

Investing in Community Health

Measuring social return on the
American Medical Association's
investment in West Side United's
impact portfolio



KEARNEY



Executive summary

Social impact investing can be part of an effective community health strategy. This report summarizes how selected American Medical Association (AMA)-supported investments in West Side United translated capital into measurable socioeconomic and health-related value, and how those findings may inform future investment, partnership and measurement efforts.

We evaluated the Social Return on Investment (SROI) of three selected loans within the West Side United social impact investing portfolio. Across the loans assessed, **every \$1 invested was associated with approximately \$4.40 to \$8.60 in estimated annual social value.** Taken together, the modeled investment base of roughly **\$4 million** was associated with more than **\$26 million** in estimated annual social impact.

What the evaluation found

	Investment archetype	Adjusted benefit	Loan amount	SROI	QALY
Loan 1	Small business & wraparound supports	\$1.2M	\$0.3M	4.4x	2.1
Loan 2	Affordable housing & food access	\$8.5M	\$1.5M	5.7x	6.2
Loan 3	Holistic community campus	\$17.4M	\$2.0M	8.6x	10.2

Note: SROI reflects estimated annual monetized social value after conservative adjustments to avoid over-claiming impact. QALY (Quality-Adjusted Life Years) is shown as a complementary health-related measure and is not included in the SROI ratio.

How to interpret the results

- These findings should be interpreted carefully. The three loans represent different social impact investing archetypes, not interchangeable or directly comparable projects. They illustrate different ways investment may contribute to community health: through employment and worker support, through housing paired with food access and services and through an integrated community campus model.
- SROI is the primary methodology in this report, used to estimate annual socioeconomic value relative to resources invested. QALY (Quality-Adjusted Life Years) is included as a complementary health lens to capture health-related quality-of-life effects that may not be fully reflected in dollar-based estimates.
- Findings should be interpreted as directional modeled estimates based on the best available information, not as audited impact results or like-for-like comparisons across loans.

Why this matters

Health outcomes are shaped by social and economic conditions, including housing, income, education, transportation, food access and neighborhood opportunity. This evaluation suggests that social impact investing may help address some of those upstream conditions and root causes of poor health while strengthening the broader community ecosystem and generating measurable social value and complementary health-related benefits.

Three lessons

1. Social investment impact can be measured. This report demonstrates the viability and utility of SROI methods for estimating the annual socioeconomic value associated with selected outcomes relative to the resources invested.
2. Different investment models create value through different pathways. Employment, housing, food access, education, recovery supports and clinical access each contribute through distinct mechanisms.
3. Partnerships matter. The strongest modeled results were associated with models that combined community ownership, multi-sector collaboration and integrated services.

Call to action

For AMA and health care leaders	• Inform future social impact investing strategy, strengthen data-sharing and measurement partnerships and refine evaluation methods over time. • Encourage health systems to pursue community lending/social impact investing as a practical strategy for community impact.
For funders and partners	• Consider co-investing in models that align with health goals, demonstrate measurable value and strengthen the local ecosystem of housing, food, workforce, education and care supports.
For physicians and care teams	• Identify recurring community health needs that could be addressed through community-based investment, referral partnerships and advocacy for upstream supports.

Bottom line: The selected AMA-supported WSU loans suggest that investments in community conditions can generate measurable annual socioeconomic value and complementary health-related benefits. With stronger data partnerships and continued co-investment, this approach can help scale community solutions that improve health where people live, work and receive care.

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Introduction

The American Medical Association (AMA) is an Anchor Mission Partner in West Side United (WSU), supporting WSU's mission to eliminate the life expectancy gap between Chicago's West Side neighborhoods and the downtown Loop. A nonprofit organization and coalition, WSU brings together health care institutions, community organizations and residents to drive economic investment. The AMA has contributed to WSU's social impact investing portfolio, which WSU defines as "a strategic effort to mobilize capital toward community development projects **that drive measurable social and economic returns**. Rather than relying solely on grants or philanthropy, the initiative focuses on using **low-interest loans deployed via Community Development Financial Institutions to support mission-aligned businesses and infrastructure** on Chicago's West Side."¹

While evaluation of this type of investment strategy is difficult, **a promising methodology is Social Return on Investment (SROI)**, which estimates both the economic and health impact of investments.² Unlike traditional return on investment (ROI), which focuses on organizational profit or financial return to an investor, SROI does not imply that value is captured financially by the investor or the loan recipient; rather, it reflects a measure of socioeconomic value created for beneficiaries and society more broadly.³

In 2024, the AMA partnered with Kearney to conduct an SROI evaluation of three selected loans within the WSU portfolio. SROI was used to estimate the annual socioeconomic value associated with those investments, while Quality-Adjusted Life Years (QALY) was used as a complementary lens on health-related quality-of-life effects. While it is difficult to parse out a direct one-to-one contribution from the AMA's direct investment in comparison to investment from other stakeholders, these results offer a directional signal of the value and effectiveness of a community-driven strategy for social impact investing. This report presents the results of our assessment and considers implications for community health strategy, cross-sector partnerships and future investment decisions.

It is important to note that loans are not directly comparable, and our objective was not to evaluate any one particular loan in contrast to another. Rather, each loan may be viewed as an **illustrative archetype of approaches to community impact**:

- **Loan 1** supported a neighborhood restaurant that combines employment with worker supports including subsidized meals, affordable health-related services and financial literacy or leadership training. This is an example of a small business serving as a platform for wraparound support for workers and promoting employment stability.
- **Loan 2** supported an affordable housing development that pairs stable housing with healthy food access and supportive services for residents, including social, employment, transit and health-related supports. This is an example of how a housing development can address several basic needs that influence health at the same time.

¹ <https://www.westsidewestside.org/programs-info/impact-investing>

² Yates, B.T., Marra, M. Social return on investment (SROI): problems, solutions... and is SROI a good investment? Evaluation and Program Planning. 2017; 64:136-144.

³ Corvo L, Pastore L, Mastrodascio M, Cepiku D. The social return on investment model: a systematic literature review. Meditari Accountancy Research. 2022;30(7):49-86.

- **Loan 3** supported a holistic community campus that integrates housing, health care, education, food access, recovery supports and programming for different populations. This is an example of an ecosystem model designed to address multiple social drivers of health at once.

Taken together, these archetypes show several ways mission-driven investments may contribute to community health. This work also provides a data-driven methodology for quantifying economic and health impacts of collective impact investments.

