Community Investment for Health
Findings from Six Health Systems Investing in Affordable Housing

Overview

Given the multiple social, environmental and economic factors that contribute to people's well-being, one organization or sector alone cannot create and sustain healthy communities. Hospitals and health systems — as anchor organizations, or placed-based economic engines, dedicated to health in their communities — can make lasting upstream investments to improve community health by working in partnership with others.

Community Investing and Affordable Housing

Hospitals and health systems have a long tradition of supporting essential services in communities, including affordable housing. The funding streams historically used by hospitals to address housing, such as community or philanthropic grants, are oftentimes lifelines to their recipients and the community as a whole. However, overcoming systemic barriers that prevent structurally marginalized communities from truly thriving calls for innovative tactics implemented by cross-sector partnerships. Leveraging capital and expertise across sectors, such as community development and investing, can help health care organizations achieve more meaningful and lasting systemic change than health care-driven strategies alone.

Given the inextricable link between affordable, safe housing and people's well-being, hospitals and health systems are increasingly identifying ways to address the growing mismatch between people's incomes and high housing costs (see Exhibit 1, AHA's resource *Housing and Health: A Roadmap for the Future*). This is where upstream community investments that generate financial as well as social returns come into play. Such investments by hospitals and health systems can help meet community-identified needs for affordable housing by overcoming market failures.[1]

Exhibit 1. Housing and Health: A Roadmap for the Future

Millions of Americans experience housing instability that threatens their health and well-being. An umbrella term for the continuum between stable, secure housing and homelessness, housing instability ranges from substandard living conditions like exposure to allergens or pests to severe rent burdens to homelessness. By partnering with other community stakeholders to address housing insecurity, hospitals and health systems can work to reduce disparities in health outcomes for their patients and community.

Housing and Health: A Roadmap for the Future examines the impact of housing instability on people's health and outlines opportunities and avenues for hospitals to reduce housing instability in their communities. This tool shares strategic considerations for how to tailor a housing strategy to meet community needs and case examples of how hospitals are addressing housing instability during the COVID-19 pandemic.

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Accelerating Investments for Healthy Communities

From 2018 to 2021, the Center for Community Investment (CCI) led [Accelerating Investments for Healthy Communities (AIHC)](#), an initiative designed to increase health system investments in addressing upstream social determinants of health, with an emphasis on affordable housing. With funding from the Robert Wood Johnson Foundation (RWJF), CCI provided intensive coaching to a cohort of six nonprofit health systems and their community partners across the country on how to refine community investment strategies for affordable housing to leverage existing resources and make the greatest impact on community health. (See Exhibit 2 for a list of participating health systems.) Bringing CCI's [capital absorption framework](#) to life, AIHC aimed to help participating teams:

- think strategically and systematically about how to deploy their community's and health system's financial resources, land and expertise;
- advance affordable housing as a platform for creating healthier communities for all people; and
- adopt effective financing mechanisms and unlock investments by other stakeholders.

In addition to team-based and peer-to-peer training and coaching, the six AIHC health system teams had the opportunity to apply for and receive two types of funding. The accelerator pool supported activities to further the articulation of shared priorities, preparation and execution of the pipeline, or strengthen the enabling environment by funding community engagement capacity, legal and consulting services, and project staff support, among other efforts. The capital pool was available to provide investment of up to $1.5 million intended to "galvanize other investors to support local projects and system change by providing national resources and visibility" and required at least a one-to-one match by the health system on same or better terms.

Exhibit 2. AIHC Participating Health Systems and Project Locations

Boston Medical Center – Boston, Massachusetts

CommonSpirit Health – San Bernardino, California

Nationwide Children's – Columbus, Ohio

Kaiser Permanente – Prince George's County, Maryland

UPMC – Pittsburgh, Pennsylvania

Bon Secours Mercy Health – Cincinnati, Ohio; Baltimore, Maryland

Report Purpose and Context

The American Hospital Association (AHA), in collaboration with NORC at the University of Chicago (NORC), served as the evaluation learning partner to better understand the participating health systems' internal progression to improve community health through community investment. (See Exhibit 3.) The work was guided by the overarching question, "What will it take for leading health care organizations to devote more and different assets to investments in affordable housing and other upstream factors that improve community health?" This report summarizes the findings of interviews with the participating hospitals and health systems about their AIHC participation.

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The interviews were designed to learn how AIHC, and more generally community investment efforts, were integrated into the health system, and covered such topics as historical organizational commitment to housing and motivation for joining AIHC, strategic and mission alignment, structure of the AIHC team, making the case and sustaining leadership engagement, integrating the work into the system's overall strategy, and outcomes and impact to date. (See Appendix: Methods.)

