NACEDA Webinar
**Demonstrating Return On Investment to Health Providers**May 8, 2020

**Featured Speaker:** Kendra Smith, Vice President of Community Health, Bon Secours Mercy Health

**Discussion Facilitator:** Elana Brochin, Program Director for Health Equity, Massachusetts Association of CDCs

**Participants:**

* Jacqueline Ramirez, Housing California
* **Denise McCardle Ladden,** Housing & Community Development Network of New Jersey
* Sarah Franzini, Housing & Community Development Network of New Jersey
* Rick Sauer, Philadelphia Association of CDCs
* Garrett O’Dwyer, Philadelphia Association of CDCs
* Jenny Connelly-Bowen, Community Builders Network of Metro St. Louis
* Gary Newcomer, Community Builders Network of Metro St. Louis
* Jessica Love, Prosperity Indiana
* Sharon Legenza, Housing Action Illinois
* Jocelyn Smith, Georgia ACT
* Bambie Hayes-Brown, Georgia ACT
* Thomas Obioha, Community Development Advocates of Detroit
* Joe Kriesberg, Massachusetts Association of CDCs
* Jessica Love, Prosperity Indiana
* Garrett O’Dwyer, Philadelphia Association of CDCs
* Suzanne Gunther, NACEDA
* Frank Woodruff, NACEDA
* Jeremy Brownlee, NACEDA
* Megan Schacht, NACEDA

**Suzanne introduced facilitator Elana Brochin, Program Director for Health Equity at the Massachusetts Association of CDCs.**

Elana works to promote health equity through policy partnerships and technical assistance to MACDC members. As Healthcare Project Manager at the Massachusetts Attorney General's office, she managed update of the AG's community benefit guidelines before coming to MACDC.

**Elana Introduced Kendra Smith, Vice President of Community Health for Bon Secours Mercy Health.**

Kendra specializes in addressing infrastructure and equity in order to improve community health outcomes. She Worked at St Clair Superior CDC in Cleveland and Christian CDC in Chicago. Although she works in the healthcare system but she sees herself as one of us in community development.

**Kendra’s presentation**

**Her background**

Bon Secours Mercy Health is a Catholic health system headquartered in Cincinnati and reaching system is 7 states in the U.S. and Ireland. Kendra previously worked at ProMedica. She has a Master's degree is in urban studies from Cleveland State, and worked at CDCs and as a housing planner.

**Social determinants of health**

A lot of systems that are starting to think through what a holistic approach to health and well-being. They frame it as health equity. Addressing root cause issues on the front end costs less money than addressing health problems on the back end.

“Social determinants of health” is really what every community- based organization has been working on for a long time. Healthcare folks need to be respectful and think about how we enhance that work. One of the ways we do this is to look at disparity in health equity and access to care.

**Strategies for engagement**

Find out is if your hospital or health system is working on an anchor mission strategy with the Democracy Collaborative. It’s very effective to tell healthcare folks if they want to improve community and health, they need to think about what their position as an anchor institution and economic investment. If the health provider is not into anchor mission strategy, talk to them about the greater good and the community that surrounds or is near the hospital.

Understand potential sources of funding from hospitals and health systems: community benefit dollars, impact investment pool, grants and philanthropy. Find out about the specific pots of money the health provider has before you approach them. Health systems are moving away from sponsoring one-time events and looking at long-term impact investments including large grant dollars for very specific programs They’re looking to make long-term investments in both brick and mortar and in people with some ROI for the hospital. They’re also looking at social determinant domains. When someone wants to build housing, that could take all our money. We’re probably not going to be able to provide operational funding operational funding.

ProMedica does pre-medical screens for every patient for 11 social determinants of health domains--hunger transportation utilities, domestic violence, housing, food access, financial stability, social supports and social networks, education, employment, etc. They’re looking at what buckets of intervention look like to get somebody access to housing, food, jobs and financial counseling.

