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Health, Hospitals and Affordable Housing: National and New Jersey Perspectives

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TABLE OF CONTENTS

SECTION ONE

Executive Summary

The Housing and Medical Care/Hospital Challenge

The 1949 Housing Act declared the goal that every American deserves a "decent home and suitable living environment." While progress surely has been made to realize that goal, a significant contemporary housing challenge remains. As of 2019, 37.1 million households—nearly a third of all households in the United States—are housing cost burdened, spending 30% or more of their income on housing. Also of concern, 17.6 million households, representing one in every seven homes, are severely cost burdened, spending more than half of their income on housing. Compared to homeowners, housing costs are generally more burdensome for renters. According to 2019 American Community Survey data, 46% of renters are cost-burdened, compared to 21% of homeowners. Likewise, 21% of renters are severely cost-burdened compared to 9% of homeowners.

This affordability challenge disproportionately affects lower-income households. For households earning less than $30,000 annually, 81% of renters and 64% of homeowners were cost-burdened. Minority households are also disproportionately affected, as 29% and 26% of Black and Hispanic renter households, respectively, are severely cost-burdened. For context, a lower share (21%) of white renter households were paying more than half of their income for housing. Almost one-tenth of minority renter households (9.7% for Black households and 8.7% for Hispanic households) reported they were facing eviction as of late 2021, about double the figure reported by white renter households (4.4%) (Weeden, 2021). New Jersey faces similar challenges. As of 2019, 85% of low-income households in New Jersey were cost-burdened and 71% were severely cost-burdened (NLIHC, 2021a). Even more concerning, many Americans are unable to afford housing at all. Nationally, approximately 580,000 individuals are homeless, with approximately 10,000 homeless individuals living in New Jersey.

The health care system is an outsized component of American society. In 2020, the U. S. spent $4.1 trillion or about one-fifth (19.7%) of the nation's total Gross Domestic Product (Centers for Medicare and Medicaid Services [CMS], 2021). The health care sector employed about 22 million workers in 2020, or about 14% of all U.S. workers (Laughlin et al., 2021). U.S. healthcare spending is projected to grow by about 50% to $6.2 trillion by 2028 (CMS, 2021). Under the United States healthcare system, most Americans, 54.4%, are covered by private insurance, 17.8% and 18.4% of the population are covered under Medicaid and Medicare, respectively, while 8.6% of the population remains uninsured (Congressional Research Service, 2021). Individuals receive their health care at various locations including hospitals that are either private, public, or non-profits. Non-profit hospitals are the most common, comprising 58% of all hospitals in the nation. Under the Affordable Care Act, non-profit

hospitals are responsible for completing a Community Health Needs Assessment (CHNA) to identify and address unmet health needs in their respective communities (Tikkanen et al., 2020). The assessment involves identifying key health needs and issues through systematic, comprehensive data collection and analysis, followed by development of a community health improvement program to implement long-term programs, initiatives, and strategies to address the identified areas of need (CDC, 2018). Notably, four major New Jersey health system CHNA's were reviewed by the Bloustein studio, and housing was an area of concern in three of them.

Despite advancements in health care, the prevalence of chronic disease, the growing financial burden on both the consumer and institution, and uneven access to health care remain major issues for the medical establishment. The number of individuals with multiple chronic diseases is rising, with more than a 5% increase in the number of American adults with multiple chronic diseases from 21.8% in 2001 to 27.2% in 2018 (Boersma et al., 2020). The burden of chronic illnesses falls on lower-income individuals and people of color. Non-Hispanic blacks are twice as likely as non- Hispanic whites to die from diabetes and African American adults are 60% more likely than non- Hispanic white adults to be diagnosed with diabetes by a physician (U.S. Department of Health and Human Services, 2021). These chronically afflicted individuals account for 75% of hospital stays, office visits, home health care, and prescription drugs (Anderson, 2010). An estimated 84% of health care costs can be attributed to the treatment of chronic diseases (Hayes and Gillian, 2020).

In recent years, healthcare providers have begun to understand the importance of the social determinants of health. Individuals from lower-income backgrounds, with less education, or a lack of access to stable, affordable housing are often confronted with worse health outcomes. Those suffering chronic homelessness are found to be "more likely to become ill, have greater hospitalization rates, and are more likely to die at a younger age than the general population" (Maness & Khan, 2014). For example, the average lifespan for an individual experiencing homelessness is 30 years lower than a housed individual. Given the importance that housing plays in social life, there is an increasing recognition that access to affordable housing is central to physical, economic, and social well-being—a concept referred to as "Housing First." The challenge of realizing "Housing First" is confronted by the lack of subsidized housing in the United States. Of the nation's some 142 million total housing units, only about 7.7 million (5.4 %) are federally subsidized.

Lower-income and individuals experiencing homelessness account for a significant portion of all hospital emergency room visits. Though they comprise only 4 to 8% of all emergency room patients, frequent Emergency Department (ED) users account for somewhere between 21 and 28% of all emergency room visits (Kanzaria et. al., 2017). According to a 2016 study analyzing the characteristics of approximately 12,000 frequent ED users, such patients were more likely to be Black, rely on Medicare or Medicaid, and have a chronic illness such as diabetes or asthma (Saef et. al., 2016). Individuals experiencing homelessness, in particular, frequently use emergency care services, with the average person visiting an emergency room as many as five times per year. In 2017, individuals experiencing homelessness accounted for nearly 1% of all hospital admissions in New Jersey, despite comprising less than 0.1% of the total population. As frequent ED users are often incapable of paying for hospital services, they impose a significant strain on hospital resources. Each frequent ED user costs a hospital over $18,000 a year, with the highest users costing over $44,000 per year (Green Doors, n.d.).

Hospitals have found various reasons for investing into affordable housing. A major concern of hospitals and healthcare institutions is staffing turnover. Staffing turnover is currently viewed as the number one problem hospitals are facing by hospital administrators (American College of Healthcare Executives, 2022). Currently, roughly one-third of all hospital employees earn $18 or less per hour, placing most housing options firmly out of reach. Less-expensive housing options are often far away from hospitals, forcing lower-income employees to commute long distances, which contributes to high turnover. In response, healthcare institutions can look to provide nearby affordable housing for the hospital workforce as an incentive to reduce workforce turnover by reducing long commutes and providing an employee perk. Additionally, hospitals can use affordable housing investment as a way to improve and/or stabilize their host neighborhoods. As anchor institutions, hospitals have begun many processes to improve their host neighborhoods primarily through social determinants of health like housing. In some cases, providing a community amenity like affordable housing can help bolster the case for hospitals to receive preferential property tax treatment that can result in significant financial savings.

This understanding of the social determinants of health, among other reasons, has helped motivate hospitals to become involved in affordable housing. When hospitals pursue affordable housing, they help improve the immediate neighborhood around the hospital by investing in the neighborhood. This is the same as when other anchor institutions, or place-based mission-driven entities, such as universities and government agencies leverage their economic strengths alongside their human and intellectual capital to benefit the health and social welfare of their neighboring communities for a sustainable long-term duration (UCSF, 2019). In cities such as Philadelphia and Chicago, university hospitals have embraced their roles as anchor institutions, investing in their local communities. Investing in affordable housing allows hospitals to provide a community amenity and bolsters the case for hospitals to continue receiving preferential property tax treatments. For example, in Morristown, New Jersey, the community tried to make the local hospital pay more taxes than they were currently paying under their Payment In-Lieu of Taxes (PILOT) arrangement. An investment in affordable housing may change community opinion of this tax situation and bolster local support for hospital PILOTs.

Response to the Housing and Medical Care/Hospital Challenge

Recognizing the importance of the role housing plays in securing positive health outcomes, some housing finance agencies have partnered with healthcare providers to initiate various projects aimed at providing frequent ED users with stable, affordable housing. The Bloustein spring studio reconnaissance study examines some prominent such efforts in New Jersey and nationwide.

In August 2018, the New Jersey Housing and Mortgage Finance Agency (NJHMFA) announced a program designed to encourage healthcare providers to invest in affordable housing in their local communities. This is the first such initiative by any state housing finance agency. Under this pilot New Jersey effort, called the Hospital Partnership Subsidy Program (HPSP), NJHMFA provides up to $4 million to a hospital interested in developing affordable housing units in its local community. In return, the hospital matches that contribution and provides additional support for developers. The hospital must set-aside units for supportive housing for individuals with special needs to qualify for funding. Though not strictly

required, NJHMFA prefers mixed-use projects with access to ancillary healthcare services, such as urgent care or substance-abuse habilitation clinics.

As of 2022, this program has funded three projects, two in Newark and one in Paterson, with the Paterson project currently under construction. The first Newark HPSP project is a partnership with University Hospital to build 78 affordable rental units. Of those 78 units, 16 will be supportive housing units. This Newark total project value is $54.7 million (NJHMFA, 2022). The development is in preconstruction and expected to be completed in the middle of 2023. The second Newark HSPP project is a collaboration between Newark Beth Israel Medical Center and Pennrose LLC. This development plans to build approximately 70 units for residents earning an average of 60% of Area Median Income (New Jersey Department of Community Affairs, 2020). The Paterson HPSP project is currently furthest along, with half of its 56 units completed, with the remaining half slated for completion by Fall 2022 or Fall 2023. This Paterson HPSP project is a partnership between St. Joseph's Hospital and the New Jersey Community Development Corporation, both with deep roots in this city. The total cost for this project was approximately $27.4 million.

Other healthcare providers across the country have initiated similar programs. In 2016, six healthcare providers in Portland, Oregon teamed up to construct permanent housing for members of individuals and families dealing with chronic medical conditions and substance-abuse disorders. Aided by a $21.5 million donation provided by these six healthcare providers, the project constructed three buildings with these populations in mind. The development includes 382 units which could serve around 2,000 people. In addition to the money from the health care providers, the city housing bureau will contribute about $9 million and Central City Concern—a nonprofit provider of low-income housing that will own and manage the three new buildings—will finance the remainder of the $69 million through tax credits, loans and private fundraising (Flaccus, 2019). Likewise, the Lincoln Land Institute, with funding from the Robert Wood Johnson Foundation, initiated in 2018 the Accelerating Investments for Healthy Communities (AIHC) program, which partnered with healthcare providers across the country to provide affordable housing for their local communities. The AIHC program helped the participating hospitals and health systems continue pursuing affordable housing through a two-phase process. The first phase focused on better understanding the local communities and markets surrounding these hospitals, and the second

phase involved developing and executing affordable housing projects. A summary overview of the HPSP, Portland, AIHC and other efforts is shown in Exhibits 1.1 through 1.4 and Appendix A.

Lessons and Policy Recommendations

Though these programs are in their infancy and this study is reconnaissance in nature, they provide valuable lessons for housing agencies and healthcare providers interested in investing in affordable housing for shelter and healthcare benefits. Housing developers and partnering healthcare providers under these programs interviewed by the Bloustein Studio point towards several core challenges in developing hospital-associated affordable housing.

The Challenge of New Initiatives and Partnerships

Delivering affordable housing is a challenge for even seasoned housing professionals as it often requires layers of complex subsidies. Focusing on healthcare, hospitals understandably often lack enough knowledge about real estate and development to navigate the affordable housing development process. The often technically complex and lengthy procedures for securing entitlements and federal housing tax credits may present herculean barriers for healthcare providers, with a steep learning curve. Likewise, hospitals lack staff with the technical expertise necessary to bridge these gaps. In tandem, affordable housing agencies and developers, not having worked with the health care system or hospitals, face a steep learning curve in new partnerships.

The Challenge of Financing

In Bloustein studio interviews, healthcare providers stressed the financial problems they faced in doing affordable housing, including the minimum investment required (sometimes millions of dollars) for participation in the pilot initiatives. These healthcare providers don't have the capital reserves for this necessary investment, as their housing outlay is not currently reimbursable from their medical payment system. Included in these financial challenges as well are the resources these healthcare providers may have, such as owned buildings and land, that do not count for the required investment in the pilot initiatives. Additionally, the competitiveness of the housing financing programs, such as the Low-Income Housing Tax Credits (LIHTC), pose a financial challenge. The difficulty in securing a 9% LIHTC credit due to the limited availability compared to the uncapped 4% credit hurts the financial capability of these healthcare providers as the 9% tax credit typically allows the projects to get around a 70% subsidy for new construction and significant rehabilitation. Additional financing would contribute to further investment in hospital supportive housing programs down the road. With more financing, hospitals may increase their investment in affordable housing and add additional hospital staff dedicated to helping hospitals navigate the affordable housing process.

This report seeks to educate all parties involved in the affordable housing and healthcare connection. This requires educating hospitals about affordable housing and the affordable housing community about healthcare and hospital systems. To this end, this report makes a number of recommendations.

First, the report looks at the Community Health Needs Assessment (CHNA) as it is a required documentation for non-profit hospitals to maintain tax-exemption status. Similar to what the Community Reinvestment Act (CRA) has done for stimulating bank's investment in their host communities, CHNA requires healthcare institutions to consider the health needs of the community. In preparing a Community Needs Health Assessment, hospitals could focus more on housing and the other social determinants of health. Understanding the community's housing needs and challenges potentially helps a hospital understand its community's medical needs. This often-overlooked element is central to understanding the community's health needs as a whole.

Second, to better incentivize local developers to develop affordable housing units with a supportive housing element, this report recommends changes to the various funding mechanisms available for affordable housing projects so as to encourage hospitals becoming involved in such developments. Amendments to New Jersey's Qualified Allocation Plan and the new Aspire program may encourage further investment from hospitals and help to expand hospital affordable housing programs. Other subsidy recommendations—that can be found in Exhibit 1.5—include New Market Tax Credits (NMTC), Opportunity Zones (OZ), HUD § 221(d)(4), and the PILOT program.

Third, the New Jersey Special Needs Housing Subsidy Loan Program (SNHSLP) provides capital financing to create permanent and affordable supportive housing and community residences for individuals with special needs. New Jersey's special needs populations include disabled and homeless veterans; homeless individuals and families; individuals with mental illness, and physical and developmental disabilities; victims of domestic violence; individuals in treatment for substance abuse; ex-offenders and youth offenders; youth aging out of foster care; runaway and homeless youth; individuals with AIDS/HIV; individuals 18 years and over coming out of nursing homes; and individuals in other emerging special needs groups identified by state agencies (NJHMFA, n.d.) This report recommends amending the definition of "special needs" under the SNHSLP to include frequent ED users. While a frequent user of emergency services may qualify as an individual with special needs, hospitals should be granted the flexibility to determine which populations qualify for their affordable housing projects. This flexibility allows projects to better address the needs of the community.

Fourth, state Medicaid agencies should utilize Section § 1115 Waivers to formally integrate housing supports into the core Medicaid program. These waivers grant state Medicaid programs additional flexibility to alter program components and can be used for experimental, pilot, or demonstration projects assisting the goal of the Medicaid program. As such, various states across the country have been experimenting with the waivers to link healthcare and housing together.

Some of these states include Oregon, California, Utah, and Colorado. Hospitals and health systems should seek to work with their Medicaid agencies or Medicaid plans to develop strategies and programs that use the 1115 Waiver's experimental flexibilities to implement or expand supportive housing efforts.

Finally, state housing finance agencies could continue to collaborate and partner with anchor institutions, which, as mentioned earlier in the report, are place-based mission-driven entities, such as hospitals, universities, and government agencies. As well-established community pillars, anchor institutions often have the financial and social capital necessary for a successful collaboration.

Encouraging further partnerships with these entities may prove integral for expanding investment in social determinants of health like workforce development, education, and economic stability along with affordable housing. While this effort is reconnaissance in nature, the authors hope that this report's finding will provide valuable information that will help not only hospital affordable housing programs, but additional affordable housing programs in the future.

Exhibit 1.1: Hospital Affordable Housing Program Overview

Program Name	Summary	Pages
Hospital Partnership Subsidy Program (NJ HPSP)	• Started 2018, the NJHMFA Hospital Partnership Subsidy Program (HPSP) aims to encourage hospitals to invest in affordable housing in their local communities. • NJHMFA offers up to $4 million for development and construction costs; hospitals then match the amount and may provide land or a building for the project as their investment • NJHMFA applicants are evaluated on meeting a variety of criteria to be eligible for funding, such as if the project is mixed use/mixed income • Based on the program's initial allocation of $12 million, NJHMFA hopes to build 3 to 4 housing complexes with approximately 220 units total.	35-36
Accelerating Investments for Healthy Communities (AIHC)	• AIHC is designed to encourage investments into affordable housing by nationally participating hospitals and to advance policies and practices moving towards equitable housing solutions. • Developed by Lincoln Land Institute's Center for Community Investment from 2018 to 2020 • Interdisciplinary approach to connecting health institutions with affordable housing • Six hospitals participated in Phase II of the program	45-50

Portland	• A partnership between five major hospitals and a nonprofit health care plan to create affordable housing • $21.5 million provided by the hospitals out of a total amount of $69 million • Constructing three buildings with 382 housing units	56
Other	Mayo Clinic - Rochester, Minnesota: • Helped fund First Homes Community Land Trust • Provide 875 affordable housing units for those earning 80% AMI • By the mid-2020s, First Homes projects having spent over $360 million dollars on revitalization spending	33

Exhibit 1.2: Example Hospital Affordable Housing Developments

Barclay Street Housing, Paterson, NJ 	• NJ HPSP project • Construction began in 2018, with completion expected in 2022 • Developed in conjunction with the Paterson-based New Jersey Community Development Corporation and St. Joseph's Hospital • Mixed-use project with medical facilities on ground level • Total 56 affordable units with 10 units set-aside for individuals with special needs • Preference given to individuals with chronic health conditions.
University Hospital, Newark, NJ 	• NJ HPSP project • 78 affordable rental units • 16 supportive housing units • Income Averaging at 60% of AMI • Ground floor clinic and hospital office space

Newark Beth Israel Medical Center, Newark, NJ 	• NJ HPSP project • Approximately 70 affordable units • Residents earning an average of 60% of Area Median Income • Some supportive housing units directed at individuals and families experiencing homelessness
Bon Secours Hospital, Baltimore, MD 	• AIHC project • Developing affordable housing in distressed neighborhoods since the late 1980s . • 802 affordable units (completed as of 2019) . • Example: Gibbons Apartments - 80 unit affordable housing development • 58 unit building (proposed for future) • Renovating row houses and schools, as well as new construction
Nationwide Children's Hospital, Cincinnati, OH 	• AIHC project • Healthy Homes Affordable Housing Initiative started 2008 • Have impacted more than 450 homes through • Full-gut renovations • Home Repair Program • Health Rental Homes Program • Serves 90 lower-income households • Residences at Career Gateway • 58-unit affordable housing project

Exhibit 1.3: Example Financial Components of the Hospital Affordable Housing Developments

Barclay Street Housing - Paterson - NJ HPSP - 56 Units		
LIHTC 4% Proceeds	$11 million	40%
NJ HMFA Note	$4.8 million	19%
NJ HMFA HPSP	$4.5 million	16%
St. Joseph's Matching Contribution	$4.5 million	16%
Deferred Developer's Fee	$1.5 million	5%
NJ HMFA Special Needs Housing Trust Fund	$1 million	4%
TOTAL	**$27.4 million**	**100%**

St. Joseph's Health and the New Jersey Community Development Corporation partnered to develop a mixed-use affordable housing complex. Upon completion of the Paterson project, the building will have a total of 56 units, with a ground floor dedicated to social and health services. Of these 56 units, 10 will be set aside for designated special needs populations. A large share of the funding for the project came directly through 4% Low Income Housing Tax Credits (LIHTC). While there were several other funding streams, most of the funding came directly through the New Jersey Housing and Mortgage Finance Agency and St. Joseph's Health.

Enterprise, a low-income housing syndicator, used funds from investors at TD Bank to provide the upfront capital for the project in exchange for the 10-year stream of tax credits granted to the developer under the LIHTC program.

University Hospital - Newark - NJ HPSP - 78 Units		
HMFA Mortgage Financing	$22 million	40%
LIHTC 4% Proceeds - Wells Fargo	$18 million	33%
NJ HMFA HPSP	$6 million	11%
Multifamily Rental Housing Production Fund	$3.5 million	6%
University Hospital's Matching Contribution	$3 million	6%
NJHMFA Special Needs Housing Trust Fund	$1.6 million	3%
HOME Grants (Essex County and Newark)	$0.6 million	1%
TOTAL	**$54.7 million**	**100%**

The University Hospital project will include 78 housing units, with 16 supportive housing units. The project is receiving the majority of its funding from NJHMFA mortgage financing and LIHTC 4% proceeds. The remaining project funding comes from two other NJHMFA programs, University Hospital's program match, and HOME grants.

Nationwide Children's Hospital - Residences at Career Gateway - AIHC - 58 Units		
LIHTC 9% (Ohio Equity Fund Nationwide IV)	$9.8 million	81%
RiverHills Bank Loan	$1.4 million	12%
General Partner Equity	$0.4 million	3%
City of Columbus Loan	$0.3 million	2%
Deferred Developer's Fee	$0.2 million	2%
TOTAL	**$12.1 million**	**100%**

The Residences at Career Gateway are a community housing development which aims to revitalize the south side of Columbus and connect residents with meaningful workforce support. Syndicated through the Ohio Housing Finance Agency (OHFA), the project was awarded $1 million in Low- Income Housing Tax Credits (LIHTC) over ten years. In Ohio, developers can apply for either a Competitive (9%) Credit or a Non-Competitive (4%) Credit. Residences at Career Gateway were awarded a Competitive Credit (9%). The developer, NRP Holdings LLC, also utilized a $1.5 million Housing Development Loan for the project (RiverHills Bank Loan). The Housing Development Loan program is funded through the Ohio Department of Commerce and provides short-term, low-interest loans to developers who have been awarded the competitive LIHTC credit or Bond Gap Financing.

