



Investing in a Healthier America: The Role of Social

Determinants

Ascension

Alliance for Health Reform

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MARILYN SERAFINI: Welcome everybody. I know there are a few more people coming in, but we are going to go ahead and get started.

So, we are here today to talk about the social determinants of health. And many of you, of course, have heard the stories of the person who needed an air conditioner to keep them out of the ER or a refrigerator to keep insulin from going bad. And those are stories that we have been hearing for a little while. Yet, they are a very small component of what we are talking about, when we are talking about social determinants of health. Social determinants of health, social factors that affect health are as broad as poverty. We are talking about healthcare and we are talking about medical care and we are talking about investments in housing, nutrition, criminal justice and other social supports. This subject is getting a lot of recognition lately and it's increasing the discussion about what this is, where it's happening and what the challenges are that need to be overcome so that we can break down some of these silos in investments and move forward.

So, today we are going to explore the challenges associated with breaking down these silos and we are going to hear about to what extent this is already happening and what is being to happen to address – to bring together medical needs with social needs and we are going to be discussing the interaction.

So, I would like to first thank our sponsor for today's event, Ascension. And I'm going to turn the mic over for a few minutes to Mark Hayes, who is Senior Vice President of Federal Policy.

MARK HAYES: Great. Welcome everyone. I'm so glad you are here. Ascension is very, very pleased to sponsor this event. We think that this is one of the new big things when it comes to health status, because everyone is starting to realize that all of these other factors affect someone's health long before they end up in the healthcare system or in someone's emergency room. And Ascension is interested in looking at new ways to break down the silos in the Federal government to encourage greater inter-departmental cooperation on housing and transportation and nutrition and all of these different things that we do, to enable communities to be able to overcome those barriers at that individual and community level. So, we are very glad that you all are here and excited to hear from the panel. So, thank you very much.

MARILYN SERAFINI: Great, thank you very much, Mark. Okay, switching mics and getting into panel mode. So, before I introduce our panelists, I'm going to just go over a few housekeeping items. First, if you are live tweeting with us today, or if you would like to, the hashtag is SDOH – social determinants of health – SDOH. Also, I just wanted to let you know that about half of our session today is reserved for Q&A, so get your questions ready. You will have several different ways in which you can ask your questions once we get to that portion of our program. There are two microphones in the audience if you would like to stand and ask a question. Also, in your packets, you have a green card. If you would prefer to write a question, once we get to the Q&A portion, our staff will be around to collect those cards and will bring them up to me and I will present

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those questions to the panelists. Also, you can Tweet your questions if you would prefer, again, using the hashtag SDOH.

I know it's very early to start begging for this, but I'm going to anyway – before you leave today – we hope you will stay for the whole program, but before you leave, whenever that is – you have a small, very brief evaluation in your packets and we would greatly appreciate it if you would fill that out before you do leave.

Okay. So, now, let's turn to our panel. We have Lauren Taylor, who is a health service researcher based at Harvard Business School. Lauren is going to provide us with the latest data about how we are dividing our funding between medical and social services. She co-wrote a book titled *The American Healthcare Paradox*, which has received quite a bit of attention for its discussion about the optimal division of resources.

David Fukazawa is managing director for health and human services at The Kresge Foundation. David is going to talk about how to achieve that optimal division of resources and how to change clinician thinking in addressing this issue.

Sameera Fazili is a senior visiting advisor to the Federal Reserve Board of Atlanta's Community and Economic Development Group. And Sameera is going to describe examples of cross-cutting collaboration.

And finally, Stuart Butler is a senior fellow at the Brookings Institution. He is going to identify obstacles to progress and how spending can be reallocated as opposed to coming up with new spending to address social determinants.

So, without further delay, we are going to turn first to Lauren.

LAUREN TAYLOR: Super. Okay, good afternoon guys. I am so thrilled to be here with you and I have got seven minutes, I'm on the clock to run through a bunch of the data that was provided both in the *American Healthcare Paradox* and since the publication of the book back in 2013. So, I thought I would divvy up our time roughly as follows: I can share some of the spending allocation data, which really seemed to kind of galvanize a new conversation about social determinants of health, because for a long time, you know, this has been a field forever in schools of public health, but it often didn't have dollars and cents put to it. So, some of what the book has done and some of what our follow-up work has done, is to really say, look, here is how much this stuff costs and so I will share that with you.

Then, I thought I would share a little bit about this huge question of, which social services or which social determinants of health do we think has the strongest evidence base? I can tell you what I know. I don't feel a thousand percent confident that that question is answered yet, but I will give you a sense of what the research says. Then, I thought I would share just briefly some of the kind of emerging models of integration between health services and social services and lastly, some of the real challenges that I

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think we are starting to see among those kinds of innovators who are really out there, trying new things.

Okay, I'm down to six minutes, here we go. So, the book was called *The American Healthcare Paradox* and so it's always worth starting there and saying, what is the American healthcare paradox? To myself and my co-author, Betsy Bradley, it was this huge amount of spending on health services – something around 18% of GDP, and yet, fairly lousy population health outcomes. So, if you think, there are 34 OECD countries – OECD being the Organization for Economic Cooperation and Development. When you look at, for instance, maternal mortality, the U.S. ranks 25th out of 34. Life expectancy – 26th out of 34. Low birth rate infants were 28th out of 34. So, the paradox says, how could we be spending so much money and putting so much emphasis on health, reforming it, paying more for it, paying differently for it, and still seemingly getting these outcomes that are not top notch? The answer that we came up with, was one that had been again, kicking around schools of public health for a long time. Up to 60% of health is really determined by things other than your healthcare and your genetics. Those are usually called the social determinants of health and they are things like, the environment and the air you breathe, the quality of the water you drink, how much exercise you get, these sorts of inputs. And so, we said to ourselves, okay, well, if we think that 60% of our health is really caused by these social determinants, we are not accounting for that when we are just banging our heads against a wall, saying we are spending 18% of GDP and not getting great health outcomes. So, the first insight was, is there another way to think about what each country spends to get a healthy population and really build that into the empirical analysis so we could see something different?

So, everyone has seen the bar chart of health service spending in all the OECD countries and the U.S. is always huge, right? At 18%, much more than any of our peers. And this was kind of the first iteration of our data analysis, where we said, well, what if we stack social service spending on top of health service spending? So, what you are seeing here is all the OECD countries on the X-axis, the blue bars are health service spending and the orange bars are social service spending. And social service spending is kind of a proxy for what we were thinking about as attention paid to social determinants of health. That spending on housing, education, police, job training, nutrition, these kinds of things. And so, what we found is, if you stack those bars and you look at, as a whole, health and social, what does the U.S. spend? We are no longer a huge spender. We kind of look more middling. But, when we created this bar graph, there was one other really interesting feature which is, if you look closely, the U.S. is the only country apart from Mexico, which is the smallest bar all the way over on your right – the only country that spends more on healthcare than social. And in fact, we have almost a completely inverted ratio from what the hypothetical average, OECD country is. So, to put that more simply, for every dollar that we spend on healthcare in the U.S., we match that with 90 cents on social services. Whereas in the average OECD country, every one dollar spent on healthcare is matched by two dollars on social services.

So, that is an interesting insight, but of course what is key is, does it matter? And this was kind of the beginning of this whole book journey and now my PhD. What we found was

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that this ratio of health service to social service spending is actually more predictive of health outcomes at the country level than your health service spending or your social service spending alone. So, we found it to be very associated with infant mortality, premature death, longer life expectancy, the kinds of things that we have always had so much trouble actually attaining in the U.S.

Then the next question that we got was, okay, well, Lauren, it's interesting that you can do this across countries. You can compare us to Switzerland and Norway. Can you do it inside the U.S.? So, this is what this graph shows you. It's a heat map, again, of this same ratio – social to healthcare spending, where your kind of Kelly green are your states that most prioritize social service spending and your red are those whom mostly strongly prioritize health service spending. You all can locate your home state and we can talk more on Q&A about what this looks like and what it means. Unfortunately, I think this heat map looks a great deal like virtually every other heat map you see in health services or public health, where we have this real challenge down in kind of the Bible belt, which raises questions about: Is it the ratio that is driving the health outcomes? Or do poor health conditions drive the ratio? Right? Because sick people consume a lot of health care. And so, there is something of a vicious cycle that happens here, where the causal arrows can go both ways.

