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DISCUSSION PAPER

Can Community Development Improve Health?

Emerging Opportunities for Collaboration between the Health and Community Development Sectors

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Primary issue:

A new body of practice is emerging in the Southeast that brings health and community development professionals together to improve both health and economic outcomes for low- and moderate-income communities. The work often centers on improving the health outcomes and fiscal efficiency of health care systems by investing in the social determinants of health.

Key findings:

Practitioners in both the health and community development sectors are starting to address health and community development issues in an integrated manner. These efforts often focus on opportunities to improve health outcomes and reduce health spending by intervening in the social determinants of health, which research suggests are the primary drivers of health outcomes. In the Southeast, the work has included hospitals investing in affordable housing, community development financial institutions offering low-cost financing to build community health centers and combat food deserts, and Medicaid offices using Pay for Success finance to pay for prevention. State and local governments, as well as foundations, can play an important role helping catalyze and support these integrated solutions.

Takeaways for practice:

Community development professionals may find new partners and funding sources from inside the health sector, due to the health benefits or health care cost savings that may come from a community development project. Health industry professionals can leverage community developers' expertise in finance, housing, and public-private partnerships when trying to address the upstream factors that drive population health. Governments and philanthropy may be able to drive new fiscal efficiency and quality improvements in health care and community development programs by facilitating health and community development partnerships.

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Abstract:

The two sectors of community development and health have long worked in the same neighborhoods, but they have not always worked together. This is starting to change, due in part to a growing recognition among health experts of the social, economic, and environmental factors that drive health outcomes. These social determinants of health have become the basis for new collaborations between community development and health professionals. This paper introduces professionals in both sectors to this emerging area of practice through a series of case studies of innovators in the southeastern United States. Case studies look at ways to bring housing and health professionals together, opportunities to leverage community development finance tools, and efforts to use Pay for Success to improve Medicaid spending. This discussion paper reviews early lessons on how to build a successful health and community development partnership, including an examination of the incentives for community developers, health professionals, state and local governments, and philanthropy to participate in these collaborations.

JEL classification: I11, I14, L31, P46, R51, Z18

Key words: social determinants of health, affordable housing, health and housing, community development financial institutions, Medicaid

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international affairs where she served as chief of staff. Before her time in government, she was a clinical lecturer at Yale Law School, where she helped lead the community and economic development clinical program. She also worked at ShoreBank, the nation's first CDFI bank. Her work in finance has spanned consumer, small business, housing, and microfinance. She received her law degree from Yale Law School and her bachelor of arts in social studies from Harvard College.

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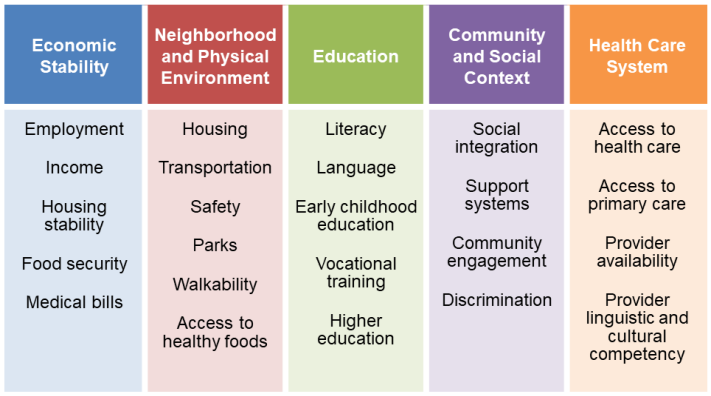
Comments to the author are welcome at sameera.fazili@atl.frb.org.

Introduction

This paper is the first in a two-part series examining the growing collaboration between the health and community development sectors in the Southeast. Differences in history, language, and funding have traditionally kept the two industries working in separate silos. That is starting to change. This series will examine the scientific, economic, and policy factors driving the two sectors toward greater collaboration.

Community development encompasses a wide range of disciplines. What unites the field is a mission to improve the economic, social, and environmental conditions for lower-income individuals and/or economically distressed communities. At their best, community developers are entrepreneurs who craft multi-sector partnerships to help solve a community-level problem, while also integrating the community's voice and blending public, private, and philanthropic funding. In some places, community developers might focus on building quality affordable rental housing; in others, they might offer after-school programs for youth. Programming depends on assessing the needs of the community and the available resources.

Figure 1: The Social Determinants of Health



Sources: Adapted from Heiman and Artega, 2015 and Department of Health and Human Services *Healthy People 2020* website

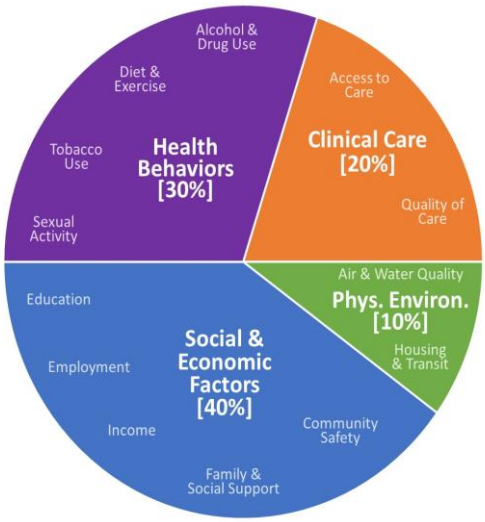
Health workers and community developers interacting with one another is not altogether new; the two sectors have long worked in the same neighborhoods and with the same populations. However, the pace and scale of partnerships have grown in the past decade, as the health care industry has become more focused on the Triple AIM goals of reducing cost, increasing quality, and improving population health (Berwick, 2008). The first section of this paper orients readers to the concept of the social determinants of health (SDOH), summarized in figure 1, which offers an intellectual bridge between the health and community development sectors. The second section showcases a range of innovators in the Southeast who are bringing health care and community development practitioners together to tackle the SDOH. The third section takes a closer look at running a successful health and community development partnership. The second paper in the series will focus on the changing market

dynamics inside the health care industry that may provide new avenues for deeper collaboration between the two sectors.

