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The Paradox of Colorblind: Private Nonprofit Hospital Community Benefit Investments and the Social Determinants of Health

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Nonprofit hospitals are required to provide "community benefits," although this term and the associated levels of spending are not clearly defined. Over 75% of private nonprofit hospital community benefits are allocated to providing medical services for those who cannot afford care, and fewer investments are made to address structural and social determinants of health (SDOH). In particular, this spending is rarely used to redress racial inequities that shape health. In addition to spending on charity care and medical services, some private nonprofit hospitals invest in non-medical strategies to improve health outcomes. In California, private nonprofit hospitals report $12 billion in annual community benefits that include spending on non-medical strategies intended to improve health-promoting conditions for vulnerable populations. This comparative case study analyzes data from organizational documents, interviews, and media communications to examine how hospital community investments in housing and workforce development are rationalized and deployed to address SDOH in Los Angeles County. Findings indicate that community-based resources are essential to align hospital investments with community need and to avoid "colorblind" decisions that emphasize socioeconomic need yet do not adequately address racialized barriers to health. Policy and practices that promote targeted capital investments and prioritize the disproportionate needs of communities of color are needed instead of colorblind hospital community investments that perpetuate racial inequities in health.

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Introduction

California is considered a bellwether for strategies to improve population health,[1] yet racial inequities in health persist. Although life expectancy has increased for all Californians, African Americans have the lowest life expectancy, the highest death rates for breast, prostate, lung, and colorectal cancer, and disproportionately higher death and maternal mortality rates statewide.[2-4] African Americans also experience high levels of social vulnerability, which may help explain these persistent health inequities. For example, in Los Angeles County, African Americans account for 40% of people experiencing homelessness, and they are disproportionately impacted by residential racial segregation, housing discrimination, labor market discrimination, predatory lending, mass incarceration, and child welfare system involvement, all risk factors for adverse health outcomes.[5,6] Although racial inequities in health are costly,[7] less than 5% of health care spending is allocated to social programs;[8] thus hospital spending to address social determinants of health (SDOH) may be an effective strategy to improve health outcomes.[9-11]

In California, private nonprofit hospitals report $12 billion in annual community benefit spending[12] on charity care, health professions education and training, and other community benefits to comply with state and federal requirements. Since 1994, the California State Legislature has required nonprofit hospitals to report annual community benefit spending according to categories that distinguish between community benefits for vulnerable populations and community benefits for the broader community. The use of race-neutral or "colorblind" terms to define "community" and "vulnerable populations" can result in the needs of communities of color being overlooked. Because county-level disparities in poverty and other SDOH disproportionately impact communities of color,[13] private nonprofit hospital community benefits in housing, workforce development, and other non-medical strategies could be used to ameliorate racial inequities in health.

This comparative case study[14] examined two Los Angeles County hospital investments to address SDOH: a direct loan issued by Dignity Health to finance the construction of an 80,000 square foot housing development in the North San Fernando Valley and a Kaiser Permanente capital project that helped nearly 500 Baldwin Hills-Crenshaw residents obtain trade union and health care jobs. In both cases, "colorblind" resource allocation decisions that emphasized socioeconomic need yet did not specify or track race were rationalized and deployed. These colorblind approaches to hospital community investments can perpetuate racial inequity and limit the potential health benefits derived from improvements in housing and workforce development.

Table 1: Examples of Colorblind Versus Racial Equity Hospital Investment Approaches[15]

Principle	Colorblind Approach	Racial Equity Approach
Race Consciousness	Site capital projects in geographic areas without consideration for historical racial discrimination and disinvestment	Prioritize capital investments and community building strategies in communities disadvantaged by racism and disinvestment
Structural Determinism	Implement strategies that address individual health risk factors and SDOH	Allocate resources to address the effects of racism and other root causes of health
Intersectionality	Use of one-dimensional geographic definitions of community that minimizes racial inequities	Align resource allocations with multiple intersecting forms of social exclusion
Community Voice	Limit engagement/decision-making opportunities for local residents from communities affected by racism with lived experience	Provide leadership and employment opportunities to local residents from communities affected by racism with lived experience
Disciplinary Self-Critique	Allocate resources to racial/ethnic groups with greater opportunity access and fewer needs	Remove organizational and individual barriers that impede resource allocations to address racial inequities in health

Source: Table adapted from Ford, C. and Airhihenbuwa, C. (2010). The public health critical race methodology: praxis for antiracism research. *Social Science & Medicine.*71(8):1390

This study used a Public Health Critical Race lens[15] to interrogate whether racism and its impact on health inequalities are considered when hospital investment decisions are made (Table 1). Race has been integral to the development of Los Angeles, and the responses of African American residents to racism have further shaped housing and employment practices.[16] Housing and jobs are two essential determinants of racial inequities in health. Housing stability can affect multiple health outcomes over the life course and across generations.[17,18] For example, housing interventions have been used to mitigate the effects of asthma, injury, obesity, poor indoor air quality, and social isolation; and both individual household and community housing interventions produce health impacts.[17,19,20] Similarly, investments in workforce development, education, and employment opportunities can mitigate the myriad health impacts of precarious employment in communities with disproportionate need.[21-23] Both hospitals in this study prioritized housing instability and economic insecurity as key drivers of health, which were used to identify housing and workforce development as potential investments to examine.

