

HOSPITALS BUILDING HEALTHIER COMMUNITIES

Embracing the anchor mission

by David Zuckerman

with contributions from Holly Jo Sparks, Steve Dubb, and Ted Howard

The Democracy Collaborative at the University of Maryland

March 2013



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Design by Kathleen Hayes

ABOUT THE AUTHOR

David Zuckerman is a research associate at The Democracy Collaborative. He has assisted with multiple feasibility studies of anchor-led economic development projects around the country and is a co-author of *Recommendations for a Metropolitan Washington Community Wealth Building Initiative*, a Democracy Collaborative report for the Washington Regional Association of Grantmakers. Zuckerman also serves as principal editor of Community-Wealth.org's newsletter. He received his Master of Public Policy from the University of Maryland, College Park.

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Foreword



By Jamie Harvie, Executive Director, Institute for a Sustainable Future

The *British Medical Journal* recently declared climate change the biggest public health threat of the 21st century. In the United States, the Centers for Disease Control and Prevention has called obesity our nation's largest public health threat. In the midst of these pronouncements, the current economic crisis and associated deliberations over the merits of the Affordable Care Act have also provided a deepened awareness about healthcare's impact on the overall economic health of our nation. At the heart of this conversation is a debate over the role of public health and prevention, and to what degree the bio-medical model should predominate. This model, which has shaped "modern" medicine, has been around since the mid-19th century, and has as its focus the physical processes of disease; as a result, it overlooks issues such as social and environmental factors or belief systems. Studies indicate that behavior and environment account for roughly 70 percent of our health outcomes, and medical care only about 10 percent. Yet, 96 percent of our national health expenditures are focused on medical care, with only four percent dedicated to prevention.¹ On one hand, these findings highlight the irony of the hospital as anchor institution model itself. That is, that we are asking healthcare institutions to "invest" their economic power in health. But, on the other hand, this data provides an important framework and a necessary pathway forward to ask ourselves, "What is healthcare for?"

Historically, clinical medicine and public health have been detached from one another. As physician Ted Schettler aptly describes in his paper, *Toward an Ecological View of Health: An Imperative for the Twenty-First Century*,² each of these health spheres bring their own sense of ethics, bases for intervention, and time scale, and each has competed for attention and limited financial resources. The bio-medical model has been largely dependent on a set of products and services that reinforce its economic influence. As we read the following report, it is important to understand these historical dimensions. Though clinical medicine and public health have some of the same interests at heart, the economics of the healthcare sector ironically puts them in competition with one another for a limited supply of power and influence—often to the detriment of health outcomes. It has become clear that health disparities and social determinants of health are key drivers of chronic disease and health impacts; we must think beyond a biomedical model to include meaningful primary prevention strategies if we are interested in resolving the healthcare crisis. As Dr. Schettler has highlighted, "the healthcare sector could make an important contribution. . .by re-examining its social contract with society and asking whether twentieth-century assumptions, programs, and services are adequate and appropriate for the twenty-first century." The most at-risk populations are those without access to affordable food, safe housing, personal safety, and a clean

environment. These same individuals lack a collective economic voice, and their needs will have to be met in our evolving healthcare model.

Clearly, as a nation and a planet, we are now engaged in conversations about how to not only bridge but weave together the silos of health, power, and influence in the broader health sector. Provisions of the Affordable Care Act work to integrate disease treatment with public health and prevention, though it is still too soon to see how successful its implementation will be for improving the health of the country. Recently, the Institute of Medicine held a landmark summit, titled, “Integrative Medicine and the Health of the Public,” to explore integrative approaches to health. And, as David Zuckerman describes in this timely and astute report, a variety of hospital leaders are “beginning to adopt an anchor-institution strategy that utilizes not-for-profit hospitals’ long-term, place-based economic power to improve the long-term welfare of their communities.” The nascent concept of health beginning outside of hospital walls is starting to take some form. This is why the anchor institution model holds such promise. Because if done correctly, it can redistribute economic power to support greater health equity and reinforce the foundational understanding that health is built in community.

The Institute for Healthcare Improvement (IHI), a leading organization working to improve health and healthcare, believes that new designs can and must be developed to simultaneously accomplish three critical objectives: 1) Improve the health of the population; 2) Enhance the patient experience of care (including quality, access, and reliability); and 3) Reduce, or at least control, the per capita cost of care. This approach (which is called “Triple Aim”) melds the population health model with the bio-medical model. To be successful in this goal, Donald Berwick, M.D., then Medicare/Medicaid administrator and IHI’s president and CEO, outlined a seven-step process based on successful healthcare models from across the country.³ Berwick’s approach is informed by the work of the late Nobel Prize-winning economist Elinor Ostrom. Her research showed how regular people have been able to develop rules and institutions to successfully manage shared resources, such as water rights, grazing rights and fisheries—all central to the health of populations. What Berwick has argued is that communities need to define their healthcare commons, the collective resources that can treat disease and promote health, and to develop community-based strategies. These can include medical technologies but also healthy food environments, housing, livable jobs, parks, and so forth. He further argued that ultimately it is communities themselves that are going to need to take responsibility to define their “healthcare commons,” set goals, develop metrics, and establish a healthcare solution, which includes but is not limited to the traditional healthcare system.

As we move into a new century with large urban population pressures and a host of ecological health pressures, the answer to “What is healthcare for?” becomes even more important. And this question is not unique to the United States. The National Health System in the United Kingdom published a *Route Map for Sustainable Health*, which explicitly supports the need for a paradigm shift. It advocates for the transfer

from the institution-led paradigm, to a community-led one that accounts for the future of society and the environment, and is informed by partnerships with patients and communities in a more open decision-making system. In *Shaping Cities for Health*, University College, London and the Lancet Commission advocate a similar place-based, community-driven approach. These collective signals keep flashing and reminding us that we need to include community as an equal partner and recognize that the need to address disparities can only occur through a reallocation of resources. Moreover, they strongly suggest that healthcare begins in community, not in traditional hospitals.

As we read Zuckerman's landmark report, we can appreciate the power and possibility within a hospital anchor institution model. We can learn important lessons from those leading the effort, and share on how creativity can support models of health promotion, which promise to move us beyond the decaying economic model at present. Their leadership and foresight in addressing key drivers of poor health should be embraced and celebrated. It is also important to remember that we are in a time of transformation; the economic power and influence of the 20th-century hospital must shift, so that we can extend health outside of hospital walls, for the benefit of all. So let us embrace the collective wisdom of these leaders and communities, in a "commons-health" partnership. And, if we are successful, we will have not only hospitals as strong economic anchors, but equally strong community partners woven together in a resilient web.

Notes

1. Larry Cohen, "Doctor support critical in the fight for community prevention," *KevinMD.com:Physician*, Jul 10, 2011, <http://www.kevinmd.com/blog/2011/07/doctor-support-critical-fight-community-prevention.html>, accessed October 23, 2011.
2. Schettler, T., *Toward an Ecological View of Health: An Imperative for the Twenty-First Century*, Paper presented by The Center for Health Design® and Health Care Without Harm at a conference sponsored by the Robert Wood Johnson Foundation, September 2006.
3. Institute for Healthcare Improvement. "Berwick: It's Our Job to Redesign Healthcare, Contain Costs," originally published in December 2009 *Leadership e-newsletter*, <http://www.hfma.org/Templates/Print.aspx?id=18653>, accessed Dec 28, 2012.

Preface



By Ted Howard and Gar Alperovitz¹

Over the last 15 years, large not-for-profit, place-based institutions have increasingly recognized their role as leading economic engines in their communities. In the process, some anchor institutions have adopted strategies to strengthen the local economies where they reside. A few institutions—some of which are highlighted in this report—have gone further: working not only to strengthen but to completely transform distressed surrounding neighborhoods and improve the lives of low-income residents by rethinking how they do business and engage their communities.

From an employment and procurement perspective, not-for-profit hospitals are the most prominent anchor institutions in the United States. There are nearly 3,000 nationwide (not including 1,000 state and local government hospitals, some of which are also registered as 501(c)(3) organizations). These not-for-profits had reported revenues of more than \$650 billion and assets of \$875 billion as of August 2012.² Many are situated in struggling communities.

Until recently, only a few hospitals had implemented anchor strategies—deploying the institution’s full financial and human resources to benefit the community in which it is based. But now a growing number of hospitals are beginning to design and implement more comprehensive anchor strategies in which they leverage the business side of their organization (through their procurement policies, for instance) to benefit the local economy. Many institutions are strengthening their community engagement and economic development efforts. Some are rebuilding strained connections with alienated local residents. Others are adopting interventions focused on addressing social determinants of health, such as housing conditions, employment opportunities, environmental exposures, and asset preservation.

For many, the link between the well-being of their surrounding neighborhoods and the financial strength of their institution has been a powerful incentive for this shift in priorities. The case studies highlighted in this report, and the survey of other promising practices from around the nation, show how a range of institutions have moved forward in a variety of productive directions. They are asking how these strategies can transform surrounding neighborhoods, while more deliberately building community wealth for long-term, low-income residents. *Hospitals Building Healthier Communities* aims to aggregate many of these individual efforts and provide a resource for hospitals considering adopting or further integrating community engagement and economic development into their daily operations and their core mission.

A central objective of this report is to evaluate how these institutional initiatives serve those most in need. Increasingly hospitals are incorporating economic inclusion goals that address core issues of poverty as a means to improve resident health in struggling communities. For some, engaging in efforts to build community wealth in low-income communities might seem beyond the scope of a hospital’s mission. It is true that historically hospitals have taken a rather parochial view of what promoting health means, most often focused on providing surgery and acute care, supplemented by service-oriented community health clinics. However, this understanding is also evolving.

In recent years, public health research has helped reinforce the significant link between poverty and poor health. Yet, as a nation, about 95 percent of healthcare spending is for direct delivery of medical services—and not aimed at addressing social determinants of health, such as socioeconomic factors (joblessness, etc.) and environmental hazards. In this context, it is worth reiterating the oft-cited point that the zip code you live in is a better determinant of your life expectancy than your genetic code.

Ultimately, we believe that only through a sustained institutional commitment to a long-term, comprehensive community-building strategy can hospitals achieve their social mission and fiscal objectives. As described in this report such strategies may also help hospitals meet Community Health Needs Assessment requirements that have come into effect as part of the Affordable Care Act. This commitment requires hospitals to strategically invest financial and human resources to benefit the community in which they reside, with an enhanced focus on the welfare of low-income residents in particular.

Arguably, hospitals have consciously embraced their roles as anchors more slowly than other large place-based, not-for profit institutions such as universities. Still, noteworthy strides and significant accomplishments exist, as exemplified by the hospitals profiled in this report. Collectively, they pose a challenge to other institutions to more effectively utilize their position as economic engines and powerful community anchors. Our hope is that *Hospitals Building Healthier Communities* not only expands this important conversation but spurs hospitals, local philanthropy, community-based organizations and policymakers to action.

Notes

1. Ted Howard is the Executive Director of The Democracy Collaborative. Gar Alperovitz is the Lionel R. Bauman Professor of Political Economy at the University of Maryland.
2. Internal Revenue Service, Exempt Organizations Business Master File (2012, Aug) The Urban Institute, National Center for Charitable Statistics, <http://nccsdataweb.urban.org/>

Executive Summary

At the center of all this, going back to our starting point, are the hospitals, and what the hospitals mean to this community. And they mean at least as much [as] universities do to their communities.

- Oliver C. Henkel, Jr., Chief External Affairs Officer, Cleveland Clinic¹

Today, the mid-20th century economic model that often centered local economies on core corporate employers that employed blue-collar workers is increasingly hard to find. In its place, nonprofit or public employers such as universities and hospitals—often referred to as “anchor” institutions—have increasingly become the economic engines of their communities. As the word “anchor” implies, anchor institutions, once established, rarely move location. In large measure because of their community (nonprofit or public) ownership, these anchors are truly tethered to their communities regardless of the prevailing economic winds; their mission, invested capital, and customer relationships bind them to their communities.²

Universities and not-for-profit hospitals (often referred to as “eds and meds”) are the most prominent examples, although other anchor institutions include local governments, zoos, museums, and related cultural institutions. Nationwide, universities have endowment assets in excess of \$400 billion, expenditures greater than \$350 billion, and employ nearly four million. Hospitals have an even greater impact. They employ more than 5.4 million people, have expenditures in excess of \$675 billion, and spend more than \$340 billion each year on goods and services. Of all charitable nonprofits in the United States, not-for-profit hospitals alone comprise more than 40 percent of total revenues and 25 percent of total assets.³

Some anchor institutions have recognized that their expanding economic impact and connection to their location strategically position them to produce targeted community benefits if they leverage their resources effectively. *Specifically, as economic engines, anchors are well situated to catalyze place-based community revitalization strategies if they consciously choose to do so.* Some of these anchor strategies include redirecting purchasing to local and diverse businesses, expanding local workforce development and hiring, and aligning real estate and housing development to spur local commercial business investment and the local housing market.⁴

Of course, it is one thing to be, *de facto*, an anchor institution, and it is quite another for organizational leaders to *consciously* recognize and adopt that role. Elsewhere The Democracy Collaborative has written about the role of universities as anchor

institutions.* Arguably, the conscious development of an anchor institution mindset among universities has proceeded more rapidly than in hospitals. But driven both by growing recognition of the interdependency of health and economic outcomes, as well as by the increasing importance of their industry, hospital leaders too are beginning to adopt an anchor-institution strategy that utilizes not-for-profit hospitals' place-based economic power to improve the long-term welfare of their communities. An April 2012 survey on behalf of the American Hospital Association even found that 98 percent of hospital CEOs—regardless of ownership status—“agree, at least at some level, that hospitals should investigate and implement population health management strategies.”⁵ This finding shows that hospital leadership recognizes the importance of looking outside their institutions' walls for effective health solutions. Still, it is time to push the conversation even further.

In the first section of this report, we highlight previous research on anchor institutions and the impact hospitals have in their communities. We examine four reasons that encourage not-for-profit hospitals to adopt strategies that deploy their resources to impact the physical, social, and environmental conditions of their surrounding community. An anchor institution strategy: 1) aligns with a hospital's mission, 2) generates economic returns to both the community and institution, 3) helps satisfy its community benefit requirements to the federal government, and 4) provides an opportunity for a hospital to justify its tax-exemption and reduce its financial burden to local governments. Not all of these reasons have prompted the anchor institutions highlighted in this report to implement the strategies they have chosen, but in each case, at least one of these four reasons has influenced the decisions made.

The second section of this report examines the evolution of the U.S. hospital, focused primarily on the not-for-profit hospital sector and its unique ability to portray itself as a private actor with a public mission. We explore the tension between its drive for market efficiency and its need to fulfill its mission. This delicate balance has only become more difficult as hospitals became increasingly market-oriented and as government began to demand greater community benefit requirements to justify tax exemptions. We also explore how hospitals have historically engaged their local communities and how new Internal Revenue Service (IRS) requirements and provisions in the 2010 Affordable Care Act are changing expectations and creating opportunities.

Section Three highlights promising trends and best practices in community building from across the nation. Summarizing *some* of the different options available to anchor institutions in their communities, these strategies are divided into seven categories: sustainability practices, minority- and women-owned business purchasing, housing

*The Democracy has published two reports on the role of universities as anchor institutions: *Linking Colleges to Communities* (2007) by Steve Dubb and Ted Howard, and *The Road Half Traveled* (2010) by Steve Dubb and Rita Axelroth Hodges (since updated and rereleased as a book in 2012 for Michigan State University Press' series on Transformation in Higher Education).

EMERGING TRENDS AND BEST PRACTICES FROM ACROSS THE NATION

Sustainability Practices

- Kaiser Permanente (Oakland, CA): Healthier Hospitals Initiative, California Freshworks Fund
- Catholic Healthcare West (San Francisco, CA): Healthier Hospitals Initiative, California Freshworks Fund
- Union Hospital (Northeast MD): local food purchasing
- MetroWest Medical Center (Massachusetts): community supported agriculture (CSA)
- Cleveland Clinic and University Hospitals (Cleveland, OH): Evergreen Cooperatives
- Bon Secours Health System (Bronx, NY): Youthmarket and Youth Farm

Minority- and Women-Owned Business Purchasing (program start date noted below, if available)

- Broward Health (Florida): 1990
- University of Texas M.D. Anderson Cancer Center (Houston, TX): 1997
- Detroit Medical Center (Detroit, MI): 1998
- SSM Health Care (MI, OK, IL and WI): 2001
- Carolinas HealthCare System (NC, SC): 2001
- Tristate Health Care Diversity Supplier Consortium (Cincinnati, OH): 2010
 - UC Health
 - Mercy Health
- Catholic Healthcare Partners (Ohio)

Housing Development

- St. Mary's Health System (Lewiston, ME)
- SwedishAmerican Hospital (Rockford, IL)

- Nationwide Children's Hospital (Columbus, OH): "Healthy Neighborhoods, Healthy Families"
- St. Joseph's Hospital Health Center (Syracuse, NY)

Capacity Building

- St. Joseph Health System of Sonoma County (Northern CA): Neighborhood Care Staff, ACTION
- Sinai Health System (Chicago, IL): North Lawndale Employment Network

Local Hiring

- Wrangell Medical Center (Wrangell, AK): Rural Health Careers Initiative
- Partners HealthCare (Boston, MA): Partners in Career and Workforce Development

Community Investment

- Catholic Healthcare West (San Francisco, CA): Community Investment Program
- Rhode Island Hospital, St. Joseph's Hospital, and Women & Infant's Hospital (Providence, RI): South Providence Development Corporation
- Baystate Health (Springfield, MA): Wellspring Initiative
- University of Pittsburgh Medical Center (Pittsburgh, PA): Pittsburgh Promise

Multi-Institution Partnerships

- Hartford Hospital (Hartford, CT): Southside Institutions Neighborhood Alliance
- Cincinnati Children's Hospital, Tri-Health, and UC Health (Cincinnati, OH): Uptown Consortium
- Cooper University Hospital (Camden, NJ)

development, capacity building, local hiring, community investment, and multi-institution partnerships. By no means an exhaustive list, this section serves to illustrate the variety of ways hospitals are engaging their communities and the potential possibilities if these strategies were combined.⁶

Section Four provides five case studies, offering their stories as detailed examples of how health systems and individual hospitals are employing anchor strategies in their communities, the impact those strategies can have, and the implementation challenges they face. Their success and limitations should serve to engage—and challenge—not-for-profit hospitals regarding the possibilities of an anchor institution mission and how to better incorporate the needs of the poor in future efforts. The institutions profiled have taken the first steps toward addressing social determinants in their communities such as the environment, poverty, unemployment, inadequate schooling, affordable housing, crime, and other social issues.

Over the course of 2011 and beginning of 2012, we conducted site visits and phone interviews. The opinions of those interviewed reflect primarily those in leadership positions within the institutions. Below, we briefly introduce the five cases:

ROCHESTER, MINNESOTA: MAYO CLINIC

Representing the center of a \$8.5 billion health system, Mayo Clinic's hospital operations in Rochester employ more than 33,500 people and maintain 1,132 beds. Mayo operations here also procure more than \$1 billion in goods and services annually, profoundly impacting the economies of the state's third largest city and the greater region of southeast Minnesota. Recently assuming a larger role in spurring local revitalization of the surrounding region and Downtown Rochester, Mayo has begun to consciously target local and diverse suppliers in the area. It also served as the principal funder for First Homes, a community land trust that has to date developed 875 units of affordable housing available to all community residents.⁷

LA CROSSE, WISCONSIN: GUNDERSEN LUTHERAN HEALTH SYSTEM

Operating across parts of western Wisconsin, northeastern Iowa, and southeastern Minnesota, Gundersen Lutheran Health System employs more than 6,000 people and has revenues in excess of \$1.3 billion.⁸ Anchoring the system is its 325-bed hospital and multi-specialty clinic in La Crosse, Wisconsin. In 2008, Gundersen established an aggressive program called Envision to achieve environmental leadership in the areas of energy conservation and renewable energy, waste management, recycling, and sustainable design. In order to accomplish its goals, Gundersen has set local food-purchasing goals, developed local alternative energy sources, established a multi-stakeholder food cooperative, rehabilitated old buildings into affordable housing and other facilities, built

environmentally friendly infrastructure improvements, and offered financial incentives for local homeownership.

BALTIMORE, MARYLAND: BON SECOURS HEALTH SYSTEM

A 125-bed facility with more than 950 employees, Bon Secours Baltimore is the flagship of the nine-hospital Bon Secours Health System, a \$3.3 billion not-for-profit Catholic health system stretching from New York to Florida. As Southwest Baltimore's primary anchor institution, Bon Secours Baltimore Health System has adopted an approach to community and economic development since the 1990s that focuses on revitalizing neighborhoods and rehabilitating housing, providing family and women's services, offering youth employment and workforce development, and expanding financial services. As a result, Bon Secours' larger system has since institutionalized these practices through its Healthy Communities initiative, which is modeled on Baltimore's approach and requires each system hospital to develop community-specific initiatives that reflect the social determinants of health. Bon Secours Baltimore has also refocused efforts to increase local purchasing from minority- and women-owned suppliers.

DETROIT, MICHIGAN: HENRY FORD HEALTH SYSTEM

Anchored by the 802-bed Henry Ford Hospital in Detroit, Henry Ford Health System has revenues of more than \$4.2 billion, employs more than 10,000 people within the city and procures more than \$650 million from its Detroit institutions.⁹ Henry Ford actively recognizes its position as an anchor institution, working with many partners to increase its impact in the community. Through a multi-institution partnership, Henry Ford has coordinated with Detroit Medical Center and Wayne State University to help revitalize Midtown Detroit by encouraging their employees to live, work, and invest in the same community. It has also helped found a local business incubator at Wayne State, set active goals to procure from local and diverse suppliers, and used its purchasing power to persuade suppliers to relocate to Detroit. Further still, Henry Ford has helped finance education partnerships for high-risk youth, is focused on acquiring and rehabilitating reclaimed properties, and has helped push local infrastructure improvements.

CLEVELAND, OHIO: UNIVERSITY HOSPITALS SYSTEM AND CLEVELAND CLINIC HEALTH SYSTEM

Our last case profiles two institutions and their collective and individual efforts to integrate anchor institution missions. Linked by a common geography, the flagships of these two health systems are separated by less than two miles. Collectively, University Hospitals and Cleveland Clinic have been important partners, with the Cleveland

Foundation and Case Western Reserve University, in working to transform Cleveland's Greater University Circle.

University Hospitals System comprises the 1032-bed, former academic medical center of Case Western Reserve University, and six community hospitals across Northeast Ohio. The system employs more than 24,000 people and generates revenues in excess of \$2 billion annually.¹⁰ A key initiative has been University Hospital's Vision 2010 project, a \$1.2 billion, five-year strategic growth plan that started in 2006. As part of Vision 2010, University Hospitals set separate goals to procure from local, minority- and women-owned businesses, and actively aimed to create new supplier capacity within the city. It also hired a third party to hold it accountable, voluntarily entered into a unique Project Labor Agreement, and has now started to apply this vision to its entire supply chain purchasing. Further still, University Hospitals is involved in other job creation and wealth building initiatives in the community.

Despite Cleveland Clinic's global presence, the vast majority of the system's operations are based in Ohio, where the system is the largest employer in the northeast part of the state and second largest in the state. Cleveland Clinic's main campus alone employs more than 26,000 people, has revenues of nearly \$4 billion, and procures more than \$1.5 billion in goods and services annually.¹¹ In recent years, it has adopted a variety of anchor strategies, including shifting a percentage of procurement locally and to minority-owned businesses, participating as an anchor partner in a comprehensive neighborhood revitalization effort, implementing childhood wellness programming in local school districts, and positioning itself as a leader in sustainability.



Finally, in the conclusion, this report provides recommendations for how a hospital or health system can more consciously begin to integrate an anchor institution mission, sustainably and comprehensively. Drawing from the case studies, promising practices and our own work, these suggestions provide a starting point for improving community health *and* building community wealth in struggling neighborhoods. First, an anchor institution mission requires buy-in from senior-level executives, a commitment to a long-term strategic plan, and independent officer positions dedicated to accomplishing institutional priorities. Second, hospitals should seek to change the culture of their entire organization, involving doctors, nurses, researchers, and other employees, in order to deploy their human and financial resources most effectively and create staff buy-in for an anchor institution mission. Third, hospitals should develop indicators and metrics for engagement, focus attention on specific projects, and embrace flexibility and patience when necessary. Fourth, hospitals should recognize that community engagement and building community capacity are long-term investments that are integral to successful implementation of an anchor institution mission. Fifth, hospitals should engage community and local political partners, as well as other anchor institutions, as they integrate an anchor institution mission into their overall operations.

INTEGRATING AN ANCHOR INSTITUTION MISSION—SUMMARY OF RECOMMENDATIONS

- Hospital**
- Secure buy-in from senior-level executives.
 - Detail goals and commitments in a long-term strategic plan.
 - Establish independent officer positions for anchor-related objectives.
 - Foster organizational culture change at all levels, including doctors, nurses, researchers, and other employees.
 - Develop indicators and metrics for engagement.
 - Focus on specific projects and embrace flexibility and patience.
 - Understand the importance of community engagement and building community capacity as long-term investments.
 - Engage community and local political partners, as well as other anchor institutions.
 - Reassess institution policies regarding charity care, Medicaid patients, and bill collections.
 - Leverage existing federal and state resources for place-based economic development.
-

- Philanthropy**
- Convene anchor institutions and forge partnerships.
 - Increase dialogue regarding the importance of hospitals as anchors.
 - Encourage an anchor framework through specific initiatives.
 - Provide important seed, predevelopment, and matching funds.
 - Recognize the unique position of health conversion foundations.
-

- Policy**
- Evaluate and publish collected data for Schedule H, along with best practice examples. (IRS)
 - Create an award to recognize leading hospital-community partnerships. (Dept. of Health and Human Services)
 - Require mandatory community benefit reporting requirements that at a minimum align with federal requirements. (State government)
 - Establishing a liaison office to identify possible partnerships and coordinate efforts with local economic development. (Local government)
-

Finally, hospitals should reassess their policies regarding charity care, Medicaid patients, and bill collections to ensure that they do not preclude low-income families from building or keeping their assets.

Hospitals must be the lead actors in this process; however, philanthropic support can also be a powerful catalyst. This report encourages foundations to recognize four capacities in which they promote an anchor institution mission. First, foundations can serve as conveners, bringing together anchor institutions and forging partnerships. Second, foundations can increase dialogue regarding the importance of hospitals as anchors and encourage an anchor framework through specific initiatives. Third, foundations can serve as funders, providing important seed, predevelopment, and matching funds to develop broader anchor partnerships. Finally, health conversion foundations are uniquely positioned to promote place-based revitalization and help align hospitals with their anchor institution potential.

Policymakers should also help create a more constructive environment for hospitals to embrace an anchor institution mission, and we recommend five steps, in particular. First, the IRS should evaluate and publish the data it has collected since implementing Schedule H, offer examples of best practices in guidance, and work collaboratively with other federal agencies, such as the Department of Health and Human Services and the Centers for Disease Control and Prevention, to capture other evidence-based practices in the spheres of community benefits and population health. Second, the Secretary of Health and Human Services should create an award to recognize leading hospital-community partnerships that develop integrated anchor institution strategies. Third, hospitals should look to leverage existing federal and state resources for place-based economic development opportunities (e.g., Choice Neighborhoods). Fourth, state governments should require mandatory community benefit reporting requirements that at a minimum align with federal requirements or further emphasize the role of community building activities. Finally, local governments should collaborate with hospitals to support community development strategies, by establishing a liaison office tasked with identifying potential development partnerships and guiding their efforts in ways that align with local economic development goals.

There is no denying a hospital's impact in its community. But in recent years, the question raised has been whether that impact is as beneficial as it should be, especially in low-income neighborhoods. Now, through new community benefit requirements, not-for-profit hospitals are being asked to demonstrate—in a more transparent and standardized process than ever before—how they differ from their for-profit counterparts. For hospitals that choose to embrace an anchor institution mission, the answer to that question is clear. For a hospital to fully achieve its stated mission of promoting a community's physical and mental health, hospitals must also improve the community's social and economic health. Our hope is that this report will help guide hospitals, supported by foundations and policymakers, in that direction.

Section One

Hospital as Economic Engine and Anchor Institution

What a hospital does in a community in terms of being a role model can be huge. If you get hospitals ahead of the game on some of these things, it can bring the rest of the community along.

- Anna Gilmore-Hall, former Executive Director, Practice Greenhealth¹²

AN ANCHOR INSTITUTION MISSION

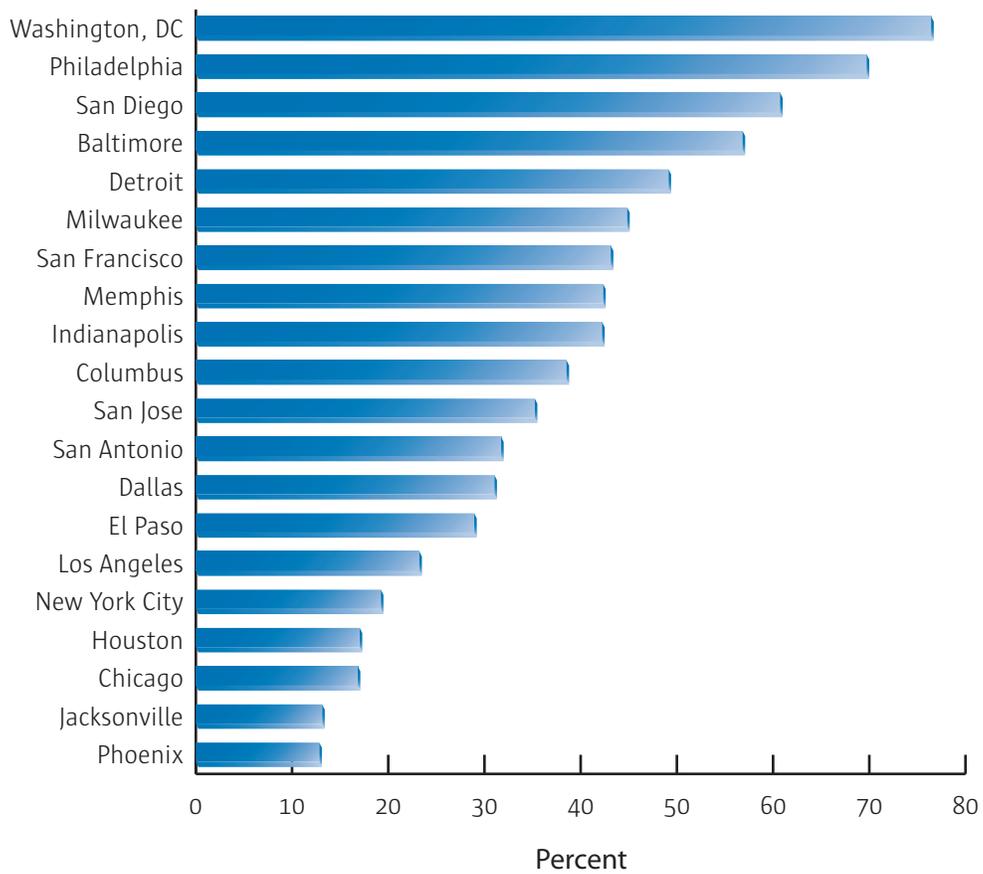
According to a 1999 Brookings Institution study by Ira Harkavy and Harmon Zuckerman, in each of the largest 20 U.S. cities, a university or health system was among the top 10 private employers “despite [the cities’] differences in age, region, and development pattern.” The authors’ examination of the field helped quantify the economic importance of anchor institutions to their respective communities. The number of jobs provided by universities and hospitals as a share of employment among the top 10 private employers ran the gamut from just 13 percent in Phoenix, Arizona, to nearly 77 percent in Washington, DC. However, as an average across all 20 cities studied, their share of employment reached nearly 35 percent. Although no equivalent study has updated these figures, there is little doubt that the share of jobs from universities and health systems has only increased in the past decade as traditional manufacturing jobs have diminished and as demand for educational and health services has increased. As a result, these figures likely underestimate the impact of anchors as economic engines. In a 2008 article for *Governing* magazine, Harkavy noted that recent growth has been especially significant among health institutions.¹³

The overwhelming importance of these institutions to their communities has prompted a new body of scholarly work outlining the opportunities for anchors to leverage their resources to revitalize the local community to the mutual benefit of both entities. Michael Porter, a professor in the Harvard Business School and founder of the Initiative for a Competitive Inner City (ICIC), is often credited with popularizing the term “anchor institutions.” *Leveraging Colleges and Universities for Urban Economic Revitalization:*

An Action Agenda, published by ICIC in partnership with CEOs for Cities in 2002, was the first comprehensive examination of how urban universities could utilize a strategic framework to improve decaying urban cores. The ICIC’s action agenda appealed to universities to look beyond the edges of their campuses and engage the community.¹⁴

Universities have proven receptive to initiating steps toward a comprehensive approach of fulfilling an “anchor” role, and subsequent academic work has expanded this discussion to the health sector. In 2006, Community-Campus Partnerships for Health helped connect these two ambits by adapting ICIC’s 2002 framework to health institutions

EDS AND MEDS JOBS IN TOP 10 FIRMS



Source: Ira Harkavy and Harmon Zuckerman, *Eds and Meds: Cities’ Hidden Assets*, Washington, D.C.: The Brookings Institution Center on Urban and Metropolitan Policy, September 1999, 5..

and identifying promising practices in the field. Authors Jen Kauper-Brown and Sarena D. Seifer offered an evolved strategic framework, which includes the role of a health system in improving the quality of life locally through its capacity as a community or neighborhood developer. This approach built upon the ICIC's earlier work, which implied the possibility of community development activities but did not explicitly focus on them.¹⁵ As the possibilities for anchor institutions to transform communities becomes increasingly clear, an increasing number of not-for-profit hospitals are acting as important catalysts for neighborhood revitalization.

SCALE, SCOPE, AND IMPACT OF THE HOSPITAL SECTOR

Collectively, hospitals have become one of the largest industries in the United States. There are nearly 5,000 non-federal, short-term, general, and other specialty hospitals, which the American Hospital Association typically refers to as “community hospitals.” They include not-for-profit, for-profit, and state and local government institutions. Community hospitals are the second-largest source of private-sector jobs, employing more than 5.4 million people in the United States—an increase of 25 percent (nearly 1.1 million jobs) since 1993. In 2009, hospitals spent approximately \$342 billion on goods and services alone. During that year, they also added 24,000 jobs per month, even as the nation continued to suffer from the effects of the worst economic recession since the Great Depression.¹⁶

The not-for-profit hospital is the cornerstone of the American hospital system. More than 2,900 community hospitals are not-for-profit institutions, comprising 58 percent of all community hospitals. Additionally, not-for-profit hospitals maintain significantly more beds relative to their state, local, and for-profit counterparts: nearly 70 percent of all available beds in the nation. Geographically, nonprofit hospitals are most greatly concentrated in New England, the mid-Atlantic, and the East North Central states of Illinois, Indiana, Michigan, Ohio, and Wisconsin; however, they operate in every state in the nation. The same cannot be said for state and local government and for-profit hospitals.¹⁷

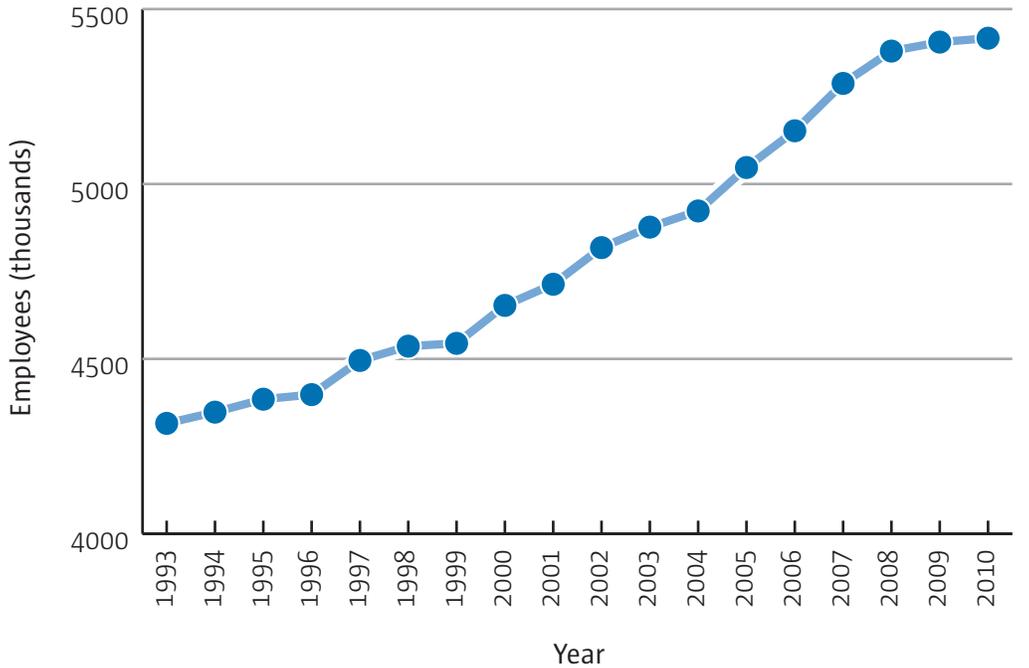
Another lens for viewing the economic impact of hospitals is through national health expenditures, which topped 18 percent of U.S. gross domestic product (GDP), or \$2.74 trillion, in 2011. Hospital expenditures represent nearly one-third of this spending and grew the most rapidly of any healthcare cost over the 12-month period ending July 2011. Total health spending jumped nearly two percentage points of GDP from the start of the recession in December 2007 and has climbed from just 7.1 percent of GDP in the 1970s. While healthcare expenditures have increased rapidly historically, this most recent spike is “largely attributable to slow GDP growth rather than high health spending growth,” according to Charles Roehrig et al., at the Altarum Institute, reflecting the recession-resistant nature of the industry. As the U.S. economy continues to

sputter, health expenditures as a percentage of GDP may rise even faster than originally forecast.¹⁸

At a local impact level, hospitals have an important economic presence in rural communities. The 21st century has seen the birth of the “hospital town,” with rural hospitals often the principal employers. Forty percent of all community hospitals are still situated in rural areas. Whereas the customer base for urban hospitals is often from outside the immediate urban area, rural hospitals primarily serve their local region. Even so, the revenue supporting rural hospitals often originates outside the region – with Medicare and Medicaid providing important resources. As Kauper-Brown and Seifer noted, as a result, “the presence of a hospital in a rural community increases the attractiveness of the community for residents and businesses, thus indirectly affecting the overall level of community economic activity.”¹⁹

Within urban communities, hospitals have a significant economic impact too. According to Guian McKee, an associate professor of public policy at the University of Virginia,

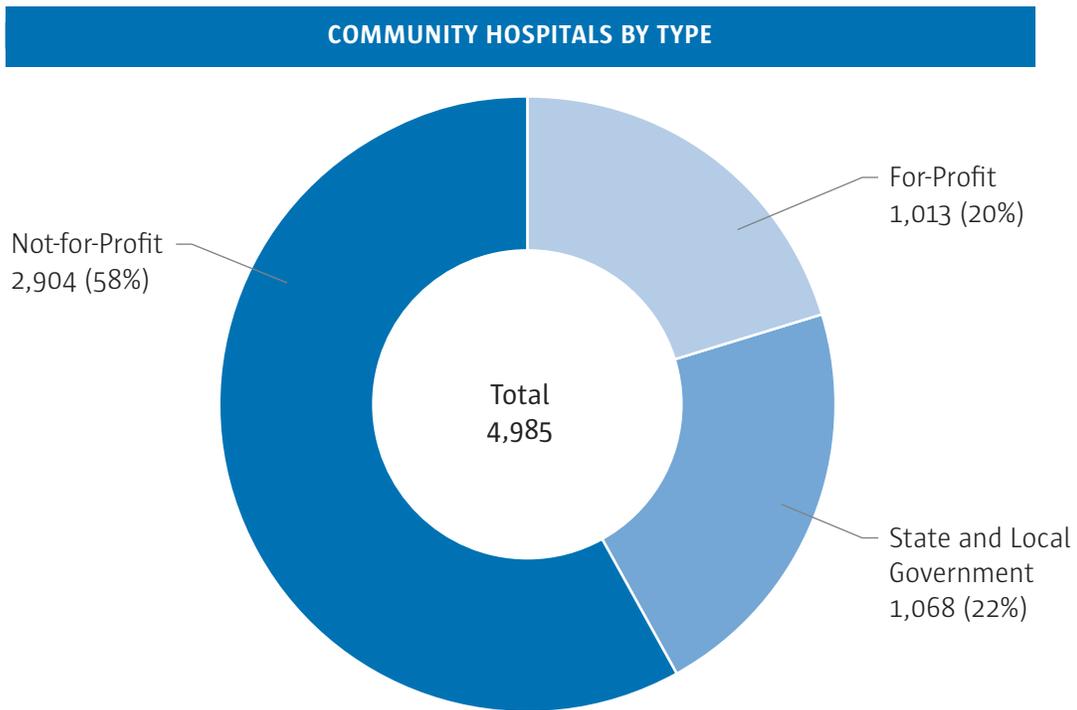
FULL- AND PART-TIME HOSPITAL EMPLOYEES



Source: AvalereHealth analysis of American Hospital Association Annual Survey data, 2010, for community hospitals. Data for Chart 6.2.

