ANNOUNCER:
Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Dr. Gabriel Kaplan interviews Dr. Douglas Jutte, Executive Director of the Build Healthy Places Network. Together, they discuss the relationship between housing and the physical resources located in the community and the lack of economic opportunity and health.

DR. GABRIEL KAPLAN:
Hello. Today we're speaking with Dr. Doug Jutte, who is the executive director of the Build Healthy Places Network, which is a national organization that catalyzes and supports collaboration across the sectors of community development and health with the goal of increasing investment in low-income neighborhoods, maximizing the health benefits of these investments, and improving health outcomes. Dr. Jutte was previously working as a pediatrician and currently sits on the board of trustees for Mercy Housing, a national nonprofit affordable housing developer, and the board of directors for the Mercy Loan Fund, a national CDFI, and we'll learn more about what those are today in our conversation with him. Dr. Jutte, thank you so much for joining us today. Really appreciate your time.

DR. DOUG JUTTE:
It's great to be here. Thank you for having me.

DR. KAPLAN:
So if you could, can you provide our listeners with a brief overview of the community development world where these funds come from, and why these entities exist and have been created by communities and different levels of government.

DR. JUTTE:
Absolutely. And you know it's interesting, so I didn't know about this whole field, as a pediatrician, as a public health national, and in short what I learned—and I'll tell you a little bit more detail—but this whole sector, this mature industry with thousands of organizations are basically focused on reducing poverty and improving low-income neighborhoods to improve the opportunities for people living there and the insight that I had and that we're working on is that the work that these organizations do is addressing social determinants of health, improving them and thus improving health.

And so there's, a there's a health ROI, a health return on investment, which has made it actually really easy to work across sectors. In short, the commute on the sector really is those—if you ever wonder how grocery store gets built in a low-income neighborhood, or how affordable housing gets built somewhere where there's a housing shortage, or how a charter school gets
built in the neighborhood, it's often these organizations, the community development sector, and these different types of organizations really rose out of the war on poverty back in the '60s.

So most of them date back to the '60s, and the late '80s, early '90s. So they've been around for a long time. And the main players I sort of think of in three different categories. The first are the community development financial institutions—they go by CDFI's. These are effectively nonprofit banks, is the easiest way to think about it. So these are financial institutions that are not only willing, they are by charter required to make investments into neighborhoods that regular banks won't touch.

So they have to invest in low-income neighborhoods and they're particularly skilled at weaving together funding from a variety of sources to make them available at the neighborhood level. The second major group are CDCs, community development corporations. So you can imagine the confusion that arises when you talk about CDCs with the health audiences thinking about a place in Atlanta. But community development corporations are a grassroots, often local neighborhood level organizations that are really on the ground and working with the community— are represented by the community really—that help identify where the needs are.

The amazing thing to me is, there are probably about, at last count around 1,100, maybe even 1,200 CDFIs, these nonprofit banks—1,200 of them across the country. I think there's about over 4,000 CDCs across the country. So they're really in every neighborhood, which I think is an exciting thing as a health person is this is not some type of organization that only exists on the East Coast or only exists on the West Coast, or you know, it's really they're really everywhere. And the third major group are the affordable housing developers, and most of them are nonprofit. There are a few for-profit but, again, mission-driven focused on building affordable housing for low income people and their particular expertise is on housing.

And so you can imagine how the CDFIs that do the financing, the CDCs with their committed local community groups, and the affordable housing developers all kind of intersect and interact around a given effort.

Gabriel, I didn’t say anything about the money. So is that what you wanted to hear, about where the money comes from too or how big this is.

DR. KAPLAN:
Yeah. So if you could tell our audience a little bit about where these funds come from, why these entities exist, and also just mention that governments sort of play a role here.

DR. JUTTE:
Exactly. No, government plays a huge role. So this I think the second striking thing. So first is the sheer number of these organizations and the fact that they've been around for decades and have been very successful in the work that they do. The second is the sheer scale of about 200 billion dollars a year are invested annually into low income through the Community Development registry a lot of this money comes to the federal government in the form of tax credits. So what's interesting about that is it's not in the budget, it's just through the IRS and it engages for-profit companies that are getting tax credits off of their tax bills but provide that money to low-income neighborhood and organizations working in low-income neighborhoods. So for example the Low Income Housing Tax Credit has built the majority, has subsidized the

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majority of affordable housing built over the last 40 years. In addition there’s a new market tax credit, which is used to support small businesses and start businesses in low income neighborhoods.