The broader implication is not that one model is universally best, but that multiple community lending strategies may contribute meaningfully when they are tailored to local need, designed around social determinants of health and implemented through strong partnerships.

Why this matters

Background

West Side United was launched in 2018 by Rush University System for Health, Ann & Robert H. Lurie Children's Hospital of Chicago, Cook County Health, Sinai Chicago and UI Health to address the social drivers of community health across Chicago's West Side.

The AMA joined the collaborative in 2020 and later expanded its role as an Anchor Mission Partner in 2022. By June 2024, WSU and its partners had collectively invested \$11.58 million in West Side neighborhoods through social impact investing, with the AMA committing \$5 million since 2020.

Taken together, these investments have funded well over 600 loans for small businesses and contributed to the expansion of affordable housing, community spaces, healthy food options, job development and educational programs. Investments are made through three Community Development Financial Institutions (CDFIs)—nonprofit banks that make low-interest loans to small businesses and nonprofits along with training and technical assistance. It is important to note that these loans carry an expectation of repayment; they are not grants.

Context for the investment

The AMA's investments are distributed to community-based organizations and businesses on the West Side of Chicago, a culturally and racially diverse area marked by long-standing structural barriers in health, housing and employment, with disproportionately fewer opportunities for investment support. This context matters because health outcomes are shaped by much more than medical care alone.

Research shows that social determinants of health—including income, education, housing and neighborhood conditions—account for up to 50% of health outcomes, exceeding even the influence of medical care.⁴

Many West Side residents face persistent barriers in accessing health care, stable employment, affordable housing and quality education.⁵ This long-standing disinvestment translates into profound differences in life expectancy. According to the latest data available, residents in some neighborhoods live up to 20 years fewer than those downtown. Even within the West Side, life expectancy varies significantly across neighborhoods: South Lawndale (83 years), North Lawndale (71 years), West Garfield Park (70 years) and Lower West Side (84 years) (see Figure 1). Neighborhoods that are majority Black bear the brunt of health inequities that reflect both structural racism and generational disinvestment and consequently the lowest life expectancies.⁶

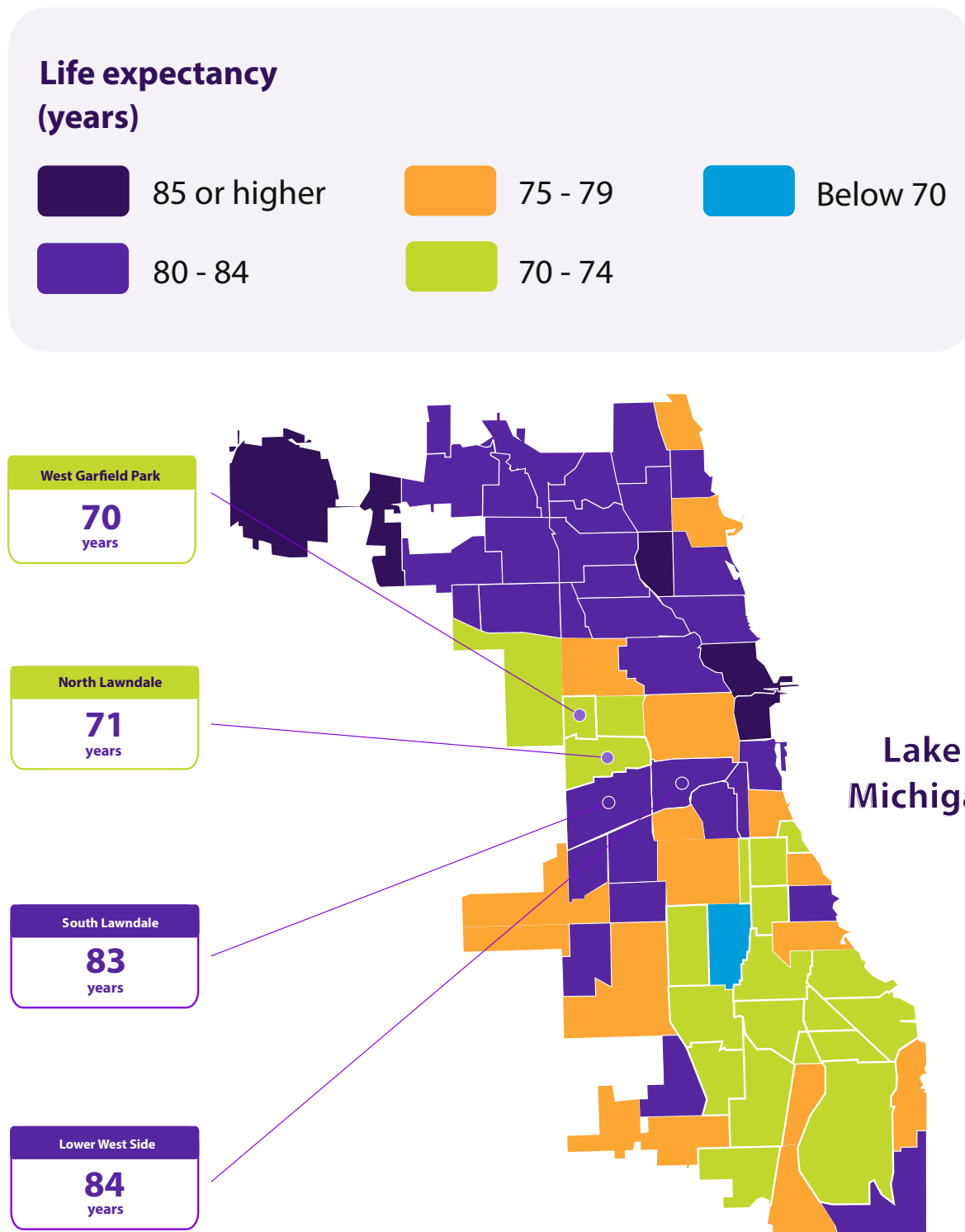
⁴ Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *Am J Prev Med.* 2016;50(2):129-135.

⁵ Ansell DA. *The Death Gap: How Inequality Kills.* University of Chicago Press; 2021; Roesch P, Lange-Maia BS, Shapiro E, Hightower DO, Verma V, Prachand NG, LaFlamme E, Jaco A, Ansell D, Homan S; West Side United Metrics Working Group. *Mobilizing to Action: Overcoming Chicago's 16-Year Life Expectancy Gap.* In: Benjamins MR, De Maio FG, eds. *Unequal Cities: Structural Racism and the Death Gap in America's Largest Cities.* Johns Hopkins University Press; 2021.

