Forging Partnerships Between Hospitals and CDC’s

Investing in Community Health

Overview of the Training

- Introductions, Overview and Goals
- Visioning
- Community Benefits, DoN, PILOTS, and Other Policies
- Community Health Needs Assessment
- Case Study
- Partnerships
- MACDC Next Steps
What is the Vision?

• What can hospitals do to advance health equity in your community?
• What can CDC’s do to address social determinants of health?
Health is primarily defined by social and economic determinants:

Data from "County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute

Massachusetts resource commitments disproportionately focused on health care spending 2001-2014

Community Development and Health

“Community development is an enterprise that helps low-income people and communities by giving them access to financing and other tools to build affordable housing, start businesses, and build community facilities such as charter schools, health clinics, and child care centers. In short, community development helps make struggling communities more vibrant economically and stronger socially. A connection that is not made often enough, however, is why and how these interventions potentially make communities healthier as well”. David Erickson and Nancy Andrews, Health Affairs, May 2017

http://content.healthaffairs.org/content/36/11/2056.full

Community Development Activities

- PHYSICAL DEVELOPMENT AND COMMUNITY PLANNING
- ECONOMIC DEVELOPMENT
- ASSET DEVELOPMENT
- COMMUNITY ORGANIZING, BUILDING, AND EMPOWERMENT

Strategic Imperative for Institutions

“Public and private payers have been shifting reimbursement even before the ACA. These arrangements are increasingly value based and emphasize outcome focused provision of care, increased quality and risk assumption. Current and future costs are pushing plans and providers upstream”

Jean McGuire, Urban Health Research and Practice, Northeastern, 2016

Why Hospitals and Health Systems Invest Upstream

Potential to:

- Produce better health outcomes
- Reduce health care costs
- Produce financial returns and savings
- Leverage the resources of foundations, banks, private investors, government, etc.

Move Upstream

Risk Factors/Social Determinants

Move to Accountable Care Organizations
Opportunities and Challenges for CDCs

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of knowledge about hospitals and community benefits/DoN</td>
<td>• ACO model provides strong revenue incentives. Hospitals are increasingly motivated to address social and physical determinants of health as they move along the continuum from fee-for-service towards capitation.</td>
</tr>
<tr>
<td>• Lack of consistent relationships or buy in among hospitals and community members</td>
<td>• CDC boards allow for the possibility of direct, grass-roots participation in decision-making.</td>
</tr>
<tr>
<td>• Conflicting priorities and expectations of both hospitals and CDCs</td>
<td></td>
</tr>
</tbody>
</table>

Specific Hurdles for CDCs

- Hospitals are “conventional investors”
- Hospital investment committees have limited understanding of community development
- Different evaluation methods and standard of evidence between medicine and community development
- Social determinants require long term investments that do not readily provide “ROI”
Specific Advantages of CDCs

- Deploy resources that does not require the hospital to develop new skills as a lender or investor.
- CDC’s can leverage hospital resources with other capital, and can provide a degree of risk protection for hospitals by absorbing any defaults or losses.
- Utilize the Community Investment Tax Credit

Community Investment Tax Credit

- **What is the Community Investment Tax Credit?**
- The Community Investment Tax Credit (CITC) is a 50% refundable state tax credit allocated to state-certified CDCs
- Raised $12.85 million with over $5 million from individuals in the first two years – a new source of funding for many CDCs who have traditionally relied on foundations, corporations, government contracts and earned revenue
- The CITC program is currently authorized through calendar year 2019 with up to $6 million in credits available each year, representing $12 million in fundraising potential.
Overall Economic Power of Hospitals

• The nation’s non profit and for profit hospitals are a tremendous economic force
• Procurement: $340 billion in goods and services
• Total Expenditures: $782 billion
• Investment portfolio’s estimated at at least $500 billion
• 4% of total national employment
• $62 Billion estimated spent on community benefits

http://democracycollaborative.org/content/can-hospitals-heal-americas-communities

Boston Ranks No. 1 For City Income Inequality

http://www.wbur.org/news/2016/01/14/boston-income-inequality-brookings-2016-update
Suffolk County health outcomes

HOW DO COUNTIES RANK FOR HEALTH OUTCOMES?
The green map below shows the distribution of Massachusetts's health outcomes, based on an equal weighting of length and quality of life. Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at countyhealthrankings.org.

