The Role of Employee Benefits in Building a High-Impact, High-Performance Community-Based Development Organization

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The community-based development field has made significant progress in the past 30 years.[1] Community-based development organizations and community development corporations (CDCs) now play a significant role in producing affordable housing, developing local economies, and hosting job-training programs (Grogan and Proscio 2000; Harrison, Gant, and Weiss 1995; U.S. House 1995). CDCs accomplish their missions under difficult circumstances (Walker and Weinheimer 1998), relying on sporadic income based on project revenue, government programs, philanthropic support, and over the past 15 years, support from national and regional intermediaries (Walker 2002). The national and local support structure for these organizations has progressed to the point where CDCs and like organizations can claim a high level of stability and impact (Ferguson and Stoutland 1996; Hoereth 2003).

Despite the progress CDCs have made in both improving distressed neighborhoods and establishing themselves as solid organizations, a critical set of organizational challenges must be addressed before CDCs can be relied on as a significant antipoverty strategy (Weinheimer 1999; LISC 1998, 2002):

- Uneven patterns of skill acquisition.
- Uneven patterns of leadership and staff recruitment.
- Lack of clear standards for organizational performance and impact.
- Organizational cultures that do not motivate and value talent sufficiently.
- Uneven patterns of core funding support.

These needs cannot be blamed solely on the lack of a solid income stream. Growing high-performance organizations, as part of a larger community development field, presents a complex challenge (Rodriguez and Herzog 2003). This paper examines and summarizes one important aspect of building high-impact, high-performance community development organizations: assessing the role of benefits in attracting and retaining good leadership and staff. Despite sparse evidence, enough work has been done over the past few years to give a better sense of whether benefits represent a looming crisis or a manageable issue that will not retard the progress of these organizations.

SALARY AND BENEFITS: THE MAJOR ISSUES

Limited academic and applied literature exists on the role salary and benefits play in improving the work of CDCs and raising the satisfaction of employees. Indeed, an important work looking at the "management challenges" of the CDC field highlighted critical issues such as the lack of trained property managers but did not examine the significance of benefits in attracting and retaining property managers (Bratt et al. 1994). Other literature addresses such challenges as the oversupply of CDCs, the loss to retirement of the founding generation of leaders, questions of governance and board responsibilities, and management expertise in general; but even these studies include only a minor mention of salary and benefits (Rohe, Bratt, and Biswas 2003; Zdenek and Steinbach 2000, 2002). In part, the absence of detailed analyses may result from a prevailing sense by researchers, stakeholders, and funders that any deficit found in the salary and benefits structure of the field would conclude with a call for significant infusions of resources beyond the reach of most funding entities. Despite these difficulties, some researchers have addressed the role benefits play in building the infrastructure of the field.

FIELD CONTEXT: A SHORT HISTORY OF BUILDING AN EMPLOYEE-BENEFITS INFRASTRUCTURE

In the mid-1980s the CDC field expanded rapidly, masking its status as a relatively young, turbulent, growing industry (McNeely 1994, 2001). The norm for the field exhibited low salaries, almost no benefits, and high turnover among staff and executives. Stakeholders, funders, and technical-assistance providers worried that such norms limited the impact of CDCs. In 1991, in response to a "salary and benefits crisis," seven national community development intermediary organizations began to explore the connection between benefits and retention and to discover methods of intervening. The concerned organizations were the Center for Community Change, the Development Training Institute, The Enterprise Foundation, the Local Initiatives Support Corporation (LISC), the National Congress for Community Economic Development (NCCED), the National Council of La Raza, and the Neighborhood Reinvestment Corporation. Finding very little data, the organizations commissioned a study in 1992 by Charles W. Cammack Associates (a benefits consulting firm) and Audience Concepts (an organization specializing in market studies and focus groups.) The study reported a high percentage of groups with medical benefits but a severe deficit in pensions. Only 22 percent of the organizations reported the availability of any pension, of which very few enlisted an employer contribution. Moreover, the study identified the cumbersome process of evaluating and installing pension plans

as a major barrier for organizations. Cost, though an issue, seemed almost secondary to the administrative burden and time involved (Audience Concepts and Charles W. Cammack Associates 1992).

