members include both local residents and leaders of community organizations. In her role on the advisory board, Ms. Anderson has advocated for affordable housing. She and her colleagues on the board have expressed concern that problems with housing affordability and stability are negatively affecting child health. These problems are particularly acute because of unusual housing market pressures in the area.

Boston Children’s has listened. “This was not an area that the hospital historically had been engaged in, but when members shared with us how housing instability and homelessness has affected many families that they are familiar with, we decided to join with local advocacy groups to develop legislative remedies and work with other partners to strengthen support systems to address this issue,” said John Riordan, Director of Community Relations and Partnerships at Boston Children’s. Such work includes support for the Healthy Food, Healthy Homes, and Healthy Children state bill (H 429/S 94)—which aims in part to prevent family homelessness—and participation in the Boston Foundation’s Health Starts at Home initiative in order to better coordinate homelessness prevention efforts for families that utilize Boston Children’s primary care services. Going forward, these voices and experiences have the potential to inform the stated priorities in Boston Children’s next CHNA.

Bon Secours Hospital in Baltimore is a 72-bed acute care hospital that has the mission “to help people and communities to health and wholeness by providing compassionate, quality health care and being good help to all in need in West Baltimore, with special concern for the poor and dying.” The hospital is part of the Bon Secours Health System, a $3.3 billion nonprofit Catholic health system that owns and operates 19 acute care hospitals across Maryland, Virginia, South Carolina, New York, Kentucky, and Florida. Bon Secours serves West and Southwest Baltimore, which together have about one third of the city’s 620,000 residents, and focuses its geographically specific community benefit spending in the low-income, medically underserved area of Old Southwest Baltimore. While the primary community benefit service area is relatively small, with a population of about 18,000 people, deaths from heart disease are 35 percent higher compared to Baltimore as a whole, and in the toughest areas average life expectancy is 64.2 years—7 years less than the city-wide life expectancy of 71 years. Acknowledging these dire circumstances, Bon Secours’ 130-year presence in the community features a tradition of community engagement and responsive programming and services. The hospital spent $19 million on community benefits in fiscal year 2014 and its CHNA is comprehensive in scope, calling for healthy people, a healthy economy, and a healthy environment.

The Community Housing program is an integral part of Bon Secours’ efforts to promote a healthy economy.

Bon Secours’ central office has required every one of its hospitals, by 2018, to assess the housing needs in the neighborhoods they serve and plan for ways to make improvements.

Bon Secours has partnered with Enterprise Homes in a variety of capacities to pursue the housing element of its economic revitalization efforts. For one of the Community Housing program’s first projects called Bon Secours Apartments, the Bon Secours affiliate Unity Properties acquired 59 vacant row houses near the hospital and contracted with Enterprise Homes to renovate them. The project was completed in three phases from 1997 to 2003 and resulted in 119 units of affordable housing for families. In 2007, working together as joint-venture partners, Unity Properties and Enterprise Homes developed the 80-unit New Shiloh Village senior apartments under contract with the owner New Shiloh Baptist Church. Most recently, Unity Properties has taken the lead as the developer and has retained Enterprise Homes as a development consultant. One such project completed in 2016 is the 80-unit Bon Secours Gibbons Apartments. Throughout Bon Secours’ various projects, financiers
have included subsidiaries of Enterprise Community Partners, private banks, and public agencies such as the US Department of Housing and Urban Development (HUD) and both the Baltimore City and Maryland State Departments of Housing and Community Development.

As the hospital’s approach to housing development has evolved, so has Bon Secours’ perspective on the centrality of housing to health care. In the late 1980s, Bon Secours in Baltimore was a 208-bed hospital without any housing units whose leadership decided to develop affordable housing in reaction to broad-scale neighborhood divestment. Such development aligned with the spirit of Bon Secours’ mission. By 2016, buoyed by the evidence supporting housing as a social determinant of health, Bon Secours’ central office had required every one of its hospitals by 2018 to assess the housing needs in the neighborhoods they serve and plan for ways to make improvements. In Baltimore, Bon Secours has decreased its clinical capacity to 72 beds and increased its housing portfolio to 728 housing units, with the aspiration to a portfolio of 1,200 units, in response to the combination of community needs identified by Bon Secours, changing conditions in the health care and housing markets, and advancements to the methods of delivering medical care. Bon Secours in Baltimore had also started exploring the possibility of providing supportive housing, which is commonly recognized as an effective way to house and care for individuals who are formerly homeless. Individuals who are chronically homeless and living on the streets may have substance use challenges or chronic mental illness, and will frequently rely on emergency rooms for health care and shelter.