Understanding the Social Determinants of Health: Can Community Development Improve Health?

In city after city, life expectancy varies dramatically between neighborhoods, even if those neighborhoods are just a few miles apart. In New Orleans, for example, those differences can run as high as 25 years.[1] The reason is due in part to the economic, social, and environmental drivers of health, often referred to as the social determinants of health (SDOH). As a result, zip code may predict health better than genetic code does. When the SDOH are considered, medical care may influence just 20 percent of health outcomes in a community.[2] By comparison, as figure 2 shows, up to 50 percent of health outcomes are driven by socioeconomic factors—for example, whether a person can afford fresh fruits and vegetables—or the built environment—for example, if a child's house is free from mold. This research has driven many health experts to look for ways to intervene "upstream" to address the conditions that cause poor health to occur in the first place (Heiman and Artiga, 2015).

Figure 2: The Factors Affecting Health Outcomes



Source: Adapted from the University of Wisconsin's *County Health Rankings* model (2014)

However, the U.S. health care system is not designed to address the SDOH. Our delivery system—from hospitals to physicians to health insurance companies—focuses primarily on one-on-one clinical interventions after an illness is diagnosed. Here is where community development can enter the picture. Community developers are skilled at intervening at the environmental and social levels—the precise upstream factors driving health outcomes. What they lack, though, is a nuanced understanding of health concepts and health systems. That is where the public health community often steps in. Public health, with its deep expertise on the SDOH, can often serve as a translator and bridge between the community development and health care sectors.

[1] Life expectancy maps of different cities and regions in the country are at the VCU Center on Society and Health.
[2] These estimates are from the University of Wisconsin Population Health Institute's model of population health.

Breaking the Silos: Bottom-Up Innovation

So how can practitioners weave together two sectors with different languages, goals, and funding? In this section, I examine three different strategies currently in use in the Southeast to blend or braid community development and health spending. Innovators are testing and piloting integration strategies at the state and local level. This experimentation is made possible by the federalist nature of health and community development programs. The division of authority between local, state, and federal resources means new approaches can be tested at almost any level of government. In this section, I look at three case studies that showcase efforts to unite affordable housing with health care, to leverage community investment tools to address health care concerns, and to manage state Medicaid spending better through the new field of outcomes-based finance.

Investing health dollars in housing

Housing can have a large impact on an individual's health. Access to quality affordable housing has been shown to improve health outcomes in some populations (Butler et al., 2017). The quality of the housing is an important variable, since conditions like mold or lead paint can generate health problems. Neighborhoods also matter. They affect a person's access to amenities like green space for exercise or grocery stores for fresh vegetables. Addressing the housing and built environment challenges faced by low-and moderate-income households has long been a concern of community developers. Therefore, partnerships addressing health and housing have been at the leading edge of efforts to integrate health and community development.[3] In more recent years, these partnerships have looked for ways to leverage health care *funding* to advance affordable housing interventions.[4]

One of the best-studied examples of how a housing intervention can improve health is the field of supportive housing. Supportive housing integrates social, behavioral, and health services with affordable housing for chronically homeless individuals. The chronically homeless often have a chronic health condition such as physical or mental disabilities, HIV/AIDS, or substance abuse disorders. As of 2016, the U.S. Department of Housing and Urban Development (HUD) estimates that 22 percent of homeless individuals qualify as chronically homeless (Henry, 2016). Homeless individuals are expensive for health insurers and hospitals alike to manage, as they are prone to use costly emergency room (ER) services or face hospital admissions due to complications from their underlying chronic conditions. Rather than treat these individuals in an institutionalized setting, supportive housing allows them to receive both medical and social services in a community-based setting. In some models, medical therapy or behavior change is mandated to maintain housing access, while in "Housing First" strategies, the person is housed with no preconditions.

Supportive housing programs often target people who pose a high cost to public budgets, due to their frequent interactions with the social safety net or criminal justice systems (Collins et. al., 2012). Numerous studies have shown supportive housing, and especially the Housing First variant, leads to

[3] The Department of Housing and Urban Development (HUD) and the Centers for Disease Control and Prevention (CDC) developed a useful guide on best practices in health and housing collaborations.
[4] Mercy Housing and the Low Income Investment Fund published a recent paper highlighting innovative transactions that use health sector dollars to fund affordable housing transactions.

lower overall cost of services for homeless individuals (Gulcur et. al., 2003; Larimer et al., 2009). Cost savings are generated from decreased use of health care services and/or decreases in incarceration rates. Given that many of these clients receive Medicaid, supportive housing is often viewed as a way to control spending for high-cost users of state Medicaid programs. The evidence of the benefit of Housing First models to both patients and taxpayers has become so strong that Housing First became a core component of federal homelessness programs after 2009 with the passing of the Homeless Emergency Assistance and Rapid Transition to Housing Act.

