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Community Health Centers And Community Development Financial Institutions: Joining Forces To Address Determinants Of Health

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Abstract

Community health centers and community development financial institutions share similar origins and missions and are increasingly working together to meet community needs. Addressing the social and economic determinants of health is a common focus. The availability of new federal grants and tax credits has led these financial institutions to invest in the creation and expansion of community health centers. This article reviews the most recent trends in these two sectors and explores opportunities for further collaboration to transform the health and well-being of the nation's low-income communities.

Primary Care Determinants Of Health Organization And Delivery Of Care
Safety-Net Systems Health Promotion/Disease Prevention

Community health centers are an important component of the nation's safety-net health care system.[1] This type of health care organization made its debut as two community health centers in Massachusetts and Mississippi in 1965. Today there are nearly 1,200 community health center organizations that operate more than 8,000 urban and rural delivery sites. Located in every state and most US territories, they serve more than twenty-three million predominantly low-income and minority patients—a population that makes sixty million patient visits annually.[2]

Community development financial institutions are private entities operating as investment vehicles that raise capital and invest in economically distressed communities. The community development finance sector, as with community health centers, was born out of grass-roots self-help movements, in this case to provide access to capital otherwise denied to minority and low-income populations.

Community development financial institutions offer a particularly promising partnership for community health centers with regard to financing. The two sectors are closely aligned in their origins, organizational composition, and community mission. In addition, the social determinants of health—defined by the Centers for Disease Control and Prevention as "the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities"[3]—serve as focal points for both types of organizations.

In this article we briefly trace the history and origins of the two sectors and explore ways in which their missions and strategies can be linked in an effort to improve the health and well-being of communities.

Background On Community Health Centers

Community health centers were founded in the mid-1960s in the Office of Economic Opportunity as part of President Lyndon B. Johnson's War on Poverty. They were based on the model of community-oriented primary care developed by Sidney and Emily Kark,[4] which explicitly connected social and economic conditions on the one hand and health and disease on the other.[5] Their charge—to "reintegrate the traditional separation between public health and personal health services by defining health broadly and providing preventive, environmental, and outreach services as well as medical treatment at one

facility"[5(p52)]—has a surprisingly modern resonance as researchers, policy makers, and health care industry professionals incorporate these principles into current health policy and practice.

Community health centers can receive the designation of "federally qualified health center" from the Health Resources and Services Administration (HRSA), which is part of the Department of Health and Human Services. Federally qualified health centers are supported by federal grants to help cover the cost of serving the uninsured; receive free malpractice insurance under the Federal Tort Claims Act; and are entitled to Medicaid reimbursement at a rate that approximates their costs. In 2009 Medicaid accounted for 37 percent of the nationwide total of $11 billion in community health center revenues. HRSA grants were responsible for 17 percent.[6]

Community health centers must attain a high threshold to gain the designation of federally qualified health center. They must be located in a federally designated medically underserved area or serve a medically underserved population; be governed by a board of directors more than half of whom use the health center; provide access to comprehensive primary health care, preventive, oral health, and mental health services; provide care for all patients, regardless of their ability to pay; and comply with performance, accountability, and reporting requirements established by HRSA.[5,7–9]

Contributions Of Community Health Centers

Community health centers play three important roles in their communities. As described below, they are clinical care providers, business development engines, and community development agents.

Clinical Care Providers

Community health centers provide vital clinical support for low-income communities. Access to primary and preventive care is pivotal to the educational and economic success of low-income families. A study comparing patients of community health centers with nonpatients in their communities found that center patients more frequently—by a wide margin—reported having a regular source of care, making mental health visits, and, for women, making obstetric/gynecology visits.[10]

In a similar vein, a study of Colorado Medicaid patients found that after demographic variables were controlled for, community health center patients were one-third less likely to use an emergency department, be admitted to a hospital, or have a readmission within ninety days, compared to their Medicaid peers who were not center patients.[11]

Business Development

In 2009 community health centers generated more than $11 billion in total revenue and approximately $20 billion in direct and indirect economic activity in their local communities. They also produced more than 189,000 jobs in some of the country's most economically deprived neighborhoods. Moreover, centers create good jobs, with career ladders, at all levels of capability and educational attainment, which in itself promotes the health of the community.

