Prescription for Healthy Communities: Community Development Finance

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Building a healthier nation will require substantial collaboration among leaders across all sectors, including some—for example, leaders in child care, education, housing, urban planning and transportation—who may not fully comprehend the importance of their roles in improving health.

—Beyond Health Care: New Directions to a Healthier America, Recommendations from the Robert Wood Johnson Foundation Commission to Build a Healthier America

We are at a crossroads in the fields of both community development finance and public health. Persistent poverty in many of our nation's communities, along with increasing economic challenges faced by the working poor, are forcing a realization that traditional approaches to community development finance focused on affordable housing and business development are not sufficient to move and keep families out of poverty. Since the 1990s, Community Development Financial Institutions (CDFIs) and their partners have augmented traditional community development approaches with investments in human development (child care, education, and workforce development), family economic security (savings, insurance, and asset building), and "green" initiatives aimed at better positioning low-income residents to achieve health and financial security. Although the current economic crisis has interrupted and in some cases drastically reversed progress, innovation within the field continues to advance these trends.

Declining health status in the current generation of Americans, escalating health-care costs, and stark, persistent disparities in health outcomes among income and ethnic groups similarly call into question the traditional approach to health care in the United States, which has primarily focused on the treatment of disease. As stated in the 2009 report of the Robert Wood Johnson Foundation Commission, "Building a Healthier America" (RWJF Commission Report): "Although medical care is essential for relieving suffering and curing illness, only an estimated 10 to 15 percent of preventable mortality has been attributed to medical care. A person's health and likelihood of becoming sick and dying prematurely are greatly influenced by powerful social factors such as education and income and the quality of neighborhood environments."[1] Faced with this evidence, health practitioners and advocates are increasing their focus on preventing disease through physical and social environments that promote better health outcomes and community-based initiatives that promote healthy behavior.

1 http://www.commissiononhealth.org/Report.aspx?Publication=64498.

Developments in both fields set the stage for a coordinated approach. By articulating a vision for healthy communities and more directly fostering the human development, physical well-being, and economic prospects of community residents, both community development finance and public health are poised to improve outcomes. The shift is particularly important for services targeted to children, who have the greatest vulnerability to unhealthy conditions. If we cannot better position our children for health and financial security, we face continuing, rampant increases in chronic disease and medical expenses, lost productivity, and lost income.

Coordinated effort requires adjusting both community development finance and public health practices to leverage the respective resources of each effectively. The RWJF Commission calls for society to adapt a "culture of health" to inform not only community development but also school, workplace, and public-policy priorities. As described in the sections that follow, we suggest that the field of public health adapt a "culture of community development finance" as an essential component of scaling successful models of community, school, and workplace health promotion.

The RWJF Commission Report identified a range of ways to improve health at local, state, and federal levels–"practical, feasible and effective solutions often hiding in plain sight"–but noted that these programs generally are not funded to achieve scale: "Too often, while start-up funds are provided to establish programs, funders move on to other issues once programs are under way. The value of collaboration to create a broader base of support is a key theme of this report and a necessity if successful programs are to expand across sectors and across the nation."[2]

The prevailing funding model for community-based public health has relied on public and private grants.[3] We suggest that community development finance is an essential, if perhaps unrecognized partner in taking scaling efforts to the next level. Combining mission focus and investment discipline, community development finance brings highly developed skills in identifying and financing organizations that are both committed to improving conditions for vulnerable populations and capable of repaying investments. In general, such organizations are unable to obtain the financing needed for scaling from commercial sources. This may be because these organizations focus in markets that are small and perceived as too risky; lack assets or credit history; have early-stage needs (such as the predevelopment phase of a real estate project); and depend on innovative approaches to problem solving (which carry the risk of untested, new business lines).

Community development finance aggregates subsidies and flexible capital from public and private sources to directly finance such initiatives or to structure credit enhancement that attracts additional, larger volumes of commercial capital. While much more capital is needed to finance the range of qualifying initiatives, community development finance has

2 RWJF Commission Report.

3 Major institutions, such as hospitals and large clinics, are generally able to also raise bond and other debt financing.

invested billions of dollars in projects that effectively enhance health. Examples include mixed-income transit-oriented development; quality early child care, high-performing public charter schools and other educational programs that offer nutritious food and physical exercise programs along with academic support; social services enriched housing; and community health centers. Increasingly these strategies are executed with green approaches that conserve resources, avoid harmful building materials, and are landscaped to promote safe physical activity. In addition, such projects bring both services and jobs to urban and rural low- to moderate-income communities.

The field of community development finance in turn can benefit from the medical framework for defining healthy community that is offered by the field of public health. Often this framework takes the form of a needs assessment developed in the context of a city, state, or region (which corresponds to a bank's assessment area or CDFI's market area). Public health also brings infrastructure to gather and analyze longitudinal data on both health status and health-care costs of populations by income, ethnic group, and geography, providing important social and economic impact data to reinforce output measures traditionally tracked by community development finance practitioners. Finally, health interests bring significant public and private financial resources that community development finance needs but has seldom tapped, including potential grants and investments from health-focused philanthropy, health-focused public funding (including the federal stimulus), and a share of the nation's significant, ongoing health-care expenditures. Health-care expenditures were estimated as 15.3 percent of GDP in 2006, and amount that is $2 trillion per year and projected to grow.[4]

Plans for coordination between community development finance and public health need not be complex. Indeed, public health interventions are often astonishingly basic, historically depending largely upon clean water and proper sanitation. As Len Syme's article in this journal points out, lack of proper sanitation is no longer the main cause of morbidity and mortality in industrialized nations. Our communities have generated new disease-producing agents, such as pollutants of air, water, and food. We have also learned, he notes, that disease occurs more frequently among those with fewer meaningful social relationships and those in a lower social class. These are risk factors that community development finance and public health can work together to minimize.

The benefits of collaboration between the fields will be greatest if focused on those of lower social class–those known to health policy advocates and philanthropy as "vulnerable populations" and known to community development finance practitioners as low- to moderate-income and minority communities and persons. Extensive evidence documents this popu-

4 World Health Statistics 2009 (Geneva: World Health Organization, 2009), 114. Available at: http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf.

lation's greater health risks that also potentially bring catastrophic financial consequences.[5]

One example of a cost-effective prevention that could be implemented in partnership with community development finance practitioners was highlighted in a 2008 study prepared by the Trust for America's Health. The study found that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could significantly reduce chronic disease and save California households, insurance companies, and public coffers more than $1.7 billion in annual health-care costs within five years–a return of nearly $5 for every $1 of expense. Evidence suggests that implementing these programs could reduce rates of Type II diabetes and high blood pressure by five percent within two years; reduce heart disease, kidney disease, and stroke by five percent within five years; and reduce some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years.[6] Community-based programs such as those cited in the study are frequently offered by organizations that CDFIs finance, including but not limited to schools open after hours for children to play with adult supervision, farmers markets and other venues providing access to nutritious foods in low-income communities, and child care, youth, and health organizations providing guidance on how to make good choices about nutrition and tobacco use.[7]

If collaboration between community development finance and public health offers the prospect of creating a virtuous circle in which strategic investments help residents of low-income communities to make healthy choices and generate health-care savings, the risks of failing to join forces appear likely to perpetuate the existing vicious circle in which these residents fall further behind in health and income. The RWJF Commission Report cautions:

5 As an example of the high risks and costs of chronic disease among vulnerable populations, overweight is by far the most common public health nutrition problem facing women and children participants of the federal Women, Infants and Children Program (WIC). . . . Taken together, well over one-third of California WIC children are overweight or at risk for obesity, with the highest rates among Hispanic, African American, and Native American children. The reported consequences are staggering: increased rates of Type II diabetes, heart disease, respiratory difficulties, psychosocial problems, and adult obesity cost California an estimated $25 billion annually and will kill more people than AIDS, violence, car crashes, and drugs combined. http://www.calwic.org/docs/federal/harnessing_WIC_obesity.pdf.

6 "Prevention for a Healthier California: Investments in Disease Prevention Yield Significant Savings, Stronger Communities," 2008: http://healthyamericans.org.

7 Health care uses primary, secondary, and tertiary types of prevention, offering different opportunities for disease prevention and medical savings: (1) Primary prevention involves taking action before a problem arises to avoid it entirely, rather than treating or alleviating its consequences. (2) Secondary prevention is a set of measures used for early detection and prompt intervention to control a problem or disease and minimize the consequences. (3) Tertiary prevention focuses on the reduction of further complications of an existing disease or problem, through treatment and rehabilitation. Many factors influence whether specific prevention efforts result in cost savings. Tertiary efforts involving direct medical treatment or pharmaceuticals often have higher costs. Secondary efforts, including early detection and intervention to control a problem or disease and minimize the consequences, are more cost effective if targeted to at-risk populations. Community-based primary and secondary prevention efforts may be low-cost and have demonstrated results in lowering disease rates or improving health choices without involving direct medical care, including promoting increased levels of physical activity, improved nutrition and reduced tobacco use. http://healthyamericans.org.