Though the focus of this report is on the health systems, addressing societal factors that influence health through strategies like community investment is only truly successful in partnership with the people and communities affected. Health care organizations should not be expected nor attempt to resolve systemic problems like housing instability alone. In fact, a core function of the capital absorption framework that CCI created and used throughout the project is defining "a collective understanding across stakeholders that encompasses both the problem they're trying to solve and their strategy for addressing it at this moment."[2] Moreover, engaging in cross-sector community partnerships is a core capability of population health[3] and key to addressing societal factors that influence health.[4]

Exhibit 3. Defining Community Investment and Health System Roles

What is community investment?

The Center for Community Investment defines **community investment** as "investments intended to improve social, economic and environmental conditions in disadvantaged communities while producing some economic return for investors. Community investment (sometimes called impact investment) can be used to create the social and physical environments that support community health over the long term, including things like small businesses, affordable homes and grocery stores. Health care organizations have an array of assets — land, financial resources, relationships, expertise, etc. — that can be harnessed to support community investment."

On the other hand, using grants or **spending** is "making a financial contribution to a community organization for goods and services without an expectation that the money will be repaid."

With respect to addressing housing instability:

- **Spending** would include activities such as subsidizing rent payments for individuals and families, either directly or through a community organization, or supporting the salary of coordinators that connect families to housing options.
- **Investing** would include activities such as providing a below-market loan to a developer or lending money to a fund that rehabs or builds new affordable housing.

For more information, see *Investing in Community Health: A Toolkit for Hospitals* (Center for Community Investment, 2020) and *Place-based Investing: Creating Sustainable Returns and Strong Communities* (Healthcare Anchor Network, 2017).

What roles can health systems play?

Partnerships come in different shapes depending on the stakeholders, their priorities and the issue at hand. The key is to identify potential partners that can come together around shared interests and commit to collaboration. Each stakeholder, including the health system, has to articulate its role in the initiative. Potential roles in a community investment partnership include:

- **Anchor.** Initiating and taking the lead role, leveraging resources and influence.
- **Partner.** Joining a community coalition or collaborating with other stakeholders.
- **Advocate.** Supporting policy positions at the local, state or national level.
- **Investor.** Investing dollars into individual projects, funds or intermediaries.

For more information, see *Housing and Health: A Roadmap for the Future* (American Hospital Association, 2021).

Findings

Strategic and Mission Alignment

This section describes how AIHC aligns with health systems' missions and strategic priorities. At each system, the initiative is built on a history of broader internal and external initiatives to address affordable housing and other social determinants of health in local communities. This context informed how AIHC influenced and interacted with each system's broader efforts to address SDOH and social needs.

All participating AIHC health systems had a history of community health improvement or community investment to address SDOH, including housing. Such experience was a prerequisite for participating in the initiative, as the objective was to help those leading-edge systems accelerate and deepen their work in this space. Many health systems' housing efforts were positioned within broader efforts to revitalize or engage with neighborhoods and to serve as an anchor organization. Health systems with well-established housing initiatives spoke about AIHC within their broader housing portfolio, describing how efforts complemented each other, rather than describing AIHC as a stand-alone program. (See Exhibit 4.)

Across health systems, AIHC is positioned within a broader context of related external initiatives. For example, four health systems participate in the Healthcare Anchor Network, and respondents described how the overarching values and strategies of the anchor mission complemented the AIHC community investment focus (Exhibit 5). As one health system leader explained: "The framework that we laid out by adopting this [Healthcare Anchor Network] mission philosophy and process has been something that people can understand and embrace. And that's really been driving our conversations and our process for how we continue to instill this and make this, truly, part of the fabric of the work that we do in the organization."