The seven organizations pursued pension options for the field. In forming the National Benefits Consortium (NBC), they hoped to use their combined credibility to "endorse" a reliable, cost-efficient, customer-centered package and help small CDCs avoid replicating the selection process on an individual basis. In 1993, the NBC published a request for proposals. From 16 responses, NBC chose Metropolitan Life to offer a range of plans from a simplified employee pension (SEP)/IRA to a full 403(b). In 1994, the NBC launched the national plan and began promoting membership. As more and more organizations adopted the nationally available plan, individuals could carry their pensions with them within the industry; the more organizations that used the same supplier, the more likely the individual could retain the same pension provider from job to job. Today, the Metropolitan Life plan remains in place and functioning. The company has since decentralized the plan to its agents across the country and provided them with education to market it to appropriate nonprofits.

In 1994, the NBC decided to broaden its human resource agenda by inviting seven additional national and regional organizations to join it in forming the Human Resource Consortium. Each organization sponsored a local CDC leader as one of its two representatives on the Consortium. The Consortium sought to promote best practices and information sharing within the five major areas of human resource development: recruitment and retention, compensation and benefits, career development, education and training, and human resource management (Glickman, Devance-Manzini, and DiGiovanna 2000; Devance-Manzini, Glickman, and DiGiovanna 2002).

Inspired by the Consortium's work, the National Community Development Initiative, a consortium of 11 national community development funders, put its substantial resources behind the 1996 launch of the Human Capital Development Initiative (HCDI). A major infusion of money to the field followed, the first such effort intended to increase the human resources capacity of local organizations. Administered by the NCCED, the program included a number of national research and demonstration initiatives hosted by 12 community development support collaboratives.[2] HCDI provided the collaboratives with resources to analyze local human capital needs and experiment with a variety of interventions for improving human capital investment. HCDI supported a number of studies of salaries and benefits, as well as efforts by the collaboratives to improve compensation. The

salary studies helped educate the field, particularly its boards, leading to salaries that are more competitive and improvements in benefits due to group buying (Glickman, Devance-Manzini, and DiGiovanna 2000; Devance-Manzini, Glickman, and DiGiovanna 2002). Toward the end of the HCDI program, the NCCED began offering group purchasing of insurance products. After this rich history, the field must ask whether any of the above experiments led to improvement and innovation in the provision of benefits by CDCs.

ACADEMIC INQUIRY

Unfortunately, academic efforts to study the impact of benefits on improving CDCs do not provide much to examine. In one of the only academic studies of salaries and benefits in the community development field, Ban, Drahnak-Faller, and Towers (2002) found a nuanced set of issues that argues against simplistic analysis and solutions that rest on the availability of resources. Surveying 30 human service and community development organizations in Allegheny County, Pennsylvania, the authors looked at the "seriousness" of problems commonly reported by practitioners as they struggled to attract and keep staff because of low salaries and benefits. Respondents reported that their ability to pay comparable salaries and benefits lagged behind the private sector (and to a certain extent the public sector), but such a deficit did not prevent them from hiring their first choice in professionals at all levels of the organization. Practitioners reported that new employees predominantly based their decisions on motivations such as social change, working with communities, and finding a place in an organization that values their work. Moreover, the sample reported relatively low turnover related to other opportunities paying higher salaries and more benefits.[3]

Ban, Drahnak-Faller, and Towers conclude that executive directors in the sample probably had an accurate view of motivational factors superseding concerns for higher salaries and benefits. They did not have, however, an overall conception of how to create high-performance organizations. The executive directors reported that positive organizational culture and personal motivation attract and retain personnel, but they did not have the training to intentionally create such an environment.

The Ban, Drahnak-Faller, and Towers study presents one extreme of existing studies on salary and benefits. Applied studies also exist that calibrate and assess the impact of salary and benefits on CDC performance. We took some of the salary and benefits surveys generated during the HCDI and assessed the validity of the common hypoth-

esis that CDCs are not on par with other nonprofits regarding salaries and benefits. The data in these surveys do not lend themselves to the complexity and nuance found in the Ban, Drahnak-Faller, and Towers study, but they indicate that CDCs do not lag significantly behind other nonprofits in the quality of salary and benefits.

METHODOLOGY

This paper uses two sets of data to draw conclusions. The first set of data combines and summarizes (through content analysis) surveys of salary and benefits commissioned by five community development support collaboratives in Portland, Cleveland, El Paso, New Orleans, and Chicago. First, we establish a baseline and make some summary judgments regarding the effect of salary benefits on CDC organizational development as a class of organizations. We then match the five salary and benefits surveys of CDCs from the HCDI project with data on the larger nonprofit community in those same cities to produce a simple aggregate analysis.[4]

Recognizing that five geographic cases might contain specific biases (such as the strength of the local CDC infrastructure and the age and size of component CDCs),we thought a broader survey of salary and benefits might yield more widely applicable findings. Therefore, from July to August of 2003, we fielded a nonrandom survey of CDC executive directors throughout the country.[5] Using an existing list of more than 2,000 CDCs, we randomly selected a maximum number of three CDCs in any targeted locality. The survey is nonrandom in the sense that the original list was not generated in a random fashion and probably contains bias relating to size and organizational tenure.

