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NEW DIRECTIONS FOR COMMUNITIES:  
HOW THEY CAN BOOST NEIGHBORHOOD HEALTH

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**Welcoming Remarks**

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**A Conversation on the Role of Social Factors in Improving Health**

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**Panel: Healthy Communities**

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**Panel: National Policy Implications**

MODERATOR: STUART M. BUTLER  
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## P R O C E E D I N G S

MR. BUTLER: Good morning, everybody. My name is Stuart Butler. I'm a senior fellow here at the Brookings Institution, and I want to welcome you to the discussion today at Brookings about how communities and communities' institutions can boost neighborhood health. I want to welcome everybody who's online watching this program today.

Now, it's accepted, I think, generally, that the United States has among the best medical facilities available for anybody, but also recognizing that it takes a village to promote health in our communities. Local institutions and non-medical services, like housing, schools, social services, are crucially important in ensuring that communities are healthy.

But unfortunately, in America today, we spend an enormous amount of money fixing people, and not enough on dealing with those issues and with those resources that are available in communities to help people be healthy.

It's time, I think, for us to spend a little less time on fixing people, a little more money and time on reducing the need to fix them.

For example, if you look at the amount of money the United States spends on medical care, as you probably know, we are spending over 17 percent of our GDP on health services in this country, well above other countries in the world, but if you take together the amount we spend on health and medical services and social services and combine them, we're pretty much just a little bit above the median level in the world, so for the combination, we are pretty much in the middle.

The issue is that of that total amount, the proportion that we spend on medical services as opposed to other services, many of which improve health, is actually extremely high compared to other countries.

The average for the industrialized countries in the world of the combination of medical services and other social services is to spend about 37 percent of that combination on health care services. In the United States, it is 64 percent. We are a complete outlier. We spend far more fixing people with medical care and far less than other countries by comparison in dealing with these social factors in health care.

This morning we're going to explore this issue a little bit more with three panels. The first panel, which I will be joining, too, will be looking at the role of social factors in improving health care in our neighborhoods and communities.

In the second panel, we'll hear from some individuals who are tackling these same factors sort of on the front line and involved in linking together social services and medical services to improve health care generally.

To wrap up, we'll have a panel that will look at some of the implications of all of this for public policy and for the conduct of the way in which we run our health system in this country.

Before we begin, I would just ask you to silence your cell phone so it doesn't interfere with the broadcast of this event.

I'd also like to thank the Aetna Foundation, which has contributed to support this event, and we are very grateful for that, and Dr. Garth Graham, president of the Aetna Foundation, who will be joining us on the third panel.

As always, I'd like to reiterate Brookings' commitment to independence and to underscore that all panelists will be giving their own personal views.

The opening panel, as I said I'll be joining, will be moderated by my colleague, Dr. Kavita Patel. Kavita has many years immersed in both public policy and actually in the practice of medicine. She's a practicing primary care internist at Johns Hopkins Medicine and at D.C. Sibley Hospital here in Washington.

She's a nonresident fellow at Brookings, and was previously the manager of clinical transformation at the Brookings Center for Health Policy. She has also been a researcher at the RAND Corporation. She served in the Obama administration as a health adviser in the White House, and also on Capitol Hill where she served on the late Senator Edward Kennedy's staff, and among the senior staff of the Senate Health, Education, Labor, and Pensions Committee, which is the big committee that handles health care issues, along with Finance.

She will be moderating the first panel, and she will be joined by Dayna Matthew. Dayna is a nonresident senior fellow here at Brookings' Center for Health Policy. She's also a professor at the

University of Colorado School of Law, at the Colorado School of Public Health, and at the University Center for Bioethics and Humanities.

She was recently a Robert Wood Johnson health policy fellow in Washington and served in the office of Senator Debbie Stabenow.

Last but by no means least, she's the author of "Just Medicine - A Cure for Racial Inequality in American Health Care."

Let me hand it over to Kavita.

DR. PATEL: Thank you, Stuart, and welcome to everyone, those in person and watching on the Web. What we're hoping to do this morning -- Washington, D.C. is sometimes filled with a lot of chaos, a lot of noise, but we know what really emerges from that are voices that can actually bring stories forward, and can help us not only to think at kind of a very high level, but also bring that back down to a very practical level.

This morning, I think we are going to very much take you through that journey, so I'm excited to not only be a part of it, but also to join two of my colleagues. What we are going to hope to do for the next half hour or so -- I couldn't be more pleased -- I will tell you candidly, I've known Stuart now since I first worked for Ted Kennedy, so it's probably been about 14 years.

Stuart is very kind of understated, but he will be the first person to tell you he's not a health care expert, but what he really is is an expert in kind of thinking about our country's problems in a variety of directions.

This seems like a very appropriate topic for today and for this year, the topic of access to health insurance, but in the context of budgets. In my mind, when I thought about Stuart, I always kind of thought well, he's the budget expert. It's been over the last several years that Stuart has applied that knowledge in thinking about kind of economic and budget issues to health care.

I think what's impressive to me is somebody -- I'm trained as a doctor, so of course, I think about health care all the time, somebody like Stuart brings a background that's very diverse, and he has really identified and we are eager to get into that this morning, how he applies some of his knowledge of thinking on a national scale but acting at a local level, and then also taking those lessons from the local context to the national stage.

I have to say, Professor Dayna Matthew, who is right next to me -- you can Google all of us and see what Google brings up. Dayna, I think, has been one of the preeminent scholars in really helping to push our thinking about health equity.

Those terms sometimes feel very loaded, like, oh, health equity or community health or population health, but Dayna has done over her career -- she's still young, so she's going to have more to do -- what she has done over her career has been to really kind of push kind of consciousness about how our actual infrastructure of health really contributes to inequities in a serious way, but then how we can also be part of a solution.

Because she comes at it from a legal perspective -- by the way, this is like a limerick, a budget expert, a lawyer, and a doctor. (Laughter) Somehow there's like a riddle to be found in all of this.

I think the fact that the three of us actually are all kind of interested in the same problems speaks so highly to one, this really is a community issue, you can't find the answers in traditional, and two, I think there's a beautiful timing to this because all three of us have come at this for very different reasons in our lifetimes, and I think there is just this great intersection.

I'm actually going to start, if you don't mind, with you, Dayna. You have written both in book and narrative, written beautifully about thinking about these intersections.

When I was studying health care disparities, I really had a hard time understanding how do I bring that forward and how to think in my day-to-day life about health care equity and what we're doing to contribute to disparities unintentionally or how we contribute to inequities, just speak a little bit about your work and also kind of knowing that this is a policy audience, and there are people from the front lines here, because I know some of you, and there are people who work in policy sectors, non-profits, help us understand what we can take away from this.

MS. MATTHEW: Sure. Thank you for the introduction. I love the part that I'm young.

DR. PATEL: You are.

MS. MATTHEW: This is a very knowledgeable audience, so I'll use some words that are probably known to everyone. I originally come to the problem, as Kavita said, as a lawyer. So, lawyers are concerned with justice, a loaded word, lawyers are concerned with equity and equality, not the same, but we're concerned with both of those.

So, when I think about health on the population level, one of the things that concerns me most, both from the problem side and from the solution side, is inequity, because if we don't appreciate that inequity means that resources needed to be healthy are inequitably distributed, then our solutions won't focus on the fact that inequity will be exacerbated if we don't look at it.

When we look at neighborhoods and communities that are concentrated, not only in poverty, but even modest income neighborhoods that have concentrations of under resourced, so that would be food sources, educational opportunities because the poor schools are located in the poorest neighborhoods, employment opportunities, environment where people can exercise, exposure to hazards, like pollution.

You were talking about stories. One of the things we are working on right now in Colorado is something called the Interstate 70 Relocation Project.

Well, this is in a neighborhood that's called Elyria-Swansea, where in the 1800s there was a melting plant, so it's a Superfund site. There's a petroleum refinery. There is a pet food factory. There is the National Western Stock Show located there, and you know what comes with stock.

(Laughter)

Now, a six-lane highway is going to be expanded to eight lanes. All of this is concentrated in a neighborhood now that you can get the demography. Elyria-Swansea is 84 percent Latino and 44 percent of the people are under 400 percent of the Federal poverty level. So, this community is repeatedly assaulted from an external and internal health perspective.

If we don't look at solutions that are going to address the inequities, both environmentally and physically, then that community will be left out and health disparities will continue there.

DR. PATEL: Just a follow on, and then I want to bring Stuart in. What can we do? Sometimes putting that kind of consciousness out there, it feels like it's so hard to understand kind of where to go from there, and I think that personally has been a struggle for me.

I know you teach, you are kind of bringing on a next generation of legal scholars and I'd argue more interdisciplinary focused scholars, what are you trying to teach them or what are you trying to have them take away from like the I-70 experience?

MS. MATTHEW: So, there are two things. One, we have to think -- of course, everything to a lawyer looks like a legal problem.

DR. PATEL: We're in D.C., a lot of people feel that way.

MS. MATTHEW: I'd say there are two things. One of the things we're concerned about is more equitably distributing burden and benefits, and secondly, we're looking at new ways to pay for those benefits, right?

So, school financing is a great example. The way we do housing stock is another great example. One of the things we have is the Colorado Health Equity Project. One of the things we're very concerned with is the fact that even though housing is becoming unaffordable in Colorado, we need to be thinking about mixed housing neighborhoods by zoning, that's a law. We need to be thinking about financing projects that will include multiple income families in one location.

So, these are legal problems and finance problems that I think we need legal and financing solutions for.

DR. PATEL: On our next panel we're going to hear from one of the leaders at D.C. Housing Authority, so it will be great to hear what's similar between Colorado and D.C., and I know there's a lot.

Do you find that also battling -- we call it nepotism, there is certainly a sense of cultural, people feel very personal, obviously, about where they live, have you encountered that or had experience with the attitudes of neighbors and nepotism?

MS. MATTHEW: Absolutely. The reason the I-70 corridor is a great example of this is because despite the poverty and the demography, this is a neighborhood where there are four generations of homeowners. Even though the highway project is going to displace 200 families, one of the questions is where are they going to go, right?

So, where are people who have had affordable housing going to go in Colorado, which is now one of the nation's fourth leading economies in terms of growth. Those neighborhoods are going to change, so social capital is going to change, that changes health, right? Social networks are going to change, that changes health.



Availability of community affects health, and that's one of the things that I'm really excited about in terms of this conversation, that we understand that we're not talking about health any more at an individual what I call "retail level," but we have to think about health in the community so we can affect population, like the population in Elyria-Swansea.

DR. PATEL: That's great. Stuart, let me ask you to kind of jump in. Maybe, Stuart, you can set up a little bit of what you've been leading, not only here at Brookings but kind of the conversations you have been leading across different sectors, to just give us some takeaways, and also thinking about - I know I can tee up hard questions for both of you, but also teeing up for you, Stuart, kind of what is your prescription, per se, kind of how can we think differently about these issues at a policy level?

MR. BUTLER: Sure. Well, first of all, thank you for your very kind comments. I'm actually a historian by background. I would say the study of history is everything with examples. That's kind of in general how I look at these issues. I tend to look across the spectrum and say what's involved, what helps us understand the particular issue.

As you also mentioned, one of the things I've been doing here at Brookings is bringing together, in fact some of the panelists, and a number of people from very different sectors to really brainstorm on how can we understand what's going on in health, and also health in the economic sense of communities, why do some people move up and others don't.

How can we think about this and learn from each other and understand that to appreciate what happens in the health area, you have to understand what's going on in these other areas, such as housing and transportation, as Dayna mentioned.

We certainly have learned, if you look at the research in this area and the conversations we've had, I think both here and in general are appreciating a lot more how these other non-medical factors influence health care. We're learning a lot about how what happens to a child in the early years, everything from stress to abuse and so on, can have long-lasting effects on health care.

So, if we can deal with some of those issues up front at the beginning, then we'll have a big payoff, so to speak, both for the child and for our costs later on.

We know as Dayna said that housing can be really important. If you have substandard housing, it's very much linked to things like respiratory problems, other kinds of problems. Obviously, lead paint, things like this we know about. Just dampness, poor neighborhoods, and so on.

Falls, if you think about the elderly. The Centers for Disease Control estimates that we spend probably about \$30 billion a year fixing people who have fallen, and in many cases this is an elderly person who is in an apartment maybe with rugs that are slippery or with a bathroom that is not really well designed and it's more easy to fall and so forth.

We also know that cultural issues are a factor. What's going on in a neighborhood, what the norms are. If people are smoking everywhere, then the people start to smoke.

We know there are a lot of connections between these factors and health care. Part of what I'm trying to do is to look at what could you do to intervene in certain ways to get these different sectors to talk to each other, first of all, to share their insights, and to deal with a lot of the issues associated with where spending takes place.

Let me just end with this, take, for example, this issue of falls among the elderly. Everybody can appreciate that. If we could do something to reduce the level of falls, it would have significant effects on the number of elderly people who end up in the hospital and end up in long-term care. Long-term care now, nursing home care, the median in the United States now is \$82,000 per year.

If you can prevent somebody from ending up in a nursing home, not because they want to be there, but because of a medical problem, you can not only improve their lives, but have considerable reductions in costs.

Our system is not set up to say okay, if it's going to cost us \$82,000 over here, why don't we take some of that money and prevent the problem over there. Of course, what we find is that programs are not designed to do that. Health care is health care. Housing is housing.

How do we start to look at budgets in this way. How do we look at rules for payments. That's what we are really trying to dig into. We have a problem here, I think, of we have to both understand the contribution that social institutions and social services in the community have to improve health and reduce costs, we have to understand that, and then we also have to understand that we have to actually take steps to get these different sectors to start to appreciate how they can help each other,

and also to set up a budgetary and payment system, an incentive system, so that doing good is rewarded rather than very often penalized.

When a hospital today does things that make it less likely that people will come to the hospital, that means their revenue goes down. The chief financial officer does not see this as a particularly wise use of money, even though it makes sense to everyone, and that's the sort of thing we have to really tackle.