The National Association of Community Health Centers estimates that every $1 million in federal funding for centers' operations yields $1.73 million in return.[12] Furthermore, each $1 million of federal funding leveraged an additional $270,000 of state and local grant funding and an additional $70,000 of foundation and private grant funding. These efforts create vital, viable, and sustainable public-private partnerships that contribute to the environment, economy, and health of communities, reaching beyond those who use the centers for their health care.[13]

Community Development

Since their inception, community health centers have addressed the upstream causes of poor health through a variety of community programs, sponsored directly or in partnership with others, that connect patients to resources and assistance. These programs allow community health centers to work beyond the sphere of health care delivery to address the social determinants of health, by promoting individual and community health more comprehensively through broader lifestyle, education, and environmental interventions.

A recent study funded by the Kresge Foundation and carried out by the Institute for Alternative Futures, the National Association of Community Health Centers, and Clinical Directors Network began the process of identifying and categorizing such interventions[14] (for preliminary study results, see Appendix Exhibit 1).[15]

Health Policy Opportunities And Alignment

As of the date of publication of this article, deficit reduction efforts in Congress create uncertainty with regard to federal and state funding for community health centers. Yet community health centers have traditionally enjoyed broad bipartisan support.

In 2001 Congress passed a $700 million, five-year initiative that helped double patient volumes at such centers between 2001 and 2010.[13] Economic stimulus funds appropriated under the American Recovery and Reinvestment Act of 2009 directed $2 billion to community health centers' expansion—$1.5 billion for capital and $0.5 billion for service expansion. In 2010 the Affordable Care Act, recognizing that expanded health insurance enrollment would generate new demand for primary care, committed another $11 billion ($1.5 billion in capital and $9.5 billion in service expansion) to double health center capacity yet again—to roughly forty million patients by 2015.[12]

Community health centers are poised to play a vital role in many of the health care delivery changes included in the Affordable Care Act. Many of these changes incorporate the Wagner Chronic Care Model, which is designed to improve the quality and monitor the care of people with chronic diseases and which forms the basis of the patient-centered medical home.[16]

For example, a 2009 Commonwealth Fund national survey of federally qualified health centers found that 84 percent of centers surveyed had capacity in at least three of the five patient-centered medical home "domains." Those domains are same-day or next-day appointments and after-hours telephone clinical advice; tracking patients by diagnosis using an electronic health record—also known as a patient registry; tracking referrals; tracking laboratory tests and providing patients with results; and collecting and reporting data on clinical outcomes and patient satisfaction.[17]

Patient-centered medical homes, "health homes" designed for high-cost and high-need patients, and accountable care organizations are emerging as primary care models. All depend on high-performing primary care; require community outreach for at-risk, hard-to-reach patients; use geographically based integrated networks of providers and community-based resources; and are predicated on the ability to collect and share information electronically.

These new models entail progressively wider circles of responsibility and accountability for patient care and satisfaction; care integration and coordination; a focus on community and population rather than individual patients; and incentives that encourage and support prevention and health promotion before the onset of costly diseases. They also represent a movement away from institutionally based care and toward care that is provided in the community.

A logical model in this progression, but not yet represented in public policy, is the community-centered health home, which extends the patient-centered medical home concept to the community level (see Appendix Exhibit 2).[15,18]

The payment methods that support these new models of care move increasingly away from fee-for-service payments and toward capitation, which pays a flat sum to cover all of the expected care needed by a patient based on a host of medical, social, and environmental factors. This development has the potential to provide funds that can be invested in nonclinical prevention and upstream interventions—for example, visiting a young asthma patient's home to investigate the presence of mold or other allergens—thus allowing community health centers and other providers to pursue their larger vision of community health and wellness.

Growing Financial Sophistication

The community health center sector has matured and grown more sophisticated over recent decades. Increasingly, strong and capable chief executive officers and clinical leaders, coupled with more effective governing boards, have encouraged care networks to expand, while maintaining a strong financial position and providing high-quality care to a growing patient population.