⁶ West Side United: <https://www.westsideunited.org/>

Figure 1

Live expectancy by West Side neighborhood



Source: Chicago Health Atlas.

Methodology at a glance

Kearney conducted an SROI evaluation of three selected loans within WSU's social impact investment portfolio to estimate the annual socioeconomic value associated with those investments relative to the resources required to enable them. Because the loans differed in scale, maturity, operating model and intended impact, they were treated as distinct investment archetypes rather than directly comparable projects.

The methodology followed a common logic across all three loans. Kearney worked with the AMA, WSU and participating organizations to understand each project's activities, target populations and intended outcomes. Those activities were then mapped into value chains linking inputs, outputs, outcomes and measurable indicators. Outcomes with sufficient evidence and credible inputs were translated into financial terms using program data, public sources, academic literature and health economics benchmarks.

To avoid overstating impact, the SROI model estimated adjusted incremental benefit rather than simply counting all observed positive outcomes. Adjustments included attribution (% directly attributed impact), substitution (% with no viable substitute) and partnership (% shared with any co-delivery partner) effects where relevant.⁷ QALY was assessed separately as a complementary health-related measure and was not included in the SROI ratio. Inputs were triangulated across interviews, public and published sources and available health or administrative data, but the findings should still be read as modeled estimates rather than audited impact results.

A fuller explanation of assumptions, data sources and limitations appears in the appendix.

SROI methodology

SROI is an outcomes-based framework used here to estimate the annual monetary value generated from selected social impacts relative to the investment:

$$\text{SROI} = \text{Total adjusted social value created} / \text{Total investment}$$

In practice, the analysis uses value chain mapping to link funded activities to measurable outcomes and then applies evidence-based financial proxies to estimate the value associated with those outcomes.

For each selected loan, the value chain was mapped to identify:

- the activities enabled by the investment,
- the outputs produced by those activities,
- the outcomes experienced by beneficiaries (participants, residents, workers or households) and
- the financial indicators used to translate those outcomes into monetary terms.

⁷ Adjustments made by applying a % factor to the impact number. Attribution refers to the % of the impact that can be attributed specifically to this program. Substitution refers to the % of the impact that would have been most likely provided by another service if this program was not in place. Partnership refers to the % of the impact that needs to be shared with another organization as the work was done in partnership.

This structure was necessary because each loan generated value through different pathways. For example, a restaurant loan created value through employment and worker supports; a housing development created value through stable housing, food access and site-based services; and a holistic campus created value through multiple integrated supports. **Therefore, the evaluation used loan-specific value chains while maintaining a common SROI logic and calculation structure across all three.**

The analysis then estimated incremental benefit, or the portion of value that was additional and plausibly linked to the loan-supported intervention rather than to other factors.

Where possible, the model distinguished between direct outcomes for participants, such as increased income or reduced risk associated with instability, and broader system-level effects, such as avoided public or health system costs. Outcomes that were important but not credibly monetizable were generally captured qualitatively or through the complementary QALY analysis.

Calculation of incremental and adjusted benefit

After estimating gross outcome value, adjusted factors were applied to avoid overstating impact. The model did not simply count all positive outcomes associated with an organization's programming; it sought to estimate the portion of benefit that was additional and plausibly linked to the intervention being evaluated.

These factors were selected based on the structure of each program pathway, the role of partner organizations, available evidence on likely outcomes and input from participating organizations. Where uncertainty existed, assumptions were applied conservatively.

- **Attribution:** an adjustment reflecting the extent to which outcomes were influenced by other organizations, partners or contextual factors, rather than by the loan-supported intervention alone.
- **Substitution:** an adjustment reflecting cases where the value generated may have displaced other benefits or supports that beneficiaries would otherwise have received.
- **Partnerships:** an adjustment for activities delivered jointly with partner organizations; only the appropriate share of value was assigned to the modeled intervention.

These adjustments are consistent with standard SROI practice and were applied conservatively to avoid over-claiming impact.

SROI results

All three selected loans were associated with positive estimated social returns, with SROI ratios ranging from **4.4x to 8.6x**. This means that, across the loans assessed, every \$1 invested was associated with approximately \$4.40 to \$8.60 in estimated annual social value.

Table 1 summarizes the key modeled inputs and outputs underlying each loan's SROI result. It presents the estimated adjusted benefit, the cost used in the denominator of the SROI calculation, the resulting SROI ratio and the complementary QALY estimate.

Table 1: Loan-level results

	Investment archetype	Adjusted benefit	Loan amount	SROI	QALY
Loan 1	Small business & wraparound supports	\$1.2M	\$0.3M	4.4x	2.1
Loan 2	Affordable housing & food access	\$8.5M	\$1.5M	5.7x	6.2
Loan 3	Holistic community campus	\$17.4M	\$2.0M	8.6x	10.2

Note: SROI reflects estimated annual monetized social value after conservative adjustments to avoid over-claiming impact. QALY (Quality-Adjusted Life Years) is shown as a complementary health-related measure and is not included in the SROI ratio.

Taken together, the findings suggest that different forms of social impact investing may create value through different mechanisms. The central implication of these findings is not that one model is universally best, but that multiple community lending strategies may contribute meaningfully to community health when they are tailored to local need, designed to address social determinants of health and implemented with strong partnerships.

Loan-level illustrations of impact



Case study: Loan 1

- Neighborhood restaurant combining employment with worker supports such as affordable health-related services, financial literacy and subsidized meals.
- Illustrates a **small business archetype** in which value is created through employment and wraparound support.
- SROI: **4.4x** impact per \$1 invested (5.8x compared with a similar control restaurant); QALY: **2.1** years.
- Shows how even a relatively small-scale, privately owned business can contribute to community health through a targeted support model.



Case study: Loan 2

- East Garfield Park housing development with on-site food hall and social services.
- Represents a **housing development archetype**, addressing a foundational social determinant of health, especially critical for low-income families.
- Supports housing, food access and transportation.
- SROI: **5.7x** impact per \$1 invested; QALY: **6.2** years.
- Medium investment; shows scalable housing-based model.



Case study: Loan 3

- Holistic community campus offering housing, health care, education, food access, recovery supports and related programming.
- Illustrates a **broader ecosystem archetype** designed to address multiple social determinants of health through an integrated platform.
- Substantial partnership-leveraged programs include housing, health-related services, food access, substance use support and youth-oriented programming.
- SROI: **8.6x** impact per \$1 invested; QALY: **10.2** years.
- High investment; shows how integrated, partnership-based models may create value across multiple pathways rather than through a single intervention.