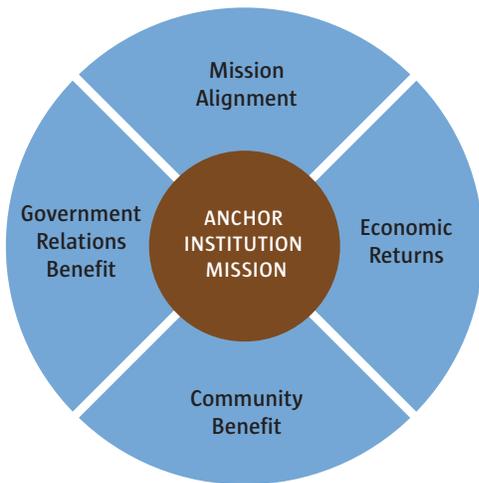
“hospitals play a particularly critical role” in the nation’s “high poverty” cities. For the 26 major cities (population of 250,000 or greater) with the highest poverty rates in 2007, hospitals were the largest employers in five of the ten poorest cities and in eight overall. Hospitals ranked among the top five largest employers in 25 of the 26 cities. Furthermore, McKee noted that these rankings “actually understate the centrality of hospital-related employment” because they did not include employment in the category of ambulatory health-care services, which includes outpatient clinics and surgery centers – businesses that are often linked to specific health systems. Including this category, the health-care sector then ranked as the largest employer in 21 of 26 “high-poverty” cities in 2007.²⁰

Hospitals are often proximate to these communities in need. In 2011, ICIC reported that America’s “inner cities” are home to 350 hospitals, or approximately one in 15 of the nation’s largest hospitals. These hospitals combine to spend more than \$130 billion annually. Even as cities face unprecedented economic challenges including high unemployment and a wave of home foreclosures, many anchor institutions remain economically strong. This disparity in economic circumstances often contributes to neighborhood resentment and the belief that these institutions are not vital to the “local economic fabric.”²¹



Source: American Hospital Association, *Fast Fact on US Hospitals*, Chicago, IL: American Hospital Association, Jan 3 2012, 1.

EMBRACING AN ANCHOR INSTITUTION MISSION



Of course, notwithstanding neighborhood resentment, health systems in these communities play a critical economic role. However, the sentiment from many of these institutions is that they have done their “civic part” simply by virtue of serving as the area’s largest employer, reinforcing the disconnect between the community and institution.²² Yet, as many of the health systems identified in this report have recognized, the vitality of the community and hospital are not mutually exclusive. Consequently, an anchor institution mission that seeks to utilize hospital economic and human capital to revitalize local communities 1) aligns with a hospital’s mission, 2) generates economic returns to both the community and institution, 3) helps satisfy its community benefit requirements to the federal

government, and 4) provides an opportunity for a hospital to justify its tax exemption and reduce its financial burden to local governments.



MISSION ALIGNMENT

In our research, the most commonly cited reason for a hospital’s embrace of an anchor institution strategy is that it is not only compatible with, but necessary for the institution to realize its mission of promoting the health of the community it serves. With increasing frequency, hospitals recognize that socioeconomic problems and environmental hazards affect their operations and that addressing these social determinants aligns with their institutional mission. Bon Secours Baltimore’s CEO Dr. Samuel L. Ross, explained it this way: “People are doing more and more [community development] because the realization is we can’t improve health just sitting around in the walls of the hospital. . . . If we really want to improve health, we have to go further upstream.”²³

One community engagement strategy that many hospitals have already begun to embrace is community-based participatory research (CBPR). In this strategy, health practitioners partner with community members to address community health needs by co-developing solutions that are “acceptable” and “feasible” for the community to adopt. CBPR’s focus on both environmental hazards, as well as the social inequities that exacerbate them, is helping illustrate more clearly how social determinants affect public health.²⁴

Similarly, anchor institution investments represent another strategy to promote health and wellness by reducing social barriers and environmental hazards in the community. Examples range from direct linkages such as helping build or finance a grocery store in

a food desert and providing access to healthy food at reasonable prices, to indirect linkages, such as promoting a high degree of local ownership, as counties with successful small business sectors have lower rates of mortality, obesity, and diabetes.²⁵ A hospital's decision to leverage its resources to target specific social determinants of health, such as access to safe, affordable housing; educational, economic, and employment opportunities; healthy food options; inexpensive transportation methods; and other socioeconomic and environmental challenges is just as important as addressing the issue of healthcare access for low-income populations. An anchor institution strategy involves addressing the root causes of poor health and not just the symptoms.

In a 2002 *Health Affairs* article, researchers from the Robert Wood Johnson Foundation found that 60 percent of premature deaths could be linked to social circumstances, environmental conditions, and behavioral patterns whereas only 10 percent could be linked to inadequate access to healthcare. By contrast, they found that approximately 95 percent of all U.S. health expenditures are spent on direct medical services, leaving only about five percent for broader population-wide public health improvement. Although healthcare spending has more than doubled in the past fifteen years, the ratio of health expenditures remains almost exactly the same today — hospitals are still focused overwhelmingly on direct medical care.²⁶

This reactive strategy has had dramatic economic and health repercussions. Just examining the impact of one major health problem — the obesity epidemic — it becomes clear how social determinants are crucial to people's health and the types of health problems hospitals treat as a consequence. We can begin to see why some of the hospitals highlighted in the best practices and case studies section have adopted anchor strategy approaches to health improvement. Anthony Iton, MD, JD, MPH, and Senior Vice President of Healthy Communities at the California Endowment, noted in the documentary *Weight of the Nation* that currently, “We are living in somewhat of a damage-control mode, where we are waiting for people to get sick, hospitalized — diabetes, stroke, cancer. And we're investing enormous amount of money in trying to mitigate the chronic disease state. That's a huge drag on our economy.”²⁷

A recent Centers for Disease Control and Prevention (CDC) survey shows that more than two-thirds of adult Americans are overweight and more than a third are obese. Health issues stemming from obesity affect every part of the body and contribute to: diabetes, hypertension, gall bladder disease, liver disease, kidney disease, blindness, foot infections, asthma, arthritis, and many other health ailments. Annually, seven out of every 10 deaths are a consequence of chronic conditions.²⁸

Disproportionately, these impacts are felt in impoverished communities. Explained Iton, “The rates of chronic disease are much higher in low-income communities and the rates of obesity-related chronic disease are much higher. . . Being poor doesn't just mean that you don't have enough money, it means that you are also going to be exposed to influences and forces that are bad for your health.” A correlation can be seen at a

macro level too: of the 10 states with the highest obesity rates, nine rank among the nation’s poorest.²⁹

Obesity is just one example. Organizations committed to promoting public health, like the Robert Wood Johnson Foundation, have been leaders in demonstrating how socioeconomic circumstances and health issues are linked in many other ways. Citing multiple studies, Dr. Rosalind J. Wright of Beth Israel Deaconess Medical Center noted examples of this connection, including “the effects of income inequality on mortality, the links between residential segregation and black infant mortality, and the impact of neighborhood deprivation on coronary risk factors, low birth weight, homicide, morbidity as well as all-cause mortality in certain communities.”³⁰

Access to medical care is important, but so is changing the built environment—or any environmental aspect modified by human activity—so that it is more conducive to healthy outcomes. Health outcomes are inherently place-based. Often cited by public health and healthcare practitioners alike, a person’s zip code is a greater determinant of one’s life expectancy than her or his genetic code. A successful anchor institution strategy requires that a hospital recognize that its institution’s mission to promote health and well-being is as much for the patient who walks through the door as for the one who would have if a community intervention had not been made. A vibrant, stable neighborhood with locally owned businesses; safe, affordable housing options; healthy food access; and a community fabric that incorporates sustainable transportation options is also a healthier one.³¹



ECONOMIC RETURNS

A hospital’s mission can be a powerful motivator for action. But tight margins can easily restrict its ability to realize that mission. In order for a hospital to embrace a comprehensive anchor institution strategy, there must exist a mutual benefit to hospital and community.³² Hospitals that have begun to change their practices are recognizing the economic advantages they gain from such a strategy. Clearly, not every investment has a short-term return—and some may be viewed more appropriately through a community-benefit lens—but hospitals should not view all anchor strategy investments from a charity perspective. In fact, health systems can create an economic advantage from an anchor strategy, including, but not limited to “increased demand for their products and services, more success in hiring and retention and the ability to leverage private money.”³³

Some hospitals are reevaluating their upstream interventions because of the staggering health effects of certain chronic conditions like obesity and diabetes that are heavily influenced by social factors. However, another reason hospitals located in low-income communities are reassessing their health strategies is because of the tremendous costs to provide continuing care for these individuals—especially for those

who cannot pay. In *Weight of the Nation*, Thomas Frieden, MD, MPH, Director for the CDC, explained, “Someone who is obese, on average, costs more than \$1,400 to care for more per year than someone who is not obese. Someone with diabetes on average, [costs] \$6,600 more to care for per year than someone without diabetes. Collectively, obesity costs about \$150 billion a year.” In total, 75 percent of total U.S. health spending goes toward treating chronic conditions. These conditions are expensive and are the consequence of factors outside a hospital’s walls; in this situation, upstream interventions help alleviate downstream costs.³⁴

There are other bottom-line reasons to considering an anchor strategy. To date, the solution to those who could not afford medical treatment was to write off this cost as charity care. This solution encourages low-income individuals to seek treatment at the most expensive point in the healthcare system. At the same time, charity care still consumes the bulk of a hospital’s community benefit activities. Consequently, this tradeoff, which is needed to ensure low-income people receive some level of healthcare, is a lose-lose situation: it exacerbates healthcare costs especially for those institutions situated in communities with high levels of uninsured residents and fails to create any sustainable solution for those who have no health insurance. Community health centers reduce some of the burden on hospitals, providing a lower-cost solution to treatment with some including a focus on social determinants. Still, these centers cannot fully address the vast number of people outside the health insurance system.³⁵

In contrast, an anchor strategy that addresses the socioeconomic barriers in the community helps residents within their service area achieve the economic security required to afford health insurance. The economic inclusion part of the Greater University Circle Initiative in Cleveland, Ohio—supported primarily by the Cleveland Foundation, Cleveland Clinic, University Hospitals and Case Western Reserve University—has helped establish worker-owned businesses that hire from the local service area. In addition to providing a living wage and an opportunity to build assets through profit sharing, these new businesses provide no-cost health insurance for their employees.

Other hospital systems, such as the urban, not-for-profit Partners HealthCare in Boston, Massachusetts, and the rural, public Wrangell Medical Center in Wrangell, Alaska, have adopted separate but similarly focused economic inclusion initiatives by training and employing local residents. Not only do these strategies enable low-income individuals to secure health insurance, but these programs also help meet the workforce needs of these institutions in a targeted and strategic way. In 2006, *New York Times* columnist Bob Herbert described Partners HealthCare effort: “There are good jobs with good benefits at Brigham and Women’s. If a substantial number of those jobs could go to residents in the struggling Boston neighborhood, the benefits would spread throughout the area, like a cool front on a muggy summer afternoon. All parties would benefit.”³⁶

A focus on procuring from local and minority suppliers is another way to leverage a hospital's resources to benefit the bottom line. A hospital's economic impact can be magnified when even a small portion of its procurement is concentrated in the institution's service area. According to the American Hospital Association, each hospital job and dollar spent supports approximately two additional jobs and \$2.30 of additional business activity outside the institution's walls. Profiled in greater depth in Section Three, hospitals are recognizing that purchasing from minority vendors means building capacity in the local community, creating jobs, and helping increase the number of people with health insurance. LeeMichael McLean, Director of Business Development and Networks for the New England Region for VHA, Inc., remarked, "I have no question that people understand" this argument.³⁷

However, he cautioned that this reason alone would not be a strong enough reason to persuade hospitals to source locally and from minority-owned suppliers if these businesses were not also market competitive. McLean explained why these businesses tend to be competitive. "Oftentimes, [minority- and women-owned businesses] can be more nimble than a large business. Oftentimes, they are producing those goods locally. So they could retool more easily than a large multinational." Additionally, hospitals often lack the knowledge of what businesses even exist in their community. Through helping co-develop local businesses, University Hospitals and Cleveland Clinic are also using their purchasing power to not only benefit the local community but to fill gaps in their supply chains.³⁸

Hospitals also recognize the potential for an anchor strategy to help their institution attract and retain employees. Young employees today want to live closer to work and are becoming increasingly concerned with a hospital's approach to community and the environment. Bon Secours Baltimore and St. Mary's Health System in Levinston, Maine implemented neighborhood revitalization strategies partially because the physical condition of the surrounding community was negatively impacting employee recruitment efforts. On the other hand, Mayo Clinic in the 1990s faced an affordable housing crisis that was driving away new employees, compelling them to help finance a community land trust that created a permanent stock of affordable housing. Other hospitals offer employer-assisted housing programs, helping revitalize an impacted neighborhood while enabling new employees to become invested in the institution and community. Henry Ford and Detroit Medical Center provide financial assistance for potential homeowners and renters seeking to live in Midtown Detroit, while St. Joseph's Health System in Syracuse, New York; Cleveland Clinic; and University Hospitals offer guaranteed mortgage programs to help eliminate certain costs associated with home ownership.³⁹

An anchor institution strategy can also benefit a hospital's bottom line by helping attract new customers. As some hospitals seek to transform themselves into "destination medical centers" for customers from across the world, and as domestic medical tourism increases, the community in which a hospital is located will play an increasingly important role in attracting new patients. Cleveland Clinic and Mayo Clinic are

both health systems that have recognized this shifting reality. As a result, the market has helped influence their decisions on how to participate in neighborhood revitalization efforts.⁴⁰

Hospitals leaders recognize that just as it is difficult to see the immediate benefits of a community building strategy on health outcomes, it is also not always possible to see its immediate benefits on the financial returns of a hospital's balance sheet. There are many different strategies—as purchaser, investor, capacity builder, and community developer—that an institution can use to deploy its resources to promote community revitalization. In the words of Michael Porter of Harvard Business School, each option provides separate opportunities for “shared value.”⁴¹ Anchors can also embrace multiple strategies simultaneously and magnify their impact, as profiled in the case studies in Section Four.



COMMUNITY BENEFIT REQUIREMENTS

Even if mission- and margin-related reasons do not motivate a not-for-profit hospital to adopt an anchor institution strategy, new federal requirements for community health needs assessments under the 2010 Affordable Care Act and for community benefit reporting by the IRS may provide the necessary impetus. These requirements are still subject to further revision by the IRS, but changes in early 2012 now allow for a not-for-profit hospital to use anchor and community-building strategies to help satisfy its obligation to meet the health needs of its community. Hospitals should recognize that these new requirements help provide a connecting piece between mission- and margin-related reasons for adopting an anchor institution strategy, permitting the development of strategic plans to address community health needs. These changes also offer these institutions a new opportunity to engage local stakeholders and repair strained community relations that often exist between them.

The first decade of the 21st century brought renewed scrutiny from the federal government regarding whether not-for-profit hospitals were contributing their fair share to the community, in exchange for the generous tax subsidies they were receiving. A December 2006 report by the Congressional Budget Office estimated that not-for-profit hospitals received \$12.6 billion in annual tax exemptions and the entire hospital industry received \$32 billion in federal, state, and local subsidies annually. Historically, not-for-profit hospitals have often not helped matters by implementing sometimes zealous efforts to avoid treating unprofitable patients (explored in more detail in Section Two) and by overestimating their community benefit. For instance, prior to the new IRS requirements, one health system was counting its entire payroll, including its six- and seven-figure compensation to senior administrators, as part of the community benefit it reported annually. Although this type of reporting was an outlier, hospitals more commonly reported charity care based on charges, instead of at cost, and included bad

debt and Medicare shortfall in their community benefit calculations—all of which can no longer be counted as community benefit under new reporting requirements.⁴²

Clearly, serious financial barriers prevent some hospitals from expanding their community benefit and community building activities. For example, 23 percent of not-for-profit hospitals in 2006 were in the red. However, not-for-profit hospitals have been more financially stable during this last decade than any time in their history. Profits are robust. The combined net income of the 50 largest not-for-profit hospitals increased more than eight-fold to \$4.27 billion between 2001 and 2006. In 2008, the *Wall Street Journal* noted that *more* not-for-profit hospitals were profitable than their for-profit counterparts (77 percent versus 61 percent).⁴³

The culmination of this tension between record earnings and a valuable tax exemption has compelled the federal government to reevaluate hospitals' community benefit obligations. In 2008, the IRS decided to take a wait-and-see approach, deferring to advocates within the health field instead of legislators who wished to see a mandatory charity-care threshold for hospitals. Consequently, hospitals have been granted flexibility in how they target their community benefit activities but also must demonstrate to the IRS that hospitals are committed to earning their not-for-profit designation. As part of their Form 990 annual filings, not-for-profit hospitals must now prepare a Schedule H form, which is intended to create transparency regarding hospitals' community benefit activities while maintaining the expansive frame of the IRS's community benefit standard, first established in 1969.⁴⁴

The IRS's goal is to enable a thorough review of the community benefit standard through increased standardization. Surveying more than 500 hospitals in 2006–2007, the IRS discovered that hospitals had widely different criteria for what constituted "community benefit." On average, hospitals reported that community benefit expenditures represented nine percent of total revenues; the median was six percent. Uncompensated care represented more than 50 percent of those expenditures. Excluding the 15 leading research hospitals in this study, uncompensated care amounted to 71 percent of all community benefit activities. However, it is highly probable that these self-reported numbers overstated hospitals' actual community benefit, because, as noted above, Schedule H did not permit hospitals to include certain costs as community benefit, noted Stephen Miller, then IRS Commissioner of Tax Exempt and Government Entities, in remarks before the Attorney General of Texas in 2009.⁴⁵

Since these new requirements have been implemented, a key question has been what is the role of community building in community benefit reporting. Community building activities, which align with the strategies and goals of an anchor institution mission, are "those activities that get at the root cause of health problems," noted Julie Trochio, Senior Director of Community Benefit and Continuing Care at the Catholic Health Association. These activities aim to address social determinants such as housing, economic development, environmental improvements, workforce development, capacity

building, and coalition building. Schedule H, which was originally adapted from the Catholic Health Association’s own guidance for community benefit reporting, included one notable change: the draft version did not include a community building category. After advocates petitioned strongly, the finalized version of Schedule H did include community building—but as a separate “Community Building Activities” section, reported in Part II.⁴⁶

This change has had important consequences, creating confusion on how community building counts toward a hospital’s community benefit activities, which in addition to charity care, includes unreimbursed Medicaid and other government means-tested programs, community health improvement services, community benefit operations, health-professions education, subsidized health services, research, and cash and in-kind contributions. Put another way, the IRS limited community benefits to those activities that had traditionally been understood as directly promoting, or improving, individual or community health. In contrast, community building activities address the health and well-being of a community indirectly, reducing or eliminating environmental hazards and social barriers. Consequently, the IRS has been hesitant to allow community building to count as a community benefit because of this limited “direct connection,” requiring hospitals to explain the link between this type of intervention and the health of the community in Part VI of Schedule H. The IRS’s position on community building has contrasted with the view of nearly the entire not-for-profit hospital sector, which considers community building as an important component of community benefit activities.⁴⁷

After several years of discussion between the IRS and hospital and healthcare advocates, such as Catholic Health Association, Community Catalyst, and Healthcare Without Harm, the IRS issued limited but important changes in Schedule H instructions in February 2012. According to the revised instructions for the 2011 Schedule H, “some community building activities may also meet the definition of community benefit” and be listed under the community health improvement services category in Part I.⁴⁸ This change is significant because it now allows hospitals to embrace community building *if* they effectively make the case for it.

Although technical, it is important to understand how the definitions of certain terms connect to create this opportunity. In order to be included as a community health improvement service, an activity must 1) be carried out or supported for the purpose of improving community health or safety; 2) be subsidized by the organization; 3) not generate an inpatient or outpatient bill; 4) not be provided primarily for marketing purposes; 5) not be more beneficial to the organization than to the community; 6) not be required for licensure or accreditation; 7) not be restricted to individuals affiliated with the organization (e.g. employees and physicians); 8) meet at least one community benefit objective, including improving access to health services, enhancing public health, advancing generalizable knowledge, and relief of government burden; and 9) respond to a demonstrated community need.⁴⁹

If a community building activity satisfies the above criteria, it can count toward community benefit in Part I. All of the above requirements are relatively straightforward to interpret with the exception of how a hospital can show it is addressing a “demonstrated community need.” Schedule H instructions specify three ways that an activity can qualify as a community need: 1) if it is identified by a community health needs assessment completed by the hospital (now required by the 2010 Affordable Care Act); 2) if the hospital can provide documentation that a government or another nonprofit organization requested it to initiate or continue addressing a specific need; or, 3) if government agencies or “unrelated” nonprofits are partnered with the hospital in addressing the need.⁵⁰ Therefore, allowing certain community building activities to count as community health improvement services is critical because many of the best practices (or components thereof) highlighted in the report would meet one of these three criteria and the other requirements for a community health needs improvement.

As Professor Sara Rosenbaum of George Washington University’s School of Public Health and Health Services pointed out, “The IRS is looking for evidence that someone has thought about this, not a dissertation.” In other words, hospitals just need to highlight existing, reputable research on how their community building activities count as a community health improvement services—and there is no shortage of research showing these connections. Rosenbaum suggested utilizing government publications to rationalize hospital activities, such as the U.S. Department of Health and Human Services’ *National Prevention Strategy* or the CDC’s *Guide to Community Preventive Services*. Rosenbaum added, “If the CDC has done this, then that should be good enough for the IRS.” Ultimately, this broader change in the instructions also illustrates how Schedule H is continually evolving, as the IRS tries to determine what constitutes the correct balance of expenditures for hospitals to report.⁵¹

In addition to the above requirements, the Affordable Care Act also requires *each* hospital facility of a not-for-profit health system to complete a community health needs assessment at least once every three years, beginning in the taxable year after March 23, 2012. These needs assessments should include input from “persons who represent the broad interests” of the community. In a written report, a hospital must detail, among other stipulations, a “prioritized description of all” identified needs along with a “description of the process and criteria used in prioritizing such health needs.” Ideally, the priority of such needs should be a subject of community input. This report must also be made “widely available,” which means it must be posted on the institution’s website. Additionally, each hospital must report how it will address the needs identified in new questions added to Schedule H, including attaching its most recent implementation strategy and an explanation for why a hospital facility intends not to address certain needs. Failure to comply with these reporting requirements results in a \$50,000 excise tax penalty for each non-compliant facility and, more significantly, may risk an institution’s tax-exempt status.⁵²

The community health needs assessment provides an opportunity for a hospital to embrace an anchor strategy for two reasons. First, community health needs can be broadly interpreted; often, communities do not view the absence of disease but rather specific social determinants of health as their top health priorities. Hospitals should use this opportunity to expand the conversation on health needs so that the assessment captures the full range and diversity of social determinants of health. Hospitals should see this as an opportunity to solicit resident—along with community health center and public health organization—input, *and* as a starting point to rebuild strained community relationships that often exist with organizations and communities that feel ignored and overlooked by their local hospitals. Since health needs identified by this assessment qualify as a “demonstrated community need,” hospitals have additional incentive to examine community building activities that can satisfy both an assessment’s implementation strategy as well as the hospital’s community benefit requirements.

Second, each hospital facility is required to do an assessment of its community.⁵³ As hospitals have merged together into large health systems, there has been concern that individual hospitals have become even more disconnected from the health priorities of their communities. Granted, the IRS has made allowances for hospitals that serve the same community to coordinate their efforts to complete a needs assessment. However, ultimately, the community health needs assessment compels each hospital, regardless of the size and geographic dispersion of the health system, to reexamine the needs of the community it serves.

University Hospitals in Cleveland provides one example—it identified poor community safety, high rates of unemployment and financial hardship, low educational achievement, and lack of family and social support as primary community health needs and is targeting them as part of the hospital’s community benefit program. The institution cites its financial commitment to funding the Evergreen Cooperatives that employ local residents and its financial contribution to the NewBridge Cleveland Center for Arts & Technology to educate unemployed adults as different community benefit initiatives it has undertaken and as strategies for addressing these core community problems.⁵⁴

A second example is Community Health Network, a not-for-profit health system located in Central Indiana with more than 11,000 employees, which actively assesses whether its community benefit programs address social determinants of health. In Community’s 2010 Schedule H, it described its participation in the local and surrounding counties’ community health needs assessment in 1996 as the beginning of its “journey into the social determinants of health.” In the assessment, residents responded to the question of what a healthy community looked like to them. They answered, “clean and safe streets, NOT the absence of disease.”⁵⁵

In adapting its approach to community benefits to meet this new understanding of community need, Community Health Network evaluates each of its initiatives based on

five categories “that reflect how we address the factors impacting the health of those whom we serve:” cultural impact, economic stabilization, education support, health-care, and social protection. The result is that Community has implemented a variety of programs to address community need, including helping fund a matched-savings account program to assist residents to build assets, rehabilitating community housing, providing affordable homeownership opportunities, financing grant-supported streetscape and pedestrian improvements, and addressing food-scarcity issues through financially underwriting a Community Supported Agriculture (CSA) program and a new food cooperative.⁵⁶

The federal government is asking for more from not-for-profit hospitals. No longer is the vague “promotion of health” itself enough for a hospital to enjoy tax-exempt status. At the same time, the federal government is giving hospitals an opportunity to embrace an anchor institution mission with limited risk. The initial investments of human and financial resources required to implement anchor strategies are in essence down payments on the long-term financial benefit (either until that investment breaks even or creates savings) a hospital receives from a healthier and more stable community. As Jessica Curtis, Project Director for Community Catalyst’s Hospital Accountability Project, noted, “The community benefit write-off allows hospitals to take on some risk in a planned way.”⁵⁷

Additionally, hospitals have a natural opening to reengage their local communities, beginning a constructive, on-going relationship and helping to alleviate the mistrust that currently exists for many residents living nearby these institutions. With the Affordable Care Act now upheld, the next few years will prove pivotal for hospitals to demonstrate their impact in the community. The combination of Schedule H and the requirements under the Affordable Care Act give hospitals a framework to demonstrate that they can better deploy scarce resources and respond to the needs of their communities than the federal government could if it received those tax-exempt dollars instead.



IMPROVING RELATIONSHIPS WITH STATE AND LOCAL GOVERNMENT

States and local governments have also asked more from not-for-profit hospitals as public resources have become increasingly scarce. States seeking more comprehensive answers have adopted their own approaches to community benefits, with a wave of changes occurring during the 1990s. In addition, local governments have adopted other approaches to receive greater contributions from nonprofits, including implementing payment-in-lieu-of-taxes (PILOT) programs, working to alter or remove property tax exemptions, or levying fees for specific municipal services.⁵⁸

All of these attempts have one thing in common: cities and states are financially struggling to provide even basic services. Often the perception is that not-for-profit hospitals, which comprise the single largest source of revenues and assets of any

charitable nonprofit, are not doing enough.⁵⁹ As these demands likely increase, they create another opportunity for hospitals to reshape their commitment to their communities in terms of an anchor strategy, collaborating proactively with local governments to increase their financial contributions and impact while maintaining greater control over how those resources are distributed.

Community benefit requirements at the state level tend to differ from those at the federal level, and it is not yet known if or how states will respond to the changed federal framework. As of August 2010, 15 states had laws or regulations regarding community benefit requirements and nine more had linked those requirements to “broader hospital licensure laws, interpretive attorney general guidelines and property tax exemption standards.” All but seven states had implemented either or both mandated and voluntary community benefit reporting requirements. The mandatory community benefit reporting requirements vary widely, while those with voluntary measures tend to closely adhere to the Catholic Health Association and IRS norms.⁶⁰

In contrast to states, local governments and municipalities have most frequently sought greater contributions through PILOT programs, which seek to mitigate a municipality’s loss of property taxes through voluntary payments from tax-exempt institutions. Since 2000, at least 117 municipalities in 18 states have implemented some version of a PILOT program to recoup lost revenue. Since these programs are voluntary, their impact has been mixed. In some situations, when nonprofits have balked at the idea, local governments have reacted by challenging and revoking an organization’s tax-exempt status. Baltimore, Boston, Philadelphia, and Pittsburgh are among the largest cities to implement PILOT programs, with Boston’s program serving as one of the “longest standing” and “most revenue productive” in the country.⁶¹

Boston’s effort to increase contributions from its nonprofit sector provides an interesting example of how a community benefit program can fit within a PILOT framework. In Fiscal Year (FY) 2009, Boston received nearly \$16 million in PILOTs, including more than \$1 million in individual contributions from Massachusetts General Hospital, Brigham and Women’s Hospital, and Tufts Medical Center. Still, these contributions from hospitals amounted to less than 10 percent of their tax obligation if they were not exempt, and the city continues to push for a greater commitment. Importantly, the program allows for community benefits to offset a portion of its PILOT obligation, providing an opportunity for an anchor institution to utilize its resources more strategically to have a community impact more aligned with the institution’s mission.⁶²

These challenges to not-for-profit hospitals are unlikely to abate in the coming years. Despite Boston’s success, legislators in the community continue to petition the state for taxing authority on nonprofit institutions. Another example is Provena Covenant Medical Center in Illinois, which lost its property tax exemption after the Champaign County Board of Review challenged the hospital based on its debt collection practices and the amount of charity care it provided. The Illinois Department of Revenue revoked the

exemption and, in 2010, the state’s Supreme Court upheld the decision.⁶³ The continued push by state and local governments for not-for-profit hospitals to contribute more financially to their surrounding communities is one last reason why these institutions stand to gain from approaching their community benefit activities from a community building and anchor framework. An engaged hospital can more effectively accomplish its mission, improve its bottom line and meet its federal, state, and local community benefit obligations by adopting strategies to spur neighborhood revitalization.



In 2010, The Democracy Collaborative published *The Road Half Traveled: University Engagement at a Crossroads*, a study that examined ten universities’ anchor strategies and their efforts to incorporate economic inclusion practices and “contribute to building individual and community wealth in distressed and underserved neighborhoods.” Authors Rita Axelroth Hodges and Steve Dubb noted that the scale of these institutions means that they have an impact on local economic development, “whether positively or negatively, intentionally or unintentionally;” the same is equally true for hospitals. A hospital’s decision to embrace its anchor institution mission—altering its behavior as a purchaser, investor, capacity builder, and community developer—could positively impact the physical condition of a community, but it could also negatively impact the long-term condition of low-income and diverse residents as rising property values or increased rental values push them out of the community.⁶⁴

Toward this end, Axelroth Hodges and Dubb noted, if an anchor institution does not actively pursue strategies “to maintain a mixed-income neighborhood (through such means as inclusionary zoning, community land trusts and/or a broader policy commitment to mixed-income development), anchor institution strategies bear the risk of promoting, albeit without intending to, gentrification and less diverse communities.”⁶⁵ In the following sections, this work will explore some of the anchor strategies hospitals have begun to use in their communities. None have fully achieved an anchor institution mission. Nonetheless, their accomplishments and limitations provide lessons and a framework for understanding the role of not-for-profit hospitals in low-income communities across the nation.

Section Two

The American Hospital—a Private Institution with a Public Mission

[Public health] is an area where hospitals, as visible community organizations, could exert effective moral leadership in the next decades. The tensions of the concept of the hospital as charity and business have never been more visible.

■ Dr. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*⁶⁶

THE BIRTH OF THE AMERICAN HOSPITAL

At the core of the American hospital system is the not-for-profit hospital, categorized as voluntary or nonprofit based on era. It has been defined by the notion of “voluntarism” and its ability to straddle the line between a public mission and private ownership. In turn, federal; state and local; and proprietary, for-profit hospitals all exist in orbit around the voluntary hospital and the role it has assumed in the American healthcare system. This delicate balance reflects the American preference to seek private solutions to public problems, and speaks to the not-for-profit hospital’s ability to adapt in periods when the public has demanded more of it as a social institution—providing care for those without—and in eras of increased focus on market efficiency and the financial bottom line. Today’s calls for an increased role in providing “community benefits” to justify the hospitals’ tax-exempt status have emerged in a period of record profits for some of the country’s largest health systems.⁶⁷

Here we do not seek to provide a comprehensive history of the American hospital system. Rather, our focus is on the appropriate role of the hospital as an anchor institution and community builder. Naturally, the history of how voluntary hospitals have interacted with their communities and how they have justified their preferred, tax-exempt status is an important factor in understanding this broader question. Furthermore, an examination of this history helps illustrate the roots of the public’s current expectations for

THE AMERICAN HOSPITAL: A TIMELINE OF KEY EVENTS

- 1894** Wilson-Gorman Tariff Act marks first attempt to create tax exemption for “charitable purposes.”
- 1921** National Hospital Day established, illustrating the hospital’s rapid evolution as a community institution.
- 1934** American Medical Association’s Council on Medication and Hospitals revises how it classifies hospitals, officially creating the nonprofit hospital sector.
- 1946** Hill-Burton Act provides the first large-scale federal financing of private, nonprofit hospitals.
- 1956** IRS revenue ruling requires nonprofit hospitals to provide charity care to maintain their tax-exempt status.
- 1965** Medicare and Medicaid enacted.
- 1965** Federal government’s Office of Economic Opportunity establishes first community health center.
- 1969** IRS issues Revenue Ruling 69-545, revising 1956 provision and establishing community benefit standard for nonprofit hospitals.
- 1970s** American Hospital Association reclassifies nonprofit hospitals as not-for-profit.
- 1974** Amendments to 1947 Taft-Hartley Act allow workers at not-for-profit hospitals to unionize.
- 1983** Participation in Social Security becomes mandatory for not-for-profit hospitals.
- 1989** Catholic Health Association publishes its first community benefit form, which provides template for Schedule H 20 years later.
- 2008** IRS makes first significant revision to Form 990 since 1979, adding Schedule H requirement for hospitals.
- 2009** Hospitals are required to complete Schedule H for the first time.
- 2010** Affordable Care Act passes. Section 9007 requires each not-for-profit hospital to complete a community health needs assessment every three years.

hospitals, particularly with regard to the IRS's Schedule H requirement for community benefit. Ever since the first U.S. hospitals were established, the not-for-profit hospital has strived to balance the tension of serving its stated "public" social mission while operating within the market-oriented, for-profit ethos of American society. This tension grew at the beginning of the 20th century, as a fee system became widespread, and peaked at the turn of the millennium, as federal reimbursement and regulatory policy accelerated the creation of a "capitalistic" hospital system in the 1980s and 1990s.⁶⁸

At the turn of the 19th century, most Americans had never heard of a hospital. The most marginalized poor sought care in almshouses while those with any financial means received their care at home. The first hospitals were not founded to provide for either of these segments of society—the former would not have been deemed "worthy" of admittance and that latter would not have wanted to be admitted. Instead philanthropists during this period recognized a moral obligation to create a distinct entity from the almshouse that would meet the needs of the "hard working" and "deserving" poor (overwhelmingly male laborers), sparing them the "humiliating associations and permanent stigma of the almshouse." Out of this need emerged voluntary hospitals, but "social stratification" continues to be a defining characteristic of the American hospital system, determining who receives treatment and where it is received.⁶⁹

Another early trend that defined the American hospital was the heavy focus on the institution's educational function. Over the course of the 19th century, free patients at voluntary hospitals were often treated as "clinical material," subject to invasive and terse treatment from medical students. As late as the beginning of the 20th century, as even fees for poor patients became more common, hospitals would reduce rates or offer free treatment to attract patients for such purposes. Some hospitals even shifted their admission practices, only allowing patients suffering from certain diseases, such as tuberculosis, during the academic year. Today, this trend can still be seen in the disproportionate number of Medicaid patients and minorities who receive care in academic medical centers.⁷⁰

Although hospitals during much of the 19th century primarily served only the needy who were deemed morally deserving, a very small portion of pay- or partial-pay private beds was always an aspect of the American hospital system. Wealthy philanthropists, collections from citizens, localities, or state government would often provide sufficient funds to build and start a hospital. However, their endowments were often too small and government support too infrequent to provide sufficient ongoing support. Author Dr. Charles E. Rosenberg summarized it this way: "No American hospital in 1875 had an endowed income sufficient to underwrite the free medical care its community required." Consequently, from the very beginning, hospitals were always in search of operating funds, asking states for additional resources, or soliciting endowments for free beds. This fee facet of the American hospital system was a striking contrast and departure from its English precursor.⁷¹

Although comprising a small portion initially, paying patients would provide an increasingly important source of revenues by the turn of the 20th century. In 1904, non-religious, voluntary hospitals received more than half of their budgets from patient fees, and religious institutions received nearly three-quarters. The American value of a strong work ethic—with charity only to be given to the most needy—contributed to this primary method of funding until the surge in third-party reimbursement after World War II. Even during the Great Depression, voluntary hospitals—both religious and non-religious—received more than two-thirds of their revenue from paying patients.⁷²