There’s also the Healthy Food Financing Initiative, which is federal dollars used to build grocery stores in low income neighborhoods and food deserts. And the bulk I guess—so that, that's federal dollars. There's also state-level funding that often mirrors these federal dollars, but the bulk of the money actually comes from for-profit banks, which I think is a surprise to a lot of people. And the for-profit banks have to make these investments in these low-income neighborhoods as a result of legislation called the Community Reinvestment Act. There’s a law passed in the late 70s that was really fully implemented by the late 80s early 90s, and it's specifically an anti-redlining law.

And so there’s a lot of talk recently about redlining as a primary driver of some of the health and wealth disparity that we see in the country, which is absolutely true. But I think something that's sometimes not understood by our colleagues in health is that there has been immense effort to overturn that redlining over the last 30 years through the Community Reinvestment Act. And so banks are required—and they're regulated on this—to demonstrate that they're providing low income loans and other forms of resources, financial resources, into low-income neighborhoods. So that's really the bulk of that 200 billion dollars a year.

DR. KAPLAN:
That's great. You know one of the things that you've mentioned is this issue of redlining and there’s a fabulous display that's actually making its way around the country right now and it's available online which is called redesign the red line and, or, un-design the red line. And it really talks about the impact that redlining had on neighborhoods over the last century and the role unfortunately that the federal government played in really stimulating red—the whole challenge of redlining initially and how the CRA sort of sort of begins efforts to try to roll that back.

I think what's really great about these resources that you've described is one of the things that we really struggle with in public health is where do we find the resources to do this work. And what you're highlighting is that for a lot of our communities there are resources available and that the money that we can bring is really sort of something that can sweeten the pot, and we can play an important role braiding and connecting opportunities and folks who have resources, but people don't need to think that they're going to be challenged with raising the full cost of building a housing development.

But can you give our listeners a sense of the scale of this work and these investments relative to the need and the overall level of finance activity in areas of housing and economic development nationally?

DR. JUTTE:
I think what's more shocking is the scale is, is large. Now arguably it's not large enough because we haven't solved the problem obviously. But I think I think that is in my opinion due to two reasons.
One is even though as I mentioned the, the total dollars, the estimate is somewhere between 200 billion dollars a year and some have said, there was a recent report suggesting maybe as much as 400 billion dollars a year being invested nationally. Trouble is, the scale of the problem is so big that even that amount of money just doesn't touch the, as you said, decades of disinvestment that happened. I think the second problem that it runs into—and this actually is a critical point around the role of public health in supporting or maximizing the impact of these dollars—is that a lot of that money is going in, how should I say—hit and miss. It's not, it's not going in in a systematic way. And what we know from poor health is that health requires sort of everything be functioning simultaneously. So if you just build housing, which is a lot of what the community development sector is focused on over recent decades, mostly because it's a straightforward real estate deal. Housing by itself isn't going to solve chronic problems, it's not going to solve chronic poverty. It is a step in the right direction.

But if the schools are terrible, if there's not a grocery store nearby, if there's not accessible transportation or reasonable jobs nearby—it really doesn't have the impact. In fact, I tell my community development colleagues that it's almost like sprinkling vaccinations over a neighborhood and hoping for the best as opposed to really being thoughtful about what is the order in which you provide these resources, what is the dose that's necessary to provide these resources, and are you giving them at the right time and to the right neighborhood. Not—poverty is not the same in all places.

And so I think there's a real opportunity for the public health sector to help align and coordinate some of these sometimes relatively large-scale available resources that are coming into these low-income neighborhoods that we are unfortunately often unaware of.

DR. KAPLAN:
You know, what you mentioned really resonates with some of the things we've heard so far in this podcast series. You know public health 3.0, we spoke to Karen DeSalvo and she talked in that article about the concept of public health as a convener. And we've also talked with Tony Iton, and he mentions that you really have to let the community lead because it knows best what it needs first. But it really calls for that public health role to bring together a comprehensive effort to recognize that social determinants of health are myriad and multiple and they're only going to bend before a comprehensive approach that really tries to address all of them in some kind of comprehensive, coordinated fashion. Because we really have to repair the entire environment if we're going to create conditions for people to pursue their best health.