Nevertheless, we published this just in *Health Affairs* in May, and so it was a replication of the work that we had initially done at the OECD at the states. And all of this, I think, is just pointing to expanding our horizons when we are really thinking about what to do to create healthy populations. It's no longer that the conversation needs to be bounded just around medical care, quality access, insurance. Suddenly, it seems all the more important to really be thinking broadly about those inputs.

The question of which social services really produce better health and save healthcare dollars is a difficult one. The team that I'm on has worked pretty hard to put together this lit review, which I think you all receive in your packets, but in short, I would say that if you look at the research and just you are asking for what has the strongest evidence base? There are three categories. Housing comes up very, very strong. Lots of randomized control trials, lots of very strong research design in the housing literature. Nutrition support, particularly around women, infants and children and older Americans is another one that I would feel very confident saying to you, you are probably going to get a positive return on investment. And the third is case management, and importantly I would just say, I think it's case management with home visitation. That seems to be a real differentiator in the case management literature between studies that show no effect or in some cases, negative effect, and those that really show a positive effect.

I would just show briefly this slide to kind of whet your appetite for Q&A. I think there is always this question of: Okay, you showed us a ratio, Lauren, are you saying we have to spend more on social services? I would never discourage you from doing so, but I think there are other ways to think creatively about how to get social service delivery kind of fortified. One of them is really integrating and coordinating better from existing health service delivery and existing social service delivery. And this slide kind of shows you a

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little bit of different strategies that health systems are using to kind of extend their reach into the community and into social service delivery. One example is: Out in Portland, four health systems recently pooled their resources to invest 21.5 million dollars in affordable housing, which was one of the kind of, biggest and boldest, I think, forays of a health system into social services and social determinants.

And then, lastly, I would just flag for you: Among the groups that are really trying to do this and I think are out in front, the real challenge and where the rubber hits the road is in contracting between health and social services and you can see here some of the reasons why. One I would highlight is just that HIPAA creates really enormous concerns and challenges, where health service providers want to be able to share information about a patient with someone at a food pantry or a homeless shelter or even you could think a school. And of course, there is a lot of trepidation. No one wants to be caught violating HIPAA, and so, again, we can return to this, but that would be one thing to flag for you all as policy makers, to think creatively about how you could push this forward. Thanks.

DAVID FUKUZAWA: So, good afternoon. I'm going to hope to sort of continue on what Lauren started, because what she talked about in fact is very central to the story of The Kresge Foundation. What I want to be able to do, is to be able to tell you the story of how we got to the point in terms of our grant making strategy, to think about this connection between social determinants and health.

So, just a little bit about The Kresge Foundation. We are actually not a health foundation. So, we are not a Robert Wood Johnson or a Kaiser Permanent, we are actually focused on expanding urban opportunities, so we are a community development foundation, but we have a health program within that. And we started ten years ago – the foundation itself is over 90 years old, but ten years ago, we really started on a new track of thinking more strategically about our grant making. And, so we were giving sort of the opportunity to sort of think about health within this larger urban opportunity framework and what it is that really drives health. And so, we were looking at the same data that Lauren was looking at. And this OECD data was showing that we are getting terrible outcomes with paying the most money for it. So, it's terrible value for the healthcare dollar that we paid for it. And all the – and there was also this other emerging evidence that we can improve health by looking upstream. And so, we started from the beginning by thinking about a health program as focused on this. So, not a health program focused on healthcare per se, but on the social determinants.

So, we have two main strands. So, one is really looking specifically at the environmental, social conditions that actually contribute to health and we have three specific focus areas. So, one is on housing, which Lauren mentioned. The other is on food systems. As many of you know, there are parts of the country where people do not have access to fresh, healthy food. Even in Fresno, which is like – you could say, the heart of Central Valley, or parts of it, people in the city don't have access to healthy food. And the third area is built environment and transportation.

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But the other strand was sort of thinking about how we think about health in this country. And there is a lot of money in the health system. Three trillion dollars that is part of the healthcare system in this country. And as you saw from the graphic that Lauren shared – is there a way to sort of rethink how those healthcare dollars are spent? So, this is what we call accelerating our community centered approaches to health. And this started out on a sort of, at first, a clever play on the patient-centered health, but this term has actually caught currency in the healthcare field as we are talking about, what is sort of the community-centered part of this? And let me talk to you briefly about our journey.

So, back in 2008, we were looking at the possibility of healthcare reform and the possibility that 20 million people, newly insured, would show up at the doorstep of community health centers, which is sort of the federal network of community based clinics serving underserved poor. There was no capacity, in fact there was talk about a nine-billion-dollar shortfall in terms of infrastructure. How are we going to finance this? And because we have a very strong social investment practice as part of our work. And how can we sort of mix this with the idea of community development? Banks, in fact, weren't going to lend to community health centers because they didn't understand the business. But, we found in the community development finance sector an interest, because we had actually a long track record of, in the community development field, of funding low income development. Housing in particular. And we found that we could actually match - and Sameera is going to talk a little bit more about this – low income housing tax credit and new markets, to kind of basically add on community health services into housing and other low income development projects. And this led to a couple of things. One is the Healthy Futures Fund, which Sameera is going to talk about, which is in fact this mixing of financing. And then something that we looked at in terms of, how can we actually leverage social determinants through community health centers? In other words, getting community health services to think outside the box. Because, they actually have a long tradition of thinking this way. For those of you who know the history, Jack Geiger, who is one of the pioneers of the community health center movement in this country, famously prescribed food for his patients because he said that would make them healthier than any medicine.

So, flashing forward to now, we now suddenly rediscovered his truth. So, the safety net enhancement initiative was our first attempt to sort of match or connect community health centers to the social determinants. These community factors that contribute to health. Which then lead to our thinking about this sort of community centered approach. And I'm just going to briefly sort of list and talk about what this led into in the last several years. Several initiatives that we are in the midst of. One, many of you may have heard of, is the Build Health Challenge, which is a collaboration with Robert Wood Johnson Foundation, the Beaumont Foundation, the Colorado Health Foundation, the Advisory Board Company and now we have just added two or three other regional foundations. But this idea basically is to incentivize health systems to build partnerships with organizations in the community to address a disparity, using the community benefit dollars for that purpose, and to sort of build this collaboration around social determinants. And, we had an overwhelming response to the first round and we are in the midst of selecting a second round and we can certainly talk about that. The one in the middle is the

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dream, which is to take advantage of the fact that health systems right now are actively in the process of really thinking hard about how do we connect to upstream factors. And we noticed that there was a growing number of innovators in this space and this was an initiative that is with UCLA and Nemours to provide the space and infrastructure for the innovators to really come together and to build working prototypes and to be able to test this in a larger network.

At the bottom is PRAPARE, which stands for Protocol for Responding to and Assessing Patient's Assessment Risks and Experiences. And that is just simply a long way of talking about – you know, we have electronic health records, which capture patient data, specifically physical health data, but there was no way of capturing these social factors. And this is actually now a tested basically add-on to the EHR system to assess for the social risk factors. So, we can now actually, when a patient comes into an office, think about those upstream factors that may be more influential to a person's health than the physical ones. And then on the top is one that we are still developing, sort of community centered health initiatives, a community centered health homes initiative, which is to really expand this idea that community health centers, which are located in the communities of most need. How can they leverage social determinants in their work and expand this? Because there is now a clear and large cohort of community health centers that are in the middle of this kind of work. So, that is really just a snapshot of the kinds of things that we are doing and looking forward to your questions.

MARILYN SERAFINI: Thank you, David. So, now we are on to Sameera from the Federal Reserve Bank in Atlanta.

SAMEERA FAZILI: Thank you to the Alliance for Health and Marilyn for inviting me here today. I am not going to use slide, I'm just going to talk to everyone and I'm going to start off by reminding you that my remarks do not represent the Federal Reserve Bank of Atlanta or the Federal Reserve system at large, they merely represent my own views.

So, I work as a researcher there at the Atlanta Fed and I study the intersection of health and community development in particular. And it grows out of a wider body of research that my colleagues at the San Francisco Fed have been conducting for the past few years. So, some of you may be familiar with their work in this space.