Designing and funding supportive housing programs can be challenging. Medicaid cannot pay for housing, so it is usually funded through existing affordable housing programs like the Low-Income Housing Tax Credit (LIHTC) for construction of affordable rental housing or Housing Choice vouchers to subsidize a person's rent. Supportive housing's intensive case management and wraparound services are often paid for by blending several different state and federal funding streams, including programs funded by the U.S. Department of Health and Human Services (HHS) and HUD.[5] Medicaid is able to pay for some services, including primary care, behavioral health, and some substance abuse services, if the client is Medicaid eligible and the service provider is a Medicaid-accredited service provider. Some medically related transportation expenses are reimbursable through Medicaid as well. Therefore, supportive housing providers need to be able to manage a complex array of funding sources, which may each carry unique eligibility and reporting requirements.[6]

Given that supportive housing coordinates both housing and health care services for its residents, the health sector has shown interest in investing in supportive housing programs. In Orlando, Florida, the Adventist Health System played a key role in the city's homeless services system transition toward a Housing First model.[7] Adventist is a nationwide health system with 24 hospitals in Florida, seven of which are in the Orlando area. Adventist's Florida Hospital realized chronically homeless patients were overly reliant on ER care, and the patients' underlying substance abuse or mental health issues driving their emergency care episodes had not been receiving sufficient attention. Its leadership decided that better care for the homeless was warranted, driven in part by the institution's religious mission, and therefore $6 million in community benefit spending[8] was set aside to improve case management for chronically homeless individuals. The hospital also became more engaged in homelessness issues locally, joining the board of the Homeless Services Network of Central Florida, the

[5] Federal programs that can fund supportive housing services include Substance Abuse and Mental Health Services Administration (SAMHSA) grants, Community Services Block Grants, and HUD's Continuum of Care grants. The Corporation for Supportive Housing has produced a useful guide summarizing different state and federal funding sources for services in supportive housing.

[6] HHS has published two guides to assist practitioners trying to improve links between Medicaid and supportive housing. One provides an overview of supportive housing programs and the second is a primer on using Medicaid funding in supportive housing programs.

[7] Information on the Orlando program is based largely on the author's interviews with Adventist Health System staff.

[8] Under federal tax laws, not-for-profit hospitals are required to provide "community benefits" in order to qualify for a 501(c)(3) charitable tax exemption, since providing health care alone is not considered a charitable purpose. Since 2009, hospitals have had to document their community benefits spending in their annual 990 tax return using a Schedule H form. The Hilltop Institute tracks community benefit policies nationwide, and has reports summarizing hospital community benefit requirements.

region's homeless services coordinator. Adventist also placed its support behind the Central Florida Commission on Homelessness (CFCH) campaign to move central Florida to a Housing First system. Adventist then used its community benefit dollars to invest in CFCH's Homeless Impact Fund, a donor-advised fund at the local community foundation, and helped raise additional philanthropic support from JP Morgan Chase Foundation and Walt Disney Corporation.[9] CFCH used $1 million from the collaborative to provide housing and services to 100 chronically homeless families and individuals. Adventist also brought the Jacksonville-based supportive housing provider Ability Housing into central Florida for the first time. The hospital acquired the Wayne Densch Center, an existing transitional housing site, and helped convert it to a Housing First facility by leasing it to Ability Housing for a dollar a year. While Adventist made these investments primarily driven by its religious mission, it also recognized the potential these investments have to generate cost savings for the health system.[10]

Using community development finance to tackle the SDOH

While the previous example demonstrates how the health sector can invest in community development projects, the reverse is also true; community developers are investing in projects to address health. A special type of finance is available in the community development sector, and it offers a potential affordable source of financing to health-oriented projects that target low-income or distressed communities. Community development finance programs include LIHTC—which provides public subsidies for the construction of affordable rental housing—and the New Markets Tax Credit (NMTC)—which provides subsidies for revitalization projects in lower-income communities. States like Georgia have made changes to their LIHTC rules in the hopes of improving the health outcomes for low-income renters.[11] Numerous rural and urban communities have brought affordable, healthy food to food deserts by making use of NMTC financing.[12]

Projects to address the SDOH often require a combination of public, private, and philanthropic funding. A special subset of the community development industry—community development financial institutions (CDFIs)—has developed an expertise in combining funding from or underwriting projects cofinanced by these three sectors. A leading southeastern CDFI that has developed a health care practice is the Florida Community Loan Fund (FCLF), which lends statewide in Florida. In part due to the state's large supply of low-paying service sector jobs, health insurance coverage remains a challenge for

[9] Health care investments in supportive housing need not just be grants. In Arizona, the health insurer United Health Care provided a $22 million loan to develop nearly 500 units of supportive housing in Phoenix (LIIF, 2017).

[10] The hospital is tracking decreases in emergency room utilization, for example, that may result from the Housing First model in Orlando. It is unknown at this time whether the programs will ultimate lead to actual cost savings or if they will instead help the hospital avoid costs. Health care professionals distinguish *cost avoidance* from *cost savings*, due to the "woodwork" effect. The woodwork effect refers to situations where, once one patient has avoided costly treatment, a bed is freed up to treat another patient. That second patient will incur a different set of costs; therefore, the hospital did not necessarily save money by treating patient two over patient one.

[11] In Georgia, state officials made changes to the LIHTC program based on a health impact assessment (HIA) conducted by the Georgia Health Policy Center. HIAs are a tool to help policymakers and communities consider the potential health impacts of a given policy, project, or program.