**How to get an introduction to a healthcare system**

Start with folks that you know that are on the ground every day. Good entry points are community health team, population health team, foundation team, advocacy team. A lot of CEOs and board members are just now picking up on social determinants and a lot of CEOs that are not interested.

Research the structure of the healthcare system and find the community-based person who is providing grants or sitting on a community board -- somebody that really understands what it is that you're trying to do. Leverage that relationship into more introductions.

**Community Health Needs Assessments (CHNA)**

As nonprofit hospitals all of the money that we would pay in taxes is required to be invested back into the community. Every three years, nonprofit hospitals are required by the Affordable Care Act to do a community plan on how to o invest these dollars. Most hospitals will create this plan through their internal staff and do connect with stakeholders, but that's also an opportunity for us as healthcare to do better on the outreach.

I tell my team to coordinate CHNA with neighborhood plans and bank CRA work to focus dollars on those investments There is larger impact than when everybody is trying to fund one-off things from different plans. The healthcare provider probably doesn't have a lot of experience on their staff with direct investment into community.

If you have a planning process happening, invites somebody from the hospital. Ask to see their Community Health Needs Assessment, which by law has to be on a website. Talk to someone about their process. When their time is coming up to redo the CHNA, ask to be invited to that process. That way, some of the bigger needs in your community begin to rise to the top, from different perspectives and that really helps for healthcare to guide you know where we're making investment.

**Showing Return On Investment**

Hospitals will have a Key Performance Indicator document that has been approved by the hospital board that dictates where community benefit dollars can be spent, shows the incentive structure within the hospital, and how operationally they decide to make contributions. It’s like the strategic plan of the hospital. Show how the KPI connects to the community work you're doing.

The number one thing that we look for is how our investments improve health outcomes. How does your program and our potential investment help lower costs for the hospital to do business? How does it help improve health of patients?

We’re looking for very specific health outcomes that you can tie to your project. For example, would we see a data decline in food insecurity or financial gains for folks? Does your project support the health anchor mission and is it evidence based?

We love qualitative and quantitative data. I love to hear resident’s stories, but at the end of the day I still have to go to convince CFO and hospital board the financial return from us investing multi-million dollars in community- based projects. We know it's really expensive to run a grocery store we know a lot of our workforce programs are really focused on entry level jobs and not always career pathways.

There's community, which is the space in the city that we're in. And then there's patients. Hospitals think about patients first. A lot of residents that live in community that are not patients. I have to think about how patients are going to be integrated in the project. That gets tricky because there's no way legally under HIPAA. You can't necessarily ask somebody if they're a patient of XYZ hospital, sometimes they'll tell you and sometimes they won't. What is that innovative way that you can work with a hospital to think about that cross sector of physical space, patients and community?

**Engaging Hospital and Healthcare System staff**

Some NACEDA members have relationships with hospital folks on their boards, as volunteers, and as investment partners. Think about how to expand and evolve those partnerships. Folks that come for one-time funding are probably not on my radar in the who have folks worked with us long term to help us build up in the community. Think about leveraging multi-level relationships.

if you know the CEO, get to know somebody on the board, in finance, on the community end, and in direct care. A community health worker right different type of access and information than a CFO or a board member. Being able to walk into multi levels of a hospital or healthcare organization is going to be key because everybody is looking at different things.

Be able to very clearly articulate what you want from the hospital. Is it dollars is a support? Is it a person is it a board seat? it an investment? Do we plan to give the money back? Figure out how it’s going to work, then think about who is missing from your partnership table. What is your value add?

In the community development space, a lot of healthcare is looking for a CDI partner, and that's mostly just as an umbrella as the sector tries to figure out what it means to be involved. They want to see are there other funders and banks and your community foundation and resident groups and the city on board. If I have to fight city council to get your project approved, that’s not really the role of healthcare, right. So making sure that your partnership table is set, or that you have a plan moving forward and can articulate that.