What I'm going to do is build on our first two speakers and talk further about the potential role for the community development sector to be better leveraged as being a disruptive and a constructive force in helping the healthcare system spend its dollars more wisely and push us towards more population health models out there. So, I'm not going to talk about social determinants of health, because Lauren covered it, but in essence, research really shows that zip code is a bigger driver of health than genetic code and the question isn't really whether environmental or social factors impact health. The biggest question is: What can or should be done about it. So, that is what brought us at the Federal Reserve System, into the conversation, because we suspected that the community development industry could be brought into the conversation to help answer the question.

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How many of you are familiar with the alphabet soup in community development? Like, CDC's – anyone? And CDFI's? Okay. CDFI's are more boutique, so I wasn't sure if folks knew them, because they finance a lot of community development transactions. But, in essence, what community developers do is strengthen the economic, social or physical environments in low income or distressed communities. They will take any approach that works, basically. They may run an afterschool program in one place, build affordable rental in another or do small business development in a third, but it all depends on what the resident's needs are. What resources can be assembled and what assets can be leveraged. They are very entrepreneurial and they don't just use grants to do their work. They are not just using philanthropic grants and public dollars, but they oftentimes are leveraging private sector capital. So, in this way, they offer an opportunity to mix market discipline and social purpose. And, they have become experts at managing cross sector collaborations. I mean, you saw Lauren's slide and David's slides – we are trying to get lots of different systems to talk to one another and that is precisely what the community development industry does for a living.

The two other reasons: We thought they would be powerful in this work is, that they have expertise at working with the same populations that social services, Medicaid, Medicare, are all serving. And they know how to build trust with the community because their work requires them to integrate the community's voice into projects. And then the last expertise they really offer is: intervene at the environmental and social levels. So, what we think community has to offer, healthcare as an expertise in crafting multisector, public/private partnerships that invest in community driven projects.

So, I will spend the remainder of my time really giving some examples of what that could be, what that could look like. First is: Let's start with the financing question, since David started talking about the Healthy Futures Fund. They can help finance new partnerships, focused on addressing social determinants of health. So, Kresge worked with LISK, which is a leading CDFI out there, and Morgan Stanley, a bank, to develop this 100-million-dollar fund to finance projects that were going to address social determinants of health. And it was such a success and hopefully David can talk about it more, that you guys committed another 100 million in 2015, so there is going to be another round of projects here. They have been able to do work in rural areas and urban areas alike. In Michigan, in rural Michigan, they took a blighted building, converted it to affordable apartments with onsite health services. In Massachusetts, they helped finance a health clinic and grocery store co-locating, so you can do some more targeted healthy food work. And that is in Brockton, so a small town in Massachusetts. In St. Paul, Minnesota, the interesting they did was finance a larger affordable housing deal with a health clinic, but also gave it a grant, because they needed grant capital to do more market research on what the health needs were in that community.

The fund is innovative in part because it shows you what you can do with existing federal resources. They use a low-income housing tax credit and then you mark it as tax credit, two Treasury incentives to catalyze private sector capital into community development deals. The second place, we look at places where community developers are helping, is to

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help plug gaps in care coordination, to drive better utilization of healthcare resources. So, I have been studying a hospital in South Florida – Baptist Healthcare and they have a hospital called Homestead Hospital in their system that has partnered with a community based organization called Catalyst Miami, where Catalyst provides wraparound social services to Homestead patients. And the partnership is funded by Homestead’s IRS mandated community benefit spending. Homestead donates office space and gives straight grants to Catalyst for this work. But, what it offers is a powerful example of the business case behind this, because the care coordination has actually improved Homestead’s healthcare spending. They saw decreases in uncompensated ER visits by uninsured patients and when they developed a targeted program on diabetic and cardiac care patients, Homestead saw readmission rates drop from 22% to just under 6% in a year.

And the third place you may look for some interesting partnerships is sharing data and expertise to solve joint problems. Here, we are starting to just see some examples, I think, of data sharing that has been driven by the first round of the ACA’s community health needs assessment process – the CHNAs. This is a very new obligation on hospitals to collect input from the community and public health experts to document the local health needs and develop an action plan on how the hospital will or will not address them. The hope is that the mandate can help instigate more cross-sector conversations and even draw hospitals into being public champions on public health issues. This can be really powerful because in many places, hospitals are the top employer and a key anchor of the local economy. So, if a hospital gets engaged in local issues, its voice really carries weight amongst civic leaders. But, it’s been very spotty and uneven. A lot of hospitals you talk to still say they run these like a “check the box” exercise, but two I will point to for you to consider is, in Cincinnati, the Children’s Medical Center mapped the addresses of kids who were being readmitted for asthma as part of their CHNA. And it made the community realize that there was a cluster of substandard housing all owned by the same landlord. So, the Legal Aid Society could use that data to organize the tenants and compel repairs. Out in California, St. Joseph’s Health System identified housing as a top priority for its community, and so joined the local affordable housing coalition.

So, I will end by having you – I don’t want you to just think that is a neat array of random transactions out there, but to really see how it could connect to your own work here and what you can do to further collaboration, innovation and experimentation at the local level here. So, the three suggestions that I will leave you think about or perhaps ask more questions are is first: The community benefits and CHNA process I mentioned, a lot of people feel are really ripe for further improvement. It’s very hit or miss, some of those dollars aren’t wisely spent. And so, researchers have been discussing ways to improve its enforcement or strengthen its focus on social determinants of health. I think there is a lot that the Community Reinvestment Act that banks have to fulfill, that process can kind of teach and help guide the further transformation of the community benefit in CHNA systems. So, I’m happy to talk about that if there is interest in Q&A.

The second is, local innovators will consistently tell you how difficult it is to cobble money from many different federal programs. If you are successful enough to raise

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money from HHS, HUD and Treasury, the compliance burden may still cripple you in implementation.

So, I will put you to what I thought was a really interesting innovation, the Performance Partnership Pilots for Disconnected Youth. Do folks know of that? Okay, not many. It was authorized in the 2014 appropriations bill and what it lets you do at the local level is blend formula and competitive grants across multiple federal agencies into one common pot with one common set of reporting rules. It requires a high level of evidence at the intervention works for its purpose, but it's a really interesting model. And the last is, the Federal government can play a powerful role helping scale evidenced based interventions. Lauren gave us that great list of what the research says, is really – drives better outcomes and better spending. So, I think if you look at the Corporation for National and Community Service, the Social Innovation Fund, it offers you a ready mechanism to help scale evidence-based interventions across the country.

So, I look forward to Q&A and I hope that my remarks helped you think about the way you can activate local creativity to help reduce cost, improve quality and improve access.

MARILYN SERAFINI: Great, thank you, Sameera. We are going to turn now to Stuart Butler of Brookings and a reminder that after we hear from Stuart, we are going to have a Q&A session, so be getting your questions ready and also if you are with us on Twitter, hashtag is SDOH. Stuart?

STUART BUTLER: Great, well, thank you very much, it's a pleasure to be here. And in my work at Brookings, I have really been looking at exactly what you have heard from the other panelists and sort of mulling over, with a whole bunch of other people coming together regularly, to think, what is the best policy environment that will help encourage exactly what you have been hearing about in terms of cross-sector collaboration to produce health? In fact, we have a study that just came out last week, which I think is outside, looking at hospitals and schools as hubs. And what this does is say, well, let's look at those, the potential and say, what is in the way and what do we need to do to actually facilitate these institutions in communities?

And I want to look at three broad areas of difficulty, of challenge regarding these things. Regarding these approaches, which has been mentioned. The data question, or at least data sharing, looking at business models – and by the way, I would very much suggest you look at Lauren's piece, the healthcare blog, specifically on thinking about business models of hospitals and health systems. And then the payment system. And these are all really linked together and reinforce each other as barriers or as problems.