Most community health centers have developed sophisticated financial and other operating capacities, including strong billing and collection practices; tight fiscal controls and high productivity; and the ability to make effective use of health information technology. In addition, more modern facilities, expert fund-raising capabilities, and strong board governance have created the necessary conditions for achieving excellence in clinical services, care management and coordination, quality improvement, outcomes management, and, increasingly, participation in practice-based clinical and translational research.

The National Association of Community Health Centers, HRSA, state and regional primary care associations, and clinical networks have helped community health centers meet high standards for quality and financial stability, training and technical assistance programs, and capacity-building professional networks. These positive forces have helped make the community health center sector more professional and business-savvy.

Finally, community health centers, which have traditionally been debt-adverse, are gaining experience in the use of outside loan capital to grow their businesses. In the past, traditional sources of outside capital, such as banks and commercial lenders, were largely unavailable to community health centers because of their low margins and the uncertainty and complexity of their revenue streams. But outside capital is now viewed as critically important to achieving the goal stated in the Affordable Care Act of doubling community health center capacity and number of patients served by 2015. The aggregate $3 billion in capital invested through the American Recovery and Reinvestment Act and the Affordable Care Act is insufficient to meet the expansion needs of community health centers, which are estimated to be as high as $16.6 billion (Allison Coleman, chief executive officer, Capital Link, interview, October 6, 2011).

Background On Community Development Financial Institutions

The community development financial institution sector began to take shape in the 1960s and early 1970s, with the emergence of community banks and credit unions supported by private foundations and religious organizations. As with community health centers, the movement to create community development financial institutions was catalyzed by the War on Poverty. The goal at that time was for local nonprofit organizations or community development corporations to apply business and management skills to encourage private investment in the social mission of alleviating poverty.

In the 1990s two developments fueled the growth of the sector. First, the Community Development Financial Institution (CDFI) Fund was created in the Treasury Department to support financial organizations that have a primary mission of promoting economic growth and creating access to capital for low-income communities.[19] Second, in 1995 existing federal regulations were revised so that banks' investment in community development financial institutions could be counted toward meeting their Community Reinvestment Act requirements.[20]

Since 1994 the CDFI Fund has itself been a substantial investor, providing more than $1 billion through grant competitions for community development financial institutions to use as financing capital, loan loss reserves, and capital reserves and to support their own operations and capacity building.[21]

Federal requirements for community development financial institutions resemble those for community health centers. To qualify as community development financial institutions and to receive federal investments, organizations must meet several regulatory requirements. They must have a primary mission of promoting community development; be predominantly a financing entity; primarily serve and be accountable to one or more identified low-income "target" markets; and provide technical assistance along with financing activities. Many also engage in policy and advocacy in their sector or community.

Congress continues to make additional financing tools available to community development financial institutions. The New Markets Tax Credit program, established in 2000, triggers private investment by making federal tax credit allocations available to community development entities, including financial institutions, nonprofit organizations, and government-controlled entities, which then sell them to investors. Community development financial institutions use the proceeds to invest in community development projects in low-income communities. Since the program was authorized in 2000, it has made nearly 600

awards, totaling $29.5 billion in tax credit allocation authority.[22] Community development financial institutions account for about 22 percent of the allocation (Scott Berman, manager, legislative and external affairs, Capital Link, interview, October 18, 2011).

In 2010 Congress authorized the Community Development Financial Institutions bond program, enabling the issuance of up to $3 billion in federally backed bonds. This program is expected to provide these institutions with another useful source of low-cost, long-term, fixed-rate investment funds.