<table>
<thead>
<tr>
<th>County</th>
<th>Rank</th>
<th>County</th>
<th>Rank</th>
<th>County</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkshire</td>
<td>12</td>
<td>Norfolk</td>
<td>10</td>
<td>Suffolk</td>
<td>11</td>
</tr>
<tr>
<td>Essex</td>
<td>8</td>
<td>Middlesex</td>
<td>3</td>
<td>Suffolk</td>
<td>11</td>
</tr>
<tr>
<td>Franklin</td>
<td>3</td>
<td>Massachusetts</td>
<td>14</td>
<td>Norfolk</td>
<td>4</td>
</tr>
<tr>
<td>Bristol</td>
<td>13</td>
<td>Hampden</td>
<td>14</td>
<td>Norfolk</td>
<td>4</td>
</tr>
<tr>
<td>Essex</td>
<td>2</td>
<td>Hampden</td>
<td>5</td>
<td>Hampden</td>
<td>4</td>
</tr>
</tbody>
</table>

Percentage of Children in Poverty

Percent of children under age 18 in poverty in 2012

https://www.bostonglobe.com/lifestyle/health-wellness/2014/03/25/child-poverty-increased-all-but-one-massachusetts-county-report-shows/9R6aJC7UWKG48ljKv0D6d0/story.html
Sources of Funds for CDC’s

$$$$$$$$$$$$$$$$$$$$$$
- Community Benefits
- Determination of Need
- Reserves
- Investment Credit
- PILOT

Community Benefit: Definition

Services, programs, and resources that hospitals devote to improving the health of the community as a whole. Includes access to care for low income patients, prevention and investment in the social and economic issues that impact health.
Key Developments in Community Benefits

- **1969**: IRS issues Revenue Ruling 69-545, revising 1956 provision and establishing community benefit standard for nonprofit hospitals.
- **1994**: Massachusetts adopts voluntary community benefit guidelines.
- **2008**: IRS makes first significant revision to Form 990 since 1979, adding Schedule H requirement for hospitals.
- **2009**: Hospitals are required to complete Schedule H for the first time.
- **2010**: Affordable Care Act passes. Section 9007 requires each not-for-profit hospital to complete a community health needs assessment every three years.

FY 2016 Community Benefit Spending

- **Massachusetts hospitals**: $642 million in community benefits =
  - $266 m in direct community benefit spending
  - $297 m in charity care spending

- **Boston Hospitals**: $321.8 million in community benefits =
  - $148.7 m in direct community benefit spending
  - $138.8 m in charity care spending


Boston Medical Center and Cambridge Health Alliance did not report during this period.

**State-wide numbers exclude Metro West and St. Vincent’s Hospital due to insufficient reporting and Quincy Medical Center which closed during this period.
New 2014 IRS Rules

The tri-annual Community Health Needs Assessment must include a plan to:

- “Prevent illness, insure adequate nutrition, or to address social, behavioral and environmental factors that influence health and emergency preparedness, not just the barriers to care” (§1.501(r)-3)
- An implementation strategy documented through the most recent CHNA


Attorney General Annual Community Benefit Report

Expenditures Utilized in the Report

Direct Community Benefit Spending
Determination of Need Expenditures
Total Net Charity Care Spending
Total Community Benefit Spending
Total Patient Expenses

Reports Available on Attorney General Website
## Total Hospital Community Benefit Spending as Percentage of Total Patient Expenses FY 2016

<table>
<thead>
<tr>
<th>Hospital Annual Total Patient Expenses (TPE)*</th>
<th>Number of Hospitals Spending &lt;3% TPE For Community Benefits</th>
<th>Number of Hospitals Spending &gt;3% TPE For Community Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $200 Million</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>More than $200 Million</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>

About 70% of tax exempt hospitals reported community benefit spending below the 3% “target level” suggested in the Attorney General Community Benefit Guidelines

*This data excludes MetroWest, St Vincent’s and QMC.