DR. PATEL: I'll ask you a little bit of the same flavor question. By the way, Stuart has been notorious for bringing these -- I forget what you call them -- strange bedfellows.

MR. BUTLER: Working groups.

DR. PATEL: They're called working groups, but I know we have talked about the fact that Stuart Butler is known for bringing together people who should have been having conversations with each other all along.

I will confess I find myself when I come to his working groups kind of sitting there going I've never had conversations with people in housing or in some of these other social sectors, and I think that's been part of what's inspired a lot of our community-based work that we're doing, even in the D.C. area.

One question for you, Stuart, I do believe we are at a very interesting nexus because there are some shifts in payment policy, as you mentioned, to kind of promote these opportunities and have hospitals think very differently about care, to be a bit more preventive, whether it's bundled payments or some sort of population health-based payments.

I know there are some financing mechanisms. Have you seen some other policy shifts allowing a little bit of that opportunity to think more preventive or upstream, so to speak?

MR. BUTLER: You're right we have been taking some steps to kind of nudge these different sectors to work together a little bit. Some of them are sticks. I was talking about the elderly.

Look at Medicare, which now, well, for some years now, has had a rule, the so-called "readmission penalty," that basically says if somebody comes in and is diagnosed with certain diseases, heart disease and others, and then the hospital discharges that person, and then they come back into the

hospital or any hospital within 30 days for the same diagnosis, that initial hospital faces a penalty, and in some cases, a substantial penalty.

Well, that focuses the mind somewhat. (Laughter) Now we are seeing more and more hospitals saying okay, let's engage in a little bit of follow up service here, let's make sure that when we give that wad of paper called a discharge, do all this, do all that, that we actually just check up and make sure they do follow up with their general practitioner, or even that we all go and see where they live and see if the fact they came in for a fall might be connected --

DR. PATEL: To where they live.

MR. BUTLER: Or maybe there's nothing in the fridge, maybe this is a person that is two bus rides away from the grocery store and just doesn't eat properly. Let's see if we can begin to make that happen, because we, the hospital, will face fewer penalties. That's a stick. I would like to see more carrots.

DR. PATEL: Sure; right.

MR. BUTLER: You're right. Certain programs, Medicaid program, particularly the managed care Medicaid program, where you have projects that actually look across the sectors a little bit more. They're doing things to address some of these issues, housing problems and so on, in order to get their general costs down.

Health plans that are capitated, that have a membership fee or a capitated fee, certainly have an incentive to look at creative ways to use that money. The rules for Medicaid are improving in that area.

I think there's been a growing interest in connecting better between particularly the hospital sector but the physician sector generally, and economic and community development a little bit better. There are institutions, community development corporations, funders that are now looking at funding different types of activities and facilities to enable connections to be made.

There's a lot going on. There is a lot of interest in using what we call "intermediaries," those individuals who connect together.

DR. PATEL: The bridging.

MR. BUTLER: A good example is a school nurse or a parish nurse in churches, in saying how can we work together with these intermediaries who know the people in the church, have got skill sets in the medical area, to work with the hospitals and physicians together, and the same with school nurses. This means addressing issues like data, access to information and so on, and licensing requirements, payment systems.

I'm glad to say I think we really are seeing a much greater interest in looking at these issues. We're not necessarily on a roll yet, but we are beginning to get close to being on a roll.

DR. PATEL: Right, people are welcoming the conversation.

MR. BUTLER: Absolutely. I think there's a great opportunity at all levels of government to do this.

DR. PATEL: I was just going to ask you, Dayna, you really have spent time, especially in the last couple of years, at a national level and regional and local level, what shifts are you seeing.

I couldn't be at Brookings -- I promised Stuart I wouldn't talk about the ACA or the HACA or any version.

MS. MATTHEW: Oh, I didn't get that memo. (Laughter)

DR. PATEL: You're right, Dayna didn't get that memo. I'm going to ask Dayna -- Stuart and I get asked about that on a daily basis.

MS. MATTHEW: I'm so glad to be the outsider because I can claim ignorance.

DR. PATEL: I am curious, Dayna, just thinking about the local/regional/national, and the very real conversation we are having about just what kind of access points and how we should think about whether it's state budgets and per capita caps or Medicaid allocations, how do you take the conversation we have been having for about half an hour and then translate it to some of the challenges with access, and even thinking through we're talking about potentially entering people into high risk pools. I would argue maybe that I-70 corridor is probably going to have a concentration potentially of people who are falling into that.

Tell me, even if you have just internally thought about this, how do you wrestle with that from an equity perspective, and what guidance can we give to people as they are also wrestling with these issues.

MS. MATTHEW: So, thank you --

DR. PATEL: It's a real easy question. (Laughter)

MS. MATTHEW: Yes. I think I'm going to focus on how we pay for things.

DR. PATEL: That's fine.

MS. MATTHEW: In fact, even as Stuart was saying earlier, there is a stick and carrot approach, but all of it involves dollars. All of it involves how we reimburse payers. Some would argue there is over medicalization of poverty and over medicalization of these social problems.

I really resist that and suggest that one of the shifts that we have seen, one of the heads of steam that we have seen is people in health care, physicians, providers, understand -- I think it was Rudolf Virchow that said this, it is self-evident that a physician or provider science must include everything, every aspect of life, that is proclaimed purpose, that is health touches, right? Everything.

It has to include housing, employment, income, and so forth, but it can only do so if we reimburse those providers in a way that gives them time and incentive to pay attention to those other factors.

One of the things I've been writing about and thinking about is why hospitals, especially safety net hospitals, are not leading the charge to protect the Medicaid expansion, right? They should be leading the charge. Not only because the head of steam that has allowed them to diversify their interests and create these collaborations that Stuart is so good at, bringing people into the room, that should be happening on the ground, right?

We should see more Catholic Hospital initiatives, working with Mercy Housing of Denver to create medical respites for the homeless, right, so we would reduce the return and readmission. Why? Because there is a financial incentive to do so.

We should see more collaboration between those who are addressing food and security, like the Boston Community Hospitals, right, farmers' markets that people can get to, transportation-wise, as well as cooking classes and educational components, that will reduce chronic disease.

Why don't we have this? We don't it because we are still reimbursing per member per month, right? We are still reimbursing people in a way that incentivizes them to think about illness instead of wellness, that incentivizes them to think about individual health care as opposed to population.

I really do think the leverage or the lever that we must address is making sure that financing is available, that is why I say hospitals should be leading Medicaid expansion, the fight to protect it, whatever the political changes to the ACA or whatever follows it, if we lose the ability to be creative about looking at bundled care, about alternative payment methods, if we lose the amount of money that is addressing vulnerable communities, then all of the head of steam is going to go backwards.

MR. BUTLER: I just might add a couple of things. One of the challenges, which flows from what Dayna said, is first of all it's hard for a physician to be knowledgeable about everything. For example, now pediatricians are being urged more and more to ask children about conditions at home, poverty, housing conditions, and so on.

They're not really sure what to do about this information. That is one of the things where I think the role of intermediaries is really important. It is really important to have kind of a cluster of people and organizations around the health system and really close partnerships so that when a physician spots a potential problem, they know how to give what we sometimes call a "warm handoff" to somebody, to address this. We're beginning to see this. Hospitals, as I mentioned, are doing this.

The second thing I think we are going to have to deal with and a challenge is what is the money spent on? If you look at something like Medicaid, I think an increasing issue is if we really wanted to do this effectively and to have the various aspects that lead to illness taken into account by the Medicaid program, we have to start using Medicaid dollars for different kinds of things than they have traditionally been used for.

That makes a lot of people understandably nervous, does this mean that money intended for people's health is now drifting into others? What does that lead to down the road?

We would also what to have more flexibility generally about the use of that funding. Well, talking about the health care debate going on, there is a big debate over should states have greater flexibility in what they do with Medicaid. A lot of people get very anxious about that.

The positive side, of course, is to say if they could, there could be a lot more exploration of ways of using what is now medical money to fix people in a way to deal with their health issues.

These are difficult issues. We are on a roll in one sense, but as people think about what could go wrong, that is the issue.

DR. PATEL: Right, unintended consequences. I know Stuart is going to get into this with our concluding panel, so I don't want to steal too much of his thunder, but kind of national implications. It goes back -- Dayna, I think you put it very beautifully, this kind of I-70. I've driven on that highway. I know exactly what you're talking about, kind of this analogy.

We now are finding that our communities -- in an ironic way, we are so connected because it's constant, whether it's social media, this or that, as I told people, I finally joined Facebook. For the longest time when I was in government office, I was not on Facebook. (Laughter) My own mother kind of forced me to be on Facebook. Once you have children, it's the only way she can see pictures of them.

When I finally joined Facebook, my sister sent me a text, like a couple of weeks ago, she was like welcome to 2008. (Laughter) I am probably the worse connected person in the entire universe.

The irony is the more connected we are, actually, the more we are struggling with inequities across -- I would almost argue even more kind of aligned, we are seeing much more of a sense that even if you're in a community, there is a sense and there is a very palpable sense in this country that you don't know where to go for help.

Getting to the audience, we have two of my favorite people in the back with mikes, so if you do have a question, just put your hand up so we can get mikes to you, and then I will call on you.

Dayna, I want to close out the panel before we get to the questions with just your thoughts on bringing it back to the community and kind of where you think -- you mentioned a little bit about food access and security, employment.

Is there a framework we can use to kind of think about bringing people together, what are some ways forward as a community that you would say okay, we're doing it. What Stuart is doing with his working groups is one potential. Are there some other things you have seen that work to just bring people together to solve these problems?

MS. MATTHEW: I have to say, I love your word "connectedness." In a lot of ways, one of the things we have seen in the I-70 corridor is a lack of appreciation for how important it is for communities to connect.



I-70 is one of two interstates that goes through this historically Latino community, I-25 going north/south, and I-70 going east/west. That bisects the community. That means people can create solutions, like the farmers' market in the northwest corridor, but I have to take two buses and take off work to get to that solution. That community is not connected.

DR. PATEL: Right, but it doesn't matter.

MS. MATTHEW: But it doesn't matter that I've got this great food resource. That is what happened in Flint, quite frankly, what we hear about the water crisis, but again, transportation, another health issue that is under appreciated, right?

If you bisect the community, you put solutions out of the reach of a community, and then they have to use the fast food stores that are very dense, they are right there.

We have got to think of connecting communities and then lastly, sorry to get philosophical, but all communities are connected to one another, right?

We all bear the cost of premature death. We all bear the cost of excess emergency room visits and readmissions. We all bear the cost of under resourced low and modest income communities, and if we think we can isolate those problems from the whole, then we're missing the picture.

DR. PATEL: Perfect. I know we have some questions. Yes, sir. If you can tell us who you are and ask your question.

MR. SELLERS: I'm a student at Howard University. My name is Jordin Sellers. I liked your narrative, this is kind of like the wedding before the funeral, but in terms of what she said specifically about how can we alternate solutions to this problem as far as health care is concerned, it seems there still needs to be a study done given the fact that health care for males or females is kind of the same thing nowadays, we're talking about whether you're a married couple or single, heterosexual or homosexual couple, we're talking about the same needs and wants.

How do you say there isn't a problem with health care if you're given the same type of health care to people in the health care community, and there really is no debate and argument from them?

DR. PATEL: I'm not sure I'm smart enough to know what that question was asking right now. You're talking about how do we know if there is truly a difference in health care between persons? I just want to make sure.

MR. SELLERS: The analogy was like this is the wedding before the funeral, so if you're going to provide health care for couples, whether you are homosexual or heterosexual, it's like health care is trying to get them premium health care if they are already, you know, celebrating something that's going to benefit this particular couple, but they are not giving them long term health care if it's going to be like I said, a wedding before the funeral, life to death, if it happens.

It's like where are we going with solving this problem if the social scientists are saying that health care as it is being provided doesn't cover life to death.

DR. PATEL: I see. Sorry, now I understand. Do any of you want to just tackle kind of thinking about -- I am just going to kind of paraphrase a little bit just to get a pointed question.

How do we think about the need for the kind of longitudinal -- that is what I think you were arguing, we need to actually study this, we are looking at health care and kind of different time constraints before what is really a longer term vision for health care.

MR. BUTLER: Well, we certainly, I think, some years ago began to recognize that health is a continuous process, which is what I think we are getting at. When you have a health system, for example, that is heavily employment based, for example, the incentives for an employer thinking about what to give to their employees is going to be different from somebody looking at that whole period.

If you try to move towards health care being connected to the person rather than where they happen to be or where they happen to work, that's been a very important step forward, I think.

We also have been doing a lot more research over the years now in looking at when you intervene at a certain point or if something bad happens at a certain point, how does that affect people over the long term, and what can we do.

I think that has been one of the reasons, particularly with regard to say children, that this focus on social determinants and what goes on in those neighborhoods has attracted the interest of people in the health care community, not just the social science community, or the sociology community,

because it does have these long-lasting effects, same as the debate over early childhood education, where does the benefit show up, is it long-lasting, is it short, and so forth.

I think in general we have seen the health care system or people researching in the health care system and practicing in the health care system, like these other sectors, like education, social science, and so forth, beginning to look at this continuum.

I think that's the core in a way of what we are talking about here today in this panel. What are these issues and factors that are going on in the early period that may end up causing the wedding to be a funeral, or causing problems, or leading to really good outcomes, and how do we learn from that.

DR. PATEL: I think you are exactly right, we don't really set up studies or think about things in that longitudinal way.

MR. BUTLER: We're getting better.

DR. PATEL: We're getting better. Stuart probably doesn't remember this. When I worked for Kennedy, one of the things I had approached you and Hank Aaron here at Brookings about was the fact that we couldn't actually get the Congressional Budget Office to think that way when we were looking at interventions that would have an effect, early interventions, even on the health care front, that --

MR. BUTLER: Researchers, like everybody else, tend to be rather siloed. It's difficult even within the health area to get people to really focus on the long term.

