THE BROOKINGS INSTITUTION

BRAIDING AND BLENDING FUNDS
TO PROMOTE SOCIAL DETERMINANTS OF HEALTH

Washington, D.C. - Wednesday, May 1, 2019

Welcome and Introduction:

STUART BUTLER, Senior Fellow, Economic Studies, The Brookings Institution

Panel 1: What is Braiding and Blending and Why is It Important?:

KATHY STACK, Moderator, Chief Executive Officer, KB Stack Consulting

STUART BUTLER, Senior Fellow, Economic Studies, The Brookings Institution

SANDRA WILKNISS, Program Director, Health Division
National Governors Association

Panel 2: Organizations Currently Engaged in Flexible Budgeting:

ANNE DE BIASI, Moderator, Director of Policy Development
Trust for America's Health

ANA NOVAIS, Deputy Director, Rhode Island Department of Health

PAMELA BROWN, Executive Director
Anne Arundel County Partnership for Children, Youth and Families (Maryland)

PATRICIA VALENTINE, Executive Deputy Director for Integrated Program Services
Allegheny County Department of Human Services (Pennsylvania)

Panel 3: Innovative Policy Steps to Support Braiding and Blending of Funds:

SANDRA WILKNISS, Moderator, Program Director, Health Division
National Governors Association

AMY CLARY, Policy Advisor, National Academy for State Health Policy

LEN NICHOLS, Director, Center for Health Policy Research and Ethics
George Mason University

SUE POLIS, Program Director, National League of Cities

JOHN TAMBORNINO, Senior Advisor, Evidence Team, Office of Economic Policy
White House Office of Management and Budget

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P R O C E E D I N G S

MR. BUTLER: Good morning, everybody. Good morning. Welcome to Brookings. My name is Stuart Butler. I am a senior fellow here in the Economic Studies division. I want to just welcome you all here, particularly those of you for whom this is the first time. And I also want to welcome people who are watching us by webcast as well.

Here at Brookings we hold a series of monthly meetings where we bring in a whole range of different people, people who are researchers, policy people, people who are practitioners in multiple fields, in particular, health, education, social services, and we kind of mix them all together in these monthly meetings, a relatively small meeting. And what we do is explore areas where better collaboration across-sectors, across these different sectors, would actually improve both the medical health and the sort of economic and social health of households and communities.

So we're looking at ways to improve that collaboration. And also in so doing to, among other things, address some of the disparities and inequities in the healthcare system, because so many of them are related to these other factors.

So, for example, we look at the areas like successful aging in place, where we know from the research and experience that in order for somebody to successfully and happily age in their own home and safely, there are a lot of other things that have to work. We have to have effective social services, we have to have safe housing, we have to have effective transportation, and so on.

So we know that a number of these things are really important. When you look at areas like adolescent mental health, we know now that unless the school is talking to the parents, and they're dealing with the juvenile justice system in some case, that child is not going to do very well in life.

So we're looking at these areas where collaboration across sectors is very important. We look at good examples, and the practitioners are often the most effective people too tell us about those, of good examples of collaboration, but we also look at what

are the barriers to collaboration across-sectors, to improve social and health outcomes and what are the needed policy steps to help improve the environment for better collaboration across these areas. And a lot of things keep coming up in terms of issues that have to be addressed.

And one of them, which just keeps coming up over and over again, whatever the topic that we're looking at, is the need to find better ways to enable funds from different programs, including the private sector, to actually work together and to be used together more effectively and creatively to produce outcomes. It doesn't matter really which area you're looking at, that is the case. So we recognize we need to find more ways, better ways of getting flexibility and innovation in the use of funds together.

And really when you look at this, as we've been talking about it, there are a couple of ways, a couple of approaches to enabling funds to be used effectively in this way. One is a term we use, "braiding". Braiding means essentially coordinating several different funding streams, including private in some case, certainly from different government programs, and getting to link together, in such a way that they can work together, but they are separate funds and they are separately monitored and measured and evaluated. And one way to look at this is the idea of braiding, like braiding hair -- different strands, as you can see. Now, if you have a teenage daughter, these would be very different colors, very bright colors (laughter), but you get a sense of coming from different programs, but coming together and kind of working effectively. That's one way to do it, and that's the most common.

The second way would be what we call "blending", to actually put all that money in one pot. This is less common, and we'll be talking a little bit about this during the panels, but all the money basically goes into on fungible group and can be used then creatively to achieve the objectives of the multiple sectors, the multiple programs. And one way to think about that is this picture, kind of looking at all these different funds coming through, coming to some intermediary, some body that brings money together, and then

uses the pooled funds in that way.

So given these discussions that we've had in this monthly group, we decided to set up a small working group of people, both inside Brookings and outside, across sections, of the kids of people I mentioned, to explore in more depth the issues associated with braiding and blending funds to achieve common objectives and collaboration across-sector, and also to help try to improve and encourage a public conversation, not just among the general public, but particularly among policy makers, about how best to make this happen in the sectors that they're in.

And so today's event is designed to help do that, to help have a conversation through panels this morning about what are the issues associated with braiding and blending, what do we know, what are the good examples, and how can we make that happen more generally and more effectively to improve the conditions, the health conditions, deal with disparities, and so on in this country.

And to start this we're going to have a short conversation among three of us about some of the issues generally, some of the sort of high-level issues that have to be addressed. We're then going to have a panel of real people who do this in the field (laughter), who actually do this stuff. And I know, as somebody who works in a think tank, we'll learn a lot, probably more from them than from anybody else. And then last, but by no means least, we're going to have a panel that's going to look at some of the policy ideas on policy steps, including what's going on, to help improve that policy climate to encourage braiding and blending.

So let's get started. And I'm going to ask Kathy Stack and Sandra Wilkniss to join me up here on the podium. We're going to have a conversation generally about this issue. Please come up and you'll be mic'd up in a second.

Kathy Stack is a consultant. And most recently she was vice president at the Laura and John Arnold Foundation here in Washington, DC. But in a way she's on the panel because she spent 30 years in the Federal Government and 27 of those years at the

Office of Management and Budget actually overseeing budgets and regulatory issues for a whole range of different agencies, including education and labor and human services programs.

Joining her is Sandra Wilkniss. And Sandra is program director at the National Governors Association's Best Practices Health Division, where she focuses on exactly these issues related to behavioral health and to social determinates of health, the various elements that come into the equation that affect health. She has had a number of academic positions and was also chief psychologist of the Inpatient Psychiatry Unit at the University of Illinois Hospital.

So I'll hand it over to Kathy and I'll join you.

MS. STACK: Great. So I just have to say, I'm really excited to be here with people from both sectors, health and the non-health social services.

So in my time at OMB I worked very hard in the sort of non-health sector to think about creative ways for blending and braiding, breaking down silos, worked on pay for success initiatives, and something called performance partnership pilots. But we were never really able to engage the health side of OMB in this same deep thinking. They were involved in implementing the Affordable Care Act, which was really hard. And I had the pleasure of meeting Stuart after I left government, discovering that there's this cadre of health policy experts that are out there trying to improve outcomes and lower costs by reaching over and collaborating with the social services side. So hopefully today will be an inspiring conversation for everybody and get us thinking very creatively.