Exhibit 4. Societal Factors that Influence Health Framework

For more information, see aha.org/societalfactors
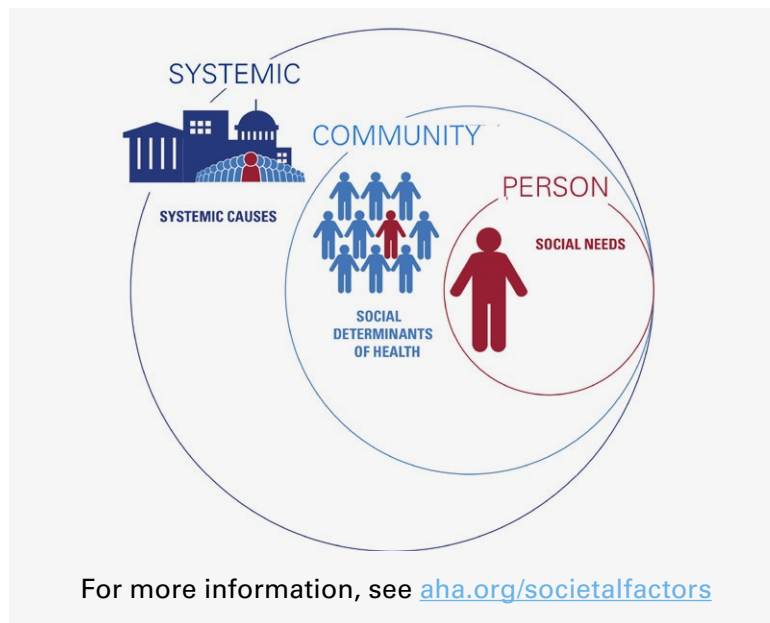
Exhibit 5. Healthcare Anchor Network

Launched in May 2017, the Healthcare Anchor Network (HAN) emerged from a desire to explore how health systems "could more fully harness their economic power to inclusively and sustainably benefit the long-term health and well-being of the communities they serve."[5]

HAN's long-term goal is "to reach a critical mass of health systems adopting as an institutional priority to improve community health and well-being by leveraging all their assets, including hiring, purchasing and investment for equitable, local economic impact."

Of the 10 founding HAN members, two participate in the AIHC initiative — CommonSpirit Health and Kaiser Permanente. Two additional AIHC participants — Bon Secours Mercy Health and Boston Medical Center — are part of the now 60-plus member network. Additionally, in November 2019, the four AIHC health systems participating in HAN joined 14 health systems pledging to invest over $700 million for place-based investing to create strong and healthy communities.[6]

In addition to alignment with existing housing efforts, AIHC team members spoke about AIHC in a context of broader impact investing or community health investment efforts at their systems. Such efforts include programs that commit a portion of the system's long-term operating portfolio to direct community investment, community investment program loans and grants to local agencies, and an impact investment collaboration between the system's treasury and community health departments. In some cases, health systems described leveraging or pooling funds for AIHC and related initiatives to maximize impact.

AIHC recruited nonprofit health systems, including faith-based, and these characteristics were commonly referenced when describing their mission-driven commitment to community investment and housing. The health systems expressed widespread acceptance that, if their goal was to improve health outcomes and boost health, it was their responsibility to support their communities. In the words of a team lead at a Catholic health system, "When you look at mission and ministry and the tenets around Catholic social teaching, human dignity, [it's] really valuing the person." See issue brief Making the Case for Hospitals to Invest in Housing for more detail.

Participating health systems view housing as one piece of a wider strategy to address social determinants of health. Systems described housing as one prong of broader community investment strategies aimed at strengthening communities by addressing social, economic and environmental factors that affect health. Team members noted the following factors as influencing the health system's strategies toward community investment and housing work.

- Strategic alignment with value-based payment models, including participation in an accountable care organization (ACO), or operating a health plan, both of which typically incentivize population health management and addressing SDOH. Four systems participate in ACOs, and three have an integrated health plan.

- Reducing disparities in health outcomes in the wake of COVID-19. AIHC team members at multiple systems noted how the COVID-19 pandemic starkly illuminated health disparities and racial inequities; interviewees noted that a shift in health care culture to focus on and address health disparities (including social determinants of health and housing issues) is underway. In some places, this work has been institutionalized.

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Community health needs assessments consistently identified housing as a need. Several systems also noted that homelessness and housing insecurity are long-standing issues in their communities. System representatives commented on the natural alignment between CHNA requirements and the process to prioritize their AIHC strategies, with one health system noting that rather than being a "three-year compliance exercise," the CHNA could be "a living document that guides your work." AIHC team members noted that hospitals and health systems considering housing work should leverage their CHNA process to ensure that initiatives align with documented community needs.

Large, multistate systems have both overarching strategic plans and priorities and more focused initiatives based on target geographies. This was operationalized in a few different ways.

- One large health system historically has taken a variety of approaches to housing work, including giving grants or below-market interest rate loans to community organizations and investing in community development financial institutions. These approaches spread resources across the system's service area, which includes 21 states.

- At another multistate system, an AIHC team member described how the community investment financial assets are centralized within the health system treasury, requiring collaboration between the system treasury team and the local market's community health team for deployment. Despite centralization of community investment resources, each local market has control over community health grants and has a community health leader, a recently formed position. This individual, usually working at the executive director level, is responsible for identifying opportunities and community priorities and linking them to the system's priorities.