## AGO Community Benefit Summary: Boston Hospital

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Estimated Total Expenditures for FY2016</th>
<th>Approved Program Budget for 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Benefits Programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Expenses</td>
<td>$26,084,100</td>
<td>$70,193,025</td>
</tr>
<tr>
<td>Associated Expenses</td>
<td>Not Specified</td>
<td></td>
</tr>
<tr>
<td>Determination of Need</td>
<td>$292,501</td>
<td></td>
</tr>
<tr>
<td>Expenditures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Volunteerism</td>
<td>Not Specified</td>
<td></td>
</tr>
<tr>
<td>Other Leveraged Resources</td>
<td>$7,024,199</td>
<td></td>
</tr>
<tr>
<td><strong>Net Charity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSN Assessment</td>
<td>$33,841,171</td>
<td></td>
</tr>
<tr>
<td>HSN Oticitted Claims</td>
<td>$169,199</td>
<td></td>
</tr>
<tr>
<td>Free/Discount Care</td>
<td>$1,841,898</td>
<td></td>
</tr>
<tr>
<td>Total Net Charity Care</td>
<td>$35,652,258</td>
<td></td>
</tr>
<tr>
<td><strong>Corporate Sponsorships</strong></td>
<td>$1,139,877</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenditures</strong></td>
<td>$70,193,025</td>
<td></td>
</tr>
<tr>
<td><strong>Total Patient Care-Related Expenses for FY2016</strong></td>
<td>$1,701,676,896</td>
<td>$1,701,676,896</td>
</tr>
</tbody>
</table>

Comments: None
The Community Health Needs Assessment (CHNA)

- Identify the community it serves
- Receive input from a broad representative group
- Collect, analyze data, and identify and prioritize most pressing health challenges facing community
- Develop an implementation plan/strategy
- Required every three years to maintain tax exempt status

Determination of Need

- Triggered by capital investment
- 2017 MADPH Regulations
- Requires programs to address named social determinants of health
- Sets standards for community engagement
- Ten Taxpayer Group: Any ten taxpayers can form a group and participate in the review of the DoN
DoN Health Priorities

Social Determinants of Health

- Social Cultural Environment
- Built Physical Environment
- Housing
- Violence and Trauma
- Education
- Employment
Significant Proportion of DoN Investment is within 128

Community Health Statewide

<table>
<thead>
<tr>
<th>Project Size</th>
<th>Local Funding to Health Priorities</th>
<th>CHI Statewide Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;$500,000</td>
<td>75% of funding dedicated to local health projects</td>
<td>25% to CHI statewide initiative</td>
</tr>
<tr>
<td>&lt;$500,000</td>
<td>90% to local projects</td>
<td>10% to CHI statewide initiative</td>
</tr>
</tbody>
</table>
Pay in Lieu of Taxes: PILOT

- In January 2011, the City adopted new guidelines for the PILOT program.
- These are voluntary payment for nonprofit institutions that own property in excess of $15 million.
- Payment is 25% of the assessed property tax value.
- Each institution is eligible for a community benefits deduction generally limited to 50% of the PILOT contribution.
Boston Pilot Payments