[12] Food deserts are lower-income areas with little access to affordable and nutritious food such as fresh fruits or vegetables. Often measured by distance to the nearest grocery store, the U.S. Department of Agriculture's Economic Research Service has created a Food Access Research Atlas to help communities identify food deserts.

residents.[13] Furthermore, 40 percent of Florida's population qualifies as low income. As a result, community health centers are a key source of primary care and preventive health services as well as much needed specialty care like dental, gynecological, and mental health services.[14]

FCLF has developed an expertise in helping community health centers use New Market Tax Credits to improve access to care for low- and moderate-income Floridians.[15] Community health centers are often not familiar with the financing tools CDFIs can offer, and so FCLF spends time working with a potential borrower to explain how low-cost, flexible financing can help a nonprofit improve its services in a sustainable way. In many instances, FCLF is able to structure the deal so a part of the loan converts to equity for the nonprofit at the end of the loan's seven-year term, resulting in lower debt payments for the community health center. That was the case for Central Florida Health Care, which is using an $8.1 million loan to expand its services in four locations, including both rural and suburban sites. This expansion will allow the center to see an additional 5,000 patients a year.[16] The project brought the first low-income health clinic to Polk County's Winter Haven, and the site also includes a teaching kitchen to offer healthy cooking and eating classes for patients to promote healthy eating habits.

Philanthropies are also recognizing the benefit of working with CDFIs to fund interventions in the social determinants of health. The Kresge Foundation partnered with a national CDFI, the Local Initiatives Support Corporation, and a bank, Morgan Stanley, to create the Healthy Futures Fund. Launched in 2012 and renewed in 2015, the fund leverages both New Markets Tax Credits and LIHTC to invest $200 million in projects designed to address the social determinants of health. The fund has been able to finance projects in rural areas, small towns, and large metros alike. Projects have ranged from colocating a grocery store and a health clinic to financing a health clinic inside an affordable apartment building.

While CDFIs can bring low-cost debt to a project, a grant to provide equity capital is often required to support the loan. The grant can be placed in the project, at the CDFI, or both. In some cases, health care organizations may be willing to invest their grant dollars or investment capital into community development projects that address a SDOH. Some forward-looking health systems—like Kaiser Permanente and Dignity Health—do just that. Kaiser has adopted a "total health" framework that focuses the company on "using all its assets to maximize physical, mental, and social well-being for its members and the communities it serves" (Norris and Howard, 2015). This approach led Kaiser to be a founding member of the California FreshWorks Fund with a $1 million grant. The fund, which operates through CDFIs, was set up to support access to healthy foods retail and distribution in food deserts. The Catholic hospital system Dignity Health is committed to "making a positive impact on the social determinants of health, particularly on the health of those economically disadvantaged communities

[13] The state has the following health insurance coverage rates, according to the Kaiser Family Foundation: 13 percent of the state's population remains uninsured, 18 percent is on Medicaid, and 10 percent have individual coverage through the Affordable Care Act.

[14] Community health centers offer health care services on a sliding scale basis so they can be affordable to low- and moderate-income patients.

[15] Information on FCLF's community health center program is based on interviews with its staff.

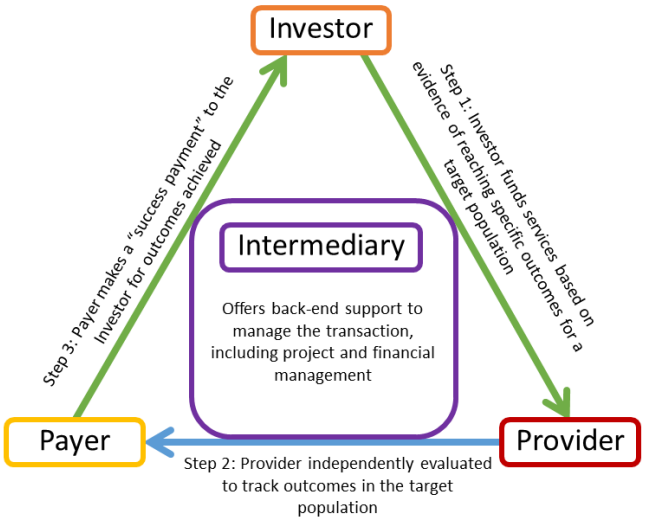
[16] To learn more about the deal, see http://www.fclf.org/meet-our-borrowers-item/cfhc-central-florida-health-care.

served by Dignity Health hospitals" (Hacke, 2017). The health system operates an over $100 million loan fund that makes investments in community development projects and in CDFIs to target the social determinants of health in its service areas.[17] Public sources of grant capital can sometimes be unlocked to help support efforts to tackle the SDOH. In Pennsylvania, policymakers realized that health promotion objectives aligned with economic development priorities, leading the state to contribute $30 million in grant funding to create a healthy foods financing program in 2004. Ultimately, the CDFI Reinvestment Fund managed those funds and was able to raise an additional $145 million in capital to combat food deserts.[18]

Using "Pay for Success" finance to improve state Medicaid programs

The power of upstream interventions to generate both cost savings and better health outcomes has made health care interventions an ideal focus for the new "Pay for Success" field.[19] Pay for Success helps to address the so-called wrong pockets problem that is endemic between highly siloed sectors. Wrong pockets refers to situations where the funding for an intervention comes from one system (such as housing) but the savings go into another system (like health). The system that pays for the intervention is not the same system that receives the benefits from it. This wrong pocket means that investments in the proven intervention are unlikely to be made, despite the benefits they could yield to families, communities, and taxpayers. The two systems cannot overcome the budgetary, administrative, and political silos that separate their work. Pay for Success deals try to overcome those silos. In a deal, investors pay for the upfront cost of the intervention. The investor is then paid back only if pre-agreed upon outcomes are achieved. The payer is usually a public agency, and the deal relies on an intermediary to help manage the transaction (see figure 3).