Just to touch very briefly on the data question: If you are going to do things differently and you are going to create interesting partnerships, both in order to know what you should be doing and what is going to pay off for your operations and also, to convince other funders or funders to support this kind of activity, you have got to have good data and good evaluation of that data. That is a big problem for many, many institutions. There are many barriers to collecting and sharing data. One is size of organizations. Very

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small organizations find it very difficult to create the infrastructure for data. You have got issues associated with privacy both in the health area through the HIPAA rules, but also if you are dealing with schools, through privacy issues with regard to student data. So, there are a lot of issues associated with that. One can begin to get around this kind of problem with guidance from government agencies in particular. The Federal government has been doing a pretty good job in giving guidance, but it needs to be stepped up even more. Part of the problem with HIPAA is, often you can do things if you understand the rules. But many organizations flinch from doing it, because they are afraid of being sued or afraid of getting into trouble.

So, giving guidance and giving particular safe harbor guidance, in other words, giving indications of, if you work in this particular area and do these kinds of things, then you are going to be pretty much on safe ground. There is a lot that can be done in terms of improving the data flow in organizations and also between agencies. Agencies are often very protective of the data they have at all levels of the government and it's very important to look at ways of facilitating those. And again, there is some efforts in that area. Data is also very important for showing the actual return on investment and here, we have the problem of – it's not just within your sector, but in order to show what an investment in your sector will mean in the future, you have got to be able to show its impact in other sectors. And this is a big problem in terms of just our lack of capacity for doing that kind of measurement. And so, building capacity in that area, where I think philanthropy is, and has an important role, is crucial.

The second area I want to touch on quickly is the business model problem. We have business models which are in many ways the reflection of the payment systems we have in health and other sectors that make it very difficult to do a lot of creative, collaborative approaches between sectors. Think of fee-for-service hospitals, for example. I have looked at a number of them. And so, a fee-for-service hospital recognizes regional literature and the public health people, they say, oh, it would be really good if we helped invest in nutrition, and work with the homeless and so on, that would do a great job. And so, they go to the Chief Financial Officer of the hospital and they say, we have got this great idea, we are going to incur all of these costs associated with this and the net effect is, fewer people will have to come to the hospital. So, the CFO says, this does not compute. So, until you have revenue that in some way reflects and gives an incentive for investing, say, in a hospital, it's going to be very difficult. The same is true when you look at things like schools; the school nurse, the school health center, can do tremendous work in improving the general health of the community, including parents and so forth. But, when it comes to a budget issue in the education budget, what is one of the first things to go? Or to be cut back? You don't cut back on the teachers, you cut back on these peripheral areas. So, looking at how to change the flow of money so that one has dedicated funding for health-related activities within schools is a critical step forward.

And this part, by saying, as Sameera has mentioned: One of the things that is happening though is that we are seeing now for non-profit hospitals, an inducement, an encouragement through IRS requirements, to say, go out and look in the community and see what has to happen in order to comply with your tax-exempt status. Do something in

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that area. So, more and more hospitals are moving in that area and that is good. We also have, of course, for financial institutions, as Sameera well knows, the Community Reinvestment Act that says, financial institutions need to focus on lower income communities and start to figure out ways to help in that area and they do some of which – such as through the CDFI's, translate into health activities.

We have also now just passed the new Elementary and Secondary Education Act, which has requirements on school districts and states, to actually look at failing schools and say, what is going on in the community there? So, I have a great idea. Why don't all of these different requirements actually talk to each other and say, within a community, how can we blend together these requirements and start doing it on a consistent basis? There is a lot of opportunity, I think, for doing that, and we should move forward.

The last thing, I will just say very quickly given the time, is that so much of this hinges on the payment systems, as I mentioned. Whether it be a hospital or a school, at all levels of the federal system. Not just at the federal level. So, we need to look at ways of encouraging through fine-tuning and tweaking the funding for organizations to plan together at the very least, so that when we are spending in different areas, at least you start bringing those agencies together to start planning, so that they do it consistent with each other. There has been some good movement in that area at the federal level. Some agencies like HUD and HHS and the Education Department, are beginning to build sort of ad hoc councils to plan together. We see this a lot at the state level as well. More than half the states now have what is called "Children's Cabinets" and this is really below the governor's level and agencies heads from different sectors that are interested in children and they now are working together in education, in health and so on, to say, "What can we do to improve the trajectory, the life of children?" So, councils of this kind, which are very prevalent at the state level, are the kinds of things that you can look at.

And then finally, as others have said, there need to be steps to specifically look at ways to blend or braid money together. Blending means literally kind of pooling it all together and saying, what is the best way to get the outcome we want? Whether it be health or some other area. Braiding means that this money is still running in parallel trajectories, parallel programs, but you actually look at ways of linking them together on the ground for specific outcomes. So, looking at ways of doing that and improving that, is going to be very, very important to achieving the kinds of breakthroughs that we have been talking about today. So, I think there are various steps – that is just touching on a small number of them. There are a number of very specific policy steps that can and should be taken to enable the kinds of collaboration that you have been hearing about, to actually take place. We have got some progress in those areas. We need to look at things, like the waiver process and others to improve the braiding and blending of money. And if we do that, I think we will see really significant impact from these kinds of collaborative ventures. Thank you.

MARILYN SERAFINI: Great, thank you very much to all of our panelists. A reminder again, if you would like to ask a question, now is the time to step up to the microphone or pull out your green card and to write a question. I'm going to start off the questions for

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our panelists by asking about the new deliver system and payment reforms that we have seen throughout our system both in the private sector and also through Medicaid. We are into all kinds of demonstrations on ACOs and bundled payments and new ways of trying things. Are we seeing any more of these kinds of activities within these experiments? Is it making a difference? Is this where the future is?

LAUREN TAYLOR: I'm happy to start us off. I think it is making a difference and I think the trap that I even fall into sometimes is thinking that there is so much discussion in health policy about value based financing, it's easy to think, we are there. You know, it's a reality and these large hospitals and health systems are running primarily on ACO contracts or value-based financing. But, in fact, we are not. And so, I think it's important to be sensitive to the fact that most health systems or providers in general really feel like they are standing with a foot in each canoe. You know, one foot is still in a fee-for-service world, where as Stuart was alluding to, if you do too a good job, if you make people too healthy, you are kind of undercutting your own revenue or business stream. While they also have one foot in this value-based financing world and are trying to figure out, with a myriad of metrics, how to deliver on the promise of these particular quality measures. And so, it's very difficult for them just – you know, I study management and when I talk to managers, healthcare administrators, often their response to my interest in social determinants is just like: We don't have brain band-width to do that, because we have so much going on trying to figure out how we are going to make this transition successful. That being said, I think the places you are seeing the most innovation around social determinants are the ones who are most strongly with that foot in a value-based financing world. They are either in multiple ACO contracts, or they are in one of these new kind of Medicaid redesigned states. In Massachusetts, we are going into a series of ACOs that are total cost of care capitation for Medicaid clients. And so, there you are seeing people get off the dime very quickly, because when you say to a system, you have got \$5,000 for each person for the year, and that is your budget. If you go over it, if they come in, if they churn in and out of the ED, or they churn in and out of the hospital, you are eating that. All of sudden, these administrators are like, oh, Lauren, come and tell me about social determinants of health. What do I do? What is the best choice? So, I do think that we are seeing this association between the type of financing or payment scheme that providers are in, and their interest and willingness to put in upfront costs to kind of build new programs. That being said, there is always a risk that they feel it's working too well and cutting too strongly into this backside fee-for-service business, which is still ongoing often in very consequential amounts.

DAVID FUKUZAWA: And I would agree that there is a lot happening. From a policy point, a particular thing that is happening on accountable health, is that in somebody's ideas, if you save money as a provider, you are supposed to get some of that savings back. But, what is happening is that the states are taking some of that money. And so, it kind of removes the incentive to save money. From a policy point of view, I think it's a particular hole that needs to be filled in.