Dignity Health and Kaiser Permanente made housing and workforce development investments in Los Angeles County, where the convergence of residential racial segregation and economic disinvestment resulted in the concentration of African American residents in targeted geographic areas that enabled them to experience the impact of these investments. Yet, in the absence of deliberate resource allocations to address racially discriminatory housing and employment

barriers, the magnitude of impact was limited, especially in one of the cases. This comparative case study demonstrates how community-informed resource allocations enable hospitals to better align investments for communities with disproportionate need in order to advance racial and health equity.

Figure 1: Map of Los Angeles County Study Site, 2016[24-26]

Methods

Los Angeles County (Figure 1) was selected as the study site due to the multiple private nonprofit hospital systems that report spending a high amount on non-medical community benefits for vulnerable populations. The county provided a shared context for policies (e.g. state law, county health programs) that may affect community benefit spending in the two hospital cases examined—Dignity Health Northridge Hospital and Kaiser Permanente West Los Angeles Medical Center. Dignity Health and Kaiser Permanente are two of California's largest hospital systems, and each was selected based on its mission, hospital location, and history of unconventional community investments. Because "[a]ll places have histories," the community history of each hospital system and the racialized history of Los Angeles housing and employment policy and practices (Table 2) are briefly described.[27]

Table 2: Select Racialized Housing and Employment Policy and Practices[16,28]

Discriminatory Housing Policy/Practice	
Description, Year(s)	*Impact(s)*
Los Angeles Investment Corp v. Gary, 1919	CA Supreme Court upheld covenants right to keep out non-Whites
Corrugated v. Buckley, 1926	U.S. Supreme Court upheld racially restricted covenants for 20 years
Los Angeles Ku Klux Klan, 1920s	Emerges to terrorize, intimidate, attack Blacks in White neighborhoods
Wagner-Steagall Housing Act, 1937	Funds slum clearance and public housing construction that disproportionately concentrates Black LA residents into racially segregated, disinvested areas
Commission on Human Relations, 1956	Los Angeles County records six bombings and four arson incidents to Black-owned homes and 17% of racial incidents occurred in the Valley
National Association of Real Estate Boards, 1950s	Code of Ethics maintained explicit provisions prohibiting realtors from showing white neighborhoods to Blacks and other minorities
Federal Housing Administration, post-1948	Between 1950-1954 only 2.4% of LA County FHA housing units were available to non-Whites despite the same delinquency rate for Blacks and Whites
California Proposition 13, 1978	Passed with support from 65% of voters, it reduced taxes that disproportionately affected Black beneficiaries of public housing, welfare, and public employment
Los Angeles Police Department, 1984-1985	Under Police Chief Darryl Gates' leadership the Police Department used the steel battering ram to disproportionately target homes in Black neighborhoods
Discriminatory Employment & Economic Policy/Practice	
The Los Angeles Shenk Rule, 1912	Charging African Americans more than others was not considered extortion or civil rights violation
Employment Discrimination, 1920s-present	Los Angeles apparel, oil, construction, aircraft, manufacturing employers refused to hire Black workers largely relegating them to domestic work
Congress of Industrial Organizations, 1936	Los Angeles Black workers excluded from most industries were unable to garner benefits received by over 15,000 Mexican CIO members
The New Deal, 1933-1939	Over 444 Los Angeles programs created opportunities that maintained racial segregation and disproportionately disadvantaged Blacks
Los Angeles Unified School District, post-WWII	The CA Teachers Association and LA County Teachers Placement Advisory Service accept racial discriminatory job requests from LAUSD schools
The Economic Opportunity Act, 1964	$20 million in LA anti-poverty funds are delayed until after the 1965 Watts Rebellion and failed to improve economic conditions in Black communities
U.S. Labor Department Moynihan Report, 1965	Influenced federal anti-poverty programs that attributed racial inequality to an undesirable Black family structure and behavior rather than racism
Hart-Cellar Immigration Act, 1965	Relaxed immigrant quotas and undocumented immigrant worker access to employment opportunities that excluded Black industrial Southern CA workers
California Proposition 209, 1996	Eliminated the requirement for employers and education institutions to maintain representation of non-White racial/ethnic groups proportional to the population