DR. PATEL: Right.

MR. BUTLER: When you start saying okay, if I'm a health analyst, how do I start thinking about housing and education. People in these fields often have very little knowledge about the databases, about the research, in each other's sectors.

Actually looking at the return to an investment of focusing on something which is non-medical in order to improve the health over the long term, sometimes it is actually very difficult to find somebody who knows what the data is, to get the kind of research needed.

That is kind of where we are now, I think, trying to find better ways of looking at returns on investments across sectors to show the impact on health.

MS. MATTHEW: I wanted to just say in response to the question, I don't know if you meant to, but you put me in mind of one other thing that we don't talk a lot about, and that is the community's role in defining research objectives, and the community's role in defining what kind of health care choices we make.

One of the things I appreciated so much about being in Senator Stabenow's office during the Flint water crisis was the first call our staff made was to people in the community to say what can we do to help you, and some of the answers were not what we expected, right.

Some of the things that we needed to research were not exactly what we would have done in our own ivory tower kind of research generation. We would come up with different solutions if we asked the populations.

DR. PATEL: People don't take the time to do that, and that's your point.

MS. MATTHEW: When you asked that question, I was thinking sometimes I just go in my corner and I think about what I want to research and really I'm thinking about what datasets I can get, and that's what I'm going to research.

We need to ask people who we are serving.

DR. PATEL: And flipping that model to bring the kind of data we need is actually something we are going to get into a little bit.

Let's go over here to this side, and then we will flip to this side. The lady on the end.

DR. POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I'm also an attorney. What you are talking about are called the "social determinants of health," and there have been lots of studies, and of course, overseas in Europe, they do it much better.

What I'm concerned about is for profit, not for profit. I think we are medicalizing things that shouldn't be medicalized. The difference between the visiting nurse service, VNA, and a for profit home health agency. In VNA, it used to be when I was using it, a non-profit. It was an institution with nurses and people who weren't nurses. They had a promotion scale. They had benefits. They had teaching and learning so you could advance your career, moving up. It was not for profit.

A home health agency, which often provides the same kinds of services, they take immigrants, they give them a couple of weeks of training, they have no benefits, they have no future, it's a

dead-end job, when they are disabled because they have tried to move a heavy person, they have taken out their backs. I've had patients like this. They are just discarded and new people are brought in.

All the intermediaries make money. The people who run the agency, the hospitals who employ them. We need to build community institutions like VNA. The building we did in Afghanistan, people need to work with the communities to set up nursing, social work, that everyone can access and everyone support.

The hospitals shouldn't be doing population health. Population health is a public health problem. The solution to obesity is not talking to your doctor. Like tobacco, public health initiatives. Reducing advertising. Putting calorie counts on food. Something that President Trump just withdrew or the FDA under President Trump just withdrew.

Think about profit, non-profit, and community institutions, which I understand is what they have in Europe.

DR. PATEL: Any reactions? Thoughts?

MR. BUTLER: Well, I think our emphasis on what we are talking about here and certainly the work we are doing here at Brookings and elsewhere is very much focused on those institutions. I'm not absolutely convinced it is a profit/non-profit issue so much as one where how do you actually get incentive structure and skill sets in place to enable a good outcome.

I think particularly with regard to community-based institutions, we are seeing improvements and addressing some of the issues associated with education and training of say nurses to play different roles, more expansive roles in the community.

I think we are looking at how to get better partnerships with exactly those institutions you referred to in those communities. That is the kind of thing we are doing, and I think where the effort is being placed, to address those specific issues that you raised.

You are absolutely correct about the ingredients, the things that need to happen, and to begin to kind of work in that area.

I think whether it is a Federal issue, we will get into a bit later, about to what extent, is the place to see these things moving more locally, and thinking of ways of committing it to happen, removing things that get in the way may be an important factor.

I would just say finally that I think there is a lot of interesting experimentation and initiatives about more localized efforts to build a village, to build a team in this way. We see it with things like community schools and communities in schools, which is setting a team in the school to look at these different things and to try to work together.

We see it here in the District of Columbia and also in Boston and a few other places in the growth of senior villages, which are institutions in the community, a mixture of volunteers and some professional staff, to really address the multiple needs of elderly people trying to age in their home and addressing all these issues.

So, I think it's coming. I think you're absolutely right to emphasize those concerns, but I think the good news is we are beginning to see some activities in these areas and some institutions growing to address what the questioner asked.

DR. PATEL: Dayna, any brief thoughts, or should we move on?

MS. MATTHEW: I absolutely respect your experience. I want to push back just a little bit. It doesn't have to be hospitals.

DR. PATEL: But I'm here to tell you they have money they should be giving. I'm just going to be an advocate that hospitals should play a role. We will get into this in the next panel.

MS. MATTHEW: Hospitals don't have to but they are a hub to use, that is a really good choice and possibility, not the only hub. Schools could be a hub. The point is to bring collaboration around public health problems. There is no institution alone that can do it, and no institution is absolved from doing it. That is my point, so I will leave it there.

Maybe we will have a conversation off line about my clients who are also patients, and will only come to see the lawyer in the clinic. They will only come to see the social worker in the clinic. The clinic, the health care provider, is a hub that the community respects and that the community relies on. So, to bring those public health services into the clinical space is very effective.

DR. PATEL: The gentleman over here in the front. I'm going to try to make sure we get to everybody. We are going to try to be very brief. Yes, sir?

MR. APGAR: Thank you. Sandy Apgar, CSIS and Brookings Metro. Have any of your study groups or programs looked specifically at the best performing non-U.S. programs to really identify practically what works and what doesn't?

Having spent almost 10 years in the U.K. in the last decade and actually experienced and lived the National Health Service and so forth, as a capitalist, I came back very much geared to a national health care system and the way they performed it, and although I've seen studies, have not focused as you all have about the NHS and its counterparts in other countries, I've never seen a direct business like clinical comparison of the practical levers of what makes them work and what is somewhat dysfunctional.

The three observations I would make as a former client, patient, and so forth of that system, first, ours is far more complex for the individual --

DR. PATEL: Complicated.

MR. APGAR: The adverse of complexity, of course, is simplicity, as any business knows, complexity breeds costs. It is inherent. When you begin to simplify complex systems, you can tease out/carve out costs.

The second is specialization. Our system seems to be so specialized that that alone for a general patient or consumer/client is a real problem. It gets in the way, the silo effect is very obvious.

The third is institutionalization, as distinct from individualization. We felt very much individual health care consumers and patients in the U.K., and finally, cost consciousness, which is all of the above three tended to diffuse the attitude toward costs.

It still is phenomenal to me that when a general practitioner or specialist recommends X as a procedure, and I ask what is it going to cost us, he or she --

DR. PATEL: I couldn't tell you.

MR. APGAR: Cannot respond. If they do, it is always with ten caveats. We don't need that as individual consumers. We need people who deliver care who know it is costing \$1,000 or \$10,000 or \$50,000, and then can be aware of that. So, observations plus a question.

DR. PATEL: Do you want to just take that briefly? I hear your accent.

MR. BUTLER: I think certainly the last part of your question or observation is right on in terms of what some of the differences are. I think there have been a lot of studies that have looked at

medical cost effectiveness and medical systems across the world, much less on what goes on in communities that have these implications, which is similar to here, and we are not as aware of that. When you look at that, there are also cultural issues that you have to sort of factor in.

I spent many years in the U.K. under the NHS. The role, for example, of the local district nurse, which is a person, an individual in the National Health Service, which is unknown here, it is a little bit like a parish nurse, you know, we are groping towards it here, but this was a nurse, a highly-trained nurse, in the community, whose job it was to make everything fit together, and not only within the medical sector, but dealing with other sectors.

My mother used to run a post office in the U.K. many years ago, and the district nurse would come by her every day to get intel on what was going on in the community. Mrs. Jones, who normally came in every Tuesday hadn't come in. The district nurse would literally bicycle off to see if Mrs. Jones was okay.

That is something we really don't have here. That is a central feature of the NHS. We don't have people like this.

I would just say yes, you're right in your first point about we in many ways are the most over regulated, the most highly regulated systems. Simplicity counts for what? Simplicity, flexibility. Complex rules are the enemy of flexibility. You just literally cannot do certain things. That is so often what we encounter here. Dealing with that is part of the solution, and giving flexibility and reducing restrictions. It doesn't mean you get substandard quality, for exactly the reasons you mentioned.

DR. PATEL: Dayna, final thought. I know there are other questions. Some of these things will come up in the next two panels, so just please reserve and we will try to get to you in the next two panels. Final thoughts to kind of round us out.

MS. MATTHEW: I'd like to end by saying I would love to see private and public streams of financing come together to address this problem. My favorite model was social impact bonds, crazy about social impact bonds. They do wonderful things for food in Boston, Massachusetts, and so forth.

I think what Stuart has called -- he's not the only one, of course -- I have really been impressed by the writing that he has done about braiding and blending public and private streams of



financing, because we have to be able to do this apart from government regulation. We have to be able to do this at various levels of community.

Looking at ways for the two sectors to combine would be a really good solution to start with.

DR. PATEL: Join me in thanking both Stuart and Dayna. (Applause) Thank you. We're going to do a little bit of stage choreography, exit left, come right.

DR. PATEL: Welcome, it's me again. Everyone is like, "Why is that lady in orange always on the stage?" So, this is actually going to be, you know, this is going to be a very fun conversation. Not because the problems are easy, but I can't think of three better people to tackle what the last panel teed up, but at a very, like, "Let's get real," kind of, you know, like we're just going to be very honest. Including, I think, where there are just, I'll be the person that kind of vocalizes, like, "God, what are we doing?" You know, some days I wake up, and I'm like, what are we doing? So, how we can get there, but, I'm really excited because the District of Columbia, the home we're in, I've now been a resident of D.C. for, you know, 15 years almost, and in a way, I think Dana's so eloquent, she put it best, "We're not very connected." And so, part of what I've very grateful for is that, as a clinician in the District of Columbia, I started noticing, over the years, that I just really saw this lack of connectedness result in, really, in my little neck of the woods, really severe healthcare problems. I see people in an ambulatory primary clinic setting, and I really struggled, and I even told Paula, I'm going to introduce people briefly, but I feel like these are friends. I would talk to each of the people, you know, in different ways on this panel, about the struggles, and I'm very thankful to the Aetna foundation, because, to be honest, without, kind of, this public/private intersection of philanthropic support, support from the District of Columbia, support from even our own hospital, Johns Hopkins, I honestly couldn't see a way forward to try to bring a community together. And I'll just start, what I want to do is just make sure I introduce each of these people. They have their formal titles, I will read them because that's important, but I'm going to tell you just a little bit about each one of them, something that you probably wouldn't have necessarily guessed from their titles, so, I'm Kavita Patel, you all know me. And then, starting at your left, is Paula Riechel, she's the advocacy and nutrition education director for the Capital Area Food Bank. But, what I will tell you that title does not speak to, is that Paula is truly one of the connectors, not just in D.C. I'm going to

let her talk about the Capital Area Food Bank, but she is one of the connectors in such an important way, in a very large geographic region for Maryland, DC, and Virginia, and one of the few women I know, very young but so mature in her years, because she really does bring, kind of, all these complex thoughts and hard questions, into a very practical way of thinking about food insecurity. And I will tell you, if any of you are family members, parents, loved ones; once you start talking about someone being hungry, that's where the conversation stops. You can't talk to them about anything else, because that feeling of gnawing, that hunger overrides everything. So, Paula's truly a hero in my book. Matt Brown, who also has a very nice title, geriatric nurse navigator at Sibley Memorial Hospital, does not do him justice either, because he's one of the people in a hospital-based setting who is what, I would argue, is leading this call to doing better in the community, and he, whether his colleagues like it or not, pushes the limits on how we think about not only transitions out of the hospital, but how we really think about people honestly staying out of the hospital, and doing it in a way that gives them the best chance at productivity. And I can truly say, Matt is helping to step in for a community partner who had to actually do work with the District of Columbia around aging and so, Matt, who is a geriatric nurse by training and actually practices this in a daily setting, Matt is going to speak, I hope, to what he and I overlap in working in the District of Columbia and trying to understand, how does the hospital play a role? And then, also, pushing, he and I can speak very honestly, I can, because I'm not afraid of any of my superiors, I mean, there are many days where I go to our CEO of our hospital and tell him he has to do better. I mean, this is not, it's not acceptable for me to see, you know, millions of dollars in hospital budgets, be they for profit or not for profit, and then one small, infinitesimal, miniscule portion of that goes into the community. So, that's not acceptable, our CEO at Johns Hopkins agrees that it's not acceptable. But then, getting that translated to the CF-NO, and the other, like, (inaudible) leaders is absolutely makes Matt and I, you know, that's like our daily living, right Matt?

MS. REICHEL: You see the camera, right?

DR. PATEL: I do see the camera, I'm not afraid.

MR. BROWN: I see it, too.

MS. REICHEL: I'm just kidding.