Designed to take no more than 15 minutes, the survey asked for minimal demographic information before asking questions about the role of benefits. Of the 90 executive directors contacted through letters and e-mails, 75 agreed to participate, and we made appointments to contact the executives and administer the survey by phone. The derivative survey instrument used questions from a number of existing salary and benefits instruments. Responses were entered directly into a database for later analysis.[6]

DATA FROM THE COMMUNITY DEVELOPMENT SUPPORT COLLABORATIVES

The first stage of the analysis focused on comparing benefits structures using an assessment protocol that examines the following factors:

- Health/medical insurance (including the percent of employee and family medical coverage paid by the organization).
- Vision/dental insurance and pension/retirement plans (including the level of employer contribution).
- Long-term disability insurance, life insurance, and day care.

Using this protocol, we reviewed the related contents of each benefits survey and disaggregated responses into raw numbers. Table 1 presents the summary data.

Table 1. Summary Content Analysis of Support Collaborative Benefits Data

Benefits	Neighborhood Partnership Fund	Neighborhood Progress, Inc.	El Paso Collaborative for Community & Economic Development	New Orleans Neighborhood Development Collaborative	The Chicago Collaborative
	Portland, OR	Cleveland, OH	El Paso, TX	New Orleans, LA	Chicago, IL
	N=37	N=34	N=58	N=44	N=39
Health/Medical					
Yes	100%	91%	78%	59%	82%
No	0%	9%	22%	41%	18%
Employee Medical Insurance Paid by Organization					
All (100%)	88%	100%	n/a	n/a	n/a
None	0	n/a	n/a	n/a	n/a
Other %	12%	n/a	n/a	n/a	n/a
Employee & Family Medical Insurance Paid by Organization					
All (100%)	12.5	n/a	n/a	n/a	n/a
None	68.75	n/a	n/a	n/a	n/a
Other %	18.75	n/a	n/a	n/a	n/a
Vision					
Yes	68%	35%	31%	41%	41%
No	32%	65%	69%	59%	59%
Dental					
Yes	76%	56%	33%	34%	69%
No	24%	44%	67%	66%	31%
Pension					
Yes	97%	60%	40%	16%	49%
No	3%	40%	60%	84%	51%
Long-Term Disability Insurance					
Yes	32%	35%	35%	27%	46%
No	68%	65%	65%	73%	54%
Life Insurance					
Yes	35%	56%	41%	41%	62%
No	65%	44%	59%	59%	38%
Day Care					
Yes	n/a	n/a	n/a	9%	3%
No	n/a	n/a	n/a	91%	97%

n/a = not applicable.

The table indicates that, in aggregate, a *significant* majority of the composite survey CDCs provides health and medical, although noncomparable data make it impossible to determine if all the CDCs pay for the entire package. The Portland collaborative stood out, though: 88 percent of the CDCs paid for the full cost of health and medical. Roughly half of the organizations provide the rest of the basket of benefits except disability and day care, which most organizations do not provide.

We must interpret the table with care. The summary data capture only a binary choice, not the depth and quality of the benefits.

Examining all categories of benefits in Table 1, Cleveland, Chicago, and Portland stand out as high performers, with their CDCs offering strong salary and benefits packages. We interviewed the executive directors of those three collaboratives for an explanation of their relative strength in the analysis. All three pointed to the following factors:

- Long-standing programs to help CDCs gain access to information about instituting cost-effective benefits programs.
- Local efforts at collectively negotiating and buying benefits packages.
- The relative longevity of their CDCs—many have been around for 15 years or more, giving them the experience, credibility, and resources to do the more creative budgeting necessary to offer competitive benefits packages.
- A connection to larger organizations (such as a church or hospital) through which coverage may be available.

In summary, the CDCs in the collaboratives seem to offer much of the basic benefit packages that one would expect in any organization. Next we must determine if these general findings hold in our national survey of CDC directors.