Unconventional hospital investments are a positive deviance—a distinctive and consistent demonstration of exceptional organizational performance—that require in-depth qualitative analysis to identify practices that quantitative analysis may not reveal.[29] Therefore, this study collected and triangulated data from multiple sources. First, publicly available information from organizational websites, news articles, press releases, and other media communications were collected and reviewed. Next, 16 community health needs assessments and community benefit implementation plans produced between 2013 and 2016 were analyzed to examine the community investments of both hospital cases (Table 3). Next, semi-structured interviews with 20 hospital leaders and community-based organization (CBO) staff were conducted, audio-recorded, and transcribed. Because the implementation phase for both hospital case investments concluded prior to data collection, the completed projects were analyzed. Direct observations and field notes were based on limited access to 12 community meetings, events, and site visits. All primary data was collected between December 2018 and January 2020.

A constructivist grounded theory approach[30] was used to code and analyze the data. Open coding was used to identify codes based on word phrase frequency and a priori assumptions about the rationales, resources, and relationships that informed these investments. Selective coding was used to organize and analyze data according to primary codes and emergent patterns. This iterative process was instructive because successive interviews provided new insights and revisions. Pattern matching enabled thematic patterns to be identified within each case, across interview participant groups (i.e., theoretical replication), and across both cases (i.e., literal replication).[14] Explanation-building techniques were also used to develop hospital case profiles and resource logic models.

Results

Dignity Health's Housing Investments

In 1854, the Sisters of Mercy arrived in San Francisco to serve the sick and impoverished and establish charitable hospitals throughout California. Eventually, two congregations merged to form Catholic Healthcare West, and by 2012 the organization was renamed Dignity Health to emphasize its commitment to compassionate health care. Historically, the organization acquired hospitals that maintained its mission to serve the disenfranchised and invest financial assets into local communities. Since its founding sponsorship, Dignity Health has been a 30-year strategic partner of Mercy Housing, another nonprofit, and has provided land, low-cost leases, community grants, and on-site wellness services to support affordable community housing.[31]

Several housing investments have been made through its Community Investment Program (CIP), which redirects retirement holdings and other assets into the communities where its hospitals are located. A $2 million development loan to the Corporation for Supportive Housing was used to create permanent affordable housing for frequent users of emergency rooms, shelters, jails, and other highly-vulnerable populations, and $75,000 was deployed to the Los Angeles House of Ruth to provide comprehensive support and transitional services to homeless women and children survivors of domestic violence.[32] Other investments have included a $700,000 line of credit to Stocktonians Taking Action to Neutralize Drugs for an affordable homes sales program in

Stockton, CA,[33] and a $1.2 million bridge loan to complete the Arrowhead Grove Project in San Bernardino, which helped secure $20 million in funding from the California Strategic Growth Council.[34]

Between 2015-2016, homelessness in the San Fernando Valley increased by 30%, and the local Northridge Hospital, accordingly, prioritized affordable housing as a community need (Table 3). In 2016, Dignity Health provided LA Family Housing Corporation (LAFH) a $3,051,000 direct bridge loan to finance construction of the Irmas Campus. This decision enabled much-needed capacity to be built in the San Fernando Valley. Although Dignity Health did not determine the project location, it did choose to align its investment with the Northridge Hospital rather than its California Hospital Medical Center located in downtown Los Angeles (LA) where over 45% of the county's unsheltered and disproportionately African American population resides.[5]

The Irmas Campus project built by LAFH with the loan from Dignity Health resulted in over 300 housing units for a total of 500 residents. The project also included a Federally Qualified Health Center and a large community space. The multipurpose design enabled LAFH to coordinate multiple on-site wellness services for adults, children, and families including healthy meals, vocational training, and medical and behavioral health services. Unlike the Kaiser Permanente case, Dignity Health formed fewer partnerships overall: for the Irmas campus project, hospital leaders took a more indirect approach of financing a project led by one large nonprofit organization. Dignity Health benefitted from the professional experience of multiple departments within LAFH, but this may have led to fewer strategies to address racial inequity. Outreach strategies, for example, appeared to be based on professional knowledge rather than lived experience.