Figure 2

Loan 1: Annual SROI charter

Loan name	Loan description		
Loan 1	Restaurant providing employment and leadership training in Austin.		
Time frame 2022 (1 year)	Total funding \$272K (100% CCLF/AMA)	QALY 2.1 years	SROI 4.4x

←----- Impact of activities -----→

Activity 1: Restaurant employment Provide employment at restaurant to previously unemployed people. ~\$1.0M Adjusted incremental benefit		Activity 2: Subsidized meals Provide monthly front-loaded points for food. ~\$75K Adjusted incremental benefit	
Beneficiaries	Financial indicators	Beneficiaries	Financial indicators
Restaurant employees (25 total)	Increased disposable income due to employment.	Restaurant employees (25 total)	Savings in meal costs due to subsidized meals.
Activity 3: Financial literacy and leadership training Provide financial literacy and leadership training (e.g., credit education). ~\$67K Adjusted incremental benefit		Activity 4: Access to health care Provide affordable health care at \$35/month including dentistry and mental health services. ~\$19K Adjusted incremental benefit	
Beneficiaries	Financial indicators	Beneficiaries	Financial indicators
Restaurant employees (25 total)	- Increase in savings balance. - Reduction in debt.	Restaurant employees (25 total)	- Reduction in health care costs due to prevention screening. - Reduction in costs due to decrease in emergency visits.
Management staff (5 total)	- Increase in savings balance. - Reduction in debt.		

Figure 3

Loan 2: Annual SROI charter

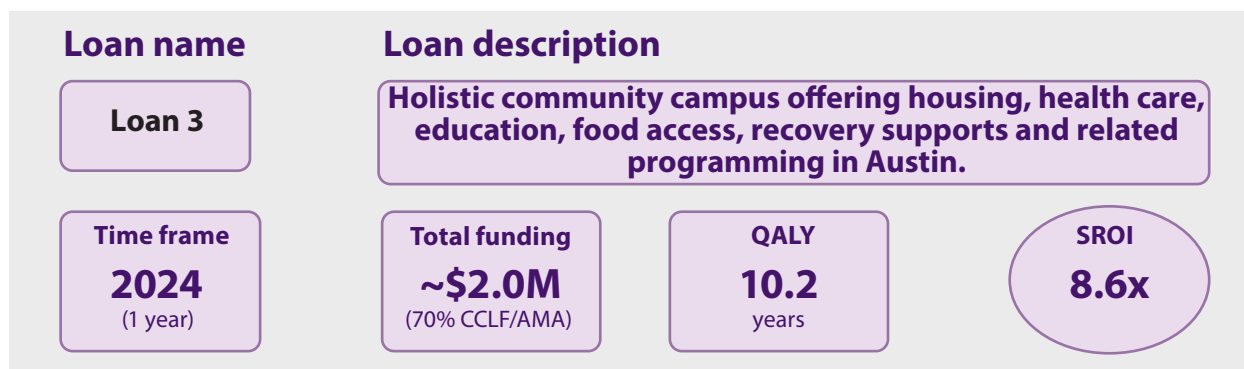
Loan name	Loan description		
Loan 2	Affordable housing development with on-site food hall and social services in East Garfield Park.		
Time frame	Total funding	QALY	SROI
2023 (1 year)	~\$1.5M (33% CCLF/AMA)	6.2 years	5.7x

Impact of activities

Activity 1: Housing initiatives Build 50, 1-3 bedroom apartments with a gym facility and recreational space in the housing complex.		~\$4.6M Adjusted incremental benefit
Beneficiaries Housing residents (100-125+ total; 65% adults, 35% children)	Financial indicators - Reduction in financial costs due to permanent housing. - Decrease in mental health treatment costs. - Increase in income. - Reduction in health care costs due to gym access. - Reduction in costs due to childhood poverty.	
Activity 2: On-site social services Provide financial and employment support services, public infrastructure education and health support services.		~\$2.0M Adjusted incremental benefit Partner with organization 1 and organization 2 (25% attribution)
Beneficiaries Housing residents (100-125+ total; 65% adults, 35% children) On-site social services staff (4 total)	Financial indicators - Increase in savings balance. - Increase in employment from employment services and public transit. - Decrease in personal transportation spending due to increased public transit use. - Decrease in emergency visits due to health support services. - Increased disposable income due to employment.	
Activity 3: On-site food hall Provide access to healthy food through on-site Black-owned restaurants.		~\$1.6M Adjusted incremental benefit
Beneficiaries Housing residents (100-125+ total; 65% adults, 35% children) Restaurant staff (30-35 total)	Financial indicators - Reduction in health care costs due to improved nutrition. - Increased disposable income due to employment.	
Activity 4: On-site general services Provide employment to office management staff and city infrastructure workers required for utilities like water and gas lines.		~\$226K Adjusted incremental benefit
Beneficiaries Management staff (2 total) City infrastructure workers (15-24 total)	Financial indicators - Increased disposable income due to employment. - Increased disposable income due to employment.	

Figure 4

Loan 3: Annual SROI chart (continued)