Bon Secours Hospital - Gibbons Apartments - 80 Units		
LIHTC 9% Proceeds	$15 million	77%
Private Permanent Loan	$2.5 million	13%
HOME Investment Partnerships funds	$0.8 million	4%
Other Sources	$0.7 million	4%
Maryland Department of Housing and Community Development Rental Housing Program funds	$0.5 million	2%
TOTAL	**$19.5 million**	**100%**

Bon Secours opened Gibbons Apartments in 2016 to provide Southwest Baltimore residents a vibrant community and living space. The mixed-use development comprises 80 affordable units across 32 acres and will eventually house retail and recreational uses. The $19.5 million development was financed primarily through 9% LIHTC allocation which covered almost 80% of development costs. The LIHTC credits were facilitated by Enterprise Community Investment with Capital One as the purchaser. A private permanent loan from Capital One for $2.5 million raised the capital stack to cover 90% of development costs. The additional $2 million was funded by a loan from Baltimore's HOME Investment Partnerships program and a grant from Maryland Department of Community Development Rental Housing Program.

Exhibit 1.4: Recommendations for Enhancing the Hospital Affordable Housing Programs

Recommendation	Summary	Pages
Qualified Action Plan (QAP)	• Alter state QAP criteria and point system • Include criteria to incentivize supportive housing projects such as increasing the percentage of supportive housing required to achieve points	59-60
Funding Programs	• Make use of all of the available funding programs available • Pursue FHA 221(d)(4) Construction or Rehabilitation Loans, New Market Tax Credits, funds through Opportunity Zones, Neighborhood Revitalization Tax Credits, and tax credits under the Aspire Program	60-64
§ 1115 Waivers	• § 1115 Waivers can be used for experimental, pilot, or demonstration projects assisting the goal of the Medicaid program • California, Colorado, and Oregon, among other states, use these waivers for supportive housing programs • NJ is currently in the process of submitting a waiver to integrate housing and Medicaid	64-65
Special Needs Housing Subsidy Loan Program (SNHSLP)	• Definition of Special Needs under the SNHSLP includes a variety of populations • Expand the definition to include frequent users of hospital emergency care services	65
Community Health Needs Assessment (CHNA)	• Incorporate a required Affordable Housing component of a non-profit hospital's CHNA • Require more explicit and in-depth analysis of the targeted community's Social Determinants of Health • Include of affordable housing experts as part of the solicitation of community and health experts' requirements • Utilize Robert Wood Johnson University Hospital - Somerset County as model of affordable housing in CHNA	65-67
Anchor Institutions	• Hospitals should lean into their role as anchor institutions in their communities	68-69

SECTION TWO

Overview of U.S. Affordable Housing

Affordable Housing

This section sets the framework for this report's focus on housing and healthcare. It begins by looking at the housing affordability challenge in the United States through the housing supply, wages, housing and ownership and the impact of COVID-19. This is followed by a brief look at the major U.S. affordable housing subsidies of the 20th century and an overview of healthcare and hospitals. The final part elucidates the connection between healthcare and affordable housing.

The Housing Affordability Challenge

The housing affordability crisis in the United States stems from high housing costs relative to low wages, and it disproportionately impacts people of color and ethnic communities. Freddie Mac (2021) estimates place the national housing supply deficit at 3.8 million units out of an existing housing stock of 141.2 million units at the end of 2020. A combination of increasing costs for building raw materials in recent years and the decades-long trend of the underbuilding of entry- level homes contributed to the nation's housing supply shortage. Before the COVID-19 pandemic, for every 100 extremely low-income renter households in the United States, there were only 37 affordable and available rental homes (National Low Income Housing Coalition [NLIHC], 2021a). In New Jersey, there was an even lower rate of only 32 affordable and available rental homes per 100 extremely low-income renter households. The pandemic compounded the problem with the high demand for housing as more people could work from home, leading them to seek housing with more space and at a lower cost (Freddie Mac, 2021; Joint Center for Housing Studies of Harvard University [JCHS], 2021).

As noted, low wages also contribute to the affordability crisis, with people of color and ethnic communities disproportionately impacted. Looking across all income levels of hourly workers, the hourly pay of Black and Hispanic workers is lower than the hourly pay of white workers. The disparity ranges from Black workers and Hispanic workers at the 10th percentile wage making 13% and 10% less, respectively, than White workers to as much as Black workers earning 26% less and Hispanic workers earning 29% less than White workers at the 70% percentile (NLIHC, 2021b). This income inequality contributes to differences in homeownership rates and the number of cost-burdened households, households paying more than 30% of household income on housing. In 2019, 20.4 million renters in

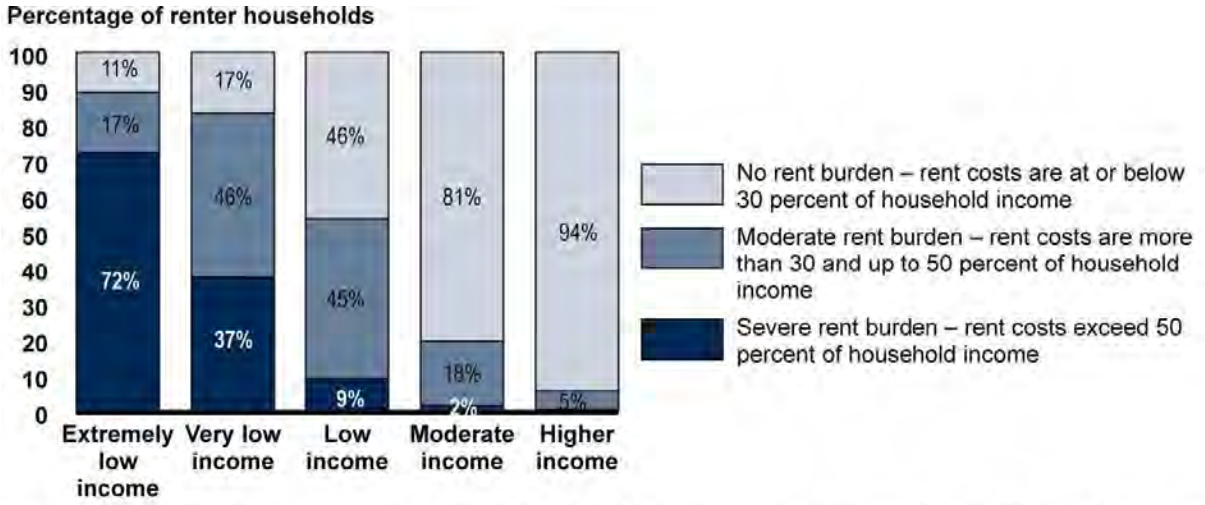
the United States (46% of all renters) were cost-burdened. Yet more daunting, 10.5 million of those households (24% of all renters) were severely burdened, spending more than 50% of household income on housing (JCHS, 2021). Additional data for 2019 looking at cost burdens by race shows 54% of Black and 52% of Hispanic renters were at least moderately burdened compared to 42% of white and Asian renters.

The housing challenge is not surprisingly related to constrained household income, whereby those earning the least relative to Area Median Income (AMI) face the most daunting hurdles in affording housing. For housing affordability and other analytic purposes, household incomes are often categorized into the following categories by AMI cohort:

- Extremely low income: up to 30% AMI
- Very low income: 30.1 to 50.0% AMI
- Low income: 50.1 to 80% AMI
- Moderate Income: 80.1 to 120% AMI.

The nexus between household income (i.e., share of AMI) and the housing affordability challenge for the United States is detailed in Figure 2.1. For example, about seven tenths of extremely low-income renters are severely cost-burdened.

Figure 2.1



Source: (GAO, 2020)

While so far, this report has been examining the housing situation of renters, what about the housing attainment of the "American Dream"—homeownership? The overall national homeownership rate has been on an upward trend since 2016, increasing from about 63% in 2016 to almost 66% in the first quarter of 2021. For non-Hispanic white households, the homeownership rate in the first quarter of 2021 was even higher at 73.8%. In contrast, the homeownership rate for Black-alone households was much lower at 45.1%, and the homeownership rate for Hispanic households was 49.3% (U.S. Census Bureau, 2021).

The COVID-19 pandemic exacerbated the inequalities in housing in the United States. More than half of all renters in the United States lost income between March 2020 and March 2021, and almost half of all the households that lost income in early 2021 earned less than $50,000 (Joint Center for Housing Studies of Harvard University, 2021). As of March 2021, 55% of low-income renters and 44% of low-income homeowners lost their jobs since the pandemic, with higher rates seen among people of color, and leading almost 25% of low-income renters and homeowners to fall behind on housing payments. Almost one-tenth of minority renter households (9.7% for such Black households and 8.7% for Hispanic Households) reported they were facing eviction as of late 2021, about double that displacement faced by white renter households (4.4%) (Weeden 2021).

What about subsidized housing—do these units ameliorate the housing challenge? Yes, but there are few subsidized units relative to the need. For example, take the number and context of subsidized housing units in the Garden State. In 2019, New Jersey had an estimated 167,778 subsidized housing units, only 4.6% of New Jersey's housing units (HUD User, 2019; U.S. Census Bureau, 2019). For the same year, New Jersey had a deficit of 205,285 affordable and available rental units for extremely low-income households, and 85% of low-income households were cost- burdened and 71% were severely cost-burdened (NLIHC, 2021a).

The combination of low income, job losses and disruptions, housing supply shortages, and increasing housing demand perpetuate the affordable housing crisis. There is a deficit in the number of housing units across the country and in New Jersey, and the units that do exist cost too much for many low-income households and households of color.

The dearth of affordable housing units has contributed to homelessness across the United States and within New Jersey. Point-in-time data from the United States Interagency Council on Homelessness (USICH) estimates approximately 580,000 people were experiencing homelessness in the United States on any given day in 2020, and 9,662 of those people (1.67%) were in New Jersey. Of the 9,662 people in New Jersey, 1,081 people are experiencing chronic homelessness (USICH, n.d.). When individuals experience homelessness, they face declines in their mental and physical health (Health Affairs, 2018). Many of these individuals become frequent visitors of hospitals and health care institutions to manage their health. Though frequent Emergency Department (ED) users comprise only 4 to 8% of all emergency room patients, they account for somewhere between 21 and 28% of all emergency room visits (Kanzaria et. al., 2017). The health needs of people experiencing homelessness and the associated health care costs illustrate the necessity for collaboration between hospitals and housing developers.

People experiencing chronic homelessness are more likely to be disabled. Around 19% of the homeless population suffer chronically. Some of the issues that lead to homelessness include high unemployment rates, lower incomes, less access to healthcare, and higher incarceration rates (National Alliance to End Homelessness, 2021). The data from public schools reported that 13,929 students experienced homelessness between 2018-2019. Among them, 42 students were unsheltered, 1,754 in shelters, 1,538 in hotels/motels, and 10,595 were doubled up (USICH, n.d.). The major cause of homelessness as reported in 2019 is leaving a shared residence. This accounts for 8.2% which is about 1,230 households. Further causes were loss or reduction of job income (13.6%) and eviction (11.8%). Prior to being homeless, these persons managed to stay in permanent housing (21.4%), emergency shelter (20.8% and stayed with friends and family (17.9%) (Monarch Housing Associates, 2019).

There is increasing recognition that a roof over one's head and affordable shelter are key to physical, economic, and social well-being—a concept referred to as "Housing First." The challenge of realizing "Housing First" is confronted by the paucity of subsidized housing in the United States. Housing First helps by prioritizing to provide permanent housing to people experiencing homelessness and serves as a platform to pursue personal goals as well as improve their quality of life. This policy focuses on housing as a foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. It caters to both the homeless and individuals with any degree of service needs (National Alliance to End Homelessness, 2016).

While a logical first port of call for Housing First is public subsidized housing, that shelter resource is in short supply. Of the nation's some 142 million housing units, only about 7.7 million (about 5%) are subsidized (Zonta, 2018; Lajoie & Stamm, 2020). An overview of these 7.7 million subsidized housing units by housing subsidy program (e.g., public housing and Section 8) and the income cohorts of the households (by percentage of AMI) served by these respective programs is shown in Figure 2.2. The text below provides further detail on the major U. S. housing subsidies.

U.S. Response to Providing Affordable Housing

Public Housing

Public housing was a pioneering federal program created by the 1937 Housing Act that provides publicly owned housing for economically constrained households (see Figure 2.2). The federal government provided the capital funds for building the housing units, and local governments reduced the development's property tax obligations by accepting a payment-in-lieu of taxes (PILOT). The tenants paid for much of the costs of operating the buildings through their rent. A key program for housing the poor, there was a peak of about 1.4 million public housing units in the mid-1990s. Today that number has fallen to about 950,000 units. The program was challenged on many fronts (Schwartz 2015, 176): initial construction was often far from the highest quality, there was frequent inadequate maintenance, the developments were tasked with housing the poorest of the poor (thus concentrating poverty), and common building design left much to desire (high-density towers on superblocks that were isolated from the surrounding neighborhoods). In response to these challenges, there were various ameliorative

efforts through Hope VI and other programs over the past few decades to provide more sustainable public housing through better design (e.g., demolishing failed high-rises and replacing these with lower-density buildings), more encompassing subsidies (e.g., Section 8 and low-income housing tax credits explained shortly) as well as through other changes (e.g., combining social support services along with more affordable shelter). Public housing remains the most significant program in the United States to house low-income households, households whose income lies between 30% and 50% of the Area Median Income (AMI). Of the approximate 950,000 public housing units, the lion's share about 70% serves extremely low-income households, with another 19% serving very low-income households, households whose income is below 30% of the AMI (see Figure 2.2).

Mortgage Subsidies and Below Market Rate Housing (BMIR)

The assisted housing programs expanded in the 1960s in the form of privately-owned housing (unlike public housing) which was made affordable through Below Market Interest Rate (BMIR) financing. Some of the programs during that period include Section 202, 221(d)(3), 235, 236, 502, 515, and 521. For instance, the Section 236 is a combination of a BMIR subsidy (an interest as low as 1%) and a very long repayment (40-year) mortgage term which results in lower rents than offered by conventionally financed projects. Section 202 provides BMIR financing for senior multifamily rental housing and sister programs aided by other populations in need of assistance. All these multifamily rental programs focus on households with below-median incomes but above public-housing levels (U.S. Department of Housing and Urban Development, n.d.).

Section 8 Program

Authorized in 1974, the Section 8 program provides rental subsidies for eligible tenants' families residing in newly constructed, rehabilitated, and existing rental program and cooperative apartment projects (U.S. Department of Housing and Urban Development, n.d.). It was developed partially as a response to the limitations of BMIR subsidy as Section 8 is a deeper and broader subsidy than BMIR financing (e.g.: BMIR does not subsidize operating costs).

Section 8 operates as follows. The tenant pays 30% of their income for housing and the difference between that payment and the total Fair Market rent (FMR calibrated by location) is the federal subsidy. For example, the FMR for 1-bedroom and 2-bedroom rental units in Middlesex County as of 2021 are $1,371 and $1,753 respectively. At first, Section 8 was project-based (e.g., a Section 8 subsidy would be given to a specific privately-owned multifamily building). More recently, Section 8 is disproportionately given directly to eligible tenants in the form of vouchers and certificates that enable qualified tenants to secure privately owned rental apartments on their own that are then subsidized through Section 8 vouchers or certificates. Section 8 aids about 3.4 million housing units. Of that total, there are about 1.2 million project-based Section 8 units (35%) and about 2.2 million (65%) section-8 voucher-supported units (see Figure 2.2). For both the Project- based Section 8 and the more portable Section 8 support (vouchers and certificates), about three- quarters of the households aided are extremely low income

and the remainder are mostly very low income (see Figure 2.2 for details). While a very effective deep subsidy, and when tenant-based (as opposed to project-focused) providing a flexible, household- focused form of shelter assistance, unfortunately new incremental Section 8 assistance is very limited.

Figure 2.2

Subsidized renter-occupied housing units

	Income level				
Program	Extremely low	Very low	Low	Moderate	Total
	Up to 30% of AMI	30.1%–50% of AMI	50.1%–80% of AMI	80.1%–120% of AMI	
Housing vouchers	1,627,403	473,516	131,068		2,231,987
Project-based Section 8	874,908	249,435	46,057		1,170,400
Public housing	675,707	186,080	96,762		958,548
Total	3,178,017	909,031	273,887		4,360,935
U.S. Department of Agriculture Section 521: Rental Assistance Program	283,307				

Note: AMI stands for area median income.
Source: CAP calculations of data from U.S. Department of Housing and Urban Development, "Assisted Housing: National and Local: Picture of Subsidized Households," available at https://www.huduser.gov/portal/datasets/assthsg.html (last accessed February 2018); U.S. Department of Agriculture, "Rural Development Datasets, Multi-Family Section 514 and 515 Management," Active Projects December 2016, available at https://www.sc.egov.usda.gov/data/MFH_section_515.html (last accessed February 2018).

CAP

Source: (Zonta, 2018)

Low Income Housing Tax Credit

The Tax Reform Act of 1986 created the Low-Income Housing Tax Credit (LIHTC), which provides incentives for developing affordable rental housing through federal tax credits administered through the Internal Revenue Service (IRS). The LIHTC allocation is lengthy and complex as it begins at the federal level with each state receiving an annual LIHTC allocation based on state population. Each state's Housing Finance Agencies administers the LIHTC distribution (Keightley, 2021). The HFAs allocate the tax credits to competing affordable housing projects based on a state established Qualified Allocation Plans (QAPs). The latter sets forth a selection criterion (and awarded points) that reflect the state agency's housing priorities. For example, more points may be given to proposed housing developments that serve the neediest of households (e.g. those with the lowest incomes) for the longest periods of time, that have a larger share of family- oriented units (e.g., more 2 or 3-bedroom as opposed to studio and 1-bedroom), that are "ready to go" (e.g. have all the their approvals in place), that are located in preferred locations (e.g. near transit and places of employment) and that satisfy other state established priorities.

LIHTC offers two tax credits: the 9% tax credit and the 4% credit per year over 10 years, or a total 40% to 90% credit over a decade. They are different in award processes, investor benefits, and financing

structures. The 9% credits are offered to states by the IRS annually to provide eligible projects through a competitive process by the state housing finance agencies as framed by each state's QAP. The 9% tax credit typically means the projects get around 70% subsidy for new

construction and significant rehabilitation. As noted, the 9% credits, the LIHTC that offers the deepest subsidy, are very competitive. There are in tandem the non-competitive 4% credits. The projects that receive at least 50% of their funding through tax-exempt bond financing are automatically eligible for 4% tax credits. The projects will receive this non-competitive allocation from the state HMFA. There are far more 4% credits than 9% credits. There is no limitation on the total amount of 4% tax credits available each year (Scally, Gold, & Dubious, 2018, p. 4). In other words, the 9% LIHTC offers the deepest subsidy but are very competitive to secure while the 4% LIHTC are a shallower subsidy but are uncapped and available as of right.

Each state receives a 9% LIHTC allocation authority equal to $2.8125 per person with a minimum small population state allocation of about $3.2 million (Keightley, 2021). For New Jersey, with a 2021 state population of about 9.3 million (9, 267, 130), that gave the Garden state a LIHTC resource of about $26 million. The state allocation limits do not apply to 4% credits, which as noted are automatically packaged with tax exempt bond financed projects (Keightley, 2021). Since authorized in 1986, LIHTC subsidized about 48,000 projects and about 3.1 million housing units, LIHTC is thus one of the largest sources of affordable housing assistance in the United States (there are about 950,000 public housing units and about 3.4 million Section 8 aided homes- project and tenant based). LIHTC is a formidable tax credit and represents about $8 billion annually in foregone federal tax revenue (LaJoie & Stamm, 2020).

Housing Finance Agencies

To meet the affordable housing needs, states have established Housing Finance Agencies. State Housing Finance Agencies (HFAs) are state-chartered, non-profit organizations that provide financing and services for residents in need of affordable housing. Although organization varies from state to state, most HFAs are quasi-governmental entities that operate as independent organizations governed by state-appointed directors. Most of these entities were first established in the late 1960s through 1970s and most are structured as independent entities that are largely financially self-sustaining, requiring no or only limited state budget allocations or other state support. HFAs are responsible for administering a variety of affordable housing programs that facilitate the development, construction, and rehabilitation of homes and rental apartments for low and middle-income households. HFAs issue federal tax-exempt bonds, secure LIHTC credits and tap other resources to expand housing opportunities of different forms. These agencies have become major players in providing affordable and other needed housing. As summarized in the National Council for State Housing Agencies [NCSHA] (2020):

> For more than 50 years, state HFAs have played a central role in the nation's affordable housing system delivering financing to make possible the purchase, development, and rehabilitation of affordable homes and rental apartments for low-and-middle income households. HFAs have provided affordable mortgages to more than 3.3 million families to buy their first homes through the single-family Housing Bond Program, HFAs have also financed approximately 4.6 million low-

> and-moderate income rental homes, including about 3.6 million rental homes using the Housing Credit. (p. 4)

According to the NCSHA (2021), the bulk of HFA activity is centered on three federal programs: Housing Bonds, Housing Credits, and Home Investment Partnerships (HOME).

Housing Bonds

To finance below-market interest rate mortgages for lower-income first-time homebuyers, HFAs issue tax-exempt housing bonds, commonly known as Mortgage Revenue Bonds (MRBs). MRB mortgages are restricted to first-time homebuyers who earn no more than the area median income (AMI). Because the interest payments are tax-exempt, investors are willing to accept lower yields on MRBs. Issuers then pass interest savings on to homebuyers through below-market interest rate mortgage loans that lower the costs of homeownership. Since the program's inception in 1978, over 3 million lower-income homebuyers, approximately 100,000 per year, have taken advantage of MRB to purchase their first home.