Fiscal Year 2016 Payment in Lieu of Tax (PILOT) Results

<table>
<thead>
<tr>
<th>Medical Institutions</th>
<th>FY15 PILOT</th>
<th>Total Exempt Value</th>
<th>% of Taxable</th>
<th>FY16 PILOT</th>
<th>Less Community Benefit Credit</th>
<th>Cash PILOT</th>
<th>1st Half PILOT</th>
<th>2nd Half PILOT</th>
<th>FY16 Total PILOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Israel Deaconess</td>
<td>$187,887</td>
<td>$851,520,405</td>
<td>25.218,932</td>
<td>$6,190,468</td>
<td>($12,096,549)</td>
<td>$3,946,172</td>
<td>$5,948,317</td>
<td>$3,986,144</td>
<td>$12,944,673</td>
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<tr>
<td>Boston Children's Hospital</td>
<td>$111,805</td>
<td>$665,889,998</td>
<td>29.595,716</td>
<td>$5,208,652</td>
<td>($2,493,933)</td>
<td>$6,721,837</td>
<td>$5,673,837</td>
<td>$8,091,037</td>
<td>$10,068,771</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>$137,873</td>
<td>$770,506,300</td>
<td>22.493,003</td>
<td>$6,673,850</td>
<td>($2,518,284)</td>
<td>$5,006,049</td>
<td>$3,147,745</td>
<td>$3,147,745</td>
<td>$6,294,834</td>
</tr>
<tr>
<td>Brigham and Women's Hospital</td>
<td>$1,238,046</td>
<td>$794,571,336</td>
<td>29.942,012</td>
<td>$6,086,653</td>
<td>($2,801,424)</td>
<td>$3,281,346</td>
<td>$1,312,380</td>
<td>$1,312,380</td>
<td>$3,281,346</td>
</tr>
<tr>
<td>Dana-Farber Cancer Institute</td>
<td>$12,876</td>
<td>$246,233,403</td>
<td>23.375,194</td>
<td>$1,899,148</td>
<td>($896,274)</td>
<td>$940,148</td>
<td>$432,387</td>
<td>$452,387</td>
<td>$942,387</td>
</tr>
<tr>
<td>Faulkner Hospital</td>
<td>$1,422,148</td>
<td>$101,386,400</td>
<td>1,193,148</td>
<td>$1,563,148</td>
<td>($570,074)</td>
<td>$376,074</td>
<td>$289,697</td>
<td>$289,697</td>
<td>$578,074</td>
</tr>
<tr>
<td>Mass General Hospital</td>
<td>$306,909</td>
<td>$1,594,478</td>
<td>374,705</td>
<td>$137,362</td>
<td>($14,101)</td>
<td>$137,362</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Harvard Vanguard</td>
<td>$284,886</td>
<td>$1,188,840,920</td>
<td>393,586</td>
<td>$35,013</td>
<td>($34,660)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hebrew Rehabilitation Ctr</td>
<td>-</td>
<td>$24,544,930</td>
<td>-</td>
<td>$24,544,930</td>
<td>($24,544,930)</td>
<td>$24,544,930</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Joslin Diabetes Center</td>
<td>-</td>
<td>$99,293,179</td>
<td>-</td>
<td>$99,293,179</td>
<td>($99,293,179)</td>
<td>$279,029</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mass Eye &amp; Ear Infirmary</td>
<td>-</td>
<td>$110,906,130</td>
<td>-</td>
<td>$110,906,130</td>
<td>($110,906,130)</td>
<td>$110,906,130</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mass General Hospital</td>
<td>$2,664,516</td>
<td>$1,769,590,792</td>
<td>32,950,812</td>
<td>$8,375,083</td>
<td>($8,375,083)</td>
<td>$8,375,083</td>
<td>$8,375,083</td>
<td>$8,375,083</td>
<td>$8,375,083</td>
</tr>
<tr>
<td>New England Baptist Hosp</td>
<td>$194,811,975</td>
<td>$2,284,390,020</td>
<td>971,186</td>
<td>$844,798</td>
<td>($844,798)</td>
<td>$844,798</td>
<td>$844,798</td>
<td>$844,798</td>
<td>$844,798</td>
</tr>
<tr>
<td>New England Baptist Hosp</td>
<td>-</td>
<td>$106,941,600</td>
<td>-</td>
<td>$14,916,916</td>
<td>($14,916,916)</td>
<td>$14,916,916</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal: 8 hospitals</td>
<td>$4,007,041</td>
<td>$5,944,432,483</td>
<td>1,657,377,207</td>
<td>$42,891,287</td>
<td>($12,637,304)</td>
<td>$59,473,483</td>
<td>$9,171,207</td>
<td>$9,171,207</td>
<td>$59,473,483</td>
</tr>
</tbody>
</table>