So, Stuart, you mentioned that blending and braiding comes up repeatedly in your working groups. And I want you to just take us through why it's so important.

MR. BUTLER: Sure. Well, I mean the root of it is that we know that in order to be successful in really every field, whether it's having a child successfully graduate from high school or somebody to do well in terms of their health, we have to have other elements in play all the time, other effectors. And we call these social determinants of health. I

actually talk about social determinants of everything, because I think whatever sector you're talking about, that is generally true.

And as I said at the beginning, it's really important to have the various funding streams work together successfully. So one of the things we've been really thinking about and looked at very carefully, is that this is really important in some key areas. I mentioned aging, for example. Unless you have -- if somebody is going to successfully age at home, unless you have social services provided to them, unless their home is safe, so they're not likely to fall, unless there's good transportation, unless you deal with the issues of loneliness and isolation, it's not going to be successful. So we are trying constantly to look at ways of bringing this together.

It turns out, we discovered in our conversations, that this is easier said than done, that there are a lot of barriers to this. Sometimes different agencies don't easily work together, they're not used to doing that, as you mentioned. Sometimes people who have the lead are not familiar. We find things like data is often not shared, so we don't actually know across-sectors what's going on with people. So in order to look at things like aging in place, you've got to figure out how to do that.

And so that means -- and this is what really comes up in our conversations -- you've got to start thinking about procedures, bodies, what kind of actual procedures do you put in place, what rule changes do you make, what incentives do you put into place, to get people who are responsible for money from these different sectors to actually plan together and exchange information and work together. So that's one of the things we feel really came out of our conversations, really important, to think about the structure of government itself and what bodies need to go into place.

The second related piece is something that we call -- just me and my economists -- the wrong pocket problem. And this is kind of arises from the fact that sometimes in order to solve a problem or to improve a situation, in say the health area, improving somebody's medical situation, it actually makes sense to invest in another sector,

say housing. So if you're thinking about reducing the number of falls so that fewer people, fewer elderly people end up being rushed to the emergency room and then having a very expensive procedure under Medicare, or maybe Medicaid if they're poor, it's often best to look at how do you improve their bathroom lay out, how do you look at things like nutrition in their home and deal with those. That's somebody else's budget. So what you end up doing, the challenge you have to face, is that often to get a real value added savings, or an improvement in one sector, you really want somebody else in another sector to do the investing, so they have all the costs. You know, maybe housing, the guy who runs housing, is asked to spend more money, and the person who's running the Medicaid program gets the benefit. So this does not compute in most people's minds in terms of how you get this to happen.

So we're thinking about ways of addressing that wrong pocket problem. Partly we look at things like how do you induce or how do you change the budget in, say, the housing area to deal with these issues of aging or health. But another way to look at it is how do you make it possible for maybe the -- if the health program, Medicare and Medicaid, is going to benefit from investments in the housing and have savings, maybe Medicare and Medicaid ought to be the programs that actually invest in the housing, because they're getting the return.

So another issue, which is really important that we focus on, is how do you look at changing -- in the health programs particularly -- how do you make it easier for them to invest in other areas that have a payoff in healthcare. And that involves often legislative changes. Sometimes you're just not allowed to do that. We're seeing improvement in this area, which we all know, but that's really important.

So I think those two areas of how do you set up the structures and then how do you set up the incentives and make it possible for programs to begin to mix up their money more in order to achieve those, those are the two things I think really come out of our conversations.

MS. STACK: Great. All right, Sandra, you focus on state level issues, so what's happening at the state level to reduce the silos and the fragmented efforts at addressing social determinants? And what are you seeing as some of the main obstacles to blending and braiding?

MS. WILKNISS: Yes, thank you. And I'll pick it up with the two important elements that Stuart ended on which is what are the structures and how do you bring together some of the financing structures.

I thought it might be really helpful to talk a little bit about what we've learned in our work with governors and their senior policy advisors through the Center on how they're achieving cross-sector and cross-agency collaboration around some real priority areas for governors. And it's actually really increasing. So I'm hoping to provide some opportunities for discussion and to stimulate some ideas about what seems to be working and where is there some momentum and where are some remaining challenges, which Stuart already highlighted some, but I can add a couple at the end of this.

And I would say that much of this is still in the braiding space. I think that's probably a fair statement. But I will also say it's really exciting because I think a lot of the cross-sector, cross-agency work is in part driven by appreciation of the value of the determinants of everything -- I love that. Not just the determinants of health, the determinants of everything is really driving a lot of the conversation, which I think is very encouraging. And governors are aware of it and I think they're taking the lead in establishing some of this cross-sector work.

So a few examples I just wanted to hit the highlights on given the time this morning where this is occurring -- there are others that we can note, but some of these are really the hot topics going on across the country. And so of course a big lesson learned is when it's a hot topic you capitalize on it and it can really drive change. So a few buckets -- complex care programs --Stuart already alluded to a little bit of this -- but in the Medicaid space on the state side these are the folks that often are referred to as high utilizers of costly

services or high needs, high cost populations. There is a lot of cross-sector work going on there, and I'll highlight that in just a couple of minutes. Of course, in the opioids crisis, in the opioids response base there is a lot of cross-sector work even outside of health, human, and social services, which are implicated in a lot of the other programs I'm going to talk about, and really bring the public safety and the corrections elements. So supply and demand and bringing in the whole spectrum and what's happening there.

Children's cabinets I think are a really good example of governance structure -- and we're going to hear more about those a little bit later when we hear from our second panel what's happening on the local level and perhaps what's happening on the State level around these children's cabinets that allow child and youth serving initiatives to flourish. And these are just in a nutshell usually on the state level established by Executive Order or legislation and are comprised of state agency leads that touch anything to do with children and youth to really think collectively and collaboratively around policy solutions, exchanging information, and financing strategies.

And then, finally, the fourth one I want to highlight is school safety. We know this is such an important topic over the last short period of time, and this also brings together really different sectors to work collaboratively and to think about how are we going to pay for what we want to do to keep children safe, healthy, and successful. So, again, public safety, education, and health and human services sectors.

So briefly on each of these in the complex care space, especially in the Medicaid program, (inaudible) are really doing data driven work, looking across health, human services, Medicaid, and social service providers to really understand who are we talking about and how best do we meet their needs and the cost effective ways that gets people out of acute care settings and institutional settings where quite frankly they're not getting good care, they're not improving, and it's really costly to the States.

So some examples of how the funding sources are being brought together to address some of those needs are though Medicaid programs, through behavioral health

block grants, and really importantly through some of the social services sectors. I think that many of the focus areas are food insecurity, transportation needs, housing, and employment supports. Housing is the big one. I know everybody in this room, and probably who is listening in today, has heard a lot about housing initiatives. And I think that there are a number of states that successfully have brought together their health and housing sectors. It is a real challenge. I point you to a road map that we pulled together a couple of years ago, an NGO called the Housing is Healthcare, that highlights how complicated all of the financing sectors are with respect to bringing in the capital, the operations, the services, supports to really put together a comprehensive housing solution that also provides wraparound social support services.

