Stanford SOCIAL INNOVATION Review

Viewpoint

A Checkup on PRIs

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For one leading health funder, program-related investments promise to help underserved populations.

BY MARGARET LAWS

Back in 2006, I helped the California HealthCare Foundation (CHCF) launch its Innovations for the Underserved program. The goal of the program was to fund "disruptive innovation." In using that term, we took our cue from Clayton Christensen, a professor at Harvard Business School, who defined a disruptive innovation as one that "brings a much more affordable product or service that is much simpler to use into a market." We quickly realized, however, that most typical CHCF grantees—nonprofit health care organizations and research centers, for example—were not likely to engage in that kind of disruption.

At about the same time, a number of companies that create disruptive technologies were knocking on our door. CHCF had sponsored a project that explored how online medical visits could expand patients' access to care, and that experience had put us in contact with various mission-driven, for-profit technology companies. We did not, at that point, have a mechanism for working with them. But we saw an opportunity to recruit entrepreneurs in Silicon Valley—the epicenter of health care innovation and investing—to join us in serving the needs of underserved populations. Indeed, we believed that we could catalyze a new market for disruptive health technologies.

In the fall of 2010, CHCF launched the Health Innovation Fund—a $10 million experiment in program-related investing. Through the fund, we were able to invest programmatic dollars in for-profit companies as long as the primary purpose of each investment was to advance our mission. In making program-related investments (PRIs), we aimed to accelerate the adoption of innovations that either showed cost savings to safety-net providers or improved access to care for patients. (We used the term "safety-net providers" to describe entities that serve Medicaid patients, people without health insurance, and other populations that have difficulty accessing care.)

Many foundations struggle to enable grant-funded programs to scale up and to become sustainable. And more and more foundations now view PRIs both as a way to achieve greater impact and as a potential source of capital that they can use to invest in new opportunities. The approaches that these institutions take vary. Some foundations invest endowment funds in ventures that reflect their mission and values; others, like CHCF, pursue mission investing solely out of their programmatic funds. Whatever strategy they pursue, their goal is generally the same: to achieve sustainability and scale through the mechanism of a for-profit, growth-oriented company.

The Health Innovation Fund has now reached its five-year mark, and CHCF continues to manage it. Earlier this year, I left CHCF after working there for 17 years. As I made the transition to a new venture, I paused to reflect on the legacy of the Health Innovation Fund. How did it evolve? And what did we learn from the experience of creating it?

BUILDING A PORTFOLIO

In starting the Health Innovation Fund, CHCF took three important steps.

Identifying needs. Through its grantmaking work, CHCF had built strong relationships in the safety-net provider community. By leveraging those relationships, we identified unmet needs and, more important, areas in which provider organizations would be highly motivated to work with health technology companies. We wanted to connect two players in the health care market—technology start-ups and safety-net providers—whose paths don't otherwise tend to cross.

Sourcing investment opportunities. Our location in the San Francisco Bay Area placed us in an ideal position to develop relationships with early-stage companies. We connected with business incubators and accelerators that have a health focus—organizations such as RockHealth, StartUp Health, and Healthbox. We presented our model for impact investing at health technology and mission investment conferences. We made venture capital firms aware of our goals and asked them to refer appropriate companies to us.

Selecting companies to fund. We sought out companies that fit two essential criteria: They had to demonstrate a potential demand for their product or service among

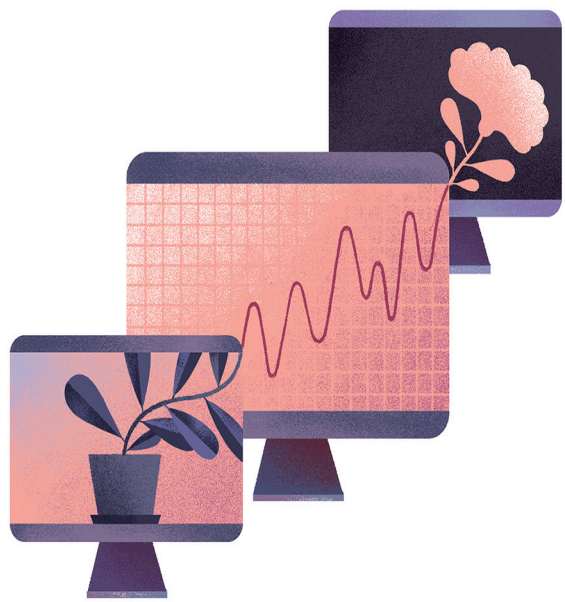

ILLUSTRATION BY MARINA MUUN

MARGARET LAWS is chief executive officer of HopeLab, a nonprofit organization that develops health technology products. She was director of the Health Innovation Fund at the California HealthCare Foundation from 2010 to 2015. (The fund continues to operate under its current director, Melissa Buckley.)

safety-net providers in California. And their product or service had to align with our goals of increasing access to care, lowering the cost of care, and improving the health care experience of underserved patients. In addition, we targeted companies that showed a capacity for significant growth and scale, and we looked for companies that had an experienced management team.

