a less-threatening position than facing him directly, Perri noted.

After a brief conversation, Palka shook the man’s hand as a promise to return with some dry clothes, perhaps a sleeping bag, to replace belongings soaked by the rain that pummeled Pittsburgh earlier in the week.

“We meet them where they are, but we don’t leave them where they are,” Palka said.

“We Remember”
Withers and his colleagues savor their successes but never forget their losses.

Operation Safety Net created a memorial wall of bronze plaques beneath a highway overpass in downtown Pittsburgh. It commemorates individuals known to have died since 1989 while homeless in Allegheny County.

“We remember” tops each plaque, which also notes the year in which the person died. Most feature the individual’s full name, sometimes with their street name, but some bear only their street name, such as “Sarge” and “Angel.” Some plaques bear no name, just “unknown,” the individual’s identity lost forever on the streets.

“We believe you are no longer cold, hungry, lonely or frightened,” reads the large plaque above the smaller individual plaques. “May you watch over us from a warm, caring home above.”

Each year on December 21, which is National Homeless Persons Memorial Day, the appropriate role of health care in addressing needs of patients to entire neighborhoods. A second strategy focuses on creating new incentives for health care organizations to invest in community needs. Current underinvestment stems partly from uncertainty about the size of potential returns, the appropriate role of health care in

Focus on Neighborhoods
What will it take to motivate action on place-based health? Several emerging strategies hold promise.

First, health systems should consider focusing interventions not only on high-risk individuals, but also on high-risk neighborhoods. “Hot-spotting” neighborhoods offers an opportunity to invest limited resources in ways that have spillover effects beyond individual-level quality improvements.

The Cincinnati Children’s Hospital Medical Center recently piloted such an approach. In 2015, the medical center identified 2 neighborhoods in Cincinnati with high levels of preventable health care use, housing instability, and food insecurity with the goal of reducing inpatient bed days among children with asthma. It introduced a comprehensive program that included outreach to children to ensure they had their medications; a transitional care team to address medical and social needs as patients were leaving the hospital; partnerships with local schools, law firms, and community organizations to address issues such as housing rights and hand hygiene; and presentations at community meetings and building complexes. The initiative reduced hospitalizations in the 2 intervention neighborhoods by 20% and the monthly inpatient bed-day rate by 18%. No such reduction was found in matched control neighborhoods. Based on this experience, the medical center is extending its social-needs screening beyond individual patients to entire neighborhoods.

Creating Incentives
A second strategy focuses on creating new incentives for health care organizations to invest in community needs. Current underinvestment stems partly from uncertainty about the size of potential returns, the appropriate role of health care in
place-based investments, and whether returns will accrue to the investing organization or elsewhere (for example, a patient may change health plans before benefits are realized). One innovative proposal, known as the Collaborative Approach to Public Good Investments (CAPGI), has been advanced by researchers at George Mason University and Harvard Business School.

Consider the example of patients at risk of missing medical appointments because they lack access to reliable transportation. Many patients, especially those with mobility challenges, would benefit from greater community investment in nonemergency transportation services, but payers and health systems are unlikely to make such investments without the possibility of financial reward. The CAPGI model would enlist a trusted, independent broker (such as the Transportation Research Board) to convene stakeholders and develop estimates of how many patients are affected, the expense associated with adding new transportation services, and the initial and downstream costs of missed visits and poorly managed chronic conditions. Each payer and health system would then invest resources, based on its local market share, for an independent community organization to expand transportation services. (In this example, payers may also be subject to an additional tax to offset losses that health systems may incur. Although payers are likely to benefit from reduced use of acute care services, health systems, depending on their payer mix, may not.) Any eventual savings are pooled and distributed, with the notion that self-interest in recouping returns may drive initial investments.

**Social Impact Bonds**

A third strategy features social impact bonds, which are increasingly being used to finance interventions addressing community needs. Social impact bonds bring together local governments, social service organizations, and investors to improve a clearly defined social outcome with the rate of return dictated by how effectively the pre-specified outcome is achieved.

The first such bond was launched in England in 2010 to reduce recidivism rates for incarcerated individuals leaving Peterborough Prison. The program reduced recidivism rates by 9%, exceeding the 7.5% target set by the Ministry of Justice, and investors received a 3% annual rate of return. Social impact bonds have since been rapidly introduced around the world, with nearly 140 bonds in more than 2 dozen countries. A social impact bond in California, for example, has raised capital to reduce childhood asthma hospitalizations, and a similar effort in South Carolina aims to reduce infant mortality rates. Evaluation of these programs is ongoing, but social impact bonds have now raised more than $200 million to improve health and social outcomes in the United States.

Merging capital and community health promotion can also be accomplished through new applications of existing federal regulations. Banks and hospitals, for example, are required to invest in their communities to maintain a certain regulatory status. The Community Reinvestment Act requires banks to meet the credit needs of the local community, and in 2016, new regulatory guidance expanded such “community development” to include health-promoting activities. Although hospitals have long provided charity care, the Affordable Care Act introduced additional community benefit requirements to maintain their nonprofit status. In a recent example, Community Reinvestment Act funding from banks was blended with health system financing in Toledo, Ohio, to make cooperative, neighborhood-based, health-promoting investments, such as in affordable housing.

**Relocation Assistance**

Finally, research suggests that providing low-income families with vouchers to relocate from high-poverty to low-poverty areas can improve health outcomes. Robust evidence comes from the Moving to Opportunity experiment, through which the Department of Housing and Urban Development randomly assigned low-income families to receive housing vouchers to move to a better neighborhood. Research has found that the program had positive health effects for those given the opportunity to move, including better physical health (such as lower rates of obesity and diabetes), better mental health (such as lower rates of anxiety, depression, and behavioral problems), and improved subjective well-being. Programs that provide low-income families with support in addition to vouchers—such as housing search assistance, help engaging landlords, and short-term financial support—can substantially increase the likelihood they are able to move. Recent work has suggested moving effects are significant even later in life: Medicare survivors of Hurricane Katrina who moved to lower-mortality areas experienced lower mortality than those who moved to higher-mortality regions, a finding substantiated by a more general study of Medicare beneficiaries.

Programs like Moving to Opportunity offer important ladders up for low-income families but must be complemented by policies to help create more salutary environments in high-poverty neighborhoods. Doing so takes on new urgency amid rising income inequality and economic segregation. Several approaches—hot-spotting neighborhoods, novel financing models, and relocation vouchers—are emerging as avenues to promote action on place-based health equity.