Pluralism marks another notable characteristic of the American hospital system, as evidenced by the ethnic, racial, and religious groups who established hospitals at the end of 19th and beginning of the 20th century. Although these hospitals represented an important source of pride for their communities and the ability for them to care for their own, many of these institutions came about in order to protect insular or isolated communities in a diverse nation. For example, many of the religious medical institutions were formed not simply as extensions of the religious order but as a response to the Protestant proselytizing that took place unofficially in voluntary hospitals at the time. Between 1865 and 1885, for instance, the Catholic community opened more than 154 hospitals, doubling the number of Catholic hospitals nationwide. Also during this period, religious and ethnic hospitals departed partially from their acute-care focus to care for elderly patients and other patients with chronic diseases and even treat certain incurable diseases such as tuberculosis and cancer. Although the American hospital system remains pluralistic, federal standardization would effectively blur the distinction between, and reduce the autonomy of, the different types of institutions during the 20th century.⁷³

The American hospital's evolution as a center for acute care has also affected how it viewed its role within the community. Only for a brief period in the middle third of the 19th century did hospitals stray from this primary focus. As improvements in technology and medicine increased the hospital's ability to treat acute conditions at the end of the 19th century, surgical admissions, not medical care, became the norm. A shift away from the hospital as a surgery center only began to occur in the 1990s with the rapid increase in outpatient clinics. However, although chronic conditions are the most common health concerns affecting the population today, hospitals still focus on the acute phases of these conditions, providing “the shortest possible stay and the most intensive treatment.”⁷⁴

This “narrow” view of the hospital's role led to criticism as early as the beginning of the 20th century. However, calls for the hospital to embrace a role as “a center for public education, community health, or social reform” often fell on deaf ears. Historically, these roles and care for the “down-and-out, the incurable, and the chronically sick” were considered the responsibility of the government, not voluntary (and by extension, proprietary) hospitals.⁷⁵

Rosenberg has described this mentality as “inward vision and outward glance.” As Stevens explained, this description highlights the hospital as an institution focused on the “needs and priorities” of its own — doctors, administrators, and trustees — and viewing the patient as simply a “bodily mechanism” instead of as a “social being or family member.” In short, the American hospital system — taken as a whole — most often has been reactive, not proactive, with regard to community and public health. The combination of a focus on acute care, the importance of paying patients, and the acceptance of national goals and standards over time (despite the diversity of origins of each hospital) have had the effect of incentivizing the individual hospital to focus its community outreach “to create good feelings” about the institution rather than “change the community’s health.”⁷⁶

THE VOLUNTARY HOSPITAL AS A “BENEVOLENT” INSTITUTION

The consequences of these characteristics of American hospitals on local communities are important considering the voluntary hospital’s historic designation as a “benevolent” institution, intrinsically endowed with a “public” mission — and the public assistance these institutions have received because of this mission. Early voluntary hospitals do not fit neatly into the category of public or private. Technically private, the “public” mission of the institutions enabled voluntary hospitals to position themselves as unique from for-profit institutions and worthy of special exemptions.⁷⁷

For the first three quarters of the 19th century, the trustees of voluntary hospitals viewed their activities through the lens of serving the community, motivated by the “traditional notions of Christian responsibility and the obligations of class,” according to Rosenberg. As a result of these motivations, it was not unusual for state legislatures to provide monetary assistance to these hospitals. By the turn of the 20th century, nonsectarian, private charitable hospitals received one eighth of their income from local tax subsidies. Sectarian institutions also received subsidies in many cases — 66 hospitals in Pennsylvania in 1919 alone. As Stevens noted, hospitals touted their role as “public institutions.” As long as their “autonomy” was not compromised, hospitals strongly sought subsidies. Today, federal and local governments have begun to demand a “demonstrable quid pro quo,” requiring tangible community benefit to justify government support through tax-exempt status and other subsidies.⁷⁸

Of all the exemptions that not-for-profits petitioned the government for, the main one that remains is their tax exemption. The notion of exempting an organization from taxes because of its “charitable purpose” was first codified into law when the Wilson-Gorman Tariff Act of 1894 established the “first federal peacetime income tax.” Although this Act was later ruled unconstitutional, the “tax exemption” designation has since been an important facet of American society. By 1900, in many states, voluntary hospitals were also exempt from local property taxes. In recent years, the public, policymakers, and even hospitals have generally thought of a hospital’s community

benefit as the dollar amount of free care it provided despite a more expansive community benefit definition since 1969. Even still, the “promotion of health” and “providing health services” alone have often been justified as sufficient enough charitable purposes to justify tax-exempt status.⁷⁹

Voluntary hospitals also benefited from the doctrine of “charitable immunity,” which exempted hospitals from tort liability, or prosecution from harm caused to a patient. Failed court challenges to both the tax-exempt status and tort-liability exemption in the 1920s and 1930s would further solidify the “unspoken assumption” that not-for-profits were inherently “good” and provided better service than for-profit hospitals. This tort-liability exemption existed as late as the 1960s in some states.⁸⁰

Voluntary hospitals also stressed their “public” function to avoid certain labor costs, such as social security requirements and the unionization of their employees. Becoming an organized political bloc in the 1930s, voluntary hospitals aggressively and effectively sought to position themselves as charitable institutions instead of “competitive” industries. As a result, the 1935 Wagner Act and later the 1947 Taft-Hartley Act exempted nonprofit hospitals from the obligation to negotiate with unions. Similarly, the hospital lobby succeeded in exempting nonprofit hospitals from all aspects of the Social Security Act in 1935. As the distinction between not-for-profit hospitals and their for-profit counterparts became less clear, these exemptions disappeared also. Amendments to Taft-Hartley in 1974 ushered in a wave of unionization and participation in Social Security finally became mandatory in 1983.⁸¹

THE GROWTH OF THE AMERICAN HOSPITAL—1880s TO 1929

Between 1880 and the First World War, affluent Americans began to consider hospital care, accelerating the growth of the American hospital system. Wealthier patients recognized the benefits of treatment in hospitals and middle-class Americans were changing their attitudes also. Whereas the first American hospital survey in 1873 only identified 178 hospitals, by 1923, there were nearly 5,000 hospitals across the nation. Despite this growth and excess supply of hospital beds nationwide, more than half of all U.S. counties lacked any type of hospital in the 1920s.⁸²

Increasing demand from middle-class Americans and limited options, as private rooms proved too expensive and care in the hospital’s general wards was not considered respectable, would push hospitals in a consumer-oriented direction. Beginning in 1920s, hospitals “invented” the semi-private room, a middle class staple that still exists today. This era marked an important shift in the American hospital system, as improvements in technology increased hospital costs, as the medical profession’s moral responsibility for providing free care to the “needy” faded, as providing free care increasingly became financially unsustainable, and as hospitals sought to “maximize private patient income.”⁸³

The growing importance of private patient fees in supporting many of the rural, community hospitals was reflected in a large portion of the expansion in the number of U.S. hospitals in this period, especially the early 1920s. However, Stevens noted, “consumerism did not. . .mean the formal growth of hospitals as businesses or the rejection of ‘community’ as a primary theme.” Rural hospitals were important sources of community pride, representing the power of voluntary organization and strength of “community solidarity,” and did not maintain the same poverty stigma associated with urban hospitals. Locally raised capital would prove vital to the rural community hospital movement and “pragmatism in money raising” helped ensure a variety of hospital ownership models: local government (town- and county-owned), nonprofit, proprietary corporations, and physician-owned. An informal national policy, focused on independent local hospitals in contrast to hospital networks or regional systems, solidified during this decade.⁸⁴ In general, the continued need for community financial support in order to maintain operations would compel rural hospitals to adopt many uniform practices before any governmental regulatory standards were ever implemented.⁸⁵

Building on the rapid expansion of the preceding 40 years, the 1920s witnessed even greater economic growth for the American hospital, propelled by successful fund-raising drives and a large number of bequests. In just the five-year period from 1925 to 1929, \$890 million was spent on construction of hospitals and related institutions—a sum that would not be achieved again until the 1950s (adjusting for inflation). By the end of the decade, the hospital industry had already achieved tremendous scale and economic impact in the U.S. economy—second only to iron and steel. Numbering more than 6,700 nationwide (including sanatoria and related institutions) and located in more than 60 percent of all counties, by 1930 hospitals were already the largest employer in many smaller towns and cities.⁸⁶

REDEFINING THE VOLUNTARY HOSPITAL

The Great Depression brought the first systemwide challenge to hospitals in the United States, marking the emergence of a clearly defined nonprofit hospital sector. By 1929, rampant hospital growth and limited systemic planning had created overcapacity, with more than one third of all hospital beds in the U.S. lying vacant. Hospital care was distributed inequitably across social classes, with the wealthy disproportionately using hospital services and beds for non-acute conditions in short supply. Stevens highlighted a “running joke” during the 1920s: “there were two classes of people in hospitals, those who entered poor and those who left poor.”⁸⁷

Through becoming a “well-organized, visible, and coherent” lobbying body during the 1930s, religious, charitable, and nonsectarian nonprofit hospitals recognized their common shared interest, embraced voluntarism, and sought to distinguish themselves from public hospitals and for-profit institutions. The American Medical Association’s Council on Medication and Hospitals aided this cause significantly in 1934, when it

revised how it classified and published its hospital statistics, now highlighting three hospital sectors: government, proprietary, and nonprofit.⁸⁸

The combination of religious and other nonprofit hospitals into one sector solidified the dominance of nonprofits in the hospital industry. The nonprofit sector represented approximately two thirds of all hospitals and admissions (excluding federal hospitals). And despite closures, nonprofit hospitals fared significantly better than proprietary and municipal hospitals during the Great Depression, growing in total value from \$1.2 billion to over \$1.3 billion during the 1930s.⁸⁹

All of this occurred without nonprofit hospitals having to change their behavior or provide any tangible community benefit. On the national stage and before Congress, they effectively positioned themselves as quasi-government, “benevolent” institutions that were not “competitive” and staffed by low-paid workers motivated by the “right values.” Furthermore, they specifically argued that it was not the role of the nonprofit hospital but government to provide for the “indigent,” subsidizing those in need in both voluntary and public institutions. In seeking to protect their income stream, voluntary hospitals also waged a campaign against public hospitals that were beginning to accept paying patients, convincing the California Supreme Court to rule in 1936 that public hospitals had a “different, lesser mission” and could only provide care to “indigent” patients with some minor exceptions for part-pay patients. This ruling, which reduced competition for nonprofit hospitals significantly, would remain intact for decades, only lifted in the late 1960s after Medicaid was enacted.⁹⁰

By the early 1940s, a new financing mechanism was needed to fund the construction of nonprofit hospitals; the local capital that had earlier supported the construction of community hospitals was no longer sufficient. Whereas nonprofit hospitals had secured multiple exemptions during the Great Depression, direct government funds appropriated during this period financed primarily public hospitals. However, the hospital organizations had become well organized and politically astute.⁹¹

The 1946 Hill-Burton Act signified an important landmark in U.S. hospital history, providing the first large-scale federal financing of private, nonprofit hospitals. Over the next 25 years, the law directed \$3.6 billion toward the construction of nonprofit and municipal hospitals (while excluding most for-profit hospitals) in mostly smaller rural and lower-income communities. In the first 20 years, more than half of the nearly 4,700 projects undertaken occurred in communities with less than 10,000 people, helping create small-scale, technologically modern, acute-care hospitals. By 1955, nearly two-thirds of all American short-term hospitals had fewer than 100 beds. (By 1996, mergers and acquisitions had reduced that number to 45 percent.) In the same period, nonprofit hospitals increased their assets from \$2.7 to \$5.2 billion and doubled them again by the early 1960s, aided by federal financing. Furthermore, the legislation would dramatically impact hospital employment, cementing the hospital’s role as an important economic engine. Short-term hospital employment would double from the time the

legislation was enacted to one million people by 1960 and increase to two million by 1972.⁹²

Hill-Burton is also an important first with regard to community benefit requirements, requiring hospital grant recipients to provide a “reasonable volume” of free or discounted care. However, specific levels were never quantified and enforcement was nonexistent, partially because these institutions were still “trusted to further the public good” voluntarily. As a result, “hospital noncompliance was widespread” until amendments to the law were passed in 1975 and 1979.⁹³

In the wake of Hill-Burton, the 1950s represented a period marked by autonomous, local control for hospitals and a contrast between the functioning of rural community and urban hospitals. Stevens explained the contrast: small and midsize hospitals in homogenous communities were “relatively cheerful” institutions in the 1950s and early 1960s, supported by the presence of hospital volunteers—a phenomenon “virtually unique to the United States.” Alternatively, urban hospitals reflected a different reality, organized with a clearly defined hierarchy, patient subservience, and poor employee working conditions. These differences consisted in front of a backdrop of rising systemic problems: increases in the proportion of the elderly and those who had chronic illnesses in the population, income disparities in distribution of medical services, and the rising costs of medical technology.⁹⁴

Additionally, despite Hill-Burton requirements and an IRS revenue ruling in 1956 that required nonprofit hospitals to “provide as much charity care as they could afford” as a condition for their tax-exemption, “relatively little” charity care at that time was provided. The exact amount of charity care is unknown but the percentage of “uncollectable” payments from charges—a reasonable measure for how much care was given away during the decade—was smaller in nonprofit hospitals than both proprietary *and* government hospitals—3.5 percent of total charges versus 5.9 percent and 6.2 percent, respectively.⁹⁵

THE IMPACT OF THIRD PARTY REIMBURSEMENT

The passage of Medicare and Medicaid marked another important point in the history of the American hospital, altering incentives for the nonprofit sector and further reducing the distinctions between the historically defined roles of the three hospital sectors. Although the movement for health insurance coverage in the United States gained traction after World War I, with 39 states passing workmen’s compensation laws by 1919, private, “voluntary” health insurance coverage originated in the 1930s with Blue Cross Blue Shield. Insurance coverage accelerated in the 1940s, when World War II wage controls forced companies to compete for workers by offering attractive fringe benefits. By the end of the 1940s, employer-provided health insurance was institutionalized in American society.⁹⁶

From the nonprofit hospital's perspective, health insurance, or prepayment from a third-party entity was attractive, because it provided a financing mechanism for a large number of consumers. If insurance could also cover the poor and elderly, prepayment schemes could supply new customers by providing options for those who previously only had access to limited charity care and public hospitals. However, employer-provided health insurance did not provide an answer for low-income and, especially, elderly Americans, who watched from afar as hospital costs increased to unaffordable levels.⁹⁷

Passed in 1965, Medicare and Medicaid answered this dilemma by providing hospital and medical benefits to elderly and low-income Americans, respectively. Additionally, these social programs had the impact of affirming “the central importance of the hospital in American medicine,” supporting the nonprofit hospital system over a governmental one.⁹⁸

Hospital expenditures had already spiked previously, more than quadrupling in the 15-year period before the passage of Medicare from \$2.1 billion to \$9.1 billion. However, Medicare and Medicaid pushed this growth even faster, as hospitals had the ability to set their own fees. By 1980, Medicare and Medicaid spent \$35.5 billion combined on hospital care of all kinds, or approximately half of the total expenditures of all community hospitals (i.e. nonprofit, for-profit and local government). At the same time, in the decade following passage, the average cost per patient in real terms more than doubled and total assets of community hospitals nearly tripled from \$16.4 billion to \$47.3 billion.⁹⁹

Despite this surge of public money into private hospitals, Medicare and Medicaid actually reduced the amount of charity care nonprofit hospitals provided. The IRS amended its early ruling that required a threshold of charity care in 1969 because it was deemed that the increase in coverage from Medicare and Medicaid would reduce the need for uncompensated care, therefore making it difficult for nonprofit hospitals to satisfy the requirements. Instead the IRS created a more expansive “community benefits” obligation in Revenue Ruling 69-545.

A hospital would meet its charitable obligation by promoting the health of a broad enough portion of the community, operating in the public interest, and satisfying the following five factors: being administered by a community board, maintaining an open medical staff, operating a full-time emergency room available to all regardless of ability to pay, providing hospital services to all those who could pay directly or through third-party reimbursement, and reinvesting surplus revenue in mission-related activities such as patient care, research, or infrastructure. Although a hospital was not obligated to accept “indigent” patients, “its willingness to do so” provided an important indicator of community benefit.¹⁰⁰

The IRS ruling is significant because it established the principle of community benefits that still applies today, expanding the obligation, albeit slightly, for nonprofit hospitals to their communities. However, over the next 40 years, “certain factors in the 1969

revenue ruling appear to be less helpful. . .in distinguishing tax-exempt hospitals from for-profit hospitals,” explained the IRS’s Steven Miller. During this period after the passage of Medicare and Medicaid, the nonprofit hospital was rapidly assuming a different focus and responding to new incentives. Indeed the sector was no longer nonprofit but not-for-profit, according to the American Hospital Association. The 1970s ushered in an era where surplus was no longer disavowed but praised, as governmental pressures for improved efficiency increased. At the same time, the 1970s saw an increase in the for-profit hospital industry as Medicare’s cost-plus system provided investors with generous profit-making opportunities, further pushing not-for-profit hospitals in a profit-making direction.¹⁰¹

Today, revenue maximization for a not-for-profit hospital is the norm and negative impacts to the bottom line are weighed heavily before embracing a change that may strengthen its “public” mission. All of the multiple exemptions not-for-profit hospitals once received—from tort liability, unions, social security, and even competition from public hospitals—have disappeared. Only the sector’s tax exemption remains intact and even this is under attack. An article by Robert Clark in the *Harvard Law Review* in 1980 argued that the distinction between for-profit and not-for-profit hospitals had disappeared to the point that maintaining the tax-exemption was a form of unfair competition against for-profit hospitals. Similarly, when tort liability for public hospitals was overturned in 1978 in the Michigan case of *Parker v. Highland Park*, the court was explicit in its view that all hospitals were operating with a similar purpose—pursuing profit—stating: “The modern hospital, whether operated by a city, a church, or a group of private investors, is essentially a business.”¹⁰²

Rosemary Stevens has written that the “importance of federal policy in stimulating a capitalistic hospital system cannot be overstated.” In addition to Medicare, federal grants from Hill-Burton disappeared by 1974 and philanthropic contributions declined dramatically in the 15 years after Medicare. In 1968, philanthropic and government funding financed 45 percent of hospital construction, whereas by 1981 it represented just 16 percent. As a result, not-for-profit hospitals began to raise expansion capital by issuing debt through tax-exempt bonds or from surplus through fee increases. Again, in just the 15 years after the passage of Medicare, debt as a percentage of total capital financing increased from 40 percent to 80 percent. As not-for-profit hospitals embraced financing through debt and sought capital through the development of affiliated for-profit businesses, the “nonprofit nature” of these institutions became yet more opaque. Not-for-profit hospitals were becoming even less connected to the communities they were intended to serve, depending no longer on public and community capital, and “emphasizing technology” instead of “the rapid expansion of community service, for which reimbursement was largely unavailable,” according to Stevens.¹⁰³

THE CHANGING COMMUNITY BENEFIT LANDSCAPE

In the late 1980s and 1990s, as private and public third-party reimbursement entities exerted pressure on hospitals to slow the cost of a previously unchecked fee-for-service system and as market pressures dictated new decisions, hospitals reacted by becoming large-scale health systems and increased the use of group-purchasing organizations to acquire goods and services more cost effectively. By the turn of the 21st century, the not-for-profit healthcare system had morphed significantly from its humble voluntary hospital origins. In fact, the term “voluntary” and the historical significance associated with its usage had all but disappeared.¹⁰⁴

As hospital operations grew and became further removed from the local community and as the number of uninsured steadily rose, pressure again increased on hospitals to justify their coveted tax exemption at the federal level in the 1980s and in states such as Texas, California, New York, and Massachusetts in the 1990s. In the first decade of the 21st century, this pressure would again shift to the federal level, culminating in revisions to the IRS’s 990 Form in 2008 through the addition of Schedule H—an attachment to the report form specifically designed to provide transparency regarding a hospital’s community benefit activities.¹⁰⁵

The Schedule H form was adapted from the Catholic Health Association’s own efforts in this area, beginning nearly 20 years earlier in 1989. Julie Trocchio, who joined the organization in 1988, noted that the goal of this document was to give not-for-profit hospitals the ability to both demonstrate and quantify their community benefit in the face of mounting criticism. Trocchio added, “We wanted to be able to use the same rigor and accounting for community benefit as they were using elsewhere in the hospital.” The association’s community benefit form has been updated regularly since 1989. As Congress pressured the IRS regarding hospital’s community benefits in the mid-2000s, the IRS looked to the Catholic Health Association because its system had been in place nearly 20 years.¹⁰⁶

Two years later, the 2010 Affordable Care Act added additional requirements for not-for-profit hospitals, as noted in Section One. How states and localities will alter their own community benefit requirements in response to these changes is unknown at this time. It is also equally important to note that the IRS also does *not* specify a minimum threshold of community benefit a hospital needs to provide in order to maintain its tax exemption.¹⁰⁷ In the coming years, the latter question may well be answered, as the IRS obtains a more robust data set on community benefit activities from standardized reporting and as a reasonable community investment threshold becomes clearer.

GOING FORWARD

From the perspective of benefiting the community, and specifically those most in need, the history of not-for-profit hospitals in this country is mixed. Often the rhetoric of the prominent lobbying organizations, such as the American Hospital Association and Catholic Health Association, was effective in verbally portraying hospitals as “benevolent,” “good” institutions with a “public” mission in order to receive special exemptions and benefits. However, the level of such services actually provided has often been far different.¹⁰⁸

Excluding instances of certain religious voluntary hospitals caring for chronic patients in the late 19th century and other unique instances of exceptional levels of charity care along the way, not-for-profits as a sector have pushed aggressively to avoid treating those who were most in need of their services. Almshouses in the 19th century gave way to public hospitals at the turn of the 20th century because voluntary hospitals argued that the poor and needy were the responsibility of the government, not hospital trustees and administrators. Similarly, the federal hospital system emerged after World War I because voluntary hospitals, again, were not interested in treating the long-term conditions of veterans returning home; this trend continued with the establishment of the Veterans Administration hospital system post-World War II—community hospitals simply did not want the responsibility of caring for patients that did not fit the acute-care model.¹⁰⁹

In an additional benefit, at the same time Medicare and Medicaid were enacted, not-for-profit hospitals further reduced their responsibility for the most needy when the federal government’s Office of Economic Opportunity created community health centers, providing low-income individuals with healthcare options beyond just charity care. The system of community centers (now known as Federally Qualified Health Centers) that has since developed, including a large expansion under the 2010 Affordable Care Act, has reduced the burden on not-for-profit hospitals to provide care for low-income Americans, further whittling away the argument in favor of their tax-exemption.¹¹⁰

Furthermore, “patient dumping,” or transferring undesirable (i.e. unprofitable) patients to local government hospitals from not-for-profits was a common practice from the 1930s until legislation prohibited it in 1986. However, just as this practice faded, the art of “skimming” or neglecting those who cannot pay and providing them with minimal services emerged as a replacement strategy in the mid-1980s. Even as hospitals moved more aggressively to tout their community benefit voluntarily since the 1990s, many hospitals inflated the actual value by counting charity care based on charges, instead of at cost, and including bad debt and Medicare shortfall in their community benefit calculations. One health system, as noted in the introductory section of this report, even went as far as to include its entire payroll, including the wages of its highly paid executives, as part of its community benefit activities—now prohibited by the new IRS reporting requirements in 2009. Far too often, as Stevens argued, hospital

community engagement is more an effort “to create good feelings about the hospital rather than change the community’s health.”¹¹¹

Despite their shifts away from the provision of medical care for those most in need, not-for-profit health systems still represent the backbone of the American healthcare system and have been important providers of charity care in the United States.¹¹² Going forward, we must ask whether they have done enough to warrant their distinction from for-profit entities and, if not, whether they should be doing more to deserve a costly tax exemption. This question is especially critical today, since their profitability has not gone unnoticed by federal, state, and local governments. We must then follow up on that question by asking whether the best policy and societal response is to simply require hospitals to provide more charity care or invest in additional health interventions that only address symptoms rather than root causes. Is this the most efficient use of resources? Does this strategy really leverage effectively not only the foundational piece of our health system but one of the most important economic engines in our communities?

As the following sections will demonstrate, a more appropriate direction addresses the health of communities in a meaningful and permanent way. A small percentage of hospitals have adopted promising anchor strategies in their efforts to strike the delicate balance between acting in the public interest and maintaining healthy revenues. The promising practices in Section Three and the case studies in Section Four will help illustrate how not-for-profit hospitals can embrace a community engagement framework that seeks to address root causes of health problems, strengthening the local economy and neighborhoods, improving the environment, and bettering public health.

Section Three

Emerging Hospital Trends and Promising Practices

This growing recognition of housing, neighborhoods, and factors such as income and education—the “social determinants of health”—has led the health sector. . .to look beyond improving access to health care to address root causes to help people avoid getting sick in the first place.

- Majorie Paloma, senior policy adviser and program officer, Robert Wood Johnson Foundation¹¹³

As noted above, the vast majority of health systems still focus primarily on treating the symptoms of poor health, and place relatively little emphasis on addressing the causes, whether through their community benefit programs or their hospital operations. However, as incentives slowly shift, hospitals are beginning to embrace strategies traditionally promoted by public health advocates.

Although the number that falls into this group represents only a small percentage of the entire sector, the number of examples *is* growing, as hospitals think differently about how to address social determinants of health. These hospital examples also include revitalization efforts that direct resources to spur economic development and stabilize low-income communities. Examining some of the different anchor institution strategies available to hospitals, this section highlights best practices and promising trends, divided into seven categories: sustainability practices, minority- and women-owned business purchasing, housing development, capacity building, local hiring, community investment, and multi-institution partnerships.

SUSTAINABILITY PRACTICES

Beginning in the late 1990s, a few hospitals began to modify their procurement and operating methods to mitigate the environmental hazards they were creating. They sought to better align themselves with their core mission of promoting health by changing practices that were having the opposite impact. This trend has gained momentum

in the past decade, representing an important example of hospitals recognizing the broader impact they have on the community beyond the direct health services they provide.

The foundation for this sustainability movement traces back to a 1996 U.S. Environmental Protection Agency (EPA) report that named the healthcare sector as the third leading cause of the release of the toxin dioxin into the environment—mostly from medical waste incinerators. Two organizations were formed in the aftermath of this release: 28 organizations came together that same year to form the Health Care Without Harm coalition. Two years later, the American Hospital Association and the EPA initiated Hospitals For a Healthy Environment (H2E) when they signed an agreement to reduce healthcare system pollution. Although funding for H2E was cut under President George W. Bush’s administration, it reemerged in 2007 as a membership-funded, nonprofit organization called Practice Greenhealth. Together these two organizations have helped move environmental sustainability in healthcare from the fringe to the mainstream.¹¹⁴

Kaiser Permanente, a not-for-profit health insurance company based in Oakland, California, that also operates 37 hospitals, and Catholic Healthcare West, the nation’s fifth-largest health system based in San Francisco, were two of the earliest health systems to recognize the opportunities and benefits of more sustainable practices. Noted Anna Gilmore Hall, former executive director of Practice Greenhealth, they “were the leaders in this, and really championed this.” Their motivating factors were both mission-related and financial.¹¹⁵

Gary Cohen, founder and CEO of Health Care Without Harm, explained that the first step was to illustrate the contradiction between the core hospital mission of promoting health and hospital practices that created public health hazards. The next step was identifying the solutions—finding different products in the marketplace in some cases and, in others, utilizing the purchasing power to create new markets. Key to making this work was that many of these changes were cost-effective or even generated cost savings. Today, Kaiser Permanente estimates it saves \$26 million annually because of sustainability practices such as an Environmental Preference Program and a Sustainability Scorecard, which “helps the company evaluate and select products without harmful chemicals.”¹¹⁶

Together, these two hospital systems and two nonprofit organizations, along with several other hospital partners, helped found the Healthier Hospitals Initiative—a “call-to-action for the entire industry” to promote a more sustainable business model. Practice Greenhealth’s membership growth is also indicative of the rapid movement toward sustainability practices, with membership growing at an annual rate of more than 20 percent since its founding. Today, membership stands at more than 1,100 organizations—the vast majority of which are hospitals.¹¹⁷

As health systems have altered their environmental practices, many of these changes have also had positive economic development impacts. Slowly, this work has begun to engage communities more directly. Although the practice of greening internal operations has gained significant traction within the industry, Cohen observed that “there are not enough people thinking about situating themselves in the community as an economic driver for healthy, sustainable communities. . .how you use your purchasing power in the community—it’s a new idea.”¹¹⁸ Perhaps one of the most direct connections between stabilizing communities and sustainability practices has been the increase in sustainable food purchasing, which has had the result of shifting hospital spending locally.

The combination of a focus on sourcing sustainable meat options and organic produce and efforts to reduce carbon emissions has increasingly led hospitals to purchase from local producers. In Maryland and the Washington, D.C. metropolitan area, 40 hospitals are now consistently purchasing fruits and vegetables locally during the growing season and twelve hospitals are procuring in the same way for meat or poultry, with another four in pilot stage. The 122-bed, not-for-profit Union Hospital in northeast Maryland, with a staff of more than 1,250 and operating revenue of \$130 million, now purchases 44 percent of its meat, poultry, produce, and dairy locally, including 100 percent local pasture-raised beef and 90 percent local pasture-raised poultry.¹¹⁹

These changes in procurement are having a positive impact on local vendors. For example, at least eight Maryland farmers are supplying meat and poultry to local hospitals. One vendor saw its sales increase 66 percent between the fourth quarters of 2010 and 2011; over 10 percent of its sales are now to hospitals. In just the fourth quarter of 2011, hospitals in Maryland procured nearly \$60,000 worth of meat and poultry from just five of these producers. Procuring local food has occurred because hospitals are seeking to secure sources of healthier food. Louise Mitchell, Sustainable Foods Program Manager of Maryland Hospitals for a Healthy Environment (MD H2E), remarked, “Leading hospitals in this region deserve a lot of credit for their persistence, determination and strategic thinking on how to make it work.” Increased demand by employees, medical residents, students, and visitors has also helped propel these efforts forward.¹²⁰

MetroWest Medical Center, based in Massachusetts, has adopted a similar strategy, partnering directly with Silverwood Organic Farm to provide its employees with healthy produce using the CSA model. Community-supported agriculture provides greater market stability for a producer because customers pay for a season’s worth (in this case, 20 weeks during summer and six weeks during winter) of produce up front and receive distribution on a weekly basis at either the farm or the hospital. The process removes the distributor in the middle and allows individuals to connect directly with the source of their food. In order to encourage hospital employees to join, CEO Andrei Soran provided a financial incentive to employees to sign up. MetroWest has also provided its employees with opportunities to join egg, meat, and coffee CSAs.¹²¹

A different strategy has emerged in Cleveland, Ohio, where the local producers lacked the capacity to supply the anchor hospitals' demand. Here, Cleveland Clinic and University Hospitals, along with Case Western Reserve University, helped co-develop Green City Growers Cooperative—a 3.25-acre urban greenhouse located just two miles away in Midtown Cleveland. Recently opened in December 2012, this employee-owned urban greenhouse will produce three million heads of lettuce and 300,000 pounds of herbs annually at full capacity while employing 42 workers—nearly all of whom will be hired from targeted, low-income neighborhoods surrounding the anchor institutions. This business will help double the lettuce supply capacity of the local food market, meeting the hospitals' demand for healthier food and helping to stabilize the adjacent impoverished neighborhoods.¹²²

On the West Coast, California FreshWorks Fund illustrates another innovative method to increase the supply of fresh food in low-income communities. Both Catholic Health-care West and Kaiser Permanente served as founding members of this California Endowment initiative in 2011, investing \$2.5 million and \$1 million, respectively, to help seed what is now a \$264 million private-public partnership loan fund. Modeled after Pennsylvania's Fresh Food Financing Initiative, the fund aims to increase access to healthy food in underserved communities by enabling economic development that “supports healthy communities and inspires innovation in healthy food retailing.” In addition to reducing the number of food deserts across the state and providing new retail jobs, grocery stores generate positive externalities by increasing local property values and tax revenues.¹²³

On the East Coast, Bon Secours Health System has invested in a variety of sustainability best practices that have helped promote economic development and revitalize the local community. In the Bronx borough of New York City, Bon Secours, partnering with local community organizations, has co-sponsored a farmers market in a neighborhood in which 30 percent of residents visited a food pantry in 2009. It has since opened another site in a second nearby neighborhood. Called Youthmarket, the Bon Secours initiative differs from traditional farmers markets, offering free health services, bilingual cooking demonstrations, and free deliveries to homebound residents. From an economic development lens, Youthmarket, now in its third year, in addition to providing income for regional farmers, is fully operated by neighborhood youth who manage each aspect of the business from ordering inventory to balancing the books and are paid \$10 an hour. A similar project, called Youth Farm, based in the Inwood, Washington Heights, and South Riverdale neighborhoods, employed 12 youth in 2011.¹²⁴

MINORITY- AND WOMEN-OWNED BUSINESS PURCHASING

Another area of rapid industry change is in what is known as supplier diversity. Although only a few health systems had dedicated supplier diversity programs as early as the mid-1990s, targeted purchasing in this area gained momentum over the last decade and

has become an important healthcare trend. These programs focus on increasing the number of healthcare system suppliers who are minority-, women-, and veteran-owned (and in some cases, locally owned too).¹²⁵

Several factors have helped propel this trend. From a compliance standpoint, since 1993, hospitals that receive federal awards—grants or other contracts—have been mandated to take steps to “utilize small businesses, minority-owned firms, and women’s business enterprises, whenever possible.” At the same time, a heightened internal focus—from leadership to employees to suppliers—has become a point of pride of many health systems. Some hospitals, such as Parkland Hospital in Dallas, Texas, cite additional factors including the flexibility, customization, and cost competitiveness that smaller, more diverse businesses often bring to the marketplace. Finally, others, such as Broward Health and Norton Healthcare that are highlighted below, draw the important connection that supporting minority- and women-owned businesses, which are often located in the surrounding community, keep resources local and help improve the physical and economic health of their communities. One example, Nationwide Children’s Hospital, includes locally owned businesses as diverse suppliers, and states explicitly that the hospital is “committed to the economic health of the neighborhood in which it resides.”¹²⁶

Despite the growth of minority- and women-owned business contracting since the late 1990s, these firms are still underrepresented in the marketplace and healthcare supply chain. In 1993, when the National Minority Medical Suppliers Association conducted its first annual survey of hospital material services managers, it found that hospital purchasing of medical and surgical supplies from minority-owned supply firms was negligible. By 2005, they reported improvement but still found the number lagging at far below one percent. Of the more than \$100 billion dollars worth of health system procurement from all businesses, only \$200 million was directed toward minority organizations.¹²⁷

In 1999, Premier, Inc.—at the time, the industry’s largest healthcare GPO or “group purchasing organization”—began implementing supplier diversity initiatives due to requests from its member health systems. Through 2004, a total of only 24 minority-owned businesses and 18 women-owned business received contracts worth a combined total of \$31 million. However, in 2005 alone, Premier increased its purchasing from minority- and women-owned businesses to \$47.6 million. If veteran-owned enterprises are also counted, then the 2005 purchasing figure rises more than six-fold to \$321 million. But even that total only represented 1.3 percent of Premier’s total procurement that year. The largest GPO today, Novation, which manages more than \$40 billion in contracts, has also sought to increase its procurement from diversity vendors. In 2010, despite increasing the total number of diverse vendors by a third, and being added to *Minority Business News (MBN) USA* magazine’s “Corporate 101” list as a top corporation for supplier diversity, Novation only contracted \$340 million from these vendors, or less than one percent of its total purchasing. These numbers mark a

significant improvement from 2005 but still illustrate a strikingly low level of diversity purchasing of medical supplies.¹²⁸

Total industry figures are similar. According to *Diversity Inc.*, overall supplier diversity spending by health systems equaled \$2.71 billion in 2011, an increase of 21 percent from the year before. Nonetheless, hospital procurement from diversity suppliers nationally also remains *less* than one percent. In Northeast Ohio alone—a leading region for diversity procurement—spending jumped 33 percent, from \$339 million in 2010 to \$450 million in 2011.¹²⁹ On an individual basis, leading healthcare systems procure more than \$47.6 million annually from minority- and women-owned businesses, illustrating the strides made at the individual level since 2005. Although more common today, these individual efforts are still the exception, evidenced by a national rate that has not yet markedly improved.