> The economic implications of our nation's health shortfalls are sobering. . . . The costs of medical care and insurance are now out of reach for many American households, pushing some families into bankruptcy, draining businesses, reducing employment and severely straining the budgets of federal, state and local governments. . . . The current path of rising costs and rising rates of chronic disease is simply not sustainable. Greater access to effective, efficient medical care is important for our nation's well-being, but medical care cannot deliver wellness, nor can health care system reforms alone bring costs under control. Instead, we need a new vision of health that rests on changing the lives of Americans in ways that lead to healthier, longer lives.[8]

To frame the possibilities for collaborating on that new vision, the following sections discuss a definition of healthy community, identify tested models for replication, profile investors, and assess a way forward.

Defining and Building Healthy Communities: Two Fields, One Objective

In formulating a definition of healthy community that aligns community development finance and public health interests, a logical first step is to refer to the meaning of community development in the Community Reinvestment Act (CRA), which has provided the regulatory framework for bank and other community development finance for decades.[9] While the CRA does not tell us what constitutes a healthy community, it states that community development includes:

1. Affordable housing (including multifamily rental housing) for low- or moderate-income individuals
2. Community services targeted to low- or moderate-income individuals
3. Activities that promote economic development by financing businesses or farms that have gross annual revenues of $1 million or less
4. Activities that revitalize or stabilize low- or moderate-income geographies, designated disaster areas, or distressed or underserved nonmetropolitan middle-income geographies[10]

As of 2007, National Community Reinvestment Coalition reported more than $407 billion in 375,000 CRA loans and investments that advance community development across urban and rural assessment areas nationwide.[11] Often these investments have had a transforma-

8 RWJF Commission Report.

9 www.ffiec.gov/CRA; see also "Revisiting CRA" at http://www.frbsf.org/publications/community/cra/index.html.

10 http://www.occ.treas.gov/fr/cfrparts/12cfr25.htm.

11 John Taylor and Josh Silver, "The Community Reinvestment Act: 30 Years of Wealth Building and What We Must Do to Finish the Job," http://www.frbsf.org/publications/community/cra/index.html, 2009.

tional effect on neighborhoods, jump-starting both housing and commercial development in areas of persistent blight. Their impact has been more limited, however, on the health, education, earnings power, and poverty status of neighborhood residents. The evidence suggests that absent a more deliberate focus on human development, low- to moderate-income communities continue to face dim prospects of graduating their youth from high school, much less preparing them for college or secure financial futures.

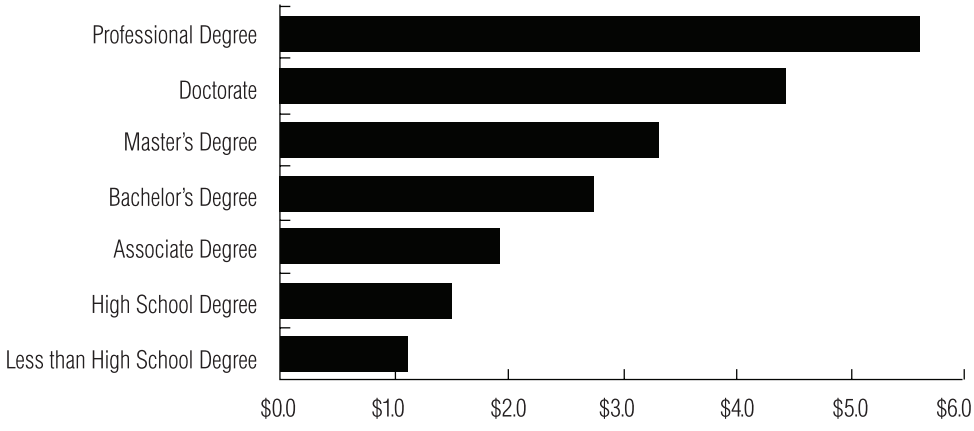
We are learning that these poor educational outcomes also affect health, with consequences that are far graver than we previously understood.[12] We have long known that lifetime earnings are correlated with educational level (Figure 1). Recent research documents a strong correlation between health outcomes and both education and income. "When socioeconomic factors were added into the Framingham Risk Scoring risk assessment . . . the proportion of low-income and low-education patients at risk for death or disease during the next 10 years was nearly double that of people with higher socioeconomic status."[13] The effects of good education are of a magnitude that, if high school graduation were a prescription drug, it would be a "blockbuster".[14]

12 Nationwide, only about 70 percent of students earn their high school diplomas. Among minority students, only 57.8 percent of Hispanics, 53.4 percent of African Americans, and 49.3 percent of American Indians and Alaska Native students graduate with a regular diploma, compared to 76.2 percent of white students and 80.2 percent of Asian Americans. High school dropouts face long odds of landing a good-paying job in the ultra-competitive job market of the twenty-first century. In addition, they generally die earlier, are less healthy, more likely to become parents when very young, more at risk of tangling with the criminal justice system, and more likely to need social welfare assistance. http://www.all4ed.org/about_the_crisis.

13 A University of Rochester Medical Center study published in the June 2009 *American Heart Journal* noted that doctors who ignore the socioeconomic status of patients when evaluating their risk for heart disease are missing a crucial element. The study found that the accepted risk assessment model, known as Framingham Risk Scoring (FRS), does not accurately predict whether a person of low income and/or less than a high school education will develop heart disease or die in the next 10 years. When socioeconomic factors were added into the FRS risk assessment, the proportion of low-income and low-education patients at risk for death or disease during the next 10 years was nearly double that of people with higher socioeconomic status. http://www.sciencedaily.com/releases/2009/06/090616133936.htm.

14 In the pharmaceutical industry, a blockbuster drug is one that achieves acceptance by prescribing physicians as a therapeutic standard, most commonly for a highly prevalent chronic (rather than acute) condition. From a financial perspective, a blockbuster drug is typically defined as achieving annual worldwide sales exceeding $1 billion, http://www.ftpress.com/articles/article.aspx?p=1163084. While the medical savings from a nearly 50 percent reduction in heart disease risk factors associated with improved high school graduation rates have not been estimated to GPS' knowledge, economic savings well in excess of $1 billion per year from improved graduation rates have been. Assuming based upon Figure 1 that every high school graduate realizes $400,000 in lifetime income that he or she would not otherwise receive, it takes only 2,500 additional high school graduates per year to generate a $1 billion differential. Per the U.S. Committee on Education and Labor, there are almost three times this number of high school dropouts per day: "Nationwide, 7,000 students drop out every day. . . . Research shows that poor and minority children attend . . . so-called "dropout factories"—the 2,000 schools that produce more than 50 percent of our nation's dropouts—at significantly higher rates. . . . A recent report by the McKinsey Corporation showed that if black and Latino student performance had reached the level of white students by 1998, the GDP in 2009 would have been between $310 billion and $525 billion higher—or approximately 2 to 4 percent of GDP. The report also notes that achievement gaps in this country are the same as having "a permanent national recession." May 12, 2009, http://edlabor.house.gov/newsroom/2009/05/high-school-dropout-crisis-thr.shtml. The full McKinsey Report, "The Economic Impact of the Achievement Gap in America's Schools," is available at http://www.mckinsey.com/App_Media/Images/Page_Images/Offices/SocialSector/PDF/achievement_gap_report.pdf.

Figure 1. Worklife Earnings for Full-time Year-round Workers by Educational Attainment*[15]
(in Millions of 2005 Dollars)



The pronounced health and financial risks among many whom CRA sets out to serve suggest that traditional investing to comply with the regulation may be necessary for healthy communities, but it is not sufficient. Applying a public health lens broadens the perspective and points the way to promising new avenues. A healthy community is described by the "Healthy People 2010" report of the U.S. Department of Health and Human Services as

> One that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders—where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options.[16]

Incorporating these dimensions into community development finance practice offers potential to reinvigorate the sector's efforts to alleviate poverty while engaging the expertise of public health to drive better results. Public health and health-focused philanthropy organizations have developed useful templates to clarify further what constitutes a healthy community and what actions the range of stakeholders must take to create such communities nationwide (Figure 2 and Appendices A and B).

For example, given the observation that health outcomes are closely correlated to neighborhood conditions and a mandate to "identify interventions beyond the health care system

15 Mark Kantrowitz, "The Financial Value of Higher Education," NASFAA Journal of Student Financial Aid 37, no. 1 (2007); U.S. Census Bureau, "The Big Payoff: Educational Attainment and Synthetic Estimates of Work-Life Earnings," July 2002. http://www.census.gov/prod/2002pubs/p23-210.pdf.

16 http://www.cdc.gov/healthyplaces.

that can produce substantial health effects," the RWJF Commission Report articulated ten recommendations for building a healthier America (see Figure 3 and Appendix B). While some of these depend largely on public-sector programs, many, including promoting access to high-quality child care, education, nutritious food, physical activity, and health care, are promoted through CDFI investment strategies, often with capital invested by CRA-motivated banks (See examples in Figure 4).