The complexity of Los Angeles' housing instability crisis, where upwards of 50,000 Los Angeles residents were unhoused, motivated Dignity Health to invest in multiple strategies. More than $100 million in CIP funds were leveraged to support prevention and diversion, housing stabilization, new and rehab construction, and respite care over a 10-year period. In 2019, Dignity Health rebranded as part of a $29 billion merger with Catholic Health Initiatives to form CommonSpirit Health, the nation's largest Catholic nonprofit health care system. Conditional approval from the California State Attorney General required the organization to provide free medical care to individuals earning up to 250% of the poverty level, maintain an established minimum of charity care and community benefits spending across its California hospitals, and invest at least $20 million in integrated housing and health care services to address homelessness.[35]

Table 3: Characteristics of the Two Case Study Sites in Los Angeles County, 2014-2016[24,36-38]

Hospital System Characteristics		
System Affiliation	**Dignity Health**	**Kaiser Permanente**
Year Founded	1854	1942
Year Hospital Opened	1955	1974
# of Hospital Beds	424	305
Operating Margin	-0.77%	8.07%
Total Equity	$338,241,795	$587,236,010
# of Medical Facilities	29 hospitals, 400 care facilities	38 hospitals, 635 medical offices
# of Employees	9,000 physicians, 62,000 employees	20,487 physicians, 245,475 employees
# of Service Area Residents	1.3 million	1.3 million
Case Study Hospital Characteristics		
Facility Name	Northridge Hospital Medical Center	West Los Angeles Medical Center
Prioritized Health Needs	1. Primary Care Access 2. Oral Health 3. Mental Health/Substance Abuse	1. Mental Health 2. Obesity/Overweight 3. Diabetes
Prioritized Health Drivers	Access to care barriers, poverty rates, insurance, transportation, culture, education	Health insurance, health care access, healthy eating, physical activity, cardiovascular disease management, employment, nutritional access, homelessness, substance use, income
Community Demographics		
% African American	4.1%	19.8%
% Latino	48.6%	34.7%
% White	33.7%	33.9%
% Asian/Pacific Islander	10.8%	8.2%
% Uninsured	6.0%	19.3%
%Unemployed	7.2%	14.2%
% No H.S. Diploma	21.7%	18.2%
Community Benefit Spending		
2014 CB Total*	$50,539,880	$27,902,162
Targeted Spending**	$47,664,978***	$25,502,887
2015 CB Total*	$36,028,858	$39,972,386
Targeted Spending**	$32,895,652***	$38,018,990
2016 CB Total*	$53,456,796	$28,002,536
Targeted Spending**	$50,844,379***	$25,863,638

** Excludes Medicare **Spending for Vulnerable Populations ***Spending for those Living in Poverty*

Kaiser Permanente's Investment in Workforce Development

Kaiser Permanente began in California providing health care to industrial workers in the 1930s, and by 1945 the general public was able to enroll in its prepaid health plans. In 1953, a $3 million Los Angeles Medical Center opened to the public despite the admonition of the Los Angeles County Medical Association, which deemed the prepaid group practice unethical and an economic threat, despite its accessibility to charity care patients. Two years after the 1965 Watts Riots, Kaiser Permanente opened the Watts Counseling and Learning Center to serve local children and families through diverse culturally relevant education, counseling, and outreach programs.[39]

Decades later, the decision to open a medical office building in the Baldwin Hills-Crenshaw neighborhood aligned with community and business needs. A report commissioned by the Los Angeles Housing and Community Investment Department described the 152-acre site as "blighted."[40] Further, the $90 million capital project was designed to be integrated into the community and support local employment. Even the security company hired during construction was a minority-owned firm that employed 70 local residents. Importantly, the investment furthered a regional goal to build livable communities: a two-mile walking path and almost three miles of green space were produced; 48% of trade union workers were locally hired; and 40% of construction contracts and $22 million in procurement went to women, minority and/or veteran owned businesses.[41]

The local Kaiser Permanente hospital prioritized economic security—which it defined as "having stable access to employment, educational, and housing opportunities"— as a driver of community health based on the "severity of the issue in the service area, and depth and breadth of partner organizations working" on the issue.[42] Workshop collaborations with local high school parent centers, workforce development partnerships to update procurement policies, and local educational partnerships to create workforce development programs and pipelines were identified as investment strategies to improve economic security in the community.[43]

To align its investments (Table 3), Kaiser Permanente negotiated business needs and hospital resources across several departments: Public Affairs, Community Benefit, Human Resources, National Facilities Services staff and executive leadership. As the general contractor, Turner Construction Industries was, in part, hired for its community engagement commitment and demonstrated capacity to fulfill local hire agreements. It managed the multi-million dollar construction project and recruited 2nd Call—a local CBO that gives former felons, offenders, and parolees "a second chance to love life"—to lead the community outreach.[44] The Asian American Drug Abuse Program (AADAP) helped coordinate training programs through the West Adams WorkSource Center it manages.