One early leader in setting targets for supplier diversity was Broward Health (then North Broward Hospital District), located on Florida’s southeast coast. Created in 1951 by the state legislature, Broward Health is comprised of four public hospitals serving Broward County with more than 1,500 beds in total. In 1990, the Board of Commissioners established a Supplier Diversity Program, voluntarily setting an initial target in 1994 of procuring 12.5 percent from minority business by 2005. It exceeded this target in 2004, achieving 15 percent that year and set a new goal of 17 percent for 2005. Additionally, in 2004, it was the first recipient of Premier’s annual Diversity Supplier Award. As of 2005, it had five full-time staff fully involved in supply chain diversity decisions. In accepting the award, hospital manager LaRae Floyd summarized the economic impact of this spending, which “translates into \$48 million . . . and most of that business, at least 80 percent, goes back to our local community. . . We care about the clinical health, as well as the economic health of our communities.” In 2011, Broward Health purchased slightly more than \$42 million from diversity vendors, representing 10 percent of its total procurement.¹³⁰

In 2005, the University of Texas M.D. Anderson Cancer Center in Houston, Texas, was awarded Premier’s second annual Diversity Supplier Award. Similar to federal rules, the Texas legislature requires state agencies to “make a good faith effort” to procure from historically underutilized businesses (HUB), or majority-owned minority- and women-businesses. Since M.D. Anderson implemented its program in FY 1997, expenditures with HUB firms have increased from \$18.8 million to \$79.1 million in FY 2008, representing more than 10 percent of its procurement. Each year M.D. Anderson strives to revise its targets upward; it set targets of \$95.7 million for FY 2009 and \$106.8 million for FY 2010 (12.9 and 13.7 percent, respectively, of total procurement). Instead of establishing an overall HUB procurement target, M.D. Anderson sets specific goals for five categories: 1) building construction, 2) special trade construction, 3) professional services, 4) other services, and 5) commodities. For FY 2012, these targets were 19 percent, 22.7 percent, 38.4 percent, 17.4 percent, and 12.2 percent, respectively. Based on the FY 2010 procurement totals (a conservative estimate since expenditures, on

average, have grown year to year), M.D. Anderson aimed to procure more than \$115 million in goods and services from HUB enterprises in FY 2012.¹³¹

Other early adapters of supplier diversity programs include Duke University Health System in Durham, North Carolina (1984); Saint Luke's Health System in Kansas City, Missouri (1990s); Detroit Medical Center (1998) and Henry Ford Health System (1998) in Detroit, Michigan; SSM Health Care in Michigan, Oklahoma, Illinois and Wisconsin (2001); Sacred Heart Medical Center in Spokane, Washington (2001); and Carolinas HealthCare System in North and South Carolina (2001). Although current procurement goals are not publicly available, between 1999 and 2004, Detroit Medical Center purchased annually between \$35 and \$55 million in goods and services from minority- and women-owned businesses. During that same period, SSM Health Care grew its program rapidly, increasing its purchasing from diverse businesses from \$1.5 million in 2001 to \$72 million in 2004. Additionally, each organizational entity is focused on achieving a 10 percent discretionary spending goal for minority- and women-owned businesses. Eight years after starting its program, Carolinas HealthCare System procured \$112.6 million in 2009, through its Supplier Diversity Program, exceeding all previous years and representing an increase of more than 40 percent from 2008.¹³²

A rare regional approach to increasing minority- and women-owned business procurement is occurring in Cincinnati, Ohio. Initiated by a call to action at the inaugural South Central Ohio Healthcare Supplier Diversity Symposium in 2010, the Tristate Health Care Diversity Supplier Consortium formed that year. The Consortium comprises local hospital systems, the Greater Cincinnati Health Council, and community organizations, and is currently co-chaired by two hospital CEOs. The Consortium has implemented a "comprehensive plan" that establishes long-term diversity spending goals for all participating members that include: purchasing 10 to 15 percent of the organizations' goods and services, procuring 15 percent of their professional services, and targeting contractors, subcontractors, and suppliers for 25 to 30 percent of all construction project dollars. Two other goals of this effort are to "maximize the local impact" of these programs and to strive to set yearly targets for ensuring that 25 percent of construction workers are minority or female.¹³³

In speaking about the regional initiative, Howard Elliott, a supplier diversity consultant who has played a pivotal role in guiding this process, envisions that local participating hospitals will start to approach these targets by 2014. Elliott also pushed an earlier effort to improve supplier diversity purchasing in the late 1990s that culminated in area hospitals committing to purchase their courier services from a local minority-owned business. However, this first regional initiative "plateaued" over the next decade. Elliott cited the fact that although senior management was interested, they "didn't drive it" or institutionalize the practices within their organizations. Additionally, the tracking systems and metrics that had been implemented were also inadequate.¹³⁴

This time around Elliott sought input from each participating hospital and system to craft a “common definition that all would get behind.” The Consortium cites \$98 million as its diversity-spend starting level, using a blend of 2009 and 2010 reporting from the participating members. According to Elliott, 2011 represented the “getting-our-act-together year,” as he worked closely with hospitals to ensure that the quarterly numbers they reported to him properly represented their diversity procurement. By 2011, with “everyone now on track,” participating hospitals collectively increased their diversity purchasing to \$116 million, or 5 percent of total procurement. The Consortium has non-public internal goals for the next two to three years, including plans to work collectively on “breakthrough projects” to help them get to their long-term targets.¹³⁵

One of these participating members is UC Health (formerly Health Alliance of Greater Cincinnati until 2010), comprising four hospitals and other health service operations that procure more than \$250 million in goods and services annually. After receiving a “D” grade from a consulting firm for its diversity-inclusion practices in 2005, UC Health began having weekly meetings on supplier diversity that still occur. As part of its new effort, UC Health upped its diversity spending from just \$4.3 million in 2005 to \$34 million by 2008 (from one percent of total purchasing to 10 percent). Additionally, in 2008, minority- and women-owned businesses completed more than one-third of the work for the system’s new behavioral and health center in Mason, Ohio. To date, since 2005, UC Health has procured more than \$125 million in goods and services from diverse suppliers.¹³⁶

Another important member of this effort is Mercy Health, a local health system comprising six hospitals. Mercy Health is part of Catholic Health Partners, which is the largest health system in Ohio and one of the largest not-for-profit health systems in the country, employing more than 32,000 people and operating more than 100 health facilities, including 24 hospitals. Having won Premier’s 2010 Diversity Supplier Award, Catholic Health Partners now aims to procure 10 percent of its total purchasing from diverse vendors. In 2011, it purchased \$58.9 million (6.4 percent of total purchasing) from minority- and women-owned businesses, tripling its 2010 spend and surpassing its internal goal of \$45 million for 2011.¹³⁷

In Cincinnati, Mercy Health, which procures more than \$300 million in goods and services annually, has set its own goals to meet the 10 percent target by 2012. From just spending 3 percent with diverse suppliers prior to 2010, Mercy Health (for total operations) nearly doubled its 2011 spending target (\$12.3 million), procuring \$23.4 million from minority- and women-owned businesses. The goal for 2012 is \$26.5 million (for Mercy Health alone its \$22.1 million), and through April 2012, Mercy Health had already spent \$7 million. Additionally, the health system has committed \$47 million (more than 25 percent of total costs) in contracts to diversity suppliers for the completion of Mercy Health — Hospital West; 22 percent of that workforce is made up of minorities and women.¹³⁸

HOUSING DEVELOPMENT

As medical research continues to affirm the connection between a community's socioeconomic status, environmental conditions, and its health, a few hospitals have embraced anchor institution strategies that seek to address local issues traditionally seen outside the scope of a hospital's mission. The oft-cited observation that one's zip code is more important to a person's health than their genetic code has begun to convince some health system leaders to spend resources on affordable housing, infrastructure improvements, and other aspects of the built environment that are negatively impacting community health. As Majorie Paloma, a senior policy adviser and senior program officer at the Robert Wood Johnson Foundation, emphasized: "In many cases there exist 10-year life expectancy gaps between people living just a few miles apart." In some cases, this gap is even greater.¹³⁹

Bon Secours Health System in Baltimore, Maryland, and Mayo Clinic in Rochester, Minnesota, profiled in detail in Section Four of this report, have been important hospital leaders in this area. Other hospitals that have undertaken neighborhood revitalization projects focused on affordable housing include Yale-New Haven Hospital in Connecticut, St. Mary's Health System in Lewiston, Maine, and SwedishAmerican Hospital in Rockford, Illinois.¹⁴⁰

Based in Lewiston, Maine, St. Mary's Health System, formerly known as Sisters of Charity Health System and a member of the New England region-wide Covenant Health System, sought to revitalize one of the most distressed areas of the city through the construction of affordable housing, beginning in 1999. The dilapidated condition of housing around the 233-bed St. Mary's Regional Community Center not only impacted the system's ability to recruit new staff, it also represented the "greatest need in the community," according to then-CEO James Cassidy. Before the project could commence, Cassidy had to first convince his trustees that this nontraditional use of hospital resources was appropriate. In the end, they voted unanimously in favor of the first downtown housing construction in the city since 1940.¹⁴¹

In partnership with the Maine State Housing Authority, which financed the home purchases through its first-time homebuyer program, and a local nonprofit that provided homebuyer education training, St. Mary's contributed \$250,000 to the project, which helped attract the additional capital needed for the \$2.2 million initiative to construct 12 units of affordable townhomes. It also oversaw the project through the formation of the not-for-profit developer Neighborhood Housing Initiative (and St. Mary's vice president of facilities supervised the construction of each unit). This important first step in neighborhood revitalization helped draw an additional \$15 million in new investments to the area, including a satellite facility for a local college, new rental housing, and the renovation of a public theater. Additionally, in order to promote community stability, all of the homeowners were required to stay at least 10 years, or pay back the home purchase subsidy they had received if they sold earlier.¹⁴²

Another effort to revitalize a distressed community began in 2000 when SwedishAmerican Health System, serving 12 counties in northern Illinois and southern Wisconsin, sought to redevelop the six-block area surrounding the SwedishAmerican Hospital campus in Rockford, Illinois. Committing more than \$4.1 million to date, the hospital's foundation spearheaded the effort to transform the neighborhood from a primarily "at-risk," renter-occupied neighborhood to a more stable, owner-occupied neighborhood. Since the foundation began its effort, homeownership has increased from 35 percent in 2005 to more than 50 percent by mid-2008.¹⁴³

As part of its community building efforts, SwedishAmerican has, to date, rehabilitated 24 existing homes, partnered with Habitat for Humanity to construct new single-family homes, and purchased and renovated a 24-unit apartment complex. The foundation has also financed the building of a new playground and two neighborhood parks, provided more than 75 "50/50" matching grants to neighborhood homeowners for home improvement projects, and established an employee homeownership assistance program for homes bought within the target area, which includes a \$5,000, five-year forgivable grant (\$10,000 for low-income employees) to employees in good standing. As a result of the changes in the neighborhood, new commercial development has occurred, the city of Rockford has granted an additional \$200,000 to the foundation to continue its efforts, and two TIF (Tax Increment Financing) districts have been created nearby.¹⁴⁴

More recently, Nationwide Children's Hospital (Nationwide) in Columbus, Ohio and St. Joseph's Hospital Health Center (St. Joseph's) in Syracuse, New York have also initiated or partnered in affordable housing development projects in their communities. Nationwide's "Healthy Neighborhoods, Healthy Families" initiative was announced in September 2008 as a multi-pronged approach to revitalize the community that surrounds its downtown campus. Initially conceived by Nationwide, the initiative has become a public-private partnership between multiple stakeholders, including the City of Columbus, United Way, and Community Development for all People (CD4AP), that targets five areas: affordable housing, health and wellness, education, safe and accessible neighborhoods, and workforce and economic development. In offering its rationale for why it would undertake such an extensive community-building approach in 2010, Nationwide explained, "We know our organization will thrive if we are located in a vibrant community. The hospital's mission is to create a healthier future for every child, for every reason. To accomplish this, we must take a much more active role in the surrounding community."¹⁴⁵

Nationwide sees affordable housing as integral to a healthy and thriving community, defining it as the "cornerstone" piece of the larger initiative. Targeting 38 square blocks around the hospital on Columbus's South Side, the hospital has committed \$3 to \$5 million over a five-to-seven-year period to rehabilitate vacant and abandoned housing, and construct new homes. Partnering with CD4AP to create a nonprofit housing subsidiary, Nationwide set an initial goal to "impact" 40 to 60 homes within a three-to-five-year period, but in 2010 alone, it "renovated or repaired" 45 homes. It has since

revised its target to increase the community's available affordable housing by at least 100 homes by 2013. For homeowners already living in the community, Nationwide has created a home repair program that provides grants for exterior repairs. The hospital provided 19 such grants in 2010.¹⁴⁶

Just a year after Nationwide began its initiative, in 2009, as part of a \$220 million facilities expansion, St. Joseph's, a 431-bed hospital located within the Prospect Hill neighborhood on Syracuse's struggling North Side, "made a commitment to help revitalize the neighborhood by further establishing itself as an economic anchor, as well as a catalyst for community development," noted an American Hospital Association case study. In addition to creating a green-jobs workforce development program and engaging local neighborhood groups so that local businesses could "capitalize on this economic potential," the hospital commenced a strategy to revitalize two nearby blocks that had been historically blighted. The hospital's foundation contributed \$250,000 to help finance the \$11 million, 50-unit development of "green" affordable housing. The hospital has also contributed \$125,000 per year through 2010 to the Metropolitan Development Association to aid additional development in this neighborhood and matched a federal EDA grant of \$125,000 to develop a North Side master plan.¹⁴⁷

The second phase of this revitalization initiative involved partnering with a housing organization to rehabilitate 20 dilapidated properties and target them primarily to employees through the hospital's employer-assisted housing initiative. St. Joseph's offers a Guaranteed Mortgage Program—eliminating the lender's risk and allowing the employee to reduce their down payment and closing costs, avoid purchasing private mortgage insurance, and finance at a lower interest rate.¹⁴⁸

CAPACITY BUILDING

Capacity building for community groups and local organizations is often an important anchor strategy for building stronger community partners. Often, low-income communities lack knowledge, resources, and skills because of their socioeconomic status. As a result, hospitals have realized that through capacity building, local residents can become better advocates for community health needs and more actively and ably participate as capable partners in a neighborhood revitalization strategy. A capacity building initiative helps empower the community and generates a level of buy-in that is critical to a hospital's agenda. Through this type of outreach, hospitals can slowly overcome mistrust and alienation that might have existed in surrounding communities.

In Northern California, St. Joseph Health System of Sonoma County has actively tried to build community capacity through its Healthy Communities department, focusing on community organizing, leadership development, and partnership and coalition building. Its Neighborhood Care Staff (NCS) consists of five (as of 2010) community organizers working to mentor community leaders in low-income neighborhoods in five

communities that have unmet health needs. A companion program to NCS, Agents of Change Training in our Neighborhoods (ACTION), aims to provide leadership and advocacy training for local residents, community groups, and organizations. The Healthy Communities department established ACTION in 2002 to help residents, who may not be accustomed to “organizing themselves and addressing problems”, to “shift their mind-set and become more proactive.”¹⁴⁹

Through an organic process of ongoing interactions and relationship building, St. Joseph community organizers identify potential community leaders, offering them a free, three-day training session on community organizing. After this training, they continue to assist these community residents “build their local groups, develop their action strategies and undertake the work of community change.” In FY 2011, as a result of ACTION training and mentoring for more than 24 residents and more advanced training for previous program graduates, St. Joseph’s capacity building efforts helped residents form six new community gardens, consolidate four neighborhood-based groups and transform them into autonomous local organizations, and change local policies in four jurisdictions to support neighborhood beautification, community gardens, and healthy school menus.¹⁵⁰

In addition to partnering with the City of Chicago to develop affordable housing, Sinai Health System has also played an active role in empowering local residents. It is one of the founding partners of the North Lawndale Employment Network (Network), a “partnership of community-based organizations, economic development agencies, and businesses working together to meet the workforce development needs of North Lawndale residents and employers.” Through its Sinai Community Institute (Institute), Sinai served as the Network’s fiscal agent and its executive director served as the Network’s board chair from 1997 through February 2000 when it achieved its nonprofit status. The Institute also housed the organization until October 2003. Since its establishment, the Network has built up an annual budget of \$1.3 million and employs 18 staff members that coordinate multiple initiatives focused on job readiness and placement programs for formerly incarcerated individuals and low-income residents. One of its initiatives is Sweet Beginnings, LLC, a social enterprise and urban-agriculture honey business that sells its products primarily at local farmers markets. Incorporated in 2006, by 2010, a total of 170 people had worked for the business, with a recidivism rate of only four percent.¹⁵¹

LOCAL HIRING

Through local hiring practices, hospitals can satisfy their institutions’ workforce needs and provide stable employment opportunities for residents in low-income communities. In addition to targeting hiring in specific communities, these initiatives often involve workforce training and mentorship components to increase the skills of those in the community and the overall success of such efforts. As an additional benefit,

hiring from the local community reduces the carbon footprint of the hospital that is generated by commuters. Furthermore, a hospital is helping local low-income residents achieve the financial security needed to maintain a healthy lifestyle, reducing the number of people in the institution's service area that lack insurance and potentially benefiting its bottom line.

Located approximately 800 miles north of Seattle, the eight-bed Wrangell Medical Center (including a separate, fully-licensed 14-bed long-term care facility) is a public hospital serving the remote island region and economically depressed community of Wrangell, Alaska, population 2,500. Opened in 1968, this community anchor has developed the Rural Health Careers Initiative, providing onsite clinical training, health career mentoring, and financial assistance for education, in order "to grow its own workforce and help Wrangell residents attain job skills." Without this initiative, residents would have to seek training and education off the island, a choice that is too cost-prohibitive for many who live in the region. As a result, Wrangell Medical Center has trained and mentored more than 200 students since 1993, hiring the vast majority and creating cost savings for local students estimated at more than \$285,000.¹⁵²

Just a few years after the inception of the Rural Health Careers Initiative, the not-for-profit Partners HealthCare in Boston, Massachusetts, which includes the two academic medical centers Massachusetts General Hospital and Brigham and Women's Hospital, began the job readiness program Project RISE in 1998. The federally funded Project RISE evolved into the Partners in Career and Workforce Development (PCWD) program when Skillworks, a citywide workforce development initiative, provided Partners with a three-year, \$1 million grant to design and implement a new program.¹⁵³

Targeting low-income residents, this initiative has since become institutionalized—jointly funded by Partners Community Benefits Program and Human Resources. It strives to change the way employers hire and promote entry-level workers from Boston's neighborhoods. The program provides training, career counseling, case management, and, most importantly, entry-level job placements in positions such as front desk receptionists, clerical assistants, registration coordinators, operating room assistants, and laboratory aides. As of FY 2011, more than 400 people have participated in the program; 62 in that year alone. To date, the graduation placement rate at Partners is nearly 90 percent with an average starting rate of \$14.38.¹⁵⁴

COMMUNITY INVESTMENT

Some health systems have adopted anchor approaches that stand out because of their efforts to invest resources in lending and business development. Catholic Healthcare West's (CHW) \$2.5 million investment in the California FreshWorks Fund, noted earlier as a sustainability best practice, is just one of many below-market interest rate loans it has invested in nonprofit organizations since it began its Community Investment

Program (CIP) in 1992. According to CHW’s Standards for Mission Integration, through CIP, “the System facilitates collaborative partnerships to improve the health status and well being of persons in CHW service areas and other communities in need.”¹⁵⁵

In FY 2011, CIP allocated \$70 million for loans and \$10 million for loan guarantees. Borrowers included nonprofits developing affordable housing, providing job training, financing neighborhood revitalization, offering needed medical services, and helping build wealth in underserved communities. In just FY 2011, CHW reported that its program loans helped finance the construction of 16,324 units of housing and eight nonprofit facilities serving children, youth, women, families, seniors and individuals who are disabled and/or homeless. Additionally, loans were provided to 28 Community Health Clinics during the state’s budget crisis. Investments in 2011 helped leverage an additional \$160 million in capital.¹⁵⁶

As of June 30, 2011, there are \$39.5 million in outstanding loans to 52 organizations and an additional \$14.5 million in loans approved that have not yet been distributed to nine organizations. Since the program’s inception, CHW has lent a total of \$132 million to 221 organizations; \$84 million of the principal has been repaid.¹⁵⁷

Another example of community investment is provided by three Providence, Rhode Island-based not-for-profit hospitals. Rhode Island Hospital, St. Joseph’s Hospital, and Women & Infant’s Hospital joined forces to provide \$1 million in critical, early-stage funding for the nonprofit South Providence Development Corporation over its first five years. The nonprofit is focused on helping revitalize this struggling community through a variety of economic initiatives including business development and job placement. In 1999, South Providence effectively leveraged this early capital and a federal grant to purchase vacant property that had once been used for manufacturing and repurpose it into a business incubator focused on “green” and other businesses. The Gordon Avenue Business Incubator—Rhode Island’s first commercial “green” building—opened in November 2002, with 18,000 square feet of net leasable space, two shared conference rooms, and an exhibition area. As of 2006, South Providence had assisted 216 neighborhood residents find employment and helped create 26 jobs for local residents through financing and launching a for-profit, neighborhood-based recycling company called CleanScape. It also partnered to help create two other local enterprises—Horton Interpreting and AccuLab.¹⁵⁸

Initially conceived as a University of Massachusetts Amherst (UMass) project in 2010, the Wellspring Initiative is another anchor-supported business development initiative. Wellspring hopes to stabilize struggling communities by developing a network of employee-owned businesses that leverage the purchasing power of anchor institutions in inner-city Springfield—the poorest metropolitan area in Massachusetts. In 2011, the Robert Wood Johnson Foundation awarded the lead community-based organization working with UMass—Partners for a Healthier Community—a \$200,000 “Roadmaps to Health” community grant to began the first development stages of this project,

which is based on the Evergreen Cooperative Initiative in Cleveland. Baystate Health, a not-for-profit health system that employs more than 10,000 people across three hospitals and multiple outpatient facilities in Western Massachusetts, has emerged as an important funder and driver in the project's first stages of development, contributing \$50,000 in matching funds and executive leadership support. Wellspring, in total, has raised \$105,000 in matching funds from multiple anchor partners, including \$5,000 from Providence Health System.¹⁵⁹

Baystate's flagship 653-bed academic medical center is located in Springfield. Steve Bradley, who serves as Baystate's Vice President for Government & Community Relations & Public Affairs, was interested in the idea of "intervening in neighborhoods to build capacity and revitalize them," explained Dr. Frank Robinson, who doubles as Executive Director of Partners for a Healthier Community and Director for Community Health Planning at Baystate. Robinson added that Bradley "was a person in a key position that could invest [Baystate's] time and money" and Wellspring was an "idea that fit within [Baystate's] focus on what we can do in the neighborhood." Other Springfield anchors have demonstrated various levels of project commitment, with most serving only in a funding capacity. However, Robinson noted, although Wellspring is still in its early development phases and anchors have not yet been engaged on how they will participate through their supply chain purchasing, all of the anchor funders "understand that there is a larger ask—a longer-term investment that we are looking for from the anchors."¹⁶⁰

In 2007, the University of Pittsburgh Medical Center (UPMC) made a different type of community investment. Proposed in late 2006 by Pittsburgh's Mayor Luke Ravenstahl and then city school's superintendent Mark Roosevelt, the Pittsburgh Promise would only become a reality if a prominent anchor institution could commit significant financial backing; it would not be an inexpensive commitment to award every Pittsburgh Public Schools' alum that had maintained a 2.0 grade point average (GPA) (and certain residency requirements) a college scholarship of \$5,000 per year up to four years. UPMC, which had come under criticism during this period, along with other local nonprofits, for not paying its fair share of taxes despite large surpluses, committed to seeding the fund with \$10 million and pledged to match \$1 for every \$1.50 raised, up to \$100 million. Pittsburgh Promise's goal is to raise \$250 million over a 10-year period with the intent that the interest will fund scholarships in perpetuity.¹⁶¹

The hope is that the Pittsburgh Promise, which is administered by the Pittsburgh Foundation, will help spur a reversal of the city's population decline, spur public school and neighborhood revitalization, and create a competitive workforce for local employers. Although it is impossible to determine causation at this early stage regarding an effort of this scale, population decline within the city slowed dramatically between 2006 and 2009 and the population grew between 2010 and 2011. The first eligible class for the Pittsburgh Promise was the class of 2008, with 835 students receiving the scholarship that could be applied to more than 100 accredited post-secondary institutions

in Pennsylvania. From that class, 60 percent of the recipients were women, 43 percent were minorities, and 46 percent “were from families with incomes low enough that the federally determined estimated family contribution was zero. About 83 percent were eligible for state and federal grants.” Once receiving the scholarship, students are required to maintain a full-time course load and 2.0 GPA at the post-secondary institution.¹⁶²

In 2012, the Pittsburgh Promise increased the scholarship to \$10,000 per year (up to a total of \$40,000) and tightened the eligibility to those with a GPA of at least 2.5 and 90 percent attendance rate. It also expanded eligible institutions to any accredited post-secondary institution in the state. By June that year, the Pittsburgh Promise had announced that it had raised \$160 million over its first four years, with UPMC contributing nearly \$36 million. To date, 3,200 students have received scholarships totaling \$25 million.¹⁶³

MULTI-INSTITUTION PARTNERSHIPS

Health systems do not have to act unilaterally in their community work. In many cases, as evidenced by examples in this section of the report, they *should* partner with other anchor institutions, philanthropic organizations, community nonprofits, and local government to maximize their impact. A “critical mass” of support with a place-based focus, which includes targeting resources and institutional leadership *along* with community buy-in and participation, is key to creating the necessary momentum to revitalize impacted communities.

The Southside Institutions Neighborhood Alliance (SINA) in Hartford, Connecticut is an early example of a multi-institution partnership—and is now considered a national model for neighborhood revitalization. Hartford Hospital, along with The Institute of Living and Trinity College, formed SINA in 1976 and initially focused on working with community organizations on local issues and helping found a weekly community newspaper that is still published today. The alliance’s early work was instrumental in changing the institution’s perception within the community and helped lay the groundwork for a positive working relationship for future community and economic development projects. SINA strongly emphasizes its commitment to “working *with* its neighbors and not imposing its own agenda” (emphasis not added).¹⁶⁴

Throughout the 1980s and early 1990s, SINA had an active role in a variety of neighborhood revitalization projects, including operating an employee mortgage assistance program and assisting in several housing and commercial projects. By the late 1990s, Connecticut Children’s Medical and Connecticut Public Television and Radio expanded SINA’s membership to five. Despite the new members and earlier projects, a weak economy had reversed many of the neighborhood gains; as a consequence, SINA developed

a comprehensive strategic plan in 1996 that built off of its community standing and deployed its financial resources to have “an immediate and dramatic physical impact.”¹⁶⁵

At the core of SINA’s Neighborhood Initiative was the development of a 16-acre educational campus called The Learning Corridor, in partnership with state and local agencies, on top of a former bus depot that was considered among the most blighted and environmentally contaminated properties in the city. To fund the four public magnet schools, the anchors provided \$10 million in early capital, which helped leverage an additional \$102 million. Hartford Hospital “has been a key player” in construction oversight, financial planning, and on-going facilities management of the site.¹⁶⁶

Another key component of the Neighborhood Initiative was a housing program called Cityscape Homes, which sought to address the persistent problem of weak housing demand. Utilizing a “target block” approach focused first on the areas with the most blighted properties, SINA, in partnership with two local nonprofit housing organizations, maximized its economic impact, creating enough housing demand for a waitlist today and providing affordable housing options for local residents. To date, SINA has helped construct or rehabilitate at least 55 affordable homes and 74 rental units. Other Neighborhood Initiative projects include the revitalization of Park Street—the neighborhood’s and city’s busiest retail corridor—and the establishment of a neighborhood Job Center, which has served more than 3,000 people.¹⁶⁷

Other hospitals are starting to explore partnerships focused on economic development too. As the city’s largest employer, Cooper University Hospital is part of an “eds and meds” redevelopment strategy in Camden, New Jersey. In Ohio, Cincinnati Children’s Hospital, TriHealth, and UC Health, which include three of the Uptown Consortium’s five member institutions, are together focused on revitalizing Cincinnati’s Uptown neighborhoods.¹⁶⁸

This section highlighted the variety of anchor strategies available to hospitals, but it is by no means exhaustive. In the next section, this report will look at five case studies of health systems that have implemented a combination of the anchor strategies listed here. For example, three of the health systems—Henry Ford Health System and University Hospitals and Cleveland Clinic—are participating in multi-institution partnerships, but they are also incorporating sustainability, community investment, local hiring, capacity building, and supplier diversity initiatives. The following section will also explore in more depth the challenges and lessons learned by each hospital as each strives to embrace its anchor institution mission.

Section Four

Case Studies

Rochester, Minnesota:

Mayo Clinic

Mayo is the engine that drives this community and we are all interdependent.

- Steve Thornton, former Executive Director, Rochester Area Foundation¹⁶⁹

Mayo Clinic, based in Rochester, Minnesota, has been one of the largest community benefactors in Southeast Minnesota for more than a century. Similarly, Mayo's economic impact on the region can hardly be overstated. As Karel Weigel, Mayo's first Administrator for Community Relations from 1999 to 2009, summarized, Mayo is the "economic driver" of Rochester, and "Rochester is the economic driver for essentially all of southeast Minnesota."¹⁷⁰ Mayo's role as an anchor is evolving as it starts to assume a greater role in spurring local revitalization of the surrounding region and Downtown Rochester and as it begins to consciously target local purchasing in the surrounding community.

In 1863, Dr. William Worrall Mayo settled with his family in Rochester and began his medical practice. After a tornado destroyed most of the homes and commercial structures on the north side of town and killed 24 people in 1883, the Sisters of Saint Francis offered to build Saint Mary's Hospital "on the condition" that Dr. Mayo and his sons provide the medical care. Soon other doctors and researchers became partners as demand increased, and Mayo became the world's first private integrated group practice. Today, this type of practice is the norm in the United States, and Mayo is one of the largest in the nation with more than 1,700 medical doctors. More than 58,000 doctors, nurses, scientists, students, and allied health staff work together at Mayo Clinic locations in the Midwest, Arizona, and Florida.¹⁷¹ Together, Mayo's facilities purchase more than \$1.8 billion in medical supplies, equipment, and services across five states.¹⁷²

The center of the health system is its operations in Rochester. Partially as a result of Medicare reimbursement issues, in 1986, Mayo Clinic acquired the 335-bed Rochester Methodist Hospital and the 797-bed Saint Mary’s Hospital in the city’s downtown. Together, these three institutions employ more than 33,500 people in Rochester, and serve as the largest private employer in Minnesota, capturing the workforce from a sixty-mile radius. Additionally, half of Mayo’s purchasing—in aggregate, nearly \$1 billion—occurs through its operations in Minnesota.¹⁷³

Rochester is the third-largest city in Minnesota. Significantly intertwined, the two largest industries in Rochester are healthcare services and the hospitality/tourism industry. An estimated 70 percent of the city’s 2.75 million visitors each year come to Rochester because of Mayo Clinic. From an employment perspective, the combined workforce of Mayo and those who work within the hospitality and tourism industry is greater than 44,000, which is more than 75 percent of Rochester’s civilian labor force or more than 43 percent of the entire civilian labor force for the Census-defined Rochester Metro Area.¹⁷⁴

Historically, Mayo has at many points in its history recognized its role as more than just a provider of healthcare services and community health programs; it has often been the principal community benefactor. In 1944, Mayo donated the initial \$3,500, and then soon after another \$50,000, to found the Rochester Area Foundation (RAF), helping to

MAYO CLINIC ANCHOR STRATEGIES

Neighborhood Revitalization

- Principal investor (\$7 million) in community land trust First Homes, has developed 875 units of affordable housing

Local and Minority Purchasing

- Strives to purchase food from within 150-mile radius
- Supplier Diversity Program: established 2008, includes focus on small, local businesses and mentorship component

Sustainability Practices (with Anchor Institution Mission lens)

- Donates unused food to local food bank, food waste to local farm

- Hosts farmers markets frequently in its facilities

Multi-Institution, City, and Regional Partnerships

- Partner with RAF to improve early childhood literacy skills, contributed \$750,000
- Partner in developing Downtown Master Plan for Rochester
- Developing larger diversity initiative, called “Marketforce,” with Rochester Chamber of Commerce and local community development financial institution

bring “the concept of a community foundation to Rochester,” said Steve Thornton, former Executive Director of the Rochester Area Foundation. Around the same time, just after World War II, Mayo built a subdivision in Rochester for returning physicians and residents to help with the post-war housing shortage. Thornton added that while Mayo did not own the properties, the institution helped assemble the land, contributed to the architectural and design features of the homes, and influenced the overall layout of the subdivision.¹⁷⁵

Mayo did not involve itself again with housing again until the 1990s. In 1999, RAF reached out regarding the issue of affordable housing in the greater Rochester area. During that period, Mayo, along with other local businesses like IBM, Fastenal, and Benchmark Electronics, grew dramatically and along with this growth came the corresponding need for schools and public infrastructure support. Two notable changes occurred during this time. First, as this period of growth increased the number of available employment opportunities — the overwhelming majority with Mayo, but many in the public sector as well — the availability of affordable housing dramatically decreased. Rochester was experiencing the beginning of the real estate bubble that would only burst at the beginning of the Great Recession. Noted Thornton, “Local businesses were hiring folks, starting them at \$40,000 and \$50,000 a year, and they were quitting two weeks later because they couldn’t find affordable housing.” Additionally, Mayo was spending nearly \$2 million on rental subsidies to have people live in Rochester while housing was being built.¹⁷⁶

At the same time, a cultural shift was occurring within Mayo. “Mayo Clinic and the community, while growing up together and living side by side as good neighbors, recognized the importance of interdependence and that it would be to everyone’s advantage to define and articulate Mayo’s role in Community Relations for both internal clarity at Mayo and externally for the community,” said Weigel. According to Weigel, Mayo historically worked with and supported community organizations and initiatives, but these efforts tended to be decentralized and inconsistently communicated. Additionally, at times, the community felt overlooked by the institution’s decision-making style that seemed to be communicated on a ‘need-to-know’ basis. Mayo leadership recognized that the institution needed a community point person who could not only effectively represent Mayo in the community but also represent the community back to Mayo and help it navigate a growing institution.¹⁷⁷

As a result, Mayo created the position of Community Relations Administrator to be a liaison between the community and Mayo Clinic. The position was responsible for creating and implementing a needs-based and value-driven strategic plan to measure and assess outcomes. Mayo’s efforts to increase transparency and focus on community partnership gained visibility with the implementation of the Annual Community Breakfast. Another important step in this relationship was the close collaboration between the planning departments of Mayo Facilities and the City of Rochester to release Mayo’s five-year development plans to the Rochester community. This allowed

for better planning than previous yearly updates. Together, these important communication strategies have assisted the community’s planning by anticipating civic infrastructure and workforce needs, as well as providing important background for economic forecasting.¹⁷⁸

Mayo’s expansion, a decrease in affordable housing stock, and a cultural change within the organization provided the right atmosphere for RAF to approach Mayo Clinic with a proposal to create “starter homes for working families.” The result of this meeting was a commitment by Mayo to help fund the community land trust First Homes, a proposal that aimed to build 875 units of housing over a five-year period. RAF provided the leadership gift of \$1 million but the project was expected to cost \$12.75 million; Mayo agreed to provide \$7 million: \$4 million initially and an additional \$3 million allocated on a matching basis. Weigel, who also chaired the First Homes board, estimated that another \$5 to \$7 million was raised locally. The project also received financial support and guidance later from the city as well as funding and technical assistance from Greater Minnesota Housing Fund, Minnesota Housing Finance Agency, and USDA Rural Development, to help “provide gap loans to potential homeowners and tax increment financing to developers.” In Weigel’s assessment, this project still remains “the most successful public-private partnership our community has ever done.”¹⁷⁹



A house in First Homes’ community land trust portfolio. Photo: First Homes.

There were a few components of this financial commitment that made Mayo’s actions unusual and why it represents an anchor institution best practice. The core of this proposal was not just affordable housing but a community land trust, which aims to preserve affordable housing permanently. This shared-equity strategy, which was not very common at the time, accomplishes this goal because the trust owns the land and enters into a long-term, renewable lease with the interested homeowner instead of a traditional sale. When the homeowner sells the house, the family earns only a portion of the increased property value.¹⁸⁰

The property value increase not captured by the seller is kept by the trust, preserving the affordability for future low- to moderate-income families. The percentage earned by the homeowner varies by community land trust; in the case of First Homes, the homeowner and land trust split the equity gain. For example, if a home increases in value by \$50,000, the homeowner would earn \$25,000 and First Homes would capture the remaining \$25,000 in property value, reducing the next family’s mortgage by that amount. This community wealth building strategy enables multiple families to benefit from each home built because it does not allow the equity gain to benefit just one

family. As a result, a land trust minimizes the capital investment needed per family impacted and enables each family to build some assets (rather than none if they had continued to rent) so that the family can eventually “step up” to a more expensive unit in the land trust or purchase a home outside of it.¹⁸¹

The second unusual aspect of this arrangement is how this investment was truly a community investment in terms of who benefited. Although Mayo contributed the majority of the funds to this project, they did not request that the homes be situated only in Rochester or that they be sold only to Mayo employees. The reason that this strategy was not entirely Rochester-based, said Weigel, was that “if we were [focused on Rochester only]. . .two things happen: first, the option of location would have been limited to Rochester, and second, you devastate the infrastructure from loss of taxes in the surrounding small communities.” Thornton added that Mayo declined to “restrict its gift” because it understood that the housing crisis was a community problem requiring a community solution and that the entire community should benefit. Mayo and Rochester rely on surrounding communities to supply the workforce. As a result, First Homes’ projects are found within a 30-mile radius of Rochester, and Mayo employees have purchased only about one third of the homes.¹⁸²

The only eligibility criterion for First Homes is income; anyone who earns 80 percent of state median income or area median income can apply to purchase a home. Additionally, interested homeowners have to complete homebuyer education classes as part of the purchasing process. By 2007, First Homes had reached its initial goal of 875 units of affordable housing—500 single-family homes and 375 units of rental. Of those initial 500 single-family homes, 200 are held by the community land trust. The current land trust portfolio has 210 units. To date, First Homes is the “state’s largest-ever community-based assisted-housing program.”¹⁸³

As First Homes worked toward its goals of 875 housing units, other housing opportunities presented themselves. A neighborhood that encompasses the boundaries of Mayo Clinic’s Rochester downtown campus, Kutzky Park, is filled with historic homes; however, many were converted to multi-family rental properties and many were in disrepair. RAF and First Homes again approached Mayo Clinic with a proposal to assume responsibility for completing Kutzky Park renewal projects begun by another nonprofit organization that lacked the capability to complete them. These homes were rehabilitated with updated design and landscaping and became a new part of First Homes. This offered new housing choices in historic buildings within walking distance



A house in First Homes’ community land trust portfolio. Photo: First Homes.

to Mayo Clinic and Downtown Rochester, and became a key ingredient stabilizing the neighborhood.¹⁸⁴

Of course, First Homes has had its challenges. There were problems establishing the land trust, and Mayo's matching-grant formula, while successful in leveraging contributions, relied upon raising community funds first for the final \$3 million. This extended the duration of fundraising beyond original expectations. There was also initial resistance from the Chamber of Commerce and business leaders regarding the stigma of affordable housing. Explained Allen, "We wanted to do everything through the land trust, but the first three years we just couldn't. We struggled to set up our land trust." Since First Homes was developing 100 homes each year, this obstacle is the primary reason that the first 300 single-family homes (i.e. the first three years of home construction) were not included in the trust.¹⁸⁵



House donated by local homeowner to First Homes, relocated in neighborhood. Photo: First Homes.