*All of the hospital’s Pilot was a direct credit contribution to the Boston Public Schools and Boston Public Health Commission as an exceptional expense credit according to program guidelines.*

https://www.boston.gov/finance/payment-lieu-tax-pilot-program

Hospital Reserves

**Restricted funds:** Donor designates use of a donation to a particular purpose or project. An example is a gift to build a building.

**Unrestricted funds:** Donations the nonprofit may use for any purpose. Unrestricted funds usually go toward the operating expenses of the hospital or to a particular project that the nonprofit picks.

$$$$$$
Payers and Payer Mix

Commercial/Private Payers: Blue Cross, Harvard Pilgrim, Aetna, etc.

Government:
Medicaid, Medicare
SCHIP, Bureau of Indian Affairs
Department of Defense, Veterans Affairs

Why is payer mix important?
Types of hospitals

- Academic Medical Center (Mass General, U Mass)
- Teaching Hospital
- Community hospital: (DSH and non DSH)
- Specialty Hospital (Mass Eye and Ear, Boston Children’s)
- Long term Care, rehabilitation hospital

Changing Healthcare Environment

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicaid patients.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicaid Changing market conditions.
Major ACOs in Boston Area

- Atrius Health with Tufts Health Public Plans
- Beth Israel Deaconess Care Organization with Tufts Health Public Plans
- Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
- Cambridge Health Alliance with Tufts Health Public Plans
- Children’s Hospital Integrated Care Organization with Tufts Health Public Plans
- Community Care Cooperative Lahey Health
- Partners Health Care ACO
- Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
- Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
- Steward Medicaid Care Network

Pressures on Hospitals

- Uncertainty, uncertainty and uncertainty
- Changing reimbursement system: From fee for service to value based
- Competition, mergers and market consolidation
- Care moving outside the hospital walls
- Closures
### Common Hospital Approaches to Health and Wellness

<table>
<thead>
<tr>
<th>Focus</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat Patient disease/condition</td>
<td>Hospital Care</td>
</tr>
<tr>
<td>Integrate non medical services for patients</td>
<td>Provide transportation to medical appointments</td>
</tr>
<tr>
<td>Target populations likely to become patients</td>
<td>Invest in housing for homeless</td>
</tr>
<tr>
<td>Create conditions for wellness</td>
<td>Improve air/water quality</td>
</tr>
<tr>
<td></td>
<td>Build community center</td>
</tr>
<tr>
<td></td>
<td>Hire community outreach workers/organizers to engage community</td>
</tr>
</tbody>
</table>

Robert Wood Johnson, Improving Community Health by strengthening community investment, March 2017

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### CURRENT POLICY CONCERNS
Multiple agencies with varying oversight leads to fragmentation and lack of strategic investment

- Attorney General: Community Benefit
- IRS
- MDPH: DoN
- Municipality: PILOT

Fragmentation at provider and oversight level

- Hospitals offer duplicate or competing efforts in some communities for similar health improvement goals
- Lack of strategic approach on community benefit in geographic areas where many providers co-exist
- Some geographic areas receive heightened attention for community benefit efforts and others receive less
- Attorney General oversight accomplished without regard to parallel efforts tied to DoN commitments or PILOT initiatives
Current level of community engagement in community benefit process