There are a lot of different sources of funding at hospitals. If you want your event sponsored, that comes from a different pot of money than a housing investment. Do a research on what the hospital has available.

Hospitals are looking for innovations to improve access and not have to have people come into their brick and mortar space. If we invest in housing, can our patients live there? Can we use it post-acute as folks are coming out of long-term care?

If the program is to help people get jobs, have you talked to the right people at the healthcare system to see if we can get them to work at the healthcare system? If somebody comes to me and just says I need $300,000 for my program. It's got to go to the end of the pile because I can't sell that. But if somebody comes to me and says we want to start a workforce development program, we would like the hospital to agree to take on a certain number of folks that come through, we're going to use your dollars but we've also got dollars from you know county workforce and the city and a bank, I can use that. The more specific you can be the better.

**Quantitative and qualitative information that hospitals value**

Data is going to be huge. There's a real opportunity here because healthcare is still trying to figure out how to show the returns on social and social determinants of health. The hospital already has all the public data like Census and ACS. What are you collecting that’s different, that is able to show real community impact how it's affecting people long term? Health outcomes are key if you can get that data. A great opportunity for community development is thinking through datasets that a hospital would not have access to, and how we make that available. Sometimes access to that data alone is a huge ROI and a huge incentive for the hospital.

Healthcare and community development work on two very different timelines. At ProMedica, we had 18 months to figure out how to spend this community development funding for the hospital. We need to do engagement, find projects, and we got to go because the board has given us $11 million of hospital operation dollars.

You want your data to be as comprehensive and as innovative as possible. The game plan on innovation is to think differently about how we get people access to care and access to social service and social needs. How do we invest strategically? Not all hospitals are interested in just giving away money; they are expecting a financial return so they can create some type of revolving fund opportunity. If you have a project to improve the community, come to healthcare with just a really strong plan. Some systems are interested in being the first dollar in. Some are interested in being the last dollar in. Be able to pivot and say we value you as a partner, and we think this is your value add this is the ask that we would like to make. But we're still in the phase where we're navigating and we're open to all ideas.

Tell me something that I don't know. Tell me something that my team in the hospital would have no expertise around and why I need you at my table to help us move this forward. The hospital has a business development team and they're thinking about innovation, but don't always have the internal expertise to get it all the way through. So how do you position yourself as a partner in that to help get it through make yourself indispensable and invaluable to the system in the community space?

A lot of great organizations really strive to bring together, cross-sector conversations. Widen your lens to to include health in your everyday conversations right. If you have a really robust community organizing program or community gardening program you’re working on every day, try to make the connection on how that impacts somebody's health and well-being. If folks are working low wage jobs, they probably don't have great insurance so they're maybe not going to healthcare. If they get a diabetes diagnosis, that forces people to change their eating habits but they don't have anywhere to go buy healthy food. They can’t really follow those instruction if they’re concerned about paying rent Iand are probably not going to buy their prescriptions. There are all these anecdotes and connections that exists that hospitals are really now starting to uncover.

As community development folks, you have the real-life stories to be able to tie to those anecdotes that healthcare is now just starting to discover. You can incorporate those, which is why that quantitative and qualitative is so important. You know that people that are everyday having to make those decisions and having those struggles. And so how do you show a real-life picture or real-life cost? You know what is it costing you to run your Community Food Bank. You know what is it costing you to put up affordable housing, what is it costing you to provide people jobs, where's the partnership gap. You can provide real-life perspective that for a lot of hospitals is still very anecdotal.

We’re starting to screen patients. We know in theory that if somebody is healthier it's going to cost me less money. But I might not necessarily know who those people are and what their stories are. For you guys, that's really that bridge to show that you’re addressing social determinants every day we've been doing it for 100 years for 50 years, whatever it is. Here is the evidence right that evidence base here's the evidence on these folks and why these services are important. So I think that, being able to integrate that into every conversation that you're having not just with healthcare but also with things with CDFIs and across sectors is really key. Healthcare are now are just figuring out did we get Medicaid reimbursements. They don't necessarily think about all of the holistic approach that you as community developers provide. I'd say that is key.