- Another health system has taken what AIHC team members described as a "blended approach" by launching an investment fund for affordable housing across multiple markets that predates its AIHC participation, as well as working on homelessness with a national partner. At the same time, each region works locally on social determinants of health, including housing, to meet specific community needs.

Health System AIHC Team

This section describes the composition and essential skills of AIHC team members representing health systems.

AIHC team members representing health systems varied by their department, seniority and system level, although all teams were connected in some way to the system's community and/or population health divisions or existing projects.

Many community and/or population health departments lead programs and initiatives addressing societal factors that influence health, although there isn't consistent structure where this work is based. Other departments represented in core teams included strategy and mission but, as discussed in the next section on Making the Case and Sustaining Leadership Engagement, many different departments can play vital roles in this work.

Team members' titles and roles ranged from program and project manager to executive director to vice president and senior vice president at the local and system levels. This breadth illustrates how this work transcends organizational levels to operationalize, particularly with large systems. Throughout the initiative, various team members stressed the importance of an executive sponsor or champion, which is not necessarily reflected in the team composition itself but rather a key component for making the case and sustaining the work.

In terms of team composition generally, a number of health system team members noted flexibility and changing team members as important for ensuring the correct people were at the table as goals crystalized. (See Exhibit 7.)

Exhibit 6. Resources on Key Community Partners for Community Investment and Anchor Mission Work

A guiding principle of community investment work is seeking and listening to wide variety of community perspectives and acting in step with community partners. This report focuses on team members from health systems. The following resources include more information about key community development stakeholders and their contributions to this work.

Investing in Community Health: A Toolkit for Hospitals, Center for Community Investment, 2020.

Place-based Investing: Creating Sustainable Returns and Strong Communities, Healthcare Anchor Network, 2017.

Healthcare Playbook for Community Developers, Build Healthy Places Network, 2018.

Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health, Health Research & Educational Trust, American Hospital Association, 2017.

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Exhibit 7. AIHC Health System Team Member Essential Skills/Roles

	Aligns work with organizational strategy and vision and communicate strategically	Person/people who is/are a strategic communicator and creates a clear line of sight and purpose aligned with organizational goals and strategy while telling the "story" internally.
	Owns and/or "project manages" the work	Person/people who can dedicate staff time to managing and moving the work forward rather than it being an add-on project on top of other duties.
	Engages with and builds relationships with the community	Person/people who serves/serve as the point of contact for community members and organizations to incorporate their interests and priorities while partnering on projects.
	Translates and provides content expertise on technical topics like community development and housing	Person/people who can translate the language and acronyms between the housing and health worlds — not necessarily a hospital/system employee/employees.

An essential skill that AIHC team members spoke about was the ability to connect the work to their respective health system's goals and provide strategic vision. Team members spoke about this in a few ways, noting the need for a good storyteller or strategic communicator and someone who can navigate the internal approval process as well as provide a clear line of sight and purpose. One system leader articulated this by describing a colleague's value-add to the team as "grasping these complexities and then organizing them into clear streams of work, a clear line of sight, a clear purpose, a clear goal, and in alignment with the hospital system's goal."

Somewhat relatedly, AIHC team members also stressed the importance of having a person with designated time to own and "project manage" the work. Capacity to do the work has been a theme since the initiative started. One team member articulated how it was no one's full-time job and instead they were "putting together a team from within the organization with pieces of people's time." That team member went on to say that "as you get more serious about this work, you do have to invest in capacity. You do have to invest into this being somebody's full-time job." Over time, some teams did invest in internal capacity by hiring additional staff, and at least three systems engaged with external contractors, which were partially funded through "accelerator" AIHC grant funding. As one system leader noted, having someone keep the team on track and moving forward was a game changer.

Another asset identified by AIHC health system team members was experience with community relations and engagement, particularly someone with existing community relationships or skilled at building them. Comments about this skill were often followed by statements that authentic and effective community engagement takes time and a sense of knowing one's place is key to building trust.

One health system leader described the need to integrate the role of community relations across all departments and strategies, as community wellness is an overall organizational goal. When asked whether the community relations and engagement activities should emanate from the health system or the partner community organization, the response was a mixture of both. The respondent highlighted that health care organizations can be big and complex and having one point of contact who attends meetings and events with the community demystifies things. Relatedly, having a designated community member interact consistently with and champion the hospital or health system adds another layer of support. Community engagement strategies are discussed in more detail in the sections on making the case and integration.