←----- Impact of activities -----→

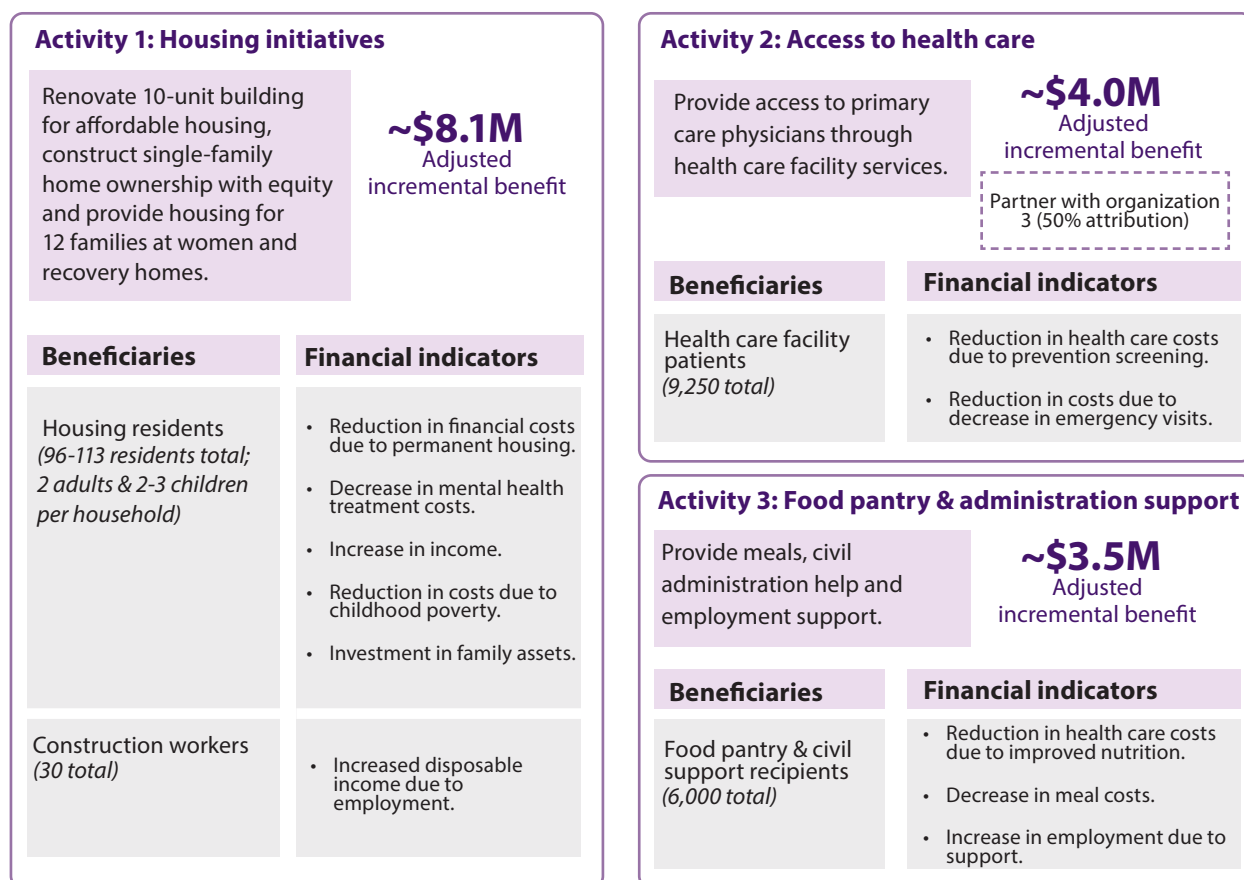


Figure 4

Loan 3: Annual SROI charter continued

←----- Impact of activities -----→

Activity 4: Campus staff employment

Provide staff with steady employment and training.

~\$803K

Adjusted incremental benefit

Partner with organization 3 and organization 4 (50% attribution)

Beneficiaries

Campus staff members
(116 total)

Financial indicators

- Increase in disposable income.
- Projected increase in income due to training and new skills.

Activity 5: School programs

Provide schooling along with subsidized lunch and snack, summer programming including a violence prevention program and after-school programming.

~\$596K

Adjusted incremental benefit

Partner with organization 4 (50% attribution)

Beneficiaries

School children
(520 total)

Financial indicators

- Decrease in meal costs.
- Reduction in community costs due to decreased violence.
- Increase in salary wage.

Activity 6: Women & children's recovery home

Provide women a stable environment for substance abuse recovery.

~\$306K

Adjusted incremental benefit

Partner with organization 3 (50% attribution)

Beneficiaries

Women in recovery home
(12 total)

Financial indicators

- Reduction in health care costs due to substance abuse recovery.
- Increase in employment.

Activity 7: Seasoned citizens programs

Provide social engagement, community involvement and physical activities.

~\$123K

Adjusted incremental benefit

Beneficiaries

Seasoned citizens
(55 total)

Financial indicators

- Reduction in health care costs due to exercise.
- Reduction in health care costs due to improved mental health.

What this means for community health

"Measuring Social Return on Investment (SROI) will allow us to clearly articulate the broader impact of our work—beyond financial returns. For Community Development Financial Institution (CDFIs) like Chicago Community Loan Fund (CCLF), this is crucial in showing funders how their capital contributes to meaningful, measurable outcomes in underserved communities. Having concrete data on SROI strengthens our ability to attract and diversify funding sources, especially in today's competitive and capital-constrained environment."

Angela Dowell, Chicago Community Loan Fund

SROI is a viable methodology for understanding the community-level effects of collective impact investment. Importantly, this method goes beyond traditional ROI calculations, which focus on the return to the organization or individual investor and instead captures social and economic value created for the community in general. As such, SROI can inform evidence-based funding and policy decisions within health care and community development, guiding resources to make the greatest impact on community health.

Future research should continue to refine and validate this methodology, with longer follow-up on investments and in a wider variety of settings. Qualitative research studies that detail the impact of these investments on communities are also needed; such studies could use community-based participatory methods as well as data collection methods like photovoice to elevate community-driven narratives and document change in the lives of community members. Future studies should also continue to grapple with challenges associated with estimating economic and health impacts as well as with the complexity of quantifying attribution versus contribution to any observed outcomes.

Physicians know the critical importance of the social determinants of health. A large body of empirical research confirms their importance; less is known about the effectiveness of community-level interventions like collective impact investment. SROI calculations are a vital component of interventions aiming to address working and living conditions across diverse communities.

Data can spur action, and better understanding the community-level effects of collective impact investment may hold the key for motivating and sustaining large-scale efforts to improve community health.

WSU offers a model for transforming Chicago's West Side neighborhoods through collaboration and investment. Impact is driven by community-based ownership, which ensures programs are locally anchored and responsive to the lived realities of residents; multi-sector collaboration, which leverages expertise across health care, housing, education and business to achieve broader outcomes; and tailored program models, designed to meet the diverse needs of specific populations within West Side communities.

Conclusion

This work underscores the critical role that community-based organizations and businesses play in creating opportunities so that all communities and all people can thrive. These projects complement clinical care by targeting the 50% of health outcomes determined by social factors.⁸ Indeed, this evaluation shows that social impact investing generates measurable benefits—including added years of healthy life, greater housing stability, and reductions in system-level costs—at a scale several times greater than the resources invested. The findings do not establish a universal formula, but they do suggest that mission-driven investment can be part of a practical community health strategy when it is grounded in local need, delivered through strong partnerships and paired with disciplined measurement.