What are governors doing? They're bringing together some of the leaders who often have never talked to each other, Medicaid, behavioral health, the housing finance authority, the continuum of care, and on the local level, the public housing authorities, and other social service providers. Never talk to each other. Really big buckets of money that are being invested in these initiatives, and how do we actually think about a successful braiding solution here. And there are a number of states who are doing this. I can point to a few -- Louisiana we will hear a little bit more about later, Michigan, and others. I'm happy to share what some of the details are there.

In the opioid space, as you all know well, governors have pulled together many governance structures in order to support the crosscutting needs here in the opioid space. Opioids response teams, command centers for some of those states who have emergency declarations around the opioid crisis, and just work groups. And we've been working with states since 2012 to try to help them organize their work in the opioid space. What is really interesting here, and again I'd love to give you a lot more detail, but just to hit the highlights, is more recently states are very innovatively braiding together the state opioid response dollars, which are the big federal dollars, to address the opioid crisis flowing to states through SAMHSA block grants for substance abuse services and mental health

services, public funds, private investments, philanthropic funds, to really address a whole host of things, including harm reduction approaches across the state, syringe exchange programs to address housing needs across the continuum of housing supports for people who are housing insecure people coming out of correction settings. Some states are actually working very closely with their public safety and corrections folks to build at a continuum the supports for people who are moving in and out of the criminal justice system and also have treatment needs around medication assisted treatment, and all the supports that help you sustainably live in the community and stay out of those settings and flourish through those treatment interventions and, again, including housing supports, reconnecting with employment, reconnecting with social networks, and braiding together all those funding streams to do that work.

I'm making it sound really simple. It is not. It is tricky. And a lot of it really is the players. A lot of it is what is the imperative, what vision have we set that is really a clear goal that cuts across all of our sectors and how are we coming together to break down some of the cultural barriers to work together around solutions that quite frankly have not -- you know, are foreign to some folks in different sectors.

Children's cabinets, really briefly, again are governance structures that are on the state level. There are others on the local level too, and I won't get into any of those details there, I'll just highlight what's happening on the state level. There are at least 12, perhaps more, that have established children's cabinets and I think they are growing. There are a couple of new administrations that are either establishing or reestablishing children's cabinets. and the goal really is how can we set on the governance level, or the legislative level, a vision around how we want to better improve outcomes for our children, youth, and family to set those goals very clearly, to force some of that cross-sector conversation, and then establish the governance data and financing strategies to actually achieve those goals and break down the barriers across the different agencies.

We'll hear from Pam Brown a little bit later today about how some of this is

playing out in Maryland. A couple of the States, or perhaps more, are actually developing children's budgets, which I think is a really important thing to dig into if you're curious in this area. And that is what it sounds like, they're actually thinking about the budget holistically across all the things they want to achieve around outcomes and indicators for the children and youth in the state, and really trying to think about how are we going to pay for this in a holistic manner.

On the school safety side, this is -- from my perspective on some of the projects we have worked with in states, has been a really interesting phenomenon. A lot of the investment and attention has come in from the homeland security public safety side of the equation. How do we really think about creating a safe environment, school hardening, bringing in school resource officers? All of this is so important, how do we bring in law enforcement to really understand where the threats are. What has really evolved over the last year, which I think is very exciting from a braiding and blending perspective, is the education supports and the health and human services supports have come in and together these three sectors are now saying, okay, we're all working at this in our silos, we all have actually very similar structures and frameworks to address these issues, how do we work more collectively together. And those conversations are happening. And there are a lot of lightening rod issues that help drive that. In the education side there's social and emotional learning and school climate are really hot topics on the health and behavioral health side. Comprehensive mental health solutions, how do we bring Medicaid into schools to actually make that linkage stronger between community-based solutions and school based solutions for kids who actually have higher needs. Those are coming together. So again we see public safety and corrections dollars, law enforcement involved in this, we see Medicaid dollars, and behavioral health block grant dollars, and then of course the dollars that flow through the education system don't come in through the state, but really come in locally through school districts, and how are those being leveraged and braided and blended. And many of those are in some of these initiatives.

I think that at this point I'll stop on some examples. I have many more to offer you. And I will just highlight a couple of more challenges to supplement what Stuart has already offered.

I think one of the challenges, and I think this is on all levels of government that we don't talk quite as much about, is we're trying to break down the silos and defragment the systems and I think there's a real appreciation that these are crosscutting issues that require not just our own sectors' expertise, but what is often happening is the silos are actually bloating and expanding and saying I can solve this in my lane, rather than necessarily reaching across the aisle. So I think what's really important is that the direction, the vision, the leadership, and the requirements to work together, to stop looking in your own lane and start reaching across for that expertise. That has been a real challenge I think on all levels of government and is also reflected in how the funds are flowing.

And, of course, one of the challenges on the state side is with respect to federal dollars that are coming into states. As they're trying to leverage all of those, and certainly in a cross-sector way, there are real challenges with misaligned reporting and accounting requirements. The timing of grants are all misaligned. And so it's very hard to think holistically about bringing those federal dollars and combining with state and local over a certain period of time to achieve a certain set of initiatives, without everything breaking down because there's that misalignment on the federal side, which I know is a challenge. Similarly with evaluation requirements and so on.

Just a couple of other things to note, and then I'll stop and turn it back over to you. Stuart already talked about the wrong pockets problem. I think there's some movement on the state part to really think about reinvestment strategies. So even though we still need to do work on the front end around the wrong pocket problem, there is some intentional thinking about if there are savings related to determinates of health on the health side, how are we thinking about reinvesting those dollars in that same initiative, at least in sort of a local microcosm kind of way, rather than doing what we usually do, and it goes

back to budget or some other program. So I think there is opportunity to leverage some of that work.

And the other thing I would say is there are often through initiatives requirements to build governance structures. So what we often see as are trying to help states work across lines is there are 10 different governance structures that are all sort of semi overlapping and doing the same thing. And part of what we do at NGA is try to help them sort out is there one, are there one or two, and how do we get those to work together, and how do we reduce some of that duplication. So I think there is opportunity to address that challenge as well. And I'll stop there.

MS. STACK: That was great. That was great. I think we're going to spend the day thinking about effective blending and braiding, but based on your observations, what do you think are the sort of key ingredients for success so that as folks are thinking about doing this at the state and local level they know that they've got the right components?

MR. BUTLER: Well, I think first of all it's very important to have legislation and rules that allow and set up these bodies. We've had some significant success of that at the federal level. If you look at the Medicare program, for example, Medicare Advantage now, just because of legislation last year, Medicare Advantage plans can spend money on areas like transportation and others, recognizing this is crucial to that. We also see in the whole waiver program, the Medicaid program, working with the states has allowed states to come forward with ideas, with ways of using money differently. And pilot programs, as well, by the federal government.

So I think legislation and federal action is certainly important. I think that figuring out effectively how to do evaluation and monitoring of funds is really important at all levels of government. Once that money is braided or blended together, you've got to make sure that the intent of that program is filled out, is fully accomplished. That can be really challenging. So I think that's a really important area.