Figure 3: An Overview of Pay for Success Transactions



Source: Author's own figure based on a review of Pay for Success transactions

Pay for Success is being used to fund upstream interventions in health that have strong evidence of improving health outcomes. In particular, advocates believe Pay for Success can help improve

[17] The Build Healthy Places Network, which aims to help health and community development professionals find opportunities to collaborate, collects and disseminates stories of health and community development collaborations that target the SDOH.
[18] Further information on the Pennsylvania program is available at Reinvestment Fund's website.
[19] Pay for Success transactions, also sometimes referred to as social impact bonds, are a part of the growing outcomes-based funding movement, which is the subject of a recent Federal Reserve Bank of San Francisco book *Investing in Results*.

Medicaid programs,[20] while also achieving policymakers' goals of controlling or reducing Medicaid spending.[21] South Carolina has emerged as an important national leader in this area with its launch of one of the first Medicaid Pay for Success transactions.[22]

South Carolina is using Pay for Success to help fund a large expansion of the state's Nurse-Family Partnership (NFP) program to 3,200 women. NFP provides home visitation services to low-income, first-time mothers and their children. The home visits help mothers have a healthy pregnancy, provide better quality care for their children, and become more economically self-sufficient. The nurses provide health care to the mother and child and serve as a coach to the mother, offering parenting and life skills training. The program, therefore, focuses on social determinants like support systems, access to care, education, and employment. Over its 40-year history, the program has been rigorously evaluated through multiple randomized control trials.[23] The studies have shown that the intensive support of low-income mothers yields benefits ranging from improved prenatal health (lower infant mortality rates and higher birth weights), fewer subsequent pregnancies for the mother, increased maternal employment, improved school readiness for the child, and decreased public benefit usage by the parent. One clinical trial in Memphis found over $12,000 in public sector cost savings by age 12 for children in the program compared to children who did not receive the program. The cost of Medicaid, cash welfare assistance, and food stamps drive the difference (Old et. al., 2010; Miller, 2015).

South Carolina has one of the highest infant mortality rates in the nation. While the national infant mortality rate is 6 per 1,000 live births, in parts of rural South Carolina the rate is over 14 per 1,000 births (Pardue and Sausser, 2016). In 2012, the Institute for Child Success, a Greenville-based nonprofit advocacy organization, started studying ways Pay for Success financing could improve life outcomes for low-income children and their parents. Based on an Institute for Child Success feasibility study, the governor's office—with technical support from Harvard's Government Performance Lab—worked with Social Finance, a nonprofit and leading Pay for Success intermediary, to develop and execute a Pay for Success project that braided Medicaid funding with private investments to improve maternal and child health outcomes. The team spent two years working to put the project together. In the end, the South Carolina Department of Health and Human Services received a five-year 1915(b) waiver from the Centers for Medicare and Medicaid Services that allowed the department to use federal Medicaid funds to pay for NFP on a fee-for-service basis, covering almost 45 percent of the per-family cost.[24]

[20] For a more in-depth discussion of improving the use of Pay for Success in Medicaid, see Allison Hamblin's essay "Key Considerations for Gaining Traction in Medicaid" in the San Francisco Fed's *Investing in Results*.

[21] Outcomes-based finance advocates are careful to note that cost savings are not always achieved. Instead, the real benefits of outcomes-based finance, they maintain, is maximizing outcomes for every dollar spent on social assistance programs and actually achieving the intended life improvements for program beneficiaries.

[22] Information on the South Carolina Pay for Success program came from interviews with Social Finance as well as comments from NFP and the South Carolina Department of Health and Human Services.

[23] The program has been extensively studied in multiple locations. For a robust summary of the evidence of the program's effectiveness, see the Coalition for Evidence-Based Policy.

[24] The next section of the paper provides a deeper description of Medicaid waivers, including 1915(b) waivers.

To receive a success payment in South Carolina, the NFP program must achieve reductions in preterm births, improved birth spacing, reduced hospitalizations and ER visits for a child before age two, and enrollment of mothers from the highest-risk zip codes. The evaluator, J-PAL North America, will also study longer-term impacts the program may have on the criminal justice system, foster care, and special education. The funding for the expansion includes $13 million from the Medicaid waiver and $17 million from national and local philanthropies. If the program reaches its goals, the state will make a success payment of up to $7.5 million, which will be recycled into sustaining the program.[25]

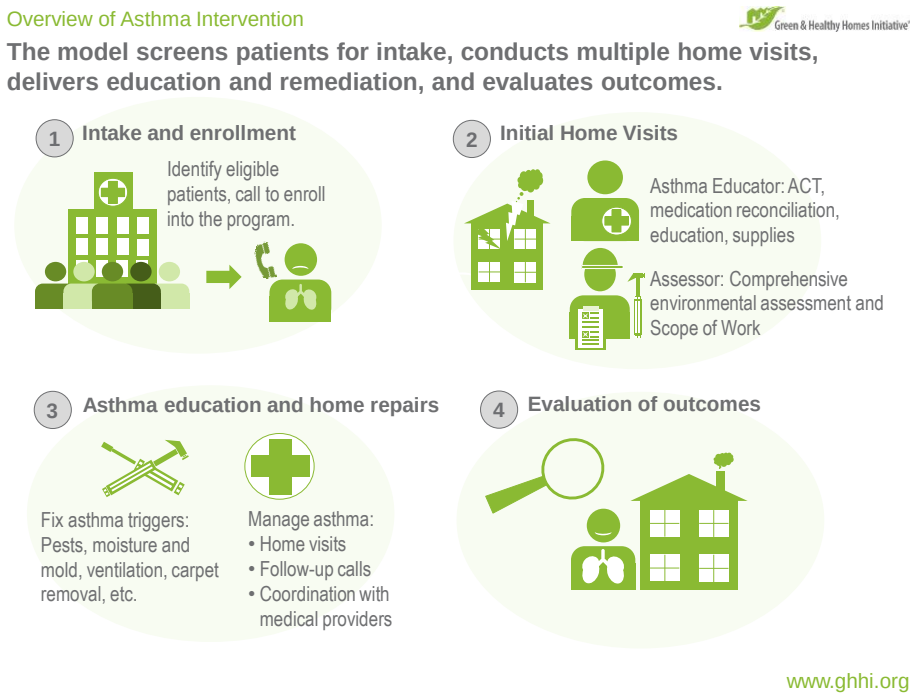
The South Carolina transaction was innovative for a few reasons. First, it was the first time a Pay for Success structure included a Medicaid 1915(b) funding waiver. Second, the transaction successfully converted NFP's long-term value into a short-term value stream, since outcomes must be achieved by year five to trigger the South Carolina Department of Health and Human Services' success payment. South Carolina officially launched the program in 2016, and it is on track nearly to double NFP capacity to 3,200 additional mothers and their children over a four-year period. The hope is that, if the program is successful, it can lay the groundwork for NFP to utilize further Medicaid funding in the future in South Carolina rather than relying largely on philanthropic funders.