During the first investment phase, 2nd Call led door-to-door canvassing and recruited residents to weekly support sessions in a South Los Angeles church. This ensured that hard-to-reach, unemployed and predominantly African American residents could learn about the available trade union jobs and free training. During the second phase, AADAP used its network to inform local residents about the health care jobs available. Over 800 mostly African American and Latino residents attended the first outreach event. Kaiser Permanente's sole ownership of both phases of

the project determined how its investments were targeted. Its project labor agreement (PLA) reflected a deliberate choice to improve community economic security by requiring that 50% of all new trade workers resided within a five-mile radius. As one hospital leader stated, "This community holds a special place in our hearts. We've cultivated many wonderful, productive relationships with community partners throughout the area, and we all are eager to see our work towards a re-energized Baldwin Hills–Crenshaw community flourish."[45]

In both cases, the hospital investments leveraged distinctive organizational histories and resources. Dignity Health's housing investments began with its founding charter and included a 30-year affordable housing partnership and Community Investment Program aligned with its mission. During Kaiser Permanente's 65-year history in Los Angeles, it constructed several hospitals, ambulatory care and community facilities that improved conditions and produced economic benefits in underserved areas.

The Paradox of Colorblind Hospital Community Investments

Despite racial inequities in employment and housing, neither hospital investment explicitly focused on racial equity. Table 4 summarizes both hospital investments. Although hospital community health needs assessments included data on racial health disparities (e.g., racial/ethnic differences in diabetes prevalence) and social inequalities (e.g., neighborhood differences in poverty rates), disproportionate need was not attributed to racial/ethnic inequities. Instead, community leaders often described racialized needs with more nuance and understanding of the impact of racial discrimination than hospital and organizational partner staff from outside the community. Resource allocation decisions informed by these community leaders (e.g. door-to-door outreach in specific neighborhood blocks) often focused on specific barriers that were identified using lived experience rather than community health needs assessment reports. As one Kaiser Permanente community partner described:

> But I just know that in my community - I'm specifically talking about the Black and Brown community now - some of those things that might happen in other communities don't manifest itself like it do in our community. So therefore, there's a level of training that has to happen before we get out there into the battlefield. And I call the work area "the battlefield."— Interview, 2019

For Kaiser Permanente, the decision to align hospital resources with specific community needs was influenced by the lived experience of community partners and their knowledge of the needs of Black communities. For example, because African Americans accounted for 71% of the Baldwin Hills-Crenshaw community, 9% of the LA population, and less than 2% of the LA County construction industry[45], Kaiser Permanente resources were leveraged to address specific employment barriers. Targeted outreach activities, equipment and training fees, weekly support groups, mentorship, and event sponsorships were provided to address racialized workforce barriers. Although these resources were available to all community members, they often focused on the specific and disproportionate needs of African Americans.

Table 4: Summary of Community Investment Strategies Stratified by Hospital Cases

	Dignity Health	**Kaiser Permanente**
Community Investments		
Investment Type	Indirect investment to LAFH*	Direct investment to community
Hospital System Resource(s)	$3,051,000 bridge loan	$90 million capital project, wages paid
Local Hospital Resources	Multiple $10,000-$25,000 community benefit grants, sponsorships	Multiple $10,000-$50,000 community benefit grants, sponsorships, local procurement
Non-Financial Resources	Hospital volunteers, sponsored events, community advisory group participation, employee knowledge, professional relationships	Volunteers, onsite employer events, community advisory group participation, training coordination, program planning, employment placements, leadership development, employee knowledge, personal/professional relationships
Organizational Partners		
Hospital Department(s)	Community Investment Program, Community Health	Community Benefit, Public Affairs, Regional Community Benefit, National Facility Services, Human Resources
Primary Partner(s)	Los Angeles Family Housing Corporation	Turner Construction, 2nd Call, AADAP**
Additional Partner(s)	Northeast Valley Healthcare Corp, Valley Presbyterian Hospital, Kaiser Permanente, LA Homelessness Services Authority, Hope of the Valley, Neighborhood Legal Services, local government	West Adams WorkSource Center, Urban League, YMCA, Community Build Inc., LA Chamber of Commerce, Goodwill of Southern CA, CA Employment Development Department, Los Angeles Unified School District, Pace BusinessSource, local schools, neighborhood councils, local government
Community Impact		
Impact Outcomes	263 bridge + 49 supportive housing units,FQHC***, 4,300sq ft community space, 500 residents housed	Over 500 residents employed, 48% local hire, 40% diverse business contracts, 100,00sq ft medical facility, community space, community pride, new collaborations
Indicators Tracked	Access to nutrition, employment, education, social connectivity, transportation vouchers, permanent housing, service referrals, clinic visits, recuperative care spending, money saved,	Resident interviews, job placements, full-time employment, hours worked, wages paid, attrition, recruitment events, employment counseling, local procurement