Figure 2. Healthy Communities[17]

Unhealthy Community	Healthy Community
Unsafe even in daylight	Safe neighborhoods, safe schools, safe walking routes
Exposure to toxic air, hazardous waste	Clean air and environment
No parks/areas for physical exercise	Well-equipped parks and open spaces/ organized community recreation
Limited affordable housing is run-down; linked to crime-ridden neighborhoods	High-quality mixed-income housing, both owned and rental
Convenience/liquor stores, cigarette and liquor billboards, no grocery store	Well-stocked grocery stores offering nutritious foods
Streets and sidewalks in disrepair	Clean streets that are easy to navigate
Burned-out homes, littered streets	Well-kept homes and tree-lined streets
No culturally-sensitive community centers, social services, or opportunities to engage with neighbors in community life	Organized multicultural community programs, social services, neighborhood councils, or other opportunities for participation in community life
No local health-care services	Primary care through physicians' offices or health center; school-based health programs
Lack of public transportation, walking or biking paths	Accessible, safe public transportation, walking and bike paths

17 RWJF Commission Report.

Figure 3 - Recommendations From the Robert Wood Johnson Foundation Commission[18]

1. Ensure that all children have high-quality early developmental support (child care, education and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.	6. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.
2. Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.	7. Create "healthy community" demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.
3. Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.	8. Develop a "health impact" rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
4. Feed children only healthy foods in schools.	9. Integrate safety and wellness into every aspect of community life.
5. Require all schools (K-12) to include time for all children to be physically active every day.	10. Ensure that decision-makers in all sectors have the evidence they need to build health into public and private policies and practices.

The RWJF Commission's criteria for what constitutes a healthy community seem basic (Figure 2 and Appendix A), yet it is precisely the inadequacy of such basic conditions in most low- to moderate-income and minority communities that constitute many of the so-called adverse social determinants of health, driving disparity, increased chronic disease, and rising cost burdens.[19]

For example, while achieving good health requires choosing healthy behaviors such as eating a nutritious diet, exercising, and not smoking, health professionals agree that it is much harder to make these healthy choices in either urban or rural low- to moderate-income communities. As the RWJF Commission observes: "Many people live and work in circumstances and places that make healthy living nearly impossible. Many children do not get the quality of care and support they need and grow up to be less healthy as a result; many Americans do not have access to grocery stores that sell nutritious food; still others live in communities that are unsafe or in disrepair, making it difficult or risky to exercise. While individuals must make a commitment to their own health, our society must improve the opportunities to choose healthful behaviors, especially for those who face the greatest obstacles."[20]

Although the field of community development finance has to date generally placed less emphasis on strategies that directly affect the physical health and human development of

18 RWJF Commission Report.

19 See discussions in RWJF Commission Report; Place Matters, http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137443/apps/s/content.asp?ct=6997411; and www.unnaturalcauses.org.

20 RWJF Commission Report.

low- to moderate-income persons, practitioners who have applied such focus represent the cusp of innovation and demonstrate the potential. As profiled in Figure 4 and the following articles in this journal, CDFI-financed health-enhancing projects include:

- NCB Capital Impact's (NCBCI) loans for nonprofit health-center facilities described by Scott Sporte and Annie Donovan, which in partnership with bank, insurance, foundation, and public-sector lenders, finance entities that meet the primary-care needs of many of the nation's Medicaid recipients and uninsured in underserved areas. NCBCI has expanded on this successful model in three ways: (1) by incorporating New Markets Tax Credit incentives in selected transactions, (2) by adding working capital loans to help borrowers expand or manage delays in state reimbursements, and (3) by partnering with Capital Link, a national technical assistance provider that assists health centers in deal structuring, financial planning and management.
- Pacific Community Ventures' equity investments in small businesses that provide quality benefits for workers described by Allison Kelly and Kirsten Snow Spalding, including health coverage and the VidaCard Prepaid MasterCard®, which offers employers a means to help both insured and uninsured employees pay for uncovered expenses, including preventive care, insurance premiums, or co-payments.
- The Reinvestment Fund's lead financing role in fresh food supermarkets of varying sizes and descriptions in urban and rural communities throughout Pennsylvania, a model described by Marion Standish of The California Endowment and Judith Bell of PolicyLink that is being adapted in other states through collaborations between The Reinvestment Fund, other CDFIs, foundations, and banks.
- The Low Income Investment Fund (LIIF) and other CDFIs' increasing investments in human capital development described by Nancy Andrews, which for LIIF alone include direct financings of $60 million in early child care, $200 million in high performing charter schools, $500 million in services enriched affordable housing and $40 million in other facilities, such as for health care, domestic violence shelters and youth recreation. Generally, these investments utilize public and philanthropic sector credit enhancement or tax credits to attract much larger sums of senior debt from banks, insurance companies, and pension funds.
- The Disability Opportunity Fund's housing solutions for disabled persons and their families described by Charles Hammerman. The fund's financing leverages public-sector subsidies to structure financing for affordable, accessible, and supportive housing for the disabled, including the developmentally disabled and increasing numbers of families of military and the elderly.

These investments spur development that is consistent with the "Healthy People 2010" healthy communities definition, catalyzing resident wellness while creating significant numbers of local jobs, particularly in child care, health care, and retail or other healthy food

delivery systems.[21] The potential benefits, ranging from decreased childhood obesity to dramatically improved high school graduation and college matriculation rates, to increased employment, income, and health coverage, are correlated with significantly improved long-term health outcomes and, therefore, reduced health-care costs. As tested models, these investments offer the potential to be replicated in communities across the country. Doing so requires commitments of capital by a broad range of investors.

Figure 4. Scaling Success in Healthy Community Investments

The field of community development finance is increasing its focus on projects that improve health and reduce health-care costs in low-income neighborhoods. Successes and plans from CDFI-financed initiatives include:

For health-care delivery:

- NCB Capital Impact has extended over $429 million in loans to community-based health-care providers for over 20 years to create more than 2.9 million square feet of community health center space where providers meet the health-care needs of more than 350,000 low-income, underinsured, and uninsured patients annually. In addition, NCBCI has provided innovative financing to substance abuse rehabilitation/behavioral care facilities, adult day health care facilities and assisted living/continuing care facilities.
- Nonprofit Finance Fund provided $500,000 in financing to the District of Columbia Primary Care Association to cover start-up costs of Medical Homes DC, which will leverage some $145 million for facilities, quality improvements, and administrative services to rebuild and increase access to DC's primary-care system for 210,000 low-income residents. Goals include to provide better health outcomes, reduced disparities and decreased expensive emergency room visits; anchors for economic development in the health centers' neighborhoods; quality entry-level jobs and hiring from the community; and to increase traffic from patients and those who accompany them for potential businesses nearby (research by Capital Link based on 2006 data demonstrated that 11 DC health centers generated a $210 million impact on the District's economy and approximately 2,100 jobs).[22]

21 Job growth in these sectors is expected to be among the most robust nationwide. The Department of Labor identifies Education and Health services as a supersector that is projected to grow by 18.8 percent, and add more jobs, nearly 5.5 million, than any other industry supersector. More than 3 out of every 10 new jobs created in the U.S. economy will be in either the healthcare and social assistance or public and private educational services sectors. Combined food preparation and service workers are fourth in occupations with the largest projected increase in number of jobs from 2006 – 2016. See Appendix E and http://www.bls.gov/oco/oco2003.htm. May 13, 2009.

22 http://www.regionalprimarycare.org/primary-care-medical-homes/medical-homes-dc.aspx

For supportive and safe housing:

- The Corporation for Supportive Housing reports decreases of more than 50 percent in tenants' emergency room visits and hospital inpatient days and more than 80 percent in use of emergency detoxification services, a $1,448 decrease in dependence on entitlements per tenant each year, increases of 50 percent in earned income and 40 percent in the rate of participant employment when employment services are provided in supportive housing, more than 80 percent of homeless people with mental illness remaining housed a year later (at least a third of those people living on the streets and in shelters have a persistent mental illness) and 90 percent of tenants with substance abuse problems remaining sober for one year, versus approximately 55 percent who live independently or in halfway houses.
- CDFIs such as Rural Community Assistance Fund and CASA of Oregon have provided thousands of units of safe migrant housing, reducing risks for this vulnerable population (see Appendix D)

For quality education, a linchpin for children to achieve financial security and good health:

- In California, where in 2008 approximately one in three high school graduates completed the courses required to gain admission to a four-year college (with lower college-readiness rates for minority students), the College-Ready Promise is a newly formed coalition of five charter school management organizations (CMOs) that have earned a reputation for excellence in serving low-income and minority students, with more than 75 percent of their graduates over the past two years attending four-year colleges. Alliance College-Ready Public Schools, Aspire Public Schools, Green Dot Public Schools, ICEF Public Schools, and Partnerships to Uplift Communities operate 85 public schools with more than 28,000 students, primarily in Los Angeles County (Aspire also runs schools in East Palo Alto, Modesto, Oakland, Sacramento, and Stockton).
- Collectively, these CMOs have received hundreds of millions in facilities financing from a range of CDFIs, including the Low Income Investment Fund, NCB Capital Impact, Local Initiatives Support Corporation, and Raza Development Fund. Many of the schools provide Revolution Foods' nutritious lunches and several use Playworks' active recess program. The Bill & Melinda Gates Foundation recently awarded the Coalition $60 million to increase teaching effectiveness so that more students graduate college-ready.
- In rural Arkansas, the CDFI, Southern Bancorp, recruited and financed the charter management organization, KIPP Houston, to a town of 15,000. KIPP Delta

charter school opened in Helena-West Helena's abandoned train station, soon expanding into previously abandoned buildings on the town's main street. KIPP achieved 100 percent college matriculation in its first graduating class, in an almost 100 percent African American student body where the academic scores for this population were typically in the 15th percentile. KIPP Delta plans to open 12 charter schools in the region. In addition to financing charter schools, CDFIs finance a range of supplemental educational services that support both academic achievement and health-promoting behaviors such as safe physical activity and not smoking. These include Boys and Girls clubs and similar organizations around the country.