DR. PATEL: There's something that comes with a little bit of age, where you just don't

care anymore. You're just like, I'll get a job somewhere. Someone will hire me, it's okay. I'm not afraid to speak truth to power. And then finally, so, Adrienne's title, also, she's very fancy, executive director of the District of Columbia Housing Authority. What the title doesn't necessarily convey is that Adrienne is probably one of the few people who also, she sits in these healthcare conversations, she's patient, she kind of stomachs this, and she is, kind of, like, itching to, kind of, burst out of the gates, to really talk about, not just where housing has a role in all these things we're talking about, but how much she's fighting in the silos of housing policy to do exactly what we're talking about. So, all these same conversations, as Stuart kind of mentioned, are the ones that you're having as well. So, the one, I just want to do, in the District of Columbia, there's so many things going on, but one of the things that we're working is actually, kind of, trying to connect. And then, I'll tell you a little bit about this to tease it up, but then I'm actually going to start with Adrienne and kind of work our way down. One of the things that we're doing in the District of Columbia, kind of with the support of the Aetna Foundation, has been to actually try to connect community partners. One, it's really to focus on high-risk populations, and I'll tell you what's interesting; when we went out and tried to talk to people about what it "high risk" mean, it was very fascinating to listen to people of very different backgrounds talk about things. Including patients, we asked patients, "Do you feel like you're worried about your healthcare?" And, what was very interesting is the different responses we get. Well validated literature, and what I use to start the conversation was, "If you've been in the emergency room, or if you've been admitted." And Matt and I start with those conversations, because we see people being admitted to the hospital, we see people going to the emergency room many times. Interestingly enough, though, patients and community partners identified things like loneliness. If people feel lonely. People feel worried that they're going to die in the next year. There were a lot of things that people identified themselves, that classified them as high risk, that our conventional medical literature wouldn't have even put into a journal. So, we are learning more and what we're hoping to also really embark on in this next phase, is how to do the reverse. Paula and some of the other partners, we've talked about flipping the model a little bit, because, as Stuart mentioned, his mother in the post office, knew more about what happened in people's healthcare, or in their daily lives, than any doctor ever could. And so, when we get to Paula, I'm hoping she'll touch on the fact that they're going to be hosting, the Capital Area Food Bank, as a community partner, and they're hosting this health and

hunger summit next week. But they're also trying and, I'll be honest, I've worked with her field coordinators, and they do a much better job identifying who they're worried about, that might be "high risk," but I would never have seen them, and they might never have had an access point with a conventional medical institution. So, we're trying not only to do things better in the healthcare setting, but we're trying to flip that and have the community partners really identify where they can help to, you can call it "hot spotting," "health compass," some way of identifying what's vulnerable in your community. So, let me stop there. Adrienne, there's so much to touch on. First, just tell us a little bit about what you're doing from this framework of housing, and especially, tell us, educate our audience, we've got a lot of smart people here, but educate us a little bit in some of the constraints you find in D.C. housing and where you see some of what we talked about in that last session, kind of, coming true to what we're doing in the District.

MS. TODMAN: Sure, good morning everyone. So, as a houser, we really focus in on the built environment. And things like working with healthcare institutions comes as a cherry on the top of the cake. But we think about, what is our responsibility to a healthy neighborhood? And we were doing this way before neighborhoods became sexy again in the past three or four years. Like, back, way back in the 90s, we began to look at our public housing communities as being unhealthy for a variety of things. Not just the lack of access to amenities and good healthcare, but just the built environment itself, the units that people were living in and also just what it meant to have a socioeconomic group that was impacted, in terms of just the level of poverty there in the neighborhood. So, we began to look at our communities differently as housers, not knowing that our end goal would be building healthy neighborhoods. We just needed to fix the units. And what we found, from that work in the late 90s to today is that smart researchers have not followed a lot of our work and said, "Wait a minute, neighborhoods matter." Look at what happens when you take an impacted community and you make it mixed income, and you create different amenities for the neighborhood. We have a great site here in the District of Columbia, named Sheraton Station. Which is in Ward 8, which was a really dysfunctional public housing site for some time. Not the people, but the units were just falling apart. And then we redeveloped it and today, it is a thriving 300-unit community. We brought back many of the families that used to live there. We have a clinic on-site, but what we've created is a place where people are not afraid to be, bring their friends. The pizza

people will show up, and it's really created a much more healthy environment. And, as a houser, that is just one strategy in terms of creating healthy communities. We have two other strategies that we use. The one that many people in this room are probably familiar with is how do you institute a mobility strategy for families? If the neighborhood is unhealthy, how do you move people into healthier neighborhoods? So, one of the things that all housing authorities do, we're very fortunate to be able to toggle between creating a play space situation, but also building initiatives, so we have our housing choice vouchers. And here in DC we're very, very fortunate if you're a local DC person, we also have a local voucher program that we should all be very thankful about. And in those programs, we are able to move families from neighborhoods that they don't want to live in, into other neighborhoods that may have stronger schools, better amenities, and better social networks for the family, in terms of where they want, the trajectory that they want their kids to go. But, it's very expensive to do that. That's a very expensive strategy. And even here, in DC, whereas HUD will give us what's called "the payment standard of fair market rent of 100%", here we've had to push the value of our voucher up by 75% so that we can afford even the neighborhoods that we were once in ten years ago. Shaw, being a great example. So, while these strategies all have different value orientations to it, some people feel like we shouldn't be moving families out of their neighborhoods, that they should be able to really invest in a current neighborhood, we're also invested in neighborhoods. But, they all cost money and we can talk a little bit later about what that means for all of us in this room, for being ambassadors for affordable housing.

DR. PATEL: Right, because, to be pragmatic, there's hard choices with that. I mean, the money is, I mean, there's real serious budget issues that are causing you to have to make decisions, obviously, and so, you know, we'll go through everyone, but I just want to plant for you thinking about, you know, we had this conversation about healthcare, healthcare resources. Have you, in a time of really, honestly creative budgeting, thought about, what does this mean if we think differently about healthcare dollars and allocations of resource. So, I'll let you think about that.

MS. TODMAN: Sure.

DR. PATEL: Matt, go ahead and just, I'd love for you, if you don't mind, I know that I set this up in many ways, I would love for you to just talk a little bit about the work you've done and thinking about, not just the hospital serving kind of as a little bit of a hub, which we referenced in the last session,

but also what could hospitals be doing better. What do we need to do a better job at doing in thinking about this notion of communities, connectedness? And then, I know Matt's gone into, you know, Stuart didn't realize this, you set it up pretty nicely, Matt's actually gone into patients' homes who have been discharged, and give us a little flavor of what those insights have given you, and kind of what we can learn from that.

MR. BROWN: All right, thank you for having me. I'm celebrating ten years as a nurse today, and I've got an award reception tonight, so getting to knock out two occasions in a suit and tie when you're used to working in PJs is –

DR. PATEL: I know, I've never seen him in a suit.

MR. BROWN: She's giving me a hard time backstage.

DR. PATEL: I almost didn't recognize him.

MR. BROWN: But with that, pajama comment aside, I am honored to be a nurse and be part of a really special profession. And with a microphone and with an audience I will say, applause for nurses, because it's –

DR. PATEL: That's right.

MS. TODMAN: I'll clap to that.

MR. BROWN: I'm grateful to be a part of it. To your question, I've done not as many home visits as I've done follow-up phone calls. And when Stuart was talking about the fall, I will never forget, and I bet I've told this story a dozen times, but the very first phone call I made was a guy that I'd gotten to know for a week in the hospital and I was checking in on him at home. And, I called him and he's hemming and hawing on the phone a little bit, and I'm like, "Bob, are you okay? Is everything all right?" And he said, "I think so." I said, "You think so? What do you mean?" And he said, "Well, I fell." And I'm like, oh boy. So, I'm a nurse, you know, falls are obviously terrible. And he said, "Well, I'm not sure, because I'm still on the ground." I said, "Oh good lord, Bob, you've got to call 911." He said, "No, no, my wife will be home in a couple hours." I said, "Is she going to be able to pick you up?" And he said, "No, probably not." And I said, "Well, you've got to call 911." He's back and forth with me because he didn't want to come back into the hospital. I eventually ended with, I said, "Is the door unlocked?" He said, "Well, no." I said, "They're going to have to kick the door in. They'll come in, pick you up, dust you

off, check your vitals and be on the way.” And I said, “If you don’t call, I’m going to call 911 and then I’m going to call your wife.”

DR. PATEL: Right.

MR. BROWN: So, he did, and I actually called back and got to speak to the EMTs and make sure he was okay, but, in that example, that first call, I learned that people don’t understand the severity of that time when you’re discharged to home. How much can go wrong, and how on high alert you need to be. And then in the home visit, would go with our former head of hospitalist and we’re in the home, and the guy had gotten his meds filled; which that right there, people can’t always do that, but he had his medications, and they were on the table and he was on the exact same drug, same pill as his wife. And the pills are, like, right here and all it takes is one cat walking by and they’re mixed up. And he was able to show us and talk through, but he had it by bottle, so we had to spend some time with him to educate him on, we need to space these out and separate them and make sure that he understood the severity of taking the meds. And I think nurses would tell you, we could do better at discharge from the acute care setting to home, to do that teaching. And, they would also be quick to tell you, more nurses would help with that, and I’m not up here to talk about nursing shortages or fix any of that, obviously, but I think the other thing we run into in that transition from acute care to home is as soon as people hear discharge, they’re gone. They’re readiness to learn is not there. They’re cleaning their inbox, they’re getting groceries, they’re not ready to listen. So, I think we need to approach education from a multifaceted, multimedia, meet people where they are, where they’re ready to learn. And we know the best discharge starts on admission, but we also know that you start talking about discharge too early you can people wound up that they’re not ready to go home. So, I think we need to be meeting them where they are, whether it’s, one of the things I’m working on at the hospital now is getting patient education videos sent to patients on their email so that the can watch them when they get home, or they can watch them prior to their surgery. And I think, just trying to have things in place to catch them, whether it’s a phone call, whether it’s, we’re sending them with an iPad to facetime with somebody, or, ideally, you have them enrolled for that two weeks in one of the villages. And somebody’s able to pop by and put eyes on them. Just have them be caught, because I think people don’t realize how critical that time is and how much they really need to be on higher alert.

DR. PATEL: Can you talk about what the villages are? Just because people might not know.

MR. BROWN: Oh, sorry.

DR. PATEL: Just, a very brief description, because I do think it's a good example of where communities have come together, especially in the District. Truly, on a voluntary basis to help out. But then, what the hospital does to be a part of that.

MR. BROWN: They're based on neighborhoods. And so, it's networks of volunteers, and there's a paid person who sort of coordinates all the services, but they, based on your neighborhood, you can pay a subscription fee, which helps maintain the organization of it. And then, you can get, not necessarily clinical things, but, like, a light bulb change, a trash taken out, somebody to drive you to medical appointments. A nice nonclinical, neighbors helping neighbors, and it's awesome and I wish they were bigger and I wish we could –

DR. PATEL: And we've been paying, so, just to be candid, because, I forget the amount, because we pay for it, but it's something like, I want to say, \$50 a month. But, we know that there's no amount that's an easy amount to pay, especially when you're living on that margin, and it's making the decision to pay your electricity bill or to be a part of a village. So, the hospital and, actually, our clinics, we're subsidizing memberships into the villages, so that people can have access to transportation and some of these other, and to help fix, like, Matt's example of the lightbulb is a very common one, were people just need help around the house, and that poses significant barriers. So, I highlight that because it's a really good example of where both philanthropic dollars, hospital based resources, can be allocated for a community based resource that helps bring connectedness within, like, an actual neighborhood. And, so, that's one of the models that's kind of a nice example. I, as the finance kind of healthcare person, try to think, how do we find a sustainable way to integrate that into the way we pay for healthcare. So, we're doing this right now on the backbones of nonprofits, philanthropic organizations, and the hospital. But, how do we actually create that into the bundled payment for orthopedics or something like that? Thank you, Matt. Paula, so, I've set it up for you to close out this all-star panel a little bit, but first, tell us about the work you're doing and then really drive home, I think each one of us are trying to bring you back to something local. I mean, you educate me constantly on just how hyper local all of this is.



But, talk about food insecurity and then this intersection of health and hunger. And, plug your summit, please.

MS. REICHEL: Oh, you're so wonderful.

DR. PATEL: We're 100% going to make sure people are going to be a part of that next Thursday, as well.

MS. REICHEL: Thank you, Kavita, and thank you for that lovely introduction. When I'm feeling, having a bad day, I will reflect back on that –

DR. PATEL: You will, just watch the webcast over and over again.

MS. REICHEL: I am a part of the Capital Area Food Bank. We're the region's largest anti-hunger organization. We reach 540,000 people across the metro area, that's 12% of our region's population. So, just to give you a thought about, and some thinking around our scale. And we reach them with 46 million pounds of good food, and I'll come back to that idea of pounds, and why that's such an important inflection and reflection point for us. But, we're essentially a neighborhood based organization, and we're rooted in the community through our 444 community based nonprofit organizations. And those organizations are the ones who access our food, distribute it, have those local relationships, have those neighborhood based relationships, and most of them are small, volunteer run, nonprofits. So, we're not talking about, like, high capacity organization, we're talking about a very committed church volunteer, and a couple other folks who run a food pantry every other Sunday, maybe two weeks out of the month. So, that forms the basis of how we operate and when we don't have a partner we look to place targeted, direct food services into the community. And so, as an institution, we're well over 30 years old, but we don't look it. But, for our entirety of our 30 years, as well as the majority of the nation's 200 food banks, we've been driven primarily by one metric, and that's output, in terms of pounds of food distributed. But we know that not all pounds are created equal. Soda is a lot heavier than leafy greens. I know, because we actually harvested two pounds of leafy greens out of our garden just the other day, and to think about how much is two pounds of leafy greens, versus maybe a 2-liter bottle of soda. And so, knowing that, and also knowing the rate of incidents of chronic disease in our community, high rates of diabetes, high rates of heart disease, high rates of obesity, and that food can be a solution, and that food can be an equalizer for members of the community. We've really stepped up

and evolved our approach into what we're calling "21<sup>st</sup> century food banking." And, 21<sup>st</sup> century food banking is where we address hunger needs while also improving the health and wellbeing of the communities we serve. And, so, we've gone through this process and evolution in our thinking about how we operate, and I just want to walk through the steps a little bit, so you get an idea of how this looks like on the ground. So, the first think we did, was we really bought in all members of our constituencies, the people we serve, the organizations, we work with, and most importantly, our food donors. So, we really wanted to turn the myth on its head that food donors just perpetuate the problem, we've actually been able to engage them, to come up and join us on our path toward a more healthy, well community. So, they're a part of the solution. So, another piece of how we've operationalized this is by focusing first on what we do, which is food acquisition, food movement, distribution, logistics, all the things that are not quite as sexy and a lot of it is behind the scenes. And so, to do that, we actually had to start from scratch and say, "Hey, what's in our inventory?" You know, we distribute 46 million pounds of food per year, what is the nutritional quality of that food? And we actually had to come up with a wellness tracker, our in-house dietician developed it, that looked at the amounts of sugar, salt, and fiber in our foods. And we're able to categorize our food as wellness or non-wellness. And that was really critical. That was just a few years ago where, for the first time, we knew the nutritional quality of our inventory, and that's enabled us to really set goals to improve that quality and to have frank conversations with food donors. We've also rethought nutrition education. So, in the past, nutrition education is, you know, your six week classes, where you're engaging a small, targeted group of people, you're having a major impact in their lives but you're asking for a big commitment. And so, we really, you know, knowing our scale and knowing what we do best, wanted to refocus our nutrition education around, how do we shift and improve health behaviors for folks? How do we send out a pound of food, but we also send it out with key messages that help folks transform that pound of food into healthy, affordable meals for their family? And so, I like to give the example of a banana. You know, it's great to know how much potassium is in a banana, but is that really going to make a difference to your everyday life? No. Well, I want to know, how do I store the banana? How do I maximize its shelf life? What are some great recipes to use bananas in a savory way for my family? Or turnips, or other fruits and vegetables that we may not be familiar with. So that's where we focused our energy, around nutrition education. And finally, and I think this connects more to what