Lastly, content and technical expertise in community development and affordable housing deals was viewed as vital, but who and what organization held that knowledge varied. When a community organization provided the expertise, it was still useful for a health system team member to be able to understand and translate the information internally. One team member noted past experience as an asset, saying they had a level of natural technical arcana given their past roles in local government overseeing zoning and land use.

Making the Case and Sustaining Leadership Engagement

This section describes the key champions and decision-makers engaged in the work and how to foster internal collaboration. Additionally, it outlines key questions identified for making a business case and aligning with the strategy and mission of the organization.

Building a Business Case

Many AIHC team members noted that their organizations had moved from the "why" to the "how" in making the business case to key decision-makers. (The Strategic and Mission Alignment section outlines much of the initial "why.") Despite having moved on to the "how," building the case was admittedly still a work in progress for some health systems, at least in terms of process. When asked about components of a business plan, most noted that processes and templates were still fluid. Instead, team members shared key questions to consider when making a business case, albeit not an exhaustive list. Questions fell into three categories: community priority and need, financial review and organizational alignment. (See Exhibit 8.)

Exhibit 8. Questions to Consider When Building a Business Case for Community Investment in Housing

Category	Questions
Community priority and need	• Is the work a priority in the community as demonstrated in the community health needs assessment? • Has the community identified a need? • Is the idea adding stability to the neighborhood or community? Does it improve health outcomes? • Are there community organizations that are potential partners already in place?
Financial review	• What financial resources are available? • Has financial risk been mitigated? • Does the approach expose the organization to the least possible risk?
Organizational alignment	• Does the work align with strategic organizational goals around health equity, community health and/or population health? • Does it align with the system's local market goals and priorities as demonstrated through the CHNA? • Is it good for patients and/or health plan members? (if applicable) • Does the work advance well-being?

One health system team lead specifically cited the importance of process, saying, "Going back to those three questions: Is it good for the community at large? To members? And is financial risk mitigated? Then using that framework to evaluate some of these other opportunities and really get to the financial decision." The same team member discussed the role of the health system in providing the muscle, but not necessarily driving the work, using the analogy of "we're the gasoline, not the engine." And with that in mind, according to the respondent, the health system should be prepared internally with "the amount, the term and any interest that's

going to be repaid" and an understanding of what measures are important to the organization before entering conversations with community stakeholders about community investment initiatives. And then "figure out how to interface with the (community investment) system as it exists today" and the community's priorities, not create something new.

When reviewing these questions, respondents also noted that one size does not fit all and emphasized the importance of matching the scope of the intervention to the depth of the problem. Historical underinvestment or disinvestment in communities took time and was done at such a large scale that it will take time and a large group effort to undo the harmful effects.

Champions and Decision-Makers

Most AIHC team members referenced the C-suite and board of directors as key stakeholders when discussing decision-making structures. While the C-Suite and CEO were noted as key stakeholders in gaining approval of community investment initiatives, respondents with more established housing programs often had additional champions in senior leadership roles who could influence decisions. Boards of directors typically became involved when the community investment initiatives included large financial decisions or a potential impact to operational dollars or both.

When asked to identify key stakeholders to engage — to make critical decisions and sustain the work — AIHC team members discussed a variety of departments and divisions within the hospitals and health systems. Exhibit 9 illustrates the breadth of responses and suggests that while the work may originate and/or live within community and population health departments, it is truly a systemwide team effort, a sentiment that aligns with recommendations in existing toolkits and resources on this topic.

Exhibit 9. Key Hospital and Health System Departments and Stakeholders for Community Investment in Housing

System level	Core stakeholders (majority include)	• Chief executive officer • Trustees/board of directors • Chief financial officer • General counsel/legal department • Health plan executives • Community and population health senior leader
	Other	• Head of mission • System foundation and other philanthropic leader • Data analytics/research team
Regional/market level	Core stakeholders (majority include)	• Community health/benefit director • Program/initiative executive director • Local hospital leader

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Collaboration and Engagement

When asked about best practices for internal collaboration and engagement, all six health systems shared advice that fell into two main categories: communication practices, and workload and team structure. Given the systemwide team effort noted previously, good internal collaboration is key for moving the work forward. Exhibit 10 summarizes the advice.