Although the initial gift of \$4 million and the agreement to contribute \$3 million in matching funds was decided quickly (a period of only five months start to finish), the process to actually secure the matching funds took considerably longer, noted Allen. Today, capital issues still represent a challenge for First Homes. At the time, the crisis was sufficient enough to allow RAF to raise \$14 million; now there is a need to recapitalize at a time when there is not an equivalent sense of urgency.¹⁸⁶

First Homes has evolved as the needs of the community have changed. Rochester's population has grown, the University of Minnesota now has a Rochester campus, and overall plans for downtown are under way. First Homes has continued to work with all of these partners to preserve housing affordability as part of a "comprehensive" strategy for revitalizing Rochester, focused primarily on seven neighborhoods in Downtown Rochester.¹⁸⁷

Over the next ten years, revitalization spending in this area is expected to be greater than \$360 million. Although Mayo has not been involved financially in First Homes since it contributed the matching funds (and donated a few properties it had purchased in the Kutzky Park area), Mayo Clinic employees continue to participate on the boards of First Homes and RAF. As a potential partner in this redevelopment, Allen noted that he believes "we'll be able to rely on [Mayo] for some additional resources for downtown housing; we've been talking to them." Mayo has not officially committed more resources to housing, according to Susan Fargo-Prosser, Communications Specialist in

the Department of Public Affairs at Mayo, although they would consider doing so based on evidence of continuing need and availability of institutional resources.¹⁸⁸

Sean Allen, former Assistant Director of RAF, explained that his organization recently collaborated with Mayo on First Steps—an initiative that aims to ensure children start school with proficient literacy skills to succeed. “It has changed the way we work with them,” he said. It “is building something; it’s a concept.” Since 2005, Mayo has contributed \$750,000 to this “public-private economic development program” that seeks to reduce the nearly 50 percent of kindergartners who enter school unprepared. Referring to this program as an investment in the community, Susan Ahlquist, former Director of Community Relations for Mayo Clinic (2008–2012), added, “We recognize the importance of education and early childhood development as key social determinants of health.”¹⁸⁹

Procurement is another area where Mayo has started to institutionalize new practices, striving to increase local purchasing and diversify its supply chain. Fargo-Prosser explained, “We try to buy all of our food served in all our cafeterias and facilities within a 150-mile radius.” This purchasing supports local agriculture, considering that the demand currently exceeds supply. Any food that goes unused is donated to Second Harvest North Central Food Bank, while all waste that is no longer safe for human consumption is donated to a local hog farm. Mayo also seeks to encourage local food purchasing by its staff by hosting farmers markets in its cafeterias, “pretty much all the time,” noted Fargo-Prosser.¹⁹⁰

Mayo has also made efforts in recent years to consciously diversify its supply chain, establishing the Supplier Diversity Program in 2008. In addition to focusing on minority and women-owned business, the program’s mission also includes veteran-owned, small, and local businesses. The challenge to achieving this goal is identifying these potential suppliers and ensuring that they are capable of performing. As a result, one element of making this effort work is Mayo’s Business Mentorship program, which, through a partnership with Rochester Area Economic Development, Inc. (RAEDI), aims to provide potential suppliers with “effective feedback and support.”¹⁹¹

An interested and eligible business applies via the appropriate channels on Mayo’s website. Then that business receives feedback from the Supplier Diversity Manager and the Supplier Diversity Ally Team regarding whether the supplier provides a product/service Mayo does not need, whether the product/service is already contracted, or whether the product/service is needed but the business does not meet necessary supplier standards. The business then has the option to take “this information and feedback to RAEDI for planning assistance.”¹⁹²

RAEDI then aids the business in identifying strategies for improving its “qualifications and chances for future success.” Next, a joint meeting between RAEDI, the business and the Supply Diversity Manager will “review any actions/results” that have occurred because of the feedback provided to the business. From here, a variety of possible next

steps are identified, which could include connecting the supplier to the appropriate applicable department Mayo Clinic, a repeat of the steps listed above, or a disqualification of the business from acting as a Mayo supplier with “clear reasoning.”¹⁹³

A larger initiative focused on diversity—“Marketforce”—is a collaborative effort between Mayo, the Rochester Chamber of Commerce, and the African Development Center, a community development financial institution serving African immigrants and refugees. Incorporating elements of the Supplier Diversity Program, it also aims to develop metrics for each activity and ensure that the small businesses are ready and “financially capable” to be dependable suppliers, explained John Wade, President of the Rochester Chamber of Commerce. Wade noted, “Another component is entrepreneurial development. As we build a vibrant community, it is very important. . .to have the flexibility, freedom, and resources to bring their products to market.” Already two years in development as of February 2012, the project is anticipated to be fully operational by the first quarter of 2013.¹⁹⁴

Mayo is “at the table” for “addressing every major social issue: homelessness, gang activity, whatever the community needs,” said Ahlquist. In recent years, it has begun to recognize its role as an anchor with more clarity. Ahlquist added, “Mayo Clinic in Rochester has always played a major role in community development and benefit as a quiet anchor within the community. More recently its role has become more visible and strategically intentional.”¹⁹⁵

In 2009, Mayo was involved in developing a Downtown Master Plan “that had all of the players involved.” Components of that plan incorporate Mayo’s vision for transforming Rochester into the “world’s premier destination medical *community*”—not just a “destination medical center.” To accomplish this goal, Mayo is making sure that community and stakeholder input is a very important part of the planning process. Wade, who co-chairs the effort with Lisa Clark, Mayo’s division chair of the Department of Public Affairs, is optimistic about the project: “It is a tremendous undertaking. We’ve aligned a lot of resources...that includes everything from transportation, to hospitality, to workforce.” In addition, Mayo itself will grow by about 10,000 employees over the next decade. Regarding the project, says Wade in another interview, “If we do this right, we will all feel the benefits of it.”¹⁹⁶

La Crosse, Wisconsin:

Gundersen Lutheran Health System

One of the biggest things we all do. . . [is] working with relationships, whether it is with La Crosse County, or Western Technical College, or other businesses. Because we are the biggest employer and have the biggest economic impact on the whole region, we see that as a leadership role, but we don't always want to be the one leading, we want others to join, and I think we are really successful with that.

- Dave Demorest, Purchasing Manager, Gundersen Lutheran Health System¹⁹⁷

Since its founding, Gundersen Lutheran Health System's mission has included a commitment to the health of its communities. That commitment has taken many traditional forms, from sponsoring healthy living events in the community to providing health screenings to working with local restaurants, convenience stores, and other retailers to offer healthier food choices. In recent years, though, Gundersen has expanded the definition of community health to include environmental and economic sustainability, measuring its success through a "two-sided green" principle. This concept requires solutions to have a positive environmental impact while reducing costs for patients and the health system. In 2008, Gundersen established an aggressive program called Envision to achieve environmental leadership in the areas of energy conservation and renewable energy, waste management, recycling, and sustainable design.¹⁹⁸

Gundersen is an interesting case study because of its use of community development strategies to achieve its environmental stewardship goals. As the largest employer and most significant economic engine in the region, Gundersen's commitment to sustainability has also enabled it to have a important community wealth building effect on its surrounding communities through setting local purchasing goals, developing local alternative energy sources, and helping found a multi-stakeholder food cooperative. Gundersen has also rehabilitated old buildings into affordable housing, and repurposed other facilities, built environmentally friendly infrastructure improvements, and offered financial incentives for local homeownership.

Formed in 1995 through the merger of Gundersen Clinic and Lutheran Hospital, Gundersen is a physician-led, not-for-profit health system, based in La Crosse, Wisconsin, and serving a tri-state area of more than 500,000 people that includes parts of western Wisconsin, northeastern Iowa, and southeastern Minnesota. The health system, with roots that go back to 1891, today employs more than 6,000 people, has operating

revenue in excess of \$1.3 billion, and operates 51 clinics throughout 19 counties in the Tri-state Region. According to a case study of Gundersen conducted by Sarah Klein and Douglas McCarthy for the Commonwealth Fund, “The population it serves, which is both urban and rural, is healthier, less transient, and more educated—but older and poorer—than the national median.”¹⁹⁹

At the center of Gundersen’s health system is a 325-bed hospital and multi-specialty clinic in La Crosse, which also operates as the Western Academic Campus for the University of Wisconsin School of Medicine and Public Health. Sarah Havens, Director of Community & Preventive Care Services for Gundersen, noted that the La Crosse Campus also serves as an “anchor for the southside neighborhood” in which it is located and has been the target of city redevelopment efforts.²⁰⁰

GUNDERSEN LUTHERAN HEALTH SYSTEM ANCHOR STRATEGIES

Neighborhood Revitalization

- Restored historic building, developing 68 units of affordable housing
- Restored historic building into a healthcare training and data center
- Provides employer-assisted housing program

Local and Minority Purchasing

- Goal: 20% food sourced locally
- Founding member of multi-stakeholder Fifth Season Cooperative
- Developed local renewable energy sources that use wind and biogas
- Employs several strategies to assist local businesses compete for contracts

Sustainability Practices (with Anchor Institution Mission lens)

- Envision goals: environmental leadership in energy conservation and renewable energy, waste management, recycling, and sustainable design

- Goal: 100% energy independent by 2014
- Donates leftover food to local Salvation Army, about 1,000 meals per month
- Reprocesses single-use items with regional supplier
- Challenges employees to reduce their environmental impact

Multi-Institution, City, and Regional Partnerships

- Developed renewable energy waste biogas project with La Crosse County (11% of total goal)
- Developed wind-power site with Organic Valley
- City-county taskforce to assess infrastructure conditions in surrounding neighborhood
- Coordinates with Wisconsin Department of Natural Resources before projects commence

Although Gundersen had an environmental mindset for a number of years, the health system launched its current environmental and economic sustainability program in 2008. Jeff Rich, Executive Director of GL Envision, a subsidiary of Gundersen Health System, remarked, “We started looking at whether it was possible—economically and technologically—to become 100 percent energy independent as a health system. And it looked like we could. So we set a goal and thought ‘what is a reasonable timeline to do all of this?’ Because if you make it too long, there’s no urgency or management changes. . .but you can’t make it so short that you burn yourself out in a year or two and can’t sustain anything else you’re doing.” By 2014, Gundersen expects to be able to meet 100 percent of its energy needs through renewable energy projects and improvements in energy efficiency.²⁰¹

Rich pointed out that in addition to becoming 100 percent energy independent, Gundersen is also striving to encourage local economic growth and development and reduce the cost of patient care through the initiatives developed under Envision. Gundersen has adjusted its purchasing and supply chain in many ways to reflect its “two-sided” green principle. One of its big efforts involved working with a vendor to meet specific environmentally friendly cleaning requirements for the organization and doing so cost effectively. The organization had anticipated a cost increase; however, Dave Demorest, Purchasing Manager for Gundersen, said the net result was a *decrease* in cost and guaranteed pricing for five years—a first for Gundersen. “We implemented it systemwide, including at our regional facilities, and at the same time, we got to move to a totally green product and save money.”²⁰²

As a result of this agreement, Gundersen was also able to standardize its paper recycling—capturing all types of paper products, including confidential documents, from 42 sites—and bring it to one location to get processed and recycled. Tom Thompson, Sustainability Coordinator and also part of the leadership team for Facility Operations, emphasized, “We had a win with standardization, a win with green cleaning, a win with the contract, and a win with recycling. All with the same project!”²⁰³

Gundersen has also established a corporate-wide, multi-device program in which their vendor for copy machines is now required to take back and recycle the old plastic ink containers that previously ended up in the landfill. Another environmental effort that has significant cost savings for Gundersen is a policy of asking vendors for the electricity requirements of their equipment and examining the products’ energy-savings features before purchasing any unit. Although these questions are not the primary determinants in deciding whether to purchase one piece of equipment over another, the answers will influence a decision between two items that are comparable in performance.²⁰⁴



Wind turbine energy project in Lewiston, Minnesota (November 2011). Photo: Gundersen Lutheran.

Gundersen's commitment to the environment at the operating level also extends to its employees. The health system worked with a Wisconsin nonprofit to develop a challenge for employees to reduce their carbon footprint called "My Envision." Set up as an on-line game, employees earned points for practices such as using energy efficient light bulbs, biking or walking to work, or installing energy efficient renovations at home, incentivizing employees to look for ways to reduce their carbon footprint in their everyday work. An important piece of employee engagement was communication and staff buy-in.²⁰⁵

As Thompson explained, "For the equipment, materials, and process changes at work, it is only successful if staff are willing to work with it and make that change. So as we communicate, it is so important for employees to understand why are we doing so. As long as they are understanding and we are providing them information. . .it will be good in the long run." Through its own initiative Gundersen encourages "active commuting," by building biking and walking trails on its property that connect to those around town. Gundersen is also exploring ways to make biking to work a more attractive option for employees by building bike shelters on campus with the aid of County grants, and is considering developing a bike-share program.²⁰⁶

With regard to energy, Gundersen has made significant strides toward reaching its aggressive target of achieving energy independence by 2014. Rich pointed out that the health system's facilities are the largest components of the carbon footprint. Therefore, one of the first steps taken to move the institution toward energy independence was the completion of comprehensive energy audits at several of the campuses. Energy costs had been increasing rapidly leading up to 2008, increasing by more than \$350,000 from 2006 to 2007, excluding campus growth. After the audits, Gundersen began the process of retro-commissioning—examining heating and cooling systems, lighting and employee behavior, and using low-cost or no-cost measures to improve efficiency and reduce energy demand. By the end of 2009, this process alone allowed Gundersen to improve its energy efficiency by 25 percent and achieve savings of more than \$1 million annually.²⁰⁷

Another strong focus has been on recycling. According to Thompson, in 2011, more than 35 percent of waste was recycled—well above the 25 percent threshold required to receive the Practice Greenhealth Environmental Leadership Circle award, which is given by a nonprofit seeking to encourage healthcare institutions to adopt more environmentally friendly practices. Whereas most facilities or health systems Gundersen's size simply "try to hit cost-neutral," Thompson pointed out that in 2010, Gundersen's recycling program alone "saved \$70,000 for the organization through rebates and cost savings." "We don't just shoot for compliance; we're going for above and beyond," Thompson added. Another example is Gundersen's food waste program. The organization tracks how much and what food waste is being thrown away, and makes adjustments accordingly. Within six months of beginning this effort, Gundersen decreased its food waste by 50 percent. Often, leftover food is usable, but due to food service regulations, cannot be served at the hospital. Gundersen has made a

commitment to donating this food, more than 1,000 meals each month, to the local Salvation Army for use in their soup kitchen.²⁰⁸

Another important component of the Envision program is the development of local alternative energy sources through community partnerships. According to Rich, one such example is a project with La Crosse County that uses waste biogas created from garbage at the County’s landfill and turns it into electricity and heat at Gundersen’s Onalaska Campus. Rich described the process: “The gas is piped into an engine on the campus and turns a generator that creates the electricity that is sent to the power grid. The engine also creates heat, which is captured and used to heat the buildings on campus.” The engine produces as much energy as the Onalaska Campus consumes, making it 100 percent energy independent. The project represents 11 percent of Gundersen’s total energy independence goal. In addition, two wind power sites—one in Lewiston, Minnesota, and the other in Cashton, Wisconsin—have been completed and will generate nearly 14 million kilowatt hours annually. The Cashton project was the result of a partnership with Organic Valley, the nation’s largest cooperative of organic farmers and a leading organic brand. Other efforts currently in development include a biomass boiler project, a geothermal heat pump project, and a cow manure digester project—all of which would come on-line by 2014.²⁰⁹



Top: Engine for waste biogas energy project on Gundersen’s Onalaska Campus (May 2012). Bottom: Wind turbine energy project in Cashton, Wisconsin (May 2012). Photos: Gundersen Lutheran.

Gundersen’s projects and initiatives have also expanded into the surrounding community. For example, the Executive Director for External Affairs and Government Relations—Michael Richards—sat on the Joint City-County Housing Task Force, which reviewed the current housing stock in the neighborhood around Gundersen. The Task Force addressed ways to make the neighborhood more walkable and provide additional green space for public use. Another step, explained Rich, has been efforts to “recycle” old buildings. One such example is a 100-year old building that once was an ice house for a local brewery. It is now being used for Gundersen’s Integrated Center for Education, which trains healthcare professionals locally and from across the nation, and a data center. Thompson added, “In that building, we had a 90 percent landfill diversion rate during renovation. So we were able to re-use or recycle about 90 percent of the building materials. . . on a 100-year old building!”²¹⁰

Additionally, the La Crosse campus, noted Sarah Havens, is the “anchor for an older neighborhood in La Crosse.” According to Havens, the housing stock in this area is

“transitioning;” by working with the local neighborhood association, Gundersen created “processes and protocols to be a good neighbor.” She explained, “For example, if an employee purchases a home in the neighborhood and commits to using more public transit, Gundersen will pay your first year’s taxes” —creating a variation of a traditional employer-assisted housing program. Other commitments that Gundersen made include developing fewer flat parking lots on campus and increasing the amount of green space in any above-ground parking areas. Both of these commitments add “positive components to the environment,” such as reducing water runoff.²¹¹



Gund Brewery Lofts (Aug 2007). Photo: Gundersen Lutheran.

Another community revitalization project has been the development of affordable housing at Gund Brewery Lofts, which opened in the summer of 2007, in an area that the City of La Crosse is striving to redevelop. Gundersen provided the land—re-zoned from a heavy-industrial to a planned-development district—and a 58,000-square-foot building to affordable housing developer Gorman and Company, Inc., who developed the building using Low Income Housing Tax Credits and Historic

Tax Credits. The historic Gund Brewery, built in 1903, was “transformed” to create 85 units—68 of which are designated “affordable housing”—located within walking distance of Gundersen’s La Crosse Campus. Rich remarked, “If it makes sense to recycle a building, we can divert materials from the landfill, keep the flavor of the neighborhood consistent, and save on the environment as well.”²¹²

In 2010, Gundersen also established a goal to purchase 20 percent of its food locally in order to both serve “foods that are fresh, not processed, and in season” and to directly impact the region’s economy by supporting local producers. This commitment to local food has had a significant community development impact and proved essential to the creation of Fifth Season Cooperative. Nicole Penick, former Buy Local Coordinator for the Fifth Season Cooperative and the current Food and Farm Program Manager for the Valley Stewardship Network, explained that in Vernon County, adjacent to the county where Gundersen is based, “Food is what we do. We have the largest number of organic farms of any county in Wisconsin.”²¹³

By becoming one of the first purchasers of products from the Fifth Season Cooperative, Gundersen was instrumental in helping launch this multi-stakeholder, wealth building organization. Combining the principles of a sustainable economy, local ownership, and building community, this innovative cooperative is one of the first of its kind in the nation with six member classes—producers, producer groups, food processors, distributors, buyers, and cooperative workers—which all help ensure that Gundersen can purchase local produce, meat, and dairy products within a 150-mile radius.²¹⁴

The idea for Fifth Season Cooperative was first introduced when Western Technical College in La Crosse hired a consultant to see how it could better meet its sustainability goals. As a result of the meetings organized by the consultant that brought together “economic developers, planners, Organic Valley, and different institutions,” said Penick, a list of recommendations was produced for how to move forward. However, the primary institutional challenge was working with so many small producers. Penick explained that Sue Noble, Director for Vernon Economic Development Association, “was hearing from all the institutions that ‘I don’t have time to talk to multiple farmers; I can’t place multiple orders to get my food out every day.’ And so Sue Noble recognized the need for a coordinator between farmers and institutional food buyers.”²¹⁵

At the same time, Wisconsin’s Department of Agriculture was offering grant money to increase buying local practices. In the process of writing the grant, which was awarded in January 2010, the idea for developing a cooperative was incorporated into the proposal. Penick noted that Noble “has been developing the Food Enterprise Center as a hub with the infrastructure for food-related businesses to aggregate, store, process, market, and distribute local food.”²¹⁶

In addition to the relationship between Gundersen, other institutional purchasers, and the local producers, Fifth Season has raised approximately \$115,000 to date from community investment stock, which pays an annual five percent dividend, to establish operations at the distribution center. As Penick pointed out, the investors gain equity in a local business, while members of the cooperative, including a representative of Gundersen, comprise its board, which provides oversight to the organization.²¹⁷

Fifth Season has also had an important role in helping mitigate food-safety costs for its supplier members. In most situations, large foodservice distributors require their suppliers to meet insurance and audit requirements that often preclude small producers from qualifying because of the cost of these requirements. In effect, this also prevents small producers from selling to larger buyers, like Gundersen, who purchase their food through foodservice distributors. To help its members compete, Fifth Season carries the food-product liability insurance policy for all of its suppliers. The cooperative also runs a mini GAP (Good Agricultural Practices) audit on all of its growers and a HACCP (Hazard Analysis and Critical Control Points) audit on its food processors. Fifth Season supplies its members with the materials and hosts the trainings needed to pass a cooperative audit. HACCP plans will also vary depending on the processor. For example, noted Diane Chapeta, Operations Manager at Fifth Season, coffee processing is very different from beef. Chapeta works one-on-one with each processor to help complete its audit. The ability for Fifth Season to serve as the connection between the



Fifth Season Cooperative’s first board, taken at the signing of articles of incorporation (August 2010). Photo: Gundersen Lutheran.

large institutions and smaller producers—effectively bridging the scale divide—was and remains essential to the success of this anchor strategy.²¹⁸

Gundersen has begun other efforts to purchase regionally while meeting its goal of decreasing waste from its facilities. Working with a remanufacturing facility in Minneapolis, Minnesota, Gundersen is able to send a large number of single-use items to a vendor who reprocesses those items and returns them at an equal or higher-quality standard than the manufacturer who made them in the first place. “They tear that product apart, clean and sterilize every component, and then put it back together in a usable format, repackage it, and then we repurchase it from them at a lower cost than ‘new’ items. And there are many products like this—mostly surgical,” explained Demorest. According to him, this process has created cost savings of 50 percent for these items, allowing them to set a goal of \$500,000 in savings for 2011. Currently, Gundersen is reprocessing approximately 87 out of a possible 300 items and hopes to expand this number in the future. Many items that cannot be reprocessed are recycled. “We throw *everything* in their bins; they don’t care what it is,” explained Demorest. “Before, we had to separate it and only put in the items that we remanufactured, and all the rest went in our infectious waste, which is very expensive. Now, they take care of all that, and still guarantee a savings.”²¹⁹

Gundersen has other local agreements too. Demorest admitted, “To be honest, some are a little bit more expensive, but because of our business relationship with those companies, and the fact that we can help local community businesses, we decided that it’s a savings in the long run.” In addition to saving Gundersen cost in freight, sourcing locally eliminates delays in shipping, is often more transparent, and strengthens the local economy. However, although all local businesses in the tri-state area are encouraged to participate in bidding for contracts, many of these small businesses are just not large enough to compete for contracts. To address this issue, Demorest explained that another strategy that Gundersen has used is to negotiate with the outside vendor to either hire the local person or to sub-contract with them. Gundersen has also been able to get some local businesses access to more cost-effective agreements that previously they could not access. In addition, they have gotten organizations to partner together to help control costs for Gundersen, while at the same time allowing each business to grow.²²⁰ These efforts utilize a similar concept to the principle behind creating the Fifth Season Cooperative, which aggregates the products of its smaller distributors, allowing it to serve as an intermediary between producers that do not operate on the same scale as Gundersen.

Gundersen has aggressively pursued a variety of environmental and community development projects in the last five years. While these efforts have not been without their challenges, “When you get some successes, you get some momentum, some pride, some accomplishments behind you—that fosters the next thing,” pointed out Demorest. Although these issues are specific to Gundersen, some of these challenges may

provide insight into how other healthcare institutions can incorporate better environmental practices and community development efforts.²²¹

In striving to adopt better environmental practices, Gundersen encounters the cost issue in almost all decisions. Demorest added, “It is important to do both sides of green, and that takes innovation. . . So some things that we might like to do we have to table because until we find the right business case, we can’t make it happen. Or here is a really good business case for something, but it isn’t the right thing to do environmentally, so we can’t do that either.” Many of the funding streams, such as tax credits that support environmental innovation in for-profit entities do not apply to Gundersen Lutheran because of its nonprofit status.²²²

Another challenge is how to effectively convey to both outsiders and those within the organization why Gundersen is focusing so heavily on environmental and community development issues. As Rich explained, it is important to constantly “tie these things” together so that people can “see the linkage” to Gundersen’s mission more easily. Doing so “helps remove the internal barriers” to projects and initiatives in this area.²²³

Although Gundersen has had success negotiating with some vendors with regard to services and reprocessing, equipment vendors have been more difficult to partner with to achieve cost and energy reductions. “Some of these units. . . consume three times more electricity than their competitors. And so we throw that back to them and say, ‘Why would we even consider you? We are going to pay less up front but not in the long run,’” noted Demorest. This is one area where paying slightly more initially saves Gundersen in cost over the lifecycle of that unit while reducing waste.²²⁴

Navigating the different regulations and opportunities at the state level has been another area that Gundersen has had to commit significant resources. Rules regarding distribution and vending across state lines vary from Minnesota to Wisconsin; grant programs and timelines are also different state to state. Trying to increase public sector buy-in, Gundersen has been actively working with Wisconsin’s Department of Natural Resources before it begins any of its projects. Explained Thompson, “We talk to them before we even put something in the ground, and so we build these relationships and when we need them we call them. . . we treat them as a partner.”²²⁵

Like most ambitious visions, Gundersen’s commitment to environmental sustainability and becoming a “good neighbor” as the primary anchor in the region is a continuing process. But there has been a strong impact already and this change of thinking and acting is pervading the culture of the organization as a whole. Thompson explained, “I look at the world differently now; I see waste opportunities everywhere now. If I drive by the landfill and see a flare, I see an opportunity; or the wind blows, or the water flows over a cliff, I just see [opportunities for renewable energy]. I look at it differently.” Demorest added, “And employees are seeing that too.” Havens concluded, “I think the decisions are made — it is not only the bottom line — it is how can we get to the bottom line the right way.”²²⁶

Baltimore, Maryland:

Bon Secours Health System

These are our roots. This is where we started. There's a significant commitment to the City of Baltimore.

- Gregory Kearns, Director, Strategic Management, Bon Secours Baltimore²²⁷

As the primary anchor institution in Southwest Baltimore, Bon Secours Baltimore Health System — through its subsidiary, Bon Secours Community Works — continues to expand the definition of its role as community anchor. Community Works' approach to community and economic development focuses on neighborhood revitalization and housing rehabilitation, providing family and women's services, offering youth employment and workforce development, and expanding financial services. Bon Secours Baltimore has also refocused its efforts in 2011 to increase local purchasing from minority- and women-owned suppliers.

As one of the largest employers in Southwest Baltimore, Bon Secours Baltimore has a 125-bed facility with more than 950 employees. Community Works has an operating budget of more than \$14 million. Bon Secours Baltimore is the flagship of the Bon Secours Health System, a \$3.3 billion not-for-profit Catholic health system sponsored by Bon Secours Ministries. Stretching across nine communities up and down the East Coast and headquartered in Marriottsville, Maryland, the health system has 23 different facilities and employs more than 21,000 people.²²⁸

Although Bon Secours began its community development efforts in the mid-1990s, Southwest Baltimore is still a community in need. As George Kleb, former Executive Director of Community Works, and current Executive Director of Housing and Community Development, noted, "We started this in earnest in 1995. . . We are already 16 years into it, and we still have a long way to go." Life expectancy in the surrounding neighborhood is 64.2 years; it is 62.9 in the neighborhood just to the east, whereas in the wealthiest neighborhoods in the city, such as Roland Park, it is 83. Bon Secours Baltimore has also had its own obstacles, encountering financial struggles in recent years due to the disproportionate number of patients it received without insurance. It had operating losses of \$20 million in FY 2008 and \$10 million in FY 2009, and broke even in FY 2010 with the help of a \$5 million operating grant from the state, according to Gregory Kearns, Director of Strategic Management for Bon Secours Baltimore. In FY

2011, Bon Secours Baltimore is expected to break even — without any assistance — and as Kearns commented, “Our budget for fiscal 2011. . . is a significant improvement — to come back from a \$20 million loss in 2008, and to work our way up that way.”²²⁹

Despite these challenges, Bon Secours is still strongly committed to its mission to serve Southwest Baltimore. In the late 1970s and early 1980s, after Southwest Baltimore had started to decline, Bon Secours Baltimore considered leaving, even purchasing land in another county. However, “it became clear that if they moved out there, there wasn’t anything that was going to be left” in Southwest Baltimore, noted David McCombs, Vice President of Enterprise Resource Planning and Supply Chain Operations for the Bon Secours Health System.²³⁰

More recently in 2011, Bon Secours Community Works changed its name to better align the organization with the new vision of Bon Secours Baltimore’s CEO, Dr. Samuel L. Ross. “[For] years. . . people were confused,” said Ross. “We had a name where people thought we were giving out money when it really was more about community and economic development...[We] wanted to publicly re-brand it Community Works, but not just to change the name but to really talk about how what exists today is phase one, and needs to be part of a larger comprehensive program that addresses the physical, the behavioral, and the psycho-social aspects of care.” Kleb added, “Basically, what we are trying to do. . . is further integrate what Community Works does with the current healthcare delivery system, but also create a new delivery system in that integration that looks at social determinants of health.”²³¹

BON SECOURS BALTIMORE HEALTH SYSTEM ANCHOR STRATEGIES

Neighborhood Revitalization

- Constructed/rehabilitated more than 650 units of affordable housing
- Clean & Green: More than 640 vacant lots converted into green spaces, 1.1 million sq. ft. cleaned up, and 133 tons of waste removed
- More than 60 minor-home-improvement grants to existing residents, totaling more than \$775,000

Local and Minority Purchasing

- Increased local, minority vendor

procurement to 6%, identified potential to reach 9% local, minority-owned

Capacity Building

- Youth landscape training program
- Offers youth employment and workforce development programs
- Operates a family support center and women’s resource center
- Provides financial literacy and tax services for local residents

Historically, the Sisters of Bon Secours entered the Baltimore community in 1881. By 1907, the Sisters had set up their first institution: a daycare center called Saint Martin's Day Nursery. Twelve years later, the hospital was built in Southwest Baltimore.



Bon Secours Baltimore Hospital. Photo: Bon Secours.

As Kleb recounted, Bon Secours Baltimore became “a prominent Catholic hospital,” specifically as a maternity hospital for Catholics from all over the region. However, the area began to experience urban decline in the late 1950s and 1960s—a decline that accelerated rapidly in the 1980s.²³²

“It got to a point where in the three blocks leading to Bon Secours Hospital. . .out of 101 units, 67 were vacant,” recalled Kleb. “In this area alone, there were somewhere between 7,000 and 8,000 vacant properties. . .basically the zip code 21223.” Also, emerging in the 1980s was the increase in

the prevalence of crack cocaine, which led to the “phenomenon of open-air drug markets.” Although Baltimore had dealt with heroin usage before this point, the open-air drug markets were something new. Perhaps the most well-known one emerged on the corner of West Fayette and Monroe streets, famously inspiring the book *The Corner* by David Simon and Edward Burns, and later the television series *Homicide: Life on the Street* and *The Wire*.²³³

A change was needed. Ed Gerardo, Director for Community Commitments and Social Investments at Bon Secours Health System, explained that in “the late 1980s and the early 1990s, we started thinking about what needs to happen in this community because, while we can provide acute-care services, and certainly our [emergency room] was becoming quite busy, it wasn’t the type of cases that should be coming in. People should not be coming in with gunshot wounds, with trauma. . .so, we said that we would do something, and we weren’t certain of everything to do, but we started with buying the row houses across the street from the hospital.”²³⁴

As a consequence, Operation ReachOut was launched in 1995, and Community Works purchased 31 vacant row houses on West Baltimore Street and an old Catholic school owned by the Archdiocese of Baltimore. However, Bon Secours learned early on to not act unilaterally if they wanted the community to embrace their community development efforts, according to Gerardo. Kleb added, “We went public and made a couple of commitments—three commitments, actually. The first commitment was that we are going to rehab the buildings on Baltimore Street. . .Second is we are going to develop services for the families in the housing and for the broader neighborhood at the site of the old school. The third commitment was that there were no longer going to be unilateral decisions: everything else moving forward will be done in partnership with the

community.” The most difficult challenge, as Kleb emphasized, was not building the houses or creating the services, but how to “operationalize,” or initiate and sustain, the partnership with the community. As he noted, “Acute healthcare is very top down, the opposite of typical community organizing and community development.”²³⁵

Just before this point, the hospital had been involved in a group called the Vision for Health Consortium, which were providers who all served Sandtown-Winchester. Sandtown-Winchester is a neighborhood just north of where the hospital is located, in which a neighborhood transformation project had started taken place, led by Enterprise Foundation founder Jim Rouse, and with increasing support from Baltimore City. Kleb explained, “Through that involvement, we became exposed to a lot of what was going on in the broader field of neighborhood transformation. . .we became acquainted with John McKnight’s work on asset-based community development.”²³⁶



Operation ReachOut Southwest Coalition meeting. Photo: Bon Secours.

The funding for the purchase of the 31 vacant properties came from a \$600,000 intra-company loan from the Bon Secours Health System’s headquarters in Marriottsville, Maryland. In order to maximize its impact, Bon Secours created Unity Properties, setting up a dedicated entity to perform the initial acquisition and pre-development. Once the properties had been purchased, the process for establishing a functioning community partnership was the primary focus. Bon Secours created a community advisory board and appointed a steering committee, comprised of neighborhood representatives from the community advisory board and other members from neighborhood associations. Other groups were involved in the steering committee too, including city planners, a few local nonprofits, and a city-wide organization called Citizens Planning and Housing Association that had worked in Baltimore’s neighborhoods since the 1940s. The Community Law Center, a pro bono law group that works with neighborhoods, and the Neighborhood Design Center, a pro bono architectural assistance organization, also participated.²³⁷

Joyce Smith, President of the Franklin Square Community Association, recalled the initial effort: “Everybody’s poor, but it’s poor whites and poor blacks. ReachOut was the first project where you got leaders from the South, which was majority white, and leaders from the North to sit down, in a room, to talk about what was needed, and not blame one another for the problems that were in the community.” Kleb explained that initially, this steering committee was tasked with two items: “First was to advise us on the housing we purchased — what kind of housing are you going to do; are you going to

do rental? Homeownership? What is it going to look like? The second was, what about the old school? What are you going to do with the old school?”²³⁸

In 1996, Bon Secours secured funding to begin the operation of a family support center. In spring 1997, the Bon Secours Center, which provides services to families with young children, was started in an unused portion of the hospital. The old school was razed, a new building constructed, and in January of 1998 the Bon Secours Community Support Center opened, eventually housing workforce development programs, financial services, family support services, and youth employment programs.²³⁹

By this time Phase One had been completed and Phase Two had just started. The initial ReachOut effort that began in 1995 became the Operation ReachOut Southwest Coalition by 1997. A grant from a local foundation allowed Bon Secours, along with “community businesses, churches, residents, partner organizations, and neighborhood associations, to develop a 20-year community revitalization plan for several contiguous neighborhoods in Southwest Baltimore.” Kleb added, ReachOut “ended up being the owner of the plan. . . Bon Secours became a member of the coalition.”²⁴⁰

Over the course of 15 months, more than 250 community residents met, shared and developed this revitalization plan. The final plan included desired outcomes and initial strategies in six issues areas: economic development, health, education, public safety, physical planning, and youth and seniors. A committee handled each issue area. Smith explained, “The committees were chaired by a community resident—the others supporting came from nonprofit people—but the leadership came from the community. . . we could always go back to what the plan said; the community stayed connected. I felt like we had a voice.”²⁴¹

Today, Bon Secours is focused on neighborhood revitalization and housing rehabilitation, family and women’s services, youth employment and workforce development, and financial services. Bon Secours Baltimore has also refocused its efforts in 2011 to increase diversity purchasing. As McCombs explained, despite difficulties in leveraging hospital resources to “support the development of business and wealth building in your local community” due to an increased reliance on “national purchasing organizations for the pricing leverage,” Bon Secours Baltimore consciously decided to identify how much of its procurement could be obtained locally. After the board of Bon Secours Baltimore expressed concern that not enough was being done to adequately identify diverse suppliers in the community, McCombs described the next step: “In Baltimore, we went through and had about \$60 to \$70 million of annual expenditures total, and we went through and identified \$40 million of that. . . that it is possible for us to look for sources locally. And then we broke that \$40 million dollars of total spending further and then said, well, where are the potential vendors that can serve that need?”²⁴²

Finding these vendors proved difficult at first. Bon Secours Baltimore went through a process of identifying government listings, talking to area diversity councils, and meeting with other area hospital systems—including the University of Maryland, John Hopkins,

and MedStar—to identify best practices. However, as McCombs explained, although governmental programs assist small businesses, accurate listings of those businesses are not well maintained. Finally, the hospital went through a company called Equifax, which maintains an extensive database of vendors. According to McCombs, “bottom line is we found we could proactively do searches by product category, by service category, or by location. . .Once we found that, I think we did a 10-mile and 20-mile sort of radius check of all certified diversity vendors.”²⁴³

The net result of this intensive process has allowed Bon Secours to identify “on a semi-annual basis another \$2 million of potential diversity vendors, which if we could successfully convert, could take our existing rate of use of diversity vendors from four percent to nine percent,” said McCombs. Even in the first few months of this effort, Bon Secours Baltimore has already pushed its diversity purchasing from four percent to six percent.²⁴⁴

Additionally, from this process, the hospital is considering creating its own registry on its website as a way to better communicate and reach out to potential vendors. Another important aspect in this process was identifying a realistic procurement target. McCombs noted, it is easy to set the mark too low, and it is also possible to set it too high, creating frustration in the organization, adding, “So now we have a destination we are getting to, we have a point, we have a target, we have a focus.”²⁴⁵

Perhaps Bon Secours may be best known for its effort in community revitalization through housing development. Beginning its work in 1995 with the initial phase of Operation ReachOut, Bon Secours Community Works has since rehabilitated and constructed more than 650 units of rental housing, including six buildings of senior housing, using Low Income Housing Tax Credits. Also, included in that total are 119 units of family apartments in 59 row houses, more than 2.5 blocks on West Baltimore Street, a major corridor in the community. When these properties were first purchased, according to Kleb, the area was two-thirds vacant. Now, he added, “there are only a handful of vacant properties on this block.”²⁴⁶



Senior housing constructed by Bon Secours Baltimore. *Photo: Bon Secours.*

In addition, Erika McClammy, Director of Housing and Neighborhood Revitalization at Community Works, explained that since 2007, Community Works has “given about 60 or so grants for small improvements ranging from carpentry to plumbing, roofing to furnace repair or new furnaces.” These grants were specifically given to homeowners,



Clean & Green before and after: 1901 Vine Street (2 blocks from Bon Secours Baltimore). *Photos: Bon Secours.*



Clean & Green before and after: 411 S. Pulaski St (south of Bon Secours Baltimore). *Photos: Bon Secours.*

and even more specifically, to those who lived on blocks that “weren’t decimated with vacant housing.” The goal of this initiative was to put “money into blocks that were starting to show problems. . . Well, once one is vacant, it doesn’t take long for others. So if you can help a homeowner shore up some of their investment, it could have a much greater economic impact on the neighborhood.” To date, these grants have totaled more than \$775,000.²⁴⁷

Another neighborhood revitalization effort has been Bon Secours’ Clean & Green initiative. Smith recalled, “When we started Clean & Green, it was a community competition program. The men in the neighborhood came out,” and took on leadership roles on the project. Put another way, “Clean & Green sprung up in the community as a way to think about how they could take over open space,” noted McClammy. In 2002, Clean & Green became a program under Community Works’ Housing and Neighborhood Revitalization.²⁴⁸

Since its inception, Clean & Green has revitalized more than 640 lots in the surrounding neighborhood through a process of reclaiming the land, planting low-maintenance grass and trees and, in some places, when there are several lots adjacent, building a community garden—especially important considering Southwest Baltimore is a food desert. In total, the program has helped clean up more than 1.1 million square feet and removed more than 133 tons of waste; more than 1,000 trees have been planted too.²⁴⁹

Another component of Clean & Green has been its landscape training program, which employs up to eight youth each year. As McClammy explained, “Our goal is not necessarily that they’ll be landscapers but to give them experience in working day to day. Although we do it in collaboration with our workforce development, it’s really been an open space management strategy and teaching. . .the trainees. . .but also we teach the community.”²⁵⁰

Community Works provides other services including family services for low-income families; a resource center for homeless, abused, and addicted women in the community; a youth employment program; and a workforce development program for local residents. Additionally, Community Works has worked to improve financial services in the community, providing individual and group instruction and counseling on money management as well as free and low-cost income tax services to local residents as an affordable alternative to commercial preparers.²⁵¹

Community Works’ practices have had a significant influence on the entire Bon Secours Health System. As a result of successes in Baltimore, the Healthy Communities initiative was instituted at the system level in 2008, as a component of the systemwide Strategic Quality Plan. Now, each hospital in the system is required to develop programs that help transform their local area into a “healthy community,” which involves a “systemic, ecological, multi-sector approach that acknowledges all of the social determinants of health such as housing, education, employment, public safety and social justice.” According to Gerardo, Healthy Communities comprised a full 19 percent of the \$49 million that was spent for direct benefits and outreach initiatives (under the much larger community-benefits umbrella) in 2010 for the Bon Secours Health System, despite the program having existed for only two years at the time. “We have a longitudinal way of doing things,” stated Kleb.²⁵²

Bon Secours has made significant strides with regard to community development in Southwest Baltimore, but the process has not been without obstacles. Since it first reached out in the early 1990s, those working to revitalize the community have learned



Community Works' Women's Resource Center.
Photo: Bon Secours.

important lessons and still face additional challenges going forward. Although the stories behind these challenges are unique to Bon Secours Baltimore, their lessons may provide insight for other hospitals that are interested in pursuing similar community development efforts.