Kavita is mentioned and the sort of, context of this panel, we've come to the realization that we can't do this alone, even though we are a large established network, we can't. We are not the only ones who are solving food insecurity who are improving community based health. So, we've made a thoughtful effort to engage anchor institutions in the community. First, we're engaging schools, so actually have food services and food programs in 73 schools across the metro region. And, particularly in elementary schools, where we know parents are most likely to shift their behaviors, and we're setting students up for a lifetime of success. So, we're sort of creating and helping be a part of that, creating their health behaviors. We're also partnering with grocery stores. So, we want to build a bridge to retail. 56% of the people that we're working with are working, they have earned income, in addition to potentially using SNAP dollars. So, we want to see them be able to utilize their dollars in effective ways in store to be able to create the most healthful meals for their family. And finally, and this points to what we're talking about next week on May 18<sup>th</sup>, 8:30 to 11:30, come and see me if you're interested. We want to crack the nut on healthcare. How do we integrate with healthcare institutions? How do we make food a focus for people who are in a clinical capacity? And, you know, we've been, this is such a learning experience for me as well, because healthcare is a very complicated field, and so for the past three or four years we've just been having frank conversations with healthcare providers and saying, "This is the problem, how do you see us working together to address it?" And that's taken many forms. Whether it be integration in the clinical setting, so sort of having food pantries or maybe food boxes at discharge as a part of a procedure and as a part in including food insecurity screening. Or maybe it's the reverse, maybe it's embedding health services in our points of distribution. So, within our food pantries, where we know the population is not going to see their primary care provider, maybe they have high blood pressure and they just don't know. We actually see that quite frequently. So, all of these pieces really come together to help us serve in a way, in this connector role, to build our network and to focus our efforts around how do we improve the health and wellbeing of our region's grandmothers, mothers, fathers, children, through a comprehensive approach.

DR. PATEL: And I'll say that some of the things Paula and I have talked about, and I'll just kind of put it to the panel and then we'll definitely save plenty of time for questions because I know we have them. For example, the blood pressure screening program, that's something done in conjunction

with the American Heart Association. You know, Paula and I have talked very honestly about the fact that, so, let's say you do screen someone positive? Okay, what then? We certainly know that you've got inhouse dieticians who have obviously great skills, better than even what I and Matt in our medical training have done. But that's maybe not enough, you know, they may need a medical intervention. Part of what Paula and I are constantly struggling with is, okay, so then, what's the natural conduit? And one, kind of, success factor we've found is, can people like me or Matt at least serve as almost like informational resources for the food pantry coordinators who have the trust and the buy-in from the community member, but, you know, don't necessarily want to go to a strange doctor. And I've got to tell you, healthcare really, you know, the way we set up our institutions, it's hard. Parking and trying to come to our clinics, and even when they're embedded inside of housing, you have to take time off work because clinics are only open in the daytime. So, we're trying to struggle with, how do we make this accessible and, Matt said it right, it's like, meet people where they are. But, unfortunately, a lot of what we set up, we don't necessarily do that. So, how do we break through those conventions to meet people where they are? And we're trying to constantly think of creative ways to do that. So, Adrienne, let me come back to you, you touched on, you know, we're in the time of fiscal constraint. It always feels, I'm sure you're having to go back to a pile of inmail with how you're dealing with your next budget cycle, how you're dealing with this. Can you, I wanted to pivot this a little bit to almost, if you had your wish list, you know, what are some things you wish you could see, either better public/private sector collaboration, resource allocation, thinking about State budgets. What is it that we could do better?

MS. TODMAN: I think that, and Stuart said this well earlier, I think there's not a lot of thought about cost-savings when we go outside of our silos. So, for instance, it will cost any large urban city roughly between 50 to 80,000 dollars a year to shelter a homeless family. It costs me roughly 15,000 dollars a year to house a family. And we keep, as housers, we keep saying that number over and over again, but we hit a brick wall, particularly when it comes to the funders at the federal level, in terms of saying, "Look, there is a value to housing that is not just about creating affordable housing." There are the other impacts to the rest of the networks that touch a family, where we will save funds. And there hasn't been, I think if I had a wish list, I think the number one thing would be, we have done this great calculation in terms of how to make a more efficient process of moving a family from a homeless shelter into a unit,

and what the cost benefits are, but we haven't really done that as well in other parts that are costing us lots of money as community, whether it be healthcare, whether it be a poor education system. We've not seen that kind of thought process that shows, if we just do a little bit here, the bang for our buck, 10, 15, 20 years from now for the child is going to save us all a whole lot of money at the end of the day. I think that that's a heavy lift. It's sometimes hard because I know if I approach the local hospitals and say, "Why don't you just give me some of your money?"

DR. PATEL: Now.

MS. TODMAN: Now.

DR. PATEL: And maybe it will a difference.

MS. TODMAN: Trust me.

DR. PATEL: Trust me, right.

MS. TODMAN: And you will save money on the backend, it doesn't go over very smoothly. So, I think it would be great to have some, I hate to, research, but –

DR. PATEL: No, but we need evidence, right, to reinforce that.

MS. TODMAN: We need evidence but we need people to buy into the fact that, if they, it's a zero-sum game. Something has to be taken away and given to another system. And that is a hard, even if we find evidence, the question is, will there be a political and, or even just the will in general, to do that. Affordable housing is expensive at the front end, but the long-term benefits for our community are just priceless. And I don't think that we think about it that way. We always think about affordable housing as being for somebody else, versus what the community impact would be.

DR. PATEL: Matt, what could, if you had to think about, you're working on transitions, you mentioned, kind of, videos or telephone calls, what's on your wish list for some things that we wish, that we know we could do better? For example, in our hospital setting, or in that transitional setting?

MR. BROWN: I think, again, just having things in place to catch people. I really liked Stuart talking about the District nurse. I feel like there is enough with –

DR. PATEL: The analogy of that.

MR. BROWN: - maybe not the 88-year-old I'm sending home, that would work? I mean, it would an actual person, but I'm thinking some sort of an online platform. Like, I live in a townhome

community and there's a Facebook group. If we could have –

DR. PATEL: The Facebook?

MR. BROWN: The Facebook, sorry.

DR. PATEL: I've joined the Facebook. But, do you find that there's a problem with people's accessibility to media online or have you found that actually pretty much people are connected in some way?

MR. BROWN: I don't have a firm answer. More are connected than not, but as they get older, they're not. I'm sort of jaded, and that's the population I work with the most, but that's getting better and better. And I think of all the boomers that are going to need care and how connected they'll be and the potential that there is for online solutions, and online communities, frankly, to help with that. And then, I think having a sort of massive list of all the services. And I know, Iona's community resource book is incredible, but having an online thing, where if you're in the city and you need help with X, Y, or Z, you could just type that in and find out what would work for you, what's affordable for you, and what options are out there. That maybe somebody could be picking up groceries for you once a week and you don't have to go hungry or have health problems associated with that.

DR. PATEL: Right. Paula, I'm hoping you're going to say this, so if you're not I'm going to hint to this. You always teach me something, but, we talked about your food pantries, I want to you to also continue with this theme of a wish list before we get to questions. So, think about some of your wish list, but, hopefully tucked in there somewhere is what you told me about how you actually need help getting the food to people because you can have all these community based organizations, but you're still finding that one of the greatest challenges is almost getting the food from the pantry into people's homes. So, tell me about your wish list in a very practical way. And also, that problem that you're seeing of getting the food out.

MS. REICHEL: Right. I think my wish list focuses most on, how do we create access to good food in every community and for every type of person. And so, building on our existing market would be to create continuity between these anchor institutions in our community so that we're reinforcing the same messages, so that folks know how to best utilize their dollars, so that we're building access points where they're needed and that we really have a sense of the need and that we're addressing it

appropriately. And that involves a whole lot of shifts and commitments from organizations of all different types, for profits, nonprofits, government institutions. And so, I think we're seeing those shifts happen incrementally, but to have a community focused and community based approach that leads to successful outcomes is my biggest wish. And in terms of sort of, you know, what we employ at the food bank, actually, we do have some sophisticated tools, one of which is a hunger heat map that shows the gaps in our services. So, it assesses the food that we're putting in the community against the need, to show gaps. And that gap analysis is really critical. And what we're finding as we're scaling, as food banks are scaling, is that we just have to invest in this last mile work, with reaching folks who are homebound, who are disabled. Who, for some other reason, maybe lack sufficient transportation to the grocery store or to the neighborhood pantry. Again, I like to stress, you think about this robust network of 444 organizations and, certainly, we have some really key partners who have a lot of capacity, but most of these are, you know, pantries that are open twice a month. So, if you can't make it twice a month, then you are challenged. So, it's about just making connections, really thinking about capacity and thinking about how, maybe, hospitals can build the capacity of the emergency food safety net, rather than maybe reinventing in within the own organization.

DR. PATEL: A very real example of this is at our hospital, you know, one thing in the Affordable Care Act has been for nonprofit hospitals to maintain their nonprofit status to kind of do a community health needs assessment, and part of those dollars have to be driven towards, actually, the community. It's been a great, you know, we can call it a carrot, stick, I don't care, but it's been a great tool to have a conversation and a practical, ongoing example, there's mobile vans that are being deployed around the district. I'm trying to figure out how we can actually take these mobile clinic ideas and actually have part of that serve as almost a food delivery service, as well. So, that's –

MS. TODMAN: We're a big fan of Capital Area Food Bank. I mean, we do our job to try to get food from your part of the world –

DR. PATEL: Exactly.

MS. TODMAN: - into our –

DR. PATEL: Right, into the homes.

MS. TODMAN: Yeah.

MS. REICHEL: And a lot of our partners are actually nonprofit housing providers, so –

DR. PATEL: Which makes so much sense, because that's a great example of literally meeting people where they are. Questions? I know this gentleman had his hand up in the last session, so maybe, back here. Before we get to your question, I'm going to close by being slightly controversial with my wish list. One, I really do wish that, we had very had time, we saw in the State of New York, the use of Medicaid dollars for housing vouchers, and there have been some very interesting studies, well validated, scientific research, that demonstrated the benefits of that use. But, certainly, that's been riddles with controversy around, is that the appropriate use of Medicaid, State budget dollars. I would absolutely, and I know, I'm setting this up hopefully for Stuart's last panel, which is kind of bring it home, but my wish list is that we do a better job teaching, not just our Feds, my friends that are all working to try to make this country a better place, but how Feds can work with State and local governments to think about these creative, kind of, Stuart mentioned this ability for States to be flexible, how we allow for that room for flexibility, but that we don't burden, in doing so that we don't overregulate it to the point where it crumbles from the weight of all the caveats and regulations and "you can't do this and you must do this," because in some ways, I actually think that's where New York faltered, because there were so many people worried that, "Oh my god, we're going to let these people get housing vouchers, and what's going to happen?" And, it really kind of crumbled under its own weight in some regards. And it was criticized, but I think it was a brave initiative and I think that the ongoing need to be creative at that level is going to be, no matter what party affiliation you are, it has to be done in a flexible way. So, how can we, as policy makers, mitigate unintended consequences, and hold ourselves accountable without overburdening and inhibiting that potential for communities to design truly flexible approaches to, whether it's the Medicaid program with dollars associated with that, whether it's dedicated housing dollars, whether it's SNAP or WIC resources. I would include all, kind of, government or public based sources in that. And then, I know this is a conversation I've had with colleagues from foundations, and you're going to meet Dr. Graham, and I know he believes this, how do we push philanthropic organizations, to think about sustainable economic models for what we're doing. So, all of us are, I mean, there was a point where I was like an addict to grant writing, and, you know, everything could be done through philanthropic organizations. We have to turn that into building it into part of our economic models. So, in medicine, we



talk about a PMPM, a per member per month. How do I get a portion of that, what I'm used to calling a PMPM to be a part of buying membership for the villages, to be a part of actually giving Paula some of that money and letting her use that for neighborhood dedicated, for you her organizations? For what Adrienne's doing? And so, I would say those are at least two of my wishes. So, I'll stop there. And the gentleman back there had a question and then we'll just open it up to general questions.

SPEAKER: Fiscal concerns have been discussed here a length. Since we have the executive director of the District of Columbia Housing Agency here, based on an article appearing in yesterday's Washington Post, I'm wondering why the District of Columbia had to pay back the Federal Government a grant of over 15 million dollars since they missed the date for filing that was required.

MS. TODMAN: Right. So, just for clarity, I'm the District of Columbia Housing Authority. Unfortunately, the entity that had to turn the money back is the District of Columbia Housing and Community Development Agency, which is the city's housing department, not the ones charged with public housing. I mean, I can't speak to that as I'm not charged with those funds, but I will say that, clearly, nobody wants to see –

DR. PATEL: Money go back.