A LIMITED NATIONAL SURVEY OF THE IMPACT OF SALARY AND BENEFITS IN CDC ORGANIZATIONS

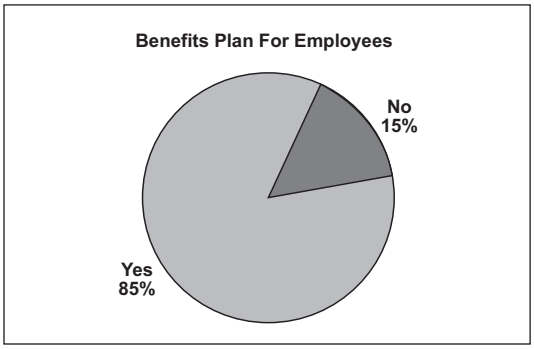
Table 2 gives some sense of the size and age of the sample used in our national survey (see the Appendix for a geographical breakdown of the CDCs). In terms of employees and budget, these are not large organizations. Most employ fewer than 10 people, have been in existence less than 10 years, and have annual budgets ranging from $100,000 to $500,000.

Table 2. National Survey of CDCs: Basic Profile

Full-Time Employees	(%)	Budget	(%)	Years of Operation	(%)
1–10	60	$100,000–$500,000	43	1–5	24
11–20	32	$500,000–$1 million	38	6–10	50
More than 20	8	More than $1 million	19	11–20	20
				More than 20	6

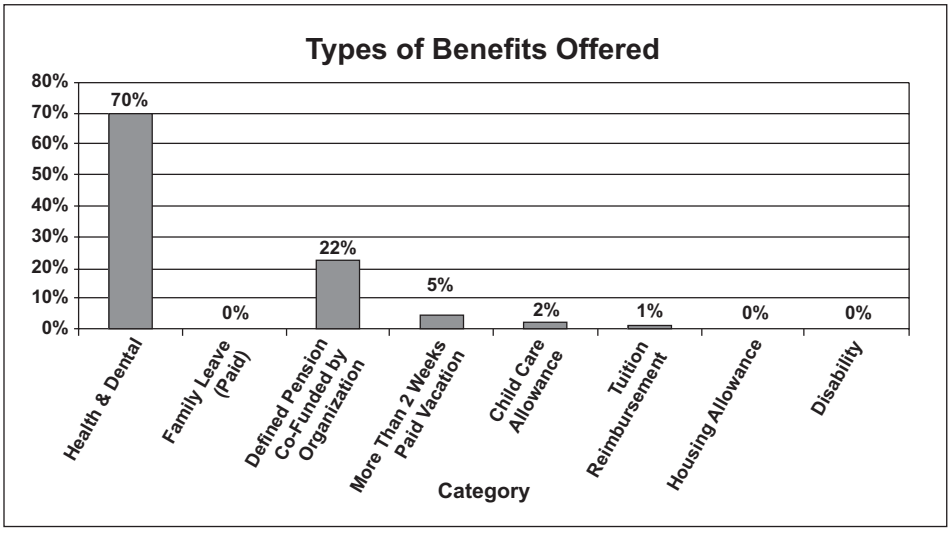
When asked if they have a clear benefits plan for full-time employees, most organizations said they do. In the context of the collaborative survey, this majority is not surprising, but it might not be expected given that the organizations in this sample are smaller and younger than the CDCs in the collaborative surveys.

Figure 1. Benefits Plan for Employees



Looking at Figure 1, one might cautiously conclude that the depth of benefits means more than the simple provision of those benefits. Figure 2 presents the types of benefits offered by CDCs. A *significant* majority provided medical and dental benefits, but provision of subsequent benefit types substantially declines. With only 22 percent of the executive directors reporting that the organization contributes to employee pension plans, retirement funding clearly remains an issue.

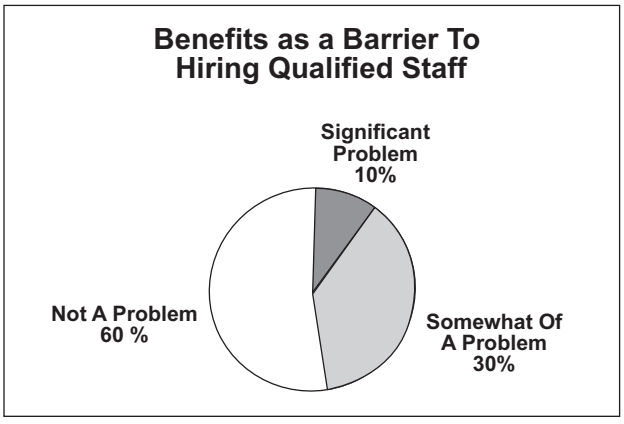
Figure 2. Types of Benefits Offered



The level of benefits, though, does not seem to play a significant role in the executive director's ability to hire highly qualified staff (see Figure 3). Similarly, executive directors do not believe that the level of benefits hinders other CDCs in their community (Figure 4).