For physicians, these findings present an opportunity for engagement. Beyond clinical encounters, physicians can help identify patients' health-related social needs, advocate for policies that expand proven community-based investments in upstream supports and build partnerships that address the root causes of health disparities. Physician advocacy for place-based investments to reduce health disparities is reflected in national efforts such as the work of the Healthcare Anchor Network.⁹ Additionally, the SROI framework explored in this report provides a valuable methodological tool to complement the advocacy and the structural competency efforts many physicians already undertake to address the social determinants of health.¹⁰

For funders and partner organizations, this evaluation provides a compelling invitation to co-invest in models that demonstrate strong SROI and align with health outcome goals. Collective action of this kind has the potential to amplify impact, extend the reach of effective programs and accelerate progress toward more equitable health outcomes. A critical first step in such work must be building strong collaborative ties with community-based organizations in the areas you seek to invest in.

The selected AMA-supported WSU loans suggest that investments in community conditions can generate measurable annual socioeconomic value and complementary health-related benefits. With stronger data partnerships and continued co-investment, this approach can help scale community solutions that improve health where people live, work and receive care.

⁸ Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *Am J Prev Med.* 2016;50(2):129-135.

⁹ <https://healthcareanchor.network/>

¹⁰ Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med.* 2014;103:126-133; Metzl JM, Maybank A, De Maio F. Responding to the COVID-19 pandemic: the need for a structurally competent health care system. *JAMA.* 2020;324(3):231-232; Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Acad Med.* 2017;92(3):299-307.

Appendix: Detailed methodology

Our process

Kearney's evaluation followed a structured process designed to move from investment selection and scoping, to value chain development and then to quantitative SROI and QALY analysis. The work combined stakeholder engagement, data requests, program documentation and external research to build a consistent analytical framework across the three selected loans. The purpose of this appendix is to summarize how the work was conducted and to provide additional technical detail for readers who want a fuller explanation of the methodology, assumptions, data sources and limitations.

Assessment scope

This evaluation focused on three loans selected from the broader WSU portfolio. These loans were intentionally chosen to represent distinct investment archetypes within WSU's social impact investing strategy and to reflect variation in intervention type, scale and available data.

1. **Loan 1** supported a local restaurant that combines jobs with worker supports such as meals, health care and financial training.
2. **Loan 2** supported an affordable housing development that pairs stable housing with healthy food access and on-site support services.
3. **Loan 3** supported a community campus that brings together housing, health care, education, food access and recovery services in one integrated model.

Project phases

The evaluation process was structured into three phases:

Phase 1: Setup and scoping

The team reviewed WSU's portfolio of social investment projects, identified key stakeholders and assessed data availability. Three priority projects were selected for SROI evaluation, chosen for their diversity of interventions and richness of available data. Setup meetings were conducted with each selected organization to confirm their participation and ensure data readiness prior to the project kick-off.

Phase 2: Value chain development and key performance indicator validation

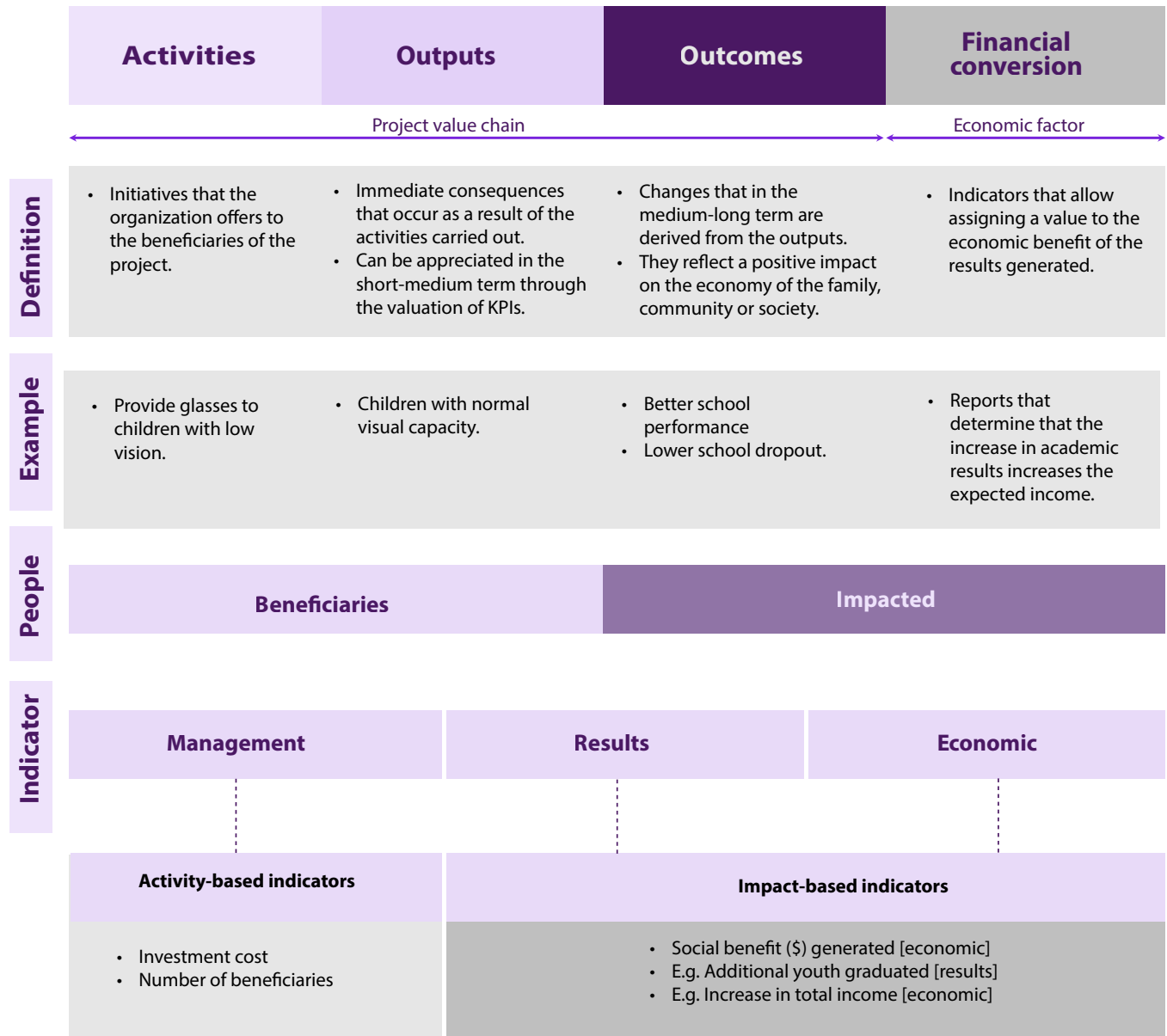
The team defined value chains for each project, mapping activities and inputs to anticipated health and financial outcomes. Tailored key performance indicators (KPIs) were developed to align with the specific scope and activities of each project. Co-design workshops and interviews were conducted with the participating organizations to ensure accuracy and validate value chains and KPIs, resulting in structured data requests for each organization.