MS. TODMAN: - money go back. I think that if there's any solace, the good thing is, that money, while may have not been used here in D.C., would be repurposed and sent to other cities. So, from a national community standpoint that's one point of view. But I can't speak to it, because it was not my agency, sir.

DR. PATEL: Another question? I thought I saw a hand over here? Yes, ma'am, back there.

SPEAKER: In the past two panels, all of the speakers have spoken to urban communities. What is being done in rural communities, especially as our rural communities age, to help build healthy communities in rural areas?

DR. PATEL: I'm glad you brought that up. We have been focusing on, obviously, D.C. in this panel, an urban area. But, does anybody want, I can speak to that. Paula, do you want to speak to that?

MS. REICHEL: I can take that. So, we serve D.C. and then all the way into Prince

William County, Virginia. So, we have a big urban center, we have suburban areas, and we have some areas that we're reaching that are rural. So, it's really interesting to think about. And, you know, one of the ways that we've thought about serving rural areas differently is, we look at where rural pockets of poverty and food insecurity exist. And the first thing we do is, of course, we look at the data and then we say, "what is happening on the ground?" So, one of those findings that we saw was that, along the Route 1 corridor, in Virginia, there was a lot of childhood food insecurity. And there was a real lack of organizations that were addressing it in a concerted way. And so, this is a great example of our grocery partners. We actually had a conversation with one of our grocery partners, Shoppers Food Warehouse, and said, you know, they're entrenched in Virginia, and we said, "Hey, this is something we'd like to take on, will you fund it?" And they actually helped us construct a mobile meals bus that goes down the Route 1 corridor and provides some meals in trailer homes and other places that are disconnected. I know we talked a lot about being bifurcated by highways. That exists in the service area that we touch. So, it's about knowing the community and then building and being flexible enough to build a targeted approach for that community. And investing in it.

DR. PATEL: And I'll say from a healthcare standpoint, one thing that I and some of our colleagues participate in, is a program called Project Echo. And it actually provides, we find that in rural areas, there's always some either a one person doctor's office, which is often the case, or maybe a rural health clinic, maybe even sometimes a critical access hospital that's designated for a rural area, but they lack certain specialty care and they often then have the challenge, if someone has a diagnosis of cancer or something that requires specialists, that they have to tell patients they need to travel sometimes hundreds of miles to get that care. We're part, if you google it, Project Echo, it's actually part of a very simple training program that's done over video teleconference for one hour a week, where we actually have people teaching other clinicians in both rural and urban areas where there's actually deserts of these providers, how to take care of patients that might require more specialty based care, but for which you just don't have it because you're in a rural setting, or you're in an isolated setting. And so, there's a great number of these issues that translate, both urban and rural opportunities. There was question over here? Yes, ma'am, back there.

SPEAKER: Thank you all very much for the information you've given to us today. I have

a question, I haven't heard anyone speak about the need for housing for trafficked children. As you might be aware, Congress reported in 2013 that over 300,000 American born children are being trafficked in our country. Washington, D.C. is considered by certain reports to be the second city with the highest incidence of human trafficking. Why aren't we doing something about this in terms of housing? There are only two organizations, FAIR Girls, and I forget, forgive me, another one, who provide services in DC to help house these children. Many of the reasons why these children do not come forward to the local police is because they have nowhere to go. Please can someone address this? Thank you so much.

MS. TODMAN: So, I think that, one of the things that I know DC does believe in is trying to find affordable housing solutions for the different populations that need it. In this particular space, there are nonprofit groups that we do work with, some of which I won't name because of obvious reasons, but one that I will is Sasha Bruce. Some of you may be familiar with Sasha Bruce's work, and they have become a very safe place, and a safe haven that, even by word of mouth, a lot our youth that feel challenged about entering the government sector, they're able to go and it's a safe place for them. And there are other organizations like Sasha. We have a strong relationship with Sasha, I know other of my government partners do, as well. There's always more that can be done. Let me suggest that. I think that we just need to find a way that individuals feel that they can enter someplace and not be judged and be safe. And sometimes that's half the challenge, particularly if it's in a government space.

DR. PATEL: All right, we're going to do the last question. And we're going to have a break, so if people who couldn't get a question in want to approach our panelists, you can. This lady in the back.

SPEAKER: Yes, thank you. Paula, I know you had a principal role in improving the food that's available in D.C. schools. I'm wondering what the situation, I've just come here from the U.K. where I was struggling to make them appreciate that, in the NHS, make them appreciate that food is medicine. I found it very ironic that the patients who were there were being fed things that were not necessarily conducive to their recovery. So, what's going on here with food in hospitals? Are you facing a similar situation to what your found in the schools?

DR. PATEL: I think it's a little worse, I would say. I mean, I'm not joking about it. I know that we did kind of a canvas of the District area hospitals, and found that all the hospitals, the major

hospitals in the District, and I don't think this is too dissimilar from other urban and rural, we basically vend out our food resources to a third party, with which we have very little, very little, like, zero, dialogue about nutrition input or output.

MS. REICHEL: And I will say, we haven't necessarily been involved in that, but, from my personal experience, what I found is actually the same third party food vendors that are servicing hospitals are also serving schools, and they're also serving businesses, prisons, they're across the board. They have different names for their different sort of segments of their business. But it's really important to have conversations with hospital administrators around, how can we contribute to health within the hospital itself? And certainly, you know, I've actually been to meetings at hospitals where I've forgotten to have breakfast and, literally, all they had was donuts. So, these are ongoing challenges. I know, within the District, there is a committee that's under the Department of Health, called the Diabetes Committee, that contains a group of clinicians and folks who are associated with hospitals who are trying to make inroads on that front and also around sugar-sweetened beverages. And the proliferation of sugar and allowance of sugar-sweetened beverages in hospitals. So, there's work being done.

MR. BROWN: If I could say something to that, we have, not for our patients, but for our staff, like, as of June 1<sup>st</sup>, if you visit the Sibley Hospital, you're not going to be able to get french fries. They're getting rid of, it's a wholesale nutrition increase.

DR. PATEL: But that was done, I know, speak to, that took effort to educate -

MR. BROWN: Yes. And my understanding, that's a Hopkins, system-wide thing and it's going to be interesting to see how that goes.

DR. PATEL: And people get angry, by the way, I mean, people -

MR. BROWN: Oh yeah, you take their french fries? Come on.

DR. PATEL: - I mean, me being one of them, sometimes.

MR. BROWN: Yeah.

DR. PATEL: People sometimes get upset about choices being taken away, but it's speaking to that lady's question about, how are we offering something that's healthier. I know there's more questions. We're going to have a little bit of a break, just to stretch, bathroom, and then get into our final panel. Join me in thanking this excellent panel. And we ran a little bit over, but let's try to be back in

the next 5 to seven minutes if possible.

MR. BUTLER: We are about to begin, so if you could please retake your seats and get comfortable, we will start the final panel. And as you're doing that, I just want to alert you, you'll see up here a Twitter site for the handle, #HealthyCommunities, so I'm told there's a lively conversation going on. Kavita's completely unaware of that because she's still talking about the Facebook. (Laughter) You can go onto the Twitter and you can see there's conversation there. And please continue this afterwards, so we can add some things to it to let people know what's going on.

I'm going to try to channel Kavita who, as you can see, has an effortless way of interacting with panelists and getting the conversation going, so I'm going to have to do that. Our task is very simple and in this last panel we're going to solve all of the problems that have just been discussed and say what policy steps are needed to deal with all of that.

I would just sort of mention to you, to urge you to look at some of the publications that we've done in this area on the Brookings site. We actually have a publication that will be coming out in the next maybe two or three weeks, actually, looking at nurses as intermediaries within the system. Wendy informed me a few minutes ago that this is National Nurses Week and so we will be doing something on nurses.

We've also got a publication that looks at hospitals and at schools as hubs. If you go onto the Brookings website and search for me or any of the others that have written in this area, you'll see a little superscript that says, Building Healthy Neighborhoods. And if you click on that, you'll see all of the publications that we've done in that area.

It's also been mentioned that we hold a roughly monthly brainstorming session here with people from different sectors and Adrienne Todman comes to that quite often, and so does Wendy on this panel. And this is where we start to kind of really digest the kinds of conversations we're having here, think about these different issues and try to come up with a set of policy steps that would really make these kinds of collaborations more effective. And that's actually supported by the Robert Johnson Foundation and, as you may know, the Robert Johnson Foundation has a whole theme called, Looking at the Culture of Health.

How do we get both behavior patterns and other institutions to work together to create

health? It's all very connected in this way. So, as I said, we're going to try to look at some of the issues that have come up in the previous panels and sort of explore some of the policy implications of this and how we could think about improving connectedness and steps in this way. And we've got two very effective and great panelists to help me in this.

And let me start with, actually, Dr. Garth Graham, on my far right here. And Garth really straddles a number of areas, which I think is one of the reasons why it's going to be particularly good to hear his insights. He's founded and is the president of the Aetna Foundation and so, therefore, is focused on its philanthropic work, but also he's written and thought a lot about health disparities, the kind that Dayna brought up in the previous panels. He served in government, god bless him, as deputy assistant secretary in the U.S. Department of Health and Human Services and has also been in the academic world as assistant dean for health policy and chief of health services research at the University of Florida School of Medicine.

Wendy Ellis, who is a stalwart member of our monthly group is project director at the Building Community Resilience Collaborative at the Milken Institute School of Public Health at George Washington University here in D.C. And let her talk a little bit more about this in a moment, but the Collaborative developed strategies for child health systems to address determinants that lead to toxic stress and all kinds of problems that we know develop from that.

Wendy also has been involved in the hospital system as manager of Children Health Policy at the national office of the Nemours Children's Health System, so we've all had some connection in some way with both the policy side, with the academic research, and with what's going on.

Maybe, Wendy, I can actually start with you, and maybe just say a little bit more about the work that you're doing across the country in different neighborhoods. Because you're not just looking at D.C., and research at the national level, but actually what's been going on in some places, we've talked about some of those at our monthly meetings. I wonder if you could just give us just a couple of minutes on the kinds of things that are going on these communities where you're fostering collaboration and what gets in the way? And what could be done, in terms of the policy environment to just make your life and the life of those communities a little bit easier?

MS. ELLIS: Sure, easy question there. (Laughter) So the Building Community

Resilience Collaborative is actually based on the research I had been doing, just trying to understand -- you know, coming from a hospital's perspective, we have so much research that really speaks to the longitudinal health impacts of children being exposed and being raised in very adverse community environments. So, understanding that we have this whole body of research called ACEs that talk about Adverse Childhood Experiences, so understanding that a child that's raised in abusive or neglectful environments where they have a parent, perhaps, that's incarcerated, or subjected to community violence, that these things actually get under the skin.

So, understanding that that's one piece of it -- and many of you have the handout that was out front there -- but there's also this other piece understanding that those experiences that are happening within the household are compounded often by what's happening in their environments, their community environments. So we've actually started talking about the pair of ACEs, not just what's happening to the individual, but what's happening to that individual within the context of their communities.

So, understanding that if you have communities -- we've talked about on these panels this morning a number of those different adversities, whether that's community disruption that's brought on by gentrification, that then leads to housing instability for families. Understanding that food and security in itself is an adversity, but it also could be consistent with a community environment that is cut off by, say, a food desert, as Dayna described earlier this morning.

So looking at those things, as a child health system, you can't write a prescription for all of these things that occur in the community, but yet you have a role to play. So I designed a process by which communities, child health systems, and other anchor institutions could potentially come together to collaborate. Sounds easy, right? Not so much.

So, what we found is that -- we're testing this model here in Washington, D.C.; in Cincinnati, Ohio; Wilmington, Delaware; Dallas, Texas; and Portland, Oregon. And what we're finding is that while it sounds good in theory that all sectors should come together, it is very hard to do. There are some things that are built into our systems that actually discourage collaboration. Some things in our financing structures that actually discouraged collaboration. So we just did -- in fact, we were in Portland, Oregon, last week doing a collaborative meeting with a couple of child health systems and Oregon Health

Authority, with the Oregon Public Health Institute. A lot of state level, as well as local level agencies, as well as nonprofits, that are very much interested in addressing these adversities that are facing children, as well as their families and communities at large.

The process of identifying the priorities. So we take them through this process of let's identify what are the pair of ACEs that are the priorities in Oregon, or in Portland? So, obviously, the opioid crisis and the result and effects of that. So, looking at the burdens on the foster care system when children are pushed out of homes because their parents are somehow either adjudicated or, worst case, when the parents have overdosed. So you've got that issue, that's one piece.

But then you've got homeless children. You know, we did a graphic that showed -- and what we found is that visualizing the problem is a lot easier to help people understand the widespread impact. So we did a visual, a chart, that showed 182,000 children in Oregon are homeless. That's a number, what's the denominator?

Okay, 182,000 children that are homeless, what we ended up doing was creating a chart that showed that across the state of Oregon there are seven really popular sports stadiums. The number of homeless children would fill seven of those sports stadiums. And it was actually more than that, so you'd have standing only capacity. That number meant something to the folks there.

We similarly did a convening in Cincinnati two weeks ago and we showed that the number of children that were at risk would fill school buses seven miles long. So, from the University of Cincinnati across the river into Kentucky, that's the number of homeless children, the number of vulnerable children in that community.

So understanding that these are just children that we're talking about. These children are part of a larger unit, the family. So how do you begin to bring together the systems, the infrastructure that impacts all of these points of care or points of service for these families?

That's the difficult part because we were able to identify the priorities in Oregon, but then when the question came, so now how will we work together, the room went silent. Because while you had those that were very passionate and interested in collaborating, then you have to think about, well, is the right person at the table to make that decision? Can I speak on behalf of my agency? Or if I drive forward (phonetic), what's going to be the implication for my revenue stream, my funding stream? How is



the state going to look upon this collaboration?

So without having some sort of okay from a higher level, meaning the funders or the revenue streams or those other stakeholders, it's very difficult to bring individuals to collaboration.