In answer to your question, Marilyn, I think there is a lot happening. I would just like to sort of identify three things that we – two things we have talked about and one thing we

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haven't. So, one is actually how we pay for this and is there a different way of paying for what we have. Because obviously, fee-for-service does not really pay for outcomes, it just pays for the service. And so, to the extent that we can begin to sort of pay for real value, you know, there are places that are moving along that track; incompletely, but I think that we will be somewhere within the next few years, getting there. Two, is community benefit dollars. So, for non-profit hospitals, this is another source of money that can actually be used for community health purposes. The third pot of money, which we haven't talked about, is in fact, this meeting tonight in DC and tomorrow, called the sort of, the Anchor Institution Collaborative. These are primarily health systems that are really thinking about their role as anchor institutions, because besides community benefit dollars, which is in essence sort of charitable dollars that you are returning back to the community as part of your non-profit community benefit. Health systems are really rethinking about their total impact on communities. So, Kaiser Permanente calls this "total health", and that is everything that they do, every dollar that they spend, actually has impact. That is on hiring, that is on buying, that is on real estate. And if you think about how health systems have sometimes the largest imprint, especially in communities where every other industry has fled, that is an important thing to think about and people are sort of thinking about the total impact of the health system on the health of the community, which gets to Stuart's point.

But the area that we have seen, probably the biggest traction, is something that Lauren brought up in her presentation, about where is the best dollar spent on health services? On non-medical services. That is on housing. Because most chief financial officers of the health system will tell you that their biggest cost is 80% of the cost on 20% of the patients and most of those are folks that are cycling in and out of ERs. And often they have unstable housing, often they are chronically homeless and have multiple chronic diseases. So, it is that dual eligible category – Medicare and Medicaid. In any case, poor populations that are unstably housed, and the best way to get to a reduced dollar is actually thinking about something like permanent supportive housing. So, there is now a huge push in both the housing side and the healthcare side, to sort of think about this problem together. There are meetings actually here today and tomorrow in DC about this issue and we will see more to come. I just came from National Academies, which is going to be issuing a consensus report on precisely this issue sometime next year. So, stay tuned.

SAMEERA FAZILI: The only thing that I would add is that I think a lot of people in this room have the power to pull the stories out of their districts, because stuff is happening and us up here who are researching it, can't find all the examples we want to talk about all the time, I definitely hear from a lot of the hospital and healthcare administrators I talk to, that they are just so overwhelmed with how much change has happened in healthcare in the past few years. They would love to take this issue on, but they just don't know how to begin to do it. So, I think there is a hungry audience for it, if you can spoon feed it to them a little. And the Federal government can sometimes do some really powerful things with just the research it puts out and the best practices it puts out. Kind of the spotlighting role you have to play here.

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STUART BUTLER: I think as we have all said, I mean, it's enormous importance of capitated managed care and encouraging these kinds of incentives. That is only going to work if in the private sector and in the public sector, there is a willingness to pay for a whole range of things that are not what we normally think of as medical care. Because ultimately, what you want to see, if you look at Lauren's first charts, is really we want to see a movement of money, quite frankly a way from medical services into health-related services. That means a big sectoral change, which is not exactly going to be enthusiastically embraced by a lot of people in the health sector. That is why it's important to think of the business model of a managed care organization or a hospital as not just giving medical services – you know, drugs and cutting you open and things like that, but to actually cover and be engaged in these other areas. So, I imagine sort of hospitals and health systems in the future being much more than medical facilities and widening their role. I think if we think of it that way, it's the right way to think of it as a business model, it's the right way to think of it as how you would get revenue and spending to alter within that. And I think it, quite frankly addresses the political issue of, how do you see one sector beginning to shrink and another expanding in order to reach the common goal of improved health?

MARILYN SERAFINI: Stuart, you have talked a lot about shifting and all of you have talked about how – we are talking about a decent amount of money here. Housing is not cheap. So, if we are providing some social services and we are simply reallocating some of this money so that we are not spending as much on the actual medical services, talk a little bit more about where you see that money coming from. What won't we need in the way of medical care if we are pushing some of that money to social services? Or is this something that just happens automatically because these people are then healthier, so they don't require more care? What exactly are you envisioning?

STUART BUTLER: Well, think of the elderly for example. Think of how many elderly Americans end up in hospitals because they fall and break their hip. They end up in a nursing home for the rest of their life, particularly if they are low-income people and can't afford supports outside. So, there is enormous healthcare costs associated with that. If we were to improve the way in which people age in their own homes, we have here in Washington DC one of the premier examples of senior villages. These are within communities of a mixture of – well, mainly non-profit organizations that are really linking together the services people need, including medical services, for people to stay in their own home. Enormous potential reductions in costs associated with that. So, it really is a question, I think, of seeing a diversion of funding ultimately from the acute care medical area, into these areas like housing, like social services, and so on, that enable people to stay out of the hospitals and healthcare system generally. That is important. I mean, how we do this, through waivers, through experimentation and so on, is what we are now engaged in. But I think ultimately you could see a huge flow of funding from these – from the medical sector per se, into these other sectors.

MARILYN SERAFINI: We have a couple questioners who would like to hear more about how exactly you blend and braid funding. There are – as I think a lot of you have mentioned, there are some conflicting incentives. For example, if you spend money at

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HUD for housing, it is the medical programs that are going to benefit from seeing reduced spending. So, how do you deal with the incentive issue and also how do you braid or blend this kind of funding?

LAUREN TAYLOR: So, I'm certainly not the expert on his panel about specifically how to do that with federal dollars, but I would just point out, this is the key. I was just so glad that it was brought up earlier. This is the key that we see in all of the other countries that do this really, really well. Is they have a single payer healthcare system that also is a single payer on the social service side, right? And I'm not saying we need to go to a single payer, but it's important to understand the logic of how the full return on investment is captured when you are paying both sides. You are paying both sectors. The best example I think we have here in the U.S. is actually the VA. They pay health and they pay benefits and as a result, one of the things that we profiled in the book, is some really innovative work that the VA actually does around blending these financing streams. It is not really a blend for them, although I'm sure if you looked at their books, it is, but they are doing co-location and they also are able to capture the full return on investment and not kind of lose all of these – lose the return to the friction associated with coordination costs between the sectors. So, I will let others speak to the logistics on how you do it, but I would just underscore that this is the kind of thinking that we need to somehow get to. One pot of money, one set of investments, one return on investment.

DAVID FUKUZAWA: That is a question that I think kind of varies, depending on what you are trying to solve. But let me go back to the housing one, because people are going to this area for a number of reasons. One is certainly, as Lauren pointed out, the results that you are getting, but also the cost savings to be had. That is why it's become such a big area. So, we have talked about the kind of high flyers or the chronic high utilizer population, but it turns out in the case that Sameera pointed out, that also for children, housing is also a factor. And in fact, asthma is the biggest chronic disease of young children and if you can reduce hospital visits that are triggered by housing related, you know, allergens, then you also can save money. So, the attention – at least the health systems are beginning to sort of think about that. What that is driving at least at local levels, is in fact this connection between housing and health, which is why there is a lot of conversation about how exactly we do this and we have GHHIs in the audience and if you want to talk to folks that are sort of in this space, but how do you braid this money? They are the folks to talk about. Just because we have kind of two knowns. We sort of understand housing finance and we kind of understand health finance and if we could sort of figure that out together, you know, then we can achieve multiple wins. And what is happening right now, is in fact a lot of local experimentation about how that happens. The other area, especially from this room's point of view, is how we – what opportunities there are with Medicaid dollars, especially on an expanded Medicaid. Even in states that haven't expanded, they are pushing this. How can we think more creatively about – especially patients that need the dollars the most? Who have actually a lot of non-medical needs. And that is a very active conversation. That is less about braiding dollars as opposed to sort of thinking more creatively about how to achieve better outcomes with the dollars we have. Because, clearly, you have to go upstream with underserved populations. You can't do this in ERs and expensive medicines, it is unsustainable.

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SAMEERA FAZILI: There are multiple levels you think about braiding and blending funding and how you get it done. At the transaction level, at the community level, I mean, I will speak in a very basic level here: If you can get a grant into a community and the CDFI can work with a bank, they can – because they have the grant capital there, they will have much lower financing costs to deliver the project and so, there is a lot of role that grants can play at the local level, but then can leverage things like CRA obligations and new markets tax credit, low-income housing tax credit, different incentive programs we have out there that actually require the non-profits at the local level, to draw in private sector capital into the transaction and into the deal. So, for those use staff different agencies and committees, I would think about which are those programs that do that kind of catalytic investment at the federal level. I will point again at the Performance Partnership Pilots and what they did was, there was statutory waivers given to the agencies to waive certain requirements, to actually allow the blended and braided approach to happen at the local level. There is going to have to be – you are going to have to look basically at what you are asking and requiring of agencies and figure out where you want to see some allowances for experimentation to happen. But, it's going to require everyone to let go a little bit of things that are in place for very, very good reasons. But, if you can have a controlled pilot in some of these spaces, we could really try to catalyze a lot of these new business models that Stuart was talking about.