“I can tell you a quick anecdote that really there is a discipline to this stuff,” said Kleb. “And it’s not just discipline like putting your nose to the grindstone and working very hard; it also has a lot to do with being patient. And letting the process play itself out and not jumping to conclusions.” Kleb said he learned this lesson early on, in the period between the development of the initial steering committee and the creation of the coalition, when Bon Secours organized a series of community meetings to discuss prioritizing neighborhood problems.²⁵³

In between the second and final meeting, recalled Kleb, “we geniuses at Bon Secours were so convinced that [the community members] were going to pick crime” as their most important priority. So in anticipation of this vote, he and others began discussions with local police to increase the presence around the open-air drug markets. Instead, the community residents chose rats and trash as their number one priority; housing ranked second and drugs third. Kleb recounted, “Imagine shutting down the international drug cartels all by ourselves. . .it is just ridiculous when I think back on it, but we had a series of clean-ups, and we engaged. . .and we learned that. . .if you’re committing to a process, you have to let it play out, and if you are not going to commit to a process, then why bother, because you are not going to solve the problem.”²⁵⁴

Although patience and withholding assumptions were important early lessons to learn, the difficulty of keeping the community fully involved and sustaining the overall momentum of this effort is a current challenge expressed by both those from within the neighborhoods and Community Works. “When they built [the Bon Secours Community Support Center] building, this building was erected because the community said we needed a place to meet. That’s how we got this building. Now the community rarely comes; if they come, they come to receive some type of service,” recounted Smith. Kleb expressed a similar sentiment: “it’s easy to organize everything for a few years, but how do you keep it going?”²⁵⁵

The participation in Operation ReachOut coalition meetings has steadily declined over the years. At the beginning of the process, the coalition would meet monthly and 80 to 100 people would attend consistently; additionally, sometimes six to eight meetings would occur in between the monthly meetings. Now explained Kleb, although the coalition meets every other month and is still relevant to decision making, he did not think that even 30 people attended the May 2011 meeting.²⁵⁶

The reason for this change depends on whom you ask. In Smith’s opinion “what happened is that Bon Secours hired more staff. . .There wasn’t a practice put in place where we would do an orientation of what [Operation ReachOut] was about so [the new staff] would understand. Now what I find is that the staff wants to tell the community what

the staff has identified.” Kleb conceded, “Then there is the reality of 2011; I mean, we are getting stuff done, people are being served left and right, and progress is being made. But in a lot of ways we are limping along, sustaining the effort. But is it flourishing? Not the way it did before, and we had kind of envisioned that this trajectory would continue, and it hasn’t. And maybe that is the life cycle of these things.”²⁵⁷

Despite this difficulty in sustaining momentum, Bon Secours Baltimore and Community Works take the long view on the issues they are confronting. And from the community perspective, admitted Smith, “However much you may hear me complain, what I like about Bon Secours, and what Bon Secours did for us in this community, is that it got local politicians to listen; it helped give us a voice.”²⁵⁸

Another obstacle that is partially linked to the previous challenge of sustaining momentum, but important to note in its own regard, is the difficulty of accessing organizing resources and managing the balance between organizing and program management. “Organizing money is hard to get right now — period,” stated Kleb. In addition, Bon Secours is currently unable to dedicate resources specifically for organizing or “for the care and feeding of the coalition.” As a result, without support from additional partners, “everybody is an organizer.”²⁵⁹

However, added Kleb, “that’s fine, except for two things. People that really like to organize aren’t necessarily great at program management; and program managers, on the flip side, are pretty much like, ‘I’m an expert in community development and that’s what I want to do.’” He continued, “So if you have to run a program all day and go to meetings all night, it is just going to be very difficult to keep your staff motivated. . . it’s one thing if you want to do something that will only take three years, and then coast on from there. . . but the stuff we are taking on, requires a lot more staying power, you have to keep it up.”²⁶⁰

Another area that has its own unique obstacles is diversity purchasing. As a result of the national trend toward standardization of supplies and services at the most cost-competitive price and the realization that certain key purchasing opportunities do not exist locally, Bon Secours’ ability to increase diversity purchasing above a certain percentage is limited. Standardization caps the target the hospital can realistically strive for with its diversity purchasing targeting, according to McCombs. Finding the balance possible between these competing interests is a recurring question for those working on this issue at Bon Secours.²⁶¹

McCombs noted that a more pressing issue is that vendors for services that could be done locally simply do not exist, such as centralized linen processing or sterilization of instruments. Explained McCombs, “Those two areas were attractive because their primary requirements were land, building, proximity, and labor. And typically, in urban communities, you have unemployment and a lot of workforce and those particular functions lend themselves to short-term training...but the missing piece is capital.” Two requirements would be needed to make these types of businesses viable:

a financier who is willing to put forward venture capital and take a risk and the hospital with a willingness to change its perspective and adopt a new set of processes for its procurement.²⁶²

In many ways the efforts at Bon Secours Baltimore and Community Works are just beginning and they are always being constantly refined. As Ross noted, “Somebody has got to have the will to do it. This is motherhood and apple pie; no one can argue that it doesn’t make sense. What they argue is that they currently don’t have the funding. They have to believe that this is the greatest country on earth and we can bend and flex.”²⁶³

Detroit, Michigan:

Henry Ford Health System

Our board, more than five years ago, before the economic meltdown, adopted as one of its six principles for an envisioned future. . .to be a significant force in the redevelopment of the city of Detroit.

- William Schramm, Senior Vice President of Strategic Business Development, Henry Ford Health System²⁶⁴

Conscious of its impact as a principal Detroit and southeast Michigan anchor, Henry Ford Health System has steadily increased its efforts over the last decade to leverage its resources to help transform and revitalize the city of Detroit. Many of the more well known of these initiatives have been coordinated with the Detroit Medical Center and Wayne State University—the other two principal anchors located in Midtown Detroit—in a collaborative, multi-institution partnership to improve the depressed economic condition of the city.²⁶⁵ Henry Ford has also undertaken other projects independently or with other regional partners, such as Presbyterian Village of Michigan, United Methodist Church, Dearborn Public Schools, Henry Ford Community College, and the Michigan State Housing Development Authority.

Founded in 1915, the not-for-profit Henry Ford Health System operates throughout southeast Michigan, comprising six hospitals, 32 medical centers, and one of the country's largest group practices—the Henry Ford Medical group, which includes more than 1,200 physicians across 40 specialties. Today, Henry Ford is the fifth-largest employer in metro Detroit with more than 23,000 employees and a workforce that is more than three-quarters female and approximately one-third minority. The health system, which has revenues in excess of \$4.2 billion annually, generates more than \$1.7 billion in yearly economic activity.²⁶⁶

The flagship for the system is Henry Ford Hospital, an 802-bed hospital based in Midtown Detroit, which procures more than \$650 million in goods and services annually. Within the City of Detroit alone, Henry Ford employs more than 10,000 people. Along with the Detroit Medical Center, the two hospital systems are responsible for a majority of healthcare services for the city of Detroit.²⁶⁷

Economically, Detroit is struggling. Population loss continues to plague the city, with nearly 240,000 people, or more than a quarter of the population, leaving the city between 2000 and 2010, according to the U.S. Census. As a result, the city has dropped

from the 10th-largest at beginning of the 21st century to the 18th-largest today. Additionally, a 2009 survey by the Detroit Data Collaborative showed that although 86 percent of the city’s single-family homes appear to be in good condition, more than 26 percent, or 91,000, of Detroit’s residential parcels now stand vacant. Consequently, the resulting low density caused by these vacancies has placed a strain on the city’s infrastructure. Although Detroit is still home to The Big Three automakers—Ford, General Motors, and Chrysler—today the three largest private employers in Detroit are the medical and educational anchors in Midtown: Henry Ford, Detroit Medical Center, and Wayne State University.²⁶⁸

Detroit is also beset with marked health disparities, and has among the highest rates of infant mortality in the country. According to Nancy Combs, Director of Community

HENRY FORD HEALTH SYSTEM ANCHOR STRATEGIES

Neighborhood Revitalization

- \$530 million campus expansion plan, goal is to leverage \$1 billion in outside investment
- Constructed transportation and façade improvements in neighborhood
- Acquires/rehabilitates properties with state’s Housing Development Authority

Local and Minority Purchasing

- Procures about 10% locally or regionally
- Goal: \$100 million from minority vendors; reached \$86 million, 660 firms in 2010
- Transparent Sourcing Policy to increase minority business opportunities
- Land acquisition to attract large suppliers to relocate to Detroit

- Provides discretionary spending contract opportunities to local, small businesses

Multi-Institution, City, and Regional Partnerships

- *Live Midtown*: employer-assisted housing program supported by the 3 Midtown anchors, Henry Ford: \$1 million over 5 years
- *Source Detroit*: Midtown anchor partnership to procure locally, \$16.5 million transferred to date
- Henry Ford Early College: 5-year clinical degree program for high school students, with local school district and community college
- East Jefferson project: partnership expands PACE program, adds affordable housing component
- TechTown: nonprofit business incubator at Wayne State University
- Partner with 3 other health systems to address infant mortality

Health, Equity & Wellness for the Henry Ford Health System, there have been several years when Detroit has ranked first in the nation; in 2011, the city ranked third. Within the numbers is a notable racial disparity. As Combs explained, “Infant mortality is three times as high among African-American women as white women.”²⁶⁹

The importance of community engagement has been institutionalized in a variety of ways for many years at Henry Ford. Dr. Kimberly Dawn Wisdom, Senior Vice President of Community Health & Equity and Chief Wellness Officer, recounted how both the current Chief Executive Officer, Nancy M. Schlichting, and her predecessor Gail Warden, had focused on the community “more than your typical CEO.” As far back as the early 1990s, Warden had helped start up the Center for Health Promotion and Disease Prevention that had a public health, disease prevention, and research focus. These earlier initiatives occurred during a period when receiving grants for, and hospital interest in, community health work was not yet common. One current community intervention, “Sew Up the Safety Net for Women and Children,” is a partnership between the CEOs of four hospital systems serving Detroit (Detroit Medical Center, Henry Ford, St. John Providence Health, and Oakwood Healthcare System) that aims to tackle the issue of infant survival by targeting three Detroit neighborhoods and focusing on certain socioeconomic determinants that contribute to the city’s high rate of mortality.²⁷⁰

Another partnership focused on a specific population is the East Jefferson project, a collaboration between Henry Ford, Presbyterian Village of Michigan, and the United Methodist Church. This effort expands on Henry Ford’s Center for Senior Independence, which is organized as a Program of All-inclusive Care for the Elderly (PACE) model that strives to keep an elderly patient “out of a nursing home” by serving them in a community setting, as well as at home. In many of the more successful PACE programs nationally, affordable housing for participants has been an important component, addressing a key social determinant for this aging population. According to John Polanski, Chief Executive Officer of Community Care Services for Henry Ford, this housing component has been missing from the current program. Polanski explained, “In the last year, we’ve been developing plans to expand the program from 200 persons. . . to upwards of 1,000 to 1,200 people over three years. In order to do that, we wanted and needed a housing partner.” Since housing has not historically been the health system’s core competency, Henry Ford partnered with Presbyterian Village of Michigan, which operates senior living communities across the state.²⁷¹

The first phase of the project, which broke ground in 2011, will include one of the city’s first assisted-living centers, with 74 affordable and six market-rate units, along with a second Detroit location for Henry Ford’s Center for Senior Independence—all located two blocks from the Detroit River. This project is being supported by a \$2 million grant from the Community Foundation for Southeast Michigan and active efforts by the three partners to leverage tax credits, loans, and grants from the state, Wayne County, and the City of Detroit. The combination of these funds will total \$24.6 million, and the project is estimated to create 350 construction jobs, 183 permanent healthcare

positions, 150 to 170 housing units, and have an estimated economic impact of \$250 million over the first decade. Polanski added that he thinks within three to five years, this PACE program could be the largest of its kind in a consolidated geographic region like Southeast Michigan.²⁷²

In addition to these community health initiatives, Henry Ford has also consciously embraced several anchor strategies. Schramm noted, “Typically, we categorize our efforts in one of three buckets: where we’re acting as a catalyst, where we’re acting as an advocate, and where we’re acting as a partner.” In a partnership, Henry Ford invests resources with the intention of leveraging additional funds. As a catalyst, Henry Ford seeks to attract capital to the area without committing its own resources. And finally, as an advocate, Henry Ford engages stakeholders and policy makers on issues such as charter school policies.²⁷³

One such partnership that Henry Ford has been involved in is TechTown, a nonprofit business incubator based at Wayne State and incorporated in 2000, that strives to spur business growth, job creation, and the revitalization of Midtown Detroit. With the help of a variety of stakeholders, including General Motors, the Kresge Foundation, and Henry Ford, among others, TechOne, the incubator’s first building facility, opened in 2004. Henry Ford assisted this project in two important ways. First, it provided office space, services, and supplies to TechTown staff prior to TechOne opening—consequently, acting as an incubator for TechTown. Second, in 2008, Henry Ford relocated its genetics labs, occupying nearly 13,600 square feet in TechOne, or nearly one entire floor of the five-story building, serving as an important anchor for the new facility.²⁷⁴

“In addition to what is going on [at TechTown]. . .we’re also focused on place making,” noted Schramm. These “place making” community investments have been heavily targeted in Midtown Detroit. Along with a coalition of supporters including the Detroit Medical Center, Wayne State, Hudson-Webber Foundation, Kresge Foundation, and the Michigan State Housing Development Authority, Henry Ford is a partner in the *Live Midtown* initiative that is administered by Midtown Detroit, Inc., a nonprofit organization dedicated to the physical maintenance and revitalization of Midtown Detroit. Live Midtown is an employer-assisted housing program that encourages employees of the three major anchors in Midtown—Henry Ford, Detroit Medical Center, and Wayne State—to live, invest and work in the same community.²⁷⁵

The pilot program, which began in 2011, had committed funds of \$1.2 million, including nearly \$440,000 released specifically to Henry Ford applicants. In the first year, 72 Henry Ford employees received Live Midtown funds. Fifteen employees purchased homes, 22 were new leasers, 34 renewed leases, and one family made exterior home improvements. The initial success of the program has led Henry Ford to commit more than \$1 million over five years, with additional matching funds from other anchor institutions, foundations, and the state. Now, over the initiative’s first two years, more than 450 anchor-institution employees have taken advantage of housing incentives,

including over 135 from Henry Ford. To date, more than \$1.5 million of funding has been released to employees through this place-based revitalization strategy.²⁷⁶

Of the initiative, Schramm is cautiously optimistic: “I think it’s still early; Live Midtown will be completely successful when we stop providing the incentives and the demand continues to increase.” Currently, market-rate apartment occupancy is about 95 percent. The same type of demand is occurring for single family homes in the Midtown area too. Despite an interest by the community to broaden the impact area, Henry Ford and other coalition members remain primarily focused on the Midtown area. “Until we get to a sustainable level I think we’ve got to stay concentrated. If you dilute it, you’re not going to see the impact,” said Schramm. The initiative also influenced the partnership of other large businesses to replicate the program focusing on the downtown central business district.²⁷⁷

In another effort aimed at revitalization, Henry Ford has entered into a joint venture with the Michigan State Housing Development Authority that is focused on acquiring and rehabilitating properties that have been claimed by the City or County because of unpaid property taxes. Other properties that are beyond repair are acquired and demolished. The overall goal of this process is to stabilize the neighborhood with regard to vacant and abandoned buildings. In contrast to the financial incentives in Live Midtown, this effort is not limited to employees. Through the same community development partnership, Henry Ford is also “helping individuals qualify for various exterior façade, energy revitalization or retrofitting for owner-occupied houses that are in the neighborhood.”²⁷⁸

For the south side of the Henry Ford Hospital campus, Schramm said that Henry Ford has a “plan for a \$530 million investment for new research, ambulatory care, and education facilities. Our intention is to design and plan in a way that will attract other kinds of investment on a scale of one to two.” The hope is that this \$500 million investment will attract nearly \$1 billion in new real estate development, such as housing, business, office and commercial, retail, some restaurants and hospitality, or even a movie theater, helping to create a campus that spans West Grand Boulevard and embraces the surrounding community. This effort is more narrowly targeted on a specific geographic area than Live Midtown, limited to the area directly south of the Henry Ford campus. To date, Henry Ford has acquired approximately 80 percent of its target property for “mission”-related development and hopes to begin construction in 2014.²⁷⁹

Several other initiatives highlight different strategies Henry Ford has employed as an anchor institution. Several blocks to the east of the Henry Ford campus, Henry Ford is striving to act as a catalyst by constructing transportation and façade improvements. As part of this effort, Henry Ford is trying to make the avenue increasingly “livable,” by installing bike lanes and green paths. From a partnership and advocacy perspective, Henry Ford is helping charter schools with property acquisition and development in the local community and is exploring the option of collaborating to create its own charter

school focused on health, wellness, well-being, and sustainability. Currently, all public charter schools are required to draw students from an open lottery. Henry Ford is working with the state to craft legislation that would allow it to provide a modified lottery that enables a geographic preference for a certain percentage of the students.²⁸⁰

Another community partnership focused on education is the Henry Ford Early College, which is a collaborative effort with the Dearborn Public Schools and Henry Ford Community College (no affiliation to the hospital system). Currently enrolling 250 students, the Early College’s intention “is to take kids, many who are at risk and have a high probability of not completing high school, and get them engaged in a track toward a clinical profession as ninth graders,” according to Schramm. As a result, these students can graduate in as little as five years with their high school diploma, associate’s degree, and clinical certificates. Additionally, students will have avoided any tuition costs because state funds support that student for the thirteenth year. The first graduating class received their degrees in May 2012.²⁸¹



Concept for housing along Trumbull Ave leading up to future campus. *Illustration: Henry Ford Health System.*

Henry Ford has also used its purchasing power to encourage businesses to relocate to Detroit and to actively purchase from existing local businesses to support the revitalization and economic stabilization of the City of Detroit. This commitment to local purchasing is institutionalized throughout the organization, explained Jim O’Connor, Vice President of Supply Chain Management Department at Henry Ford, starting with Henry Ford’s CEO, Nancy Schlichting. Although targeting local purchasing efforts had been part of the culture, Henry Ford, along with Detroit Medical Center and Wayne State, made official a new ‘Buy Detroit’ — now *Source Detroit* — effort in early 2011, leveraging a portion of the three anchors’ nearly \$1.6 billion in annual procurement to help revitalize the city. To date, approximately \$16.5 million in purchasing has been transferred to Detroit-based businesses. Added O’Connor, “Glenn Croxton, [Director of Vendor Compliance and Management in the Supply Chain Management Department at Henry Ford], and I are personally committed as well. This is something we were committed to before there was ‘Buy Detroit.’ That brought some additional structure and focus to it.”²⁸²

As part of its strategy, according to O’Connor, Henry Ford is trying to attract large manufacturers, distributors, and healthcare-related businesses to Detroit. At the same time, Henry Ford is targeting existing small businesses in the community — for example, purchasing fresh breads, sub buns, and dinner rolls from Milano Bakery in Eastern Market, a fixture in the Detroit community since 1958. This additional business, along with new

demand from Wayne State University, is credited with enabling the owner of the bakery to move from considering lay-offs to adding a second shift, according to Schramm. Jointly, Detroit Medical Center, Wayne State, and Henry Ford have also created new local contracts regarding plumbing supplies, office supplies, and containers, with the goal of helping these businesses “build volume.”²⁸³

O’Connor said that Henry Ford does not do “set asides” for competitive spending but that they encourage local businesses by actively working with them to build their capacity. “We may give them another opportunity with a smaller piece of business that is discretionary to see if they can prove themselves. . . We try to grow people that are small, but we don’t want to grow them too fast so they fail,” remarked O’Connor. To date, approximately 10 to 11 percent of total spending is purchased locally or regionally.²⁸⁴



Rendering of potential campus expansion ringing an open space. *Illustration: Henry Ford Health System.*

Procurement policy and practice is another area where Henry Ford has consciously modified institutional focus in order to spur local economic development and minority contracting. Henry Ford’s Transparent Sourcing Policy is an effort to increase the number of contracts awarded to women- and minority-owned businesses. The policy requires that any contract greater than \$20,000 be competitively bid by businesses. Randy Walker, Henry Ford Vice President and Chief Diversity Officer, emphasized “we’re striving to level the playing field. . . Our goal is that the percentage of our [minority- and women-owned] spend compared to total spend is both a national benchmark and best in class. Most of our [minority- and women-owned] suppliers are located in southeast Michigan, which is an additional local economy benefit.” Henry Ford has set a target of at least \$100 million in contracting awarded to women- and minority-businesses; in 2010, they reached \$86 million.²⁸⁵

According to O’Connor, the percentage of Henry Ford’s spending with minority firms has fluctuated but the total number of minority and women suppliers has increased; in 2010, Henry Ford worked with more than 660 minority-owned suppliers. One reason for this fluctuation is that one large minority-owned firm became a publicly traded company, removing it from the calculations. Another dynamic affecting this number is construction. As new construction and facility development cycles, expenses and opportunities increase and decrease. With regard to the construction projects, the “local” focus extends beyond Detroit to also include the tri-county level.²⁸⁶

One other major project is an effort to consolidate Henry Ford’s purchasing of medical surgical supplies into “one single vendor that is a primary source for the medical center.” According to Schramm, Henry Ford currently buys nearly \$100 million worth of these supplies from two separate vendors. As part of awarding this contract, the vendor would have to agree to relocate part of its strategic development into the City of Detroit. In order to accomplish this, Henry Ford is working to assemble 24 acres and is initiating environmental assessments (both Phase I and Phase II) on the property. In doing so, Henry Ford facilitates and helps accelerate the overall development process, creating a more viable, less risky project for the developer.²⁸⁷

All of these initiatives have not been without their difficulties. With regard to increasing diversity in the organization and throughout the supply chain, Walker emphasized that the biggest challenge has been “pushing some of these programs down to some of the business units. . .trying to penetrate, trying to engage is sometimes challenging in an organization the size of ours.” Some in Henry Ford had hoped this transformation would occur more quickly. According to Walker, the issue is less a conscious refusal to incorporate better diversity practices in hiring and to comply with the sourcing policy, but more one of employees not prioritizing these policies at the same level as the rest of their work. Commented Walker, “I just think that people get so much on their plate, they’re overwhelmed with medicine, and you have to make sure you put the right checks and balances to drive behavior. Henry Ford is continuing to work on increasing its supplier diversity, and we’re committed to it long term. We look at this as a journey.”²⁸⁸

Another challenge has been the lack of information and help from agencies within the City of Detroit regarding potential development and business opportunities. Explains O’Connor, “At times, we have had to deal with an absence of information and data.” To address this issue, the three Midtown anchors have worked to create subgroups to focus on specific commodities, such as food products, to even the possibility of a food cooperative. O’Connor noted, “When we meet, we try to look and identify opportunities and commodities. . .That’s very difficult to do within your own six hospitals, let alone when you try to do it across three different organizations. . .It can be done, but it’s hard work.”²⁸⁹

A third challenge is the ability to purchase certain supplies locally or regionally, specifically pharmaceuticals and medical devices. This supplier capacity takes time to develop in a community, and O’Connor is optimistic about the possibilities that come with this challenge. For O’Connor, it is a process of building capacity and the mechanisms for eventually being able to procure some of these more difficult supplies locally, whether through local group purchasing efforts, or other strategies. Commenting on this effort, O’Connor stated, “In fact, we think it can happen, and should happen.”²⁹⁰

A broader challenge that impacts all of Henry Ford’s redevelopment efforts is determining how to deploy scarce human and financial resources in the most effective way

possible. For example, according to Thomas Habitz, Urban Planning Specialist at Henry Ford, there have been initial conversations regarding community capacity building strategies. The focus of these strategies would involve Henry Ford lending primarily technical, but also in some cases financial, assistance to existing community organizations. In essence, the goal would be to empower existing members of the community to become more capable partners in helping revitalize the local neighborhoods. To date, there has been little movement in this area. Habitz pointed out that it is “a bit difficult to find a blueprint for this type of strategy in an environment where vacancy levels are above 50 percent. We are already taking the organization out of its comfort zone with many of the other neighborhood improvement efforts we are currently involved in.” Still, Habitz noted that Henry Ford is interested in pursuing a strategy in the future that allows for greater community ownership over redevelopment initiatives.²⁹¹

In many respects, Henry Ford remains in the beginning stages of its effort to embrace an anchor institution mission. They are working on long-term strategies to increase retail services and improve food access, support community streetscape improvement and safety initiatives, and increase access to recreation and green spaces. Currently, however, Henry Ford lacks long-term strategies to mitigate the potential displacement of low-income residents. Henry Ford’s leadership has said that the combination of limited hospital resources and the severity of disinvestment means that they have chosen to prioritize attracting new neighborhood residents as their primary focus at this time.²⁹² As revitalization efforts unfold, how Henry Ford’s different initiatives impact existing residents is worth observing and assessing. Despite this concern, Henry Ford, in collaboration with other anchor institutions, community, and local government partners, is working earnestly to transform and revitalize Detroit. As Walker noted, this process should be viewed as a “journey.” O’Connor confirmed this sentiment, adding that there is still much “hard work” ahead.²⁹³

Cleveland, Ohio:

University Hospitals System and Cleveland Clinic Health System

Our last case profiles two institutions and their collective and individual efforts to integrate anchor institution missions. Linked by a common geography, the flagships of these two health systems are separated by less than two miles. Collectively, University Hospitals and Cleveland Clinic have been important partners, with the Cleveland Foundation and Case Western Reserve University, in working to transform Cleveland's Greater University Circle.

University Hospitals System

We have done some studies of healthcare disparities [in the surrounding neighborhoods]. It is shocking. It's absolutely shocking when you look at health disparities with a racial filter, with a socio-economic filter. Our anchor institutions identified a meaningful and sustainable way to help fix the problems through Vision 2010.

■ Steve Standley, Chief Administrative Officer, University Hospitals²⁹⁵

In 2006, University Hospitals System committed to “Vision 2010: The UH Difference” — a five-year strategic growth plan that would transform the way the hospital system interacted with its community and position it as a national example of a hospital trying to achieve its anchor institution mission. University Hospitals’ \$1.2 billion investment is not its only commitment to its anchor mission, but it is a foundational and formative piece and the primary focus of this case study. This vision required a commitment to purchase locally, increase the number of minority- and women-owned suppliers, and aimed to create local supplier capacity where it did not exist before. At the same time, University Hospitals hired an independent organization to hold it accountable and voluntarily entered into a unique Project Labor Agreement (PLA) that obligated it to meet certain targets. University Hospitals’ efforts in this area did not conclude at the end

of this growth process. In fact, Vision 2010 provided the catalyst for these expectations to be applied subsequently to the organization's entire supply chain. Going forward, University Hospitals has committed to leveraging its resources to maximize its economic impact on Cleveland and Northeast Ohio.²⁹⁶

Consolidated in 1993, the University Hospitals System comprises a major medical academic center and six community hospitals across Northeast Ohio. Together, they employ more than 24,000 people, making the system Northeast Ohio's second-largest private sector employer and the seventh-largest in the state. The hospital system's revenues exceed \$2 billion annually and it procures approximately \$850 million in medical goods and services each year.²⁹⁷

Anchoring the system is University Hospitals Case Medical Center in Cleveland, a 1032-bed medical center. Originally part of Case Western Reserve University, this center was



University Hospitals Ahuja Medical Center, constructed as part of Vision 2010. Photo: University Hospitals.

UNIVERSITY HOSPITALS SYSTEM ANCHOR STRATEGIES

Neighborhood Revitalization

- Greater University Circle Initiative: foundation and anchor institution-led comprehensive neighborhood revitalization effort of surrounding neighborhoods

Local and Minority Purchasing

- Vision 2010: \$1.2 billion investment with contract goals: 5% women-owned, 15% minority-owned, 20% of workers Cleveland residents, and 80% locally based firms
- Vision 2010: third party oversight and voluntary project labor agreement that prioritized goals
- More than \$300 million (38%) within Cleveland and more than \$500 million (63%) within Northeast Ohio, in 2010

- Participation in Health-Tech Corridor

Multi-Institution, City, and Regional Partnerships

- Greater Circle Living: \$750,000 investment in multi-institutional, employer-assisted housing program

Community Investment

- Evergreen Cooperatives: \$1.25 million in multi-institutional, business co-development strategy to create jobs for neighborhood residents and allow local sourcing

Capacity Building

- NewBridge Cleveland Center for Arts & Technology: job training and skill development in healthcare for adults and the arts for youth

first founded in 1896, and contributed to the development in the early 20th century of University Circle, a collection of educational, medical, and cultural institutions. Today the area serves effectively as a second downtown district on Cleveland’s east side. This main campus also includes a dedicated children’s hospital, the region’s only National Cancer Institute-designated Comprehensive Cancer Center, and the state’s only hospital for women.²⁹⁸

Since 1950, Cleveland’s population has declined by more than 55 percent. In the first decade of the 21st century, the city suffered the third-largest decline of any major U.S. city (17 percent), only surpassed by Detroit and New Orleans. Today, Cleveland is a

majority-black city, increasing by two percentage points to 53 percent between 2000 and 2010 despite a decrease in absolute numbers of African-Americans. The percentage of whites has decreased to 34 percent in the city, while the Latino and Asian populations grew slightly in percentage and absolute terms to 10 percent and two percent, respectively. Despite the city’s diversity, racial segregation of blacks and Latinos remains high, exceeding the average for many large cities, according to the Cleveland City Planning Commission. Additionally, the neighborhoods with the highest concentration of poverty are disproportionately black and Latino.²⁹⁹

Furthermore, health disparities between low-income and high-income neighborhoods are extreme. Take, for example, Hough, a neighborhood included in the “Greater University Circle,” a term created by the Cleveland Foundation in 2005 that includes six neighborhoods proximate to University Hospitals and the other anchor institutions as part of an effort to revitalize Cleveland’s east side. According to the *Weight of the Nation*, an HBO documentary that aired in May 2012 in partnership with Kaiser Permanente, Hough residents have a life expectancy of 64 years. In striking contrast, just eight miles away in the same Cuyahoga County, the suburban town of

Lyndhurst boasts a life expectancy of 88.5 years. Of the two dozen cities and counties in which this research has been conducted to date, this 24-year difference in life expectancy is the greatest disparity between any two neighborhoods so close to each other.³⁰⁰

On the surface, Vision 2010 was a \$1.2 billion investment by University Hospitals in system infrastructure—the most visible of which was \$750 million in new construction of five major facilities, in addition to new outpatient health centers and expansions of a number of existing facilities. However, the way this infrastructure investment was coordinated involved a broader cultural change for University Hospitals. Explained Margaret Hewitt, former Vice President of Construction Services, who was hired to oversee this project, “It’s a systems change internally for University Hospitals and externally



Center for Emergency Medicine and Mary R. Horvitz Pediatric Emergency Center on the campus of UH Case Medical Center, constructed as part of Vision 2010. Photo: University Hospitals.

for how we did business.” Prior to the program, University Hospitals had no centralized construction services—each facility handled it independently; now it is systemwide.³⁰¹

Particularly transformative was the health system’s deliberate decision to target its investment to benefit the local community and regional economy. A variety of different motivations helped trigger this shift. One motivation was the realization that since hospitals have fixed locations and often invest in extensive infrastructures, they should adapt to changes in demographics and local economic conditions, said Steve Standley, Chief Administrative Officer for University Hospitals. By 2005, the situation facing Cleveland was grim. Well before the 2008 financial crisis hit, many large corporations had already migrated out of Cleveland, creating the impression that the situation in the region was growing worse. At the same time, political pressure to benefit the community at a local level increased. Furthermore, the Northeast and Midwestern blackout of 2003, which created power outages for four days, increased the hospital system’s focus on how its supply chain could react to immediate shocks, and bolstered the view that shifting purchases to local suppliers would help build resilience in those situations. All of these themes helped foster the idea of using hospital procurement practices to support the regional economy among the senior leadership.³⁰²

Furthermore, there were cultural changes in the younger generation of staff and potential hires, who wanted to know how University Hospitals could more positively impact the community and mitigate its environmental impact. Finally, from a mission perspective—both financially and morally—the argument was sound. Noted Standley, it made business sense to help create more sustainable local communities with better employment opportunities since those communities tend to have less need for uncompensated care. Together, these different motivations culminated in a focus shift for University Hospitals.³⁰³

University Hospitals set the following goals for the project: five percent of contractors were to be women-owned, 15 percent were to be minority-owned business, 20 percent of all project workers were to be residents of the City of Cleveland, and 80 percent of businesses that received contracts were to be regionally based companies in Northeast Ohio. The impetus to make these changes also came from within and outside the hospital system. At the same time that University Hospitals was moving in this direction internally, said Hewitt, “The mayor of the City of Cleveland said: don’t step in a small way. If you’re going to do it, just go for it. Give it everything you’ve got. That’s what we decided to do.” At the completion of the final construction in mid-2011, University Hospitals had met all of these targets except for the residency goal.³⁰⁴



Steve Standley, University Hospital’s CAO, with Cleveland’s Mayor Frank Jackson (left). *Photo: University Hospitals.*

Despite this one shortfall, University Hospitals exceeded other targets—92 percent of businesses that participated in Vision 2010 had some element of its operations locally based, defined as within a 50-mile radius. Additionally, as a result of an intensive process of vendor development, University Hospitals developed business relations with more than 100 minority- and female-owned businesses. Said Standley, “We spent \$3.6 million on vendor development, outreach, and monitoring; we treated ourselves as though we were a federal coupling project even though we are a private organization.” Standley added in a separate interview that this sum, which equals less than one half of one percent of just the construction budget, would have likely been spent even with the traditional model. “You’re going to do it anyway, so you might as well build something.”³⁰⁵

In order to accomplish these goals, University Hospitals implemented two external checks to keep them on target. First, it hired a third-party private consulting agency,

Minority Business Solutions, which maintained a constant presence throughout the entire process and helped provide transparency. Remarked Hewitt, “So with every conversation, they would listen through that filter. They have been very successful in finding opportunities in places where we would have never found them.” This element was especially important because as Vision 2010 commenced, a county corruption scandal regarding diversity targets dominated the political conversation. Standley added, “We knew we were doing some culture bending here. We didn’t want people coming back later, pointing fingers, and saying, ‘the numbers aren’t real’, saying, ‘these are all fabricated,’ that you didn’t really do this.”³⁰⁶



Minority Business Solutions event. Photo: University Hospitals.

Second, University Hospitals negotiated a Project Labor Agreement (PLA) between itself and the Building Trades Council, the umbrella group of 19 unions working in the construction field. In this case, the agreement went beyond the traditional PLA model, which typically commits the unions not to strike during the life of the construction project as long as union labor is being used. The Vision 2010 PLA also incorporated several notable economic inclusion elements. First, although this contract represented an agreement among private employers, the City of Cleveland was intentionally added as a third-party beneficiary and participated in negotiations over the language of the agreement. Second, University Hospitals’ focus on Northeast Ohio was included in the contract. As a result, union contractors were required to hire at least 20 percent of their workforce from Cleveland. Third, the agreement set targets for diversity hiring and allowed University Hospitals to contract with non-union contractors if the building

trade unions could not meet the targets. Fourth, the agreement recognized partnerships and contracts between union and non-union contractors, enabling increased participation and generating new joint ventures. Finally, the contract required that union contractors, local government officials, the building trade unions, and University Hospitals create diversity-related programs that develop minority- and women-owned business capacity, and increase diversity hiring.³⁰⁷

Capacity building is an important element of University Hospitals' evolution as an anchor institution. Just as University Hospitals has participated in programs that increased the number of minority- and women-owned business in the supply chain, it was also necessary for those involved in Vision 2010 to increase local capacity in order to reach the benchmarks. Hewitt explained one method of capacity building: "Through the program we found areas where less experienced contractors could put University Hospitals on their resume. We did training; we provided opportunities to say, 'I have some healthcare experience.'" This incremental approach is important from both the hospital system and contractor perspective. First, for the hospitals, it limits the risk from an inexperienced contractor since federal regulators can inspect at any time. Second, it enables the contractor to participate in a market where healthcare is the largest industry. Without this experience, it might be difficult for these contractors to survive.³⁰⁸

Another method involved incentivizing companies to relocate to Cleveland or the surrounding area. By opening a location or expanding a portion of their business to the Northeast Ohio market, a supplier would satisfy the local requirement and be considered for a contract. This process also works in reverse, incentivizing business to stay in the community. Sarah Kresnye, Community Development Manager at the Center for Health Affairs—the metropolitan hospital association representing 40 hospitals through Northeast Ohio—provided the example of Ben Venue Laboratories, the sterile-injectables manufacturing arm of Bedford Laboratories, which was going to relocate to California. Kresnye added, "Steve Standley basically said if you go, your business from us is going to leave. It made them close their California office and bring those jobs to this region. I think [University Hospitals] recognizes the difference that can be made."³⁰⁹

Business co-development is a third way to build capacity; one example of this effort is the Evergreen Cooperatives, a network of planned, worker-owned companies that University Hospitals has been instrumental in helping to launch by awarding the cooperatives contracts and providing seed funding to the overall Evergreen Initiative (\$1.25 million to date). Evergreen represents the economic inclusion piece of a broader revitalization



University Hospitals Seidman Cancer Center on the campus of UH Case Medical Center, constructed as part of Vision 2010. Photo: University Hospitals.

strategy of the Greater University Circle Wealth Building Initiative. Addressing gaps in the anchors' supply chains, these employee-owned, "greenest-in-class" businesses hire from target neighborhoods, providing low-income individuals the opportunity to own part of a business and build wealth.³¹⁰

At the same time, this effort stabilizes the neighborhoods: employees are provided an opportunity to purchase homes within a target area and since the wealth accumulation is dispersed, the majority of it will remain in the community. As of this writing, eight worker-owners are participating in the employer-assisted housing program. Since housing prices in the target communities are currently so deflated, these employees can expect to own their homes within four to five years by paying their mortgage through a payroll deduction. Additionally, as the businesses become profitable, employees share in the profits through their equity stake; over time, their "capital accounts" can grow into many tens of thousands of dollars. To date, three businesses have been launched: Evergreen Cooperative Laundry, Evergreen Energy Solutions (formerly Ohio Cooperative Solar), and more recently, Green City Growers Cooperative, which opened at the end of 2012.³¹¹

University Hospitals is involved in a number of other job creation and wealth building initiatives in the community. For example, it is a partner in the NewBridge Cleveland Center for Arts & Technology, which is developing neighborhood resident skills to support careers in healthcare for adults and provide education and training for youth in a variety of the arts—music engineering, ceramics and digital arts, among others. It is also a participating institution in Health-Tech Corridor, an initiative aimed

at promoting the start-up or relocation of biomedical, healthcare, and technology companies into Cleveland's Midtown section (further detailed in section on Cleveland Clinic Health System). This strategy is another way in which University Hospitals is using its buy local commitment to encourage companies to move into Cleveland and hire locally in order to receive hospital system contracts.

Throughout the process, Vision 2010 faced its share of challenges, providing opportunities for outsiders to benefit from some key lessons. Standley pointed out, "We have learned some good things; we have made some mistakes, but at least we did it. That is what I tell people. Was it perfect? No. Could we have done more? Yes. But at least we did it." In one respect, the idea of Vision 2010—a five-year planned and timetabled construction project—itself was a challenge. Although Vision 2010 officially began in 2005, many partners did not officially engage until 2007 even though the goals needed to be met by 2010 regardless of when they joined the project.³¹²

at promoting the start-up or relocation of biomedical, healthcare, and technology companies into Cleveland's Midtown section (further detailed in section on Cleveland Clinic Health System). This strategy is another way in which University Hospitals is using its buy local commitment to encourage companies to move into Cleveland and hire locally in order to receive hospital system contracts.