In four years, CHCF screened more than 900 companies, conducted detailed reviews of more than 50, and invested in 9. The companies in which CHCF invested ranged from early-stage ventures in which the foundation became a majority investor to more mature enterprises in which the foundation took a minority share. Investees in the latter category tended to be companies that target specific activities, such as translating a product into Spanish or funding a team to work with Medicaid customers.

The foundation made all of these investments in the form of debt or convertible debt. Most of them have five-year terms, and all of them are at below-market interest rates. Although we made these investments alongside venture funds, strategic investment firms, and the like, we chose not to support companies as part of a larger investment round. (Because each investment included a social covenant to ensure that it would continue to align with our mission, we negotiated terms separately from other investors.) CHCF typically took a board observer seat, rather than a voting member seat.

Some of the companies in which we invested are working to improve access to care. California's expansive geography and the disparities in patients' ability to reach providers have made tele-medicine an area of particular interest. Investees in this category include Direct Dermatology, which delivers remote dermatology consultations, and PipelineRx, a company that offers virtual pharmacy services to hospitals.

We also invested in companies that seek to improve the efficiency of clinics and hospitals. The need for such improvement has become especially acute in the wake of the US Affordable Care Act (ACA). The ACA expanded insurance coverage to millions of previously uninsured people, and safety-net providers are struggling to meet patient demand for services. One investee, Seamless Medical Systems, helps by providing a digital platform for patient intake and assessment.

New technologies and new service models are also helping providers improve the management of chronic conditions. An example of CHCF's investment in this area is Propeller Health, which created a device to track the use of inhaled therapies and to improve patients' ability to follow asthma and COPD (chronic obstructive pulmonary disease) medication regimens.

CHCF still has eight of its original nine investees in its portfolio. The other company, CareInSync, was one of the foundation's first investees. CareInSync developed a mobile platform that enables care teams to collaborate on plans for patients who must move between health care settings. (Successful management of such transitions can reduce readmission rates.) In 2014, Hearst Health acquired the company, and CHCF recouped its investment.

In most cases, CHCF is still waiting to judge the success and scalability of its investments. The foundation requires all of its investees to participate in an independent evaluation. Recently, for example, the *American Journal of Health-System Pharmacy* published an evaluation of PipelineRx that documented the cost savings and error reduction rates that four California hospitals were able to achieve by using PipelineRx services.

PASSING THE TEST

When we launched the Health Innovation Fund, we did so with several hypotheses in mind. First, we thought that health technology and service companies would want to work with safety-net providers—and that safety-net organizations would want to work with those companies. Second, we thought that traditional financial investors would invite a mission-focused organization such as CHCF into their investment syndicates. Third, we thought that CHCF would bring significant value as an investment partner. Fourth, we thought that through PRIs we could achieve impact on a scale that went beyond what grant-funded projects could generally achieve.

It's too soon to say whether we have fully validated each of those hypotheses, but it's not too soon to draw a few lessons from our experiment.

We learned that there are attractive PRI opportunities in domains that CHCF knows well—health care services and information technology—and significant opportunity to support safety-net providers. As it turns out, we launched the Health Innovation Fund at an opportune time. An increasing number of entrepreneurs are working to solve problems in health care that affect low-income populations, and dozens of incubators and accelerators are helping those entrepreneurs gain early-stage funding and mentoring.

We learned that CHCF could deliver significant value both to start-up companies and to investors. We provided investee companies with market intelligence on nonprofit and public-sector safety-net organizations, introductions to potential customers, and help in adapting their business models to the reimbursement practices of various payers and providers. Investors, meanwhile, were drawn to CHCF's experience with the Medicaid program and other safety-net institutions. Many investors were eager to test those markets, and CHCF could support that effort.

We learned that to be a successful mission investor, we needed to nurture an innovation ecosystem. Safety-net providers need support to become effective receptor sites for new technologies. For that reason, we provided grants to the Center for Care Innovations, a San Francisco-based organization that hosts training sessions for staff members at safety-net organizations and sponsors projects that enable providers to test new technologies and services at those organizations.

Overall, we learned that PRIs can be an effective alternative or complement to grantmaking, and that having both capabilities (PRIs and grants) at our disposal increases our ability to promote innovative and sustainable health care services. ■