MR. BUTLER: I can imagine. We'll try to talk a little bit about how do we create the environment, but I think from what you said, it sounds like it's very important to have an organization there that's got some capacity and has the trust of the people around and they're familiar with it. And I think that's one of the reasons we've looked at things like schools as being -- really could be very important in that regard. I wonder whether you think there are other institutions, and also, what are the institutions which are difficult to get to the table?

I know some people -- we'll talk about hospitals in a moment, too -- but I think some people have an ambivalent relationship with GW or some other hospital. They may think, yes, it's got the capacity and so on, but what's its objectives in life? You know, does it really fit with us? How do you build trust in someone? I think that clearly is kind of one of the issues, is it not?

MS. ELLIS: Well, so I think understanding that there is difficulty for hospitals to push forward in this work because, typically, if they're going to do work in community, they've led the charge.

MR. BUTLER: Right.

MS. ELLIS: And that stepped on a lot of toes and so that's why, strategically, I started with hospitals. Because historically, we've had a lot of work going on in communities, really great work in communities. Then you've had on the other side of this bridge, you have folks that are doing really good work in hospitals that will identify priorities in communities, and they have to lead the charge.

So I was really trying to change the mentality of our clinicians, our providers, and the hospitals to think instead of pre-identifying based upon your health needs assessment or your utilization data, what are the priorities of communities? Sit back. Let's listen and let's work together.

So it's helping what we really look at, doing a process of education with our providers and our hospitals that are involved, to really be in that place of humility and being willing to listen, and then co-create the solutions together.

MR. BUTLER: Okay.

MS. ELLIS: So that's really been the process of change within the BCR communities as

opposed to -- because hospitals are really good at that. They're very good at looking at their own data, but it's the part of just going in and what we say in our BCR meetings for physicians is, take off the white coat and let's just be a citizen.

MR. BUTLER: Let me bring Garth in a couple of ways really. One is, of course, that one of the people who pay the bills are insurers in the healthcare system. And I think probably most people would feel that insurers have not been in the lead in trying to figure out how to get smart healthcare in the community as opposed to paying bills when you go to the hospital and so on. And I'd like to hear you sort of comment a little bit on what your experience has been in that area and how you think insurers are, in fact, moving forward in this way and the what the possibility is.

The other thing I just want to ask you is, to raise another related issue, is when we start thinking about government policy in this area and what can the government do to help, which level of government do you really feel has both the best level capacity and so on? What are some of the issues with that?

DR. GRAHAM: So I guess one of things we've been talking about here all day is that all health is really local. And when you look at it, we've often used the term that your ZIP code is more important than your genetic code, and it's real. And if you look at the data that was just published yesterday by back Chris Mora (phonetic) and his group out on the West Coast, they showed an increasing gap in terms of a 20-year life expectancy gap across counties from the poorest counties up into the richest counties in Colorado. And that's a very pivotal piece of information that's been repeated in other studies looking across the board.

When you think about how we've kind of addressed this, and you alluded to this earlier, we, in general, as healthcare system overall have spent most of our money, 60 percent of our resources have gone towards clinical care in the United States as opposed to 40 percent to social services. And in a lot of other countries it's the opposite, especially Europe and other places where they spend more on social services as opposed to clinical care.

I'll tell you that I come at this from a very personal level. You mentioned kind of my background in terms of academics and government before, but I'll also tell you that I've kind of lived this, and when we first came to this country I was living in Opa-locka, Florida. And I suffered an asthma attack

from the mold that was in the building that we were living in and my sister also had an asthma attack, as well. And the fear that was on my mother's eyes as we were kind of going through this has always kind of kept me motivated through the years in terms of how we approach this work, the organizations that I work for and some of the strategies that we employ.

So I'll tell you, you asked about how do we think about this from kind of insurer payment perspective, so I think in the end we have a very consumer-centric view and we believe in addressing that 60 percent, as well. And so through Medicaid, we have a lot of activity occurring in our Medicaid programs, we're utilizing community health workers as well as other kinds of means to address both the social, economic, housing, transportation, as well as employment opportunities in a number of places across the country. One of the folks asked about rural areas, and we're doing some amazing work with community health workers in McDowell County in West Virginia, and reaching some of those very isolated individuals in West Virginia.

We also, on the Aetna broader insurance side, in Medicare Advantage have done about 330 home health assessments just in 2016. That's where doctors and nurses go in and assess the home environment of that particular patient or that particular individual and help to identify some of those challenges. And overall, then about 500,000 home visits overall working with doctors and nurses. That's on that broader side.

But I want to go back to one point and talk about how we work with communities because that's particularly important because this idea of using communities as a vehicle to effect your change is part of the strategy. The example I gave you about when me and my sister had that asthma attack when we were younger it was one of those local community organizations that kind of mobilized my family out of fear in a very acute moment. So that's why it's important to us.

So we work with a number of communities across the country to be able to mobilize change. For instance, there's the Living Healthy Community Collaborative that's in Athens, Ohio, where they have a 29 percent obesity rate, as well as one of the lowest access to fresh fruits and vegetables. And we worked with them to increase the access to fruits and vegetables by 93 percent within that local community.

We talked about the delivery of fresh fruits and vegetables over the past last year,

working with key communities in Cleveland, in Ohio, in Texas, and in Florida, delivering about 1.1 million pounds of food and built about 5,500 extra resources in terms of additional plots of land developed for fresh fruit. And that's part of kind of how we think through all of these varied approaches.

But I talked about Chris Mora's work and looking at kind of understanding county-level dynamics. And we, as well as a number of other foundations, have really kind of looked at how we work with cities and counties as particular units. And through this initiative that we have called Healthy Cities and Counties Initiative we've been working with 50 cities and counties, from small- to medium-sized cities and counties, across the country to help identify tackling some of these social determinants of health and giving them a framework in which to work with, looking at five issues, not just healthy behaviors as one issue, but also crime and community safety; looking at the built environment; looking at environmental exposure, as well as looking at some of the socioeconomic characteristics that we've been alluding to today.

And here's where I kind of want to emphasize what we're seeing on the ground because sometimes in D.C., we feel that everything that needs to happen is happening here.

MR. BUTLER: There is that tendency.

DR. GRAHAM: There is that tendency if you turn on the television. I believe the opposite. I believe there's a lot of activities that are occurring locally and elsewhere that are, quite frankly, moving the needle, and this is part of the communities that we're working with.

So, for instance, someone asked a little bit about what's occurring, in housing, as part of this Healthy Cities and Counties Initiative that we've been working on, we've seen folks in York, Pennsylvania, for instance, pull together a Healthy Housing Collaborative, where they're combining both environmental exposure, exposure to asthma triggers, as well as other environmental activities, looking at how do you use housing to address health. And so that's what's amazing to us when we saw that kind of work.

We've also seen where in San Diego, where they've been doing a lot of work on social determinants of health, they have been doing walk-and-knock programs to pull together individuals in high crime communities with local police officers and other community safety strategies, to bring together communities that deal with high crime neighborhoods. So we have to understand that there are evolving

things occurring outside of D.C. that are particularly important. Our goal is to support those communities, have them learn from each other, and uplift their kind of work so that people can learn across the board to see where things are going.

So I think the answer to your question in a nutshell, certainly I think there are a lot of activities we're doing for the business side and certainly in terms of how we invest in and work with communities. But it's important for us to understand that all health is local, much like Tip O'Neill said back in the day, but also understanding that a lot of these communities, they have very strong people who are doing very real work, and it's about working with them to help find them solutions as one of the strategies.

MR. BUTLER: I think -- yeah.

MS. ELLIS: Do you mind if I ask a question?

DR. GRAHAM: Please.

MR. BUTLER: Sure

MS. ELLIS: Because you talk a lot about --

MR. BUTLER: (inaudible)

MS. ELLIS: Well, I'm going off script here. So, no, you talk about, and I find it fascinating, it's certainly worthwhile the work that you were talking about doing and community. But one of the things that was brought up earlier by Adrienne was this, and it's tossed around so often, we talk about it in our groups, about the wrong pocket problem. So, you know, Adrienne spoke of the fact that if we were only to invest more in housing, we would save in healthcare. Yet for a hospital when they hear that, that means decrease in revenue.

So how as an insurer are you able -- or are there some strategies that are being tested around incentivizing hospitals to do more community-based healthcare, more prevention-based healthcare that doesn't necessarily drive revenue into the hospital, but certainly would have some money in the pocket to offset the chronic care versus prevention care.

DR. GRAHAM: Sure. In fact, with Medicaid, we're working in Mayville, Arizona, actually help to revitalize some housing complexes to allow people to have access to housing. So I think the concept of housing, even within our Medicaid population, has been particularly important.

You know, you see some really interesting things occurring across the board in terms of

hospitals. And I know we're going to probably talk a little bit more in terms of hospitals and community benefit. You've seen where there are certain hospitals, you've seen like Rush in Chicago and other places, where they've actually been working to address a lot of the community health needs.

And so in terms of not being too prescriptive to a particular hospital in terms of telling them what the community needs are, it might be housing in one location, it might be community safety in another location, it might be some different kinds of environmental exposure. One of the best strategies when you work with partners, whether it be hospitals, big health system, local nonprofit, is not to be prescriptive in what you think the problem is, but to go to them and to try to work with them to help uplift what they think are some of the challenges that they're working with in terms of communities.

And so we've seen that hospitals have identified, as well as other community partners have identified, a varied spectrum of potential challenges. But, again, all of these challenges are particularly local.

MR. BUTLER: Yeah. Let me kind of pick up on that a little bit for a moment. I think when -- you mentioned, I think, the so-called wrong pocket problem. And for those of you who are not familiar with that term it really means that we're talking about a situation where in order to get a real benefit over here, you actually have to invest in a totally different sector. And so the people who carry the cost don't actually get the benefit in some way, and how do you make this work? And hospitals are a classic example of this for the reasons you mentioned, that if the hospital, what was it Kavita said, the CF-No is approached and basically is told we can invest in all this to deal with homeless people and deal with this issue and go to Adrienne and invest in the housing and it will really reduce the number of people who need our services, you know, you don't have to be a CF-No to be able to say, wait a minute, I don't see how we can sustain that model if we're the ones carrying the costs and there's no benefit.

So, therefore, it forces those who think about this to think how can you look at ways in which you can kind of go up a level, in a sense, almost to say how can we look at the whole picture in some way? And there are certainly some interesting examples there.

I mean, you're very familiar, I'm sure, with Geisinger in Central Pennsylvania, which is a combination of an insurer that actually owns hospitals, has contracts with physicians, and so on, can look at the whole picture and say, well, it actually makes sense to invest in these physicians over here or in

these non-medical areas because it will reduce our costs in the hospital base and, therefore, as an insurer we're going to be able to compete more effectively and keep our costs down.

And I think when we start looking at government's role we have the same kind of analog. How can we look at these different sectors and get them to kind of work together and to get that to happen all the way down the system, right down to where it really matters, at the bottom level? I think we look at things like the waiver systems. I mean, we've got -- and demonstrations. We use waivers in Medicaid and in other programs to say, okay, if you could do something a little different there, we'll keep an eye on it, but we'll give you permission to do that for a period and then we'll study it and see if it actually works. And that might then affect the rules generally.

I think it's telling that I think both of you have brought up Medicaid, Medicare Advantage, and so on. And certainly in the Medicaid managed care area you are talking about cases there where a whole group of the population is enrolled in a plan of some kind, a Medicaid managed care plan, or a Medicare Advantage plan, and that plan as a whole has a strong incentive to look at how to keep its costs down and is more likely to experiment.

And I think in order to make that happen the federal government has to do more of what it's doing of looking at the rules and regulations with the payment systems, what can be covered, and this sort of thing to make it a little easier for experimentation to occur. So I think we've got at least some idea of how to move forward in that area.

Another issue I wanted to bring up, which we haven't really dwelled on yet, is the whole issue of data, of information. Again, we keep hearing this more and more in our conversations that if you're going to figure out how to be more cost-effective and with better outcomes of involving different sectors and community institutions, you've got to, first of all, know what's going on in those places and, also, be able to make the case to use data, to demonstrate that it might be better to use money differently.

One of the things I've learned about in Washington is that people who control budgets in different agencies, they think it's like their money, it sort of belongs to them. And they're very hesitant about letting that money go to somebody else, and it's pretty understandable, I suppose. So they've got to have pretty convincing information to make that possible, and that seems to me to be a big issue. How

much data, the lack of data, the difficulty of sharing data, how much of that is a problem?

We know privacy issues sort of come up with this. People don't like to share their information. Think about things like mental health, parents at school are very nervous about letting information about their child's behavioral problem at school be shared around too much because who knows how that may come back to haunt that child when he tries to go get a job 10 years later or something like that?

How does data affect what both of you are doing? And what are the problems there?

MS. ELLIS: So data is absolutely critical to understanding how effective we are in a collaborative environment, so being able to share that data across different agencies, whether those were the schools or the hospitals, you know, even the community-based organizations, and so that's actually been at the heart of the project that we've been working at. And part of the reason why we actually built our own data collection platform, so that we could provide a basis for those that are participating in the collaborative to be able to see each other's data and understand how working together is actually contributing to addressing the populations' needs.

But when you talk about sharing data on the individual level, you know, we actually did a lot of work early on before we even developed our own dashboard in talking to the Office of the National Coordinator and understanding what are some of the capabilities? What are the limitations? And actually, what do you have cooking that might help us to incentivize sharing of data across sectors right now?

And so one of the things, and I think is a really good example, is their CMS and ONC together put together an ELTSS of pilot that they're launching in seven states. So it's Electronic Long-Term Services records where they're allowing individuals to share their information across healthcare sectors, but also those community providers.

So you heard a lot about the villages as we spoke earlier. Well, the villages could actually share data with the healthcare provider if the patient has opted in, so that you're not just seeing what service you're providing, but the whole plethora of services that this information might be receiving.