Green City Growers Cooperative, west wall panels under construction, August 2012. Photo: The Cleveland Foundation.

Of all the targets that University Hospitals set, the only benchmark Vision 2010 failed to achieve was the hiring of 20 percent of all project workers from Cleveland. When devising these targets, University Hospitals' leadership decided that the benchmark should be simple and easily understandable; as a result, they adopted the city's own targets for its projects set forth by the Fannie Lewis Resident Employment Law. According to Standley, when this target was initially accepted, the health system's leadership did not properly understand how the law set the benchmarks. As time progressed, they realized that the 20 percent did not apply from the owner of the project's (i.e. University Hospitals) perspective but from each contractor's perspective and was based on all of the contractor's projects together on an on-going basis. Standley noted, "So we took a much harder version of [our target], which at the time was pretty unachievable." It was unachievable because University Hospitals was competing with every federal, county, and city-based project for the same pool of contractors that met this requirement and the capacity simply did not exist to meet the need.³¹³

Another challenge to localization are group purchasing organizations (GPOs), which have increased significantly in scale since the 1990s and serve to minimize hospital costs for medical supplies and related goods by seeking large national contracts. GPOs are not concerned with the geographic location of their suppliers unless their customers (i.e. hospitals) effectively pressure them. However, since hospitals in Northeast Ohio consolidated, becoming in essence three integrated health networks in the 1990s, the dynamic has shifted; they now have the market-share clout to negotiate a similar price to a national contract with a local or regional vendor. Today, University Hospitals can customize a portion of the portfolio at the regional level. Still, this shift toward regionalism required a conscious change in the culture of the organization.³¹⁴

At the regional level, certain items, such as commodities, are significantly easier to source than physician-preference items, or items that often require technical training to operate. When University Hospitals began this shift in 2006 and 2007, it made the decision to focus on commodity items and on the construction side. This limited the number of bids to national companies that would have historically gone out for a project of this scale. Admitted Standley, "I got big pushback when that happened because culturally up until that time a health system of this size always equated size, scale, and national presence and references with quality. . . [the process was] very challenging. A lot of change management."³¹⁵

Another challenge that also presents future opportunities is the limited window of time that exists to reallocate purchasing and resource decisions because of multi-year



Quentin and Elisabeth Alexander Neonatal Intensive Care Unit on the campus of UH Case Medical Center, constructed as part of Vision 2010. Photo: University Hospitals.

contracts. This is more relevant to University Hospitals’ supply-chain decisions going forward than during the execution of Vision 2010. Standley noted the need to be prepared when the “window opens.” These contracts, which range in duration from three to five years, increase the difficulty of reallocating portions of University Hospitals’ \$850 million annual purchasing portfolio. Despite this challenge, between 2008 and 2011, University Hospitals was able to double its spending in Cleveland, mostly as a result of the concerted effort of Vice President of Supply Chain, Allen Wild, who actively shifted direct spending under his control. In 2010, University Hospitals purchased more than \$300 million (approximately 38 percent) from vendors within Cleveland and more than \$500 million (approximately 63 percent) within Northeast Ohio.³¹⁶

A final obstacle that was identified and addressed early on was achieving diversity goals. According to Hewitt, when she joined the project, she stressed to Standley that University Hospitals needed to establish a position whose sole responsibility was to ensure that diversity remained a priority. It could not be just another item on a “check-list.” Hewitt pushed for third-party oversight, leading to the contract with Minority Business Solutions, because she understood that points exist in construction projects when those in charge—such as project managers—contractors, or construction managers, encounter obstacles or delays, obscuring the importance of diversity relative to completing the project on time and on cost. A third party could focus fully on ensuring that diversity remained an important priority in all phases of the project.³¹⁷

Cleveland Clinic Health System

We are only as strong as the neighborhoods in which we are located. And I can’t overstate that. That is really critically important: that these neighborhoods be as solid and as stable as they can possibly be.

■ Oliver C. Henkel, Jr., Chief External Affairs Officer, Cleveland Clinic ³¹⁸

Cleveland Clinic’s main campus is situated in Cleveland’s University Circle, a vibrant enclave of hospitals, universities, and cultural institutions, surrounded by a ring of severely distressed communities. Cleveland Clinic has historically had a reputation of having “very little regard for what happened outside of our walls,” said Oliver C. Henkel, Jr., Chief External Affairs Officer.³¹⁹ In recent years, Cleveland Clinic has worked consciously to change the perception of the institution as inward looking by embracing

the idea of itself as an anchor institution serving more than just those who enter its doors. As a result, it has adopted a variety of anchor strategies, including shifting a percentage of procurement locally and to minority-owned businesses, participating as an anchor partner in a comprehensive neighborhood revitalization effort, implementing childhood wellness programming in local school districts, and positioning itself as a leader in sustainability.

Founded in 1921, the Cleveland Clinic Health System is geographically dispersed across the United States and the globe, comprised of 12 hospitals, 18 family health centers, and several specialty health centers and outpatient clinics. As a whole, the system generates revenues in excess of \$6 billion, employs approximately 43,000 caregivers, and maintains 4,400 beds. Despite its global presence, the vast majority of the system is based in Northeast Ohio, where it is the largest employer in the region and second-largest in the state. The Cleveland Clinic's main campus alone employs more than 26,000 people, creates nearly \$4 billion in revenues, and procures more than \$1.5 billion in

CLEVELAND CLINIC HEALTH SYSTEM ANCHOR STRATEGIES

Neighborhood Revitalization

- Greater University Circle Initiative: foundation and anchor institution-led comprehensive neighborhood revitalization effort of surrounding neighborhood
- Master redevelopment plan for Upper Chester neighborhood, includes purchasing vacant land, retail development, and housing construction

Local and Minority Purchasing

- More than \$50 million from Health-Tech Corridor, in 2010
- More than \$165 million (10%) within Cleveland and more than \$270 million (17 percent) in Northeast Ohio, in 2010
- More than 400 minority vendors, \$150 million spent, in 2009.
- Goal: At least 10% of food within a 200-mile radius

Multi-Institution, City, and Regional Partnerships

- Greater Circle Living: \$1 million investment in multi-institutional, employer-assisted housing program

Community Investment

- Evergreen Cooperatives: \$250,000 in multi-institutional, business co-development strategy to create jobs for neighborhood residents and allow local sourcing
- \$500,000 investment to restore community center

Capacity Building

- \$23 million bio-tech incubator to be owned by local nonprofit
- Comprehensive childhood wellness program with local school districts

goods and services annually. Similar in function to a university endowment, Cleveland Clinic's investment portfolio is valued in excess of \$4.5 billion.³²⁰

Several reasons have prompted Cleveland Clinic to more prominently acknowledge its role as an anchor institution. Cleveland Clinic recognizes that the strength of the organization is heavily dependent upon the strength of the neighborhoods it serves. Therefore, its priority to ensure the health of its surrounding community has spurred a greater focus on active engagement as a community partner. Cleveland Clinic's community outreach goals now include: strengthening community life through effective, sustainable health education and outreach programs focusing on vulnerable and at-risk populations; enhancing neighborhoods through community building collabora-

tions that facilitate caregiver engagement; and making the region a better and healthier place to live. Cleveland Clinic also recognizes that fostering safe and stable surrounding neighborhoods is good business. For a hospital that operates most efficiently at 85 percent capacity, ensuring patients and caregivers feel secure coming to Cleveland Clinic is critical.³²¹

Henkel noted that the City of Cleveland is also a healthcare center (a large Veterans Administration hospital, in addition to University Hospitals and MetroHealth System, are also located here), and said this critical mass could be leveraged to support a

healthier regional economy through collective local purchasing efforts. One example of a collaborative effort to leverage the purchasing power of Cleveland's healthcare anchor institutions, of which the Cleveland Clinic is the largest, is the Health-Tech Corridor, a three-mile, 1,600-acre area served by Cleveland's new Bus Rapid Transit Line, launched in 2010. The vision for this corridor, which connects Downtown Cleveland to University Circle and spans 10 neighborhoods with a significant number of vacant and dilapidated properties, is to re-cast this geography as a thriving center for healthcare and biomedical businesses in Northeast Ohio. Both Cleveland Clinic and University Hospitals are heavily engaged in the development of the Corridor. In 2010, for example, Cleveland Clinic procured more than \$50 million in goods and services from companies located in the Health-Tech Corridor.³²²

Cleveland Clinic has altered its purchasing practices in other ways too. Overall in 2010, the organization purchased more than \$165 million (more than 10 percent) of goods and services within the City of Cleveland and more than \$270 million (approximately 17 percent) in Northeast Ohio. Additionally, Cleveland Clinic works with more than 400 minority- and women-owned companies. In 2009, the health system procured more



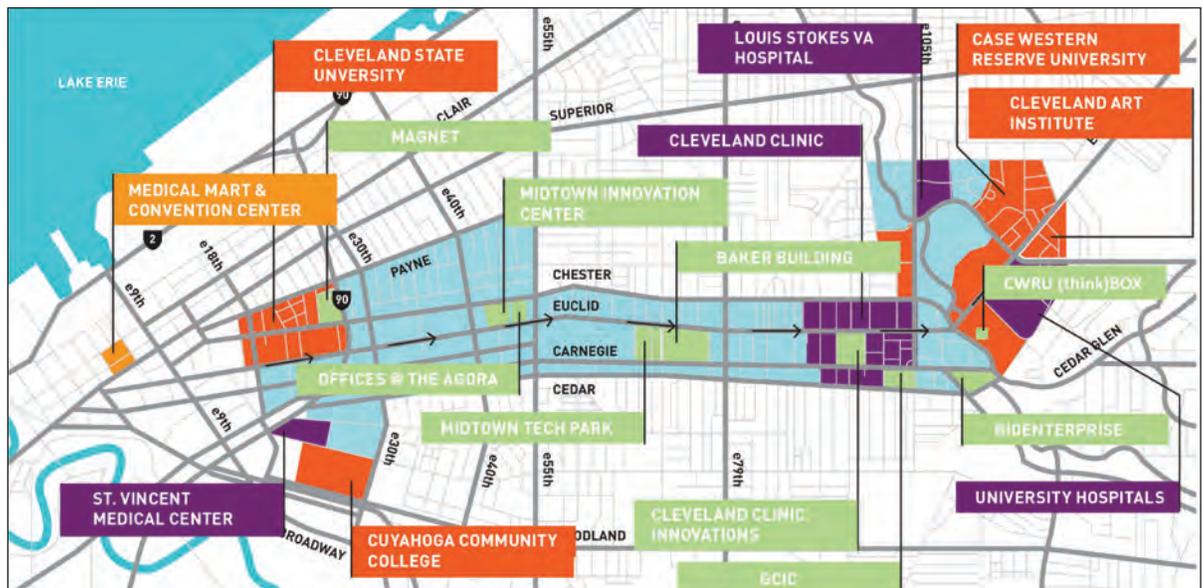
Cleveland Clinic's community farmer's market (September 2012). *Photo: Cleveland Clinic.*

than 11 percent from these diverse suppliers (including construction), or more than \$150 million. As part of its environmental commitments, Cleveland Clinic has developed local food procurement standards and, in 2011, aimed to procure at least 10 percent of annual food supplies from sources within a 200-mile radius of the campus.³²³

The hospital has also been an important partner in the Cleveland Foundation’s Greater University Circle Initiative, which seeks to break down the divide that has existed between the institutions in the University Circle area and the six disinvested neighborhoods that immediately surround them. This initiative is a multi-pronged effort that promotes buying, hiring, and living locally through strategies that also seek to connect current residents. As part of its commitment to this neighborhood revitalization effort, Cleveland Clinic has invested \$1 million into a \$4 million Greater Circle Living employer-assisted housing program and another \$250,000 (the same amount as University Hospitals’ initial investment) for the Evergreen Cooperatives. To date, one of these companies, Evergreen Energy Solutions, has constructed a solar array on Cleveland Clinic’s Zeilony Plaza and more large installations are in the works.³²⁴

Also, as part of the initiative, Cleveland Clinic has worked with the Cleveland Foundation and other partners to create a master redevelopment plan for Upper Chester, part of the targeted Hough neighborhood that is proximate to the main campus. The first phase of the plans aims to purchase vacant land, attract new retail business, and construct up to 400 new housing units.³²⁵

Apart from the broader initiative, Cleveland Clinic has undertaken several other community economic development projects. One was a \$500,000 investment in the Langston



Map of the Cleveland Health-Tech Corridor. Source: Cleveland Health-Tech Corridor, <http://www.healthtechcorridor.com/facilities>.

Hughes Center, a historic and iconic former Carnegie library, important to the Fairfax neighborhood that also now serves as a senior outreach center. Cleveland Clinic also operates a free health clinic out of the center, as another form of outreach in the community.³²⁶



Cleveland Clinic's Zeilony Plaza. Photo: Cleveland Clinic.

Another project has been a partnership between Cleveland Clinic and the nonprofit Fairfax Renaissance Development Corporation (FRDC) to construct the Global Cardiovascular Innovation Center. Opened in May 2010, this \$23 million, 50,000 square-foot building serves as an incubator for related companies, with the hope of drawing new investment to the community. Originally, this Center was to be owned entirely by FRDC, but the economic recession made financing difficult. As a result, Cleveland Clinic currently owns

the building—paying down the debt service—for a period of 15 years, at which point, it will transfer ownership to FRDC. At that point, Cleveland Clinic will lease the space from the nonprofit community development corporation, thereby providing operating revenue for the local organization. Henkel explained that it is important to the hospital that this building is owned by the nonprofit and, hence, by the community.³²⁷

Cleveland Clinic has also implemented a comprehensive childhood wellness program that brings together its family health centers, hospitals, and neighborhood partners in the school and community setting. Central to the program is the overarching '5 to Go!' message, which is modeled after programs piloted in Maine and Chicago, and aimed at preventing childhood obesity. Through the Office of External Affairs' department of Public Health & Research, Cleveland Clinic has created and partnered with national organizations to create school-based curricula for children in pre-kindergarten through high school. Working with a variety of regional districts including Cleveland Municipal School District and the First Ring Superintendents' Collaborative districts, Cleveland Clinic employs a training model that encompasses both a capacity-building element, through a train-the-teacher strategy, as well as an institution-led volunteer strategy. The developed curricula aim to enhance academic subjects, such as math, reading, and science, while teaching students about nutrition, physical activity, mental health, substance abuse, and avoidance of high-risk behaviors in order to promote wellness and healthy lifestyles.³²⁸

Cleveland Clinic has also been integrating sustainability strategies into its operations since 2007 in an effort to "support healthy environments for healthy communities." Practice Greenhealth has recognized Cleveland Clinic as a leader in this area. Christina Vernon, outgoing Executive Sustainability Officer, noted how Cleveland Clinic initially focused on recycling and waste management, but has now expanded its attention to include energy management, green building, toxicity reduction, environmentally preferred purchasing, healthy transportation, and engaging caregivers and the community

in sustainability. Now the vision of sustainable practices is further “maturing.” Vernon added, “I’m trying to lead this organization to look at the full sustainability picture. I want to talk about social issues. I want to talk about economic issues. I want to talk about ecological issues. . . Start-ups like the Evergreen Cooperatives are really perfect examples of that triple-bottom-line approach.” Vernon admitted that Cleveland Clinic has a long way to go but notes that traction is starting to build in the organization toward a “triple-bottom-line approach.” Partially, as a consequence of the Greater University Circle Initiative, and its focus on social and economic inclusion, there is greater coordination between the sustainability, diversity, and community offices.³²⁹



Global Cardiovascular Innovation Center. Photo: Cleveland Clinic.

GREATER UNIVERSITY CIRCLE INITIATIVE

As noted throughout, the efforts of both Cleveland Clinic and University Hospitals are linked to a broader community initiative, known as the Greater University Circle Initiative. Still, some long-time community residents view the area’s major anchor institutions within University Circle with a degree of mistrust and alienation.

In recent years, however, both hospitals are making progress toward integrating an anchor institution mission and deepening ties to their neighboring communities. For University Hospitals, it has involved, among other things, making a commitment to leveraging its purchasing power to improve the economic conditions of Cleveland and Northeast Ohio. This commitment was the result of a variety of motivations coalescing at the appropriate time to convince those in senior leadership that this shift was mission-aligned and financially prudent. University Hospitals made this commitment with Vision 2010 and will continue to progress in this direction even after that project is completed.

For Cleveland Clinic, its community investments in education, sustainability, workforce development, neighborhood revitalization, and outreach are working to shift its perception within the community. Of course, as with any transformation, there are bumps and obstacles along the way. But noted Henkel, “We are the Cleveland Clinic. . . the name of the city [is] in our name. And so we are here to stay.”³³⁰

Conclusion

Integrating an Anchor Institution Mission

In developing holistic, smart and innovative approaches to well-being, we need deeper understanding of our communities — how they evolve over time and how individuals live together in them, how we communicate, how we use our resources, and how we understand and respond to the complex and often surprising nature of our interdependence.

- Community Health Network, Indianapolis, Indiana, 2010 Form 990 statement³³⁰

Integrating an anchor institution mission into a hospital's overall work is a process, requiring time and intention. Some hospitals have started down this path, slowly transitioning from a narrow focus on acute-care treatments for admitted patients to emphasizing community engagement and recognizing their broader impact. These hospitals still comprise a small minority. The vast majority still remain firmly focused on a reactive model of health promotion. Achieving this transition requires an institutional commitment to changing practices that have been embedded over time in the operations and ethos of the American not-for-profit hospital.

Considered in this context, the hiring, real estate, purchasing, and investment strategies explored in this report are not just short-term programs but ongoing initiatives that require internal infrastructure (coordination, administrative support) in addition to external infrastructure (engagement process and building relationships). Hospital leadership may balk at a process, which, at first glance, may seem to broaden the hospital's mission of promoting health too far, and implement too many characteristics of social work or business agencies.³³¹ But, as this report has aimed to demonstrate, the opposite is true: A hospital should not disconnect its mission of health promotion from other social determinants of health that have traditionally been seen outside its scope of responsibility. In order for hospitals to begin to integrate an anchor institution mission, this report offers a number of recommendations.

First, an anchor institution mission requires buy-in from senior-level executives, a commitment to a long-term strategic plan, and independent officer positions dedicated to accomplishing subsequent priorities. One common thread that connects all of the

hospitals in the case studies is a commitment from senior administration to an inclusive anchor vision. At Gundersen, CEO Jeff Thompson has been an important champion of Envision. In Detroit, CEO Nancy Schlichting has been an important driving force for Henry Ford. At Bon Secours Baltimore, CEO Samuel Ross has helped reaffirm and expand the hospital's commitment to the community. At University Hospitals in Cleveland, CAO Steve Standley is an outspoken advocate for Vision 2010 and the Evergreen Cooperatives.³³²

Still, not all executive leadership and administrative staff will reach these conclusions alone. There is room for other actors to help influence leadership, such as through hospital associations assuming a larger education role or through a hospital's board or governing body, which now must authorize a community health needs assessment implementation strategy before the IRS considers it legally adopted.³³³ While the importance of executive leadership is evident, less obvious is the necessity to institutionalize these practices through long-term strategic plans and officer positions dedicated to ensuring the commitment and continuity of this outward vision irrespective of future leadership transitions.

Long-term strategic plans establish future hospital goals and help reinforce the institution's primary values. Both University Hospitals' Vision 2010 and Gundersen's Envision established concrete benchmarks that each institution hoped to achieve in critical areas. For example, in order to achieve its targets for local purchasing, University Hospitals has helped prioritize this goal through operations changes that award additional points to local businesses when reviewing project bids. For Henry Ford, one of its six principles for an "envisioned future" is to be an involved partner in the economic redevelopment of Detroit, noted Senior Vice President Bill Schramm. In adopting a ten-year strategic plan and vision in 2010, Community Health Network created a new mission statement emphasizing its commitment to the community and reconfirming the importance of fair economic opportunities as one of the five pillars of a healthy community.³³⁴ Hospitals should reevaluate how an anchor institution mission or elements thereof may align with long-term priorities.

Another important step is to establish administrative positions (preferably at the vice president level or higher) for key priorities related to anchor strategies. Practice Greenhealth conducted a survey that noted the rapid expansion of sustainability coordinator positions since the mid-2000s, as hospitals have emphasized environmentally friendly practices.³³⁵ The same change has begun to occur with regard to supplier diversity officers and, more generally, diversity and inclusion officers, such as at Henry Ford, University Hospitals, and Cleveland Clinic. Bon Secours has a position for vice president of mission at both the individual hospital- and system-level.

These positions should be independent of the pressures of specific offices, allowing them to effectively champion on behalf of the institutional priority they represent and positioning them to challenge the status quo of operations in all departments. Although the Cleveland Clinic's sustainability practices started in the construction

office, Christina Vernon explained how she helped elevate the position beyond its initial limited scope. “There’s no way I’m going to be able to influence [people in facilities and construction] if I’m embedded with them. I need to be seen as separate from these people so I can influence them directly,” said Vernon.³³⁶

Consequently, since there may be multiple positions focused on various mission-related priorities (for example, a vice president of sustainability, diversity, community outreach/benefit, mission, and anchor institution mission), some process to encourage communication, coordination, and synergy among these individuals is vital. These employees, collectively, represent a working group focused on institutional priorities that may sometimes conflict with the organizations’ short-term bottom line but create long-term value. As noted earlier, but worth reiterating, in the case of Cleveland Clinic, partially as a consequence of the Greater University Circle Initiative and its focus on social and economic inclusion, there is greater coordination between the sustainability, diversity, and community offices.³³⁷ Over time, this communication could extend to counterparts at other anchor institutions in the community, who could learn from best practices and maximize impact.

A *second* key area that needs to be addressed is organizational culture. Hospitals should seek to change the culture of their entire organization, involving doctors, nurses, researchers, and other employees, in order to deploy their human and financial resources most effectively and create staff buy-in for an anchor institution mission. Although many changes need to be institutionalized at the top, a cultural change across the entire organization is equally important. All too often, weak linkages between the local community and hospital are reinforced because they have no connection to the surrounding neighborhoods. Hospitals have adopted several strategies to invest their employees in these new organizational goals.

One way for a hospital to start this transformation is by challenging its employees through programs that complement the change in institutional priorities. An example is Gundersen’s “My Envision,” highlighted earlier, which challenges all employees to reduce their carbon footprint. Another is St. Joseph’s Hospital Health Center Foundation’s “Generations” campaign, which has asked hospital employees to donate to help implement the hospital’s master plan, which includes neighborhood revitalization efforts. As of 2010, St. Joseph’s employees had contributed nearly \$1 million.³³⁸

Another option is to incentivize employees through tying their compensation to specific goals or offering financial incentives to take part in other institutional programs. For example, Henry Ford has tied seven percent of senior executives’ bonuses to the organization’s success in accomplishing its diversity goals. Indiana Health System has also linked leader compensation to the system’s diversity goals, including its supplier diversity program. Earlier, this report also highlighted hospital efforts that provided financial incentives to employees to participate in hospital initiatives that are deemed priorities, such as MetroWest Medical Center’s Community Supported Agriculture

program and the multiple hospitals that have implemented employer-assisted housing programs.³³⁹ Hospitals have a variety of options for how to reinforce institutional priorities throughout the hospital's culture; however, what is most important to accomplish this change is a deliberate and conscious effort to do so.

A *third* focus of this report's recommendations involves the development of indicators and metrics for engagement. Hospitals should establish realistic targets and focus attention on specific projects, but embrace flexibility and patience when necessary. Measuring the success of an anchor institution mission is not an easy process. However, it is important that an organization assess accurately what its capacity is to integrate changes—this applies both to timeframe and the specific goals. For example, as Jeff Rich from Gundersen pointed out, the timeframe should not be too short as to make success impossible or too long to prevent any real momentum. Similarly, George Kleb from Bon Secours emphasized the patience necessary to maintain momentum and keep the community involved in this type of long-term project. A case study of SwedishAmerican Hospital's neighborhood revitalization efforts provided "advice to others" from the hospital, including stressing the flexibility of the program to seize opportunities as they present themselves and change course as required. It also noted the importance of having a clear chain of command with one or two people implementing decisions, and not a committee.³⁴⁰ Regardless of the focus of the project, there should be clear indicators and metrics to evaluate progress, to judge success, and to provide opportunities for reevaluation if the intended impacts do not materialize.

Fourth, hospitals should recognize that community engagement and building community capacity are long-term investments that are integral to successful implementation of an anchor institution mission. The importance of community engagement *early and often in the process* cannot be stressed enough. Hospital community benefit staff provide a natural starting point for strengthening this relationship and can use the community health needs assessment as an opportunity to increase community capacity. Jessica Curtis, Project Director for Community Catalyst's Hospital Accountability Project, pointed out that some hospitals in Massachusetts are using their assessments to do just that, by helping community members understand data, determine hurdles to their goals for a healthy community, and help create an understanding on broader health issues that makes the hospital's agenda easier to understand.³⁴¹

Curtis added that there is increasing interest among hospitals to use the community-benefit process to build community capacity to understand population health data, the social determinants of health, and participate in choosing priorities to address—a best practice long advocated by the Catholic Health Association and now incentivized by assessment requirements in the Affordable Care Act. Curtis described it this way, "It's about democratizing data and building capacity in communities to read and use the data, to choose strategies that work, and building coalitions to tackle the social determinants of health." In the process, hospitals should rethink how they staff their

projects, how they retain organizing skills, and how they pay for staff positions on community coalitions.³⁴²

Fifth, hospitals should broadly engage community and local political partners, including other anchor institutions and foundations, as they integrate an anchor institution mission into their overall work. In a 2010 *Detroit Free Press* article, Judith Rodin, President of the Rockefeller Foundation, commented, “It’s very hard to lead and take a backseat at same time, but it’s a dance you have to do.” As the former president of the University of Pennsylvania, Rodin is referencing her institution’s efforts to revitalize West Philadelphia and the obstacles she faced. Sometimes an anchor institution may have to spend years overcoming the community’s mistrust of its past practices and future intentions. In this instance, Rodin was implying that the same delicate “dance” is required for anchor institutions in Detroit (such as Henry Ford) — and those in other cities and towns — to succeed in helping revitalize their communities.³⁴³

In addition to overcoming community resistance, hospitals should also seek partnerships, including with other anchor institutions, in order to maximize impact and reduce duplicative efforts, as Henry Ford has done through its coalition work with Wayne State University and the Detroit Medical Center and as University Hospitals and Cleveland Clinic have done with the Greater University Circle Initiative. Collaboration helps increase dialogue regarding best practices and provides a method for further leveraging resources. Bill Ryan, President and CEO for The Center for Health Affairs, remarked that one of the biggest challenges he currently encounters as the lead advocate for hospitals in Northeast Ohio is that hospitals are taking a “shotgun” versus a “cannon” approach, implementing programs without a strategic focus. In early 2011, there were more than 35 different healthcare-related workforce development programs in Cleveland and the surrounding region. Sarah Kresnye, Community Development Manager, added “a lot of them are working toward the exact same thing, and they’re actually competing to the point where neither of them are nearly as successful as they could be [if they were working together]. Instead, these organizations are not communicating and creating redundancy that, in some cases, may be doing more harm than good.”³⁴⁴ To avoid this result, anchor institutions should map their current assets and possible partnerships in their communities.

Sixth, hospitals should reassess their policies regarding charity care, Medicaid patients, and bill collections to ensure that they do not preclude low-income families from building or keeping their assets. In the process of considering upstream interventions and opportunities for neighborhood revitalization, hospitals should not negate their positive impact by maintaining policies that are excessively burdensome for those most in need. A CDC report issued in March 2012 found that nearly one third of U.S. residents were experiencing a financial burden from medical care, including ten percent that are unable to pay all. Similarly, Demos’ “2012 National Survey on Credit Card Debt of Low- and Middle-Income Households” found that medical debt was a leading contributor to credit card debt, with hospital stays and emergency room visits as two of the three

leading expenses. Nearly half of households surveyed had credit card debt from medical expenses, with the average amount nearly \$1,700.³⁴⁵

Furthermore, Demos' research found that respondents with poor credit ratings reported medical bills as the second leading reason, with 55 percent saying it contributed. The survey also found that this debt caused half of these households to skip treatment, not fill a prescription, or not see a doctor—proving even more counterproductive to better health outcomes. Those most likely to avoid seeking treatment included lower income households, households with children, and those suffering from unemployment. Additionally, prohibitive policies in these areas—especially billing and collections policies—have a significant negative impact on hospitals' relations with their communities, noted Curtis. In sum, hospitals should avoid working at cross-purposes by recognizing the important connections between their various institutional policies.³⁴⁶

PHILANTHROPY'S SUPPORTING ROLE

Philanthropy has an important role to play in helping hospitals maximize their impact, providing incentives and motivations for hospitals to continue to adopt anchor strategies. The case studies in this report have focused primarily on the internal motivations and actions that have driven individual institutions; however, oftentimes, foundations have been important partners. Consequently, foundations, especially public health and health conversion foundations, should recognize the impact they can have in a variety of capacities, including:

First, foundations can serve as conveners, bringing together anchor institutions and forging partnerships. As Margaret O'Bryon, outgoing President of the Consumer Health Foundation, noted, local foundations in particular are skilled connectors of different people and repositories of valuable information about the community, existing “power structures”, and the interconnections among and between different groups.³⁴⁷ As a result, philanthropy is well positioned to help coordinate and provide a comprehensive neighborhood-revitalization lens to multiple and duplicative initiatives that are often occurring within the same community. They can play a critical role in shaping a vision for initiatives and attracting hospital support in a targeted effort to maximize impact. As a peer institution to prominent hospitals and universities in the area, the Cleveland Foundation has used its standing within the community to bring to the table multiple anchor institutions, including rival hospitals (Cleveland Clinic and University Hospitals), to participate in a comprehensive neighborhood-revitalization strategy.

Second, foundations can increase dialogue regarding the importance of hospitals as anchors and encourage an anchor framework through specific initiatives. In 2005, the Kellogg Foundation initiated the “Engaged Institutions” project, seeking to encourage universities and colleges to “more thoroughly” integrate civic engagement into their organizational structures and practices. Kellogg recognized how these institutions are

“major assets” to their communities, and how they have “enormous potential” to help address society’s “most pressing” social, economic and environmental challenges by acting as “better neighbors.” A philanthropic initiative today that promoted similar ends, asking hospitals to more consciously integrate an anchor institution mission into their organizational structures and practices, could be equally powerful.³⁴⁸

Third, foundations can serve as funders, providing important seed, predevelopment, and matching funds to catalyze broader anchor partnerships. Philanthropy can help finance projects in a variety of capacities. One example is the Robert Wood Johnson (RWJ) Foundation, which in collaboration with the University of Wisconsin Health Institute awarded 12 “Roadmaps to Health” community grants in 2011, totaling \$2.4 million. Managed by Community Catalyst, a nonprofit health advocacy organization, each grant was awarded to a nonprofit community organization focused on addressing social determinants that most negatively impacted health outcomes in their communities, including: education; employment and income; family and social support; and community safety. The RWJ Foundation strongly encourages community partnerships, and requires participation by an organization with health expertise and an investment from the community through matching funds. Although hospitals were not well represented in the community partnerships that received grants, one of the recipient projects, highlighted as an example of hospital community investment in Section Three, was the Wellspring Initiative, of which Baystate Health has been a critical partner.³⁴⁹

Another example is the Cleveland Foundation, which has chosen to be the lead funder and organizer of the Greater University Circle Initiative. Here, the Cleveland Foundation and other foundations have contributed nearly \$7 million in predevelopment and seed funding to one of the initiative’s main projects: the Evergreen Cooperatives. The Cleveland Foundation alone has contributed \$3 million—or half of the initial seed capital—to help capitalize a nonprofit revolving loan fund that will ideally grow and permanently finance the start-up of additional local businesses. In the process, the foundation’s leadership and financial commitment have attracted additional financial commitments (more than \$750,000) and critical supply chain buy-in to the project from University Circle hospital and university anchor institutions.³⁵⁰

Fourth, health conversion foundations are uniquely positioned to promote place-based revitalization, and help align hospitals with their anchor institution potential. Since 1973, nearly 200 health conversion foundations have been established, as traditional not-for-profit hospitals and health organizations have become for-profit enterprises, with the resulting sale of all nonprofit assets directed toward charitable purposes. Consequently, these foundations have become important anchor institutions in their communities because of their geographically based grant focus and have often adopted a broader definition of community health in their grant-making process. These qualities strategically position health conversion foundations to catalyze neighborhood-revitalization efforts. In a few cases, health conversion foundations have already taken the first steps, prioritizing the funding of community and economic development projects;

examples include the Alleghany Foundation in Covington, Virginia; The Byerly Foundation in Hartsville, South Carolina; The Cameron Foundation in Petersburg, Virginia; the Community Foundation of South Lake County in Clemont, Florida; McAuley Ministries in Pittsburgh, Pennsylvania; and St. Luke's Health Initiatives in Phoenix, Arizona.³⁵¹

Another example is the Consumer Health Foundation of Washington, D.C., which helped persuade a group of regional foundations to assess the feasibility of a community wealth building initiative that seeks to leverage the purchasing power of area anchor institutions, including hospitals. Although still in very early stages, this effort has helped introduce area hospitals to strategies for integrating an anchor institution mission and has garnered support for a collaborative project from a variety of institutions.

POLICY SUPPORT FOR THE ANCHOR INSTITUTION MISSION

In addition to support from philanthropic and other community partners, a policy framework that incentivizes hospitals to integrate anchor strategies into their operations is equally crucial to realizing the full impact of these efforts. This report recommends several changes at the federal, state, and local levels to enable and encourage not-for-profit hospitals to embrace an anchor institution mission.

First, the IRS should evaluate and publish the data it has collected since implementing Schedule H, offer examples of best practices in guidance, and work collaboratively with other federal agencies, such as the Department of Health and Human Services and the CDC, to capture other evidence-based practices in the spheres of community benefits and population health. In changes made to Schedule H instructions in early 2012, the IRS took an important step, enabling hospitals to count qualifying community building activities as a component of their community benefit requirements. Organizations, such as the Catholic Health Association, Community Catalyst, and Health Care Without Harm, have been important advocates for elevating the importance of community building activities and persuading the IRS to make these critical changes.

However, the IRS could do much more. It should complete its own assessment of industry best practices—informed by other relevant federal agencies and also through recommendations by outside organizations with expertise in this area. The IRS should also publish detailed data regarding Schedule H reporting, including—in aggregate and by best practices—how much hospitals spend as a percentage on community benefit activities and the breakdown of those expenditures. The vast majority of hospitals remain comfortable with repeating community benefit strategies that simply address symptoms instead of the root causes of poor health. If the IRS assumes a more active role in advocating certain practices, it is better positioned to help hospitals meet their community benefit obligations *while* enabling these institutions to also have a significant impact on improving community health.

Without the IRS taking a stronger position on effective community interventions, many hospitals will continue to neglect those community interventions that actually have the greatest long-term impact on the health of the communities they serve. A few hospitals, such as University Hospitals and Community Health Network, have recognized already what the public health field has long advocated. These two health systems have identified how efforts to mitigate unemployment and poverty can align with their implementation strategy for their Community Health Needs Assessment and goals of their community benefit program, respectively.³⁵²

However, overall, the vast majority of hospitals that have integrated anchor strategies are currently doing so primarily for reasons of mission and margin—or local government pressure—but not federal community benefit requirements. Instead, community benefit obligations should be seen as an opportunity by hospitals to seed investments for community health improvement strategies that may break even or start saving money over the long-term. In taking these steps, the IRS can encourage hospitals to begin to consider engaging an anchor institution strategy and help hospitals effectively demonstrate their potential for truly benefiting the community.

Second, the Secretary of Health and Human Services should create an award to recognize leading hospital-community partnerships that develop integrated anchor institution strategies. In 2012, the Department for Housing and Urban Development (HUD) announced the inaugural annual Secretary’s Award for Community Foundations. This award honors a community foundation in each of HUD’s ten regions that has utilized a public-philanthropic partnership to address important social determinants in the community, such as “employment, health, safety, education, sustainability, inclusivity and cultural opportunities, and/or housing access for low and moderate-income families.” Winners of the award include the Cleveland Foundation for its work with the Evergreen Cooperatives, the Boston Foundation for helping create a \$22 million neighborhood-stabilization loan fund to finance the rehabilitation of foreclosed properties, and the Greater New Orleans Foundation for its effort in cleaning up blighted properties in New Orleans.³⁵³

An award for hospitals given by the Department of Health and Human Services could have a similarly important effect on hospitals. For example, the Secretary’s Award for Hospitals Building Healthy Communities could be given to specific hospitals, not health systems (thereby stressing the geographic relevance of specific initiatives), that are implementing anchor institution strategies in order to address the impact of poverty and other social determinants on the health of their community. The award should also take into account how well a hospital is incorporating community goals into this process. The importance of reinforcing an anchor institution mission by recognizing leading hospitals should not be underestimated.

Third, hospitals should look to leverage existing federal and state resources for place-based economic development opportunities. Existing federal funding sources, such

as the Obama Administration’s Choice Neighborhoods, Promise Neighborhoods, and Sustainable Communities Initiative programs, provide immediate opportunities for not-for-profit hospitals to amplify their impact from their own local efforts. The Administration has prioritized these programs, which all seek to promote integrated and multi-sectoral approaches to poverty alleviation.³⁵⁴

Funding for Choice Neighborhoods, which seeks to transform distressed communities into mixed-income neighborhoods by focusing on revitalizing public housing and social service provision, has increased from \$65 million in FY 2010 to \$110 million in FY 2012. Another program, Promise Neighborhoods, aims to help communities replicate the Harlem Children’s Zone “cradle-to-college” academic support system as a place-based, educational strategy for poverty alleviation. Finally, the multi-agency Sustainable Communities Initiative, funded at \$100 million for FY 2012, promotes efforts to integrate housing, environmental sustainability, and transportation in metropolitan and regional planning. To date, hospitals have not been significantly represented in any of these programs, but could be important partners for project recipients of these federal funds.³⁵⁵

Fourth, state governments should require mandatory community benefit reporting requirements that at a minimum align with federal requirements or that further emphasize the role of community building activities. A standardized system of reporting requirements at the state and federal level will allow hospitals to more strategically focus the goals and project of their community benefit programs. For example, seven of the 14 states that have mandated reporting require hospitals to report only charity care, thereby compelling hospitals in these states to prioritize charity care over more effective strategies of community health improvement.³⁵⁶

Alternatively, a state that adopted a community benefit reporting requirement that was similar to Schedule H but placed further emphasis on community building activities (perhaps more in-line with the Catholic Health Association’s earlier recommendations to the IRS) could help persuade the IRS to further elevate the importance of community building. Additionally, more states adopting mandatory reporting requirements would create greater consistency and transparency regarding what benefit not-for-profit hospitals provide to their communities.

Fifth, local governments should collaborate with hospitals to support community development strategies by establishing a liaison office tasked with identifying potential development partnerships and guiding their efforts in ways that align with local economic development goals. Local governments have limited ability to legally compel hospitals to act as better neighbors. They can resort to implementing payment-in-lieu-of-taxes (PILOT) programs, work to alter or remove property tax exemptions, or levy fees for specific municipal services. All of these strategies may be necessary to fund needed city services in some cases, but they also entail a high level of risk. Such fees, for example, may alienate hospitals and make hospitals less likely to contribute the

significant resources to support broader municipal projects. In many cases, a better path for local governments might be to create anchor-institution liaison offices tasked with engaging and incentivizing hospitals and other anchor institutions to participate in community building.