Since their founding, the number of community development financial institutions has grown to 1,000 today, with at least one per state. Annual funding for the institutions has increased from $50 million in 1995 to $247 million in 2010. Their assets rose from $7.6 billion in 2001 to $23 billion in 2008.[21]

A Maturing Financial Sector

As has the community health center sector, the community development financial institution sector has grown and matured. The Opportunity Finance Network—a leading industry association of community development financial institutions—advocates for policies that bring resources to community development financial institutions. It also works to improve the performance of the sector and individual institutions. Efforts include a community development financial institutions assessment and rating system (known as CARS), launched in 2004, which promotes transparency, standardization of information, and performance across the sector.[23]

Opportunities For Convergence

Community development financial institutions typically invest in affordable housing, small businesses, child care facilities, and other projects that impart traditional community revitalization benefits. For these institutions, community health centers represent an emerging new market or "asset class," akin to charter schools, that has a sustainable revenue stream and a mission tied to improving low-income communities and that offers solutions to a pressing social problem.

For community health centers seeking to take advantage of growth opportunities, community development financial institutions offer a source of affordable capital from organizations whose community-oriented mission and vision are closely aligned with their own.

The potential partnership of community health centers and community development financial institutions meets the criteria for effective collaboration as articulated for successful medicine-public health partnerships. These criteria consist of mission fit, or alignment between potential partners' values and priorities; pooled organizational resources, with each partner bringing something complementary to the table; and pooled investment capital, with each partner having "skin in the game."[24]

Increasingly, health centers are working with financial institutions to put together sometimes complex financing arrangements that include debt, federal grant funding, New Markets Tax Credits, private contributions, and foundation grants to build facilities that meet community needs now and in the future. American Recovery and Reinvestment Act and Affordable Care Act grants for health center expansion and the availability of New Markets Tax Credits have attracted a number of community development financial institutions to the health center market over the past two years, particularly those that have invested in other "new markets" such as charter schools (see Appendix Exhibits 3a and 3b).[15]

Although there have been several new entrants, two community development financial institutions have a long history of community health center investments. One is NCB Capital Impact, a Virginia-based institution with a national presence and a large community health care financing practice. Since 1995 NCB Capital Impact has been involved in community health center projects valued at $552 million that serve 1.1 million patients annually.

The other financial institution with a long history of community health center investments is the Primary Care Development Corporation, a New York-based institution whose mission is expanding access to high-quality primary care in underserved communities through capital financing, performance improvement services, and advocacy. Since its founding in 1993 the Primary Care Development

Corporation has been involved in primary care projects (mostly community health centers) in New York State totaling $335 million and serving 650,000 patients annually.

The convergence of community health centers and community development financial institutions is also sparking new public–private initiatives—such as Health Centers for Healthy Communities, created by IFF, a large community development financial institution based in Chicago and supported by Citibank—to invest at least $75 million in private-sector capital for federally qualified health centers across a five-state region (Illinois, Indiana, Iowa, Missouri, and Wisconsin).[25] Similarly, Metlife provided a $5 million social investment loan to launch NCB Capital Impact's three-year, $75 million Healthier California program, which will finance community health center development throughout the state.[26]

Discussion And Recommendations

To achieve the greatest possible synergies between community health centers and community development financial institutions, there should be greater collaboration on all levels. Linkages should be tightened between local community health centers and community development financial institutions; state primary care associations, state health departments, and community development financial institution coalitions; national groups such as the National Association of Community Health Centers and the Opportunity Finance Network; and at the federal level between HRSA and the CDFI Fund.

These linkages are desirable because each sector could benefit from developing a better understanding of the other's complex operations and regulatory environments. Community development financial institutions need to realize the vast and solid market that community health centers represent and to deploy their resources accordingly. Health centers need to communicate their financial viability and the social impact they bring to communities.

Community development financial institutions should familiarize themselves with community health centers to understand how these models of care affect their finances and operations, patients, and the community. Centers that have completed financing deals with community development financial institutions should share knowledge with their peers. Together, the two sectors can influence social determinants of health and thus better align socioeconomic and environmental influences with health care delivery to improve health equity.

Stronger alignment would create and support a common policy agenda. On the federal level, community health centers have a stake in the fate of the New Markets Tax Credits and the Community Development Financial Institutions bond programs, and they could advocate for financial programs that specifically target community health center development. Community development financial institutions that are already financing community health centers or intend to do so have a direct interest in preserving and strengthening community health center grant funding and Medicaid reimbursement streams that allow for sound balance sheets and robust expansion.