Likewise, many HFAs use MRBs to finance the acquisition, construction, or rehabilitation of multifamily housing. To qualify for a Multifamily Housing Bond, at least 40 percent of a property's apartments must be occupied by families with incomes of 60 percent of median income (AMI) or less, or 20 percent of the apartments must be occupied by families with incomes of 50 percent of AMI or less. Multifamily Housing Bonds have provided financing to produce 1.2 million apartments affordable to lower-income families.

Finally, HFAs may also issue Mortgage Credit Certificates (MCCs), which are subject to the same eligibility and location requirements as MRBs. MCCs provide a dollar-for-dollar tax credit equal to the product of the mortgage amount, the mortgage's interest rate, and the MCC percentage, a predetermined rate typically between 10 and 50 percent. Since the program's induction in 1984, state HFAs have used MCCs to provide critical tax relief to more than 346,000 families.

Housing Credits

As previously described, LIHTC consists of an annual tax credit over 10 years, with two tiers of credit available. There is a 4% LIHTC (uncapped in amount and used with tax exempt financing) and a 9% annual credit (a capped amount that is competitively awarded according to the criteria of each state's Qualified Allocation Plan). State HFAs play an indispensable role in the operation of the important LIHTC subsidy in the United States.

Home Investment Partnerships (HOME)

The HOME program is a federal block grant that provides state and local governments with resources to address their most pressing affordable housing challenges. These challenges may include the construction of new housing where units are scarce, or rehabilitating housing where housing quality is a challenge. Participating Jurisdictions (PJs)—the state and local governments that administer the program—invest HOME funds in a wide variety of rental and homeownership programs and projects, such as new construction, rehabilitation, down payment assistance, and rental assistance for low-income families. HOME funds are often also used to assist the elderly, people with disabilities, and people experiencing homelessness. Annually, states receive 40 percent of HOME funding while local governments and other administrative agencies receive the remaining 60 percent.

In addition to these programs, HFAs also administer other federal and state programs, such as programs regarding homeless assistance, rural housing, AIDS housing, weatherization, homeownership counseling, and lead hazard control. In many states, HFAs also participate in the provision of Section 8 housing vouchers and Project-based Section 8 rental assistance.

New Jersey HFA

The New Jersey Housing and Mortgage Finance Agency (NJHMFA) was established in 1967. NJHMFA raises program funds by selling taxable and tax-exempt bonds and notes to private sector investors in national financial markets, and applying for and administering federal, state grants and housing assistance programs (Official Site of the State of New Jersey, n.d.). As other HFAs, it is active in supporting both single-family homeownership and multifamily rental housing. As of 2020, total NJHMFA bonds outstanding amounted to $1.9 billion (NCSHA, 2020). Of that total, about $0.9 billion were for single-family housing purposes and about $1 billion were bonds outstanding for multifamily. Over the 1978 through 2020 span, cumulative LIHTC allocations by NJHMFA amounted to about $563 million, supporting approximately 42,000 housing units. In 2020 alone, 1,511 net units received an initial LIHTC allocation from NJHMFA. About one- quarter of the NJHMFA's housing credit units were also supported by project-based section 8 (NCSHA, 2020). Also of note, NJHMFA does contract management for about 50,000 existing HUD subsidized housing units.

SECTION THREE

Overview of the Healthcare, Hospital, and Affordable Housing Intersection

Health Care and Hospitals

The health care system is an outsized component of American society. In 2020, the U.S. spent $4.1 trillion or about one-fifth (19.7%) of the nation's total Gross Domestic Product (CMS 2021). The United States healthcare system is a complex mix of public, private, for-profit, and nonprofit insurers and providers. All these pieces combine to provide health care for millions of Americans.

Major Healthcare Payers

Most Americans (55.4%) are covered by private insurance, typically provided by an employer (Congressional Research Service, 2021). Other main coverage areas include Medicaid and Medicare, which cover 19.8% and 19.1% of the United States population, respectively (Congressional Research Service, 2021). Medicare is a federal health insurance program that mostly covers individuals who are 65 or older and provides coverage for those under 65 with disabilities and people with End-Stage Renal Disease (Medicare, n.d.). Whereas Medicare is a federal program, Medicaid is a jointly operated state and federal program that provides health coverage for low-income individuals and families (Medicaid, n.d.). Within Medicaid resides the Children's Health Insurance Plan, also known as CHIP, which provides health coverage solely to uninsured children and pregnant women that have incomes above the Medicaid threshold but do not have health insurance. Notably, as of 2020, 8.6% of the United States population is still uninsured (Keisler-Starkey, 2021).

Health Care Providers

Individuals can receive healthcare at various locations depending on their medical needs. This includes services at physician practices, outpatient specialist care, Federally Qualified Health Centers, mental health facilities, and hospitals (non-profit, private, and public).

There are three main types of hospitals in the United States, non-profit, private, and public. Non- profit hospitals are the most common type of hospital, comprising 58% of all hospitals in the nation. For-

profit hospitals make up about 24% of hospitals, and public hospitals make up about 19% (American Hospital Association, 2022). Each type of hospital provides a wide array of medical services, but notably, non-profit hospitals are not responsible for paying federal income or state and local taxes due to their requirement to serve the community (George Washington University, 2021). On the other hand, investors or shareholders usually own for-profit hospitals and have increased freedom to make service adjustments to increase profits (Masterson, 2017). Lastly, state or local governments own public hospitals which are usually partly or fully funded by governments and tend to be more accommodating to all insurance types as well as being more affordable compared to other types of hospitals (American Hospital Association, n.d.). In New Jersey, there are 113 total hospitals, including specialty hospitals. Of these 113 hospitals, 72 are acute care hospitals (NJHA, n.d.). Notably, there is only one public hospital in the state, University Hospital. A large majority of hospitals in New Jersey are considered nonprofits, totaling 63 of the 72 hospitals in New Jersey as of 2015 (Sanborn, 2015).

As the role of health care providers and payers continues to evolve, additional focus has been put on these entities to address a wide array of social issues outside of the traditional scope of medical care. For example, due to the Affordable Care Act (ACA), non-profit hospitals are now required to complete a Community Health Needs Assessment (CHNA). These assessments were created to have hospitals identify and address unmet health needs in their respective communities (Tikkanen et al., 2020). Mandated by law, the assessments are completed every three years and from the assessment, hospitals are required to also develop an implementation plan (IRS, 2021). To satisfy these requirements, hospitals first identify key health needs and issues through systematic, comprehensive data collection and analysis (CDC, 2018). Upon completion of the needs assessment, hospitals then move onto the next phase of the process, the development of community health improvement plans (CHIP). A CHIP uses the data from the needs assessment to implement long-term, systematic programs, initiatives, and strategies to address any of the identified areas of need (CDC, 2018). While individual assessment criteria and methodology vary widely from hospital to hospital, there tend to be consistent trends of the major areas of concern for each health system which include some mixture of chronic and complex diseases.

A Bloustein studio study of four major New Jersey health system's CHNAs found a pattern of chronic diseases being prioritized (Hackensack, 2019; RWJBH, 2021; JFK, 2016; SJH, 2019). While housing was not identified as a primary area concern in any of the four CHNAs, in three of the four documents, housing was at least mentioned as a contributing factor to adverse health outcomes. Depending on the assessment, housing was simply mentioned as an area of concern to one assessment where there was a continued series of questions that sought to understand the nuances and adverse impacts of housing insecurity.

State Medicaid programs have also been experimenting with new methods of formally integrating housing supports into the core Medicaid program through the submission of 1115 waivers. These waivers allow state Medicaid programs additional flexibility to alter program components to serve their communities better (Medicaid, n.d.). An example of an approved 1115 demonstration is from California, in which local governments can directly permit county housing pools to subsidize necessary medical services (Thompson et al., 2019). These housing pools are a part of California's Whole Person Care (WPC) pilot. The WPC pilot is a program that seeks to improve care for a subset of complex Medi-Cal

beneficiaries by supporting local efforts that embrace providing care for the whole person, including housing (CAPH and SNI, 2016). As such, these pilots can use funds from the waiver to contribute to county-wide housing pools that will provide support for medically necessary housing services, with the goal of improving access to housing. These housing services can include tenancy-based care management supports as well as financial support for long-term housing costs.

Current State of Health Care

Health care in the United States has taken enormous strides in the past few decades, with new advancements in medical technologies, treatments, and innovations in the delivery of care (Institute of Medicine, 2008). These improvements have resulted in better treatment and prevention of a varying degree of complex diseases, both acute and chronic (Institute of Medicine, 2008). As the largest sector in the American economy, the impact of these advancements is felt by millions (George Washington University, 2021).

While substantial progress has been made in medical technology and treatments, commensurate progress cannot be stated for all aspects of the healthcare system. The prevalence of chronic disease, the growing financial burden on both the consumer and institution, and uneven access to health care are all major issues currently facing the medical establishment. Further, these challenges are exacerbated when looking at disparities in income, race, geography, and ethnicity.

Chronic Disease

Between 2000 and 2030, the number of Americans with one or more chronic conditions will increase by 37%, which is an increase of 46 million people (Anderson, 2010). Individuals with multiple chronic diseases are also rising at an alarming rate. In 2018, 27.2% of American adults had multiple chronic conditions, increasing from 21.8% in 2001 (Boersma et al., 2020). Much of the burden of these chronic conditions falls on lower-income individuals as the frequency of chronic conditions is higher among those enrolled on Medicaid, dual eligible adults (Medicare and Medicaid), and older adults (Boersma et al., 2020). As a result of the increased health burden, individuals with chronic disease are responsible for over 75% of hospital stays, office visits, home health care, and prescription drugs (Anderson, 2010). When looking at different races and ethnicities, immense disparities arise in terms of the prevalence of chronic disease. For example, non-Hispanic blacks are twice as likely as non-Hispanic whites to die from diabetes, African American adults are 60% more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician, and non-Hispanic blacks are 3.2 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic whites (U.S. Department of Health and Human Services, 2021).

Health Costs

The impact poor health outcomes have on the healthcare system is immense, particularly when it comes to costs. An estimated 84% of healthcare costs can be attributed to the treatment of chronic diseases (Hayes and Gillian, 2020). When taking a closer look at these costs, diabetes ($189.6 billion), cardiovascular conditions ($294.3 billion), Alzheimer's disease ($185.9 billion), and arthritis and back pain ($181.8 billion) all constitute the highest direct costs for chronic conditions

(Waters & Graf, 2018). Notably, the greatest risk factor contributing to all these conditions is obesity, accounting for 47.1% of the total cost of chronic disease (Waters & Graf, 2018).

As previously mentioned, America spent $4.1 trillion on healthcare in 2020, amounting to 19.7% of the Gross Domestic Product (CMS, 2021). Notably, over half of this spending comes from hospitals (31%) and physician services (20%) (Kamal et al., 2020). By 2028, the Centers for Medicare and Medicaid Services estimates that U.S. spending on medical care will reach $6.2 trillion (CMS, 2021). When looking at the contributors to this spending growth, the main drivers include increases in service prices and the intensity of services, representing the frequency and quantity of services utilized (Dieleman et al., 2021). Across all health conditions, the rate of spending has increased the most in emergency department care and retail pharmaceutical spending, whereas the specific health condition with the greatest increase is diabetes (neck and back pain had the second-highest rate of spending) (Dieleman et al., 2021).

Social Determinants of Health

These trends are particularly notable because they are some of the largest contributors to increased medical spending and because unhealthy living conditions exacerbate several of these conditions. Treating chronic conditions (and efforts to manage population health) is particularly challenging because chronic conditions often do not exist in isolation. The social determinants of health are a major contributing factor to the health and wellbeing of an individual as they address the environmental conditions individuals reside in. Societal factors such as socioeconomic factors, health-related behaviors, and the physical environment are estimated to account for 80-90% of the modifiable contributors to healthy outcomes for a population (Wood et al., 2016). Direct medical care accounts for only about 10-20% of health outcomes (Wood et al., 2016). This larger societal perspective concept is embodied by the Healthy People 2020 framework in which many of the health goals are outside of the traditional scope of healthcare (Healthy People, 2022).

Despite this, hospitals have historically invested little in addressing the social determinants of health (Leider et al., 2017). However, current initiatives such as Housing First, have begun to provide an evidence-based model for the importance of housing as a means to sustainable health and well-being. This concept is furthered by the financial strain hospitals are facing both in New Jersey and nationally in terms of their most vulnerable patients. In 2017, hospitals in New Jersey serviced 3.1 million "treat and release" patients of which about 24,000 were homeless patients which cost hospitals about $13

million dollars ($543 per patient). When looking at inpatient data, the financial burden significantly increases as there were 9,197 homeless individuals admitted in 2017, costing hospitals a total of about $85 million per year ($9,267 cost per visit). This issue is made worse due to hospitals receiving almost no compensation from these patients.

It is important to understand that a person's ability to reach their highest health potential is tied to more than access to and the quality of health care they receive. Even just a modest reduction in unhealthy behaviors could prevent or delay 40 million cases of chronic illness per year (Hoffman, n.d.). Addressing the social needs of individual patients is critical to reducing the structural factors which contribute to poor health. Advancing health in America will require the health care system to be active participants in helping their communities thrive—and housing is an essential component of a thriving community.

New Jersey Health Care Profile

The health profile presented to date has been national and there are understandable variations by state. Here the report briefly synopsizes New Jersey specific data to provide context for the NJ specific projects of hospitals in the Garden State collaborating with the NJHMFA to provide affordable housing. According to America's Health Rankings, New Jersey is known to be a traditionally healthy state, evident by its ranking as the eighth healthiest state in the country (United Health Foundation, 2019). However, when taking a deeper dive into specific communities in the state, many disparities become apparent. In an analysis conducted by the New Jersey Hospital Association reviewing clinical and social measures in New Jersey, life expectancy was found to be three and a half years shorter than the statewide average in New Jersey's most vulnerable communities (NJHA, 2021). Other notable disparities among New Jersey economically and medically underserved communities included a significant increase in the prevalence of chronic conditions and mental health and substance use disorders. An underlying problem is that one in seven New Jersey individuals lack health insurance (NJHA, 2021).

According to the CDC Behavioral Risk Factor Surveillance System, in 2020, 11% of Black New Jersey residents reported being diagnosed with asthma, compared to 8.7% of white residents and 9.1% of Hispanic residents (CDC, 2020). Additionally, 14% of New Jersey's Black residents reported being diagnosed by a doctor with diabetes, compared to 8.5% of White residents and 11.2% of Hispanics (CDC, 2020). When looking at health care coverage, 31.2% of New Jersey Hispanic residents do not have access to any health care coverage, compared to 11.5% of Black residents and 5.5% of white residents (CDC, 2020). The impacts of the pandemic also disproportionately affected black residents. According to hospital discharge data, Black residents suffered the highest age-adjusted mortality rate (NJHA, 2020).

While New Jersey is leading on various indicators as it relates to health outcomes, health care spending in New Jersey is rising faster than the national average. While health care spending from 2012 to 2016 increased by 15% nationally in New Jersey, spending increased by 18%. As a result of this rise, New Jersey has the fifth highest per capita spending on health care in the nation (Health Care Cost Institute, 2018). Of interest, New Jersey's inpatient utilization from 2012 to 2016 decreased at a greater percentage (19 %) than the national average (12.9%) (Health Care Cost Institute, 2018). While this trend is certainly positive, inpatient spending in New Jersey still increased due to increases in inpatient

prices. Once again this reflects the financial argument that keeping people out of hospitals is much more economically efficient than paying for long stays in a hospital.

The Housing & Healthcare Connection

Before diving into the impact of healthcare and hospital affordable housing programs, this section must first explore the relationship between hospitals and housing. This section begins by looking at hospitals' role in their communities as anchor institutions. Next, how housing intersects with health is analyzed before answering how housing can fill the gap of needed affordable housing in communities. A brief history of healthcare affordable housing programs in the late 20th century in Chicago, Baltimore, and Minnesota is provided. This section will conclude with a brief overview of the barriers limiting hospital participation in affordable housing programs.

Hospitals as Anchor Institutions

A term that has only grown more popular in recent years, anchor institutions are "large and stable institutions whose actions have an impact on the health, and social and economic strength, of their surrounding communities" (Franz et al., 2019). Most commonly associated with universities and hospitals ("eds and meds"), anchor institutions are organizations that are deeply rooted in the well-being of the surrounding communities. These institutions are a significant source of employment, investment, and taxes strongly tied to the local economy. Organizations recognize that "their future is inextricably linked to the community outside their walls." (Koh et al., 2020). Readers can see how integral hospitals are to local economies by looking at employment statistics provided by the

U.S. Bureau of Labor Statistics. In 2019, 13,944 hospitals in the United States provided 6.6 million jobs nationally (Bureau of Labor Statistics, 2019). Whether they are non-profit or for-profit, hospitals remain one of the most important institutions in their communities, and many have begun to support their communities beyond employment and taxes.

Health Impacts of Housing

Housing is just one of many social determinants of health, but its connection to hospitals and healthcare has drawn much interest and research in recent years. While hospitals can and do invest in other determinants, their role in providing housing is worth a deeper look. To understand how housing impacts health, this section will look at the health impacts of three kinds of detrimental housing situations: unstable, unsafe, and high cost.

Housing instability, or housing insecurity, is defined as "An umbrella term for the continuum between homelessness and a totally stable, secure housing situation. It may include difficulties paying rent; overcrowding; moving frequently; staying with relatives; and living in a car, emergency shelter, or transitional housing." (Reynolds et al., 2019). While the term can connect to various circumstances

and housing situations, the health effects of having unstable housing are clear. For those suffering chronic homelessness, not only does it have a serious impact on psychological well-being, but they are found to be "more likely to become ill, have greater hospitalization rates, and are more likely to die at a younger age than the general population" (Maness & Khan, 2014). Even those who do not face chronic homelessness but still suffer housing instability are met with adverse health effects. Whether it be struggles with food insecurity, increased risk of "depression, anxiety, alcohol use, psychological distress, and suicide", or decreased effectiveness of health care (such as the inability to properly store medications without a stable home) the health issues caused by housing instability are clear (Taylor, 2018).

Equally important to housing stability is the safety and quality of one's home. Research on the health impacts of lead or poor ventilation in a home has shown that not just having a stable home is enough. Adverse conditions such as poor ventilation are referred to as substandard, a term defined by HUD as "unfit for habitation." Substandard housing conditions (such as plumbing issues, infestations, and extreme indoor temperatures) are all associated with poor health. A study by the Robert Wood Johnson Foundation (RWJF) found that "approximately forty percent of diagnosed asthma among children is believed to be attributable to residential exposures" (RWJF, 2011). Exposure to extreme temperatures indoors is linked with increased mortality in vulnerable populations who often live in poor housing. Lack of safety features, like "window guards and smoke detectors," contribute to home injuries that result in "an estimated 4 million emergency department visits" annually (RWJF, 2011). Simple improvements to housing such as home safety modifications and improved heating and cooling are proven to reduce risks of injury in adults and reduce children's "nutritional risk" (Taylor, 2018).

Lastly, the affordability of housing plays a significant role in health. The same RWJF study discussed above found that families designated as cost-burdened lack access to proper and consistent healthcare and sufficient food security (2011). As noted earlier in this Bloustein studio report, the COVID-19 pandemic has only exacerbated low-income communities' housing and economic issues, particularly amongst people of color (CBPP, 2022). With increasing housing costs, the number of people considered cost-burdened or severely cost-burdened is projected to increase in the near future (Charette et al., 2015). The increasing lack of housing affordability will only lead to more issues in housing safety and stability. This is a problem not only for housing but also for healthcare.

Healthcare "Filling the Gap" of Affordable Housing

How can anchor institutions, like hospitals, assist in reducing the gap in affordable housing? The growing push for healthcare institutions to empower community development has taken two key forms of community investment. First, institutions can provide financial support through "donations, grants, and in-kind contributions'' to community projects that generate indirect financial benefits. This is an ideal resource for nonprofit hospitals, particularly as such hospital financial support can often count towards their community benefit obligations necessary for maintaining tax exemptions, or reduced property tax payments through a PILOT (Taylor, 2018). The second form is financial investments where healthcare institutions provide financial support with the expectation of short-term or long-term return on their

investments into the community. Here, hospitals will provide funding for community projects with the expectation of a return on investment through the project's own financial successes.

A study conducted by the Urban Institute surveyed 73 hospitals in 2018 to find how hospital leaders and employees feel about the connection between housing and healthcare institutions. While almost all participants agreed that housing needs were a major concern in their communities and patient populations, a lower share (just over half) of the participants indicated "they had allocated resources to address the housing needs" (Reynolds et al., 2019). Hospitals and healthcare institutions recognize the issues in housing in their particular communities but have yet to fully explore how they can address the gap in affordable housing.

There are many ways in which hospitals can invest and support affordable housing. The Urban Institute's study identified three particular mechanisms to invest in housing development and rehabilitation. First is the ability of hospitals to donate land or buildings which can solve a major hurdle for affordable housing development. Acquiring land is often one of the largest costs of developing new affordable housing. As the Institute notes, "many hospitals and health systems own land and buildings that are unused or underused" which can be utilized in affordable housing efforts (Reynolds et al., 2019). Whether it includes affordable housing development as part of planned hospital expansion or directly supporting a community's planning development with land, hospitals can tackle a key obstacle in affordable housing while also benefiting financially.