STUART BUTLER: Yeah, I think as Sameera said, I mean, we have got some examples of statutory changes, such as the P3 experiment that specifically allows for certain areas, for money to be blended much more effectively. I think we do have some progress between agencies. I do agree with Lauren that if we had one pot of money, it would be a lot better. But it may be a few years before we have a single payer system here in the United States. But that said, I think looking at different structures that allow this kind of corporation. I mentioned Children's Cabinets at the state level and I think looking at it in that way. And thinking about new structures generally. And sometimes it may not be possible to blend at the national level, but when the money gets further down the system, there may be opportunities for doing it there. The State of Maryland, for example, has a whole system of so-called local management boards and these are county level institutions, either non-profit or government institutions, and their role is to have the money coming down the system – both public money, federal and state, and private money. And look at ways of working with people in the community to literally kind of link that money together where they really are the blenders at that level to enable a small organization locally that couldn't – wouldn't have the capacity to apply for different grants from different agencies, to actually just go to the local management board and have essentially blended money given to them to do some instant creative things locally. So, I think when you start looking at it that way, the institutional structures, there is a lot of opportunity for us to be creative in that area. Not just from the top, but to allow kind of bottom-up approaches. So, state action is really important and then the setting up of these kinds of creative bodies, these new structures to facilitate it.

DAVID FUKUZAWA: Let me just add one thing. What is happening at state and municipal levels is in fact an integration in some places of health and human services. So,

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you are seeing some places that are actually trying to do this very thing and I would encourage you – a place like Connecticut, San Diego, off the top of my head, are places that have been moving ahead with this. But, they are really thinking hard about this problem of different pots of dollars that are from widely different areas. Everything from public benefit dollars like WIC, to healthcare dollars and then community development dollars. And they are sort of thinking holistically about how you sort of think about all of that for the benefit of health. So, this is not a figment of this panel's imagination. There are people that are actually doing this.

MARILYN SERAFINI: So, we are going to go to the two questions at the mics and then we are going to get to a whole slew of green card questions we have about Medicaid flexibility and block grants. So, get ready. So, if you could identify yourself please?

AUDIENCE MEMBER: Thanks so much. My name is Courtney Platson, I'm a family nurse practitioner and I live and work here in the district. I work at a federally qualified health center, where I work at a community health center and I do medical outreach to the homeless. And just to talk about your exact last point. Here in the DC, we are getting ready for health homes too, where we are trying to improve care coordination for some of the District's sickest patients. And one of the things that has been encouraging is when we come to the table, there is lots of different sectors. So, we have people from housing, from mental healthcare, from the hospitals, from community health centers. Everyone is coming to the table and the will is there, but one of the major road blocks that we keep facing is, how do we do care coordination when none of our systems communicate? So, we want to decrease duplication of services when the patient is in the emergency department and we want to get them to see their primary care provider, but I never know my patient went to the ER. So, this has been a huge roadblock for us and we are trying implement social determinants of health screening tools at our health center, so we are trying to create all of this infrastructure, but we feel like we are all in our silos doing our own work. And the will is there, but without any kind of system for us to communicate, it becomes a huge challenge. So, I wanted to hear if there is any innovation or any innovative work that is happening across the country, or ideas for how to make that work better.

STUART BUTLER: I think one area to look at is – I mean, and I'm very sympathetic and I know a little bit about what you are talking about in the District of Columbia. But I think one opportunity may be to look at the role of intermediary organizations, sort of within this. In other words, how you can use an intermediary institution to link together different organizations. I mentioned the local management boards in Maryland. If you go to Baltimore, you can go visit the Family League of Baltimore, for example, which is an intermediary institution that works with people with – it does the kind of coordination that you are dealing with. Not only that, it actually is increasingly trying to carry out the data piece, to be able to link data together. So, it's a sophisticated organization that can actually do the kind of data analysis and linkages that's maybe not possible for institutions individually within each sector. So, I think looking at intermediaries in that way can be a very important one. Even at a simple level there is an organization called Health Leads based in Boston, which simply imbeds people within hospitals to figure out

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when someone is being discharged, what are the services that they need? So, if they are a homeless person for example, or somebody where housing is an important issue, they can identify this, sign people up, do this. Just not as a cost to the hospital, but as a cost to a philanthropic organization – Robert Wood Johnson’s Foundation among other supporters. So, there are ways, I think, of using intermediaries to deal with the issue that you are talking about. It is not only a question of getting the various departments or people together and figuring out who takes the lead. There can be somebody that does that. I think that is one form of a change in business model kind of thinking that might work.

DAVID FUKUZAWA: I kind of – you have to sort of realize, this is a systemic issue and people are trying to solve actually a number of problems and we have mentioned some of them. One is financing. Others – one other is data, because you can’t do this without data systems talking to each other, much less people. And I think the third thing, which Stuart pointed out, is we need new governance models. So, how do we structure ourselves? If it’s going to be a system, we have to be in relationship to each other and intermediary is one way we do that. I have seen places that simply form their own bodies and create their own intermediaries. And I think the fourth area is practice. Because ultimately, it just means we can’t go into our corners and do our respective work and think that is going to get a better result, because it really is about changing how we work with each other. So, one astounding fact that I heard from police departments, at least in big cities, is that police officers spend 80% of their time with social services. Think about that. And if – so, police officers basically are first responders in a social service system. The LAPD decided to create a whole new unit to deal with this so that not every police officer would have to do this. So, I mean, that is one example of how we change. I mean, talk about a doctor talking about social determinants, what is the script for that? I mean, there is no pharmaceutical that you can prescribe? So, Health Leads is actually a good example of how you sort of make that transfer happen. And that goes back to how we train people in the system, including doctors. I mean, are they going to be ready for this new world?

LAUREN TAYLOR: I could just jump in with, it sounded like a question that had a tech component to it, so I would just point out – again, I hit the HIPAA concern, like that seems to be the big thing that keeps people from developing these EHR, electronic health record, plug-ins. But, in some cases, I know in Massachusetts, they have worked through it and are using state-funded dollars to do referrals from hospitals and from providers out to the community. They have not yet figured out how to do referrals back in the other direction, which is an additional challenge but the bright star in this space, I think, is Parkland Health System in Dallas and there is a physician there who developed software platform essentially and has now spun it off as a private business that is called Pieces. But what is really neat about it, is they got all of the kind of social service providers and Parkland Health System on one tech platform. Such that, when a doctor’s patient pinged on a homeless shelter or a food pantry, they did get an alert and last I checked, they were kind of toying around with some different payment models such that a small amount of money for a health system can actually be a meaningful amount of money for some of these non-profits who are doing the social service delivery. So, they were toying with, each time my patient pings off one of these other service delivery entities in the city,

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\$100 gets kind of sent from my flexible funding out to that service provider. And so, that was kind of the most progressive thing I have seen to date about really being able to, A, have a map both in your head and in the computer about where people could potentially be and have gone and hook that up so that the next time someone comes in, I get a listing if I'm the physician of – okay, I see on April 18th you were here and then you were there. So, that would be my advice of a place to go and get inspired.

MARILYN SERAFINI: Okay, next question.

AUDIENCE MEMBER: Hi, my name is Sonia Clay, I'm with the American Academy of Family Physicians. I guess first of all, I wanted to say that our family physicians and our leaders support the need to educate physicians, primary care physicians, about social determinants and a physician's role in coordinating care for their patients. I have heard a lot of discussion about shifting funds away from medical care, but I wanted to just assert that not all medical care is the same and that many cases, primary care has been shown to help reduce mortality and to improve health outcomes and really wanted to get your thoughts on that. So, again, I think we would assert that there needs to be more investments in primary care and primary care access, versus expensive hospital care or specialty care. So, I just wanted to get your response to that.