**Q&A**

**Frank -What kind of levers can state government can pull to get hospitals and healthcare players to the table?**

**Kendra** - It's definitely carrot and stick. I know we've got some Staci from New Jersey on the webinar. They’ve got this great 4% program that they're doing through the state financing agency. So anybody that works in housing development you know there's 9% deals or 4% deals. Both are a pain in the butt, nobody really touches 4% deals with a real long pole.

New Jersey incentivizes hospitals to invest in 4% deals so that we can move this along. Now at a hospital there's probably nobody on staff that even knows what a 4% deal is, but New Jersey has staff at the agency that will walk through with the hospital on how this works how their investment works what they can expect to get it done.

It’s really hard to mandate that hospitals do anything because we've got ACA which we follow of CARES or advocating back to the state right or Medicaid and Medicare as an insurance provider. I can't get funding to do this as a health system. We’re required to serve this many people and do these things, but I'm losing billions of dollars a quarter. But one of the things that we would always talk about with our advocacy director

At ProMedica, we were getting a lot of requests to advocate for LIHTC housing. ProMedica made a very clear and definite ask but we did not to support any LIHTC projects. We were very interested in supporting affordable housing without using LIHTC because LIHTC in our market of Toledo was not very successful. So, we're doing that kind of advocacy. We know LIHTC in general is a good thing for a lot of different markets and we're in more than just Toledo so we're going to do that. But I also say to ask the state to help us figure out whether it's different points in the QAP for helping for healthcare incentives. You’ve got to give us something simple That's where those multi-level relationships come in. Your advocacy person can connect with the advocacy person in a hospital. It's a different conversation than talking to the population health people.

**Elana** - I previously worked for the Massachusetts attorney general's office which produces the guidelines for community benefits in our state so I can talk a little bit to some of the guidance that we had in Massachusetts that incentivizes some of these investments. In Massachusetts, community investments by hospitals are voluntary. For hospitals, a lot of what they do really impacts their image in the community they see themselves as charity institutions, nonprofits, and community institutions. When they report their community benefits to the state, it gets published and people read it. That matters for hospitals in terms of the press and press releases, and things like that. But in Massachusetts. In the last update to our community benefits guidelines we had a number of carrots that we worked in one was that we adopted. Five health priorities which were parallel with those adopted by our Department of Public Health and which were all social determinants of health. So we asked hospitals to actually arrange their narrative about their programs, and to some extent to give some financial breakdown of how those investments mirrored our priorities, which were those social determinants of health. We also asked for folks to give a supplement to their reports for the very first time where they would talk about their role as anchor institutions in their community. So again, nothing that was required. And in fact, the investments that a hospital made as part of an anchor strategy. So if it had to do with who they were hiring but they couldn't necessarily assign a monetary value to, it that it might not be counted quote unquote into their community benefits. But it is present in their report and people do read that.

Another tool that we used was encouraging collaboration between hospitals to make sure that there wasn't redundancy and instead that hospitals were building up on one another's work in their plans but also in their community health needs assessments. It’s just so important that both members of the public, and members of CDCs, and members of public health advocacy organizations are looking at these documents. Kendra had mentioned the Community Health Needs Assessment that are required to be publicly available but that's only as important as the people who read it -- who actually use that as a basis for conversations with their local hospitals

**Sharon Legenza** - **What opportunities and barriers and especially considering healthcare layoffs?**

**Kendra** –The one thing that doesn't change even in the midst of COVID is that nonprofit hospitals are still not paying taxes so they have to spend community development dollars. A lot of social determinant dollars and investment funds come from the operations budget, but sometimes it comes from philanthropy and grants. Those dollars are not always going to be in fact impacted by something like COVID.