New York University Langone Medical Center, also known as NYU Hospitals Center, has partnered with the community development corporation Asian Americans for Equality (AAFE) and several other community-based organizations to structure the collaborative, inter-organization Coordinating Council to oversee and implement its Community Service Plan, and to implement a smoking cessation program focused on reducing rates of smoking among Asian American men and children’s secondhand smoke exposure in multifamily housing.

In partnership with NYU Hospitals Center, organizations in the primary care, child care and education, housing, and local business sectors work together to bring about changes within families and at the institutional level.

NYU Hospitals Center, with campuses in midtown Manhattan and Brooklyn, is the principal teaching hospital of the New York University School of Medicine. The hospital network describes its mission as three-fold: “to serve, teach, and discover.” Within New York City alone, the hospital’s primary service area includes 45 ZIP codes, with no single ZIP code accounting for more than 4 percent of discharges. NYU Hospitals Center focuses the $1.4 million community health improvement portion of its community benefit spending (fiscal year 2014) in the neighboring low-income communities of Manhattan’s Community District 3, which has a population of 163,000 and includes the Chinatown and Lower East Side neighborhoods. Although the median family income is $171,458 in the highest income census tract within Community District 3, the overall family poverty rate is nearly 25 percent—compared with 14 percent for all of Manhattan—and nearly 50 percent of the population receives government income support. Among this population, NYU Hospitals Center in its CHNA identifies the health needs as “reducing risk factors for obesity, cardiovascular disease and cancer.”

Together with its partners including AAFE, NYU Hospitals Center created a collaborative, community-based mechanism of oversight for its Community Service Plan. The plan uses a data-driven, “family-centered, multi-sector
to residents within its communities; and 2) the ways that had not tried quitting previously. She credits the success of quitting completely. According to Ms. Kaplan, these rates are 62 percent reported a reduction in smoking, and 23 percent reported using nicotine replacement therapy, 62 of the 126 smokers reached for a follow-up interview, 83 participated in nicotine replacement therapy. After two weeks, reached received counseling, and of those 146 partici

970 smokers through June 2016.

immigration counseling, the AAFE program reached over through its housing and services such as social service and engagement. Navigators fill important gaps in knowledge and risks and link community members to evidence based re

community navigator model “provides lay workers or resident/community volunteers the skills to educate and motivate people in the community to address modifiable health risks and link community members to evidence based resources. Navigators fill important gaps in knowledge and access to health information, policies and programs that can improve population health.” Engaging residents through its housing and services such as social service and immigration counseling, the AAFE program reached over 970 smokers through June 2016. In total, 183 of those reached received counseling, and of those 146 participated in nicotine replacement therapy. After two weeks, of the 126 smokers reached for a follow-up interview, 83 percent reported using nicotine replacement therapy, 62 percent reported a reduction in smoking, and 23 percent quit completely. According to Ms. Kaplan, these rates are extraordinary, especially because many of those reached had not tried quitting previously. She credits the success rate in part to 1) AAFE’s credibility and deep connections to residents within its communities; and 2) the ways that

NYU Hospitals Center’s smoking cessation program exemplifies this effectiveness. Cancer related to smoking and exposure to second-hand smoke is a particular concern in Community District 3. While the prevalence of smoking in New York City decreased from 21.5 percent in 2002 to 13.9 percent in 2014, the rate of smoking among Asian American men increased from just under 20 percent to 21.3 percent during that same period. Furthermore, families in Community District 3 commonly live in overcrowded conditions where “adults are significantly less likely to have adopted a smoke-free home policy than adults in other neighborhoods.” In buildings that are not smoke-free, second-hand smoke also affects children and adults who live in smoke-free homes.