Exhibit 10. Advice on Internal Collaboration for Community Investment Initiatives

Communication Practices	Workload and Team Structure
• Ensure open and transparent communication. Strive to keep counterparts in other departments and divisions up to date on the initiative. • Schedule regular meetings with key workgroups and stakeholders. • Promote honest conversations from different perspectives. • Communicate about the initiative and overall work as building a strategy and/or addressing a priority. • Be clear on "the ask" and keep it simple. • Make concepts and language accessible to stakeholders.	• Distribute leadership. • Create a multidepartment team to get internal visibility and ensure organizational alignment. • Attempt to get the right people at the table early. • Pull in stakeholders when needed. Build layers into work and team structure. • Source ideas from the local level of the health system to involve more stakeholders and ensure alignment on the ground.

Sustaining Engagement

Investing in communities and supporting affordable housing initiatives can move slowly and will require ongoing engagement with system leadership. When asked about advice and lessons learned on keeping health system leaders engaged, three major themes emerged:

- Share updates through whatever appropriate venues are available, such as workgroups, board updates and reports to managers.
- Try to anticipate and respond to leadership changes.
- Recognize that a major challenge is managing expectations and the time horizon or incremental change of these projects.

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AIHC Structure and Strategic Integration

This section describes how the AIHC operational structure spurred initial efforts at integrating community investment in affordable housing at the hospital or health system (i.e., how the work has become accepted as a natural way of doing things and how new practices associated with AIHC are becoming a normal part of organizational structures).

The most concrete and common example of how AIHC and related work were being integrated at the health system was through its operational structure or integration into internal workgroups and decision-making structures. When asked about internal infrastructure, most AIHC teams referenced the existence of a special advisory committee, subcommittee or workgroup. However, the roles of such groups varied, as illustrated in Exhibit 11.

Exhibit 11. Examples of How to Integrate Community Investment in Affordable Housing

	Role Type	Role Definition	Examples
	Strategic program alignment	Supports internal alignment across programs	• Informal workgroup on all housing-related projects • New cross-disciplinary center devoted to social impact
	Project-specific review and approval	Approves and implements work	• Team devoted to managing community investment work • Separate nonprofit entity to manage housing initiatives
	General executive approval	Existing decision-making structure supports approval of this work	• Community investment subcommittee of the board of directors

- **UPMC's** AIHC team pursues community investment and housing work under the system's newly created Center for Social Impact, which is in the UPMC insurance services division. The UPMC Center for High-Value Health Care provides in-kind funds to support this work. AIHC has helped UPMC collect information to start establishing and operationalizing a strategic plan — including how to advance and expand housing work that has traditionally been handled through community health improvement efforts or individual contracts and programs with community-based organizations — and to build support of community development corporations where the health system and the health plan have a large presence.

- **Nationwide's** AIHC efforts are embedded in the system's Healthy Neighborhoods Healthy Families (HNHF) initiative established in 2008 as a cross-department effort targeting five impact areas and guided by a current five-year strategic plan and operating budget.[7] HNHF's five impact areas are affordable housing, education, health and wellness, community enrichment and economic development.[8] A population health accelerator team of multiple departments oversees HNHF. AIHC team members noted that the connection between health and housing is socialized through the system — Nationwide's board was "the key driver" in participating in AIHC.

Outcomes and Impact

This section describes early outcomes associated with the health systems' efforts to accelerate their community investments in housing through AIHC as well as their plans to date to measure intermediate and long-term outcomes.

Establishing concrete or quantitative metrics to track and measure success in community investments in housing, including health and financial impacts, is emergent and complex.[9,10] Generally, health systems reported focusing on interim-term process outcomes, with plans to develop approaches to monitoring and measuring long-term health system and community outcomes and impacts. At the time of the interviews, second phase funding from the AIHC capital pool had yet to be deployed to health systems, and it was too early to observe long-term outcomes associated with AIHC. (AIHC projects are ongoing, and therefore, long-term outcomes of specific housing projects are beyond the scope of this report.)

Intermediate Outcomes

Health systems discussed achieving intermediate outcomes and successes, such as building partnerships and relationships with their communities through community investments in housing, including through AIHC projects.

With respect to AIHC, participating health systems described interim outcomes of their work in terms of building trust with communities and establishing meaningful partnerships. A team lead spoke to the critical importance of not only the housing outputs but also relationship building: "Trust is a product just as much as the unit count is a product." A team lead at another system elaborated further saying sometimes the win is simply creating the space for key stakeholders to come together and staying together.

Health systems sought to begin understanding more about the community members served through community investments in housing by tracking the number of people housed and/or demographics of those individuals. While supporting projects where a majority of units are affordable was a requirement of the second-phase capital pool funds, one system established specific criteria for levels of affordability related to the area's median income. Another health system leader reinforced the value of celebrating interim and incremental progress through real-world impacts on those who benefit directly from housing investments, saying that while a small number of new units doesn't solve the affordable housing crisis, it does house families now.