Phase 3: Evaluation by Kearney

Once the necessary data had been gathered, Kearney carried out the SROI analysis for all three selected loans and a complementary QALY analysis to capture broader health-related effects. This included compiling program data, financial inputs and reported outcomes from each organization.

Figure 5

Social return on investment value chain



Definitions

Defining SROI

SROI measures the economic value of social impact generated for direct beneficiaries and broader systems from program activities. In this report, “direct beneficiaries” refers to the individuals, households, employees, residents or program participants who directly receive or experience the services, supports or opportunities enabled by the investment. SROI translates program benefits into a dollar value to estimate the amount of socioeconomic value created for every dollar invested on an annual basis. For example, an SROI of 8.0x indicates that for every \$1 of investment, the program is associated with approximately \$8 of monetized social value. By doing so, SROI helps quantify how programs reduce costs across the broader health system, including fewer emergency room visits, reduced uncompensated care and better adherence to treatment.

Defining QALY

Quality-Adjusted Life Years (QALY) was incorporated as a complementary measure to assess program impact, capturing health-related quality of life improvements that may not be fully reflected in dollar-based calculations (e.g., SROI). QALY is a widely used health economics metric that provides a standardized way to assess both the quantity and quality of life gained from an intervention. This approach translates program impacts into additional healthy life years gained for participants, offering a human-centered perspective on well-being and long-term health outcomes.

Key distinction

- **SROI:** Annual, quantitative and financially expressed estimated social value relative to investment.
- **QALY:** Lifetime, health-related and focused on well-being improvements.

Together, these two measures provide a dual perspective—one grounded in economic value, the other in human health and social well-being.

SROI costing approach

The denominator in the SROI calculation reflects the investment required to enable the modeled outcomes. In this evaluation, that meant using the full relevant funding associated with the loan-supported intervention model rather than isolating AMA's capital contribution alone. This approach reflects the blended financing structures under which these organizations operate.

Example: In a nutritional support program, the provision of lunches and snacks may be linked to reduced food costs by multiplying the number of participants receiving meals by the cost per meal.

Annualized benefits were estimated for each indicator, adjusted conservatively to avoid overstating impact. Benefits were aggregated across indicators and then divided by the funding to produce the final SROI ratio. The resulting figure therefore reflects estimated social return per dollar invested in the broader intervention model under review, not a return attributable solely to AMA's share of funding. This is due to the blended nature of loan financing, which typically includes AMA funds alongside partner contributions and grants.

Figure 6

SROI calculation approach

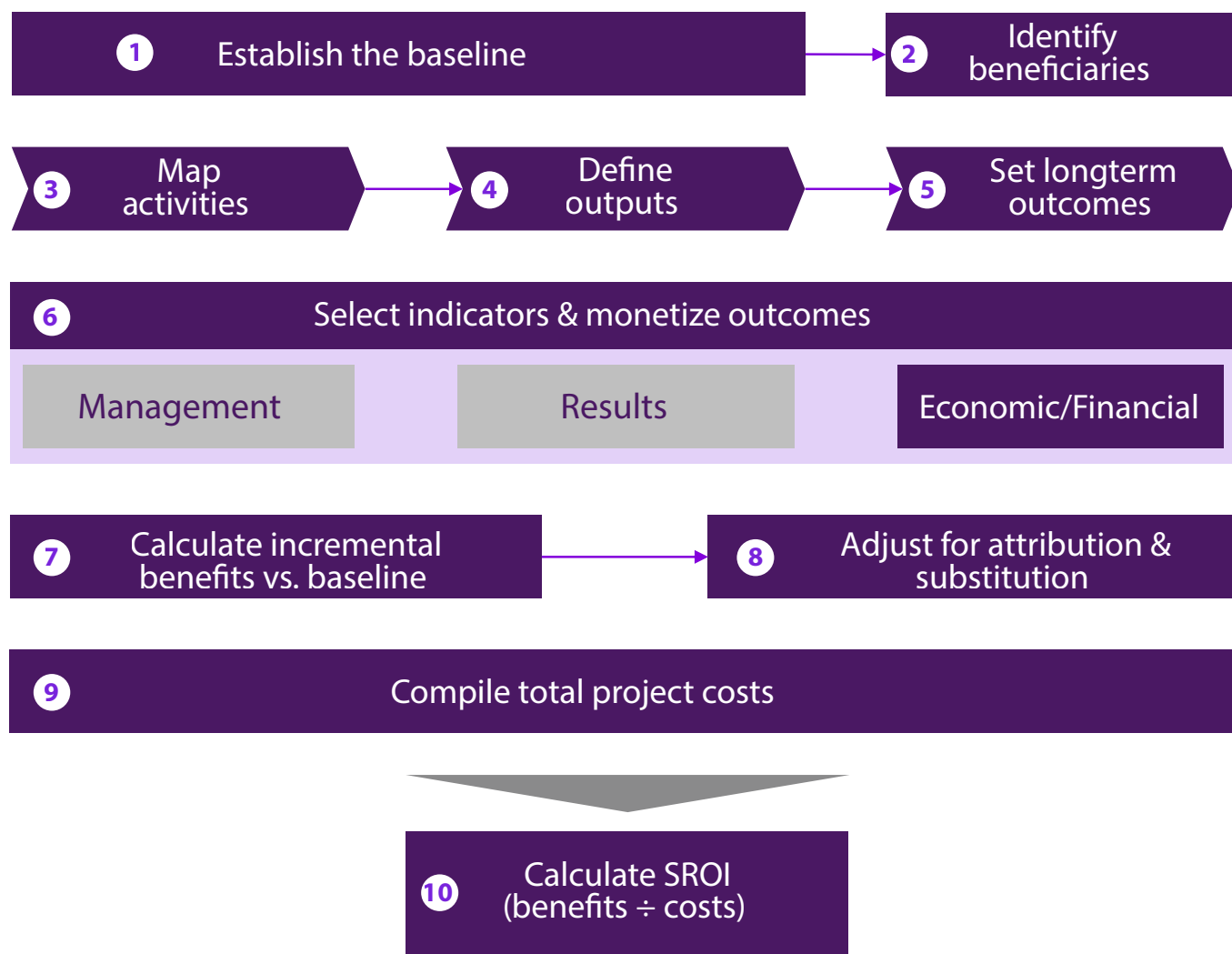


Figure 7

SROI model calculations



SROI model

Economic impact calculation

SROI quantifies the economic value each loan generates, expressed as the incremental benefit created per dollar of funding.