In addition to Boston's strategy of allowing hospitals to reduce their PILOT contribution by investing in community benefit activities, the City under Mayor Menino has established the Liaison to Schools of Higher Education to do just this with regard to university anchor institutions. A second strategy for local government officials would be to work with elected state officials to push back against hospital lobbying efforts at the state level, intensifying pressure on hospitals to be more involved in different local initiatives. A final strategy would be for local governments to actively engage hospitals in partnerships that leverage federal and state resources.³⁵⁷



In this report, we have identified four compelling reasons why hospitals should examine how to better align their institutional and community-outreach efforts could better align with an anchor institution mission. As explored in the sections that followed, some hospitals offer promising approaches for how to begin to adapt hiring, real estate, purchasing, and investment strategies to meet their own needs, while also meeting the needs of their community—even in tough economic times. This final section aimed to compile some of the insights learned from the case study interviews and other anchor institution in order to help guide hospitals interested in expanding their impact on the health of their communities. Although philanthropy and public policy can influence hospital actions, the not-for-profit hospital industry must be the lead actor.

This report does not claim to be the conclusive word on the hospital's critical role as an anchor institution. Notably, we have prioritized the possibilities and incentives for the not-for-profit hospital sector because we see it as having the strongest motivations. However, this does not exclude the impact local government and for-profit hospitals can have in their communities. Our hope is that this report encourages a broader, more holistic conversation about the hospital's role in promoting health through building healthier communities, addressing issues of poverty through a sustainable and thoughtful use of its resources. Many questions still remain unanswered as we go forward, including further research into some of the success of initiatives and strategies unearthed here.

Although we believe that the case studies and survey of promising practices provide a rich foundation for future work, we also must acknowledge the limited quantifiable metrics that currently exist to effectively assess the impact of these strategies on low-income families and individuals. Efforts to begin to develop these evaluative tools are progressing but remain in preliminary stages. This area remains a strong priority for future research and resources should be allocated to help develop and implement these metrics. As consensus is reached on appropriate metrics, a government agency,

education research center, foundation, consulting firm, or other nonprofit agency could expand upon the above recommendation for recognizing hospital best practices (e.g. the Health Secretary’s award) to include a more comprehensive ranking of leading hospitals.³⁵⁸

Other important areas for future research include: 1) How do revisions to Schedule H instructions and implementation of Community Health Needs Assessments impact hospital-community interventions? 2) How can public health officials and organizations improve partnerships with hospitals to create a coordinated approach to address social determinants and increase community building? 3) Which strategies for increasing community and/or employee buy-in have been most effective in improving community relations? 4) How does a hospital’s geographic location affect its ability to integrate an anchor institution mission? 5) What limitations and incentives exist for the more than 1,000 state and local hospitals and the more than 1,000 for-profit hospitals nationwide to begin to incorporate anchor strategies? 6) How do other changes in the healthcare marketplace—such as mergers and consolidations, accountable care organizations, and increasing third-party payer pressure to reduce readmissions—provide financial incentives for an anchor institution mission?³⁵⁹ In this report, we try to briefly provide a few insights regarding some of these questions. However, more in-depth study would greatly add to the knowledge of the field.

There is little doubt that a hospital can be a powerful catalyst for neighborhood revitalization if it embraces real estate, purchasing, and investment strategies aimed at improving the lives of those most disadvantaged in its surrounding community. Less clear is to what extent hospitals—particularly, not-for-profit hospitals—are willing to challenge themselves to do so, altering practices that have become ingrained as the sector has evolved.

Clearly, there are obstacles. Oliver C. Henkel, Jr. recounted the landscape he entered when he began his community outreach efforts at Cleveland Clinic in 2007: “I was heavily engaged in trying to understand what the role of the urban hospital is within the community we’re serving. And I thought I would look around the country for examples, of some really good examples that could perhaps guide us in our outreach activity, and there really aren’t very many, surprisingly.”³⁶⁰ Yet there are even greater opportunities and possibilities. Today, although still not the industry norm, we can safely say that more hospitals can survey the landscape and report back positively. We hope that this report aids future efforts of that type and helps provide a useful starting point for those taking first steps or expanding current initiatives today.

Appendix: Interview Subjects and Contributors

SECTION ONE: SITE VISIT INTERVIEWS

Baltimore, Maryland: Bon Secours Health System

Ed Gerardo, Director for Community Commitment and Social Investment, Bon Secours Health System

Gregory Kearns, Director, Strategic Management, Bon Secours Baltimore Health System

George Kleb, former Executive Director, Bon Secours Community Works; current Executive Director of Housing and Community Development, Bon Secours Community Works

Erika McClammy, Director of Housing and Neighborhood Revitalization, Bon Secours Community Works

Dave McCombs, Vice President of Enterprise Resource Planning and Supply Chain Operations, Bon Secours Health System

Samuel L. Ross, M.D., Chief Operating Officer, Bon Secours Baltimore Health System

Althea Saunders-Ranniar, Director of Center for Working Families, Bon Secours Community Works

Joyce Smith, President, Franklin Square Community Association

Cleveland, Ohio: University Hospital System and Cleveland Clinic Health System

Oliver C. Henkel, Jr., Chief External Affairs Officer, Cleveland Clinic Health System

Margaret Hewitt, former Vice President for Construction, University Hospitals System

Sarah Kresnye, Community Development Manager, The Center for Health Affairs

Bill Ryan, President and Chief Executive Officer, The Center for Health Affairs

Steve Standley, Chief Administrative Officer, University Hospitals System

Christina Vernon, Executive Sustainability Officer, Cleveland Clinic Health System

Detroit, Michigan: Henry Ford Health System

Nancy Combs, Director of Community Health, Equity & Wellness, Henry Ford Health System

Glenn Croxton, Director of Vendor Compliance and Management, Henry Ford Health System

Thomas Habitz, Urban Planning Specialist, Henry Ford Health System

James O'Connor, Vice President of Supply Chain Management Department, Henry Ford Health System

John Polanski, Chief Executive Officer of Community Care Services, Henry Ford Health System

William Schramm, Senior Vice President of Strategic Business Development, Henry Ford Health System

Randy Walker, Vice President and Chief Diversity Officer, Henry Ford Health System

Kimberlydawn Wisdom, Senior Vice President of Community Health & Equity and Chief Wellness Officer, Henry Ford Health System

La Crosse, Wisconsin: Gundersen Lutheran Health System

Dave Demorest, Purchasing Manager, Gundersen Lutheran Health System

Sarah Havens, Director of Community & Preventive Care Services, Gundersen Lutheran Health System

Nicole Penick, former Buy Local Coordinator, Fifth Season Cooperative; current Food and Farm Program Manager, Valley Stewardship Network

Jeff Rich, Executive Director, GL Envision, Gundersen Health System

Tom Thompson, Sustainability Coordinator, Gundersen Lutheran Health System

Rochester, Minnesota: Mayo Clinic

Sean Allen, former Assistant Director, Rochester Area Foundation

Susan Ahlquist, Director of Community Relations from 2008 to 2012, Mayo Clinic

Susan Fargo-Prosser, Communications Specialist, Department of Public Affairs, Mayo Clinic

Ryan Kirane, Director, Supply Chain Management, Mayo Clinic

Desiree Shaw-Jarman, Contract Coordinator for Non-medical and Purchase Services, Mayo Clinic

Steve Thornton, former Executive Director, Rochester Area Foundation

John Wade, President, Rochester Chamber of Commerce

Karel Weigel, Administrator for Community Relations from 1999 to 2009, Mayo Clinic

SECTION TWO: ADDITIONAL BACKGROUND INTERVIEWS AND QUOTED INDIVIDUALS

Cynthia Boddie-Willis, Director, Health Services Policy and Research, The Hilltop Institute

Gary Cohen, Founder and CEO, Health Care Without Harm

Jessica Curtis, Project Director, Hospital Accountability Project, Community Catalyst
Howard Elliott, Principal, Elliott Management Group
Anna Gilmore-Hall, former Executive Director, Practice Greenhealth
Diane Ives, Fund Advisor, The Kendeda Fund
LeeMichael McLean, Director, Business Development and Networks, VHA, Inc., New
England Region
Louise Mitchell, Sustainable Foods Program Manager, Maryland Hospitals for a
Healthy Environment
Margaret O'Bryon, President & CEO, Consumer Health Foundation
Frank Robinson, PhD, Executive Director, Partners for a Healthier Community, Inc.,
Director, Community Health Planning at Baystate Health
Martha H. Somerville, Director, Hospital Community Benefit Program, The Hilltop
Institute
Julie Trocchio, Senior Director, Community Benefit and Continuing Care, Catholic
Health Association of the United States
Marsha Willis, Senior Policy Analyst, Executive Office, The Hilltop Institute

Endnotes

1. Oliver C. Henkel, Jr., interview by Holly Jo Sparks, Cleveland, OH, Mar 15, 2011.
2. In certain cases, private, for-profit institutions can serve as anchors if their ownership structure is widely dispersed among multiple members of a community. Cooperatives and employee stock ownership plan (ESOPs) companies are examples of these type of “anchor” institutions. Ira Harkavy, et al., “Chapter 8: Anchor Institutions as Partners in Building Successful Communities and Local Economies,” In *Retooling HUD for a Catalytic Federal Government: A Report to Secretary Shaun Donovan*, Philadelphia, PA: Penn Institute for Urban Research, University of Pennsylvania, April 2009, 148. Henry Webber and Mikael Karlstrom, “Why Community Investment is Good for Nonprofit Anchor Institutions: Understanding Costs, Benefits, and the Range of Strategic Options,” Annie E. Casey Foundation, July 21, 2009, 1.
3. Ira Harkavy and Harmon Zuckerman, *Eds and Meds: Cities’ Hidden Assets*, Washington, D.C.: The Brookings Institution Center on Urban and Metropolitan Policy, September 1999, 1. Ira Harkavy and Rita Axelroth Hodges, *Democratic Devolution: How America’s Colleges and Universities Can Strengthen Their Communities*, Washington, DC: Progressive Policy Institute, Oct 2012, 1. Steve Dubb and Ted Howard, *Linking Colleges to Communities: Engaging the University for Community Development*, College Park, MD: The Democracy Collaborative at the University of Maryland, August 2007, 8. American Hospital Association, *Economic Contribution of Hospitals Often Overlooked*, Chicago, IL: American Hospital Association, June 2011, 1–2. “Note: Religious congregations are not required to register with the IRS; nonprofits with gross receipts under \$25,000 and religious congregations are not required to file IRS Form 990 with financial information. The number of organizations includes all 501(c)(3) charitable nonprofits registered with IRS (1,138,289), but revenues and assets for each subsector only include charities that filed IRS Form 990 (598,110)” (see Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010, 5).
4. Rita Axelroth and Steve Dubb, *The Road Half-Traveled: University Engagement at a Crossroads*, College Park, MD: The Democracy Collaborative at the University of Maryland, December 2010, 28–31.
5. Rita Axelroth and Steve Dubb, *The Road Half-Traveled: University Engagement at a Crossroads*, College Park, MD: The Democracy Collaborative at the University of Maryland, December 2010, 3. *Managing Population Health: The Role of the Hospital*, Health Research and Educational Trust, Chicago, IL: April 2012, 8. For full report, see: www.hpoe.org/Reports-HPOE/managing_population_health.pdf
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8. The operating revenue reflects the sum reported by Gundersen Lutheran Administrative Inc., Gundersen Lutheran Medical Center Inc., and Gundersen Clinic LTD on their 2010 Form 990s.
9. Henry Ford Health System, *Henry Ford Facts and Statistics*, Detroit, MI: Henry Ford Health System, <http://www.henryford.com/body.cfm?id=38768>, 2012, accessed May 1, 2012.
10. Sum of total revenues from University Hospital Health System, Inc. Group Return and University Hospital Health System, Inc. 2010 Form 990s.
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12. Anna Gilmore-Hall, telephone interview by Holly Jo Sparks, Mar 2011.
13. Quote from Ira Harkavy and Harmon Zuckerman, *Eds and Meds: Cities’ Hidden Assets*, Washington, D.C.: The Brookings Institution Center on Urban and Metropolitan Policy, September 1999, 1. Rob Gurwitt, “Eds, Meds and Urban Revival: In many cities, a big university is becoming the economic engine that a big corporation used to be,” *GOVERNING*, May 1, 2008.
14. CEOs for Cities, *How to Behave like an Anchor Institution*, Chicago, IL: CEOs for Cities with Living Cities, June 2012, 1. The action agenda report highlighted both best practices among existing universities and provided a strategic framework for how to implement anchor strategies. The framework focused on three elements of university activities: *operating*, *investing*, and *learning* and how these three areas could be leveraged to impact and benefit the local community. *Operating* refers to the university’s ability to shift its purchasing of goods and services and focus its employment practices locally. *Investing* refers to how the university could leverage its existing real estate and future development to promote

local economic growth; it also includes the university's role as an incubator, providing support services to start-ups and accelerating research commercialization. Finally, *learning* refers to the university's role as a workforce developer, shifting its goals to reflect the needs of the local and regional community; additionally, *learning* includes the university's role as an adviser or network builder, capitalizing on the university's knowledge base to improve local business capacity and the business environment. (see CEOs for Cities and Initiative for a Competitive Inner City (ICIC), *Leveraging Colleges and Universities for Urban Economic Revitalization: An Action Agenda*. Boston, MA: CEOs for Cities and ICIC, spring 2002, especially page 12). Steve Dubb, *Linking Colleges to Communities: Engaging the University for Community Development*, College Park, MD: The Democracy Collaborative at the University of Maryland, August 2007, 8.

15. Jen Kauper-Brown and Sarena D. Seifer, *Health Institutions as Anchors in Communities: Profiles of Engaged Institutions*, Seattle, WA: Community-Campus Partnerships for Health, 2006, 4. ICIC now includes a focus on community development in its most updated and revised framework. (see Mary Kay Leonard, et al., "What Works": *Solutions for Cities—Leveraging Your City's Anchors*, Boston, MA: Initiative for a Competitive Inner City, Mar 1, 2012, 8.)

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21. Initiative for a Competitive Inner City, "Anchor Institutions and Urban Economic Development: From Community Benefit to Shared Value," *Inner City Insights*, Vol. 1, Is. 2, June 2011. Initiative for a Competitive Inner City defines "inner city" as continuous census tracts in central cities that are economically distressed. This determination is based on the following criteria: a poverty rate 20 percent or higher or two of the three other criteria. The three other criteria are: a poverty rate 1.5 times or more than the Metropolitan Statistical Area (MSA), a median household income 50 percent or less than the MSA, or an unemployment rate 1.5 times or more than the MSA. (see Michael E. Porter, "Anchor Institutions and Urban Economic Development: From Community Benefit to Shared Value," San Francisco, CA: Initiative for a Competitive Inner City, Presented at *Inner City Economic Forum Summit 2010*, Oct 26, 2010, 6.) Final quoted text from Initiative for a Competitive Inner City, "Anchor Institutions and Urban Economic Development: From Community Benefit to Shared Value," *Inner City Insights*, Vol. 1, Is. 2, June 2011, 1–2.

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27. Anthony Iton, *Weight of the Nation: Part I*, NY, New York: Home Box Office (HBO), May 2012.
28. Home Box Office (HBO), *Weight of the Nation*, NY, New York: HBO, May 2012. Robert Wood Johnson Foundation, *Prevention Saves Lives and Money*, Princeton, NJ: Robert Wood Johnson Foundation, 2012, <http://www.rwjf.org/en/topics/rwjf-topic-areas/prevention.html>, accessed Oct 5, 2012.
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31. Stacy Mitchell, "Local Ownership Makes Communities Healthier, Wealthier and Wiser," Minneapolis, MN: *Institute for Local Self-Reliance*, July 18, 2012.
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36. Bob Herbert, "Untapped Talent," *New York Times*, Jun 5, 2006, <http://www.nytimes.com/2006/06/05/opinion/05herbert.html>, accessed Oct 30, 2012.
37. American Hospital Association, *Economic Contribution of Hospitals Often Overlooked*, Chicago, IL: American Hospital Association, June 2011, 1–2. Novation, one of the largest healthcare GPO organization, recognizes that increasing supplier diversity improves local economic vitality, providing jobs in the community. This increase in jobs also increases the amount of people with health insurance, providing a more stable and profitable customer base for the hospital. (see Novation, *Supplier Diversity Footprints: Team Initiatives, Supplier Diversity Emerges as a Business Imperative in Health Care*, Irving, TX: Novation Supplier Diversity, Spring 2012, 11). LeeMichael McLean, telephone interview by David Zuckerman, Aug 27, 2012.
38. LeeMichael McLean, telephone interview by David Zuckerman, Aug 27, 2012. CEOs for Cities and Initiative for a Competitive Inner City (ICIC), *Leveraging Colleges and Universities for Urban Economic Revitalization: An Action Agenda*. Boston, MA: CEOs for Cities and ICIC, spring 2002, 15.
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41. Michael E. Porter, "Anchor Institutions and Urban Economic Development: From Community Benefit to Shared Value," San Francisco, CA: Initiative for a Competitive Inner City, Presented at *Inner City Economic Forum Summit 2010*, Oct 26, 2010, 30.
42. John Carreyrou and Barbara Martinez, "Nonprofit Hospitals, Once For the Poor, Strike It Rich With Tax Breaks, They Outperform For-Profit Rivals," *Wall Street Journal*, Apr 4, 2008. Steven T. Miller, *Community Benefit and Nonprofit Hospitals*, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 14.
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44. Steven T. Miller, *Community Benefit and Nonprofit Hospitals*, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 9. Schedule H has six parts: I. Charity Care and Certain Other Community Benefits at Cost; II. Community Building Activities; III. Bad Debt, Medicare, and Collection Practices; IV. Management Companies and Joint Ventures; V. Facility Information and VI: Supplemental Information. (see Catholic Health Association, *The IRS Form 990, Schedule H: Community Benefit and Catholic Health Care Governance Leaders*, St. Louis, MO: Catholic Health Association, 2009, 3).
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the relevant facts and circumstances in defining the community a hospital facility serves. Generally, Treasury and the IRS expect that a hospital facility's community will be defined by geographic location (e.g., a particular city, county, or metropolitan region). However, in some cases, the definition of a hospital facility's community may also take into account target populations served (e.g., children, women, or the aged) and/or the hospital facility's principal functions (e.g., focus on a particular specialty area or targeted disease). Notwithstanding the foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs." (see Preston Quesenberry, *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals: Notice 2011-52*, Washington, DC: Internal Revenue Service, Sept 2011, 14).

54. University Hospitals Case Medical Center, *University Hospitals Case Medical Center Community Health Needs Assessment Implementation Strategy*, Cleveland, OH: University Hospitals Case Medical Center, Jul 2012, 9.

55. Community Health Network, 2010 Form 990 Schedule H, Indianapolis, IN: Community Health Network, 2011, 39.

56. Quote from Community Health Network, *Community Benefit*, Indianapolis, IN: Community Health Network, 2012, <http://www.ecommunity.com/communitybenefit/>, accessed Sept 4, 2012. In partnership with the state's Housing and Community Development Authority and a local community center, Community invested \$92,000 in IDA tax credits and other contributions to the state's matched-savings program in 2006. The accounts, which will be administered by the local community center, will enable low-income Community Health Network employees and community residents to receive a match of \$3 for every \$1 they save up to \$300 (for a combined total of \$1,200). Participants, who can stay in the program up to four years, will also learn financial literacy skills and can use the savings to purchase a home, start a business or for education. In addition to the current state allocation of \$1 million (and a federal match of \$1 million) annually, private businesses can also invest in IDA tax credits that allow them to receive 50 cents back on each dollar contributed in the form of a credit. In Indiana, state residents are eligible for an IDA program if they earn below 175 percent of the Federal poverty guidelines. (see Lynda de Widt, "Lt. Governor Announces Innovative Public Private Partnership with Community Health Network," Indianapolis, IN: Community Health Network, Jun 16, 2006, <http://www.ecommunity.com/newsroom/view.aspx?Page=302>, accessed Sep 4, 2012). Community Health System has also been an important partner in helping revitalize the neighborhoods around Community East Hospital, through the network's eastside redevelopment initiative. It has also partnered to support a public transport shuttle for the 21 neighborhoods known as "Near Eastside." (see first source listed). Community Health System also provides support for a CSA program run by a group of eastside churches and provided start-up support for the Indy Food Co-op. The Indy Food's Co-op first store—Pogue's Run Grocer—opened in December 2010; now with more than 500 members, the Grocer has helped provide a source of healthy and local food in a community that had lost two of its major supermarket chains in recent years. (see "Indy Food Cooperative Nears Milestone," Indianapolis, IN: *Inside Indiana Business*, Nov 6, 2011, <http://www.insideindianabusiness.com/newsitem.asp?ID=50646>, accessed Aug 4, 2012).

57. Jessica Curtis, personal correspondence with David Zuckerman, Nov 8, 2012.

58. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xiii, xviii, xxiv-xxv, xxx, 321. Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010.

59. Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010, 5.

60. Quote from Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 3, 6. Steven T. Miller, *Community Benefit and Nonprofit Hospitals*, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 7. Catholic Health Association, *Community benefit voluntary report by U.S. State*. St. Louis, MO: Catholic Health Association, Aug 2010. Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 8.

61. Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010, 2, 20-25.

62. Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010, 21-24.

63. Daphne A. Kenyon and Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, Cambridge, MA: Lincoln Institute of Land Policy, 2010, 2, 22, 24. Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 4.

64. Rita Axelroth and Steve Dubb, *The Road Half-Traveled: University Engagement at a Crossroads*, College Park, MD: The Democracy Collaborative at the University of Maryland, December 2010, 2, 27. Also, for additional opportunities and obstacles on directing investment for the benefit of low-income communities, see Arthur Burriss and Tamir Novotny, *Summary of Anchor Institutions Design Lab: Opportunities, Barriers and Strategies for Harnessing Anchors' Economic Impact*, Living Cities, Jul 2012.

65. Rita Axelroth and Steve Dubb, *The Road Half-Traveled: University Engagement at a Crossroads*, College Park, MD: The Democracy Collaborative at the University of Maryland, December 2010, 2.

66. Rosemary Stevens is a professor in the Department of History and Sociology of Science at the University of Pennsylvania. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi.
67. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xi, xxvi, 15, 40–1. John Carreyrou and Barbara Martinez, “Nonprofit Hospitals, Once For the Poor, Strike It Rich With Tax Breaks, They Outperform For-Profit Rivals,” New York, NY: *Wall Street Journal*, Apr 4, 2008.
68. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xi, 299.
69. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 9–10, 19, 107–109, 322.
70. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 20, 35–36, 39, 190–191, 206, 260. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 10. According to the Association of American Medical Colleges, although academic medical centers constitute only six percent of all hospitals, they provide 22 percent of services to Medicare beneficiaries, 28 percent of all Medicaid care, and 41 percent of all hospital-based charity care. (see Association of American Medical Colleges, *Academic Medicine: Where Patients Turn For Hope*, Washington, DC: Association of American Medical Colleges, 2009, 4).
71. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 32, 101–103, 105, 108–109, 239–240.
72. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 9–11, 23, 25.
73. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 8–9, 30, 100. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 111–113.
74. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 112–113, 249, 251. Quote from Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xvii, xviii, xix (quote), xxxi, 11, 26–27, 82, 84, 101, 104, 109, 151, 252, 282, 334
75. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 27.
76. For example, notes Rosemary Stevens, hospitals responded to the post-World War II increase in chronic conditions by investing in “radiotherapy departments, coronary care units and surgical specialties” instead of “programs for community education and prevention.” Additionally, voluntary hospitals would take steps to reduce the number of non-short term patients by transferring or referring them to public hospitals instead. (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi, 26–27, 84, 252).
77. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 43, 46, 223.
78. Government aid was widespread, although most common in the eastern U.S. One study found that 35 states and the District of Columbia received subsidies in 1909. (see Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 32, 105–106). Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 43, 46, 163, 167, 197, 223.
79. First quoted text from Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 1. Second quote from Douglas S. Brown, “The Governance Imperative for Nonprofit Hospitals,” Chicago, IL: *Trustee*, Jan 2010. Third quote from Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 41, (346 for quote).
80. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 41, 123–24, 223.
81. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 9, 149–150, 160–61, 164–66, 180, 237, 303.
82. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 331, 341. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 119.
83. The establishment of National Hospital Day in 1921 perhaps best demonstrates, albeit unofficially, how hospitals had been codified as a “middle-class community institution,” providing an official platform for hospital community outreach for the first time. (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi, 105, 110). First quote from page 11. Second quote from

- Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 320, 331, 343.
84. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 122, 125
85. Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*, Baltimore, MD: The John Hopkins University Press, 1987, 248–253. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 121–122, 125, 131.
86. These numbers were reported by the American Medical Association. (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 111, 118, 125).
87. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 134–135, 169.
88. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 141, 159, 161.
89. Between 1928 and 1936, individual and partnership-owned hospitals represented 43 percent of all hospital closures and government-owned represented 19 percent. In contrast, churches and fraternities only represented 11 percent and not-for-profit and for-profit corporations (grouped together) represented 17 percent. The huge disparity between the proprietary hospitals and the others is because they tended to be smaller and less efficient urban institutions with greater levels of debt. (See: Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 147, 152, 159–60).
90. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 154, 159–167.
91. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 209.
92. Although Hill-Burton required a survey of facilities and implementation plan for new construction with the goal of creating a more coordinated hospital system, the Act helped promote “decentralization” instead of “industrial consolidation or regional integration of services or facilities.” (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi, 201, 216–21, 224, 228, 231). Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 2. Guian McKee, *Health-Care Policy as Urban Policy: Hospitals and Community Development in the Postindustrial City*, Charlottesville, VA: Center for Community Development Investments, December 2010, 5.
93. First quote from Health Resources and Services Administration, *Hill-Burton Free and Reduced-Cost Health Care*, Washington, DC: U.S. Department of Health and Human Services, 2012, <http://www.hrsa.gov/gethealthcare/affordable/hillburton/>, accessed Oct 18, 2012. Second quote from Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 219. Third quote from Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 2.
94. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 232–240, 250, 252–55, 269.
95. First quote from Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 2. Second and third quote phrases from Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 269.
96. “Voluntary” insurance was an expansive term referring to not only how Blue Cross was organized by volunteers but also to how it was not compulsory in nature. Stevens also notes that this term became inherently politicized, strengthening the relationship between nonprofit hospitals and the medical profession in the fight against “socialized” medicine. Blue Cross also differed from other types of commercial insurance because of its commitment to community rating and service benefits; however, as it succumbed to market pressure, becoming less distinguishable, it eventually lost its nonprofit designation in 1986. (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 11, 83–85, 170–75, 259, 282, 285, 290).
97. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 149, 172, 257, 267.
98. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 281–83.
99. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xiii, 257, 282–85, 287, 305.
100. Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 2. See Internal Revenue Service (IRS) Revenue Ruling 69–545, 1969–2 C.B. 117. Quote from Steven T. Miller,

Community Benefit and Nonprofit Hospitals, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 5–6.

101. Steven T. Miller, *Community Benefit and Nonprofit Hospitals*, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 6. Second quote from Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi, 9, 285, 290–91.

102. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxx-xxxi, 9, 285, 290–91, 315–316, 319, 344.

103. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, 294–295, 299–301.

104. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xiii, xviii, xxiv-xxv, 321.

105. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxv, xxx, 321. The IRS has required all tax-exempt organizations to fill out Form 990, a reporting and financial disclosure document, since 1950. (see Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 3.)

106. Julie Trocchio, *Community Benefit, Environmental Improvement and Public Health: New Arguments for the IRS*, Denver, CO: CleanMed 2012, May 2, 2012.

107. Donna C. Folkemer, et al., *Hospital Community Benefits after the ACA: The Emerging Federal Framework*, Baltimore, MD: The Hilltop Institute at University of Maryland Baltimore County, Hospital Community Benefit Program, Jan 2011, 6.

108. As example, see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, or Linda Shrieves, “Are nonprofit hospitals truly not for profit?,” Orlando, FL: *Orlando Sentinel*, Jul 31, 2010.

109. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xviii, 27, 126, 221, 312.

110. Community health centers have filled in an important role in the provision of a more holistic approach to health care in the United States. The success of community health centers in providing for low-income families at a high quality and often at lower cost has been demonstrated in multiple “statistically controlled studies.” Additionally, as health policy writer Bonnie Lefkowitz notes, “[By] training and employing community residents in career-ladder positions, upgrading infrastructure, and trading with neighborhood firms, health centers actually achieve economic development, albeit on a smaller scale than the earlier community action programs had promised.” (see Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made it Happen*, New Brunswick, NJ: Rutgers University Press, 2007, 24–26).

111. Stevens noted that the theme for the 1998 National Hospital Week was “Health. . .Caring. . .Community” and that the American Hospital Association called on its members to more effectively promote “the hospital’s health agenda and the many ways hospitals benefit them.” However, the outreach ideas that the AHA suggested were promotional rather than substantial, such as “a Health fair with free blood pressure, body fat, and cholesterol screenings, asking local merchants to donate door prizes, handing out free coffee mugs and carnations, organizing Name-the-Babies contest, offering free aerobics sessions to staff, and sponsoring a community clean-up day.” (see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999, xxxi). Also, see pages 144–145, 252, 324, 342. Linda Shrieves, “Are nonprofit hospitals truly not for profit?,” Orlando, FL: *Orlando Sentinel*, Jul 31, 2010. Steven T. Miller, *Community Benefit and Nonprofit Hospitals*, Austin, TX: Internal Revenue Service, Full Text of Remarks Before the Office of Attorney General of Texas, Jan 12, 2009, 11–13. John Carreyrou and Barbara Martinez, “Nonprofit Hospitals, Once For the Poor, Strike It Rich With Tax Breaks, They Outperform For-Profit Rivals,” *Wall Street Journal*, Apr 4, 2008.

112. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Baltimore, MD: The John Hopkins University Press, 1999.

113. Marjorie Paloma, “The Intersection of Health Philanthropy and Housing,” Montclair, NJ: *Shelterforce*, Spring 2012, http://www.shelterforce.org/article/2768/the_intersection_of_health_philanthropy_and_housing/, accessed Aug 17, 2012.

114. Anna Gilmore-Hall, telephone interview by Holly Jo Sparks, Mar 2011. Health Care Without Harm, *History and Victories*, Arlington, VA: Health Care Without Harm, 2012, http://www.noharm.org/us_canada/about/history.php, accessed Aug 2, 2012. Practice Greenhealth, *History*, Reston, VA: Practice Greenhealth, 2012, <http://practicegreenhealth.org/about/history>, accessed Aug 2, 2012.

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116. Gary Cohen, telephone interview by Holly Jo Sparks, Feb 9, 2011. Quote from Lenika Cruz, “How going green saves Kaiser \$26 million annually,” Oakland, CA: GreenBiz Group, Inc., Sept 26, 2012, <http://www.greenbiz.com/news/2012/09/25/going-green-Kaiser>, accessed Sept 28, 2012.
117. Quote from Healthier Hospitals Initiative, *What We Do*, Reston, VA: Healthier Hospitals Initiative, 2012, <http://healthierhospitals.org/about-hhi/what-we-do>, accessed Aug 2, 2012. Anna Gilmore-Hall, telephone interview by Holly Jo Sparks, Mar 2011.
118. Gary Cohen, telephone interview by Holly Jo Sparks, Feb 9, 2011.
119. Union Hospital, *About Us*, Elkton, MD: Union Hospital, 2012, <http://www.uhcc.com/About>, accessed Aug 6, 2012. Louise Mitchell, “Hospitals Across the Region Increase Local, Sustainable Food Purchases in 2011.” Baltimore, MD: Maryland Hospitals for a Healthy Environment, Jan 23, 2012, <http://mdh2e.org/?s=40+hospitals+buy+local+food>, accessed Aug 3, 2012. Union Hospital of Cecil County, Inc, *2010 Form 990*, Mar 2011, accessed via Guidestar, 1.
120. Internal document retrieved from Louise Mitchell, *Mid-Term Progress Report—Mar 31, 2012*. Quote from Louise Mitchell, “Hospitals Across the Region Increase Local, Sustainable Food Purchases in 2011.” Baltimore, MD: Maryland Hospitals for a Healthy Environment, Jan 23, 2012, <http://mdh2e.org/?s=40+hospitals+buy+local+food>, accessed Aug 3, 2012.
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122. Mary Donnell, presentation, April 2012.
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124. Bon Secours Health System, *youthmarket*, Bronx, NY: Bon Secours Health System, 2012, <http://hso.bonsecours.com/healthy-communities-our-healthy-communities-new-york-new-york-city-our-strategy-and-initiatives-youthmarkets.html>, accessed Aug 3, 2012. Bon Secours Health System, *youthmarket*, Bronx, NY: Bon Secours Health System, 2012, <http://hso.bonsecours.com/healthy-communities-our-healthy-communities-new-york-marble-hill-bronx-projects-youthmarket.html>, accessed Aug 3, 2012. GrowNYC, *Marble Hill Youthmarket*, Bronx, NY: GrowNYC, 2012, <http://www.grownyc.org/youthmarket/marblehill>, accessed Aug 3, 2012. Bon Secours Health System, *youth farm*, Bronx, NY: Bon Secours Health System, 2012, <http://hso.bonsecours.com/healthy-communities-our-healthy-communities-new-york-new-york-city-our-strategy-and-initiatives-youth-farms.html>, accessed Aug 6, 2012.
125. Nationwide Children’s Hospital supplier inclusion policy includes locally owned businesses as part of its diverse suppliers. Locally owned businesses are those located within the greater Columbus Metropolitan Statistical Area, which includes all surrounding areas with direct contact to Franklin County. (see Nationwide Children’s Hospital, *Administrative Policy IV-13: Supplier Inclusion Policy*, Columbus, OH: Nationwide Children’s Hospital, Jul 1, 2008, 2).
126. Quote from Office of Management and Budget, *Circular A-110 Revised 11/19/93 As Further Amended 9/30/99*, Washington, DC: Office and Management And Budget, 2012, http://www.whitehouse.gov/omb/circulars_a110#1, accessed Aug 9, 2012. Novation, *Supplier Diversity Footprints: Team Initiatives, Supplier Diversity Emerges as a Business Imperative in Health Care*, Irving, TX: Novation Supplier Diversity, Spring 2012, 5, 8, 11, 20. Novation, LLC, *2010 Supplier Diversity Annual Report*, Irving, TX: Novation, LLC, 2011, 2. Premier, Inc., *Premier at the Helm of Supplier Diversity*, San Diego, CA: Premier, Inc., Jan 2006, 4–6. Premier, *Summa Health System*, San Diego, CA: Premier, Inc, Fall 2007, 1–2, April 2009. Second quote from Nationwide Children’s Hospital, *Administrative Policy IV-13: Supplier Inclusion Policy*, Columbus, OH: Nationwide Children’s Hospital, Jul 1, 2008, 2.
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128. In 2005, Premier purchased \$25 billion worth of medical and surgical supplies for its member organizations. (see Premier, Inc, *The Premier Alliance: 1996 to 2006 and Beyond*, San Diego, CA: Premier, Inc, Jan 2006, 9.) Premier, Inc., *Premier at the Helm of Supplier Diversity*, San Diego, CA: Premier, Inc., Jan 2006, 4, 6, 11. Novation, LLC, *Successful Program Nationally Recognized by MBN USA Magazine’s “Corporate 101,”* Irving, TX: Novation, LLC, https://www.novationco.com/media/newsreleases/2011/news_110324.asp, accessed Aug 2012.
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ABOUT THE DEMOCRACY COLLABORATIVE

Since 1999 The Democracy Collaborative has worked to build the deep knowledge, theoretical analysis, practical tools, network of relationships and innovative models representing a new paradigm of economic development in the United States. The hallmarks of this new approach include refocusing public and private resources to expand individual and family assets, broadening ownership over capital, restoring community banks and other local economic institutions, and returning wealth to communities as an essential strategy to end generational poverty, create quality jobs with family-supporting wages, stabilize communities and their environment, and address our nation's growing wealth inequality. This is **Community Wealth Building**.

The Democracy Collaborative (TDC) is the premiere innovator and field builder in the practice of Community Wealth Building, transcending underlying approaches and connecting these into an overall strategy. As the leading national voice on research, advisory and innovation for the movement of Community Wealth Building, the Collaborative promotes new models and efficient practices, informs public policy and establishes metrics for moving this work forward rapidly.

TDC sustains a wide range of projects involving research, training, policy development, and community-focused work designed to promote an asset-based paradigm and increase support for the field across-the-board. Our research, strategy and policy website — www.Community-Wealth.org — is updated regularly and is a comprehensive source for information about the community wealth building movement nationwide.

TDC is also recognized nationally as a primary architect of the Evergreen Cooperative Initiative in Cleveland, Ohio. The Evergreen Cooperative Initiative is a comprehensive community building and economic development strategy designed to transform Cleveland's Greater University Circle by breaking down barriers between the area's "anchor institutions" and its surrounding low-income neighborhoods (43,000 residents with a median household income below \$18,500; 40% of the population lives below the poverty line). The Democracy Collaborative designed the original wealth building and economic inclusion strategy that formed the basis for Evergreen; TDC's senior leadership continues to be heavily involved with the Initiative.

The goal of this anchor-based effort is to create jobs and build wealth among residents in order to stabilize and revitalize the neighborhoods of Greater University Circle and similar areas of Cleveland. The Initiative represents a "learning laboratory" and the essential building blocks of a new model of urban economic development, emphasizing as it does (1) leveraging existing place-based economic assets (primarily anchor institutions such as hospitals and universities) for community benefit (in particular, low- and moderate-income neighborhoods and their residents) and (2) green business development based upon cooperative and other broader ownership forms that reinforce core values of equity, asset building and anchoring capital in order to stabilize place.

HOSPITALS BUILDING HEALTHIER COMMUNITIES

As we read Zuckerman’s landmark report, we can appreciate the power and possibility within a hospital anchor institution model. We can learn important lessons from those leading the effort, and share on how creativity can support models of health promotion, which promise to move us beyond the decaying economic model at present.

—Jamie Harvie, Executive Director, Institute for a Sustainable Future

Detroit’s “Big Three” are no longer Ford, General Motors, and Chrysler. Today, its three largest private employers are instead Henry Ford Health System, Detroit Medical Center, and Wayne State University. Detroit is but one example of a massive shift that is taking place: nonprofit universities and hospitals have become the dominant economic linchpins in many communities across the country.

This transformation brings with it important opportunities. Unlike highly mobile corporations, universities and hospitals are geographically “anchored” to their communities. America’s nonprofit hospitals alone have revenues of more than \$650 billion and assets of \$875 billion and are often situated in struggling neighborhoods.

Increasingly, hospitals find that improving health is not just about treating the patients that come through their doors. By rethinking their economic and community engagement strategies, some hospitals are beginning to realize that by adopting an *anchor institution mission*, they can build not only more prosperous, but also much healthier, communities.

Hospitals Building Healthier Communities provides an in-depth look at six hospitals in five cities that have started to grapple with this challenge. Those case studies, and other best practices compiled from across the nation, provide a resource for—and pose a challenge to—hospitals throughout the country. Its findings expand the conversation and should spur new strategic economic approaches not just by hospitals, but also local philanthropy, community-based organizations, and policymakers.



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