The second mechanism for hospitals to foster housing development is through loan guarantees (where "an institution in good financial standing promises to assume the debt of borrowers if the borrower defaults"). Supporting housing development through loan guarantees can drastically reduce key financial issues like high-interest rates that often prevent affordable housing developers from obtaining necessary loans (Reynolds et al., 2019). The third mechanism cuts out the middleman of the previous mechanism, as healthcare institutions can provide loans directly to developers. Utilizing nonprofit community organizations like community development financial institutions (CDFIs), hospitals can directly invest money in affordable housing development projects. With a vested interest in community development, hospitals can provide loans with lower interest rates that are often necessary for development when government subsidies are insufficient.

Some hospitals have already become involved in affordable housing and the studio report's next two sections examine in a reconnaissance fashion these pioneer efforts. Section Three studies the New Jersey Hospital Partnership Subsidy Program, the nation's first such initiative by a state Housing Finance Agency (HFA), in this case the New Jersey Housing and Mortgage Finance Agency., to encourage hospitals in the Garden State to foster affordable housing. This is followed by Section Four which examines national, regional and local scale hospital affordable housing initiatives.

History of Hospital Investment in Affordable Housing

Much of what will be discussed in this report will cover recent developments in the connection between healthcare institutions and affordable housing, but it is important to note this is not a completely new

concept. Two examples of hospitals investing in affordable housing prior to the turn of the century can be found in Rochester, Minnesota and Baltimore, Maryland.

Mayo Clinic, Rochester, Minnesota

A staple of Southeast Minnesota, the Mayo Clinic has served the region since 1863. The earliest example of the Mayo Clinic investing in housing was in a post-World War II Rochester where soldiers and doctors returning from the war needed housing. Mayo "helped assemble the land, contributed to the architectural and design features of the homes" and helped develop the blueprints of the subdivision of homes they were developing (Zuckerman, 2013). After this initial investment in housing, Mayo Clinic would not invest in affordable housing again until 1999. Here, the Rochester Area Foundation (that Mayo helped found in 1944) recognized that as Mayo Clinic grew and had an increase in employment opportunities, the need for affordable housing also increased while the "availability of affordable housing dramatically decreased" (Zuckerman, 2013). Equally important to the demand for affordable housing was the Mayo Clinic's shift in how they wanted to work with the community and "increase transparency and focus on community partnerships" that would better work with the community and have them feel more involved in Mayo's decision- making process. All of this led to the creation of a community land trust funded by Mayo called First Homes that sought to provide 875 housing units of 5 years with the only requirement being that you must earn 80% of the area median income in order to be eligible to purchase a home. Mayo and First Homes met their goal of 875 units and this project would lead to various other housing projects around Rochester. By the mid-2020s, First Homes is expected to have spent over $360 million dollars on revitalization spending and remains deeply invested in Rochester's development including being a part of the Downtown Master Plan (Zuckerman, 2013).

Bon Secours, Baltimore, Maryland

Prior to becoming the Bon Secours Mercy Health network, the Bon Secours Baltimore Health System worked solely in Southwest Baltimore as the largest healthcare institution in the region. Bon Secours began working in community development efforts in the 1990s as they saw the housing crisis right at the doorstep of Bon Secours Hospital. The drug crisis mixed with the affordable housing shortage in Baltimore led Bon Secours to look at community investments beyond direct health intervention. As a result, the health system's subsidiary Community Works launched Operation ReachOut, an affordable housing investment involving 31 vacant row houses that would be rehabilitated, provided to the community, and would work directly with the community on all future decisions regarding the development. Since this initial housing development project, Bon Secours has developed "more than 650 units of rental housing, including 6 buildings of senior housing" through Low Income Housing Tax Credits (Zuckerman, 2013). Beyond the direct affordable housing investment Bon Secours aimed to get the new homeowners involved in decision-making through Operation ReachOut holding various meetings with community residents to help develop the project revitalization plan. Additionally, Bon Secours committed to providing homeowners in the area with support in the form of "grants for

small improvements ranging from carpentry to plumbing… with the goal of putting money into blocks that were starting to show problems" in an effort to prevent at-risk homes from becoming vacant (Zuckerman, 2013). Community Works remains a staple in Baltimore even as Bon Secours has expanded beyond Southwest Baltimore. The subsidiary works beyond just providing affordable housing, they now offer 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" (Zuckerman, 2013).

SECTION FOUR

Reconnaissance Case Study of the New Jersey (NJ) Hospital Partnership Subsidy Program (NJ Housing and Mortgage Finance Agency)

Hospital Partnership Subsidy Program (HPSP)

Background and Program Guidelines

There were nascent efforts in New Jersey to connect affordable housing to healthcare. For example, in 2015 the New Jersey Department of Community Affairs, in conjunction with the Camden Coalition of Healthcare Providers, announced the Housing First program, a pilot program that provided housing vouchers to the homeless and other frequent users of hospital and healthcare services.

In 2018, the New Jersey Housing and Mortgage Finance Agency (NJHMFA) announced the Hospital Partnership Subsidy Program (HPSP), which aims at encouraging hospitals to invest in affordable housing in their local communities. The program stemmed from previous government efforts to connect healthcare providers with affordable housing and community development, such as the Housing First pilot program in Camden.

Through HPSP the NJHMFA offers up to $4 million for development and construction costs; hospitals then match the amount and may provide land or a building for the project. If a hospital is interested in the program but financially unable to make a lump sum contribution, NJHMFA will offer the hospital a mortgage to assist in financing the project. In tandem with the 4% LIHTC, (the 9% LIHTC viewed as problematic to secure) developers partnering with hospitals to construct affordable or supportive housing are able to save a significant portion on their construction costs.

Due to the use of LIHTC to finance HPSP hospital housing projects, there are restrictions on the makeup of the units and their pricing. LIHTC developments require specific set asides for affordable housing and limit gross rents to no more than 30% of the designated income limit. Additionally, these affordability requirements remain in place for at least 15 years.

NJHMFA considers each application on a case-by-case basis, though the agency prefers to see mixed-use projects with proximity to the hospital. Likewise, the agency prefers on-site healthcare services, such as urgent care clinics, to occupy a space on the project's ground floor. Based on the program's initial allocation of $12 million, NJHMFA hopes to build three to four housing complexes with approximately

220 units. As noted earlier, the HPSP was the nation's first program by a state HFA to foster hospital participation in affordable housing.

While NJHMFA strives to be flexible in its approach, applicants are required to meet several criteria to be eligible for funding. First, an eligible project must be structured as a partnership between a developer and a participating hospital. Second, the hospital must match NJHMFA's funding contribution from its own funds for use in the project. Finally, the project must include a number of units set-aside for supportive housing or frequent users of hospital services.

Interested hospitals are required to submit a statement of interest that includes a description of the project's location, including a description of the project's site and its proximity to hospital facilities, information on the hospital's financial interest in real property included in the project, a description of the site's proximity to public transportation, employment opportunities, and relevant healthcare and social services. A hospital applicant must also provide information on the following: (1) the developer partner selected by the hospital, (2) the project's anticipated number of units, (3) the project's type of development, such as mixed-income housing or mixed-use, (4) the project's additional elements, such as retail space or healthcare facilities, (5) the hospital's additional financial contributions or sources of funds, and (6) a narrative regarding the project overall describing the services and amenities that will be provided to tenants.

NJHMFA - Paterson, NJ

Background

Paterson is in northwest New Jersey and is one of the Garden State's six major cities, referred to as the "Big Six." Founded in 1791, Paterson became an early industrial powerhouse due to its strategic location along the Great Falls of the Passaic River. The site famously attracted the attention of Alexander Hamilton, who proposed using the falls to spur industrial development in the then newly formed United States. Throughout the 1800s, Paterson grew into a large manufacturer of textiles, earning the name "Silk City," as silk production came to dominate the city's manufacturing sector. As with many other industrial cities, Paterson fell into a period of decline in the latter half of the 20th century. Though the city has recovered some since its nadir, Paterson still faces considerable challenges.

Demographics / Community Conditions

Paterson is the third largest city in New Jersey with a population of 159,732 as of 2020. Additionally, Paterson is one of the densest cities in the country with 17,300 residents per square mile, behind only New York, San Francisco, and Jersey City. Hispanics comprise the largest portion of residents with 61% of the total population. Much of this Hispanic population is foreign- born, with sizable communities from Peru and the Dominican Republic. Overall, foreign-born residents account for 42.5% of the population. Given the large Hispanic and foreign-born population, Spanish is the most common language spoken at home throughout most census tracts in the city. Whites account for roughly 27%, though non-Hispanic

whites comprise only 8% of Paterson's population. Finally, about one-quarter (26%) are Black, with the largest African American communities concentrated in Paterson's Eastside Park neighborhood.

Though the city has seen some recent recovery through the development of an arts district, Paterson still lags behind the state average in a number of significant metrics. According to the 2020 Census, 25% of city residents live below the poverty line as compared to a much lower 9% poverty rate statewide. Poverty in both Downtown Paterson and the Great Falls neighborhood is as high as 35%. Likewise, the family median income in 2020 was $45,141, which is less than half the statewide median family income of $102,260.

Given the extent of poverty, much of Paterson's population lives with chronic medical conditions. While New Jersey statewide has about a 10% diabetes incidence, in Paterson citywide diabetes afflicts 12% of the population (about 19,000 persons). Instances of diabetes are more concentrated near Paterson's Eastside, where more than 14% of the neighborhood suffers from diabetes and the city's downtown area diabetes rate is yet higher at 16.5%. Other chronic conditions, such as high blood pressure and heart disease, are common in these Paterson neighborhoods. Finally, obesity, which has a profound effect on an individual's overall health, is more common in Paterson than the rest of the state; 33% of the city's residents qualify as obese compared to the state average of 25%. Within Paterson, obesity rates vary between neighborhoods. Obesity is more common in the Great Falls, Eastside Park, and Wrigley Park neighborhoods, areas that include some of Paterson's lowest-income residents. In these neighborhoods, obesity rates exceed 36%.

Housing is a critically important social determinant of health. As one of the poorest communities in New Jersey, Paterson struggles to provide affordable housing for its lowest-income residents. Most housing in the city is unaffordable for families earning 30% or less of the Area Median Income. Even in neighborhoods where there are some affordable units–mostly concentrated in and around Paterson's Downtown–there is a noticeable lack of affordable housing. As of 2018, only 8% of the rental properties in Paterson were affordable for residents earning 30% AMI. As rents have substantially increased in the years following the Covid-19 Pandemic the housing affordability challenge in Paterson has only gotten worse, especially for the city's poor.

Project

Background

In response to the growing need for high-quality, affordable housing in Paterson, St. Joseph's Hospital (SJH) partnered with the New Jersey Community Development Corporation (NJCDC) and New Jersey Community Capital to construct multi-family supportive housing in the city. Launched in 2019, the Paterson project was the first program initiated under NJHMFA's Hospital Partnership Subsidy Program. Despite delays and increasing costs as a result of the COVID-19 pandemic, the project is slated for completion in late 2022.

NJCDC is a Paterson-based community development organization with decades of experience executing

projects of all sizes directed toward revitalizing the city. As a Paterson-based developer, NJCDC possesses a deep understanding of the community as well as the ability to develop meaningful relationships with a variety of different entities. For example, NJCDC is a member of the Health Coalition of Passaic County of which SJH is also a member, thus providing an opportunity for both organizations to build a strong relationship and work on several initiatives together. As such, when SJH was introduced to the project, NJCDC was a natural partner due to their familiarity and strong knowledge base of place-based development in Paterson.

SJH also has a long history of engaging directly with the community as it is the major hospital serving the city of Paterson. The hospital is the largest employer both in the city and Passaic County, in which Paterson resides. As such, St. Joseph's sees itself as the anchor institution and has long noticed the need for significant redevelopment of the areas surrounding the hospital.

In 2008, the City of Paterson designated 244 acres around the SJH campus as an area in need of redevelopment. Related, in 2009 St. Joseph's submitted an application to the city to be the master developer of the area. This move allowed the hospital to engage in a variety of community investment activities to improve the delivery of and expand access to health care and improve health outcomes. For example, St. Joseph's acquired property around the main corridors that accessed the hospital. Through this, St. Joseph's began partnering with developers to improve the patient experience as they approached the hospital. So, when the NJHMFA project was announced, St. Joseph's was prepared and willing to engage in the project as it aligned directly with its historic mission and recent activities.

Project Description

The project is set to have a total of 56 housing units with 10 of those units set aside for special needs populations. Notably, the 10 units for special needs will also come with special project- based housing vouchers. While the remaining 46 units will not have vouchers attached to them, they will have affordable rents based on the U.S. Department of Housing and Urban Development guidelines. Of the 56 units, 15 are one-bedroom, 29 are two-bedroom, and 12 are three-bedroom; thus, a good share are "family-sized". The building will also have 5,000 square feet on the first floor dedicated to community services for residents. Some examples of services to be provided include employment services, mental health services, literacy services, and health, social and other case management, among others as dictated by the building residents. Additionally, the building will have general community space and offices, health facilities, and a gym. The ultimate goal of these multiple services all being on-site is eventually to reduce visits and dependency on the emergency room.

To combat systemic structural issues associated with some of the existing housing stock in Paterson such as lead paint, inadequate ventilation, and exposure to radon, the current project building design will include various supportive housing components. These include noise dampening drapes, handrails, good ventilation, and toxin-free finishes. This is particularly important due to the chronic conditions which arise from unhealthy living conditions, particularly asthma and lead poisoning which were major drivers of emergency room utilization.

Financing Mechanisms

The total layered sources of project funds ("capital stack") for the project is $27.4 million. Importantly, the value of the property is not in the capital stack as NJHMFA did not allow the landowner (in this case Saint Joseph's Hospital-SJH) to have the property count towards the stack.

Capital Stack

- HMFA Hospital Program: $4.500,000
- SJH Program Match: $4,500,000
- HMFA Special Needs Housing Trust Fund: $1,000,000
- HMFA LIHTC (4%) Proceeds: $11,036,000
- HMFA Note: $4,845,000
- Deferred Developer Fee: $1,517,000
- **TOTAL: $27,398,000**

As a result of the program design, much of the funds for the project were coming straight from one entity, NJHMFA. This aided in simplifying the financials for the project as the project leads (NJCDC and SJH) did not have several different closing finances with varying requirements and deadlines– and inevitably rising costs. Enterprise, a low-income housing syndicator, used funds from investors at TD Bank to provide the upfront capital for the project in exchange for the 10- year stream of tax credits granted to the developer under the LIHTC program.

An additional component to the program was a requirement for hospitals to match the funding credits. From the outset of the program, SJH committed $6 million in total equity (the required $4.5 million SJH HMFA Program Match and $1.5 million for land acquisition) for the project. As a result of this significant investment, there was understandably some convincing that had to take place within SJH, but ultimately the hospital leadership came on board. SJH's previous experience working on built environment projects was key for hospital leadership's buy-in; there was an understanding of how the complex financing mechanisms work.

Challenges

Overall, there were not that many major challenges associated with the development and building process. That said, there were some challenges that had to be dealt with. This included issues when the land was being acquired for the development. For example, much of the land where the building was going to be built was already occupied by individual lots with single-family homes. As such, some of these homes had oil tanks that had to be removed and possessed, and a series of other environmental hazards had to be remediated. This is not atypical for urban infill redevelopment.

The COVID-19 pandemic, which occurred during the project's gestation and construction, increased the costs of materials significantly while also leading to significant delays in the procurement of materials, leading the project to be delayed by several months. These material and supply issues have bedeviled many construction projects in the COVID years.

An administrative challenge experienced was the realization that there were discrepancies between different entities about what constituted a "special population." Originally, it was thought that emergency room "frequent flyers" could qualify as a special needs population to be housed. However, through the existing administrative regulations, frequent flyers were not considered a special needs group. This led to having to alter the program design by creating preferences on the housing unit applications for frequent flyers and also shifting the focus to different eligible special populations.

Accomplishments

While the construction and filling of the building with residents have not been completed as of the time of this studio's analysis, there are still various accomplishments that can be identified thus far.

First, an attractive affordable housing project is being delivered—no easy feat. Further, the development process has brought closer together a variety of different institutions within Paterson to work together on one common goal. The importance of safe, healthy, and affordable housing has been brought to the forefront by several important stakeholders in the community, such as Paterson's mayor, SJH, and NJCDC. Once the project is complete and the anticipative positive impacts are fully realized, a lasting impact of the project could be renewed and continued interest in cross-sector collaboration, not just in housing but also in food insecurity, economic opportunity, transportation, green spaces, and other community concerns.

Major Takeaways

There are many important considerations to take away from the Paterson project. Despite the COVID-19 pandemic, environmental hazards, and strict financial guidelines, the project is demonstrably a success.

A key contribution to the success results from existing relationships of the Paterson partners in the endeavor. Both NJCDC and SJH understand their respective constituencies and their unique needs, and as such have been able to create a project which is appreciated by those who need it most. With SJH's existing work in the development of the area around the hospital paired with NJCDC's vast experience in housing development, it led to a relatively smooth development process. Also contributing to the success is the half -century financing acumen of the NJHMFA, the agency's vision in developing and launching the program, and keeping an open mind and flexible approach to allow for the closure on the Paterson pilot project

Regarding the financing of the project, it is important to consider that many hospitals operate on very thin financial margins. Projects such as the one described in this report seldom generate significant

returns. As such, it takes a strong commitment on behalf of the hospital that they are doing this project to improve the community, even if they risk losing money in the long run. Hopefully, projects such as the NJHMFA program will give confidence to other hospitals who may have reservations about engaging in such a financially fraught and logistically complicated endeavor. Due to complexity and uncertain finances, many hospitals may continue to be reluctant to engage in pilot programs. Additionally, since this is a new area for hospitals, data is needed to highlight that health outcomes would be greatly improved because of investment in housing and will ultimately reduce costs. In tandem, such data is crucial for allowing affordable housing outlays to be reimbursed by government (i.e., Medicare and Medicaid) and private insurance reimbursors of hospitals in the U. S.

Another takeaway is the immense need for safe, high-quality affordable housing. There need to be continued efforts to use innovative methods to increase the housing stock within communities that do not adversely impact the long-term residents. For example, zoning reform to allow for municipalities to build in high-density, low-income areas would be a step in the right direction. In parallel, communities allowing and encouraging more accessory dwelling units would be helpful.

Lastly, it is critical to ensure all entities at the state and local levels are on the same page in terms of the administrative rules and regulations surrounding every aspect of the project. These project parameters should be revisited and discussed through the development process with all of the participating entities so as to ensure there are no missteps in program design or misaligned priorities.

NJHMFA - Newark, NJ

Background

Newark, New Jersey is in the northeastern corner of the state in Essex County and historically was the largest in terms of population of New Jersey's major cities ("Big Six"). The city was settled in 1666 and grew into a hub of commerce and industry due to its strategic location and later canal and railroad access (Tuttle, 2009). Development progressed and Newark came to be a manufacturing powerhouse, earning the nickname "Brick City." As many cities nationwide, the middle 20th century onward saw Newark's population decline and economy stagnate, though more recently there has been a significant amount of new development and growth. Some of Newark's main anchor institutions include its hospitals, which serve the region. The city is home to many hospitals, and to date two of them—University Hospital and Beth Israel Medical Center—have been involved with the production of affordable housing through the state's HPSP.

Demographics and Community Conditions

According to the 2020 decennial census, Newark has a population of 311,549 people and a high population density of 12,879 people per square mile. About half (49%) of its population identifies as Black alone, 12% identifies as white alone, 2% identifies as Asian alone, and 24% identifies as some other race alone. Looking at health metrics, 39% of Newark's population has high blood pressure.

Additionally, 15.7% has diabetes, 37.7% report being obese, and 7.6% suffer from heart disease (PolicyMap & CDC BRFSS, 2018). There are an estimated 118,163 total housing units in the city. The 2020 5-Year American Community Survey estimates Newark's median household income is $37,476, and approximately 26% of the population is below the poverty level. For context, New Jersey statewide had a median household income of $85,245 and a 9.4% poverty rate.

The city has recently seen more investment in its housing stock, especially in the downtown, though a significant gap remains between the supply and need for affordable housing. Rutgers Center on Law, Inequality, and Metropolitan Equity found in 2021 that the city has a need for an additional 16,234 affordably-priced housing units (Nelson & Troutt, 2021). The study further notes that 59% of Newark's renters are housing cost burdened and almost one-third are severely cost burdened. This is despite Newark's considerable stock of affordable housing which amounts to about 24,000 affordable units (out of a total housing stock of approximately 118,000 homes). The study highlights the need for further affordable housing development and deeper housing subsidies to reduce the cost-burden for Newark's residents. One response to addressing Newark's housing need involves a community anchor institution—University Hospital and the latter's involvement in the NJHMFA's HPSP is described below.

Project

Founded in the early 1880s, University Hospital is in the Central Ward of Newark bordering the West Ward. Encouraged by the NJHMFA HSPS, University Hospital and a cadre of experienced developers have joined forces to build affordable housing. L&M Development Partners is spearheading the development group and is joined by two other companies (Type A Projects and MSquared). The University Hospital partnership reflects lessons learned in L+M Development Partners' Hahne's project in Newark, a major and successful downtown mixed-use development, encompassing housing (both market-rate and affordable units), retail, commercial, and institutional components. The project would enhance University Hospital's connection to the Central Ward and nearby West Ward.

The proposed development will provide 78 affordable rental apartments that would serve low- and moderate-income households. Of those 78 units, 16 supportive housing units will be reserved for individuals and families experiencing homelessness. The supportive units will also be paired with access to medical services. The development will include a ground floor clinic and hospital office space, which would operate in partnership with University Hospital. The project will also receive

32 project-based Section 8 rental vouchers from the Newark Housing Authority. A relatively new element from the LIHTC program known as "Income Averaging" would help individuals who do not have opportunities to rent in the regular rental markets. For example, if a unit in the building is rented by a tenant earning only 30% of AMI, another unit could be rented by a tenant earning 80% of AMI, as long as the projected average of all tenants' earnings remains at 60% of AMI. This project is using this flexible approach of mixing different incomes.