SAMEERA FAZILI: I have one quick response to that. In the research I have been doing on hospital community benefit spending, I have had a number of more public health and like, kind of health policy experts say to me, stop pushing on hospitals, they don't have the right business model incentives. Like, Stuart said to do this. It is the insurance companies and the providers directly. If you can bake it into the payment models. And that is why payment system reform in that first question on ACOs and Health Homes and all of that was really powerful and important, because it's the providers at the end of the day – I mean, a lot of providers are out there to make money, but a lot went into this to actually help people and make them healthier and if you can come up with the right – to give them the right business model and payment system where they are being paid for this in the right ways, it would be transformative and it has to operate at the provider level as well. You can't expect it to just happen with the hospitals doing this work.

STUART BUTLER: I agree with that. As I said, when I talk about the business models, often the business models are really the product of the payment system itself, and so they are distorted in my view because of that. So, partly it's trying to dig ourselves out of that payment led business model. I totally agree with you that in general if one looks at primary care, and focus on that and build that up, you are going to get savings in the health system down the road, in addition of course to investing in the social service and housing and those sorts of areas. The only challenge that comes up, and you see this recently with the pediatricians in terms of the pediatricians of being encouraged to ask all kinds of questions about food and so forth. Okay, so when they see a problem, what do they do then? And who – does this just sit in the record and nothing else happens? Who gets the other sectors involved? So, I think when you start to look at it that way, that's why I think in many ways, it is a switching of money. It's a question of saying, within the health sector – let's start moving money around so that some of these other things, not

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just that you switch more towards primary care to get savings down the road in the health system, but also that maybe you start to undertake some of the elementary social services or pay for them through the health system itself. So then, the sector itself is not being asked to shrink, but what it is doing is going to be different in the future and recognizing that some of the first responders, so to speak, right now, when they see these issues, they are not in a position to do much about it. Just like a teacher or a school nurse often can see all kinds of problems, but they don't have the backup, they don't have the money to actually go and deal with the problem that is causing the child to act up in school or not come or drop out.

DAVID FUKUZAWA: I would call out the pediatricians and AEP in particular for being great advocates for social determinants. I think AEP in particular has been a great champion of sort of thinking about that. We have certainly been supportive of primary care as part of their work. It would be remiss of me not to mention something – because we have been talking a lot about the money in the healthcare system and there is a lot of money there that can be better spent. I think probably everybody in the room would agree on that. But in fact, this is kind of a total game, if we are serious about health, and that is that – many of you have probably heard the expression “health in all policies” and the idea being that all of our investments have impact on health. Education is an important one. There is a lot of data to show, the way to live a long healthy life is to get some kind of a post high school degree, delay marriage before having kids and you are going to be okay probably for the rest of your life. But a lot of people don't in fact have that and so, there is obviously a deep connection between education and longer term health, but how do we think about our total investment in people? And I think that is the important thing here. What can we do to sort of think about how we invest in people to make sure they have a long life from the very get-go as children all the way to the end of life, which all of us are going to be dealing with soon.

LAUREN TAYLOR: I would just add the last comment that my goal, when I think about all of this stuff, is to let doctors go back to being doctors and people often hear me as, Lauren, you pulling doctors and hospitals into all of this other stuff – the housing and the schools and yadda yadda. And the idea is, I think the system has to be very connected and integrated so that individual professionals can specialize. And so, that is the kind of dream I'm chasing, if you will. And in these integrated solutions that I have seen that are happening, that we profiled in the book, the best thing I heard was when a physician said to me, since we started this partnership with a community service center, I get to go back to being an internist. I was trained as an internist, I get jazzed about internist-y things. I'm not a social worker, I'm not a nutritionist and I'm not a psychologist and I have had to fake it as being all of those things. The same way that police officers have to fake it and teachers have to fake it. Any system that can't say no, bears the burden of a broken safety net. And so, right now, hospitals who can't say, no, bears the burden. So, they get people who they just have to fake it in all of these other roles. I think the idea is, if you can create a system where the referral lines are clean and the contracts are there, and the backup and the supports are available, then as physicians, you get to go back to being physicians. So, that is my dream. I hear you and thank you,

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AUDIENCE MEMBER: And I will say, family physicians, we treat people from birth to death, so we also embrace the role of having patients navigate through various systems as well. So, thank you.

MARILYN SERAFINI: We have a number of questions that have come in about Medicaid and with any new administration, any new Congress, there are a lot of unknowns, but folks seem to be wanting to know about Medicaid block grants in particular and what the impact of block granting Medicaid could potentially have on social determinants. As a second part to this question, we have other folks who would like to know what tax reforms – where we could end up with that as regard to social determinants and also, what happens if the next administration eliminates CMS’s innovation center? So, a lot of unknowns, mostly folks are interested in knowing the potential impact of Medicaid block grants on social determinants.

LAUREN TAYLOR: I am afraid that I’m being naïve in saying this, so let me go on record by saying, I would like to be able to take it back. But, I actually – I understand the concerns about block granting Medicaid and the concerns are legitimate. That if you set a total amount, you give it to the state and the state falls on hard times or the economy crashes, there just may not be enough money in that pool of funds to support the kinds of swell that will arrive on the doors of the Medicaid office. I don’t know how to work through that problem exactly, but I do think that the idea of block granting Medicaid could be a great thing for social determinants of health in so much as it would give some of the flexibility back and allow for this kind of braiding or blending that we have been chasing in this little neck of the woods that is the social determinants of healthcare and health policy. I would say I know that in Massachusetts, for decades people have been banging their head against the wall trying to figure out how to use Medicaid funds for particular social determinants of health type things. The air conditioners, lead remediation, mold remediation, housing, it’s always a fight. Can Medicaid dollars be used for housing or just the supportive part of supportive housing? And to date, that has been a fight that the state has mostly lost and the Feds have been very narrow about what they think Medicaid dollars can be used for and it’s been a struggle to try and make those upstream investments with Medicaid dollars, because the Feds have been very clear that Medicaid is for healthcare. And so, I wonder, and this is not my area of expertise, but if we go to a block grant model, there could actually be some latitude for experimentation and upstream investment.

DAVID FUKUZAWA: I’m not going to answer that question directly, but I will say that the states that have taken the 1151 waiver like in New York, you are seeing some terrific innovation about how to move upstream and I just came from New York and a big contract with social service agencies in that city and the Child Welfare System, so there is clearly some opportunities to sort of think more broadly about how to impact the health of populations. But, if you go back to Lauren’s slide showing the heat map, that heat map also – if you were to overlay that with mortality/morbidity data, it would map pretty close. And here is the concern: That not all states would be as wise, sort of thinking about block grants. And the states that are racing ahead, will race even further ahead. And the states that are lagging behind, will sink even further. So, that to me is the danger of – we

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would need to have very strong guardrails around something like that, because the opportunity – I agree, on the upside, is very big. But, we can't simply have states continuing to sort of fall further and further behind. Think about this, for the first time ever, we are seeing increased mortality rates among white working class women and men. That is unheard of in a civilized world. Everybody has been improving, even the poor citizens in this country have been gradually improving year to year on mortality. And now, we are seeing a failure. And that is a failure not of people, as a place. So, I just keep that in mind as we – and those places kind of map to those red zones. I would just be cautious before we move on policy.

SAMEERA FAZILI: What I will say here is just – it's always important to think about – block granting will get you flexibility, but at the end of the day, as we all know, these programs still have some sort of federal accountability, some things that we are managing and measuring at the Federal level, so you just have to think about -people are going to manage what you tell them to measure, so you just have to be thoughtful what rules you put in place if you really want to drive social determinants of health to be part of that system. And then, the second thing I will do is point us back to Lauren's slide, the total allocation of spending between the two systems is I think, a really powerful lens to think of this through and be thoughtful about whether reforms in one place are just going to squeeze people into another part of the system and how can you make sure that we are just spending the dollars more wisely across all the systems, not just narrowing one piece of that larger integrative system.