A lot of health systems are really focused on efficiency, innovation and automation. They want to use telehealth and community clinics to get the least number of patients to come into the facility now. I's really going to start to change the model about how people access healthcare. So, a lot of the investment opportunity is going to be in that and data tracking. You’re not going to see them building new hospitals or really making brick and mortar investments unless it makes a lot of sense for the hospital operations. At Bon Secours, our charge has been to create a new strategic plan by August. I think the dollars will continue to exist because it's tied to the tax status of the hospital. It may not be as many dollars it may look like different investment opportunities. A lot of losses may be on the operation side rather then the actual community health and community investment sides.

**Rick Sauer – With the impact of loss of revenue experienced by hospitals due to lack of elective surgeries., how do you think this will impact their willingness to invest in affordable housing? Does the involvement of insurers become even more important?**

**Kendra** - If somebody came to me with an affordable housing deal in this environment, I would absolutely at be looking to being last dollar in. I would be looking for a full capital stack with just a little bit of an ask – probably a mid-size project that’s more manageable with less opportunity to fail. Hospitals often tie investment to their patient base so you will see a lot of hospitals asking questions about post-acute patients. Folks that are coming out of long-term nursing facilities need alternative places to live. So I think the ask is going to look a little different than just traditional affordable housing because that’s not closely tied to operations. I won't say they won't continue to do it, especially if they have strong CDI relationships, but I think it won't just be as simple as you know filling out your QAP, saying we have a hospital partner, and then you're done.

I think that government innovation is going to come in about that housing the serving. Here in Toledo the Housing Authority is going to do a development for young folks coming transitioning out of foster care. There's definitely a health element to that rand innovation so we're looking at, rather than just building some 80 percents and calling it a day. Put on your innovation cap and think about who we're serving and how it's financed. It really is your capital stack. As a former developer, I would say I need your capital stack to be at least 75% there before I can probably sell that within the system at this point.

**Sharon Legenza -** **What do you think would be a good way for state associations to pitch this?** **We work with community-based groups, but we're really on more of a state systems level. We have access to community-based groups and unique data sets is. How can we pitch our unique ROI?**

**Kendra**- State agency data and system change is really where I see the value. You have a very large-scale view. Most hospital systems have multiple locations within one state, and those communities are so different that it's hard to keep track right like what's happening in a major -- metro versus suburbs versus rural. Being able to have this high-level view of state policy both and the community development end is valuable.

Think about Medicare and Medicaid reimbursements. How do you as a statewide community development agencies tell that story? Your story is going to have a different lens than my story as a state healthcare person. How do you put a different twist on that in terms of advocacy end and data?

Social determinants and community impact data is a space where a lot of hospitals have a lot of room to grow. We get sales pitches and sales calls from new apps and tech data services that are going to help us track patient data and community data. Think about data for advocacy and systems improvement. Can you can pull data that shows me how to create system change that addresses equity and poverty and health care and finances?

One of the things I would love to see on the healthcare side is if somebody came to me with like some kind of data-share plan so we have access to patient data, which we can't even share throughout the hospital. If the community had access to either aggregated data or data that’s put together in a different way to show me something that I don't have, that's a partner that I can then leverage to either build better social determinant data than what’s being sold on the open market. Or I can go back to these vendors and say hey you want to build this for a hospital system but let's tag in a community platform on that. Let's tag in a banking platform so a lot of this data and social determinants from the healthcare side is still being built. But people are building it to sell it to healthcare from a healthcare perspective. And so how do you start to integrate these different sectors into building it? I think that’s a real opportunity for state agencies, especially as you guys know what your own data gaps are, and being able to be a partner at the table is those things are being built on the data side. The metrics that we present to healthcare have to be health related.