For child care, where quality experiences set the stage for childrens' later success:

- Self-Help Credit Union began child care lending in 1987, has lent over $42 million to quality child care providers and is part of The National Child Care Facilities Network, a group of CDFIs emphasizing child care lending that has provided over $230 million in child care finance, leveraging $877 million to create or improve 3,680 centers serving over 211,000 children across the country.
- Acelero Learning is one example of a quality Head Start manager that has equity investment from CDFIs, Boston Community Capital and New Jersey Community Capital, as well as the W.K. Kellogg Foundation. Results by combining federal Heat Start funding with state child-care funding include:
    - In Camden, N.J.: Increased enrollment from 18 to 90 children and improved staff qualifications by 100 percent so that all teachers have at least an Associate degree.
    - In Monmouth, N.J.: Increased enrollment from 330 to 506 children using the same amount of federal funds, expanded annual days of service from 190 to 220 days per year, increased average teacher salary by 75 percent, increased number of family advocates from 8 to 14, and built partnerships to provide previously untapped, much needed dental services.

For safe, nutritious food and physical activity:

- ShoreBank began sponsoring a Farmers Market in the 1970s and in 1990 brought one of Chicago's leading full-service grocery stores to its low- to moderate-income African American neighborhood. In 1999, Local Initiatives Support Corporation working with Abyssinian Development Corporation and the Community Association of East Harlem Triangle brought a Pathmark supermarket to East Harlem.

- The Reinvestment Fund (TRF) is spearheading an effort to establish supermarkets in urban and rural communities in Pennsylvania in partnership with the Fresh Food Financing Initiative. As of June 2009, FFFI had committed $57.9 million in grants and loans to 74 supermarket projects in 27 Pennsylvania counties, ranging in size from 900 to 69,000 square feet, which were expected to create or retain 4,854 jobs and more than 1.5 million square feet of food retail. TRF is working with a range of other CDFIs and partners to expand the initiative to other states.
- With equity and debt from bank and foundation social investors, including the W.K. Kellogg Foundation, DBL investors, and RSF Social Finance, Revolution Foods provides nutritious school breakfasts, lunches and snacks, serving more than 5 million healthy meals to more than 50,000 school children, 80 percent of whom qualify for free or reduced-price lunches.
- With working capital financing from the CDFI, OneCalifornia Bank, and a loan guarantee and grants from the Robert Wood Johnson Foundation, Playworks is expanding its services to improve the health and well-being of children by increasing opportunities for physical activity from its on-site programs that serve more than 70,000 students at 170 low-income schools in 10 cities to more than 650 low-income schools in 28 cities, along with training for adults to bring safe, healthy, and inclusive play to more than 1 million students by 2012.

For sustainable development, CDFIs have been in the lead of financing and tracking innovations that safeguard community health and the environment in urban and rural areas:

- Enterprise Green Communities has invested $700 million to build and preserve nearly 16,000 green affordable homes and partnered with the U.S. Department of Energy and BuildingGreen to create the High Performance Buildings Database.
- SJF Ventures, a CDFI venture capital firm with $26 million in cumulative investments, reported holdings in 28 companies that added 5,900 jobs in renewable energy and efficiency, organic and healthy consumer products and other companies offering significant employee benefits. Approximately 85 percent of the total 5,900 people employed are low- to moderate-income.
- The Triple Bottom Line Collaborative (TBLC) is an alliance of CDFIs pursuing the integration economic development and poverty alleviation with environmental issues through equity and debt investments as well as impact tracking. Collectively, members and their affiliates have made well in excess of $1 billion of TBL investments (see Appendix D).

Scaling Investment in Healthy Communities: An Overview of Promising CDFI Strategies

The field of community development finance engages in continuous efforts to attract the capital needed to scale proven initiatives, and it can benefit from potential new sources of capital from public and private investors in the health sector. Despite a general tightening of credit in the economic downturn, model investment structures and partnerships have continued to evolve between banks, CDFIs, and other community development finance intermediaries, public-sector agencies (some of which are managing one-time additional federal stimulus dollars), and philanthropic investors interested in leveraging their grant making with financial investments that reinforce their health-focused charitable missions.

Structuring investments that promote healthy communities requires due diligence from any investor, whether bank, CDFI, foundation, or government agency. Characteristics of community development financial transactions that potentially add risk and cost include but are not limited to: (1) low margin revenues (characteristic of all nonprofit service providers in low- to moderate-income communities), (2) unstable cash flows (particularly where government is the payer and budgets may be slashed or delayed), (3) low property valuations (corresponding to limited available collateral or high loan-to-value ratios), (4) multiple transaction objectives and/or sites (such as services-enriched affordable housing using "green," nontoxic building materials near a new public transportation hub, which will include a supermarket selling fresh food), and (5) complicated documentation associated with the use of tax credits or subsidized programs. Particularly when conventional credit markets are tight, these cost and risk factors create the need for more flexible capital, such as a foundation program-related investments (PRI, see below) or public-sector credit enhancements.

A flexible and relatively common deal structure is to have a CDFI create an off balance sheet fund or project financing that includes a layer of public-sector funding as a first loss fund, a larger layer of foundation PRI or CDFI subordinated debt as a second loss fund, and a much larger layer of commercial investor senior debt from a bank, insurance company, or other institutional investor. The New York City Acquisition Fund combines an $8 million, zero percent city loan as a first loss fund with $32 million in foundation-subordinated debt as a second loss fund. This $40 million in credit enhancement leverages over $200 million in bank senior debt authority to finance affordable housing site acquisition.

This model has been replicated for affordable housing in the Gulf Coast, Los Angeles, and the State of Oregon. Similar structures use grants from the Department of Education as first loss funds for charter schools facilities finance and are being planned to finance community health centers using American Recovery and Reinvestment Act of 2009 funds.

CDFIs and similar intermediaries also attract public subsidy by using tax incentives in the form of Low Income Housing Tax Credits, New Markets Tax Credits (NMTC), and Historic Tax Credits. Transactions using these programs are more difficult to close in the current environment due to fewer corporations with profits to shelter and fewer lenders willing to extend the so-called leveraged loans used in combination with equity from tax credits.

In the current environment, a particularly promising trend is the increasing number of foundations that are participating in community development finance through mission investing strategies. Defined broadly as financial investments made with the intention of advancing a foundation's charitable mission while earning a financial return, foundation mission investments can carry below-market-rate or market-rate returns on a risk-adjusted basis.

Program-Related Investments (PRIs) were created by the Ford Foundation in 1968 and defined for private foundations in the Tax Code of 1969 as meeting three criteria: (1) a primary purpose that is charitable, (2) no significant purpose of income generation or capital appreciation, and (3) no purpose of political activity that is prohibited for nonprofit organizations generally. Structured mostly as long-term debt with below market rates of interest on a risk-adjusted basis, private foundations are permitted to count qualifying PRIs against their annual five percent charitable distribution requirement.[23] Although community foundations do not have a charitable distribution requirement, most give away five percent or more of their average assets per year, and an increasing number are using PRIs in a similar fashion as private foundations.[24] Health-focused foundations, which can be private or community foundations, are also increasingly using PRI strategies, often to scale successful, health-promoting business models, such as Playworks' supervised recess services for low-income public schools (see Figure 4 and Appendix C).

In order to leverage larger portions of their endowments to advance mission (the so-called "other 95 percent"), more foundations of all types are also making mission investments that carry market rates of expected return on a risk-adjusted basis. Sometimes called Mission-Related Investments or MRIs (a term of art, since MRI is not a regulatory term), these investments meet the same financial hurdles as any conventional foundation investment while also offering social and/or environmental expected returns (Double and/or Triple Bottom Lines, or DBL and TBL, respectively). DBL and TBL investments have tended to be in market-rate, insured deposits with CDFI banks, geographically targeted fixed-income securities, and selected private equity funds, many of which support healthy community goals. For example, CDFI banks may provide SBA-guaranteed loans to minority and other health professionals who set up offices in low- to moderate-income communities. Fixed-income managers may purchase pools of the SBA-guaranteed portion of these loans to create fixed-income securities and provide liquidity to the banks for additional lending. Private equity funds may invest in health-focused businesses, such as Revolution Foods (Figure 4). Other private equity funds such as Pacific Community Ventures support the growth of businesses

23 Private foundations can count qualifying PRIs toward their annual charitable distribution requirement of 5 percent of average assets. While they are obligated to redistribute any repaid PRI principal as new PRIs or grants, this recycles charitable dollars, and foundations may use this feature to set up revolving PRI pools.

24 http://www.communityphilanthropy.org/downloads/Equity%20Advancing%20Equity%20Full%20Report.pdf. A few banks also use the term "PRI," generally to refer to long-term, fixed-rate concessionary debt to CDFIs or other community development organizations.

that provide good benefits to low-income workers, and some equity funds support real estate development in low- to moderate-income communities, including both transit-oriented, mixed-income workforce housing, and foreclosure mitigation.