Process

1. Used the value chain as the baseline.
2. Identified the number of beneficiaries and quantitative indicators for each activity.
3. Built a formula for each financial indicator's incremental benefit—the shift in value resulting from the intervention.
4. Assigned values to each demographic and economic factor using academic and reputable sources.
5. Adjusted incremental benefits for partnerships that helped generate SROI (substitution and attribution).
6. Aggregated the adjusted incremental benefit across activities, net of funding costs, to yield the final SROI.

Detailed QALY methodology

Quality-Adjusted Life-Years (QALY) provides a measure of the additional quality-adjusted years of life associated with an intervention. In this evaluation, QALY captured lifetime improvements in health and well-being that extended beyond the monetary scope of SROI. Like SROI, the process uses value chain mapping to link program activities to intermediate outcomes.

Example: Nutritional support may be associated with improved health, reduced food insecurity and better social integration, which can then be linked to relevant measurement indicators such as improved BMI or reduced malnutrition-related illnesses.

Where appropriate, published coefficients and health economics sources were used to estimate QALY effects associated with those outcomes and to calculate lifetime health-related benefit for each selected loan.

Figure 8

QALY model calculations



QALY model

Additional calculation for qualitative factors

QALY represents the additional years of perfect health a beneficiary gains from an activity, capturing qualitative impact beyond the financial return.

Process

1. Used the value chain as the baseline.
2. Identified activities that map to qualitative indicators.
3. Researched academic literature to identify the QALY value of each indicator (e.g., reduction in homelessness).
4. Aggregated each indicator's value to calculate the final QALY.

Data and limitations

Data sources and study limitations

The analysis drew on multiple data sources to ground the model in the activities, reach and outcomes of the selected loans. Inputs were used to define each loan's operating model, estimate beneficiary reach, identify relevant outcomes and apply financial proxies or health-related coefficients where appropriate.

- **Interviews with implementing organizations** to confirm program scale, reach and operational realities.
- **Peer-reviewed literature and published health economics benchmarks** to provide evidence-based coefficients and comparative measures.
- **Public national and local databases**, such as the Chicago Health Atlas and the WSU dashboard, to contextualize program outcomes within broader demographic and health trends.
- **WSU's regional health database and administrative records**, which offered detailed insights into population health outcomes and service utilization.

Inputs were verified across sources wherever possible. Information provided by organizations and through interviews was pressure-tested through follow-up discussion, comparison with public or published sources and review against the observed program model. However, the evaluation did not include a detailed audit of organization-reported data, independent verification of administrative records, site visits or field validation of program delivery. The findings should therefore be interpreted as modeled estimates based on the best available information, rather than audited impact results.

Data point estimates

This study presents SROI results as point estimates rather than ranges because the available data did not consistently support robust low, medium and high calculations across all three loans. While in principle the lack of low-high ranges for the estimates is a methodological limitation, point estimates, in these calculations, provide the most rigorous results. The loans differed in operating model, maturity, data completeness and beneficiary pathways, and so developing ranges for some assumptions but not others could have created a false sense of precision or comparability. For this reason, the report presents point estimates that reflect the best available and most reasonable assumptions at the time of analysis, with conservative adjustments applied to reduce the risk of overstating impact. The results should therefore be interpreted as directional and illustrative rather than precise or audited.

Future evaluations may be able to incorporate ranges or sensitivity scenarios if more standardized data become available across projects, including consistent tracking of beneficiary counts, service utilization, program duration, outcome persistence and project-specific attribution.

Data limitations

While SROI provides a useful framework for quantifying the social and economic value of health interventions, important limitations should be acknowledged.

First, some benefits—such as improvements in happiness, social cohesion or emotional well-being—are difficult to monetize and were not fully captured in the quantitative framework. As a result, the SROI ratios may not reflect the full value created by the selected loans.

Second, the evaluation was limited to three selected loans. Those loans were chosen to represent distinct investment archetypes within the WSU portfolio, but they do not capture the full breadth of AMA's or WSU's social impact investing activity. The results should therefore be interpreted as illustrative of selected models, not as a comprehensive assessment of the entire portfolio.

Third, while all metrics and assumptions were reviewed and aligned upon across key stakeholders, SROI requires judgment in selecting outcomes, estimating factors such as attribution and identifying appropriate financial proxies.¹¹ Health-related outcomes (e.g., improvements in mental well-being) are inherently difficult to monetize comprehensively, which means some benefits may be omitted or weakly captured through proxy measures.¹²

Finally, this assessment (and many SROI studies) did not include control groups, before-and-after outcome tracking, detailed audits or independent field validation. These factors limit the ability to make causal claims or to compare ratios directly across programs.¹³ Thus, while SROI can provide directional insight into value-for-money, its results should be treated as indicative rather than precise. However, these results demonstrate that a rigorous, replicable methodology can be applied to estimate socioeconomic return from social impact investments addressing social determinants of health.

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We are grateful for the contributions to this work from staff at the American Medical Association, Kearney and West Side United. Many people developed this work over the past five years, and this report reflects their commitment to addressing the root causes of health inequities and improving community health outcomes for all. This work would also not have been possible without the close collaboration with the three loan-receiving organizations in the west side of Chicago, whose efforts are leading to meaningful community impact and who partnered with us to develop this analysis. We also benefited from collaboration with colleagues at the Healthcare Anchor Network who generously shared their expertise with social impact investing.

¹¹ Gosselin V, Boccanfuso D, Laberge S. Social return on investment (SROI) method to evaluate physical activity and sport interventions: a systematic review. *Int J Behav Nutr Phys Act.* 2020;17(1):26.

¹² Hutchinson CL, Berndt A, Gilbert-Hunt S, George S, Ratcliffe J. Valuing the impact of health and social care programmes using social return on investment analysis: how have academics advanced the methodology? A protocol for a systematic review of peer-reviewed literature. *BMJ Open.* 2018;8:e022534.

¹³ Arvidson M, Lyon F, McKay S, Moro D. Valuing the social? The nature and controversies of measuring social return on investment (SROI). *Voluntary Sector Review.* 2013;4(1):3-18.