Pay for Success is not just a possible funding source for social service programs like NFP. The Green and Healthy Homes Initiative is testing the use of Pay for Success financing for home remediation services, to address environmental conditions that trigger poor health outcomes for asthma patients.[26] With grant funding from the Corporation for National and Community Service's Social Innovation Fund, the Robert Wood Johnson Foundation, and the JPB Foundation, the Green and Healthy Homes Initiative is undertaking feasibility studies of programs in 10 cities and one state. The studies will demonstrate if locally designed programs that combine medical care, health education, and home-based remediation services will create measurable cost savings and health improvements.[27] The programs being reviewed work to identify and eliminate home-based triggers, such as mold or poor ventilation, so asthma patients make fewer ER visits or miss fewer days of work or school. If the programs can demonstrate sufficient cost savings, the Green and Healthy Homes Initiative will work to help find Pay for Success investors for the projects. If successful, the effort will demonstrate a structure through which Medicaid can authorize the private managed care organizations (MCOs) that manage Medicaid in most states to pay providers for the medical impact of home remediation services.[28] In particular, the cost savings from decreased medical service utilization might be incorporated into the provider's payment.

[25] A fact sheet with further details on the South Carolina program is on NFP's website.
[26] Information on GHHI's program came from interviews with GHHI social innovation staff.
[27] The CDC includes the use of home visits to improve self-management education and reduce home asthma triggers as one of the evidence-based strategies it seeks to promote in its 6 by 18 initiative. This initiative targets six common, costly health conditions with 18 specific interventions to align evidence-based preventative practices with value-based payment and delivery models.
[28] In most states, Medicaid programs contract with private health insurance companies, referred to as MCOs, to manage the care for all or most of the program's covered beneficiaries. Medicaid recipients must select a MCO, and the state pays the MCO based on its number of covered beneficiaries.

One site for the Green and Healthy Homes Initiative's feasibility studies is Memphis, Tennessee. Le Bonheur Children's Hospital in Memphis houses an existing asthma program known as CHAMP or Changing High-risk Asthma in Memphis through Partnership.[29] Currently, the Green and Healthy Homes Initiative is working with Memphis-based partners to structure the transaction, having already successfully completed a feasibility study for the program (see figure 4 for an overview of the Memphis program).[30] As of summer 2017, Memphis is piloting the service delivery model and referral pathways for the coordinated asthma program. Funders for the pilot include the Social Innovation Fund, the Pyramid Peak Foundation, and the Urban Child Institute. The outcomes payer would be the local MCOs, if they receive authorization from the state Medicaid agency, TennCare. The initiative is working to recruit all three of the state's MCOs into the program, but they can launch the program with at least one. To date, the state's Medicaid office and MCOs have all shown strong support for the project and they are working with the Green and Healthy Homes Initiative and the CHAMP team to design Medicaid-compliant payment mechanisms.

Figure 4: The CHAMP/GHHI Program in Memphis



Source: Green and Healthy Homes Initiative
Note: ACT stands for an asthma control test, which allows a health care provider to assess how well controlled a patient's asthma symptoms are.

[29] The CHAMP program offers clinical care and home visitation to families of children with asthma, to train them on how to manage the child's disease at home. Pay for Success funding will allow CHAMP to deliver the home-based services and refer families to receive select home remediation services, delivered through a partnership with Habitat for Humanity and a local medical-legal partnership, Memphis CHiLD.

[30] The feasibility study demonstrated the program could offer a financial return to investors beyond just a return of principal.

The Role of Medicaid in Health and Community Development Collaborations

Collaborations across health and community development often involve Medicaid recipients, given many community developers' focus on Medicaid-eligible populations.[31] These collaborations can sometimes take advantage of Medicaid's waiver process, which gives governors the flexibility to test or pilot programs that align state policies across Medicaid, community development, and social safety net programs. The secretary of HHS must approve the Medicaid waivers at his or her discretion.