I think it's important also to figure out at what level of the federal system it is

best or what kind of organizations or bodies are most appropriate at different levels. Maybe at the national level we're talking more about interagency cooperation, councils and so on. When you get further down the system, you really are talking about in some cases new organizations or -- and you'll hear from some of those -- designed specifically to bring this money together and to do the record keeping and evaluations. So you've got to figure out exactly where in the system you have a body and what kind of body it should be.

And I say also a really crucial element is -- you'll hear this all the time -- is leadership. That unless somebody takes the initiative, who is in a position to be able to make things happen, unless they take the initiative and send the message down to other people that this is how we're going to do things, it's really difficult to see something successfully happening. You can set up a system, but if the governor is not behind it or if the county executive is not behind it and makes that very clear, and gives the incentives for people to cooperate, it's probably going to fizzle out or not be effective.

So I'd say those, to my mind, are really the critical pieces.

MS. STACK: Sandra?

MS. WILKNISS: Thank you.

And I can say -- I'll just up where you left off -- what we usually find in our work as successful is what you just said, if the governor provides leadership, both through vision -- the governor is the key administrator, purchaser, and supplier of a lot of things, so using all of those levers in the bully pulpit where necessary to really demonstrate that leadership and show the commitment to whatever the initiative is, is really important.

I think a few other elements that we find are critical is scanning the environment -- know what's already out there and let's leverage that and bring in those stakeholders who are already driving work on a local level or in another state, to help really drive change rather than reinventing the wheel, is absolutely critical. I think getting the right people to the table -- it's all about the people. A lot of this is culture change, a lot of this is taking on new things that a specific agency's mission or vision has never taken on before.

So it's getting together the right people and making sure those communications are occurring, which of course requires information exchange. We all know there are significant challenges with data exchange and information exchange in these really complex areas, and trying to work around or work with some of those challenges continues to be an opportunity.

And then I would say really focusing squarely on the delivery and the payment strategies that are needed to drive the change, and using that to help drive some of the conversation and create some of the culture change.

MS. STACK: Great. So have we left anything out as far as teeing up the --

MR. BUTLER: Well, I would just say maybe a footnote to what Sandra is saying about the community. I think one of these issues that we have in any area of allowing money to be used more fungibly across sectors, is trust. You've got to have trust at the local level, that people know that money from a particular program that is their primary funder goes into another organization in the same community, there's a reason for this and it's to everybody's benefit. So building up trust and having the right players to build that trust is crucially important.

And then I think in thinking about trust, that then I think affects where you make these decisions, who is involved, at what level. It very much affects that. I think we'll hear that these institutions which are closer to the community, that are actually doing the detail of braiding and blending money, tend to be far more trusted than something which is a direction from on high.

But I also think the other thing I would say is that constant kind of innovation and testing is really what's important. If there was a simple handbook for exactly how to do this -- well, there are some handbooks about how to do it (laughter) -- but if we had a perfect handbook we wouldn't be having to meet and talk about this. The fact is we keep learning all the time. And so this use of things like federal waivers to say to states, come with your idea about how to look at the Medicaid program, for example, and use that effectively to deal with housing issues that affect the people who are on Medicaid. Using waivers, using pilots

-- the central Medicare and Medicaid services has been very effective at seeding pilots to try these. We've got to constantly learn. And as you learn it's really important having situations that then spread that knowledge so that others -- that's why what Sandra is doing at the National Governors Association is so important, it's not just working with particular governors, but it's telling other governors and other agencies what the lessons have been. That's a really important process and it's something that we in the working group looking at this have been very attuned to, how can we think about how better to share this information. We're trying to do it, but we think others really have to do this as well.

MS. STACK: Great. I just wanted to make an observation. Certainly in my time in federal government, we often had new administrations come in, we'd have pilots, innovation, and it would be time limited. So, you know, you do something and then the next guys come in and they have their own ideas about innovation and whatever you learned from before, there was never a way to scale it. And I think the key on blending and braiding is that when you do innovation, at the same time you're thinking about how would you actually scale this within your existing funding streams. So you try it, but you have a long-term sustainable path. Would you agree?

MS. WILKNISS: Oh, I absolutely agree. And I think combined with the trust note that it has to be the people trusting and buying into this in the long-term, as well as the braiding and blending is absolutely critical.

MS. STACK: So anything else to add before we --

MR. BUTLER: No, I think that's --

MS. STACK: Okay.

MR. BUTLER: Let's hear from people who do it.

MS. STACK: So we are going to move to our first full panel and it's going to examine organizations that currently are engaged in flexible budgeting and Anne De Biasi from Trust for America's Health is going to moderate that.

Let me give you a little background on Anne. So she is the Director of

Policy Development at Trust for America's Health. She is responsible for defining the agenda and general strategy for TFAH's goal, a modernized, accountable public system, and integrate prevention into a reforming healthcare delivery and financing system. So she's developed an advanced policy on braiding and blending at TFAH. It's been a major focus. I think there are some handouts that you have or can get access to that she's responsible for.

And then prior to TFAH she was in key leadership positions in a number of nonprofit health and policy organizations. And she also did her stint on the Hill working for Senator Tom Daschle when he was the senate majority leader. She was working on healthcare. So lots of experience. Take it away. (Applause)

MS. DE BIASI: I'm going to ask my panelists to come up and join me while I introduce them, and then just give you a couple of minute overview of what we intend to do on this panel. I'm making a note that we're going to save plenty of time for Q&A. You might already have pent up questions based on that great first panel.

So, in alphabetical order, joining us today in the center, Dr. Pam Brown. She's the Executive Director of Anne Arundel County Partnership for Children, Youth and Families. That is one of 24 local management boards in the State of Maryland. We'll hear more about that.

She has also held leadership positions over the past 30 years in government, the nonprofit sector, and really all of those positions have required her to have an operational understanding of diverse funding streams and how to leverage them.

She has a Ph.D. in educational leadership from Florida Atlantic University and her dissertation focused on the importance of community partnerships in mixed neighborhoods to improve outcomes for children and families. And just to note, she's also been conducting needs assessments at the community level for the past 20 years, so will bring that experience in as well.

Anna Novais -- did I get it?

MS. NOVAIS: You got it.

MS. DE BIASI: Close? (Laughing) Brushing up on my Portuguese. Ana is the Deputy Director of the Rhode Island Department of Health. She's a clinical psychologist by training. I'm hearing a theme around braiding and blending and psychology. (Laughter) She also has 30 years of experience in public health, both in the U.S. and abroad. She has helped steer the Rhode Island Health Department's efforts to narrow health disparities and promote health equity since 1998, has helped launch Rhode Island's health equity zones, which you'll hear more about today, a signature health equity initiative of the Rhode Island Health Department.

And with us today also is Pat Valentine. Pat is the Executive Deputy Director for Integrated Program Services at the Allegheny County Department of Human Services. So even her title already speaks to integrating across the different silos. She's responsible for the management of services provided within the County Department of Human Services, both direct and contractual, which requires coordination across program, operational, and support functions within the Department, including evaluation, for example, research, fiscal, human resources, contract administration, information systems, and communications. A lot of coordination.

And Pat places a particular emphasis on leading, planning, and promoting integration of all the programmatic work within human services and, importantly, coordinating and collaborating with affiliated systems, such as education and corrections.