The same holds true on the state level. As budgets shrink and states grapple with health care challenges, both sectors have an interest in ensuring that tools and financial resources exist to preserve and expand programs that promote health and development for low-income communities. Alliances at the community or neighborhood level between community health centers and community development financial institutions clearly have powerful potential for community-level planning and the implementation of state and federal initiatives.

Alignment of funding priorities and coordination of efforts by HRSA and the CDFI Fund would produce additional synergies and opportunities. These two federal agencies regularly issue policy directives, program initiatives, and requests for proposals for significant financial resources. The fund recently closed its application process for $3.5 billion in New Markets Tax Credits allocation and will soon issue guidelines for the $3 billion bond program. HRSA recently announced a $700 million funding round for community health centers' capital development. Strategic alignment and collaboration between HRSA and the fund could accelerate community health center projects and leverage additional capital from community development financial institutions and other investors.

Finally, there is a need for rigorous, empirical research that would create the evidence base for effective policies and guide more-effective strategies and

actions. Studies need to be conducted to address such questions as the following: What are the most important correlates of community health centers' and community development financial institutions' growth, effectiveness, and sustainability? Which social determinants are most important to improving the upstream causes of illness, and which interventions are most effective? Which interventions are financially sustainable and can even generate margins that can, in turn, be reinvested to achieve double and triple bottom-line impact, producing economic "multiplier effects" and revitalizing communities?

These research questions suggest the need for a new field of "economic epidemiology," which would bring to bear analytic models of finance with population health parameters, combine analysis with advocacy, and build on the growing field of health impact assessment. The result would be an evidence base to build enduring, effective, community-based, public-private partnerships that effectively improve community health and make important contributions to the business needs of local communities.

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ABOUT THE AUTHORS: RONDA KOTELCHUCK, DANIEL LOWENSTEIN & JONATHAN N. TOBIN

In this month's Health Affairs, Ronda Kotelchuck, Daniel Lowenstein, and Jonathan Tobin write about the availability of new federal grants and tax credits that encourage community development financial institutions to invest in the creation and expansion of community health centers. Such partnerships, the authors say, are a natural fit because both types of organizations share the goal of addressing the economic and social determinants of health.

Traditionally, Kotelchuck says, community development financial institutions have stayed out of health, preferring to invest in education and housing. Now, she says, they recognize that "there is tremendous opportunity in next five years" to greatly improve community health through a different kind of investment.

Kotelchuck is the founding chief executive officer of the Primary Care Development Corporation, a nonprofit organization in New York City dedicated to expanding access and transforming primary care in underserved communities. A recognized community development financial institution by the US Treasury, it has drawn on more than $335 million in capital to finance ninety primary care projects, adding capacity to care for 650,000 more New Yorkers annually.

Before founding the Primary Care Development Corporation, Kotelchuck served as vice president for corporate planning and intergovernmental relations for the New York City Health and Hospitals Corporation and spearheaded its 1989 strategic plan, which focused in part on the need for primary and preventive care. She has a master's degree in regional planning from Cornell University.

Lowenstein is the director of public affairs at the Primary Care Development Corporation, where he oversees marketing, communications, business development, media relations, and policy and government relations. He has more than twenty years of experience leading successful health policy, communications, and fund-raising initiatives for organizations in the health care, nonprofit, and political sectors.

Lowenstein has a master of business administration degree from the Stern School of Business, at New York University.

Tobin is president and chief executive officer of Clinical Directors Network, a practice-based research network in New York City that is dedicated to improving clinical outcomes for low-income and medically underserved communities by creating community-academic partnerships having to do with research, education and training, and service.

A board-certified epidemiologist, Tobin is a professor in the Department of Epidemiology and Population Health, Albert Einstein College of Medicine, Yeshiva University; and is codirector for community-engaged research at the Rockefeller University Center for Clinical and Translational Science, where he is also an adjunct professor in the Allen and Frances Adler Laboratory of Blood and Vascular Biology.

Tobin holds a master of arts degree, a master of philosophy degree, and a doctorate, all in sociomedical studies (epidemiology and sociology) from Columbia University.

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