To implement the program, NYU Hospitals Center and AAFE used the community navigator model. The community navigator model “provides lay workers or resident/community volunteers the skills to educate and motivate people in the community to address modifiable health risks and link community members to evidence based resources. Navigators fill important gaps in knowledge and access to health information, policies and programs that can improve population health.” Engaging residents through its housing and services such as social service and immigration counseling, the AAFE program reached over 970 smokers through June 2016. In total, 183 of those reached received counseling, and of those 146 participated in nicotine replacement therapy. After two weeks, of the 126 smokers reached for a follow-up interview, 83 percent reported using nicotine replacement therapy, 62 percent reported a reduction in smoking, and 23 percent quit completely. According to Ms. Kaplan, these rates are extraordinary, especially because many of those reached had not tried quitting previously. She credits the success rate in part to 1) AAFE’s credibility and deep connections to residents within its communities; and 2) the ways that

AAFE integrated access to the program into its housing and immigration counseling services, among other services. With an additional three-year commitment from NYU Hospitals Center, AAFE has committed to expanding the program and will engage other community-based organizations in its outreach efforts going forward.

### Structuring and Originating

### Mission-Driven Financing with CDFIs

### Housing Finance in Richmond, Virginia: Bon Secours and Mercy Loan Fund

Bon Secours Richmond Memorial Regional Medical Center, in Richmond, Virginia, has partnered with the CDFI Mercy Loan Fund (MLF) to finance the creation and preservation of affordable housing in the low income neighborhoods of Blackwell and the East End, near where the hospital is located. MLF is an entity of Mercy Housing, a national nonprofit affordable housing developer which has undertaken a strategic alliance with Bon Secours. As part of this partnership, Bon Secours is on the board of Mercy Housing and the MLF, and it is an investor in both.

To finance affordable housing, Bon Secours acts as a wholesale lender, providing low-interest financing to Mercy Loan Fund, which MLF then uses to originate real estate acquisition and construction loans.

The Bon Secours regional center in Richmond is a 225-bed facility with a service area of approximately 685,000 residents across 43 ZIP codes—a significantly larger and more socially diverse service area than its Baltimore counterpart. Similar to its Baltimore counterpart, its mission is “[t]o bring compassion to healthcare and to be good help to those in need, especially those who are poor and dying.” The hospital spent $24 million in total on community benefits in fiscal year 2014, primarily focusing its geographically targeted spending in and around the East End, which has a population of approximately 48,000. Its CHNA identifies 10 priorities in the hospital’s community benefit service area, including aging services, behavioral health, maternal health, and transportation. Its housing investments in particular are intended to revitalize the community while enhancing health and the quality of life for low-income families and older adults.

To finance affordable housing, Bon Secours acts as a wholesale lender, providing low-interest financing to
Mercy Loan Fund, which MLF then uses to originate real estate acquisition and construction loans. A key partner and recipient of those loans is the affordable housing developer Better Housing Coalition, which has had a line of credit with MLF since 2002. Bon Secours initially invested $250,000 with MLF in 2009 to support the revitalization of the Blackwell and East End neighborhoods, and it has increased the investment over the years to its current level of $1.6 million. Loans do not count as community benefits per the IRS definition, as discussed above, but these loans complement community benefit spending and can foster goodwill within the surrounding community.

The combined impact of Bon Secours, MLF, and Better Housing Coalition is considerable. From 2002 to 2016, MLF provided over $2.2 million in financing to Better Housing Coalition, which used those funds to develop 44 single family homes. Drawing on financing from other sources as well, Better Housing Coalition today has completed three developments in the area. In the East End, Church Hill offers 42 multifamily rental units and over 100 single-family homes for sale to low-income families, and Beckstoffers Mill was a lumber mill that has been converted into a mixed-used property with 22 mixed-income loft apartments and 39 apartments for residents age 55 and older. In Blackwell, Oak Summit at Goose Creek has 45 single-family homes. Oak Summit II is planned, which will have an additional 40 single family homes when completed.

**FQHC Financing in California: Dignity Health and Capital Impact Partners**

Dignity Health, which is the largest nonprofit hospital system in California, provides market-rate and below-market rate capital to benefit low-income people and communities through its Community Investment Program. Funds are issued directly to nonprofit borrowers and nonprofit lenders, and have been used to originate real estate and working capital loans to federally qualified health centers (FQHCs). Dignity Health’s community benefit service areas encompass areas near the health system’s 32 hospitals in California, plus its hospitals in Arizona and Nevada. The health system’s mission is “delivering compassionate, high-quality, affordable health services; serving and advocating for [the] poor and disenfranchised; [and] partnering with others in the community to improve the quality of life.” Dignity Health invested $954 million across all its hospitals in community benefits in fiscal year 2015.