Teams acknowledged the complexity of demonstrating causal links between community investments and community-level impacts. A health system team lead pointed out that impacts may take significant time to achieve and observe, saying, "You've got to be in it for the long term. You can't get in with just one year, or one grant, and expect immediate results. It's a very, very slow and attenuated process involving multiple stakeholders, and a long time horizon." When outcomes data are hard to observe, health system leads found it helpful to share process outputs and outcomes about the housing investments themselves — for example, overall unit count, rehab costs, share of costs paid by the health system versus partners, and how investment might be multiplied by partners.

Long-Term Outcomes

When considering long-term impacts of AIHC and outcomes achieved through other community investments in housing, health systems expressed an interest in achieving and tracking financial returns and community-level impacts, including health and also outcomes related to social determinants of health.

Though most health systems were not yet observing impacts or measuring long-term outcomes of housing investments, systems defined success in communities as multidimensional rather than strictly financial. Further, a few health systems mentioned that a larger organizational focus on social determinants of health and improving health outcomes served as a rationale for doing the groundwork to track health outcomes in housing work. One system was creating a social impact assessment to track health and well-being indicators and changes in health care utilization for people aligned to an investment project. Health systems cited the following when discussing potential community-level housing impacts:

- making general improvements to social or community welfare, or "social ROI";
- reducing disparities (e.g., tracking demographics of community members served through housing work);
- building economic vitality, mobility, stability and development;
- reducing homelessness and/or examining area median-income changes; and
- improving access to education.

One team leader from another health system noted: "So [constructing affordable housing is] really changing the face of the community now — granted, it's a very slow process. But it really is adding stability to our neighborhoods, which then of course in turn it's housing, but then it's education, job creation, jobs stabilities — that kind of quality of life in general."

AIHC team members leading four health systems reported considering financial outcomes or the potential to generate financial returns as part of their agendas for community investment in housing. While it was clear financial outcomes were not the sole concern of health systems, the potential financial sustainability and returns remained of interest to system leaders. Health systems were still developing methods to track and measure downstream financial outcomes. Specific financial metrics of interest to health systems included:

- Cost of providing programs/services
- Unit cost, ongoing service cost
- Decrease in patient health care costs
- Financial returns/return on investment

One team leader described how capitated Medicaid payments provided financial justification for making community investments in areas where many Medicaid beneficiaries live. "From a business standpoint, an improved neighborhood — it equates improved health outcomes. It takes time to measure that fact. We believe it's there, and we believe we're seeing it slowly here in the work that we do." This team lead further noted what the health system has observed:

> *What we have seen is that our ED, our emergency department, visits have seen a decrease on the [neighborhood] since we've started our work. We are looking at ways to link health outcomes to the work and investment. … The affordable housing team … is responsible for the quantifiable data that demonstrates outcomes based on the number of homes that have been preserved or created."*

Four health systems described an interest in measuring patient health outcomes resulting from housing investments. As leaders at one health system pointed out, housing investments "are big, complex enterprises; the outcomes can't just be feel good" but also must be "data driven." Three health systems are building or developing assessments and action plans to track health and well-being outcomes, including utilization or self-reported outcomes.

Specific health outcomes connected with housing investment of interest to systems included:

- Health care total utilization
- ED utilization
- Health care needs (general)
- Infant mortality rates
- Incidence of behavioral health issues
- Incidence of asthma

Health systems also took varying approaches to analyzing the intersection of patient health outcomes at the community level. One health system plans for impact measures to be investment-specific rather than looking at a "blanket" set of health impacts, while another looks at metrics across the organization (e.g., emergency department visits, infant mortality rate) "to tell the story of how health is being impacted through affordable housing, economic development, [and] the role [of the system]." Exhibit 12 highlights recent academic articles that have attempted to quantify the community impact of investment on patient health.

Exhibit 12. Recent Research Studies of AIHC Health Systems' Community Investment and Development Efforts

Chisolm, D.J., Jones, C., Root, E.D., Dolce, M. & Kelleher, K.J. (2020). A community development program and reduction in high-cost health care use. *Pediatrics*, 146(2).

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Call to Action

Reversing the causes and effects of disparities in communities requires partnerships, including those led by health care organizations. Health systems participating in the AIHC initiative noted that one size does not fit all, as well as the importance of matching the scope of the intervention to the depth of the problem. Historical underinvesment or disinvestment in communities took time and occurred at such a large scale that it will take time and a large group effort to undo the harmful effects. By working with community partners, hospitals and health systems can improve individual and community well-being, reducing disparities in health outcomes and make a positive impact.