One of the most common waivers is the Section 1115 Research and Demonstration Waiver. Under a Section 1115 waiver, states can request to test innovations that fall outside Medicaid's traditional requirements. To be considered, the state's proposal must expand eligibility, improve access, improve health outcomes, or improve program quality and efficiency and be budget neutral over the life of the proposal. These waivers have been used in seven states, including Arkansas and Arizona, to support the expansion of Medicaid to people newly eligible for Medicaid under the Affordable Care Act. A second available waiver is the Section 1915(c) Home and Community-Based Services waiver. This waiver focuses on providing long-term-care services, like those traditionally offered in a nursing home in a noninstitutionalized setting. With these waivers, case management and other nonmedical services, like home health aides, can be reimbursable with Medicaid funding, as long as they satisfy other statutory and regulatory requirements. Section 1915(c) waivers have funded the medical and support services for supportive housing residents. South Carolina's Pay for Success effort used a section 1915(b) waiver, focused on reimbursements that could be made to Medicaid MCOs.[32]

Waivers not only provide programming flexibility at the state level, they can also unlock a source of federal funding for states. Medicaid funding is a joint responsibility of state and federal governments, with the relative share of federal and state dollars set by the federal medical assistance percentage (FMAP). As an entitlement program, Medicaid's budget is not subject to an annual appropriations process. The state government must pay for whatever eligible care is used, but the federal government reimburses the state for a portion of these expenses based on the FMAP. A state's FMAP level is determined in part by the income level of the state's residents and can range from a low of 50 percent to a high of 83 percent. If a state's waiver application is approved, the state can receive the federal Medicaid match for all services approved under the waiver, even if they are services Medicaid traditionally does not cover. If a waiver reaches its stated goals on cost and health outcomes, the state might even be able to petition to add the service to the state's Medicaid state plan, if the proposal is consistent with Medicaid's statutory and regulatory requirements.

Current debates on block granting Medicaid involve questions of whether to replace the current federal match system with a fixed amount of federal Medicaid support. The goal is to help control federal spending and impose more spending discipline on state programs, while providing increased state flexibility. In order for states to move to a block grant system, states would likely need to consider changes to current program structure, including changes to eligibility rules, cost-sharing rules for

[31] For a useful introduction to Medicaid programs see Herz, 2011.
[32] Crawford and Houston 2015 offer an introductory guide on Medicaid waivers with a focus on strategies to integrate health and social services programming.

beneficiaries, reimbursements to providers, and services that must be covered. Independent of congressional efforts to change Medicaid, practitioners at the state and local level have worked for years to drive cost and quality improvements in the program by improving the integration of social services and community development programs with Medicaid. This work has been further reinforced by recent research showing a correlation between a higher ratio of social spending (including the combination of social services, community development, and safety net programs) to medical spending and better population health outcomes (Bradley et al., 2016; Rubin et al., 2016).

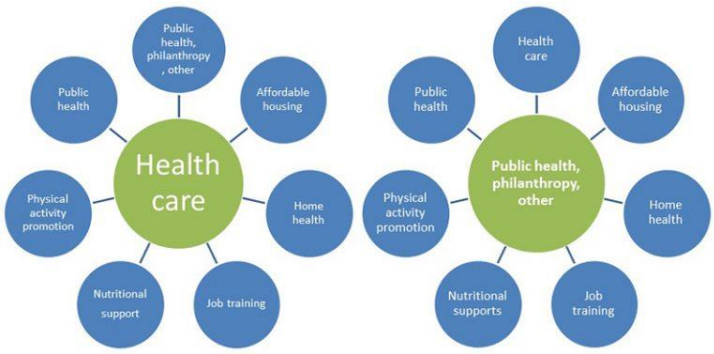
Getting Started: Overcoming Barriers to Effective Partnerships

Addressing the SDOH often relies on cross-sector partnerships, but a recent national survey of such partnerships found that most of them are quite young. The survey, led by the Rippel Foundation, found that over 65 percent had only formed after 2010 (Erickson et al., 2017). Developing and managing cross-sector partnerships has its challenges. In this section, we will look at how cross-sector collaborations in health are able to overcome coordination problems.

The Commonwealth Fund suggests the following three components of effective cross-sector health collaborations (McGinnis et al., 2014):

- The existence of a *coordinator* to help manage collaboration across sectors[33]
- The use of *quality measures and data-sharing tools* to create transparency and accountability between partners, facilitate information sharing between providers, and track outcomes
- *Payment and financing mechanisms* that both support and incentivize integrated services.[34]

Figure 5: Models for Managing Cross-Sector Collaborations in Health Care



Source: Lauren Taylor et al., 2016

What type of entity plays the role of coordinator can vary (see figure 5). Rippel's survey found that public health or health care organizations were most often in the lead; however, one-third of partnerships had joint leadership structures.[35] Baton Rouge developed a model where local

[33] The coordinator, quarterback, or intermediary role has received a lot of attention from health researchers, given how this actor can often be the linchpin to making the collaboration work. For details on state-level coordinators, see the National Academy for State Health Policy brief, and for a perspective on the strengths and weaknesses of different sectors as coordinator, see Singh and Butler, 2015.

[34] The Federal Reserve Bank of Dallas has compiled a guide for banks seeking to make health and community development investments as part of a bank's overall Community Reinvestment Act obligations.