Financing Mechanisms

The project's total capital stack is $54.7 million secured through a variety of funding sources.

Capital Stack

- NJHMFA: $22,000,000 in mortgage financing
- NJHMFA Special Needs Housing Trust Fund: $1,600,000
- Hospital Partnership Subsidy Program: $6,000,000
- University Hospital Match: $3,000,000
- Multifamily Rental Housing Production Fund: $3,500,000
- City of Newark HOME funds: $300,000
- Essex County HOME funds: $300,000
- 4% LIHTC Proceeds (Wells Fargo): $18,000,000

The project is receiving the majority of its funding from NJHMFA mortgage financing and LIHTC 4% proceeds. The remaining project funding comes from two other NJHMFA programs, University Hospital's program match, and HOME grants.

Accomplishments

The project is currently in preconstruction with full financing secured. It is expected that construction will be completed sometime in the middle of 2023. As such, it is too early to understand the full extent of benefits achieved and accomplishments resulting from this partnership. However, the development process itself has already created strong connections between the multiple project partners. Newark's existing institutions were engaged through the project and their resources were leveraged and enhanced. The University Hospital administration has gained experience and education in affordable housing development. This may strengthen and improve affordable housing development in the future in addition to the benefits to the community of new affordable units added.

Lessons Learned

Researching this project and interviewing those involved has provided valuable insight on these sorts of partnerships and projects. Building affordable housing is complex and outside the traditional scope of hospitals.There is not a standard process for approaching these partnerships, so it becomes a collaboration between the partners, and a process of trial and error.

Another lesson is the importance of community participation and buy-in. The impetus for doing these projects is that there is an existing community need, and this need is being expressed by the community,

not by an external source. These projects will succeed when they are done in communities that identify this sort of project as a community priority, not in communities where the project is forced upon them.

For the project as a whole, the studio heard there is a need for some mechanism for measuring success. As Jonathan Cortell, managing director at L+M Development Partners noted, "Maybe the end product of this conversation will be, how do we demonstrate, unequivocally, better outcomes have been achieved." As this report highlights, there are various hospital and affordable housing projects underway throughout the United States, each with their own approach and unique components. Developing a mechanism for measuring success can measure success over time and quantify if these projects have allowed better outcomes to be achieved. Without a way to measure success, it is impossible to determine what works and what does not, and future projects are likely to make the same mistakes.

Affordable Housing and Hospital Programs

Given the connection between housing and health, HFAs are beginning to recognize the need for affordable housing that better responds to its residents' health needs and, in light of the Covid-19 pandemic, housing that is more resilient to future health emergencies. NCSHA, with support from the Robert Wood Johnson foundation, has started to work with affordable housing developers and State HFAs to advance opportunities for increasing investment in hospital affordable housing projects. This program, called the Affordable HEALTH (Housing Equity and Long-Term Health) Initiative, explores the connection between housing, health, and race.

In addition to this new national approach, several State HFAs have started initiatives designed to bolster healthcare investment in affordable and supportive housing. Among the most prominent of these initiatives are the Portland Housing is Health program, the Accelerating Investments for Healthy Communities Initiative and the Camden Housing First program.

SECTION FIVE:

Reconnaissance Case Study of Illustrative National, regional and Local Hospital-Affordable Housing Initiative: Accelerating Investments for Healthy Communities (AIHC) and Other

AIHC

Background

Accelerated Investment for Healthy Communities (AIHC) is a program "designed to help participating hospitals and health systems deepen their investment in affordable housing, and advance policies and practices that foster equitable housing solutions" (CCI, n.d.). This program began in 2018 under the Lincoln Land Institute's Center for Community Investment (CCI), with funding from the Robert Wood Johnson Foundation. (The American Hospital Association (AHA), and the National Opinion Research Center (NORC) at the University of Chicago, collaborated as the evaluation partner for the AIHC initiative). The purpose of CCI is to "ensure all communities, especially those that have suffered from structural racism and policies that have left them economically and socially isolated, can unlock the capital they need to thrive" (Gaskins, 2021). CCI is designed to have an initial 10-year lifespan and is currently in year five of this timeline. Along with AIHC, CCI coordinates various other programs including multi-year initiatives focused on developing capital (Connect Capital and Connecting Capital and Community), and developing community leadership (Sprints, Field Catalyst, and the Fulcrum Fellowship). These programs, like AIHC, are committed to CCI's goal of creating community investment which CCI defines as "financing intended to improve social, economic, and environmental conditions in disadvantaged communities while producing some economic return for investors" (Gaskins, 2021).

The three-year AIHC initiative serves as a learning period for testing and refining strategies and capacities that can incentivize successful hospital and housing partnerships across multiple cities. AIHC is capitalizing on existing efforts, strategies and partnerships to create a research and best practices guidebook for hospitals nationwide. The initiative brings together health system executives and staff, representatives from local government, affordable housing developers, foundations, community groups, and community development financial institutions to answer the question "[w]hat will it take for leading health organizations to devote more and different assets to investments in affordable housing and other upstream factors that improve community health?" (AHA, 2021).

The following section describes how AIHC intended to engage hospitals in community investment through affordable housing. It first discusses the two phases associated with AIHC and the outcomes for each. Then it briefly summarizes the impact and lessons learned from the initiative in general as it concluded in December 2020. After this general overview of AIHC, presented are the experiences of two of the six AIHC participating hospitals-- Nationwide Children's Hospital in Columbus, Ohio and Bon Secours Mercy Health in Baltimore, Maryland and Cincinnati, Ohio.

AIHC Phase 1

Phase 1 of the AIHC program began in 2018 with the goal of bringing together healthcare institutions that have "already invested in the upstream determinants of community health" to learn how they can better invest in affordable housing to improve the communities they are anchored in (CCI, 2018). The first phase saw nine healthcare institutions engaging in an intensive four-month process. The nine healthcare institutions were:

1. Bon Secours Health System, focus region: Baltimore, MD and Richmond, VA
2. Boston Medical Center, focus region: Boston, MA
3. Cooper University Health System, focus region: Camden, NJ
4. Dignity Health, focus region: San Bernardino, CA
5. Henry Ford Health System, focus region: Detroit, MI
6. Kaiser Permanente, focus region: Oakland, CA
7. Nationwide Children's Hospital, focus region: Columbus, OH
8. ProMedica Health System, focus region: Toledo, OH
9. University of Pittsburgh Medical Center, focus region: Erie, PA

These nine institutions committed to attending three learning labs with each sending a cohort of four to five institution members from various hospital departments. The learning labs were spaces for the institutions to share their experiences in affordable housing investment, learn from one another, and receive feedback and individualized consultations from CCI in order to refine the "value proposition for health system investment in affordable housing" (CCI, 2018).

Robin Hacke, Executive Director of CCI, provided insight at the conclusion of Phase 1 with what lessons they gleaned from the learning labs. The four insights gained were: 1) the need for interdisciplinary perspectives, 2) expanding and harnessing diverse assets, 3) engaging with and building better relationships with affordable housing developers, and 4) learning how to best measure the impact of affordable housing investment. As these are core insights, they merit further elaboration.

1. **Interdisciplinary Perspectives** - CCI recommends that healthcare institutions seeking to staff work on affordable housing and other social determinants of health should take an interdisciplinary approach to community investment. The primary way to accomplish this is to work across departments in the institution by including chief officers, financial, clinical, and real estate professionals in the discussions of affordable housing.

2. **Diverse Assets** - CCI saw that a key growth for many of the institutions in Phase 1 was in their expansion of various assets for community investment to learn how best to leverage resources. This includes looking at endowments, donations, land, and operating funds.

3. **Building Better Relationships** - While many healthcare institutions collaborate with organizations connected to housing development, CCI emphasized strong communication and other exercises to better engage and understand developers, CDFIs, and CDCs.

4. **Measuring Impact** - Lastly, CCI saw great interest from participating institutions in learning how best to measure both the financial and health impact of affordable housing investment. Best practices were discovered to be in the same vein as both point 2 and point 3 as institutions found greater success when engaging both health experts and community experts in how best to measure impact.

AIHC Phase 2

At the conclusion of Phase 1, CCI moved forward with AIHC with the aim of engaging in more direct affordable housing investment with their partner healthcare institutions. To do this, CCI invited six institutions to participate in Phase 2. Those six participating healthcare institutions were:

1. Bon Secours Mercy Health (Baltimore, MD and Cincinnati, OH)
2. Boston Medical Center (Boston, MA)
3. Common Spirit Health (San Bernardino, CA)
4. Kaiser Permanente (Prince George's and Montgomery Counties, MD)
5. Nationwide Children's Hospital (Columbus, OH)
6. UPMC Health Plan (Pittsburgh, PA)

These institutions were committing to more than just discussions on affordable housing in learning labs as AIHC sought to partner with these institutions to "develop and begin to execute a pipeline of affordable housing projects and work with partners to advance long-term community investment in affordable housing" (CCI, 2019). These institutions were expected to develop affordable housing projects beyond their current investments. Encouraging the shelter investment, CCI would provide resources such as coaching and technical assistance, support for program development from both CCI and the Robert Wood Johnson Foundation (the latter providing the major funding for the initiative), and the

opportunity to learn and communicate with the participating institutions regularly. These efforts took various forms dependent on the institution's specific focus and unique community concerns. Some institutions focused more on the expansion of affordable housing investment into new geographic areas, while others focused on preventing evictions and foreclosures that were on the rise due to the then on-going Covid-19 pandemic. While the specific projects may have differed, CCI wanted to ensure that all were including a "framework for ensuring that housing projects advance racial equity" (CCI, 2021). Beyond just investing in affordable housing, CCI wanted to ensure that healthcare institutions also recognized key racial disparities in their communities and worked to address them as well.

AIHC Impact

Kaiser Permanente, in Prince George and Montgomery Counties in Maryland, recently pledged $200 million to invest in housing across the country; Nationwide Children's Hospital in Columbus, Ohio announced the creation of a $20 million fund to finance 170 multi-family rental units on the South Side of Columbus; and Dignity Health in San Bernardino worked with community partners and the State of California to leverage more than $20 million dollars for a housing project that is expected to create hundreds of units of affordable and market-rate housing. Currently, Dignity Health has approved nearly $100 million in community development loans, forty-five percent of which is for affordable housing. Additionally, the University of Pittsburgh Medical Center (UPMC) and UPMC Health Plan have invested millions of dollars in a number of initiatives over the past three years to spur the creation of affordable housing options for people in low- to moderate-income households, including the use of a number of financing options that support the expansion of Community Land Trusts in Pittsburgh to help promote permanent, affordable homeownership opportunities.

At the conclusion of Phase 2, CCI was able to provide a comprehensive list of the impact of the AIHC initiative as a whole. In their 2021 report, they began by sharing the impact of the initiative through various quantitative data. Between the six healthcare institutions from Phase 2, a total of $15.4 million of loans and grants were invested into affordable housing. This funding was utilized in four key ways:

- The direct development or preservation of over 1,000 affordable housing units.
- Collaboration with national foundations who invested $10 million in loans and grants for affordable housing.
- Leveraged $20 million in additional funding for affordable housing investment.
- Filled the financing gaps in projects that totaled over $330 million in development costs.

While the financial numbers are certainly impressive, CCI wanted to ensure the impact on both the community and the healthcare institutions themselves was highlighted as well. CCI described this impact on the community's "local housing investment ecosystem" (CCI, 2021). These goals were the result of stronger community partnerships and clearer objectives in affordable housing and community investment. CCI described these accomplishments with the following accomplishments as healthcare institutions:

- Developed new and stronger community relationships
- Clarified their housing priorities to be more in line with community needs
- Identified more impactful community investment pipelines
- Facilitated significant community affordable housing and preservation projects

Warranting more discussion are what kinds of returns motivate healthcare partners according to lessons learned from the AIHC program?

Hospitals and healthcare providers are, like most investors, interested primarily in a return on investment. However, there are several other factors that may motivate a hospital to invest in affordable housing in its community. Hospitals are dedicated to improving the health outcomes for those in their communities.

Thus, many hospitals see investment in the community as a way to advance their mission. "AIHC has seen such institutions subsidize housing for people with low incomes, invest in affordable housing developers and provide gap financing for housing deals, and even consider using their land for affordable housing, regardless of whether their patients and employees will directly benefit." (Gaskins, 2021).

As well, hospitals often interact with other community stakeholders and local governments. Investing in community initiatives serves as a way to strategically strengthen their relationships with the public sector. In tandem, community investment also serves as a method for both strengthening relationships with the community and bolstering the institution's reputation within the community and abroad.

AIHC has used this initiative to develop various resources for healthcare institutions to use for future affordable housing endeavors. This includes recordings of their meetings from the learning labs and various discussions between healthcare institutions, various reports and case studies from specific projects, and helpful guides and toolkits for healthcare institutions and affordable housing organizations to best engage in the affordable housing-healthcare connection. In just a short amount of time, AIHC has become a hub of resources, knowledge and connections for any anchor institution and hospital that wishes to empower community investment in the community they reside in.

To better understand these lessons, the Bloustein studio below examines in a reconnaissance fashion two AIHC participating hospitals—Nationwide Children's Hospital and Bon Secours Health System.

Nationwide Children's Hospital (Columbus, Ohio) - AIHC Initiative

Background

Columbus is the state capital and most populous city in Ohio (2020 population of about 480,000). Columbus originated as numerous Native American settlements on the banks of the Scioto River. The city was founded in 1812, near the two rivers of Scioto and Olentangy, and laid out to become the state capital. It was named for Italian explorer Christopher Columbus. Of the city's total population, the racial composition (race alone), is about 59% white, 29% Black, and 6% Asian. The city has a diverse economy based on education, government, insurance, banking, defense, aviation, food, clothes, logistics, steel, energy, medical research, health care, hospitality, retail, and technology. Beginning in the 1950s, Columbus began to experience significant growth; it became the largest city in Ohio in land and population by the early 1990s. The 1990s and 2000s saw redevelopment in numerous city neighborhoods, including downtown. Nationwide Children's hospital is located on the south side of Columbus.

AIHC Project Introduction

Nationwide Children's Hospital's AIHC efforts are embedded in the system's Healthy Neighborhoods Healthy Families (HNHF) initiative established in 2008. The geographic area targeted by this initiative had a larger minority presence compared to the city overall (64.1% Black compared to the 32.1% Black population share in Columbus citywide) as a cross-department effort targeting five impact areas and guided by a current five-year strategic plan and operating budget. HNHF's five impact areas are affordable housing, education, health and wellness, community enrichment and economic development. A population health accelerator team of multiple departments oversees HNHF. AIHC team members noted that the connection between health and housing is socialized throughout this hospital's health system and that commitment was heralded by the Nationwide board acting as "the key driver" in participating in AIHC. (AHA, 2021). The program within HNHF that Nationwide Children's Hospital ran for affordable housing projects is called Healthy Homes. The area served by the Healthy Homes initiative had a median household income of $27,376, just 40% that of the city's overall median household income of $67,207.

Project Accomplishments

Since 2008, Healthy Homes has impacted more than 450 homes, which includes:

- Full-gut renovations of existing homes
- New construction with energy efficient and green features
- Grants to current residents through the Home Repair Program

The new and rehabilitated homes typically feature tankless water heaters, rain barrels, solar tubes, low VOC paint, recycled carpet, levered door handles and energy efficient windows. Healthy Homes impacted a total of 23 homes (3 gut rehabilitations and 20 home repairs) in its first 2 years and ramping up to an average of 34 homes per year. Since its inception, Healthy Homes has generated $40 million in direct and indirect investment in the surrounding neighborhoods. HNHF program evaluation documented further measurable community improvement in reducing housing vacancy rates and increasing high school graduation attainment (Chisolm et al., 2020).

A study done on the impacts of healthcare use in Columbus found that the HNHF intervention area had a decrease in emergency room visits of 20.8% compared to 16.1% in the comparison control areas (the combined near-north and near-west neighborhoods). In parallel, the inpatient admissions decreased 12.7% in the intervention neighborhood compared to a somewhat less 12.2% in the comparison areas.

One example of an affordable housing development that Nationwide Children's Hospital has participated in is a complex called the Residences at Career Gateway. Located in the South Side of Columbus, this development contains 58-units of affordable apartments and townhomes, along with on-site career development training.

Financing Mechanisms

The total capital stack for the Residences at Career Gateway project is $11,924,026.

Capital Stack

- 9% LIHTC Proceeds (Ohio Equity Fund Nationwide IV): $9,755,024
- RiverHills Bank Loan: $1,375,000
- General Partner Equity: $375,000
- City of Columbus Loan: $250,000
- Deferred Developer's Fee: $169,002

The Residences at Career Gateway are a community housing development which aims to revitalize the south side of Columbus and connect residents with meaningful workforce support. Syndicated through the Ohio Housing Finance Agency (OHFA), the project was awarded $1 million in Low- Income Housing Tax Credits (LIHTC) over ten years. In Ohio, developers can apply for either a Competitive (9%) Credit or a Non-Competitive (4%) Credit. Residences at Career Gateway were awarded a Competitive Credit (9%). The developer, NRP Holdings LLC, also utilized a $1.5 million Housing Development Loan for the project (RiverHills Bank Loan). The Housing Development Loan program is funded through the Ohio Department of Commerce and provides short-term, low-interest loans to developers who have been awarded the competitive LIHTC credit or Bond Gap Financing.

Takeaways

The Nationwide Children's Hospital's AIHC initiative produced needed housing improvements in Columbus affected by a major city healthcare anchor institution. That effort was aided by the Center for Community Investment (CCI) and the AIHC providing resources and a network of peer hospitals to encourage affordable housing intervention. Further, there have also been continued discussions of racial equity components, pointing to the importance of this social lens in such interventions. From analyzing the projects funded by this initiative and interviewing those that have been involved, the Bloustein studio finds the following further lessons from this case study.

One lesson is the importance of knowledge of the local housing market. It is crucial that the staff working on these projects understand how to enter and work within that market. For example, Gretchen West, Executive Director of Healthy Homes, shared how at the beginning of Nationwide and Healthy Home's entrance into affordable housing, Columbus had already a "hot" housing market, so Nationwide Children's Hospital sought to add to affordable housing while not overheating the market. West also added that there has never been a bigger need for housing, particularly with the COVID-19 pandemic having a deep effect on low-income individuals. In 2020, those who have fallen behind at least three months on their mortgage increased by 250% to over 2 million households and is now at a level not seen since the height of the Great Recession in 2010 (CFPB, 2021). It has also never been so expensive to build. What is needed for these hospitals entering into this affordable housing arena is proper guidance on how to acquire funding to offset the rising expenses needed to develop these projects. For example, West mentioned the difficulty in understanding the QAP's criteria and point system and how important qualifying for LIHTC subsidies under the QAP was for developing these affordable housing projects.

The Bloustein interviews also revealed the importance of relationship building and working with the community in developing trust and understanding local priorities in hospitals becoming involved in local affordable housing. Frequent and effective communication was deemed key to ensure input from diverse community members and organizations.

Bon Secours Mercy Health System (Baltimore, MD)

Background

Bon Secours Mercy Health (BSMH) System was born out of the merger of two major health systems in 2018 and now operates its health services in seven different states nationwide while headquartered in Cincinnati, Ohio. The merger included Bon Secours Hospital, located in Baltimore Maryland, a city of about 600,000 persons, with a large minority population (e.g., about 60% Black alone in race) and an urban area facing economic challenges (e.g., a poverty rate of about 20%). Prior to the merger, Bon Secours was involved in housing and community initiatives since the late 1980s, working to provide residents in the hospital's surrounding West Baltimore area access to uplifting social services and opportunities. West Baltimore is a largely minority and lower income neighborhood (e.g., its median household income of $46,939 was below that of the already modest Baltimore citywide median of $52,164).

Bon Secours Community Works (BSCW) was created in 1991 to serve the needs of the Baltimore community holistically through programs and services. A component of that effort, BSCW's housing and community development, is responsible for developing, owning, and operating over 800 units of affordable housing in West Baltimore. Part of the prompt of Bon Secours becoming involved in this major effort was its Community Health Needs Assessment (CHNA). As George Kleb of Bon Secours explained "When you do a [CHNA] and housing keeps popping up, you're actually required to either address it in some way, or justify why you are not" (Perna, 2021). Bon Secours opted for the former activist strategy and partnered with Enterprise and other savvy affordable housing entities in its 800-housing unit effort. It is instructive to consider the following challenges to this Bon Secours housing initiative described below in a 2021 article (Perna, 2021):

> Capacity. This isn't a sideline project. You have to have people focused on and dedicated to these tasks. It's a whole other discipline. Financing, development, and management operations is different for housing than it is for running a hospital. There are some transferable skills but operating a hospital is a 24-hour a day, seven days a week, 365 days a year job. So having the capacity is number one.
>
> Secondly, financing is competitive and what I mean by that is most of what we've developed is through the low-income housing tax credits…[In Maryland] there are three times as many applicants as those who get the credits.
>
> Another one of the big challenges is that as impactful as housing can be, it's only one major factor. It's not the only one. For health care organizations, it would be really tough to just concentrate on housing when there's all these other social needs. The impact can be limited if you're just doing housing. That's why we've built a lot of different services.
>
> It's also a challenge to sustain it over time. You have to put together a business model that's going to be able to be sustained. Some of it qualifies as community benefit but I think you have to decide as an institution that you're all in and commit over time.
>
> Lastly, when you've developed 802 units over 25 years, it goes beyond new development operations, and it gets into preservation. Every one of these buildings has a physical plant that needs to be maintained…. That's not unique to healthcare organizations, that's anybody who operates affordable housing.