**Los Angeles Family Housing **Asian American Drug Abuse Program ***Federally Qualified Health Center*

In the case of Dignity Health, its investments were targeted according to need severity that was assessed using validated tools irrespective of racial inequities. Although high severity housing needs may have been affected by structural racism, investments were targeted to geographic areas and residents within the immediate hospital vicinity. The Dignity Health Community Needs Index—which produces an average score of housing, income, insurance, education, and language

barriers—was used by hospital staff to target investments. LAFH used a similar "colorblind" assessment, the 27-item Vulnerability Index Service Prioritization Decision Assistance Tool, to screen and triage unsheltered adults. Notably, socioeconomic-focused strategies were described in a manner that minimized the need to address racial inequity. According to one Dignity Health hospital leader:

> When you look at the people on our streets, you see actually more Latino and Caucasian than you do African-American… However, I think when you're looking at the current issue of: they're housing more people, but more and more people each year are going into homelessness, I think you have to address the bigger problem of affordable education for all ethnicities and socioeconomic levels. You have to look at fair wages for everyone. — Interview, 2019

Because racial discrimination has led to race-based patterns of homelessness, targeted housing investments in the Black community are needed. In 2017, Black people represented 9% of the general population in LA County, comprised 40% of the houseless population, and experienced a higher rate of returning to homelessness than all other racial/ethnic groups.[5] Because the Northridge Hospital serves a large population and geographic area—where many unsheltered residents face severe substance use, violence, precarious employment, and housing instability simultaneously—leaders found it difficult to address racial inequities. Yet, in a media interview, Dignity Health CEO Lloyd Dean acknowledged racialized patterns of housing instability by stating, "When you think about the fact that there are so many people in this country who are homeless on a given night, and then you zero in further and begin to sort that data and you see that a large proportion of those individuals that are homeless are African American, it just caused me to say we've got to be more than just a comprehensive health care provider. We've got to be in and of the community."[46] Despite his recognition of the particular needs of African Americans, the project did not target African Americans, though it did end up serving some African Americans because of their disproportionate need across Los Angeles county.

The Need for Community Resources to Address Race-Based Inequity

Knowledge of racialized patterns of disadvantage, need, and opportunity access were most often used to make investment decisions when hospital and CBO leaders leveraged their lived experience. Local hospital resources—in the form of community grants and sponsorships, community-based relationships, knowledge, and lived experience—provided critical benefits to CBOs, some of which were led by African American community members, in the Kaiser Permanente case.

Across both cases, local hospital resources were used to connect community members to opportunities that maximized the impact of the hospital investments. For Kaiser Permanente, local financial resources and information about the organization—including which jobs were available, how to navigate the selection process, and access to onsite interviews with Human Resources Talent Acquisition Managers—simultaneously addressed employment barriers and increased CBO capacity. For Dignity Health, the LAFH loan and a $1 million loan to the Valley Economic

Development Center to provide small business loans to African Americans were system-level, rather than hospital-level, investments used to address SDOH in the area.[25]

As mentioned above, Dignity Health formed few partnerships based on community lived experience, unlike Kaiser Permanente. Instead, Dignity Health engaged the professional experience of multiple departments within LAFH, a large nonprofit affordable housing corporation, which may have affected the comparatively fewer examples of strategies to address racial inequity. LAFH outreach strategies, for example, appeared to be based on professional knowledge rather than lived experience. In both cases, hospital financial resources were able to activate non-financial resources that extended benefits to local residents, CBOs, and the broader community. Kaiser Permanente's direct investment enabled it to make critical decisions that were unavailable to Dignity Health because of its indirect investment in LAFH. In the Kaiser case, the combination of capital investments and direct project ownership conferred greater authority to make equity-informed decisions. As one Kaiser Permanente partner described, "[I]f they're just trying to increase the African American experience in working or whatever, they have to negotiate their PLA in a way—the project labor agreement with the unions—in a way that pushes that, and they can because they are the owner. They can do that" (Interview, 2019).

Because race/ethnicity data were not systematically collected and reported for these workforce development and housing investments, the extent to which these investments addressed racial inequities is difficult to quantify. Kaiser Permanente nearly met its local hire goal, which likely benefited African Americans—through training and employment opportunities—given the community demographics. For Dignity Health, because the Irmas Campus provided housing to San Fernando Valley residents with the highest severity of housing instability, the disproportionate need of Latino residents may have been addressed since they account for 42% of the homeless and are underrepresented in the permanent housing population.[5] Ultimately, while housing and workforce investments addressed critical SDOH, they were "colorblind." Kaiser Permanente's direct investment and use of community lived experience mitigated its use of race-neutral approaches, and the project served many African Americans.

Discussion

The use of colorblind approaches that emphasized socioeconomic needs, yet overlooked racialized patterns in employment and housing barriers, may have limited the potential for these investments to address SDOH for Black communities. Although both hospital systems officially used a race-neutral approach, Kaiser Permanente's dependence on community lived experiences enabled a race-specific lens to be used in implementation.