So we've really got the experts, as Stuart said, the real people. I'm so happy to be able to moderate this panel today, this real-world panel. And how we're going to proceed is we're going to kind of do a fireside chat centered around five questions. I'm going to give you the questions in advance because I know you're going to want to get to the ones the last couple. So we're going to move along really quickly with the first couple of questions to make sure we get in depth the last questions.

So they're going to talk about what's the mission or goal of their organization

or agency, they're going to give us an anecdote or two about what work was impeded when they weren't able to braid or blend funding streams, some real life examples of the problems on the ground. And then they're going to talk about how they've changed that, both what sectors were involved in the changed work in terms of braiding and blending, and what funding streams are involved. So we're going to get pretty specific

And then we're going to talk about what was alluded to by the other panelists, what structures they had to put in place to do that, what governance structures, what data information system structures, and what financial management structures, and any other structures that they needed to develop that all important trust.

And then, finally, we'll talk about what the challenges they face are and what is still needed in order for them to progress their work.

So, with that, I'm going to come and join. And I want to start with something fun just to get us revved up. I'm curious, and I don't know the answer to this question, but I'm curious what different sectors you all have experience in. Some we just heard from your bios. So we're going to do a quick quiz. Just raise your hand. Who has experience in health? Healthcare? Public health? How about health insurance? Okay. Human services? Maybe child and family services? How about the education sector? How about criminal justice? How about transportation? Wow. (Laughter) Nutrition. Okay. There is plenty more, I'm sure. Anything big I missed? Like you were waiting for me to say?

Okay. As you can see, we have the perfect panel because they have worked across all of these different sectors that we have been talking about today.

So let's start out with that first question and learn a little bit more about your organization. So I'll start with you, Pat. If you can tell us a little bit more about the mission of Human Services.

MS. VALENTINE: Well, Allegheny County Department of Human Services was formed in 1996 from a number of other previously separate departments. And so it began to integrate in 1996 and it's been a process since then. There were values developed

at that point that basically said that people are integrated. You know, we can't pull out the mental health part of a person or the homeless part of a person, and therefore our approach to serving them has to be integrated.

We also talked in our mission and value statements, which have evolved throughout the years, about the essential value of each person and respect for each person. And what we have found is that coming back to those values on a frequent basis is really important. We are here for one reason only, it's not for our work, it's for the individuals who we serve. And we stress that with our staff and with our contracted providers.

MS. DE BIASI: Thank you. And, Pam, can I say The Partnership for short, is that okay?

MS. BROWN: That's fine, that's fine.

MS. DE BIASI: Okay.

MS. BROWN: Let me start by saying good morning, everybody. Let me start by saying that the State of Maryland has had a children's cabinet at the state level since the 1990s, and it was created really as a response to the way that we have siloed human health, criminal, police services over generations. And all of the different secretaries serve on that children's cabinet. And the notion was to create a cross-communication and, where possible, to start creating services that were holistic and family based.

So within about three years they decided to replicate that system at the local level and they created something called local management boards. The Partnership for Children, Youth, and Families, or The Partnerships, is one of those local management boards.

The State realized that if you were going to do that at the state level there had to be mechanics to push it down at the local level. There are 24 counties and jurisdictions, every county and jurisdiction has a local management board. The funding to begin with was a blended model of funding. Every department put in a piece and it was all placed in an interagency fund, which still exists today. It's still called the interagency fund.

They blended all those pieces together and by formula sent it out to local management boards.

At the local level, at The Partnership, all of the different child serving agencies serve on my board, so the head of child welfare and so on, the superintendent of schools serve on my board, along with citizens and others appointed by the county executive. We are tasked with being the neutral convener of all things. I am the staff person to that board, I am not the board, I'm the Executive Director. So my goal in life is to be the neutral convener. I think if you're talking about funds it is also called the trusted broker, who brings everybody together and says, you know, never mind what's happening with the child in education, there are all of these other issues and families that need to be dealt with and we need to deal with it in a cross-systems way. So it was a way of sort of forcing a conversation among all of the different agencies at the local level. And what we do is we assess needs, we figure out the gaps in services, and then we find funding to fill those gaps in services around the eight statewide resorts for child wellbeing. So a pretty complicated system.

When I first got there, there was a lot of money in the interagency fund, it was still a very blended and well-funded system. Come the recession, the whole thing collapsed and, cutting to the chase here, I became a person who learned how to braid funds and go after funds in every which way I could to try and continue the work forward. And I will talk more about that braiding, and to some extent blending, as we go.

MS. DE BIASI: Thank you.

MS. BROWN: Thank you.

MS. DE BIASI: Ana, how about Rhode Island?

MS. NOVAIS: Good morning.

Rhode Island is a small state, the smallest state as you all know, or should know. We have around 1 million people in the State. And what is unique about Rhode Island is that we do not have any local public health infrastructure. So as a state, public

health department, we act both at the state and local level. We have the same core function that any other state public health department has control of, infectious disease, health promotion and wellness, environmental health, maternal and child health, the state public health laboratory, medical examiner's office. Those are the core public health functions and we exercise them as any other state.

I think what is unique about Rhode Island is in the absence of having a public local health infrastructure we needed to create that local public health infrastructure, and we did that through the initiative that I will be talking about later, the health equity zones.

We have three leading priorities that define the work that we do across the Department and across all programs. We have a focus on the elimination of disparities and on achieving equity for every Rhode Islander, we have a focus on addressing the social and environmental determinants of health, and we also have a focus on making sure that the health system -- and we make a point of saying the health system and not the healthcare system -- to make sure that we are including community services, home based services, all of the services that are provided, that the healthcare system is of quality, assuring the quality of that system, but also assuring access to our most vulnerable population.

So that is in a nutshell how we have made priorities in terms of using the same framework and the same lens across different aspects of the health department and translating that at the local level.

And I will say that later.

MS. DE BIASI: Okay. All right. Well, I guess suffice it to say that you couldn't achieve any of your missions without working across sectors, right?

MS. NOVAIS: Absolutely.

MS. DE BIASI: We know that for sure.

So tell us a little about that. Can you each give me an anecdote, and maybe we'll start with Ana this time. Just a quick anecdote about what went wrong due to lack of flexibility to be able to braid and blend. You know, some service you weren't able to

provide, something you weren't able to do that is a part of your mission. It could be something very small.

MS. NOVAIS: I mean think about every other health department has followed Healthy People 2020 indicators. And as any other state, we have success in some areas, we have missed out in some other areas, but when we looked at the data, a deep dive on the data, and you start looking at the data by race and ethnicity, by gender, by geographic location, whatever way you are peeling off and analyzing the data, we see that we have ongoing disparities, and that even where we achieve success and achieve our benchmark for the population, we had pockets of need that were not being addressed.

And so I like to tell stories, so I think about 30 years ago before I came to the United States. You all figured it out than by my accent than by my last name. I used to work in Cape Verde (inaudible). And as a mental health coordinator I was dealing with a population that was homeless, that didn't have employment, all of the things that we talk about, but never use the words social and environmental determinants of health. But I was working with the police, with the schools, trying to even reach out those folks.