While Bon Secours Mercy Health sold the Baltimore hospital in September 2019, efforts for community reinvestment and development continued in West Baltimore under the guidance of Bon Secours Community Works (BSCW). This organization was responsible for facilitating the housing programs developed through the larger AIHC program.

Since merging into one hospital system, Bon Secours Mercy Health (BSMH) System is now based in Cincinnati, homebase of the previous Mercy Health Hospital System. Faced with an affordable housing deficit of 40,000 units across its multistate service area, BSMH partnered with Mercy Housing, a local housing nonprofit, in 2020 to begin addressing community concerns, especially needed affordable housing in predominantly Black communities. While this reconnaissance case study focuses on the

housing efforts in just West Baltimore alone, it is important to note that BSMH is operating several housing affordability programs across its multiple state service areas and has been involved in such services for many decades (Bon Secours Mercy Health Housing Team: Taking Action on Affordable Housing Crisis).

Introduction to AIHC and BSMH/BSCW

In 2019, Bon Secours Mercy Health joined the AICH initiative along with five other hospitals, and while they no longer had a physical presence in Baltimore due to the sale of the hospital facilities, they continued their work in affordable housing through BSCW. While Bon Secours had already established 802 units in the West Baltimore area prior to joining the AIHC initiative, they continued their investments in Baltimore as a nod to their history and partnerships in the area. (Cohn, 2019).

Program Accomplishments

Bon Secours Mercy Health has a dedicated development arm that partners with Bon Secours Community Works and other partner organizations to develop housing and community development projects. Part of the AIHC initiative was continuing the work that BSCW and BSMH were already doing in the communities in West Baltimore. Unlike other hospitals participating in AIHC, BSMH did not pledge a specific dollar amount to the initiative but decided to continue its pipeline of projects as well as explore ways to expand those services at BSMH hospitals across the country. Since each housing market is so unique, a customized approach is necessary to craft a housing strategy appropriate for varying local communities and their specific needs. Building trust and dialogue with surrounding communities is paramount in the process of development at BSMH (and the larger AIHC initiative).

BSMH participated in monthly calls and presentations with AIHC that served as guidance and learning tools for how to expand affordable housing programs with an emphasis on racial equity and environmental justice. Phase I of AIHC saw BSMH begin work on a 58-unit residential building on Fulton Avenue in West Baltimore.

Balancing the double bottom line of financial soundness and social impact is key to incentivizing hospitals to venture into affordable housing development. BSMH has a dedicated low-interest loan fund with $70 million in funding that it uses to finance projects. The health system wants to be a significant if not the largest lender in the capital stack of the affordable housing developments and be well acquainted with the other investors and lenders involved in the housing projects to understand their risks.

Hospital affordable housing projects often involve layers of financing. Illustrative is the capital stack shown below concerning the financing of Gibbons Apartments, a Bon Secours 2016 project. Gibbons apartments contained 80 units and was part of a 32 acre, mixed-use development in southwest Baltimore Developing Gibbons Apartments required cobbling multiple loans and subsidies to cover the $19.5 million project costs. While this housing development did not occur as part of the AIHC initiative, it highlights how BSMH has financed affordable housing developments in the past

Financing Mechanisms

The total capital stack for the Bon Secours Hospital Gibbons Apartments project is $19,460,000. A 9% LIHTC allocation covered almost 80% of development costs. Capital One provided a private

permanent $2.5 million The additional $2 million was funded by a loan from Baltimore's HOME Investment Partnerships program and a grant from Maryland Department of Community Development Rental Housing Program.

Capital Stack

- 9% LIHTC Proceeds: $15,000,000 (77%)
- Private Permanent Loan: $2,480,000 (13%)
- Maryland Department of Housing and Community Development Rental Housing Program Funds: $500,000 (4%)
- HOME Investment Partnership Funds: $750,000 (2%)
- Other Sources: $730,000 (2%)

The Takeaways

Health systems and real estate developers have different appetites for risk. Bridging the gap and incentivizing hospitals to invest in or develop housing comes with a learning curve and a good basis of trial and error. In sharing the findings and best practices, AIHC hopes that hospitals venturing into real estate will have a guide that they are able to edit and refine to their local geographical context. With over thirty years in housing development, Bon Secours, now BSMH, has learned that open conversations about risk and resources with hospital leadership are key to gaining buy-in from executive staff.
While it may not be feasible or prudent for every health system to have an in-house development arm, investments and partnerships with local developers and experienced housing entities such as Enterprise can be a quicker way into the housing market for some. Building trust with local partners can create avenues to share expertise and guide investments to a successful conclusion. Internally, hospitals should look toward building the capacity and expertise to manage complex real estate projects and understand the competitive funding structures required to fund them. A focus on creating sustainable projects, preserving them when the need comes, creates a long-term trust with the community and housing partnerships.

Housing is Health - Portland, Oregon

In 2016, six Portland healthcare providers revealed plans to invest $21.5 million in affordable and supportive housing for Portland's homeless population. The initiative, called Housing is Health, attracted additional funding from other sources, including state and local agencies and private investors such as Kaiser Permanente Northwest. The project benefited from additional investment from Medicaid under Section 1115.

The project proposed three buildings that were designed with specific populations in mind. The first included 51 units for families in North Portland, where gentrification has displaced many residents as rent prices have soared over the last decade. The second provides 153 units of permanent housing for individuals leaving transitional housing, such as halfway homes and rehab centers. Finally, the third provides 175 units for medically vulnerable individuals. This third building—the Ed Blackburn Center—includes "a primary care health clinic, treatment for substance abuse and mental health issues, and an employment office," (Tuller, 2019).

The focus on rehabilitating individuals with substance abuse and mental health issues is at the heart of Housing is Health's mission. According to Dr. Rachel Solotaroff, who ran the Portland nonprofit Central City Concern's medical services, "[one can't] simply … be attended to someone's health without housing that is grounded in community, particularly for people who are low-income, have trauma, have substance abuse disorders. … [T]o live in an environment where there is social connectedness is a good thing," (Tuller, 2016).

However, several challenges persist. Portland, a city with a significant homeless population, has struggled to combat homelessness in recent years. In 2017, as many as 1,600 people were sleeping outside, in a vehicle, or in a tent (Tuller, 2016). Many homeless individuals are unable to secure housing due to past criminal convictions. Likewise, even in scenarios where a homeless individual has secured housing in an affordable unit, rent is often a significant portion of their income. According to Tuller (2016), one woman who was able to secure housing receives $771 a month in federal disability. However, her apartment costs $505 a month, leaving her with little money to address other needs. Despite a price that is affordable compared to Portland, significant costs may limit the efficacy of the Housing is Health program as the people that the initiative is intended to benefit still struggle with recurring obstacles.

SECTION SIX

Hospital and Afforable Housing Policy Implications and Recommendations

Challenges

While the findings from the national and New Jersey case studies, along with the interviews with key decision makers and stakeholders, gave a glimpse of best practices for hospitals to approach the market of affordable housing, it also showed a glimpse of challenges that these types of programs may face. Besides the inherent difficulty of doing affordable housing, the primary challenge found was the gap of knowledge most hospitals have in the real estate arena. A common theme among these case studies was at the beginning of each affordable housing project, the scale of the endeavor became an intimidating force. Without a proper guide into the real estate market, there was a large challenge ahead facing hospitals regarding knowledge. There were many conceptual gaps to get over that would require some understandable hand holding. Applying for tax credits, working through the Qualified Allocation Plan (QAP), securing construction and permanent financing and more are not areas that hospitals are used to working in. Jonathan Cortell, from L&M Development Partners, the lead developer in the Newark University Hospital project, shared that partnering with hospitals shared that affordable housing was a new world for hospitals and that educating them was a challenge. Development is inherently complex and affordable housing with a healthcare component was exponentially challenging.

Related, another important challenge to address is that of staffing. To begin a program such as this a staff is needed with enough time and resources dedicated to delving further into affordable housing. Financing the capital-intensive housing program along with paying the staff salaries may pose a problem, as a dedicated staff, large enough to handle all the duties involved with an affordable housing program, is a very expensive undertaking. Financing overall becomes a larger issue as there needs to be enough buy- in by hospitals to this program for it to work. The budget for the affordable housing program must be sufficient to launch the project; too small a budget won't lead to a worthwhile long-term investment.

Another challenge involves working with the local community, a prerequisite for successfully doing affordable housing. This begs the question of who speaks for and represents the community. Bloustein studio interviews with key stakeholders and decision makers in the examined case studies highlighted that some community partners were not fully speaking for the community they were representing and working for. An equity issue was also raised due to this representation challenge.

Response

Exploring these case studies highlighted the different approaches the hospitals and developers are starting to take to address the various challenges outlined above. To address the financial hurdles, the projects pursued a variety of subsidies. The New Jersey projects have sought financing from the New Jersey Mortgage Finance Agency through the new Hospital Partnership Subsidy Loans Program, the Special Needs Housing Partnership Loan Program, and general housing mortgage financing. In all of the case studies in New Jersey and elsewhere the projects sought federal subsidies including the Low-Income Housing Tax Credits and HOME funds administered by states, counties, and cities. In all the cases, the individual participating hospitals invested some of their own money into the projects as well. Further, some municipalities aided affordable housing by granting property tax exemptions or reductions to the developments as was seen in the Newark University Hospital example. More detail on the individual subsidies sought and other potential subsidy options can be found in Exhibit E.

Responding to the challenges of gaps in knowledge, staffing needs and ensuring meaningful representation of the communities in which these projects are located is requiring these projects to continuously adapt. The developers and hospitals have approached the development process as a collaborative, learning experience as each has different expertise valuable to the project. Attempting to address these challenges in fluid ways have allowed ideas for best practices for these types of projects to begin to develop and are explored below.

Recommendations

The responses to the unique challenges faced by each of the health systems create learning opportunities for others looking to expand into affordable housing provision. Some general recommendations can apply to all hospitals, including gaining the support and understanding of the health system's C-suite. Partnering with housing providers or undertaking a development initiative requires dedicated funding, staff support, as well as an open mind and a slight (or more) appetite for risk. It is important that key decision-makers at the hospital are on-board and recognize that such efforts may not be purely financially justified, especially in the short run. However, hospitals need to be incentivized with demonstrated benefits such as comparing costs of quality housing and the burden of "frequent flyers" to the emergency room.

All of the case study hospitals highlighted the importance of local community partners who can advocate for the needs of the community and be a champion for sustainable and curated development. No housing market is quite like the other, even if the distance between them is only a few miles (or less). Having local affordable housing and other partners who understand the project areas economic, housing, and social fabric pave the way for developments that are welcomed and celebrated by community members.

At the federal level, recommendations for policy change include providing Medicare and Medicaid to federal housing voucher recipients. Such policies prioritize and recognize the crucial link between housing and healthcare. These broad stroke recommendations are further detailed below.

Overall Recommendations

1a. Amendments to the Qualified Allocation Plan

The Low-Income Housing Tax Credit (LIHTC) is the most commonly used subsidy for low- income housing development. Each State HFA is responsible for establishing the requirements and policies for the LIHTC program in their state. To facilitate the allocation of the tax credit, each State HFA promulgates a Qualified Allocation Plan (QAP), which details the state's eligibility priorities and criteria for awarding the most desirable tax credits (the 9% LIHTC versus the 4%). Developers seeking the 9% tax credit must submit an application that details how their project meets the criteria of a State QAP. To illustrate, a State QAP may award points for any housing project located within one-half mile of a grocery store, pharmacy, or bank. Developers that submit projects that meet a high number of QAP criteria score a higher number of points and have a greater chance of securing the tax credit.

As the state finance agency for New Jersey, the New Jersey Housing and Mortgage Finance Agency is responsible for administering the LIHTC program in New Jersey. As the total amount of funds available for the tax credit is limited, New Jersey awards credits on a competitive basis. Each year, NJHMFA establishes funding cycles and the amounts of credits available in each cycle. Therefore, an application seeking a tax credit must apply under one of the cycles set forth in

N.J.A.C. 5:80-33.4, 33.5, 33.6, or 33.7. The NJHMFA scores and ranks each application based on its cycle's point system, awarding the credit to the highest-ranking eligible applications. Under New Jersey's most recent QAP, the 2019-2020 QAP, NJHMFA establishes four distinct cycles: a family cycle, a senior cycle, a supportive housing cycle, and a final cycle. The type of project that may apply to each cycle depends on the project's characteristics; for example, non-age restricted units are eligible to apply to the family cycle.

Most relevant to a hospital supportive housing project is the supportive housing cycle. Projects eligible for the supportive housing must contain a minimum of 25% of the project's units set aside for individuals with special needs. Approximately 40% of the credits available in this cycle are made available exclusively to Targeted Urban Municipalities, including Paterson, Newark, and New Brunswick. The maximum allocation available for any one project competing in this cycle is $1.4 million.

The point system for the supportive housing cycle incorporates much of the criteria from the family cycle. This includes awarding points for housing amenities (energy-efficient appliances), community amenities (playgrounds or greenspace), and proximity to important local institutions, such as grocery stores and banks. Likewise, projects located in a Targeted Urban Municipality receive a significant number of points.

The points specific to the supportive housing cycle emphasize access to healthcare and supportive services. Projects that incorporate supportive services that serve their tenants' special needs are given priority. Points are awarded for providing a description of the project's onsite supportive services, including financial management training, budget support, and linkages with local health care prevention services.

Housing projects under the Hospital Partnership Subsidy Program incorporate many of the elements discussed above. However, given the complexity of the QAP, further modifications to the criteria and point system may serve to incentivize similar hospital supportive housing projects. QAP amendments should include awarding more points to projects that match HPSP projects. Specifically, the supportive housing cycle could award points to supportive housing projects with rental assistance from non-governmental sources, as was recommended in a 2020 policy workshop report from the Woodrow Wilson School of Public and International Affairs.

Currently, projects under the HPSP receive the proceeds from the 4% LIHTC, which, unlike the 9% LIHTC, is available as of right. However, alterations to the QAP would allow more developers to take advantage of the 9% tax credit, which has the potential to dramatically change project financing. To illustrate, consider the Barclay Street project in Paterson. Under the project's current financing structure, proceeds from the 4% LIHTC provide $11 million in funding, comprising roughly 40% of the project's total financing. The more competitive 9% credit is intended to provide about 90% of a project's financing; after factoring in the time value of money, this credit provides the funding for roughly 80% of a project's overall financing.

However, it is important to note that the QAP restricts allocation of the 9% credits, limiting the maximum annual amount that a single project can claim to $1,750,000. Taken over 10 years, the 9% credit provides a total of $17,500,000, though after accounting for the time value of money, this figure is closer to $13,000,000. Therefore, out of the $27 million used to finance the Paterson project, the 9% credit only covers approximately half of the project's total financing. In short, the limitations placed on the 9% tax credit hinders large projects from utilizing the funding source to its full potential. Therefore, 4% credits, which do not have a similar annual limit, may be more appropriate for large projects than the 9% credit. As an additional potential change to the QAP, we recommend increasing the amount of annual funding available in the supportive housing cycle, so that developers with larger projects who wish to seek 9% financing may cover more of their costs.

1b. Funding programs available to support all aspects of the project

FHA 221(d)(4) Construction or Rehabilitation Loans

HUD guarantees these loans. They are the multifamily industry's highest-leverage (up to a 90% loan-to-value-ratio or LTV), lowest-cost, non-recourse (the security is the property alone and not the borrower), and fixed-rate loan. The loans are fixed and fully amortizing for 40 years; a four- decade repayment is an exceptionally long provision for repaying a multifamily loan. The 221(d)(4) are interest-only during the construction and provide three additional years of financing at the same fixed rate. HUD loans are entirely asset-based and underwrite the property location, pro forma rents, expenses, supply in that submarket, and the development team. Although it is relatively more costly does to originate upfront and takes longer to close than traditional conventional loans, these drawbacks are more than outweighed by the 221(d)(4)'s considerable benefits of leverage (90% LTV), long repayment term (40 years), interest rate risk mitigation and non-personal recourse.

Other loan considerations include a bonded general contractor (not uncommon for multifamily financing) and a minimum loan amount of $4 million. In practice, most of the 221 (d)(4) loans are much larger ($10 million or more), and there is no maximum loan amount. There is a broad eligibility of the properties and activities that can be financed. The 221(d)(4) loans can be used for construction or substantial rehabilitation of detached, semi-detached, walkup, row, and elevator- type multifamily properties, including market-rate, low to moderate-income, and subsidized multifamily, cooperative housing, and affordable housing properties with at least five units. There is a similar broad swath of eligible borrowers including single-asset, bankruptcy-remote, for-profit, or non-profit entities. Of further note, the 221(d)(4) financing can be combined with LIHTC.

The report mentions the 221(d)(4) HUD financing here because of the many merits of this loan— a "one-stop" combined construction and permanent financing, high leverage, long term, broad property and borrower eligibility, and capacity to be combined with LIHTC. This admittedly reconnaissance case study analysis has not been able to find instances where 221(d)(4) have been used for hospital-connected affordable housing. This financing deserves a second look for such an application.

New Market Tax Credits

The New Market Tax Credits (NMTC), established in 2000, uses tax credits (39% tax credit over 7 years) to attract private investment for economic growth and community development to distressed communities (census tracts with poverty rates at or above 20% or median incomes no more than 80% of the area median). About 40% of the United States in NMTC-investment eligible. Applicants for NMTC allocations are certified as Community Development Entities by the Community Development Financial Institutions Fund. In short, NMTC attracts lower-cost capital in exchange for investors securing credits against their federal tax obligations.

While NMTC is commonly used for commercial real estate investments (e.g. hotels and offices), it is much less often used for housing—but it possibly could be if properly structured. As such, NMTC and other subsidies might creatively be tapped for hospital affordable housing, especially if such a development has a commercial property component, such as a healthcare facility. NMTC for such applications (affordable housing and health care facility combined) might further be made feasible by combining the NMTC subsidy with other aids mentioned already in the recommendations, such as LIHTC and 221(d)(4). The technical basis for these creative multifold applications is further explained below:

> NMTCs cannot be used with purely multifamily properties. There must be at least a 20% commercial property component, i.e., no more than 80% of the property can be residential. This is based on revenue, not square footage. NMTCs cannot be directly mixed with Low Income Housing Tax Credits (LIHTCs), but they can be used in the same project by utilizing a "condominium structure," i.e., by legally separating the commercial and multifamily parts of a building into two distinct ownership entities. Alternatively, a "master-lease" structure may be used, in which the ownership entity leases the commercial part of the structure out to an affiliate company, who subleases it to commercial tenants. These projects, in certain cases, could

be eligible for HUD multifamily financing, such as HUD 221(d)(4) or HUD 223(f) loans, which provide very low interest rates and extremely long (35-40 year), fully amortizing loan terms. (Multifamily Loans & National Housing and Rehabilitation Association, 2020).

Opportunity Zones

These zones are focused on long-term capital investments into low-income rural and urban communities since 2017 as part of the Tax Cuts and Jobs Act. By participating in Qualified Opportunity Funds, the program provides an opportunity for private investors to support investments in distressed communities. Federal taxes on capital gains reinvested in Qualified Opportunity Funds are deferred for investors as per the U.S. Department of Treasury. It is brought to effect if capital gains are reinvested within 180 days of the sale or exchange producing the gains. The Federal Tax Cuts and Job Act states that Opportunity Funds should hold at least 90% of their assets in Qualified Opportunity Zone stock or business property. The tax deferrals extend until December 31, 2026, or an exit from the Qualified Opportunity Fund.

The low-income census tracts with a poverty rate of 20% or a median family income up to 80% of the area median qualify as "Opportunity Zones." Around 169 tracts were nominated and approved by the U.S. Department of the Treasury within two months. In New Jersey, the designated census tracts were selected based on a formula integrating the Municipal Revitalization Index (MRI), which concentrated on key economic indicators such as income, unemployment rate, property values as well as geographic distribution such as access to transit, the value of existing investments encouraged by state programs and incentives.

Very little affordable housing has been financed through Opportunity Zones, for early investors wanted to maximize their returns while reducing risk by doing high-end developments (e. g., upscale hotels and luxury housing). But Opportunity Zones could be used for different applications, such as hospital -related affordable housing. The Bloustein studio has found one such application called Ogden Commons located in Chicago, Illinois. This development (on a site of a now demolished older public housing) is a $200 million mixed-use project involving multiple partners (The Habitat Company, Chicago Housing Authority, Cinespace Chicago Film Studios, and Sinai Health System) on a multi-acre-acre parcel located across from Mt. Sinai Hospital. (Head, 2019) When completed, Ogden Commons will include mixed-income housing (about 350 units) and 120,000 square feet of commercial space, with a portion of the commercial space containing a Mt. Sinai outpatient facility (Koziarz, 2021). Enabling the project is a complex layering of financing including monies from Opportunity Zone investors and LIHTC. In short, the menu of resources that might enable hospital-based affordable housing should include consideration of federal Opportunity Zones combined with other assistance (National Apartment Association & Urbanize Chicago, n.d.).

State Programs–Neighborhood Revitalization Tax Credit Program (NRTC)

NRTC emphasizes fostering the revitalization of New Jersey's distressed neighborhoods. The program provides 100% tax credit to entities against other New Jersey state taxes. It requires providing 60% of tax credit funds for activities related to the development of housing and economic development. Complimentary activities such as providing assistance to small businesses and promoting the integration of mixed-income neighborhoods are encouraged with the remaining balance. A total of $15 million per year is available as tax credits, and the maximum amount per loan application is $985,000.