- No clear standard of community engagement
- Community partners reported are often organizations consulted only for the assessment process. Few reports of long-term, community-based partners and their role in setting priorities, financial decisions or implementation of project.
- Burden on community groups to respond after the fact, via web-based commenting process.
- Types of community based organizations engaged not always reflective of the full community or as expansive as the IRS rules allow

Current Status of Regulations

<table>
<thead>
<tr>
<th>Agency</th>
<th>Reg/Guidelines</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS</td>
<td>Enforcement of Tax Exemption:</td>
<td>2014 Regulations</td>
</tr>
<tr>
<td>MDPH</td>
<td>Determination of Need Update of Regulation</td>
<td>January 2017 enactment</td>
</tr>
</tbody>
</table>
HOSPITALS INVESTING IN SOCIAL DETERMINANTS

Types of Hospital Investment

- **Sustainability:** Farmers market, invest in CSA’s, farm cooperatives: Housing Development
- **Procurement Policy:** Purchase local and women’s and minority businesses
- **Capacity Building:** Community organizing, employment training and pipeline,
- **Community Development:** Creation of land trusts, multi-institution partnerships

$$$$$$$$
Housing Interventions

TABLE 1: SUMMARY OF HOUSING INTERVENTIONS

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TARGET GROUP — PLACE</th>
<th>AUTHOR, YEAR</th>
<th>SUMMARIZED OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing First</td>
<td>People experiencing chronic homelessness — Deathly and Boston</td>
<td>Laitner, 2009; MSHA, 2014</td>
<td>$279,368 per person per year in net savings, and $8,954 per person per year in net savings, respectively</td>
</tr>
<tr>
<td>Special Homeless Initiative (SHI)</td>
<td>Adults with serious mental illness — Boston</td>
<td>Levine, 2007</td>
<td>93% reduction in hospital costs, resulting in $0.8 million reduction in health care costs annually</td>
</tr>
<tr>
<td>10th Decile Project</td>
<td>High-need homeless — Los Angeles</td>
<td>Burns, 2013</td>
<td>73% reduction in total health care costs; positive rate of return as every $1 invested in housing and support was estimated to reduce public and hospital costs by $3 the following year and $6 in subsequent years</td>
</tr>
<tr>
<td>My First Place</td>
<td>Foster care recipients — California</td>
<td>First Place for Youth, 2012</td>
<td>Better health outcomes; $44,000 per person per year in net savings*</td>
</tr>
<tr>
<td>Housing subsidies</td>
<td>Low-income children — Boston</td>
<td>Children’s Health Watch, 2009</td>
<td>Better health outcomes; no cost analysis reported</td>
</tr>
<tr>
<td>Meeting the Opportunity (using vouchers)</td>
<td>People living in high-poverty communities — Baltimore, Boston, Chicago, Los Angeles, New York</td>
<td>Barrientos et al., 2011; Ludwig, 2011</td>
<td>Better health outcomes; no cost analysis reported</td>
</tr>
<tr>
<td>Low-income Energy Assistance Program (LHEAP)</td>
<td>Low-income children — Baltimore, Little Rock, Boston, Minneapolis, Washington, D.C.</td>
<td>Franklin, 2006</td>
<td>Less hospital use; no cost analysis reported</td>
</tr>
</tbody>
</table>

* The savings is calculated based on a comparison of “traditional youth services” ($71,000) provided to foster care recipients who are not enrolled in My First Place and My First Place services ($44,000). These figures can be found on page 4 of the original source, available at [http://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf](http://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf)

Hospitals Invest in Housing

6 Portland health providers give $21.5M for homeless housing

By GILLIAN FLACCUS
Sep. 23, 2016

PORTLAND, Ore. (AP) — Five major hospitals in Portland, Oregon, and a nonprofit health care plan said Friday they will donate a combined $21.5 million toward the construction of nearly 400 housing units for the city's burgeoning homeless and low-income population — a move hailed by national housing advocates as the largest private investment of its kind in the nation.
Nutrition Investments