Whether Proposition 209, which prohibits discrimination and preferential treatment in public contracting based on race and ethnicity, limited how hospital investments were targeted and publicly described was unclear. Fear of violating legal restrictions may have led hospital leaders to take a colorblind approach and avoid making racism an explicit focus of targeted investments. Yet hospital community investments should be examined in the context of racism and the race-based policies and institutional practices that simultaneously confer health-related advantages and disadvantages.[50] A racial equity approach to hospital community investments goes beyond SDOH

to address "the fundamental role of macro-level forces in driving and sustaining inequities across time and context."[15] This approach would consider "the fundamental contribution of racial stratification to societal problems," community health needs, and one's own awareness of racialized patterns.[15] A racial equity approach to hospital community investments might utilize an intersectional perspective to consider needs that are simultaneously determined by interlocking categories of race, socioeconomic status, legal status, disability, and gender.[15] For example, workforce development investments can address child care, mobility accommodation, gender protection, and legal assistance needs that are barriers to employment. Race consciousness in resource allocations is necessary to address root causes of social inequities and to make racial equity an explicit goal of hospital community benefits.

Further discussion of the distinction between colorblind and racial equity community investment approaches is warranted. First, colorblind approaches (e.g. the use of race-neutral need assessment tools) overlook racism as a fundamental cause of poor health.[15] In urban environments, socioeconomic status, place of residence, and race/ethnicity shape health.[23] Racism, specifically, restricts resource access, affects the use and quality of health and social services, and limits educational, economic, and occupational opportunities for racialized groups across generations.[23,47,48] For non-White racial/ethnic groups, racialized criminalization and immigration policies also affect opportunity access, increase social health risk exposures, and impede health.[49] Because both hospital investments in this case study emphasized socioeconomic need, the social vulnerability produced by racism may have been overlooked.

Second, colorblind investment approaches (e.g. race-neutral siting of capital projects) minimize the history of structural racism that shapes opportunity access and exclusion. Capital investments in housing and workforce development are necessary, yet insufficient to address racial inequities in health in the absence of a targeted approach that allocates resources to eliminate access barriers produced by racism. Although hospital investments have funded housing quality improvements, residential-based health services, and affordable housing to stabilize households,[51,52] these investments may not address disproportionate and limited access to safe, affordable housing due to racial discrimination. Likewise, workforce training and education investments that create stable mid- to high-income employment opportunities for low-resource communities[53] may have a greater impact if resources target African Americans and Latinos and are allocated to address the disproportionate precarious employment produced by racism.[5] While the Dignity Health and Kaiser Permanente capital investments may improve economic and social conditions, their potential impact on racial inequities in health requires targeted resource allocations and the direct participation of affected communities in decision-making.

Third, colorblind hospital investments that fail to address racial inequities may unintentionally perpetuate inequalities by allowing investment benefits to concentrate among those with more resources rather than those with disproportionate needs.[54,55] Hospital investments that focus on broad geographic service areas, rather than communities with specific and disproportionate needs, may actually deepen health inequities by failing to address heterogenous needs within a population.[54] Racial/ethnic demographic changes across LA County necessitate hospital investments that allocate resources in a manner that simultaneously improves conditions for the most disadvantaged racial/ethnic groups within geographic areas and across socioeconomic groups. A racial equity approach (Figure 2) requires hospital leaders to systematically examine

hospital practices and resource allocation decisions that perpetuate inequality and racial bias.[15] Substantive community engagement through employment, hospital board placement, contracts, leadership development and capacity building, health profession training and education, and investments in CBOs provide opportunities for hospitals to promote racial equity.