Fast forward -- but Cape Verde is poor. It's one of the poorest African countries. Fast forward 30 years later, I'm here in the United States and I'm having those same conversations, I'm faced with those same challenges. We're talking about housing for our opioid crisis, how do we deal with housing, how do we deal with the homeless population, how do we deal with obesity policies when you have neighborhoods that don't have access to safe food and vegetables, they don't have access to a safe place to exercise.

So what is it that went wrong? I think everything that we do in public health has been traditionally done in a silo and has not worked, because we still have, in fact for the first time in the United States, a decreasing life expectancy. For the first time the next generation, my children, have a lower life expectancy than I have. So what are we doing right? (Applause)

MS. DE BIASI: All right. All right. Well, that's hard to follow, Pam. (Laughter) But you could give a small anecdote. Now we have the big challenge on the table.

MS. BROWN: Well, so let me base it on our needs assessment. We're a wealthy county, Anne Arundel County is a wealthy county, but there are pockets of poverty all over the county and a very bad one where every single social determinant of health is rising is the zip code 21225, that abuts Baltimore City. And everything you can imagine is there in terms of rising social determinants, where just in the needs assessment it was very clear. You could draw a picture of the map and where race inequity, ethnicity inequity, and rising social determinants lit up in this zip code.

Well, there is no funding source for that, there's no big place you can go and say we've got this crashingly bad situation with poverty, families in massive distress. So we started by gathering together a few stakeholders and we found a model that is a Casey Family Services model called Communities of Hope, and we created a community of hope. And I think that was important because it gave everybody, every single agency, and all of the agencies who were addressing its silos, those different social determinants, a geography to focus on, but also a single agenda or a shared agenda. We use the collective impact model a lot in our agency.

And so our shared agenda was to reduce poverty. Obviously the agenda within that was to stop those social determinants rising however we could. So over time we started this -- four years ago now back in 2015. This started with there were three of us in a room, there are now two hundred of us when we meet and we have many, many different initiatives going. We have reduced poverty by .3 percent, but we will take it because I believe maybe it would have even gone up had we not been there.

So I think the important thing about that, and about all of this work, is the relationships that are formed through it and the people who are doing it. Everybody has to feel good about the work, everybody has to own it, everybody has to have the same agenda,

and everybody has to be able to sell it to their silo. So you've got to be able to explain why you are spending child welfare money in a library. And so I think all of those issues -- and I'm sure we're going to talk about that a lot later -- but the personalities that are part of this and the way that we drive our agency heads to a certain set of outcomes that are very specific and narrow outcomes, make the work very difficult. Shared outcomes, shared agendas, and relationships are what drive it forward.

We started off with a small amount of $20,000 from Casey Family Services in 2015, we now have about $8 million rolling into that zip code to address social determinants of health.

MS. DE BIASI: Wow, that's amazing.

How about in Allegheny County?

MS. VALENTINE: Well, in Allegheny County, as an example of what went wrong, we have many families in child welfare who are in child welfare basically because of the addiction of a parent and all of the issues that that engenders. When we face this situation parents were often very reluctant to go into treatment because -- if it was a mother or actually more recently even a father, they could take kids under 12, but not kids over 12. And if there were no beds in those family programs, they would have to have all of their kids placed. And if they had no relatives or friends who would take the kids for a period of time, they went into foster care. And once a family gets into the child welfare system they tend to stay there longer than they would like to and than we would like them to.

So we will be opening in a couple of months a family residential D&A program. And this is a program that will hold eight families at a time where the entire family, or the part of the family that wants to, can move in. Because, you know, we talk about addiction as a family disease, but we treat the person. So at this program we'll treat the family.

This is being done by braiding drug and alcohol funds, medical assistance funds. We are the primary contractor with the State of Pennsylvania for Behavioral Health

Choices, which is the Medicaid managed care program in Allegheny County. So we have control over that, you know -- basically that funding. So it will blend the Medicaid funding, base drug and alcohol funding, and child welfare funding. Also, we do have foundation funding to start the program off.

So that is just one example of something that was really problematic that we are trying to fix and using braided funding to do it.

MS. DE BIASI: Wow, that's great. That moves us right into the next question. But just summarizing, it seems like the big problem was that you weren't achieving the outcomes you needed to achieve, particularly when it came to reducing inequities. I'm hearing that from all of you.

But you're changing that, that's why you're on this panel today. So thank you so much for being here.

And I know people are super curious to get a little bit into the weeds on technically how you do this. Because that helps us to get then to the policy issues that we can move forward to overcome some of those challenges that you have.

So maybe we can pick up and start on that, because you are already giving us an example of how you've been able to solve at least one problem in your community, housing and treating families that are affected by addiction -- so important.

So tell us, like okay you were able to bring those funds together. I know a lot of us when we hear braiding Medicaid with other funds red flags go up in our head (laughter). So, you know, what happened when you tried to do that and what -- you told u about what sectors were involved, child welfare, behavioral health, Medicaid, obviously your agency, and you told us about some of the funding streams. So what were some of the challenges in braiding those together and what did you have to do to overcome those challenges?

MS. VALENTINE: One of the challenges -- the challenges most of the time involve people. (Laughter) And it is not the money. Well, it is the money to some extent, but

it's the people. Because let's face it, the staff who are staffing our systems today grew up, professionally grew up in siloed systems where this is what this money is to be used for and nothing else. And the fact is that most of the categorical funding is categorical for a good reason. It was categorical because somebody was trying to protect a certain population, somebody wanted to make sure at the federal level that pregnant women with children had access to D&A treatment, or access to D&A prevention, or that -- you know, I won't go through all the examples, but you know what I mean. However, even though they had a benign intent in the beginning, they are now in terms of integration problematic.

And our staff, we grew up in that siloed system. So the biggest thing is constantly harping on people are integrated, you know, and if the funding is not integrated then it's problematic. This doesn't happen in fiscal. First, you've got to have an integrated fiscal staff, because if you have a fiscal staff where one unit is responsible for mental health, we -- in the Department of Human Services we have behavioral health, including MH, D&A, early intervention, aging, intellectual disability, child welfare, and community services, which is where our housing, homelessness, food programs, and Headstart goes. If you don't get people to understand that they need each other in order to accomplish their goals successfully, that's where, you know that's where the biggest challenge is and that's where I spend most of my time.

And I'm constantly staying, how about this, how about this. And we could talk about that later because we're running out of time here.

MS. DE BIASI: There's a dose of reality. But it sounds like, so people issues are the most challenging, so we have workforce training and various polices that we can put into place to try to improve that. But it does sound like your agency is structured to have that integrated fiscal structure, right?

MS. VALENTINE: Yes.

MS. DE BIASI: Because you just described a plethora of varied programs under your agency. And that's a little different than you as the neutral convener, right?

MS. BROWN: Yes.

MS. DE BIASI: Yeah.

MS. BROWN: So The Partnership is what's called an instrumentality of government. We don't get any county funding, but all of our funds run through the county financial system. So counties, or at least our financial system, runs by business units. They live in a world of business units. So for every new piece of funding you get, you're poor fiscal manager has to open a business unit and keep that business unit clean.