Figure 3. Ability To Hire Highly Qualified Employees Due to Benefits Package

Figure 4. Benefits as a Barrier to Hiring Qualified Staff.



SUMMARY

The data presented in this paper point to one clear heading: benefits do not represent the problem once perceived by community development practitioners and funders. CDCs provide a level of benefits comparable to their nonprofit colleagues. They have made significant progress on this issue over the past 10 years. Older surveys indicate that CDCs provided competitive medical benefits, but lagged dramatically

in providing pension plans (McNeely 1994, 2001; Audience Concepts and Charles W. Cammack Associates 1992). Even this finding, however, must be tempered by the fact that we do not possess empirical information on the depth of benefits provision. Except for rising costs to the organizations, we suspect that health and medical benefits do not form a barrier to attracting and retaining personnel. Not enough information exists, however, on the quality of long-term pension plans. The data from both the collaboratives and the national survey reveal that not many organizations provide funded pensions.

The lack of pensions does not seem to present a problem in hiring, but should stakeholders ask employees to ignore the lack of long-term pension plans that are staples in other sectors of the economy?[7]

On another note, the findings in this paper indicate that the most important motivators in the CDC field are mission and commitment, but we still do not have high-performance community development organizations that can harness employee commitment. The real question, then, is how to build healthy organizations that offer family-sustaining benefits while motivating and challenging their employees. Achieving this balance is a monumental step toward building high-impact, high-performance community development organizations.

Beyond comprehensive efforts to create high-performing organizations and improve the executive leadership of organizations in the field, a number of actions can continue to be performed on benefits at all levels of the field.

CDCs themselves should commit to providing competitive and equitable compensation in both salaries and benefits by reviewing their benefits package and, if needed, budgeting for improvement that bring them to standards commensurate with other nonprofits of similar size and budget. CDC board members and other stakeholders, including funders, must be involved in this review and discussion. Comparisons should be made to the following standards: What do nonprofits in the area provide? What benefits are offered by employers from whom CDCs would want to recruit or who actively recruit away CDC staff? This last question prompts us to keep in mind that CDCs compete with the private sector for certain positions (for example, loan underwriting, financial packaging of real estate, and property management).

CDCs should keep abreast of innovations in benefits improvement. Currently it appears to be in the area of pensions, but the next issues are long-term disability and daycare. Because being able to contribute to a tax-deferred 403(b) program represents a major employee benefit, CDCs should establish pension plans even if

they cannot contribute. Even these CDCs, however, should budget an employer contribution to the pension and set a goal of reaching a contribution of 6 percent over a period of years. A contribution of 2 percent should be considered the minimum. The goal may seem expensive, but a calculation demonstrates that 2 percent does not represent a large amount of money. For a CDC with six employees and a payroll of $240,000 annually, a 2 percent pension contribution is only $4,800.

CDCs can provide other inexpensive benefits. For example, a tuition reimbursement benefit helps an organization grow employees and creates an atmosphere of interest in each person that promotes retention. Intermediary organizations—whether local, regional, or national—that support CDCs also can play a role in building a better benefit structure by addressing compensation and benefits as part of their organizational development work. They can promote a standard for pension contribution by employers and help the CDCs educate their staff, board, and funders. Where intermediaries provide direct financial help, they can support adequate compensation in budgets.

To encourage a better understanding and easier adoption of plans, intermediaries and funding organizations might share information on their own benefit plans with CDCs and their boards. They can promote a nationally endorsed plan as an easy step to adopting some benefits and even help arrange group purchase or investigate group purchases for which CDCs are eligible. In a local community, it could be helpful to retain a benefits broker to help find plans or recommend a broker to CDCs so they do not have to do all the research themselves. Finally, by encouraging CDCs to gather data, or by actually gathering data and promoting their use, intermediaries can help move the dialogue beyond opinion-based decisions to evidenced-based practice.

Finally, funders can make compensation and benefits part of their grantee review discussion, signaling an interest in adequate compensation and benefits. They could amplify that signal through other means of encouraging equitable benefit plans. Foundations could share information on their own benefit plans and encourage data gathering and its use.