**Funding projects such as FQHCs can help to prevent unreimbursed healthcare costs.**

Dignity Health’s Community Investment Program builds on and complements the goals in its hospitals’ CHNAs. From 2006 to 2015, the organization provided nearly $72 million through this program to 155 nonprofit borrowers, such as FQHCs in medically underserved areas. Dignity Health issues loans and lines of credit directly to nonprofits, and it provides a suite of products that CDFIs can utilize including low-interest rate debt capital for subsequent loan origination, linked deposits that reduce interest rates for small business and affordable housing loans, and guaranties. Originating loans directly provides Dignity Health with autonomy in selecting its borrowers, while investing capital with CDFIs provides a platform that Pablo Bravo, Vice President of Community Health, describes as “a good way for us to extend our reach and leverage our capital” while minimizing the resources required to monitor capital use and repayment after deployment.

Through its Community Investment Program, Dignity Health has invested in the CPCA Ventures Loan Fund. The CPCA Ventures Fund is a California-wide loan fund that Capital Impact Partners, a CDFI, manages in partnership.
with the health clinic advocacy group California Primary Care Association (CPCA).64 The CPCA Ventures Fund, established in 1999, provides real estate and working capital loans of up to $1 million with terms as long as 5.5 years and a fixed rate of 3.175%.65 As an investor in the fund, Dignity Health provided an initial investment of $2.5 million in debt capital, which Capital Impact Partners used together with funds from additional investors to originate the loans.66 Ultimately, the CPCA Ventures Fund is one part of Capital Impact Partners’ ongoing commitment to health care. In 30 years, Capital Impact Partners has provided over $752 million in support of 506 community health centers that provide over 2 million patients annually with health care access.67

Critically, even though loans do not count as a community benefit per the IRS definition, they are on-mission and improve Dignity Health’s long-term financial stability.68 Funding projects such as FQHCs can help to prevent unreimbursed healthcare costs. In these instances, such costs arise when patients who are either uninsured, underinsured, or insured through public programs—programs which have low reimbursement rates—over-utilize hospital services for preventable conditions. While Dignity Health itself has operated health clinics, FQHCs can offer an even more comprehensive set of services, including mental health and dental care in addition to physical health care. Especially in areas that are underserved by health care institutions, the presence of an FQHC in proximity to a hospital can help to establish a continuum of care, such that patients can rely on the clinic for primary care needs and referrals to specialists.

Photo 3: Children’s dental office at Rancho Cordova Community Health Center, Sacramento, CA. This FQHC was financed directly by Dignity Health through its Community Investment Program. Photo courtesy WellSpace Health.
Hospital community benefit spending is a funding source that helps to align the work of two fields that are increasingly working together to achieve similar goals related to population health. The case studies above demonstrate five ways in which nonprofit hospitals and community development organizations can collaborate in order to further the health of individuals in low-income areas.

Nonprofit hospitals could engage in strategic partnerships with community development corporations and CDFIs to inform their community health needs assessments (CHNAs) and otherwise guide implementation of community benefit investments.

- Examples of partnerships include having a community development corporation employee on a hospital’s community benefit advisory board (Boston Children’s); drawing on a community development corporation’s expertise in forming coalitions for community collaboratives (NYU Hospitals Center); and having a hospital representative on the board of a CDFI (Bon Secours and Mercy Loan Fund).

- Community development corporations have expertise in addressing the broad range of needs specific to low-income people in their communities, including affordable housing and workforce development. Affordable, safe, and high-quality housing has been shown to impact health and is essential for individual well-being. Furthermore, as demonstrated by Fenway Community Development Corporation, workforce development programs can train and place low-income residents in a variety of health-related professions.

Community development corporations and nonprofit hospitals could collaborate to create and preserve affordable housing, along with other programs that draw on the partners’ respective strengths.

- Affordable housing is not only critical for individual well-being; housing development and renovation is an essential investment in the physical environment of a neighborhood. In West Baltimore, Bon Secours and Enterprise Homes have transformed vacant, abandoned buildings into quality housing. Such investments help to improve quality of life in a neighborhood and can, over time, attract additional investment in a neighborhood’s buildings and public realm.