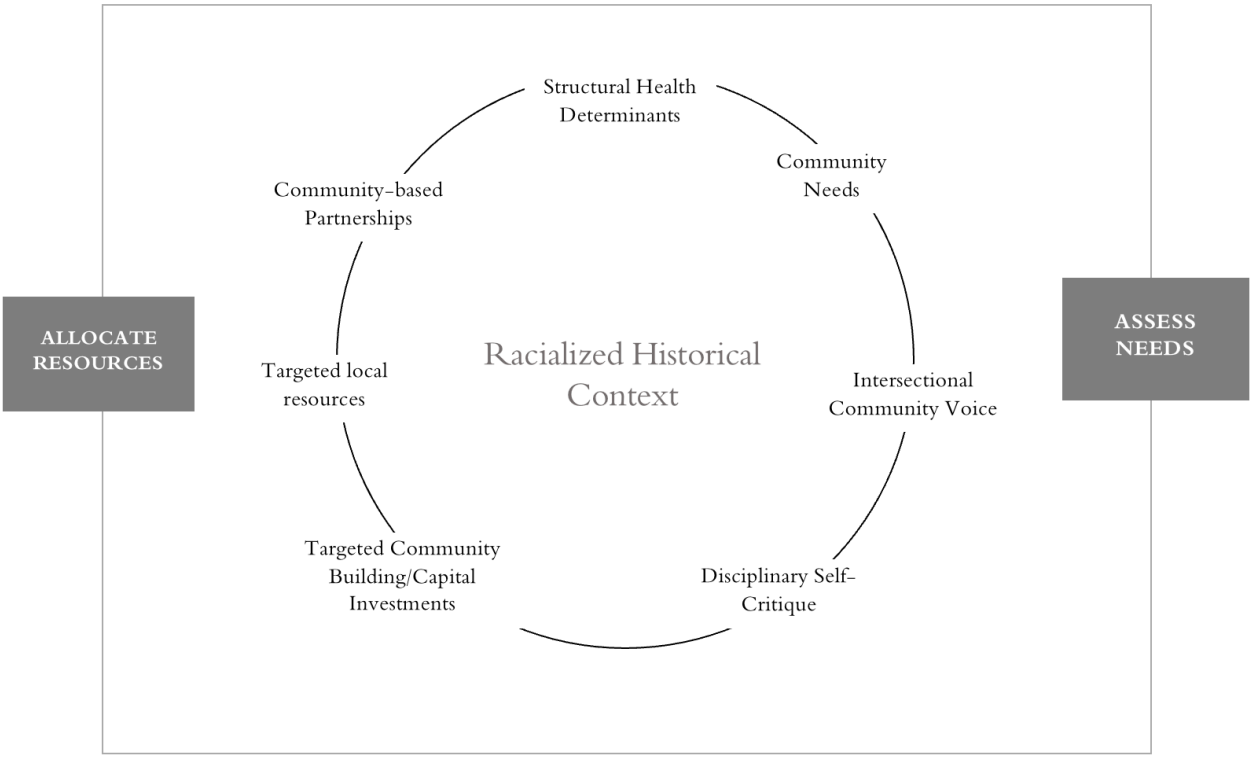

Figure 2: A Racial Equity Approach to Hospital Community Investments

The following limitations should be considered when interpreting these findings. First, bias in the data collection, while minimized through the comparative case study design and protocol, nonetheless limited reliability. Specifically, the use of snowball sampling to identify interview participants potentially limited the number of respondents and range of perspectives analyzed. Second, restricted access to internal documents necessitated a greater reliance on publicly available reports and media communications, which may reflect the selective reporting bias of hospitals and limit the internal validity of these findings. Multiple sources of evidence, pattern matching techniques, and the use of key informants to review draft hospital case profiles maximized validity. Lastly, the generalizability of these findings is limited by a focus on California private nonprofit hospital systems, and the context-specific racial inequities in health within the state.

Conclusion

There are multiple policy and practice implications related to this study. First, given the frequent exclusion of capital investments from the total amount of community benefits reported, revised reporting guidelines that include community infrastructure and workforce development activities may be established to promote opportunity access and health.[56,57] Assembly Bill 962,[58] which requires hospitals to report the proportion of contracts awarded to women, minority, and veteran-owned businesses, may provide a model for legislation that incentivizes hospital capital investments in historically disinvested and systematically disenfranchised racial/ethnic communities. Such legislation might include incentives for hospital systems operating in economically underdeveloped and medically underserved areas.

Second, California community benefit reporting guidelines should be modified to ensure that hospital definitions of vulnerable populations include racial/ethnic groups and legal status. Such a provision might motivate hospitals to use data on racial inequities in health and allocate resources to address disproportionate need. State resources could be mobilized to increase hospital capacity to monitor and report progress on racial/ethnic health inequities using a standard set of indicators that hospital community investments may impact. Community member representation on decision-making and advisory boards, with influence over resource allocations, is key.

Third, training and capacity building resources could be mobilized to support hospitals and their community partners to maximize impact. Hospitals could provide health professions education and community building activities to support core operations and capacity building needs among CBOs with priority for organizations led by members of historically disadvantaged racial/ethnic groups. This might increase the provision of training benefits to community members and leaders, including within racial/ethnic communities that may not otherwise have access to health professions education and training opportunities.

Racial inequities produce complex needs that may be addressed through community-engaged hospital investment decisions. Yet, without an explicit racial equity focus, they may fail to provide benefits to those who need it most. To the extent that California is considered a bellwether for national population health improvement strategies, if it starts to use a racial equity approach, that may provide a model for how to improve health outcomes and dispel the illusion that colorblind strategies can address social determinants of health.

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