Benefits have become competitive in the CDC world. Despite this ostensibly good news, the field needs to maintain its focus on the full range of leadership development to create high-performing, healthy organizations that can attract and retain skilled and dedicated workers. There also should be continuing efforts to improve compensation and benefits, particularly in the area of pensions. Benefits represent real costs that must be routinely budgeted into the cost of doing business. These reasonable costs certainly are less expensive than hiring new staff and dealing with high turnover.

NOTES

[1] This research was principally supported by the Living Cities Milano Collaboration, a project funded by the Living Cities funders (http://www.livingcities.org) and hosted by the Robert J. Milano School of Management and Urban Policy at the New School University. In addition to their primary affiliations, the authors are senior researchers on the project.

[2] Community development support collaboratives are local and regional entities that aggregate financial (from local and sometimes national philanthropic organizations and banks) and technical support for a designated set of community development organizations. The community development organizations receive grant and technical support as part of an organizational development process that lasts anywhere from a 2-year cycle and beyond. Many of the salary and benefits studies were funded through the National Community Development Initiative and a Ford Foundation-sponsored effort to assess and improve human capital in the community development field. Called the Human Capital Development Initiative, it was hosted by the National Congress of Community Economic Development.

[3] Much of the turnover in this sample is related to turnover of senior management. For example, a new executive director comes aboard and some employees decide that it is a good time to move on to other opportunities.

[4] To date, there has been only one survey on compensation and benefit practices in the nonprofit world which disaggregated and compared the data for CDCs to the nonprofit general performance. That survey was conducted as part of HCDI by a professional human resources organization for the Neighborhood Partnership Fund in Portland, Oregon in 2001. The survey covered 161 nonprofits in the State of Oregon, and separated for comparison 37 CDCs. In most benefits, the CDCs performed better than the nonprofit averages: more of them provided health benefits, covered a greater portion of the health benefits costs, provided a pension more frequently and gave a higher level of employer contributions to pension. The CDCs offered dental and eye care coverage on a par with nonprofits generally. They fell behind the nonprofit averages only in providing life and long-term disability insurance. There is no reason to suspect that the CDCs in Oregon are in a position relative to their fellow nonprofits different than CDCs in any other area of the country where there is a functioning funding collaborative like the Neighborhood Partnership Fund. See MLB Group, LLC report, "NPF 2001 Nonprofit Salary Survey," Portland, Oregon.

[5] Research methods employed in this part of the study include survey interviews and content analyses using descriptive statistics. The data-gathering process took place December 2002 and January 2003. Executive directors at 17 support collaboratives were contacted by letter and phone regarding the proposed study and asked to supply the most current salary and benefits information available for their respective localities (such as municipality or state), as well as relevant human capital development-related documents (training manuals, program evaluations, and so forth). Six of the collaboratives sent material. Of those six collaboratives, five provided salary and benefits surveys that offered potentially meaningful comparisons between nonprofits and CDCs.

[6] For the purposes of this paper, the survey results are meant to give timely, usable information that informs the dialogue on salary and benefits. In fall 2004 our colleagues at the Community Development Research Center at the Milano School expect to publish the results of an unbiased, random survey that includes detailed questions on the impact of salary and benefits on CDC organizations.

[7] A recent survey by Flynn Research for The NonProfit Times reveals that a higher percentage of nonprofits (87 percent) offers pension plans than the Department of Labor reports for entities overall (50 percent). Many small for-profits offer benefits that are worse than those offered by nonprofits, but pension plans are a staple among larger companies.

APPENDIX: NUMBER OF RESPONDENTS BY CITY

City	Number of Respondents	City	Number of Respondents
Atlanta, GA	3	Los Angeles, CA	3
Baltimore, MD	2	Louisville, KY	3
Boston, MA	3	Memphis, TN	2
Bridgeport, CT	2	Miami, FL	3
Brooklyn, NY	3	Milwaukee, WI	2
Buffalo, NY	3	Minneapolis, MN	2
Charleston, SC	2	New Brunswick, NJ	3
Charlotte, NC	2	Newark, NJ	3
Chicago, IL	3	Philadelphia, PA	3
Dallas, TX	1	Providence, RI	3
Denver, CO	1	Richmond, VA	2
Detroit, MI	2	San Antonio, TX	1
Hartford, CT	2	Seattle, WA	2
Houston, TX	2	Washington, DC	3
Jackson, MS	3	Wilmington, DE	2
Kansas City, KS	1	Worcester, MA	1
Lexington, KY	1	Yonkers, NY	1
Total 75			

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