- In New York City, NYU Hospitals Center partnered with Asian Americans for Equality (AAFE), which reduced the incidence of smoking in Manhattan’s Community District 3 by 1) drawing on its credibility with and deep connections to residents in Chinatown and the surrounding neighborhoods; and 2) integrating access to the smoking cessation program into its housing and immigration counseling services, among other services.
Hospitals could support legislation and fund programs to prevent, reverse, and end homelessness, following the example of Boston Children’s Hospital.

- Although not discussed at length in this paper, it follows that homelessness prevention programs are an essential health-promoting complement to providing affordable housing. For more information, see the website of the United States Interagency Council on Homelessness (https://www.usich.gov/).

Nonprofit hospitals could provide funding to CDFIs to support the origination of loans for affordable housing, health clinics, and other health-related real estate investments—while additionally supporting research and documentation of best practices. Likewise, CDFIs could seek funding from hospitals for these purposes.

- Such funding could include grants. Grants could be originated in conjunction with loans on projects that would otherwise be infeasible. They could also be used as credit enhancement, which lowers a lender's exposure to potential losses.

- Hospitals may also choose to provide capital to CDFIs in other ways. Examples include debt capital, which CDFIs can then use to originate loans; linked deposits that reduce interest rates for small business and affordable housing loans; and guaranties. Debt does not count as community benefit spending under IRS rules, but if used to fund something like a federally qualified health center (FQHC), it has the potential to generate a return on the hospital’s investment both through accrued interest and by reducing its unreimbursed healthcare costs.

- Both the community development sector and hospitals could benefit from research into best practices, which is still in its early stages.

Beyond community benefit funding, future research should examine the potential for using additional funding sources, such as the Delivery System Reform Incentive Payment (DSRIP) program, to align the work of the community development and health care fields.

- Not discussed in this paper, federal DSRIP funding is being used in various states to decrease preventable hospitalizations. Preventable hospitalizations can be addressed in part by programs affecting social determinants of health.
before the Affordable Care Act, community needs assessment has been a well-established best practice for guiding hospitals’ community benefit planning. See, e.g., Catholic Health Association of the United States. “Social Accountability Budget.” St. Louis, 1989.


19 Data for the case studies was collected through a review of publicly available documents, including CHNAs and implementation plans, and through interviews with staff at the hospitals and their community development partners.


25 Boston Children’s Hospital provides funding to the Fenway Community Development Corporation under the auspices of Massachusetts state community benefit requirements. For the purpose of this case study, the differences between the federal and state requirements are immaterial.


30 Ibid.

31 The Fenway neighborhood has unusual housing market pressures due to the neighborhood’s proximity to the Longwood Medical Area and the presence of Boston University, Northeastern University, the Berklee College of Music, and the Colleges of the Fenway. Two-thirds of Fenway’s 32,000 residents are college or graduate school students and nearly three-quarters of the neighborhood’s adults age 25 or older have a college degree (Boston Redevelopment Authority. “Boston in Context: Neighborhoods.” Boston, MA, 2016). Land prices and rents in the area support development of what the Boston Redevelopment Authority calls “flashy new apartment and condominium towers,” and they are sufficient to spur interest in expensive air-rights development on top of the Massachusetts Turnpike, which runs through the neighborhood. (Boston Redevelopment Authority. “Fenway at a Glance.” Boston Redevelopment Authority, 2016. http://www.bostonredevelopmentauthority.org/neighborhoods/fenway-at-a-glance; Boston Development Authority. “MassDOT Turnpike Air Rights Parcel 7 Citizen Advisory Committee.” Boston Redevelopment Authority, 2016. http://www.bostonredevelopmentauthority.org/planning/planning-initiatives/massachusetts-turnpike-air-rights-parcel).

32 Ibid.


36 Bon Secours Baltimore Health System. “Community Health Needs Assessment.”

37 Ibid.


40 Ibid.


42 Ibid, 1.


46 Kaplan, Sue. “Updated Figures.”


48 Ibid, 7.

49 Ibid.

50 NYU Langone Medical Center. “NYU Hospitals Center Community Health Needs Assessment and Community Service Plan.” 20.

51 Kaplan, Sue. “Updated Figures.”