Although direct mission investing in the health sector has been limited to date, there is a 40-year track record of well over $2 billion in PRI investing in community development sectors that counter the adverse social determinants of health (see Figure 5).[25] The investments have generally performed, demonstrating the creditworthiness of a range of sectors that reinforce health in low- to moderate-income communities, from affordable housing and minority small-business lending, to charter school, child care, human service organization, sustainable development, and, most recently, fresh food supermarket finance.

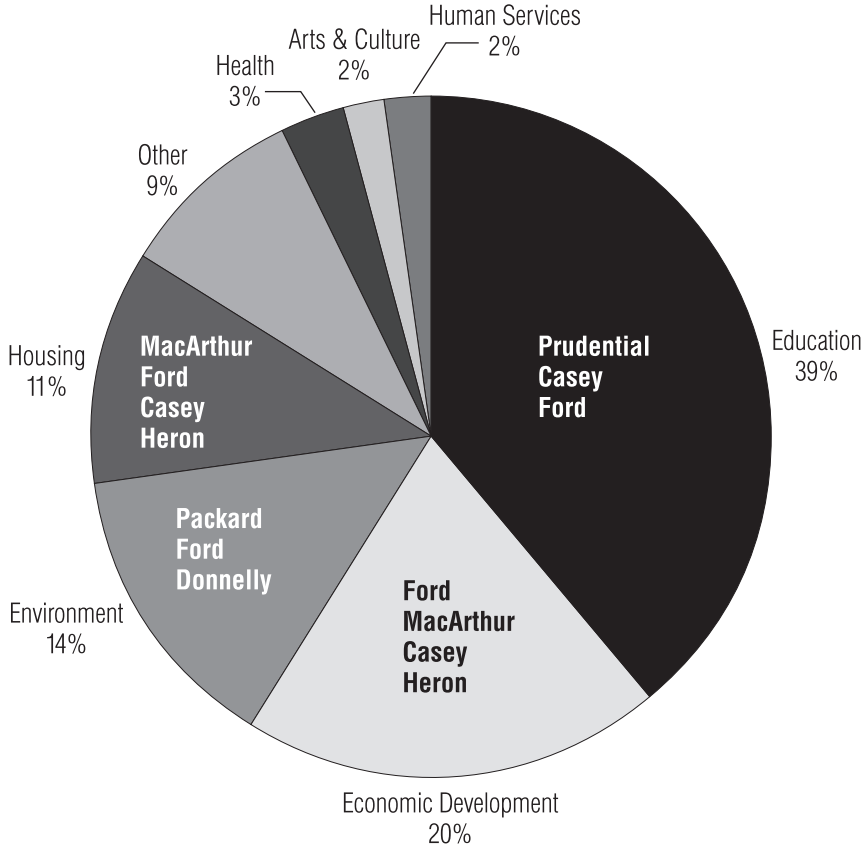
Excluding outliers in the initial years of PRI practice, foundations report repayment rates of 96 percent on mission investing debt over a 40-year period.[26] Loss rates have improved with the evolution of due diligence and portfolio monitoring practices by foundations, and particularly as an increasing number of organizations such as CRA-motivated banks and other social investors have chosen to partner with CDFIs and similar specialized entities to execute their mission investing strategies. An industry-wide survey of CDFI intermediaries reported loss rates of under one percent for each year between 2000 and 2006.[27] While the current environment presents challenges for all investors, CDFIs have proactively managed the heightened risk. In addition, there are now sophisticated due diligence tools, such as the CDFI Assessment and Rating Service (CARS™), and investment partners (including CRA-motivated banks and niche-specialized CDFIs) and services that can assist foundation investors with identification of high performing CDFIs, due diligence, deal structuring, and portfolio monitoring processes.

25 FSG Social Impact Advisors' 2007 retrospective on 40 years of mission investing tracked $2.3 billion in cumulative investments through 2006, based upon a survey of 92 foundations. Since that time, GPS estimates that foundations originated $200 million in PRIs per year on average, so that cumulative mission investments now likely exceed $3 billion. Note that the Education volume in Figure 5 is skewed by one anonymous foundation that anecdotally provided major support for higher education versus K-12 education in low- to moderate-income (LMI) communities. However, an increasing number of foundations are providing PRI financing to intermediaries that finance high-performing charter schools that serve primarily low-income students.

26 FSG Social impact Advisors, 2007.

27 CDFI Data Project, 2007 http://opportunityfinance.net/store/downloads/cdp_fy2007.pdf.
Although loss rates were higher in 2007, the CDFI industry has taken extensive measures to manage risk and contain losses. As of June 2009, a survey of CDFIs reported lower charge-offs than at year-end 2008 (1.1 percent at June 30, 2009, versus 1.7 percent at December 31, 2008) and a slowing in the pace of increased delinquencies. CDFI Market Conditions Reports, www.opportunityfinance.org. Despite this generally strong performance, some of the largest foundation and bank investors in CDFIs have extended forbearance on interest and principal for a period of time as they more closely evaluate the challenges that individual CDFIs in their portfolios may be facing due to the adverse economy and tightened credit environment.

Figure 5. Mission Investing Segmentation by Program (2001–2005)[28]



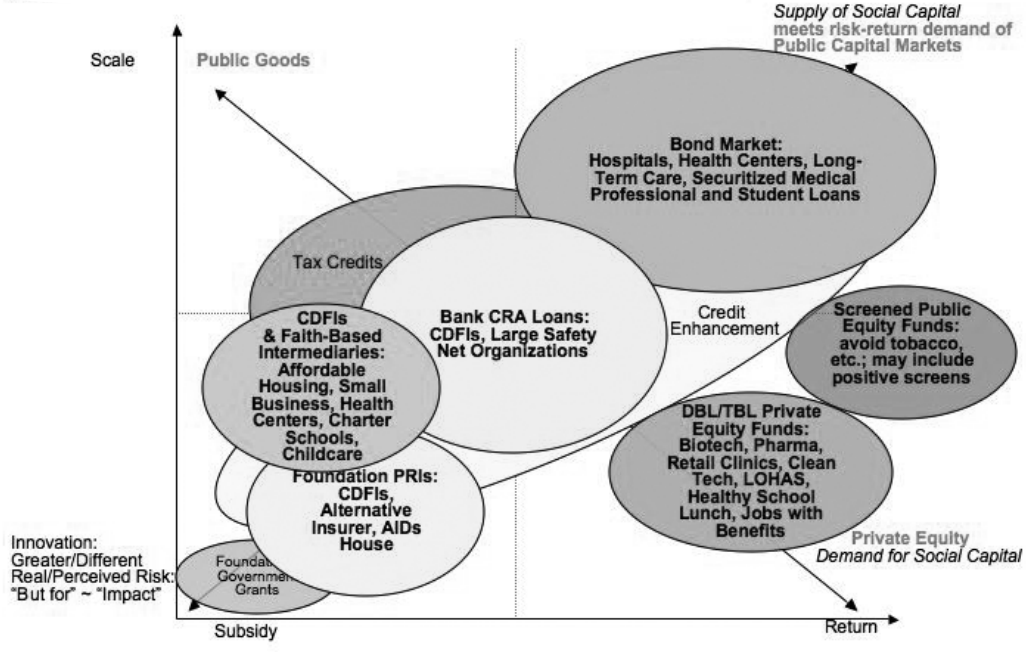
Consistent with their grant making, health-focused foundations currently considering mission investment strategies within the United States focus primarily on health care (financing for community health centers and the supply of health-care professionals in underserved communities), health coverage (alternative insurance, medical savings, and medical debt programs), and healthy community (access to quality child care, education, physical activity, healthy food, and jobs in a sustainable environment).

Given the need to attract large volumes of capital to scale successful initiatives, foundations as well as CDFIs often use PRIs as credit enhancement to leverage investment from the commercial capital markets. Structured as guarantees, subordinated debt, or, in some cases, tax credits that reduce transaction risk for bank or bond lenders, foundations and CDFIs aim

28 FSG Social Impact Advisors, Compounding Impact, 2007. http://www.fsg-impact.org/ideas/item/485.

to attract a portion of the estimated $200 trillion in global capital markets (Figure 6).[29] In the current environment, when new grant or PRI resources may be limited due to reduced endowments, foundations are increasingly interested in guarantees as a means to leverage their balance sheets for the purpose of mobilizing capital from third-party investors.

Figure 6. Mapping US Health Care Financing Supply & Demand For Health Care, Health Coverage, Healthy Communities[30]



Key: CDFI – Community Development Financial Institution; LOHAS – Lifestyles of Health and Sustainability; DBL/TBL – Double and/or Triple Bottom Lines of Financial, Social and/or Environmental Return

29 Guarantees are a special form of PRI that can be counted against a private foundation's charitable distribution requirement only if disbursed. Under normal circumstances, a disbursement would imply that the guarantee was called and the underlying loan was in default. However, some foundations disburse funds into reserve accounts for guarantees, counting these disbursed amounts against their charitable distribution requirements.