DR. JUTTE:
Well you know what's interesting about that is the—and what's been exciting for me in this work—is that those on the community elements, that those with these other resources are actually driving toward the same goals, which is better functioning neighborhoods, healthier residents, and greater opportunity for the children and families and individuals in the neighborhood. They have the same goals and very different approaches, right, talking through real estate is through developing buildings and infrastructure.

But with the goal of serving those individuals, and so if one approaches them and said, to say we can help you achieve your goals more effectively or more efficiently or at greater scale—they're all over that, like, they're ready and excited to partner. This is not about dragging people
to the table. This is about saying this is some information we know about human development and about the underlying causes of poverty, that they are more than willing to think about how their resources can be used in a way the most effectively. So I think that's been one of those fun things about working in the sector.

DR. KAPLAN:
Right. You mentioned in a chapter in the practical playbook that the current level of this kind of investment is quite small compared to the need and that a lot of it is just one-off projects. How can this kind of work take place as part of a broader, more integrated plan to help transform a community? Are there are examples of that?

DR. JUTTE:
Yeah, I mean it really, a lot of it really isn't that, it's actually as you suggested. You know the fact that Karen DeSalvo mentioned a convening role I think is an interesting one. One example that I've seen that has been particularly effective in this is a model that it's a specific organization, this is Purpose Built Communities. But what I like is the model, that really could be applicable beyond just that particular organization. The reason I mentioned Purpose Built is because their approach is inherently comprehensive.

So if you haven't heard of them, they're an organization, a nonprofit based in Atlanta that provides long-term, free consultation advisory services for supporting neighborhoods that are interested in trying to do comprehensive reinvestments or redevelopment of the neighborhood, while keeping residents there is a real focus because early efforts resulted in a lot of displacement. There's real effort to keep people in place. They're working in at least 25 communities that are active parts of their network, but they've been working with 50 or so across the country and there are two, well actually three main components that I find really interesting.

Again not, not that it's just about this particular purposeful effort but rather it's applicable I think to many communities into your question. One is that they focus on three main pillars: affordable housing mixed income housing, actually so diluting poverty but providing adequate housing. Second is making sure the education system is really strong so that children can break out of these neighborhoods and succeed. And the third is sort of what's called community health, but it really is, I think those of us in public health would think about somewhat broader, all the other good stuff right, like having grocery stores, having parks to play in, having a bank branch, having perhaps the doctor's office nearby—all of the stuff that we take for granted in middle income neighborhoods—that they focus on those simultaneously, which is getting to your point: you have to do them at once. The other two key components which I think set that effort slightly apart from others: One is they define a specific geography. So it's an actual functional neighborhood line can be drawn around. And what that means is everybody in that neighborhood is the responsibility of the other.

So rather than programmatic solutions that sometimes result in increasing disparities, in my opinion, so great things like headstart require a family to have the wherewithal to know that there is a headstart program to get their child signed up and to get them there every day. That is a big lift for some families. And in fact the worst-off families may not succeed, which can actually worsen the disparities between those that are doing better and those that are doing worse. But

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what they call the secret sauce of this approach—this is kind of getting really to the meat of your question—is a community quarterback. And a community quarterback is a usually a new freestanding 501c3 nonprofit, so often quite small—2, 3, 5, 7 people whose sole job is coordinating all the different threads and ideas so that the affordable housing is happening at the same time the groceries start happening, the same time as the school is being improved, same time that the community clinic has been built or expanded, making sure the bus routes combined with what’s needed for that neighborhood, and they represent, they have boards that represent the community itself and the other stakeholders.

And so I think what we're often missing in this, again related to the convening that Dr. DeSalvo mentioned, there is a coordination component that I think really we're not, we've not tackling properly and focusing and making sure you're thinking about everybody in your neighborhood and that needs will vary over time, resources vary over time, but somebody whose primary focus every day is focusing on how to make sure everything's working as well as possible in that neighborhood is a key component. That's something I think we need to think more about how we finance and fund and support.