STUART BUTLER: I think we are all saying that there is a potential for real success in using a block grant model to pursue social determinants. If it is done right with the appropriate guardrails. The discussion of block grants gets mixed up, first of all, in the budget question and some people think block grant is merely a way of reducing spending on poor people. And then also, I think there is concern that giving flexibility to states means, name your southern state, certainly just won't do what is required. But if you think of it in a more broader way and I think most conservative health analysts like myself and others kind of think about this. First of all, we think of it as a per capita arrangement, so that that way if the proportion of people who fall into poverty during a business cycle increases, so therefore the Medicaid money also becomes a block of money, an amount of money kind of related to the person that can be flexible. And also, that it's done in the context of essentially the waiver model of how the Federal government and the state manages the Medicaid program. As David said, if you look at the 1115 waivers, there has been incredible innovation as a result of that. But the way that waiver works, any waiver like that works, is the Federal government essentially is saying, this is the outcome we are looking for and come with your proposal and if you meet the conditions, the guardrails and so on, it looks really interesting, then go ahead and we are going to evaluate it. I think it's critical to have that model in place with a block grant of Medicaid and also with the evaluation, because of course it's an evaluation not just for the particular state, but to draw the general lessons from that experiment so that other states can see it and can emulate it or refine it or try a variant in some other ways. It has got to be a dynamic model like that across state lines as well as from the Federal government to the state. With regard to the Innovation Center, I think it's going to be

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under fire, to put it mildly. But, I think when you think of innovation, you can think of it as kind of bottom-up or top down. I think the Innovation Center is an example of a top down view of experimentation, where the center itself has a kind of preconceived view of what it thinks is going to be a good development, like ACOs and so on, and then tries to push experiments kind of down the system. The alternative vision is kind of what we have been hearing about on this panel, which is the bottom-up sort of view. To say, well, let's see what is cooking out there and let's then make it easier for that to happen. I think if the Innovation Center became much more like that, of saying, what is out there and what can we do in Washington to facilitate what you are doing, measure it, give you some funding and so on. But we are not coming in with a preconceived view of exactly what happens. First of all, I think that would be more effective and I think secondly, it would be much more in line with a philosophy of the Congress now, the majority in Congress and the new administration.

MARILYN SERAFINI: So, we are coming to our last couple of questions. I want to remind everybody to please fill out your blue evaluation form before you leave. We have several folks who really want to understand both the evidence behind cost savings and also the evidence behind improving health outcomes. One question is: What are the overarching goals? Should it be to reduce costs? Should it be to improve health outcomes? Should it be both? Also, we have one questioner who is referring to an article at the beginning of this month in *The New England Journal of Medicine*, that seemed to indicate that permanent supportive housing as an intervention didn't yield net cost savings.

LAUREN TAYLOR: I didn't see the article and whoever has a question, you are welcome to email me or think about it. I think the ROI or kind of cost accounting on these things is always complicated. I will tell you what the evidence says and then I can challenge that evidence just as quickly. The evidence says that if you choose the most vulnerable populations, you do get a positive ROI. And so, that goes for housing, but it's basically the theme across all of the social determinants of health literature and it makes sense, right? Because if you are a researcher or you are an organization doing a pilot, you want to show positive ROI and so, you select into your sample the sickest, the most chronically homeless, the ones with multiple morbidity. So, in some ways it's a function of selection what your return on investment is going to be, right? If you choose chronically homeless people with both physical and mental kind of challenges or morbidities, then guess what? Those people are really costly now and virtually anything you do, housing, nutrition, case management, is going to create a positive ROI. I think the really sophisticated question is: At what point, as you move up kind of a socioeconomic gradient, do you tip from positive ROI to negative ROI? And that is like a magic question, the literature that we don't yet know. I would say the added complication about measuring this stuff is, you know, as was alluded to before, it matters if you count the initial investment. So, for instance, from a healthcare perspective, healthcare organization's perspective, someone coming in and making a housing investment could look fabulous if it's decreasing kind of the costs associated with a very kind of chronically homeless population. So, it can look positive, but then if you step back and you say, okay, now we also want to take into account the cost of the actual housing,

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meaning we want to take a more holistic approach, then it can flip negative. So, all of these studies are just a little bit complicated in that way. You can kind of find studies that say, in some ways, whatever you want. I do think, on housing, the preponderance says that for chronically homeless individuals and families, housing is a positive ROI. I would never tell you that I think this is a clean literature or a unanimous literature. Partly, I would say, because we don't have something like the NIH funding social service investments and measuring the return on investment from a social service perspective. So, I always caution people, if you are sitting as the head of a health system or the head of a Medicaid agency and you are trying to figure out what to do with a marginal dollar, if you are just looking at, how high is the stack of evidence, the stack of evidence will always be higher for the medical investment, right? You are always going to have more available evidence for the MRIs and for the new drugs, et cetera. So, I think we need to get out of this idea that being evidence-based means you just go with whatever has the most evidence. I think we could also look at the quality of evidence and kind of ask difficult questions about why don't we have as much evidence over here? And it's because it hasn't been funded, it hasn't been thought about, there are ethical challenges. So, the measurement is a long and difficult discussion and it just takes some time, but I'm on call if anyone wants to do some translation with me.

SAMEERA FAZILI: The only thing I would want to add to that is that when we talk about things like cost savings and health outcome improvements, it's – some interventions are going to be evidence-based and then there are going to be the replicators out there and why I think the social innovation fund at CNCS is really interesting, is because they provide funding to like, do replications, but they also provide technical assistance because not every program is going to be run well. So, they offer technical assistance so that the new groups are trying to start and replicate, get the support they need to run it well.

STUART BUTLER: Yeah, I think as Lauren said, one of our problems in this area is really just thinking about inter-sector collaboration, is relatively new, and the research and the data is just not caught up with what is going on in the field. And so, we do need to have an investment in really measuring this – sometimes it's called a social return of investment. The broad and multi-sector return and developing the methodology as well as funding the studies. There are groups like the American Public Human Service Association, it's done a lot of work kind of looking at methodology. Council in large public housing authority is going to be interested in these connections between housing and health in particular. They are making progress in this area. The fact is, we have a dearth – we don't have enough analysis in this area to make it clear what the impacts are. The problem then from that, among other things, it then becomes hard to convince budget committees and so on, to start changing the funding if you can't demonstrate it. So, we really do need enormous investment in this area from the research side to show these kinds of connection, what actually pays off and how one sector can benefit from an investment in another sector for that first sector's objectives.

DAVID FUKUZAWA: Just a very quick comment on cost versus outcomes. Are people familiar with the triple aim that was in health care improvement? Some of you are. We

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really have to get better outcomes and lower costs and we have to get better population health. So, those are the three aims. A better quality of care, lower cost per capita and better population health. Even though IHI kind of came up with that idea, I think it's pretty well accepted now in the industry that this is kind of the standard that we have to achieve. So, one at the expense of the other really won't get us there.

MARILYN SERAFINI: Okay, we are a little bit over our time. Let's see if we can handle the last question at the mic. Let's keep them short.

AUDIENCE MEMBER: Carl Polzer, I have been working with long term care providers on policy issues for many years. There is a real strong institutional bias with long term care toward nursing homes. As people said, they get paid for both housing and healthcare, but home and community based settings is where the emphasis is now and at home and assistant living, under Medicaid law you can't get paid for housing. So, the states usually use SSI – supplemental security income of about \$8,000 a year to pay for the housing, which is about half of what you need to put somebody in assisted living. So, another thing to put on the table would be a supplement for SSI, for people who are nursing home eligible in Medicaid and you might be able to get the numbers up in assisted living above 200,000, where you have a million people plus, getting nursing home services under Medicaid. Just a reaction.

STUART BUTLER: I agree.

MARILYN SERAFINI: Okay, so let's move on to the last question.

AUDIENCE MEMBER: Marcia Greenfield from Leading Age and we represent non-profit aging services, housing and providers and healthcare providers. I just wanted to comment that there is actually some very interesting research going on, on the use of service supported senior housing as a way of reducing Medicare and hopefully Medicaid costs, both the SASH project in Vermont, the Center for Applied Research, our research center has done some really in-depth look at using supportive housing as a way of reducing healthcare costs and I think that we will see more of that as we go on. I wish my housing people had come to this, because I think they could have also added to this conversation. And I wanted to thank you, because this has been really very, very interesting.

MARILYN SERAFINI: Great! Please join me in thanking our panel for a very interesting conversation that I'm sure will go on for quite some time. And if I could ask you one more time to please just take a moment to fill out your evaluation form, it will help us to help you. Thank you for being here today.

[applause]