State Programs–New Jersey Aspire Program

To address the ongoing economic impacts of the COVID-19 pandemic and build a more robust, fairer New Jersey economy, the New Jersey Economic Recovery Act of 2020 creates a package of incentive, financing, and grant programs. The Aspire program supports the development of commercial, mixed-use, and residential real estate projects in New Jersey by providing tax credit awards which are calculated based on the percentage of total project costs with actual percentages dependent on the location of the project and the type of projects (like residential or commercial).

There are a few aspects considered to be eligible for this program. During the application, the developer must show that the redevelopment project is not economically feasible without the incentive award and will be economically viable for the duration of the eligibility period. A project financing gap may exist (which includes a determination by the Authority that the project will generate a reasonable and appropriate return on investment) and that the project is located in a targeted incentive area. The program also expects to show the amount of its contributed capital or equity, which totals at least 10% to 20% of the total development cost for a redevelopment project located in a government-restricted municipality.

To qualify for an incentive award, a residential project must have a total project cost of at least $17,500,000 if located in a municipality with a population greater than $200,000 or of at least $10,000,000 in a municipality with a population less than $200,000 according to the latest Federal decennial census. Alternatively, if it is located in a qualified incentive tract or government- restricted municipality, the total project costs for residential must be at least $ 5,000,000. The eligibility criteria also require that a residential project consisting of new units have at least 20% of the units for occupancy by low-income and moderate-income households with affordability issues.

State Programs–NJ Affordable Housing Trust Fund

Then should say how NRTC, Aspire and NJ Trust Fund—as examples of the many subsidies states offer–could be used for hospital affordable housing programs.

The Affordable Housing Trust Fund provides financial assistance to spur the development of affordable housing in New Jersey. This program currently distributes funds to support affordable rental and housing projects with twenty-five or fewer units. Overall, the program allocates a total of $60 million for these projects, which are reserved for those earning less than 80% AMI (Levinsky, 2020).

Financing is distributed through three funds: the Municipal Settlement Fund, the Neighborhoods Partnerships Fund, and the Innovation Fund (Levinsky, 2020). The Municipal Settlement fund provides financing to help municipalities meet their affordable housing obligations. The Neighborhoods Partnerships Fund provides financing for community development projects that are part of a coordinated state investment projects, including projects under the Neighborhood Preservation Programs, Main Street Program, or Neighborhood Revitalization Tax Credit program. Finally, the Innovation fund provides financing for innovative projects, such as makerhoods and tiny homes.

The programs described above demonstrate New Jersey's continued commitment to affordable housing, particularly under Governor Phil Murphy's administration. As these programs are often designed to provide financing for novel or non-traditional affordable housing plans, hospitals may consider them for additional sources of funding for affordable housing projects in the future.

2. Applying for Medicaid § 1115 Waivers

§ 1115 of the Social Security Act grants the Department of Health and Human Services (HHS) the authority to approve experimental, pilot, or demonstration projects that assist the Department in promoting the goals of the Medicaid program. As these experimental projects are intended to give states additional flexibility in designing health care policies and programs, HHS may waive many of the statutory elements traditionally required under the Social Security Act.

The Center for Medicare and Medicaid Services (CMS) reviews each state proposal on a case-by- case basis, ensuring that the proposed demonstration project aligns with the mission of the Medicaid program. States must provide evidence that a proposed demonstration project is budget neutral with respect to federal funds. In brief, to limit federal exposure to needless expenditures, states must demonstrate that, during the course of a proposed project, Federal Medicaid expenditures will not exceed the estimated Federal spending that would occur without the demonstration.

Demonstration programs are generally approved for a five-year period, which HHS may extend for additional three- or five-year periods. In 2015, HHS implemented a fast-track review process for proven demonstration programs; under this fast-track review, demonstration programs without substantial changes are granted extensions without needing to repeat the lengthy review process. California, Colorado, and Oregon used § 1115 waivers to address patient social needs, providing additional support for health and social service partnerships and providing greater flexibility to fund social interventions (Alderwick, Hood-Ronick, & Gottlieb, 2019). In Oregon and California, community health workers sought to connect patients with health and social services, providing the most intensive care coordination for highly vulnerable groups, such as people experiencing homelessness or those recently discharged from a jail or prison (Alderwick, Hood-Ronick, & Gottlieb, 2019).

Most significantly, these demonstration programs have provided a substantial investment in housing. One rural coordinated care organization in a rural Oregon county used its Medicaid savings to develop twenty tiny homes for its homeless population. Likewise, several counties in California used § 1115 funding to invest in "medical respite facilities for homeless patients, on- site supportive housing services, and tenancy-sustaining services—such as helping residents manage their money and shop for groceries," (Alderwick, Hood-Ronick, & Gottlieb). Many other states, including Utah, have submitted similar supportive housing proposals.

Given the novel and experimental nature of hospital supportive housing programs, many states hoping to implement or expand such programs may benefit from the § 1115 waiver.

3. Expanding the Definition of Special Needs

The New Jersey Special Needs Housing Subsidy Loan Program (SNHSLP) provides financing for projects that create permanent and affordable supportive housing or residences for individuals with special needs. For the purposes of the SNHSLP, individuals with special needs include individuals with mental illness, individuals with physical or developmental disabilities, victims of domestic violence, homeless individuals or families, disabled or homeless veterans, individuals with HIV or AIDS, or individuals in treatment for substance abuse. Additionally, State agencies may elect to recognize individuals in other emerging special needs groups as individuals with special needs under the SNHSLP. Currently, frequent users of hospital emergency care services are not considered individuals with special needs. Many frequent users have special needs that are recognized under the Program. If frequent users of emergency services do not further have to demonstrate that they have special needs, hospitals have the flexibility to design affordable housing projects with this target population in mind.

4. Community Health Needs Assessment

The Affordable Care Act developed the Community Health Needs Assessment (CHNA) as a way to require non-profit hospitals to engage in community benefit efforts that key health needs in the community. As the program enters its 12th year, there are opportunities to transform the CHNA in ways that will encourage more non-profit hospitals to address affordable housing as a key community health need. As of now, a vast majority of CHNAs focus primarily on direct health issues in the community such as substance abuse, diabetes, and heart disease (Atlantic Health 2021). With the growing body of research into the impact of housing on health, this report aims to encourage more hospitals to look beyond just direct health intervention in their CHNA. Healthcare institutions with experience in community investment have already seen the role the CHNA can play in affordable housing. As George Kleb, the Executive Director of Bon Secours Community Works, stated

> When you do a community health needs assessment and housing keeps popping up, you're actually required to either address it in some way or justify why you're not...Even if you're not oriented towards providing housing or any of these programs, if you're just looking at it as a

> barrier to access the care, you're going to want somebody taking care of that (as cited in Perna, 2021).

There is opportunity for the Affordable Care Act and CHNAs to serve a similar role as the Community Reinvestment Act (CRA) and its role in pushing banks to invest into the communities they are chartered to do business in. A 2003 study by the St. Louis Federal Reserve Bank found that census tracts with CRA activity had "lower vacancy rates, higher homeownership rates and higher growth in owner-occupied units" when compared to tracts without CRA activity (Bostic & Robinson, 2003). With proper guidelines, the CHNA can have a similar impact on housing through hospital investment as the CRA had through bank investment. This section will first breakdown the requirements of the CHNA and other elements of the Affordable Care Act and pinpoint areas where affordable housing can play a larger role. To conclude, there is discussion of an example of a CHNA that has incorporated affordable housing in the past and highlighted key components that can become standard within the CHNA moving forward.

CHNA Requirements

The current CHNA has the following requirements for non-profit hospitals under IRS section 501(r)(3) in order to maintain their tax exemption 501(c)(3) non-profit status. The hospital must complete five steps to successfully complete a CHNA. First, define the community it serves. Second, assess the health needs of that community. Third, solicit input from "persons who represent the broad interests of that community" including health experts (IRS, n.d.). Fourth, develop and document a written report. Fifth, make the report available publicly. This report recommends incorporation of affordable housing in four out of the five steps.

For step one, this report recommends the explicit incorporation of social determinants of health as part of the definition of the community being served. This would require hospitals to identify key demographic and community data related to the social determinants of health. While many of the CHNAs reviewed state that they have identified data on social determinants of health, few go in- depth into the various determinants' data unless deemed important for the specific priority. By explicitly requiring specific data for each social determinant that must be shared, CHNA will not only highlight potential issues in the community but allow for easier comparison and analysis between non-profit hospitals. For affordable housing, a hospital would look at key housing data in the community and identify the percentage of the population that falls under a standard such as those under 80%, 50%, and 30% of the area median income (AMI). Through this process, hospitals will be required to look beyond direct health statistics in their community assessment and recognize other key issues in the community that are negatively impacting health.

Once the community and its social determinants of health status has been defined, the hospital must next assess the health needs of the community. In a typical CHNA that prioritizes direct health intervention, the assessment of needs will focus predominantly on developing behavioral health programs, supporting non-profit organizations that are mission-aligned, and identifying at- risk

populations that can then be connected to existing care programs (Atlantic Health, 2021). In a CHNA that seeks to address affordable housing and other social determinants of health, this section would first address the impact of identified issues like unstable housing on a person's health. Providing data on the increased Emergency Room visits, lower average lifespan, and other health implications of unstable housing will show the importance of why a hospital would choose to get involved in affordable housing. This section will play a vital role in normalizing the intersection between housing and health.

The third step in the CHNA requires the solicitation of input from both representatives of the broader community and health experts. In several of the examples reviewed for this section, hospitals will highlight survey data to show community input based on "what [community members] perceive to be the most urgent matters in their community" (RWJUH Somerset, 2021). For this section, the CHNA can include identified non-profit and community organizations with missions aligned to one or more social determinants of health in the community. Specifically for housing, this would require hospitals to get feedback from organizations committed to affordable housing such as the city housing authority, CDCs, and housing justice organizations. Surveys provided to the community would need to explicitly ask questions regarding social determinants of health to gauge community concern for each. By including a targeted approach to community and expert input when it comes to affordable housing needs, the CHNA will provide a comprehensive look at the housing need in the community that may not be accessible without the hospital's role as a community anchor institution.

Lastly, the final step of the CHNA process requires hospitals to make their report publicly available. To encourage affordable housing investment, an additional requirement could be for the CHNA report to be directly shared with the housing organizations identified in step three. Beyond sharing the required report, the CHNA can require a community presentation with an identified community organization. This presentation would allow for direct distribution of the report that may otherwise be missed by community members and allow for immediate feedback from the community that report is addressing.

Case Study – Robert Wood Johnson University Hospital – Somerset County

An example of a CHNA that can serve as a model for future CHNA requirements comes from Robert Wood Johnson University Hospital (RWJUH) and their 2021 CHNA for Somerset County, New Jersey done in collaboration with the Healthier Somerset Coalition (RWJUH Somerset, 2021). The assessment stands out as one of the longest CHNA reports at over 250 pages. Additionally, the CHNA's primary method for determining community need was "through a social determinants of health framework" and goes in-depth with the various categories of each identified social determinant (RWJUH Somerset, 2021). This section looks specifically at the sections RWJUH dedicates to housing and how it can be used as a framework for future CHNA's including housing.

The CHNA begins with a look at the findings of community surveys as they relate to each of the social determinants of health. For housing specifically, RWJUH found that "the high cost of housing and lack of affordable housing was a frequent theme" amongst respondents (RWJUH Somerset, 2021). This survey finding is backed with data and graphs that not only highlight the concern of affordable housing, but who in particular is most concerned such as those who are lower-income, immigrants, and people of color. The assessment next provides a comprehensive look at what respondents felt were their "top health issues or concerns in the community" and found that housing was tied for fourth at 11.4% of respondents believing it to be a top concern (RWJUH Somerset, 2021). Here is a comparative look at not just social determinants of health, but direct health issues like substance abuse and obesity as well. Even when incorporated with those various categories, housing remained a priority for community members.

Housing is next mentioned in the section titled "Community Vision and Suggestions for the Future" where community members and public health experts provided "suggestions for future programs, services and initiatives" (RWJUH Somerset, 2021). For housing, respondents spoke of the need for more affordable housing frequently as well as the need to address the issues the COVID-19 pandemic has had on housing affordability. While no direct strategies were provided, the need for affordable housing was clear. What may have made this section more substantial would have been the incorporation of insight from housing experts in the Somerset community to provide more concrete suggestions for future programs.

The report continues to provide key demographic information related to housing including "households whose housing costs are 25%+ of Household Income" which is provided not just for Somerset County but all other counties as well as New Jersey as a whole to see how the county compares. RWJUH also includes data provided by the NJHMFA specifically for Somerset County regarding homelessness. But this report goes beyond simply sharing data, it goes in-depth into the meaning of concepts that may be complicated for those not familiar with housing or public (RWJUH Somerset, 2021).

5. Improving Anchor Institution Participation

Anchor Institutions are defined as place-based mission-driven entities, such as hospitals, universities, and government agencies that have the power to leverage their economic strengths alongside their human and intellectual capital to benefit the health and social welfare of their neighboring communities for a sustainable long-term duration (UCSF, 2019). Hospitals are key institutional agencies according to this concept as they understand the role of affordable housing as a social determinant of health.

Apart from boosting the local economy and providing jobs for the community, healthcare anchor institutions can do more by becoming active civic participants in improving health and well-being in their surroundings (Maurrasse, 2016). According to Maurrasse (2016), hospitals should lean into their status as anchor institutions and:

- create meaningful partnerships with local city economic development corporations to provide small-business training and providing space for community development meetings
- provide below-market-rate loans for incubating new businesses
- purchase and support local produce for hospital canteen and supplies
- invest in job training for individuals in the community for entry-level and healthcare job opportunities
- strengthen the community by building partnerships with community developers to provide housing, education, jobs, and basic livelihood for the neighborhood

There is evidence from the above findings that housing is an important element of sustainable and affordable healthcare but thorough research and cost analysis can help incentivize smaller healthcare institutions to realize that the overall expense of developing quality housing can significantly lower the cost of covering 'frequent flyers' in the emergency department. A study in this direction by Koh et al. (2020) highlights the benefits of the 2010 Affordable Care Act (ACA) in promoting hospitals to offer community services in exchange for expanding its services and undertaking large capital projects.This also allows hospitals to receive significant federal tax exemptions to perform a community health needs assessment and establish a plan to address these issues. State-level finance agencies have already set their intentions to build in urban centers and not in isolation from such institutions. This increases community engagement and promotes healthier cities. States should also encourage sponsors to have the capital to improve housing in these centers which can thereby benefit the neighborhood as a whole.

In addition to state-level involvement, progress was achieved through training and educating hospital-administration about the benefits of the program and what a partnership would look like at University Hospital, Newark. Jonathan Cortell, managing director of L+M Development Partners, said that the strategy was to always collaborate with existing institutions that are well- established in the community. The exchange of success in such partnerships can encourage other anchor institution investments. In an interview with Robin Hacke from the Center for Community Investment, she suggested that successful

projects are linked to those institutions that have the least reservations about orienting themselves to improving community health as a key mission.

Anchor Institutions are not limited to hospitals. The University of California San Francisco (UCSF) Anchor Institution Initiative seeks to advance health equity in under-resourced communities through workforce development, procurement, and community investments. Universities also have a significant role in influencing social, cultural, and economic well-being of an area as a place-based economic power with human and intellectual capital to address the social determinants of health. Through local hiring, collaborations with community partners and stakeholders, providing education pathways for those who cannot afford it, connecting with local businesses, and working with the state to promote affordable housing are a few of the many ways in which universities can indulge in community investments. University housing in the form of dormitories and apartments for students at an affordable price ensures less competition for the off- campus housing market. This secures the demand of the local community since students are temporary residents who are willing to share a household with several occupants and pay higher prices thereby increasing the value of homes in the neighborhood. With the development of affordable housing, universities can also house their staff and community members.

Areas that lack big institutions such as universities and hospitals are still surrounded by smaller anchor institutions. Schools, religious institutions, and major corporations foster relationships with their community members with initiatives to promote physical and cognitive well-being. These initiatives range from day care, youth services, mental health services, after-hour cultural and recreation programs, sports programs, and financial incentives for promoting healthcare and education from major corporations.

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STUDIO STUDENT BIOGRAPHIES

Tristan Gibson, MPP 2022. Tristan Gibson is a second-year Master of Public Policy student at the Edward J. Bloustein School of Planning and Public Policy at Rutgers—New Brunswick, with a concentration in health advocacy. Tristan has had a mix of professional experiences during his professional tenure in both the community development and healthcare sectors. His most recent experience has been in the Office of Medicaid Innovation in the New Jersey Department of Human Services where he is working on the integration of Medicaid and housing. Tristan seeks to use his knowledge to create sustainable and meaningful solutions that ensure all populations have access to high-quality, equitable healthcare and the ability to live in affordable, vibrant neighborhoods. Tristan holds a Bachelor of Science in Public Health and Communication Studies from The College of New Jersey.

David Glaze, MCRP 2022. David Glaze is a second year M.C.R.P. student at the Bloustein School of Planning and Public Policy, concentrating on Development and Redevelopment. He is interested in the interaction between planning and law, particularly as it relates to land use administration and regulation. Prior to attending Bloustein, David earned a J.D. from Cornell Law School in 2019, where he was an Articles Editor for the Cornell International Law Journal. During law school, he interned for the New York Attorney General's Office in Syracuse and the Environmental Protection Agency in Chicago. He also holds a B.A. in Experimental Psychology from the University of South Carolina.

Surya Jacob, MCRP 2022. Surya Jacob is a second-year Master of City and Regional Planning candidate at the Edward J Bloustein School of Planning and Public Policy, Rutgers University, New Brunswick. She is concentrating in Community Development, focused on Housing, Land and Finance, as well as pursuing the Real Estate Development/ Redevelopment Certification. Prior to Bloustein, she worked as an architect and interior designer in India and Canada for 7 years and is pivoting towards a career in urban planning to engage in more extensive projects with her experience of working at the microlevel on single family homes and multifamily residential projects. Her interests include affordable & mixed income housing, urban redevelopment, and housing finance. Surya holds an undergraduate degree in Architecture from R.V. School of Architecture, Bangalore, India.

Hashaam Jamil, MCRP 2022. Hashaam received a Bachelor's degree in Psychology and Sociology from the University of Pittsburgh in 2018. Hashaam spent much of his undergraduate career working for various nonprofits and community organizations where he found a passion for community engagement and empowering the voices of members of underrepresented communities. Upon graduation, Hashaam worked first for Public Allies Pittsburgh, a nonprofit dedicated to empowering local leadership through community engagement and professional development. Returning to New Jersey, Hashaam worked as a Program Manager for Jersey Cares working with volunteers in Essex County Branch Brook Park to care for one of the oldest parks in the country. Hashaam is now pursuing a Master's degree in City and Regional Planning with a concentration in Community Development and Housing.

Zainab Kazmi, MCRP 2022. Zainab Kazmi is second-year City and Regional Planning student at the Edward J. Bloustein School of Planning and Public Policy. She is pursuing a concentration in Housing and Community Development and Redevelopment. Zainab received a BA in Economics at New York University in 2016, with minors in Political Science and Spanish. She is passionate about working within her community and learning about new places with unique strengths and challenges. Zainab works at FHI Studio, a consulting firm in lower Manhattan where she specializes in equitable community engagement practices for short- and long-term neighborhood and city planning projects. She has experience with project management, online engagement practices, meeting facilitation, economic analysis, and engaging minority and Environmental Justice populations. Notably, she was the engagement lead for the City of Bridgeport's POCD, PlanBrigeport which was recognized by the CCAPA in 2019 for its inclusive and extensive community engagement process. Zainab believes that great plans come from engaging all facets of a community to capture the diversity of a place and keep residents and stakeholders engaged beyond the planning process.

Divya Mahadevan, MCRP 2023. Divya Mahadevan is a first-year Master of City and Regional Planning student at the Edward J Bloustein School of Planning and Public Policy at Rutgers – New Brunswick. She is concentrating in Community Development & Housing along with International Development. She received her Bachelors in Architecture from the American University of Sharjah in the United Arab Emirates and worked in the Middle East as an architect for two years. Her passion to engage with the community and build for vulnerable populations stemmed from volunteering in humanitarian projects in Africa, India, and the Middle East. This experience has motivated her to realign her architecture and design practice to international development and planning in the global south. She hopes to work in community redevelopment, affordable housing and design transformation which can easily span across regional and international contexts.

Jesse Nelson, MCRP 2022. Jesse Nelson is a second-year graduate student at the Edward J. Bloustein School of Planning and Public Policy pursuing a Masters in City and Regional Planning (MCRP) concentrating in Environmental and Human Health Planning. He received a BA in Economics from the University of Delaware, graduating in Spring of 2019. He has a passion for sustainability and resiliency paired with finding equitable solutions. In the fall of 2020, he interned at the Jersey City Office of Sustainability helping complete their first ever Climate Action Plan. In the Summer and Fall of 2021 he interned at Rutala Associates, helping with a variety of projects in the Atlantic City region ranging from Municipal Carbon Footprint analyses to grant applications. Along with his internships, Jesse works part-time for the non-profit organization 3GNY - Descendants of Holocaust Survivors where he helps run their speaker training program designed to train grandchildren of Holocaust survivors to best tell their grandparent's story of survival in a suitable manner for a classroom.

Amanda O'Lear, MCRP 2022. Amanda O'Lear is a second-year graduate student in the Rutgers University Edward J. Bloustein School's Master of City and Regional Planning program, concentrating in Land Use and pursuing the Coastal Climate Risk and Resilience graduate certificate. Over the past year, Amanda worked at the New Jersey Climate Change Resource Center housed at Rutgers University and is a Fellow for the New York City Panel on Climate Change. Amanda's interests include pursuing innovative strategies for coastal climate adaptation and resilience, environmental justice, and furthering affordable housing efforts. She holds a Bachelor of Arts in Environmental Studies and Geography from the University of Connecticut.