It doesn't take a lot of people. It's really about making sure these resources are aligned. As I said you know that's where affordable housing and all those others with community development money—how do we link it to health? That would be one way to do that.

**DR. KAPLAN:**

So there's a lot of concern in communities that are transitioning in areas of growth and urban development around the negative consequences of gentrification; how can communities make the kind of rehabilitation investments that are needed to improve health without touching off of a wave of gentrification that ends up excluding those who would most benefit from investment and increased opportunity?

**DR. JUTTE:**

Yeah, I know it's a huge concern. And two thoughts about that: One is most of the country is not at risk of gentrification. I think that's a key point that we often forget. There are a lot of very prominent places, all the major cities on the coasts are a huge risk of gentrification. But Akron, Ohio is not at risk of gentrification. Dayton, Ohio, which is where I grew up near there; Davenport, Iowa, you know there's a lot of places that have been disinvested, swaths of Milwaukee, you know you think about Spartanburg, South Carolina—these are not places that are at risk of gentrification and so sometimes that fear of gentrification can prevent meaningful and important investment.

However, to your point, there are a lot of places that are a huge risk of gentrification all along the coast. You know I live in the Bay Area, so Oakland is just being crushed right now. The key in my mind, interestingly, is actually bringing in these community development partners sooner rather than later, because again, they're mission driven. And if the key, if you—and I've actually reviewed a lot of that gentrification literature—the key is creating affordability in the setting of gentrification. Who does that? Mission driven community development organizations.

So you mentioned earlier I'm the board of Mercy Housing, which is the largest nonprofit affordable housing developer in the country. Mercy is ready and willing to come in and excited to build housing that will be permanently affordable because it's their own portfolio. The nuns are not going to let it become too expensive for the local residents. And so bringing in players

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like that, who have some of their own resources but could also align with local resources is I think one of the key ways. And so in general I think there's sometimes a misunderstanding of development which leads to gentrification and community development that is actually mission driven and is one of the most effective ways of preventing the displacement that will come with increasing housing costs in particular.

**DR. KAPLAN:**
That's great. So for our listeners who want to get started with this where do they begin? How do they learn about and explore this world of the other CDCs and where should they start in their communities.

**DR. JUTTE:**
Well of course, I've spent the last minute not only places networks about five years old and that kind of audience you're talking about is exactly our audience. And so a couple places one you mentioned the Practical Playbook that's available online for free. And I have a chapter in there that was written specifically for an audience like this, summarizing in I think in about 12 to16 pages, community development. I think that's a particularly it was really basically designed for the exact audience you talking about. And second I guess really from you know from my own perspective is a lot of the materials I have on our own websites so buildhealthyplaces.org are for this audience.

So we have essays that summarize interesting stories, we have a gentrification essay, we have examples of children's hospital investing in neighborhoods. We also have a series of case studies that can be valuable; a jargon buster we put together to really help understand CDCs versus the CDC. There there's also a partner finder which they think maybe the another important tool that we created that helps an individual identify which of these local CDCs, community development corporations sit nearby, which CDFIs or the financial institutions are nearby, because the beauty is each of these organizations has a CEO or an executive director who would be more than happy to have a doctor or a public health professional give them a call and be like, “What are you doing in our neighborhood? How can I work with you, how can you work with me? So I think those are some initial ideas.

**DR. KAPLAN:**
That's great. So for our listeners, that's buildhealthyplaces.org. I really recommend it. I'm actually looking at the homepage now and I can see that there are all kinds of resources and jumping off points to the neighbor works America, your playbook, principles for the field community development, one on one community close ups, discussions about early childhood, and discussions about your network and who's in that and the network common series, which is really useful. So both of those are really great places to start.

Dr. Jutte thank you so much for your time today. I really encourage our listeners to explore this world that you were in the middle of and to seek out those folks in their communities who are doing this CDC work this community development corporation work. I begin to have conversations about what they need, how they can be supported and what we can bring to the table that will help galvanize and accelerate those efforts. So thanks so much for your time.
DR. JUTTE:
Great I appreciate it. And I look forward to have anybody reach out anytime. We’re happy to talk further.

DR. KAPLAN:
Great.

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