**TABLE 2: SUMMARY OF NUTRITIONAL ASSISTANCE INTERVENTIONS**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target Group</th>
<th>Place</th>
<th>Author, Year</th>
<th>Summarized Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Women, infants, and children — Maternal, Infant, and Child Nutrition Program (MIPN)</td>
<td>Low-income women and children — selected cities and states (U.S.) and nationwide (Canada)</td>
<td>Fadel, Jiang, &amp; Gilewski-Davis, 2015; Nguaino et al., 2010; Nguaino et al., 2010; Obermeyer, Wayland, &amp; Beaton, 2002; Debevec et al., 2007; Gao, 1992; Mulvihill et al., 2012</td>
<td>Better health outcomes; $176 million per year in net savings in 0.5 years</td>
</tr>
<tr>
<td>2</td>
<td>Healthy Start</td>
<td>Low-income women and children — selected cities and states</td>
<td>Kheir &amp; Minnigala, 2014</td>
<td>Better health outcomes among same groups</td>
</tr>
<tr>
<td>3</td>
<td>Food assistance programs</td>
<td>Older adults — nationwide</td>
<td>Kim &amp; Fonggala, 2007</td>
<td>Better health outcomes; no-cost analysis reported</td>
</tr>
<tr>
<td>4</td>
<td>Resident Opportunities for Self-Sufficiency (ROSS)</td>
<td>Older adults and people with disabilities — nationwide</td>
<td>Ski, 2009</td>
<td>Better health outcomes; no-cost analysis reported</td>
</tr>
<tr>
<td>5</td>
<td>Home-delivered meals</td>
<td>Older adults — nationwide</td>
<td>Thomas &amp; Mor, 2015; Thomas &amp; Mor, 2015; Thomas &amp; Davis, 2015</td>
<td>Better health outcomes; a 1% increase in meals delivered to the homes of older adults was estimated to be associated with reductions of $0.5 billion in Medicaid costs; a $25 annual increase in home-delivered meals per older adult was estimated to be associated with a 0.3% decline in nursing home admissions</td>
</tr>
</tbody>
</table>


Research on Community Interventions

The Vision

INVEST IN YOUR COMMUNITY

WHERE
Focus on Areas of Greatest Need

WHAT
Know What Affects Health

WHO
Collaborate with Others to Maximize Efforts

HOW
Use a Balanced Portfolio of Interventions for Greatest Impact

1. Focus on areas with the highest burden of disease.
2. Partner with multiple sectors to maximize impact.
3. Use a combination of strategies to achieve the greatest impact.

VISIT www.cdc.gov/CHNnavig for tools and resources to improve your community's health and well-being.
Forging Partnerships Between Hospitals and CDC’s

Community Benefit Delivery Structure

• Community Benefit Structure:
  Committee, Mission, Who, Which Community Groups?
• Where does community benefit fit into the hospital structure? Is it part of the strategic plan?
• What is the focus of the CHNA?
Hospital Decision Making

- C Suite: CEO, CMO, COO, CFO, CTO etc.
- Driving force: Costs, Costs and Costs
- Community Benefits/ population health often not integrated
- In smaller hospitals, part of communications and marketing

Key Factors

- Start with the CHNA and Leverage existing relationships to reach out to top leadership
- Identify a “champion”
- Know what to ask for: Understand the priorities and frame the ask as mutually beneficial
- Understand the decision-making process
- What is the “ROI” on your project
Building Partnerships: Change Proceeds at Speed of Trust

Success
- Transparent structure and decision making process
- Develop a clear strategy and plan
- Identify the specific objectives and to be addressed
- Statement of Mission and common goals/ clear commitment and structure
- Trust: Building trust based relationships

Hospital System Partnership

Deploying All Kaiser Permanente Assets for Total Health

Bringing together mission, brand, knowledge, and capabilities

http://democracypartnership.org/sites/clone.community-wealth.org/files/CHHAC-4_0.png