30 Figure 6 suggests that the supply of grant and below market-rate funds for innovative and early stage projects is very limited and historically has come from the public sector, faith-based investors, philanthropy and CDFIs (who typically raise their capital from these other investors, as well as from CRA motivated banks). As borrowing organizations become more experienced and manage larger projects, they need larger volumes of financing, which they may be able to access from larger, commercial debt markets, particularly if financing structures include credit enhancement. Such financing structures are often sponsored by CDFIs on behalf of their borrowers. The equity markets expect a high level of risk as a matter of course, and increasingly are financing companies with Double Bottom Line and Triple Bottom Line, health-enhancing products. GPS Capital Partners, LLC, 2009.

The Way Forward

Effective collaboration between community development finance and public health requires concerted strategy development, followed by investment from a range of institutional investors representing community development and health interests, including CDFIs and similar intermediaries, government, foundations, banks, and other commercial capital markets investors. Collaboration efforts can benefit from considering the following Strengths, Weaknesses, Opportunities, and Threats (preliminary SWOT analysis):

Strengths:

- A high level of mission commitment within both the community development finance and public health fields, with a focus on vulnerable populations and particularly children in low- to moderate-income and minority communities.
- A growing awareness of shared mission objectives and interest in collaborating, which set the stage for community development finance to develop a "culture of health" and public health to develop a "culture of community development finance."
- Complementary skills and resources: for community development, this includes skills in identifying and financing high-performing and innovative community organizations, including by aggregating a range of public and private subsidies to credit enhance significant volumes of commercial financing; for public health, this includes a medical framework for defining healthy community, outcome measures that track longitudinal changes in health status and health-care costs among income, ethnic, and geographic groups and access to sector-focused financing sources.

Weaknesses:

- No broad vision for healthy community that specifies the importance of private-sector financial investment has yet been articulated in policy or private initiatives.[31]
- While certain tested healthy community finance models exist, no systematic assessments of demand have been conducted, so there are no estimates of qualified demand. (Demand estimates have been prepared for specific sectors, such as affordable housing, community health centers, and charter schools.)
- Investing in healthy communities requires large investments up front for results that may be difficult to measure in the short term.
- Proposed collaboration between community development finance and public health presents learning curves for each on the other's delivery systems, business models, agencies, financing sources, and language.

Opportunities:

- Untapped investment potential from a range of mission-driven private investors, including health-focused foundations.

31 Isolated examples exist, such as among the Codman Square Health Center and its partners in Boston.

- One-time federal stimulus funds, a range of which can be leveraged in investments that jump-start health-enhancing projects in low- to moderate-income communities.
- Significant job creation outcomes as a by-product of investment in health-enhancing community services and projects, which allow low- to moderate-income communities to command an increasing share of the nation's more than $2 trillion in annual medical expense as income to local health centers, related businesses, and health-care workers.
- The health-care-reform debate has raised awareness of the physical and economic effects of the deteriorating health status of Americans, increasing interest in finding community-based and cost-effective ways to prevent disease.

Threats:

- The economy may experience a protracted recovery, limiting the amounts of government and private-sector capital available for investment in healthy communities.
- Ongoing consumer advertising by the range of industries offering products and services that are harmful to health–particularly the high volume of ads that are targeted to children–will continue to jeopardize investments designed to motivate healthier choices. In this regard, community development brings useful lessons about the need for strong regulation and education as parallel strategies with market-driven solutions to social problems.[32]
- A new influx of any product, service, or disease that causes widespread health threats (including new strains of illicit drugs or natural pathogens) could create distraction.
- Unclear federal policy goals or weak local policy leadership could prevent the focus needed for the proposed collaborations to be a success.
- Regulations affecting community development financing are in flux, including but not limited to the CRA. This may reduce the willingness of banks and other institutional investors to extend financing for community development projects. A reduction in the number of banks and CRA programs, along with generally tighter credit, also threatens to reduce the supply of capital.

32 The community development finance field was launched in response to redlining, the deliberate withholding of credit by lenders in low- to moderate-income and minority communities. Community development finance offered nonpredatory, asset-building loans and financial services. Predatory providers, however, soon glutted the same markets with products that undermine household financial security. The current lack of nutritious food supplies in low-income communities—leading to their designation as "food deserts"—bears some similarity to financially redlined areas. The concentration of unhealthy food and other products (tobacco, liquor) in these communities, while perhaps not designed as predatory per se, bears parallels to the glut of predatory financial services and threatens residents' human capital as predatory financial services threaten their financial capital. As communities increase access to healthy food through investments in supermarkets, farmers markets, school lunches, and other initiatives, it will be important to maintain efforts to both educate residents about the risks of unhealthy products and curb the availability and advertising of these products.

- Effective community development strategies usually require direct input from and ownership by community members, which often requires a lengthy and potentially costly process.

Perhaps the greatest threat is taking no action to better coordinate community development finance and health-care strategies, given trends of deteriorating health status, which undermine the benefits of traditional community development investments and generate debilitating health-care costs. The good news is that action is already under way. Models of community development finance that promote human development and health have been tested and continue to evolve. Indeed, they and the community development finance organizations that sponsor them may be some of the most valuable assets that are "hiding in plain sight." An important next step is to ensure that the models and partnerships become better known and more widely applied to scale both the health and economic benefits.

Conclusion

The fields of community development finance and public health can improve poverty alleviation and health outcomes through collaboration focused on financial investments that improve the quality of life for all people who live, work, worship, learn, and play in low- to moderate-income and minority communities.[33] The goals of reducing poverty and improving health outcomes are mutually reinforcing, as both sets of outcomes are enhanced by investments that increase access to quality child care, education, affordable housing, and other local services in a sustainable environment, while producing jobs for local residents.

Lisa Richter is principal and co-founder of GPS Capital Partners, LLC, a consultancy that assists foundations, banks and institutional investors in the design and execution of profitable investment strategy that enhances public-purpose goals. Her work spans asset classes and issue areas, incorporating place-based and investment focus to increase equitable access to opportunities, particularly in community development, education, and health. She is currently writing a guide to mission investing with Grantmakers In Health. *This article was prepared with support from the W.K. Kellogg Foundation, which supports children, families, and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society.*

33 http://www.cdc.gov/healthyplaces.

Appendix A: Healthy and Unhealthy Communities[34]

Unhealthy Community	Healthy Community	Example Community Development Finance Intervention
Unsafe even in daylight	Safe neighborhoods, safe schools, safe walking routes	Foreclosure mitigation strategies are critical at this time to minimize abandoned property, which attracts crime. In addition, mixed-use affordable housing, commercial and facilities developments, including health care centers, bring needed foot traffic to low- to moderate-income communities, and charter schools and child care centers, often as "green" infill development that may offer safe, extended day activities, promote a sense of community and restore derelict sites.
Exposure to toxic air, hazardous waste	Clean air and environment	Use of brownfields, restoration, and green building techniques to retrofit hazardous environments and increased attention to situating of housing, schools, and other projects in areas that are remote from hazardous conditions.
No parks/areas for physical exercise	Well-equipped parks and open spaces/ organized community recreation	Situating of charter school and child care facilities adjacent to parks where possible, with use of parks for recess and other supervised physical activity.
Limited affordable housing is rundown; linked to crime-ridden neighborhoods	High-quality mixed-income housing, both owned and rental	The community development finance field has produced hundreds of thousands of units of affordable housing, including rental and ownership opportunities. It is increasingly using green building techniques that both improve air quality and lower operating costs. As noted, efforts to preserve these developments are critical in the wake of the foreclosure crisis.
Convenience/liquor stores, cigarette and liquor billboards, no grocery store	Well-stocked grocery stores offering nutritious foods	Public-private partnerships such as Pennsylvania's Fresh Food Financing Initiative and use of creative financing tools such as New Markets Tax Credit are leading to new fresh-food outlets in urban and rural communities.
Streets and sidewalks in disrepair	Clean streets that are easy to navigate	Mixed-income housing developments may replace concentrations of public housing, restoring original street grids to promote pedestrian access to local goods and services.
Burned-out homes, littered streets	Well-kept homes and tree-lined streets	While these factors are typically supported by public dollars, residents tend to maintain and/or invest in the appearance of properties where a range of public and private investors, including community development organizations, are actively involved.

34 "Unhealthy and Health Community Profiles," RWJF Commission Report; Community Development Finance Activity, GPS Capital Partners, LLC.

No culturally-sensitive community centers, social services, or opportunities to engage with neighbors in community life	Organized multicultural community programs, social services, neighborhood councils, or other opportunities for participation in community life	Many CDFIs have become facilities and cash-flow lenders to nonprofit organizations in order to ensure that quality human services and opportunities for community life are available at the neighborhood level. This includes programs that serve youth, such as YWCAs and Boys & Girls clubs. It also includes faith-based organizations that often anchor community life. Supportive housing is a model in which health and social services are offered on-site for disabled residents, particularly those at risk of repeat visits to emergency rooms. In San Francisco, a network of such housing has reduced costly emergency room visits by residents some 58 percent in the first year. [This result is from San Francisco Department of Public Health's Direct Access to Housing program that provides permanent housing with on-site supportive services for approximately 600 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=501.]
No local health-care services	Primary care through physicians' offices or health center; school-based health programs.	A small number of community development lenders have become expert in the structuring and financing of community health center facilities and cash-flow needs. Some specialist developers of and lenders to charter schools facilities have indicated interest in incorporating school-based clinics in their facilities designs.
Lack of public transportation, walking or biking paths	Accessible, safe public transportation, walking and bike paths	The "smart growth" segment of community development has led the field in transit-oriented developments. While these are typically public-private partnerships with long planning horizons, they often include mixed-income housing and retail development that brings additional benefits to the community.