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Acknowledgments

About the American Hospital Association

The American Hospital Association (AHA) is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA advocates on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups. Founded in 1898, the AHA provides insight and education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

About AHA Center for Health Innovation

The AHA Center for Health Innovation, created by the American Hospital Association, enhances hospital and health system transformation and accelerates innovation at scale. The Center was formed in September 2019 from the merger of AHA's Health Forum, Health Research & Educational Trust, Data Center and The Value Initiative. The Center serves as a key partner to AHA members, supporting their innovation and transformation journey with new tools, data products and analytics, learning collaboratives, conferences and virtual expeditions, market intelligence and advisory services. Visit the Center website at www.aha.org/center.

About NORC

NORC at the University of Chicago is an objective, nonpartisan research organization that delivers insights and analysis that decision-makers trust. As a nonpartisan research organization and a pioneer in measuring and understanding the world, NORC has studied almost every aspect of the human experience and every major news event for more than eight decades. Today, NORC partners with academic, government, nonprofit, and corporate clients around the world to provide the objectivity and expertise necessary to inform the critical decisions facing society. Visit www.norc.org.

Appendix: Methods
Primary Data Collection and Analysis

AHA conducted four rounds of interviews with AIHC health systems and community team members between September 2018 and December 2020 (see Exhibit 13). Each interview was conducted by one to three AHA staff using a semistructured interview guide. All interviews were recorded with the respondents' consent and professionally transcribed.

Exhibit 13. Overview of AIHC Interviews

Phase	Date	Total interviews	Total respondents	Respondent type	Key topics
Phase 1: Baseline	September–October 2018	8*	23	Health system team members	Motivation for joining AIHC, assembling team, developing investment plan
Phase 2A: Follow-up baseline	May–June 2019	3	7	Health system team members	Changes to AIHC initiative, assembling team, developing investment plan
Phase 2A	May–June 2019	9	10	Community team members	Motivation for joining AIHC, community context, health system's role in community
Phase 2B	November 2019–January 2020	14	20	Team leads, health system leaders	AIHC initiative updates, team function and roles, stakeholder engagement, making the case, strategic alignment
Phase 2C	October–December 2020	14	19	Team leads, health system leaders	AIHC initiative updates, team function and roles, stakeholder engagement, making the case, strategic alignment, integrating the work, impact of COVID-19 on AIHC
All phases		**48**	**79****		

*Includes two interviews for health systems that participated in phase 1 only.

**Total does not reflect unique respondents, as some respondents participated in multiple interviews.

All interview transcripts were coded using NVivo software and a codebook developed for each interview phase. The team from AHA and NORC conducted thematic and content analysis of the coded interview transcripts. The earlier interviews provided helpful information about the structure of AIHC teams and motivation for participating in AIHC. To ensure that findings reflect the most current and comprehensive information from respondents, this report draws heavily from interviews conducted in phases 2B and 2C, particularly for discussion of strategic and mission alignment, making the case to decision-makers, outcomes and lessons learned. Baseline and phase 2A interviews informed our initial understanding of the health systems' past experiences with community investment in housing and strategic planning and mission alignment with AIHC.

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Secondary Data Review

To enhance our understanding of the context and implementation experience of health systems over the course of AIHC, the team from AHA and NORC reviewed information such as hospitals' community health needs assessments, proposals to participate in the AIHC initiative (for phases 1 and 2) and status updates completed as part of technical assistance provided by CCI. Status updates provided by CCI and Mt. Auburn Associates during monthly calls also informed the AHA/NORC team's understanding of each health system's AIHC initiative.

Background Context

Started in 2018, the AIHC initiative continued through 2021, including during the COVID-19 pandemic when many hospitals and health systems across the country faced unprecedented challenges. The team from AHA and NORC scaled back interview plans, and CCI's technical assistance switched to virtual to accommodate participating health systems as they managed additional priorities. Nonetheless, all six teams continued working on their projects despite the pandemic-related burdens facing the health care organizations and the larger communities they serve.

The final interviews did touch on the impact of COVID-19 and increased attention to reducing disparities in health outcomes and the health systems' community investment efforts. These topics are not featured prominently in the findings because responses were still emerging at the time of interviews.

Lastly, while this report refers to the participating health systems as a proxy for each team, throughout the AIHC initiative the project teams distinguished themselves by their respective geography — e.g., Team Boston, Team Pittsburgh, etc. — as the work was shared across stakeholders.

Endnotes

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