So if you're at the Food Bank and you're looking at I need to have food brought to Ms. Johnson, you're able to open up and see, but Ms. Johnson is also diabetic. So that's going to inform the



type of choices that I'm making for this individual. Or you could see the types of medication that they're on and know that they're going to need an increased need for hydration or it might be something that contradicts with having citrus juices.

So you can really make informed choices for individuals at the community level, so that you are reducing that return into the hospital system. But, you know, when we get hospitals talking about sharing data, the lawyers. So you've got the CFOs and then you've got the lawyers that get involved.

MR. BUTLER: I'm shocked to hear that, lawyers. (Laughter)

MS. ELLIS: You know, but one of the things in our conversations with ONC it was made very clear that patients always have the option to share their data. This isn't necessary clearly communicated to patients.

MR. BUTLER: Right. I think that's a really important point and it's good that you mentioned the Office of the National Coordinator, at the federal level in terms of trying to inform people how to use data, I mean, we hear a lot of so-called HIPAA rules, the regulations that make it difficult to share medical data, there are equivalent so-called FERPA rules in the education area. You can't say too much about a student to anybody, so the school nurse is trying to figure out what's going on with this child and it's very difficult to get that information.

MS. ELLIS: Yeah, we had examples of where HIPAA and FERPA actually worked together.

MR. BUTLER: That's right.

MS. ELLIS: Delaware's a very good example --

MR. BUTLER: That's right.

MS. ELLIS: -- where they're able to share records between the medical community and the school-based nurses so that what's happening in the school clinic is being shared back to the provider.

MR. BUTLER: And I think, from the ONC down, I think one of the possible solutions is actually to provide a lot more both information about what you can do, to dispel a lot of often myths about what you can't do. People tend to be risk averse, understandably, if they think lawyers are going to be involved, especially.

And maybe give some kind of safe harbor approaches to say, well, if you basically operate in this way, you're going to be basically okay to kind of go down the system in that way. I think that's -- certainly we've discussed a lot in our group in terms of how to just enable what can be done to enable people to be aware of that, so that it doesn't become a fear factor in just resisting these things.

DR. GRAHAM: Right. And so, you know, there are two levels of data when I think about this. So for instance, in terms of the work we're doing here with Kavita and some of the activities around D.C., so in D.C., 10 ZIP codes generate 83 percent of the hospital discharges. So that kind of aggregate data and being able to target resources is particularly important, and so there is a utilization of data.

Now, the HIPAA and the other protection standards on the federal education side allow for individual protection, but do allow for a lot of decent population analysis and being able to target some of what we're doing now. But I'll tell you in terms of how I think about this, I think there is the population-level data, but I do think it's important to be able to assess individual patients and individual dynamics. Those 330,000 home health assessments that we do through Medicare Advantage are particularly important. And I'll give you a personal example.

About five years ago, there was a patient that I would constantly take to the cath lab and open her up and constantly assume that part of the challenge was that she was not being compliant with her medications. Then we were able to do a home visit and realized that the challenge was actually her navigating to get water to take her pills. So it's a simple like that in terms of understanding some of the individual home dynamic. And that's why it's important, as I kind of alluded to earlier, to be able to get in and understand a lot of those home health dynamics, as well, but being able to understand some of the population-level data. And so I think they're both equally important in terms of being impactful.

MR. BUTLER: I'd like to move to questions from the audience or observations. Please try to keep them short. And this is the solutions panel, so we'd be really interested in sort of your observations or questions about particular steps that could be made to solve some of the problems that we've talked about.

There's a question over here first, then one in the back. And if you could just introduce yourself, as well.

MR. OLSON: Hi, Andrew Olson from the Green and Healthy Homes Initiative. Do you

think it would be useful to have a mechanism that led a health plan invest directly in preventative services? Just a really brief, normal question for you.

DR. GRAHAM: Yeah, so I think there is a lot of investment now in preventative health services. I think the question many times in terms of when we take this to the next level is making sure that we have enough investment overall, certainly nationally in terms of preventative health services. Right now, by the way our healthcare system is structured, we end up paying a lot on the back end for once people are hospitalized and secondary prevention even after they've had their first acute MI or something along those lines. But I think generally we all believe that shifting more towards prevention is particularly important.

That's where the consultative data comes in line, right? So you're able to kind of identify some of those area that are the highest need and be able to invest appropriately. But remember what I articulated to you earlier in terms of understanding what preventative services mean. There are clinical preventative services. That's a USPTF and everything that goes along with this. And they're understanding what are the social needs of an individual community and how those social needs end up driving the clinical outcome.

And if you look in the data the Chris Mora just published yesterday and has been getting a lot of coverage, that data points to at least 60 to 70 percent of the need being in the social services arena as opposed to the raw clinical arena when we think of preventative services.

MR. OLSON: So how valuable do you think it would be if you had a mechanism that let you invest in that social area and count it towards your medical cap rates?

DR. GRAHAM: Yeah, so I think part of what we've kind of been talking about here are different strategies in terms of how one -- certainly I gave the examples of how we invest in social services and some of the various things we're doing through community health workers. This is on the kind of Aetna side of activities and so on. And so I think there are organizations like us and others that believe in that investment in social services, and so I think that mechanism exists.

The question is, how as a broader healthcare system do we start to move towards mobilizing more around a lot of these social determinants of health, as well?

MR. BUTLER: I think one of the things, just to add on to that quickly, you used the word

“investment” a couple times, and I think there’s a big difference between investing in the sense of putting a significant amount of capital into building up something as opposed to covering it in the sense of, okay, if you have this service or if you go get a social service or a housing voucher, for example, we’ll pay that as paying a benefit in some way.

And I wanted to just, again, if I can get you to put your philanthropy hat on again and think as a philanthropist, I think there’s a lot of conversation about what is the role of philanthropy in helping to build up that initial investment, including in things like data and so on. I wonder whether that may be a particularly important piece in which philanthropy can help in all of this in the investment stage, so that then as you, putting your other hat on, are working for a company that’s an insurer can actually come in and have the basic investment there and say, okay, now how can we modify our payment systems, you know, our benefit structure and so on, so you can make -- you being the person, you can make use of that investment so that we can all get better health and we as an insurer can lower costs?

DR. GRAHAM: Right. So from the philanthropy perspective, I’ll tell you that that is a broad onus in terms of the mission of philanthropy, not just in the corporate but the non-corporate philanthropy. I sit on the Board of Grantmakers in Health and that’s basically all the various grantmakers around healthcare in general. And that is part of one of our main challenges, is how to not only invest appropriately, but for a lot of these investments be self-sustaining.

MR. BUTLER: Right.

DR. GRAHAM: And so if you look at even the projects that I outlined to you earlier in terms of a lot of these local community projects, the best thing to be able to do is to invest locally and all these folks will stand up their activities, and then allow them to leverage various other mechanisms, whether it be local businesses or other local entities that are equally invested in outcome to produce long-term sustainability.

And so I think part of the challenge and part of the strategy on the philanthropic side is how to invest in a way that creates community sustainability. And the real secret for that is to have the community buy in and to be able to leverage a lot of those local resources appropriately.

MR. BUTLER: We have a question at the back, that lady way back, and then down here.

MS. MARSHALL: Hi. My name is Imani Marshall. I’m an Emerson National Hunger

Fellow with the Congressional Hunger Center. And Wendy, you brought up the opioid epidemic and some of the work that's being done in Cincinnati to address that, that you've been looking at. And I think that kind of the messaging around addressing this issue has been really powerful in moving our conversation of substance abuse to -- from one about criminalization to one about treatment and health care.

But one kind of gap that I've seen is there has been a long history of criminalizing drug use and sale, especially in communities of color. And so I was wondering if you could speak to work that you've seen through the BCR being done to address that and looking at the generational impacts, especially on toxic stress living in kind of over-criminalized communities.

And then, Garth, additionally, you talked about work being done in San Diego around community safety. And so I was wondering if you could speak to that initiative, as well. Thank you.

MS. ELLIS: So with regard to -- I think, you know, you would be irresponsible to not recognize that our opioid crisis in this country has been received with quite a bit of sympathy as opposed to how our crack epidemic was received 20, 30 years ago with not quite the sympathy, right? So there in itself is really the tale of two responses here.

But one of the things that I think is really telling about the opioid crisis as opposed to crack epidemic is that you are seeing this so widespread across the country. You are seeing this really striking at the heart of the middle, of what was once a solid middle class.

And so what we are saying, particularly Cincinnati is a really great example of this overall loss of hope, desperation in our country. You know, there was a figure that came out and I don't know if any of you saw it and The Washington Post did a really great series last year about the crisis. And within the time that that was released we also have figures that show that white American women were dying at younger ages. So we're looking at our mortality rates for white women, which typically should be the healthiest and has been historically the healthiest group in our country, actually you're seeing the rates for their mortality drop. That's telling you something else is going on beyond just the opioid crisis.

And it really does speak to what is happening within our healthcare system, clearly, and our other systems that are points of care, so that is housing, that is thinking about public transportation. Do people even have access to jobs?

So one of our sites we looked at only 6 percent of the actual jobs that provide a living wage are accessible by public transit while people at the same time the phenomena of gentrification is going on. So people are getting pushed further and further out, which means their access to both stable employment, housing, all of the resources that they have depended upon have become less available to them.

So what we're seeing in response to the opioid crisis is this awakening. It actually is an opportunity for an awakening of how our other systems are failing, not just we have an increased need for mental health and substance abuse, but why are people resorting to this? What is at the heart of our pain? What are we dulling ourselves from so greatly that we are seeing, you know, children discovering their parents overdosed? What do you think are going to be the outcomes for those kids three, two, five years from now? So you don't have to wait.

And I think we had this earlier conversation about the longitudinal impacts and looking at the long rate of return. We can now see that if you have a child that has been affected by their parents' opioid addiction at two years old, do you think that kid's going to go to school ready to learn at five? What do you think their third grade reading rate is going to be?

So we can really collapse the window of impact and that's really what has driven a lot of our systems to come to the table in our five cities is that it's provided an opportunity for everyone to see where they have skin the game and have a role in addressing the issues.

MR. BUTLER: Garth, did you want to answer?

DR. GRAHAM: Sure, yeah. So as part of that Healthy Cities and Counties Initiative that we've been doing, we've been working with a number of cities and counties to tackle local problems. And again, the idea here is that you have local either city or nonprofit who understand these neighborhoods and can do things effectively with our additional support. And so we've seen an umber of kind of key things around this area of community violence.

So in Kansas City, they're treating violence as a disease. So what do I mean when I say that? We talked a little bit here about prevention and how you treat early as opposed to treat after a hospitalization or after an illness. And so the idea here is how to use the CDC Aim for Peace Initiative and use de-escalation tactics and use going to communities where there is a high prevalence or a high

burden of various kinds of especially individual violence, and teach de-escalation tactics to a lot of younger communities, as well as all the folks across the spectrum that are higher risk. So identifying the higher risk individuals, like we would do in clinical medicine, and teach preventative approaches before reaching an outcome that is undesired. And that activity in Kansas City is particularly important. And that shows one community solution.

The other that we're seeing in San Diego is a different strategy. And the other strategy there is how to bring together local law enforcement as well as local community members to go to individual homes and engage folks around some of these broader communications about how to make communities safer.

And so the concept that we've kind of identified here and if you kind of leave with any conclusion from my perspective is that a lot of these challenges are local and the solutions are local, as well. Though, again, as I said earlier, though we sit here in Washington, D.C., we have to understand that there is a body of work, an amazing body of work, occurring in communities across the board, and it's about how we lift up some of that work, support some of that work, and allow people to learn from each other.

MR. BUTLER: I think that's a good comment in order to wind up this panel, I think, and this meeting. I mean, there's an enormous body of work going on. I think that we certainly here in Washington, in a Washington think tank, recognize very much that both the ideas and the things on the ground that are happening are really important to look at and to understand and to get a sense of what's going on. And then what is the environment in which we can enable those efforts to blossom.

Yeah, do you want to --

MS. ELLIS: Yeah, do you mind if I put a note?

MR. BUTLER: You want the last word, okay.

MS. ELLIS: Well, no, no. I think that it's great that we can sit here and be academic on this conversation, but there is a real absolute sense of urgency in our response here. And, you know, we talk about hospitals wanting to do the right thing, but I have two of my hospitals that have had to pull back on some of their population health initiatives and going upstream because the real crush of revenue is a very real thing. Fifty million dollars between two hospitals, \$50 million in cuts in the prevention health

efforts, which meant that our work that we were doing upstream, we had to scramble and get new partners.

So how do you find the balance in what you're investing in that really does help to incentivize this within our anchor institutions so that we can move forward? We do have to move beyond research to reality. Yeah.

MR. BUTLER: Oh, yeah, I certainly understand that. I was actually about to say that. (Laughter) But money and revenue is very important.

But as I said, and we've all agreed at the very beginning, we spend an enormous amount on healthcare in this country. So it's not that we actually lack in principle the cumulative resources. We're just not spending them -- not we're just not spending them -- we're not spending them often in both the most effective way within the healthcare system and certainly between the healthcare system and other systems, other sectors that are critical to that. And this is what we very much focused on I think in all of this conversation.

I suggested this might be the panel that solved all the problems and I think we've certainly touched on a lot of them, but not all of them. It's very much an ongoing issue. It's very much, as I said, both a question of looking at what's going on in the communities, how we can think about how structures -- federal, state, and local -- can be better aligned, how money can be better aligned, the role of these areas. And it's an ongoing part of our work here.

I want to thank the panelists here. I want to thank the previous panelists and Kavita, my kind of co-host, as well, and co-mentor. (Laughter) I've learned a lot from you over the years. And thank you, again.

Please monitor our work here. Please let us know about things that you're doing that are very relevant to this. Please don't hesitate to do that because this is what we're trying to do, we're trying to learn from everybody in the field. We're trying to learn what policies can help and what get in the way, and try to solve some of those.

So thank you again. Have a good day and thank you very much for attending.

(Applause)

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