Appendix B - Recommendations from the Robert Wood Johnson Foundation Commission[35]

Recommendation	Commission Rationale and Commentary	Example of CDFI Financing Intervention
1. Ensure that all children have high-quality early developmental support (child care, education, and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.	Children who do not receive high-quality care, services, and education begin life with a distinct disadvantage and a higher risk of becoming less healthy adults, and evidence is overwhelming that too many children are facing a lifetime of poorer health as a result. Helping every child reach full health potential requires strong support from parents and communities, and must be a top priority for the nation. New resources must be directed to this goal, even at the expense of other national priorities, and must be tied to greater measurement and accountability for impact of new and existing early childhood programs.	CDFIs are leading providers of child-care facilities finance, often incorporating technical assistance on best practices for the design and situating as well as financing of sites. Lack of conveniently located, appropriately designed child-care facilities is a major barrier to meeting the need for additional quality child-care slots, particularly in low- to moderate-income communities.
2. Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.	These federal programs must have adequate support to meet the nutritional requirements of all American families in need. More than one in every 10 American households do not have reliable access to enough food, and the foods many families can afford may not add up to a nutritious diet. Nutritious food is a basic need to start and support an active, healthy, and productive life.	CDFIs are increasingly financing supermarkets (see Figure 4 and following) and some CDFIs help to sponsor Farmers Markets that provide fresh food in low- to moderate-income communities. Both venues increasingly accept Food Stamps. CDFIs and similar intermediaries also provide financing to local farmers and sustainable value-added food producers.
3. Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.	Many inner city and rural families have no access to healthful foods: for example, Detroit, a city of 139 square miles, has just five grocery stores. Maintaining a nutritious diet is impossible if healthy foods are not available, and it is not realistic to expect food retailers to address the problem without community support and investment. Communities should act now to assess needs to improve access to healthy foods and develop action plans to address deficiencies identified in their assessments.	Pennsylvania's Fresh Food Financing Initiative (FFFI), which partners with the Philadelphia-based CDFI, The Reinvestment Fund, is the model for several supermarket initiatives that increase access to fresh food, provide jobs, and improve the attractiveness of low- to moderate-income urban and rural areas. NCB Community Impact has long financed sustainable food cooperatives.
4. Feed children only healthy foods in schools.	Federal funds should be used exclusively for healthy meals. Schools should eliminate the sale of "junk food," and federal school breakfast and lunch funds should be linked to demonstrated improvements in children's school diets.	New social enterprises such has Revolution Foods provide nutritious breakfasts, lunches and snacks in public schools with financing from double bottom-line equity and debt funds capitalized by bank and foundation investors.

35 Sources: Recommendations and Commentary, RWJF Commission Report; Community Development Finance Examples, GPS Capital Partners, LLC.

Recommendation	Commission Rationale and Commentary	Example of CDFI Financing Intervention
5. Require all schools (K-12) to include time for all children to be physically active every day.	One in five children will be obese by 2010. Children should be active at least one hour each day; only one-third of high-school students currently meet this goal. Schools can help meet this physical activity goal through physical education programs, active recess, after-school and other recreational activities. Education funding should be linked to all children achieving at least half of their daily recommended physical activity at school, and over time should be linked to reductions in childhood obesity rates.	The CDFI, OneCalifornia Bank, provides working capital financing to Playworks with a guarantee from the Robert Wood Johnson Foundation. Playworks provides supervised recess in public schools serving low-income students in several cities, with expansion to additional cities under way.
6. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.	Progress on many fronts—smoke-free workplaces, clean indoor air ordinances, tobacco tax increases, and effective, affordable quit assistance—demonstrates that this goal is achievable with broad public and private-sector support.	The RWFJ Commission Report suggests that early intervention that provides children with nurturing, stimulating environments and models for healthy behaviors "may be the most effective strategy for improving the health and well-being of our nation." Boys & Girls Clubs and similar organizations offer still needed tobacco guidance (per the Centers for Disease Control some 20 percent of high school students smoke). CDFIs are a main source of facilities finance for quality child care and youth development facilities nationwide.
7. Create "healthy community" demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.	Demonstrations should integrate and develop successful models that can be widely implemented and that include multiple program approaches and sources of financial support. Each "healthy community" demonstration must bring together leaders and stakeholders from business, government, health care, and nonprofit sectors to work together to plan, implement, and show the impact of the project on the health of the community.	Codman Square Health Center is one example of a health-focused neighborhood revitalization strategy in a low- to moderate-income, minority community, incorporating affordable housing development, financial counseling, and a charter school that prepares students for health careers. CDFIs have provided financing for affordable rental and limited-equity housing projects by the Codman Square Neighborhood Development Center. [http://www.codman.org/; http://www.csndc.com/about.php#fp.]

Recommendation	Commission Rationale and Commentary	Example of CDFI Financing Intervention
8. Develop a "health impact" rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.	All homes, workplaces, and neighborhoods should be safe and free from health hazards. Communities should mobilize to correct severe physical deficiencies in housing, and health should be built into all efforts to improve housing, particularly in low-income neighborhoods. New federal housing investments should be held accountable to demonstrate health impact.	Enterprise Community Partners' Green Community Initiative has created a set of building criteria designed to result in high-quality, healthy living environments and reduced utility and maintenance costs associated with single- and multifamily housing, among other goals. The Triple Bottom Line Collaborative articulates broad criteria for projects that advance community equity, economic and environmental goals (see Appendix D). [http://www.greencommunitiesonline.org/about/mission.asp, http://tripleblc.ning.com.]
9. Integrate safety and wellness into every aspect of community life.	While much remains to be done to create safe and health-promoting environments, many schools, workplaces, and communities have shown the way, with education and incentives for individuals, employers, and institutions and by fostering support for safety and health in schools, workplaces, and neighborhoods. Funding should go only to organizations and communities that implement successful approaches and are willing to be held accountable for achieving measurable improvements in health.	The CDFI's emerging focus on human development and health and its ongoing application of sustainable development and "smart growth" practices support this goal.
10. Ensure that decision-makers in all sectors have the evidence they need to build health into public and private policies and practices.	Decision-makers at national, state, and local levels must have reliable data on health status, disparities, and the effects of social determinants of health. Approaches to monitor these data at the local level must be developed by, for example, adapting ongoing tracking systems. Funding must be available to promote research to understand these health effects and to promote the application of findings to decision-makers.	Many CDFIs already report outputs to the federal CDFI Fund and other investors, and a number prepare analyses to better convey their health and other social impact. CDFIs can benefit from partnering with the health sector, which has significant longitudinal and demographic health status and health-care-cost tracking systems in place. [See CDFI Data Project, 2007 http://opportunityfinance.net/store/downloads/cdp_fy2007.pdf.]

Appendix C - Healthy Community Investment Structure and Impact

Example of Investee and Use of Proceeds	Possible Structure	Credit Enhancement, Tax Credit, or Subsidy	Example of Nonbank Investors
Health Care			
Federally Qualified Health Center or "Look-Alike" Facility Provides community-based care and medical home for coordinated care of chronic disease	Direct loan to health center Loan to CDFI or similar intermediary that lends to health centers	Facilities: New Market Tax Credit; USDA and HRSA guarantees; foundation subordinated loans, guarantees or grants	MetLife Kresge Foundation Rhode Island Foundation California Community Foundation
Federally Qualified Health Center or "Look-Alike" Working Capital Enables expansion or continuous service during reimbursement delays	Direct loan to health center Loan to CDFI or similar intermediary that lends to health centers	Foundation subordinated loans, guarantees or grants	New Hampshire Charitable Foundation investment in NCB Capital Impact
Health Coverage			
Nonprofit-Sponsored Insurance Company Provides affordable insurance for freelance workers in New York and selected states.	Long-term, low-interest loan to nonprofit insurance company sponsor, which it invests as equity in insurance company subsidiary	Foundation grants	Ford Foundation New York State Health Foundation Prudential Social Investments New York City Investment Fund
Family Economic Security: Bank or Credit Union; typically a CDFI Promotes household savings and use of Earned Income and Child Care Tax Credits; provides nonpredatory household, business, and nonprofit organization finance	Market- or below-market-rate certificates of deposit, which can fuel general lending by the depository, or trigger or serve as a guarantee for particular loans by the depository	Foundation guarantees of bank or credit union loan(s) to selected borrower(s), such as nonprofit organizations in a particular sector. For enhanced deposit insurance: CDARS, a bank service that extends FDIC insurance up to $50 million per depositor National Federation of Community Development Credit Unions' nominee accounts, which extend the amount of federal deposit insurance available per credit union depositor	Annie E. Casey Foundation F.B. Heron Foundation WK Kellogg Foundation John D. and Catherine T. MacArthur Foundation