**Jessica Love - Do metrics that we present to healthcare have to be health-related? When we talked with a major insurer last year, they were more interested in our payday lending alternative work than housing. if we were to pitch participation in that program to a healthcare system, do we have to present health data or do financial capability data points meet their needs?**

**Kendra** - Major insurers are very different than healthcare systems. They’re thinking about Medicare and Medicaid. They get coverage reimbursement for social determinant activities. So, if they connect somebody to financial counseling, workforce training, or to any type of social program, 9 times out of 10 major insurers are not getting reimbursed for those services – or it’s pennies on the dollar.

ProMedica is one of the few healthcare systems that also has an insurance subsidiary, Paramount insurance which is state Medicaid, Medicare. So pregnant moms will oftentimes be connected to a community health worker to make sure they’re getting to appointments. The reimbursement rate for a prenatal visit is $25 to a healthcare to an insurer. We know that doesn't cover anything. What's not covered at all, is if I connect somebody to a financial counselor. There's no reimbursement there so for an insurer. They're very much going to be interested in those types of programs you can show that that if they can get somebody in these social programs, the reimbursement money they’re spending as a healthcare system lowers, which makes the reimbursement rate that you've already approved go further. Those conversations are going to be very important a lot of health insurers now.

Healthcare systems are working to get social determinant interventions covered -- and that's all the way up to the federal level. Those conversations are happening as state, Medicare, CMS on the federal side, and at the state level for a health care system. That conversation has a little bit less traction because the reimbursement isn't coming straight to the healthcare system. A health care system is going to say, If I have a patient that has not paid their bill historically, we know there may be screening positive for financial trouble. So, if I can get them in a system it will help pay the bill which helps my bottom line. So there's a different value add there for those systems. Healthcare data is important, but it's not everything. If you're really trying to think about financial services, show how increasing somebody's credit score increases disposable income and earning potential. How does all of that release stress and burdens if I'm making more than living wage and I have more disposable income? If my credit goes up, can I get a different type of housing? Tell us the story that's directly related to the program. Same goes for food and for workforce.

Think about what healthcare value add it's showing if I improve somebody's financial well-being. They're more likely to visit a healthcare provider so that creates an access carrot for the hospital if the patient is able to pay their bill. The patient is able to follow their interventions so now it's this holistic picture that healthcare is a part of. I think you have to think about health and well-being in the same space, we talk a lot about hierarchy of needs. Access to health care and being healthy are two different things. Show how your programs help people be healthy. That can be mental health, financial health, physical health. behavioral health. All of it is already tied in together. That should be one aspect of your pitch to either an insurer or a system.

**Garrett O’Dwyer** - **How we can best evaluate the circumstance that a hospital might find themselves in as a result of the COVID crisis and make a pitch?**

**Kendra** -Monitor Community Health Needs Assessment implementation plans. Multi-level relationships are going to be key. Changes in healthcare are going to be happening at that board and C suite level. If you already have access to somebody at that level, have honest conversations about what it looks like operationally from the hospital. If you don't have that established partnership, approach them as a community partner to gain information.

As a community partner, the right angle is always going to be that you serve the same community. We really want to see how COVID is in your operations and how you’re going to help the community post-COVID. You know what barriers what are going to exist. Start that conversation either through the community health team or the foundation team.

Think about those easy-access community-based entries into a hospital if you don't already have that relationship. We're having conversations all the time with United Way and county health departments. These entities invite hospitals to the table. If that’s not already happening, most communities are having community-wide COVID conversations. Health equity is a great lens for conversations with hospitals right now as we see all of the data around COVID and communities of color and disabled communities. Health equity is a great entry point regardless of whether the hospital has bought into it or not. It will most definitely be a conversation that has to happen in the sector. I think it’s a good time to come to the table with your equity goals, but hospitals are likely to be a bit tight lipped for until at least the end of the year. Hospitals are dealing with clinical operations and community. We lost a billion dollars and are thinking about it as we have to make tough decisions in the sector. And so being able to really leverage yourself in that will be key.