So you can imagine if you've got different amounts of -- funds coming from different places, how the poor fiscal people are constantly trying to manage their business units and figure that out. They are most frightened of federal funds. (Laughter) Federal funds are the nightmare of all funds. Let me tell you, my finance manager dreams about federal funds all the time, because we're constantly afraid we'll go to jail. So we have federal funds, we manage state funds, we have county philanthropic funds, we have individual donations, and we work on several years. So we work on the federal fiscal year, the state fiscal year, which is obviously July through June, we work on a calendar year with foundations, and then we work with whenever donors want to give us money year. So you can imagine our county fiscal department -- who is used to managing like say public works and a certain set of funding -- has to manage this crazy little agency who isn't even part of a line item budget. It's very, very difficult for them. It's also very difficult for us to explain to them what we're trying to do.

The only success I would say in blending that we've had working with our county fiscal people is when it's majority philanthropic funds. And that's always because it's less accountable, because individual donors basically want to know that you did something good for a family. So they're happy if you did something good for a family. If you then start moving that into county granting systems, into other systems, then all of the fear of you misspending public money -- which is really what it's all about -- it's fear of misspending, it's fear that is mounting.

For those of you who manage Federal funds, the dreaded word "supplanting", that's the go to jail word. You will go to jail if you supplant funds which basically means you use Federal funds and another set of funds for the same thing. So, imagine when you're mixing funds together, how easy it is to fall into the trap of supplanting. There is no accident with the Federal government. You can't claim you did it by accident. The bars look the same.

So, really the issues around finances are to go with funding streams and then how whatever your agency set appears, whether it's a county setup like mine or a state setup or even not for profits, how you then manage that inside an accounting system so that you actually get a clean audit, which is what our financial people want. They want a clean audit and so the dangers in braiding and blending is that that will not happen. It will be audit findings that then create a creative action plan.

MS. DE BIASI: Absolutely. I wanted to draw out 2 points that you both have made that we hear a lot. One is that categorical for a reason. Right? So, coming back to that, we do hear fears about what happens if we braid and blend these things together. Then what happens if it becomes, maybe, a block grant, and then is reduced in future years? Even from the political prospective of the applicancy for those different pots of money that were categorical again for a reason. If we use them differently, will we still be able to maintain those funds that we are able to maintain through the kind of sector specific advocacy, or issue specific. So that's a really important point you're raising.

Also around the fear. We laughed, but this is true. We hear this a lot from States. Sometimes the government will offer some flexibility, but States won't adopt it. Why is that? Because they are afraid, you know. We hear that big Inspector General, you know, coming down on you. This happens. It happens in the schoolhouse phase, for example, and those people have long memories of those things. We did that 20 years ago when they told us we could and the Inspector General came and took millions back from the State and I lost my job, you know.

So, those fears -- we laugh, but I think it prevents States sometimes from taking advantage of opportunities or localities, those fears. We want to hear it from Anna now about the health equity zones that you alluded to earlier, because it sounds like while your agency also has varied programs and a graded structure, even though it's still within one sector, you set up this initiative really to do a different level of integration that occurs across the rest of the department. Right?

MS. DE BIASI: Absolutely. In fact, it's now also occurring across State government because it's not just the health department that is investing in the health equities zones. So, if you go back to the point of believing that what determines our health outcomes, it's things such as housing, location and jobs and schools, quality of schools and all of that. Public health is so good at telling people what to do. We say to people, "don't smoke", which is a good thing. We say to people, "exercise 30 minutes a day; eat your fresh fruits and vegetables". But we don't really look at how can people truly exercise that choice, do that. How can that happen at the local level?

So, the health equity zones was our commitment to our local communities to truly listen to the communities, go back to the basics of what is important for them? How do they define health? What were their health priorities? How do they want to address those priorities? So, we ask communities to define -- to draw a line on a map, define their zone, what they call their health equity zone, to come together, key stakeholders from the community, do a needs assessment, do an assets assessment, come up through a community prioritization process with their priorities, the fellow plans of actions that were based on evidence based programs and then we funded them.

How did we fund them? We braided funding. We braided Federal funding with State funding and we used categorical funding. We used blog grant funding. We truly created a thread, the thread that you saw at the beginning with CDC funding, CMS funding for from State innovation models. We were fearless, because even on the categorical funding, if you really read the guidance, they all say for us to address racial and ethnic disparities. They all

say for us to address the social determinates of health.

So, we are doing what the Federal government asked us to do. We are addressing those determinates. So, as folks develop their plans of action, we use the blog grant funding for prevention block grant, to really address more of the infrastructure needs and cross cutting issues. Then depending on their plan of action, we pull funding from the thread and the braid that we create. So, if a community says that they want to address diabetes as a priority, we pull funding from the diabetes categorical funding to fund that initiative. If they tell us that they want to do a sidewalk, which there is no categorical funding for that, we pull funding from our State General Revenue.

If they say they want to address community relationships because their adolescents are having trouble with police relationships, we can pull funding from maternal and child health because maternal and child health is supporting early healthy adolescent development and to be claimed and propose, then that impacts health adolescent development. So, we created this structure where we were able to braid the funding, keeps the categorical integrity of the funding by pulling specifically than to fund at the local level. Is it hard? Absolutely. Is it challenging? Absolutely. But we created that accountability system at the department level, and at the community level, it's not -- we delete the burden and the challenge and we support the community by funding them that way.

Because there were plans connected with that funding stream at the back end, we are able then to report back to the Feds for every penny that we spend how it was spent, and we did pass the Attorney General without any funding. So, I think that is success.

PAMELA BROWN: We have time for just really one more question. I want to make sure you guys get to say what you want to say. So, we'll leave this pretty open ended, but I think we do want to dig more into the challenges. So, you've talked about how you've overcome some of them with integrated fiscal management structures, with ways to be able to account and track, as Stuart and Sandra were talking about on the first panel.

One of the things you haven't mentioned, and I wonder if anybody wants to bring it into the conversation, they were talking about the data sharing. I wonder if you wanted to bring that into the conversation. I realize that we have 2 government and one quasi-governmental agency here, right? But governments still does differ.

You didn't really realize if there have been any change to your governments. I'm curious about the data sharing in the governments. We always use those 3 categories, kind of a agencies, CMS, but maybe there is another category. It's probably in the work force development.

PAMELA BROWN: I know. I'm suspecting that we should be raising up as important policy areas.

MS. DE BIASI: I think all of that is true. So, from leader sharing agreements, while we have leadership, when you didn't need a sharing agreement within the health department, as we start receiving funding from other agencies, CMS, from Seams, Etc. We needed to create those agreements. But that's not hard to create. You'll have your legal department to figure it out and it's done. It may take time but they've always figured it out. I think the issue of trust and the issue that you raised in terms of relationship and people. It's important not just from people being used to work like this, we think they're siloed, but it's also because they feel accountable to that funding and it raises anxiety at the staff level when they are being challenged by management to do things in a different way.