Harrison Pippin, MCRP 2022. Harrison Pippin is a second-year Master of City and Regional Planning candidate at Edward J Bloustein School of Planning and Public Policy, Rutgers University, New Brunswick. He is concentrating in Community Development and Housing. During his time at Bloustein he has had the opportunity to work professionally in land use planning, community development finance, and transportation planning research. He holds a Bachelor of Arts in Environmental Studies and Sociology from Randolph College in Lynchburg, Virginia.

APPENDIX A – OVERVIEW OF HOSPITAL AFFORDABLE HOUSING PROJECTS TO DATE

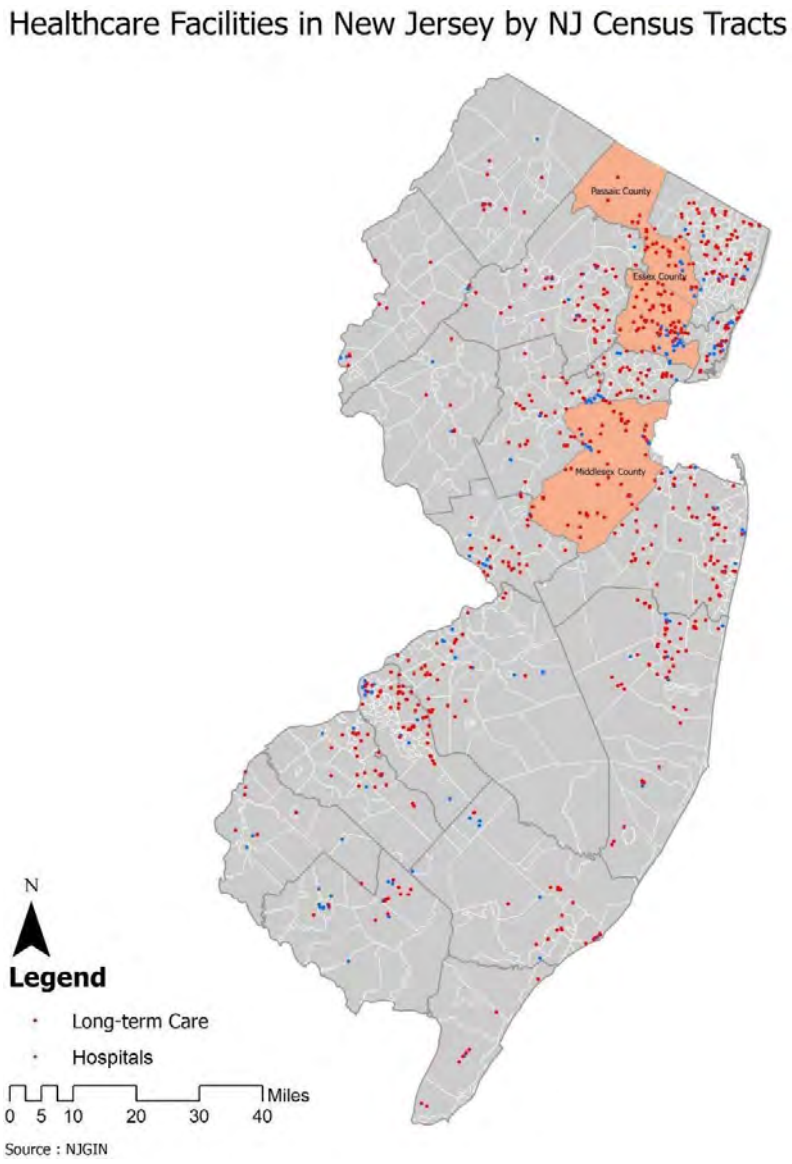
New Jersey HPSP				
LOCATION	PARTICIPANTS	HOUSING PROFILE	FUNDS	HEALTH SERVICE PROFILE
New Jersey (Newark - Bergen Street)	Newark Beth Israel Medical Center, Pennrose, LLC, RWJBarnabas Health	Six-story building with 65 to 70 apartments	• $3.04 million in mortgage financing from NJHMFA • $9.5 million total funding • 4% LIHTC The organizations have proposed the $25.7 million development under the state's Hospital Partnership Subsidy Program	
New Jersey (Newark - Fairmont)	University Hospital, L+M Development Partners Type A Projects, MSquared	78 affordable rental apartments 16 supportive housing units reserved for homeless individuals and families	• $32.9 million total funding • 4% LIHTC • Additional tax abatement from Newark	Planned to have an 8,000-square-foot clinical space. Project must also include 10-15 units set aside for individuals identified by the hospital as frequent users of its services and must offer supportive services to them and other residents.
New Jersey (Paterson)	St. Joseph's Health, New Jersey Community Development Corporation	70-unit development on a vacant lot about 300 yards from the hospital	• $23.2 million total funding • 4% LIHTC	

AIHC (Accelerating Investments for Healthy Communities)				
LOCATION	PARTICIPANTS	HOUSING PROFILE	FUNDS	HEALTH SERVICE PROFILE
Maryland - Baltimore (West)	Bon Secours Mercy Health, Center for Community Investment, Healthcare Anchor Network	802 units (completed as of 2019) affordable 58-unit building (proposed for future) Renovating row houses and schools, as well as new construction	• $70 million towards Social Determinants Of Health Investment	
Maryland (Purple Line Corridor in Prince George's County and Montgomery County)	Kaiser Permante, JP Morgan Chase, East Bay Community Foundation, NHT, Enterprise Community Partners and the University of Maryland National Center for Smart Growth	Seeks to maintain the 17,000 homes within one mile of the Purple Line corridor For individuals with incomes at 60% or less of area median income	• $5 million investment in a loan fund that supports the preservation and production of affordable housing	Mission to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.
Massachusetts-Boston (Roxbury) (Dudley Square) (Codman Square)	Boston Medical Center	323 units of affordable and market-rate housing Mixed-use development with Good Food Markets supermarket. Rehabilitate 35 units of Codman Square NDC's supportive housing. Unit upgrades at Boston Housing Authority (BHA) properties to better meet tenants' health needs.	• $10.98 million total funding	
Ohio (Linden) (South Side)	Nationwide Children's Hospital, Healthy Neighborhoods Healthy Families initiative, City of Columbus Land Bank.	17 new affordable rental housing units and rehabilitating three others. Invested in the transformation of over 350 vacant and abandoned properties Rents will range between $725 and $850	• Linden Healthy Homes Fund is a $4.2 million effort	
Pennsylvania - Pittsburgh (Highland Park) (Hazelwood)	UPMC, Neighborhood Allies, Bridgeway Capital	117 total affordable units in Highland Park and Hazelwood.	• $7.95 million affordable housing loan fund	
San Francisco (Arrowhead Grove)	Dignity Health	400 units of affordable housing proposed Leverage more than $20 million for the Arrowhead Grove Neighborhood Revitalization project	• $20 million on local projects • Provided a $1.2 million bridge loan to help fill a funding gap in the development of the Arrowhead Grove Neighborhood Revitalization project	Taking steps to help homeless people find housing to limit unnecessary ER visits and reduce wasteful health care spending.

Other				
LOCATION	PARTICIPANTS	HOUSING PROFILE	FUNDS	HEALTH SERVICE PROFILE
Oregon (Portland)	Providence, (Adventist Heath Portland, Kaiser Permanente Northwest, and Legacy Health)	Three buildings with a total of almost 400 living units for homeless people 382 housing units in three apartment complexes in strategically targeted areas of the city	• Five hospital systems invested in a $21.5 million project	One site will include a medical clinic for people with mental illness and drug addiction along with additional hospital-style housing for homeless people who are dying, recovering from serious illness or surgery, or transitioning from a mental health crisis.
California (Northern California - Sacremento)	Sutter Health		• $30 million campaign to try to end homelessness in three Sacramento-area counties	
Colorado	Centura Health's Mercy Regional Medical Center has partnered with Housing Solutions	Prioritize housing vouchers for frequent users of the emergency room.		Many had diabetes and depended on insulin — which needs refrigeration. Kidney failure was one of the most costly diagnoses for the hospital.
Denver	Denver Health, Denver housing Authority	Repurpose a mothballed building on the hospital campus into affordable senior housing Including 15 apartments designated to help homeless patients transition out of the hospital.		
Florida (Central Florida)	Florida Hospital		• Donate up to $6 million over the next three years to address homelessness in Central Florida	
Illinois (Chicago)	Mount Sinai Hospital	Including 300 multifamily mixed-income housing units 30,000 square feet commercial development	• $20 million total development • LITHC funding • Opportunity Zones	
Michigan	Trinity Health		• $80 million Transforming Communities Initiative.	The health system aims to leverage existing resources and serve as a long-term partner by offering capital and other support to promote efforts related to reducing teen smoking and obesity.
Ohio (Cleveland)	MetroHealth	Building 250 affordable housing units with expanded green space and community programs such as an economic opportunity center	• $60 million investment	

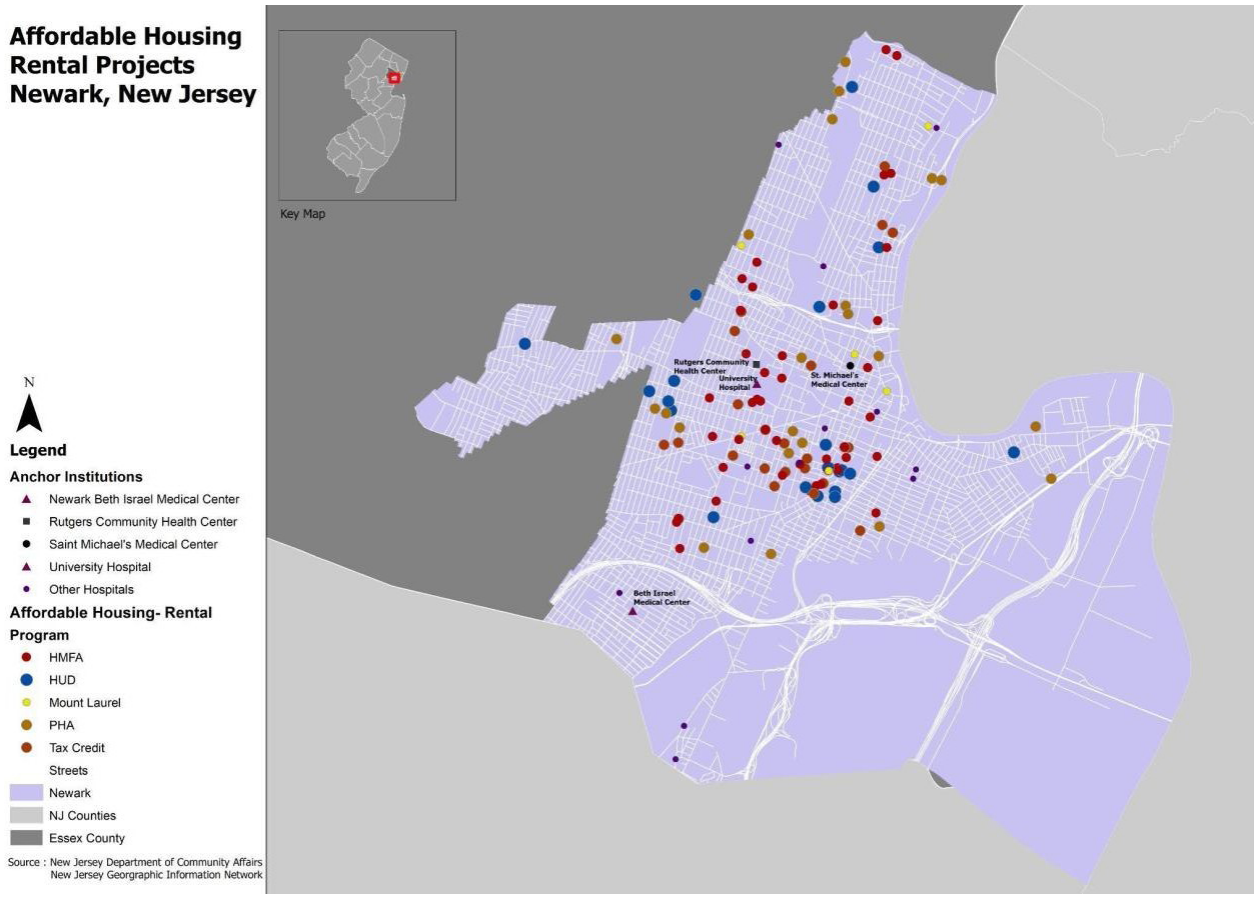
APPENDIX B – PILOT GIS HEALTHCARE AND HOUSING ANALYSIS

Exhibit B.1 : Locating hospitals and long term care in New Jersey



New Jersey is home to 113 hospitals and 71 acute care hospitals. There are 13 hospitals in Essex County serving a population of 800,401 people in an area of 127 sq.miles., and 4 in Passaic County. There is 1 Hospital per 61,569 people and 1 hospital per 9 sq. miles (Hospitals in Essex County, n.d.).

Exhibit B.2 : Affordable Housing Rental Projects by program in Newark



The are 49 projects by HMFA, 21 by HUD Projects, 7 by Mount Laurel, 26 by PHA, and 24 by tax credits.

Exhibit B.3: Spatial Examination of Population Trends - University Hospital, Newark by Census Tracts

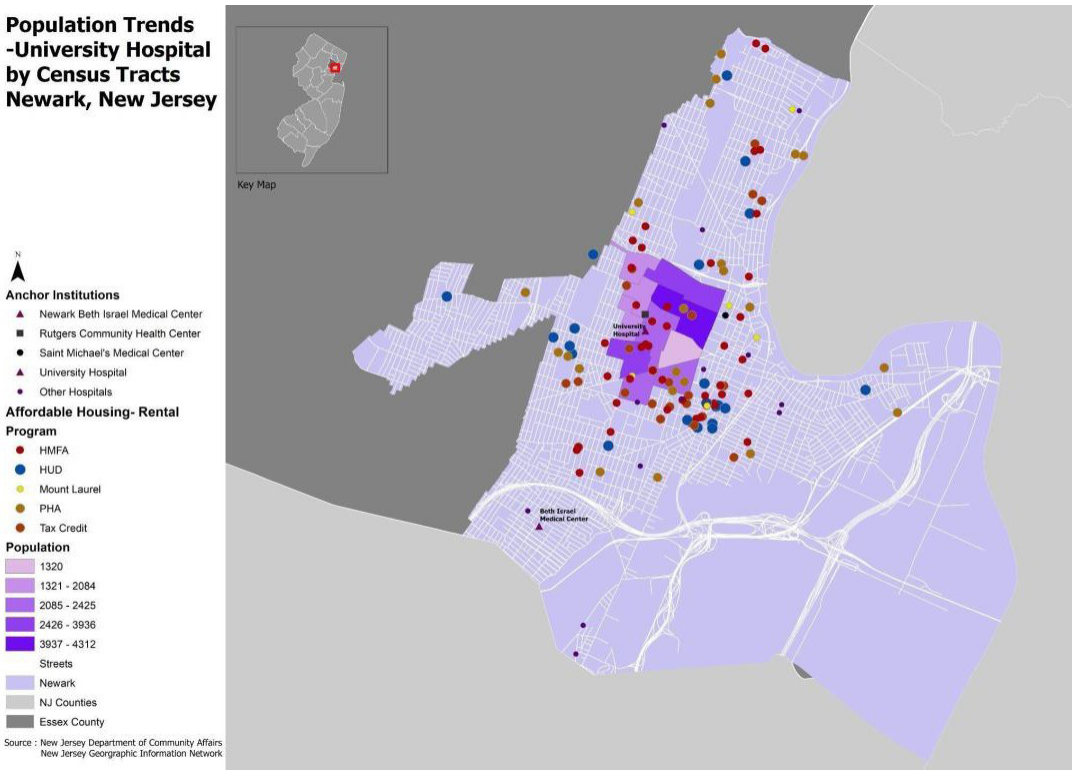


Exhibit B.4: Unemployment and Poverty Rates - University Hospital

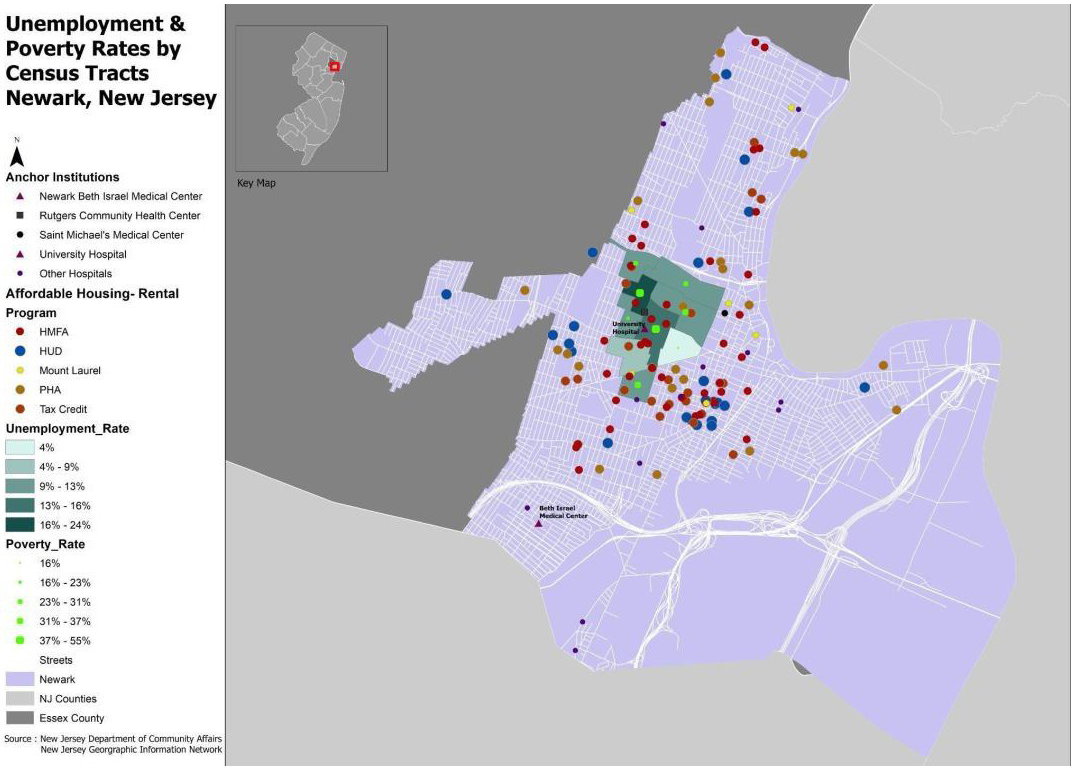


Exhibit B.5: Median Household Income - University Hospital

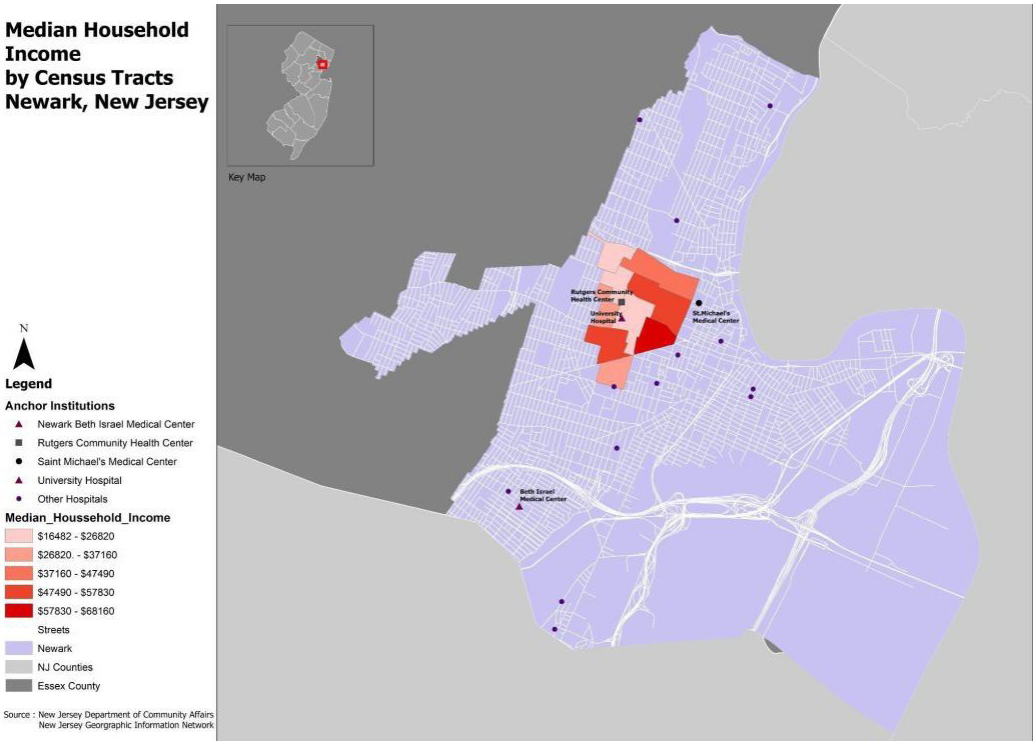


Exhibit B.6: Health Conditions - University Hospital

Exhibit B.7: Health Conditions - University Hospital

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This report, Health, Hospitals and Affordable Housing: National and New Jersey Perspectives, was produced by students as part of a graduate-level studio course at Rutgers University's Edward J. Bloustein School and Planning and Public Policy.. For questions about the content of the report, please contact Dr. David Listokin, Distinguished Professor and studio director, at (848) 932-2374 or listokin@rutgers.edu.