Example of Investee and Use of Proceeds	Possible Structure	Credit Enhancement, Tax Credit, or Subsidy	Example of Nonbank Investors
Healthy Communities			
Obesity Prevention: For-profit healthy food vendor to schools Provides nutritious breakfasts, lunches and snacks in public schools where childhood obesity is a high risk	Equity investment via private equity fund Working capital line of credit via intermediary	Private equity fund works with portfolio companies to identify local government subsidies for hiring of workers from low- to moderate-income areas or accessing space at below market- rental rates.	W.K. Kellogg Foundation Annie E. Casey Foundation Bay Area Equity Fund. [Revolution Foods had initial investment from the Bay Area Equity Fund I, whose nonbank investors include the F.B. Heron Foundation, Ford Foundation, John D. and Catherine T. MacArthur Foundation, Sand Hill Foundation, Peninsula Community Foundation (now Silicon Valley Foundation) and Annie E. Casey Foundation, as well as Catholic Healthcare West, Contra Costa Employees' Retirement Association, California State Automobile Association, and several insurance companies.]
Education: Nonprofit provider of structured recess in low-income pubic schools Provides daily, safe physical activity emphasizing team play, which also reinforces fitness	Working capital line of credit from local CDFI bank, which is guaranteed by foundation deposit in the bank. [Some guarantees can be secured by unfunded pledge of assets.]	Foundation guarantees working capital loan, which subsidizes interest rate on bank debt to nonprofit borrower	Robert Wood Johnson Foundation
Education: Charter School or Charter Management Organization High performing charter schools and charter management organizations provide improved educational outcomes, and better educational outcomes are correlated with better health outcomes. Charter facilities also often incorporate green, healthy building techniques.	Subordinated debt or guarantee for facilities financing by CDFIs, banks or the bond market	Federal Department of Education Credit Enhancement for Charter Schools Facilities New Market Tax Credit USDA guarantees for rural charter schools Foundation subordinated loans, guarantees or grants	Prudential Foundation Walton Foundation Annie E. Casey Foundation The Broad Foundation Bill & Melinda Gates Foundation

Example of Investee and Use of Proceeds	Possible Structure	Credit Enhancement, Tax Credit, or Subsidy	Example of Nonbank Investors
Housing: Improved health outcomes are linked with safe and services enriched housing in urban, rural and reservation communities, including for the disabled and farm workers and their families. Achieving housing stability also calls for foreclosure prevention, where possible.	Subordinated and senior debt for all phases of housing development: predevelopment, construction and permanent mortgage	Low Income Housing Tax Credit USDA Rural Rental Housing Indian Housing Loan Guarantee Federal Housing Administration HOME National Stabilization Program	John D. and Catherine T. MacArthur Foundation Annie E. Casey Foundation F.B. Heron Foundation Ford Foundation Rockefeller Foundation The California Endowment

Appendix D: Balancing Environmental, Economic and Health Concerns in Urban and Rural America

Investing in healthy communities can take many forms—from financing toxin-free housing to financing facilities that house quality child care, education and health care, to financing businesses that operate to restore or sustain a healthy environment. Often a higher initial investment is needed to install sustainable and energy efficient design elements for buildings or agriculture. These investments maintain the safety and productivity of natural resources that support rural economies. They also lower both environment toxins and ongoing energy use and other operating expense affecting all economies. As such, they are critical investments for low-income urban and rural communities.

The health risks in rural environments can be extremely severe, yet easily overlooked given the pressing problems of larger, urban communities. For example, migrant farm workers are among the most disadvantaged, medically indigent persons and have the poorest health of any group in the United States. The infant mortality rate among migrants is 125 percent higher than the general population, and the life expectancy of migrant farm workers is 49 (compared to the national average 75 years).[36] Toxicity from pesticides, physical straining and equipment risks are particularly high for migrant farm workers. Weather- and equipment-related risks are high for other rural occupations, such as fishing, logging and farming and ranching, which ranked first, second and sixth among the 10 most dangerous jobs in the United States reported by the Bureau of Labor Statistics in 2009.[37]

CDFIs have been investing to mitigate the special risks of rural communities for decades. As examples, Sacramento-based Rural Community Assistance Corporation, founded in 1978, continues to be a leader in financing safe migrant farm worker housing, as well as rural facilities and infrastructure. Community and Shelter Assistance Corporation of Oregon (CASA), founded in 1988, continues to finance a high volume of migrant worker housing and to provide asset building financial services.[38]

More recently, CDFIs throughout the nation are pursuing triple bottom line (TBL) financing strategies to stimulate local economies that restore or sustain the environment while promoting community wealth building (equity) and generating a financial return. As described by the Triple Bottom Line Collaborative (TBLC), elements of the approach include a commitment to delivering capital with triple-E impacts (economy, environment and equity), willingness to work with business borrowers and commitment to measuring and quanti-

36 Health conditions of migrant farm workers can be improved through not only safe housing structures but also through learned behaviors that promote a healthy home environment, such as removing pesticide-ridden shoes before entering one's home. http://www.ohsu.edu/croet/aghealth/family.html

37 http://www.classesandcareers.com/education/2009/09/25/2009s-10-most-dangerous-jobs/

38 http://www.rcac.org/, http://www.casaoforegon.org

fying the mission outcomes of investments (TBL Scorecard).[39] TBLC members include Coastal Enterprises, Inc., Four Directions Development Corporation, Montana Community Development Corporation, Mountain Association for Community Economic Development, Natural Capital Investment Fund, Northern Initiatives, Self-Help, ShoreBank Enterprise Cascadia, and Southern Mutual Help Association, Inc.

There are tensions inherent in the TBL approach. As described by TBLC member, ShoreBank Enterprise Cascadia, "Poverty trumps the environment . . . People struggling for solvency make decisions that solve the crisis at hand. Therefore, an honest long-term commitment to a triple bottom line demands an institutional commitment to delivering economic opportunity that follows directly from environmental well-being. CDFIs–formed in response to the crisis of limited investment engines for distressed communities–are a natural responder to structural environmental issues that threaten economic security."[40] In practice, and increasingly in urban as well as rural communities, CDFIs are applying the TBL approach by investing in diverse natural resources, real estate, community facilities, affordable housing and related community development enterprises with three criteria in mind:

- Economic feasibility, or financial merits of the project;
- Equity contribution of the project to individuals and families in the form of good wages, local ownership of resources (businesses or property) and asset creating opportunities;
- Benefits and effects of the project's operations, products, services, supply chain and related policies and practices on the environment.[41]

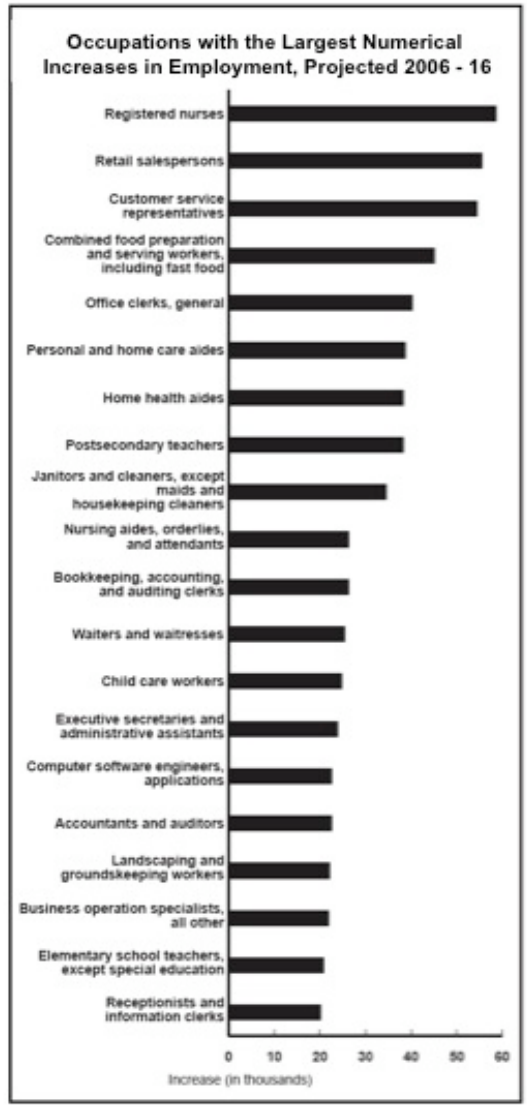
TBLC members apply these principles to financing services that promote community health and well-being–child care, education, health care and social services–along with business. Considering the demonstrated, increased risks to health from a contaminated environment, the comprehensive TBL approach offers great promise as a strategy to create healthier communities and residents for the long-term.

39 Other elements of the approach include: desire to apply the principles to the CDFI's own operations, convinction that TBL financing is an important business opportunity for CDFIs and committed to forging related capital, policy and R&D initiatives. http://tripleblc.ning.com/forum/topics/tblc-at-ofn-2008.

40 ShoreBank Enterprise Cascadia. Measure What Matters: ShoreBank Enterprise Cascadia's Commitment to Triple-Bottom-Line Metrics http://www.sbpac.com. ShoreBank Corporation has a broad commitment to triple bottom line investing under which it has disbursed more than $1 billion in sustainable financing through bank and nonbank affiliates since 2000.

41 Ibid.

Appendix E: Jobs Growth Outlook by Sector[A2]



42 U.S. Department of Labor, http://www.bls.gov/oco/oco2003.htm (last updated May 13, 2009).