[35] For a discussion of the pros and cons of a health care entity being the center of the collaborative, see Taylor et al., 2016.

government—the mayor—was at the center and a nonprofit was ultimately created to play the hub role. Leveraging the collective impact framework, the nonprofit's 16-member board brings together representatives from the insurance, health care, philanthropy, education, government, and nonprofit sectors. This high level of coordination helped the local hospitals work together in 2015 on their federally mandated community health needs assessment (CHNA) and create the first joint CHNA (Costanza, 2016).[36]

While many observers laud collaboration, the difficulty of bringing different stakeholders together to work toward a common purpose is challenging. Rippel's survey included questions on key strategies for overcoming common challenges in collaboration, summarized in figure 6. A more distinct set of coordination challenges often affect health and community development collaborations. These include:

- Language: Every field and specialty has its own terminology that can make it hard to communicate with outsiders. Therefore, translators must often be in place to help each sector communicate with the other. The Build Healthy Places Network has developed a "jargon buster" section on its website to help health and community development professionals understand one another. In Atlanta, the Healthy Places Research Group brings together researchers and practitioners focused on the relationship between health and the built environment, and helps them learn each other's methodologies, goals, and languages.
- Standards of evidence: For health insurers or health care professionals to change their established practices requires a certain level of scientific evidence. Health stakeholders may need to conduct pilots with community developers in order to collect the data necessary to argue for larger-scale change. However, communities do not need to start from scratch; a growing body of research helps support partnership development. HHS's *Healthy People 2020* and the Centers for Disease Control and Prevention's (CDC) *Health Impact in 5 Years (Hi-5)* both catalog and summarize research on nonclinical strategies that show evidence of improving health at the patient and community-wide levels.[37]
- Time lines: The time lines for the different stakeholders in a collaborative may vary. For example, MCOs often have one- to five-year contracts in place with state Medicaid offices, and therefore, MCOs are looking to achieve benefits within the contractual time frame. Affordable

[36] Performing a triennial community health needs assessment is an obligation of not-for-profit hospitals under the tax code. Every three years, a hospital must engage in a consultative process with local community leaders and public health experts to identify top health needs and priorities. The hospital must also develop an implementation plan detailing which community health needs it plans to address, and what steps it will take to address those needs. The CHNAs must be publicly available, and many hospitals post them on their websites. The requirement was part of the Affordable Care Act and became mandated starting in 2012.

[37] The *Healthy People 2020* site offers a list of data points communities might consider measuring to track a given program's effectiveness at addressing a SDOH: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health/objectives. The *HI-5 initiative* focuses on nonclinical, community-wide interventions that have evidence of a positive health impact in five years and have evidence of cost savings or cost-effectiveness over the lifetime of the target population. See https://www.cdc.gov/policy/hst/hi5/ for an overview; for the full list of interventions and the evidence of their health benefits, see https://www.cdc.gov/policy/hst/hi5/interventions/index.html.

housing developers often focus on 15- to 30-year time lines, the length of time their public subsidies require properties to remain affordable. As collaborations come together, the time frame for results must align with the funding used to support the program. Creative solutions can address this problem; some see hospital community benefit funding as a useful one-time payment mechanism to help overcome timing mismatches (Mercy Housing et al., 2017).

- Data sharing: For collaborations between health care, human services, and education providers, data sharing continues to be a barrier to integrated or collaborative work. Each entity has a different set of privacy laws governing data use and sharing that can pose a barrier to developing more person-centered case management systems (Butler & Diaz, 2016). However, local governments can sometimes help facilitate data sharing, as can hospitals and federal agencies (Ibid).

While collaborations between health and community development may be in their early stages, they continue to be bolstered by the growing evidence of the role the SDOH play in affecting health outcomes.

Figure 6: Tips on Building a Successful Multi-Sectoral Health Partnership

Source: Erickson et al., 2017

Conclusion

A greater recognition that health care alone is insufficient to drive large-scale improvements in health for all Americans has led the health sector to look for opportunities to partner with the community development sector to address the social determinants of health. This effort to increase the integration of health into community development and vice versa is national in scope, and this paper has highlighted the work of innovators in the Southeast, a part of the country with poor health, high poverty, and low economic mobility rates. As the sectors come together, they are realizing additional benefits from partnership.

For health stakeholders, community developers can serve as both a disruptive and a constructive force in efforts to drive improvements in the health care system's ability to address the SDOH, control spending, and improve quality of care. Community developers' expertise in crafting multi-sector, public-private partnerships that invest in community-driven projects is powerful. Community developers can devise ways to fund these partnerships through mixing public, philanthropic, and private capital, as the Florida Community Loan Fund demonstrates. In this way, community developers can mix market discipline with social purpose. Their expertise in integrating the community's voice into a given project means community developers know how to build trust with the populations the health sector may be trying to reach. Finally, community developers know how to intervene in the social, economic, and built environment factors that research shows ultimately drive population-level health outcomes.

For community developers, they are learning health stakeholders can be powerful allies at the local level, as Adventist Health Systems demonstrated in Orlando. The health care sector is often a leading employer in many regions, and can therefore be an influential civic voice. Furthermore, hospitals and health insurers can become a source of grant or investment capital for community development deals, as Kaiser Permanente and Trinity Health are doing. In addition, the health care sector can be a source of service contracts for community developers, as some supportive housing organizations have demonstrated; in this way, social services nonprofits may be able to diversify their funding streams by engaging in a health collaboration.

Finally, both governments and philanthropy are recognizing that collaboration is sometimes the key to balancing cost and effectiveness. Funding multi-sector collaborations can help governmental actors overcome their own bureaucratic silos and meet fiscal efficiency goals, with or without the use of Pay for Success financing. Medicaid is often the system that most benefits from such collaboration, and its various waiver programs offer states flexibility to experiment with collaboration, as South Carolina is doing. Local government can also be a key supporter of these cross-sector innovations, including through leveraging its convening power, as Baton Rouge has shown.

The Southeast stands as fertile ground for new health and community development solutions, with an array of poor economic and health indicators across urban, suburban, and rural markets. The highly context-specific nature of both health care and community development markets makes them especially ripe for local level innovations. The next paper in the series will delve deeper into the economics of the health care system, offering a closer look at the payment and delivery system reform

pressures facing the health care system and how they incentivize health and community development collaborations.

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