So, work force involvement is an important component, being able to engage and train your train to be able to look differently. So, we did create a series of supports and trainings in terms of how to write grants. So, this story that I'm telling you is the story that the diabetes program manager is telling when they apply for funding to CDC for diabetes, because like that, the authorization comes from the Feds and they cannot tell after, oh, I didn't know. They knew. We said that in our grant application. If they didn't pay attention, that's another problem, but we did say it very clearly that that's what we were going to do.

So, you need to train the staff. And you have a lot of issues with the Federal agency because we all know that our relationship is with the project officers and it changes from one to the other. That is the difference between your relationship programs and project officers at the leadership level. That's another challenge, how much you can push our Federal funders, push back at them and have that ongoing engagement. Relationships are important. I say it's people, but it's more relationships that you built with your staff and with the Federal agency and every other partner. So, you build a trust and they allow you to really challenge yourself and the system so you can really do things differently.

PAMELA BROWN: Thank you, Anna. Did you want to raise something?

SPEAKER #3: Thank you, Sherry.

MS. DE BIASI: Okay.

PAMELA BROWN: Well, of course, if you are trying to be create family systems and family outcomes like well-being. You need data from all of the systems that you are working with, child welfare, health, education and so on. We created an innovation project about 7 years ago that was based about kindergarten readiness and early childhood. There were many partners, including social services, health and so on, the education system.

We started out very bright and bushy tailed thinking we're going to do something wonderful here. Everyone will see it's an innovation. Everyone will want to share data. It's going to be a fabulous thing. Well, first of all, everybody's data is kept in different systems. I'm not even going to start with all the confidentiality issues on it.

Let's start with the systems, the clunky old systems, the systems where you can't even pull out an Excel spread sheet of the data that you want because the system won't allow you to do it. The systems won't talk to one another. Then there's all the protections on systems. There's all the HIPPA's, and the BERPA's and the FERPA's and all of those things. So, we look for a software system that might create the firewalls that would

allow you to -- if we could even figure out how to pull the data in to protect the data and actually share the data that was identified and we would have a single indicator in all of that.

So, we found a software system called Efforts to Outcomes which was the only one at the time that would actually allow -- I'm sure some of you know it -- that would actually allow -- and we managed to persuade the school system to buy it for us. Then we spent the next 3 years going bouncing between attorneys at the State level around sharing data. The only data we managed to share was our data within our different programs, some Headstart data and a little bit of health data. We still are moving that forward. We are still trying to talk to the State about how to do it. What happens is we had an MOU for 5 years. It kept going to attorneys who would mess with the language. Then it would go to the next attorney who said, "I don't like that language. That has to go back to child welfare". Well, we're not doing that -- and so on. That MOU still has not been signed. Three of the original attorneys are no longer there. All of the secretaries are no longer that and we are really back at Ground Zero with that.

So, I would say that data sharing across Silo's is horrendous, especially if you want to know that you have made any impact with the initiative that you have started. It's so important and it's so difficult. In terms of governors, I've explained our governors to some extent. I think I'm very lucky because I actually report to County Government as an employee, but because they don't pay me, they don't really know what to do with me. My Board is an advisory Board. So, they don't really know what to do with me either. So, for this 10 years, it's been Pam Brown's perfect job because I don't have a boss, which means I could -- I shouldn't say -- Stuart, I love you. I'm sure you're watching somewhere, but it means that I have a lot of freedom. So, in terms of governments, I would say that not having any is great. My local management board is obviously all of the child serving agencies. We've added a guided coalition to that of consumers who use services, including youth. And we have strategic advisors from sectors.

We have the caucus of African American leaders who is a strategic advisor

for any new initiative and saw it and kisses and blesses it, and says either, "That's terrible, Pamela, okay, we'll give it a shot". So, we have 3. We have 1 for trauma. We have 1 around homelessness. And we have 1 for the African American caucus.

So, that's how we do our governors. I'm sure you can tell it's very local and it's very anachronistic. So, when you start dealing with big systems, it's much harder to do those things.

SPEAKER #3: That's incredible engagement. Oh, golly. Do you want to add something to it before we move on?

MS. BROWN: We're a local foundation community, invested heavily in our data warehouse. So, our data warehouse is considered a community asset. It's got information, not only from human services, but from criminal justice, education. We've got data sharing agreements all over the place, and our data folks have developed an application called Client View where we and our contracted providers can go into this application and see the systems in which any individual client is involved.

It's wonderful from that standpoint. The issue we still get, the "Oh, that's confidential. You can't have this information in there". However, we have taken the position and have legal opinions that say as long as the agency is serving that person, that they, for the purposes of continuity and coordination of care, are able to access that information. And I will stop there, because we are a bit over.

MS. DE BIASI: No, we're not over as a panel. We now have time for Q & A. So, that was a good trick that he did with the time. So, I know about half of you in the room. So, I know you have questions. If you don't mind, just tell us who you are and who you work with as you present your question. There's someone here with a mic who can come to you. I know one right in the back wall there.

MR. SHAG: Hi, I'm Michael Shag. I've been on a lot of advisory committees and commissions for Arlington County, across the river in Virginia. My question I ask you is if you get beyond the data sharing challenges, what do you need to do so that local units

can use the data effectively and learn from it and adjust programs because a lot of agencies have a monitoring evaluation cycle that can be years long, but you've already maybe tried something new and you've learned from it, but you haven't been able to change your actions.

MS. DE BIASI: Great question. Could you hear it? He was asking when you get beyond the data sharing, how can you actually work with the business unit to use that new information that you have effectively because of the long monitoring and evaluation cycles you sometimes have in place? Did I get that right?

MS. ALEXANDER-SCOTT: So, speaking for Allegany County, we use it primarily in 2 ways. Number 1, for analysis. We've got an analytic team that is really very good and in which there has been significant investment. So, we use it for analysis and that provides information back to the program staff about what is working, who they're serving, in a more than surface view. The second thing, though, is it can be used for day to day programs. So, when the child welfare worker looks into Client View and sees that somebody has bounced around to 5 different DNA programs or mental health programs over the past 6 months, it provides some ability to ask questions about what's been the problem. So, we use it practically that way and also if somebody is sort of trying to hide the fact that they have a DNA problem, the Client View does provide the actual information to the provider. So, we use it analytically and practically.

MS. NOVAIS: In Rhode Island, one of the uses that we've done with our local health needs assessments from the community provides a better story about public health and what's happening really at the local level that most times sharing data doesn't allow you to have that point of view, but the other practical use we use it for our presentation as a health department that is led by the community and then we are using it today with our hospitals. As you know, DACA requires all the hospitals to do needs assessment. So, we are connecting those assessments that are happening at the local level as fulfilling that requirement, but then asking hospitals to invest in those local needs assessment identified

priorities. So, it's driving the investments at the local level.

MS. BROWN: So, we're creating, and have been for a while, a public facing dashboard. We use something that's called results-based accountability which basically asks if anybody is better off because of what you did. We're really into wellbeing and how you measure wellbeing. So, that public facing dashboard will be simple and will be open to the public to see what progress we are making in basically holistic initiatives and strategies.

MS. DE BAISI: Thank you all. Any other questions? To Debbie.

MS. CHANG: Hi, Everybody, I'm Debbie Chang. This is a great panel. Thank you again. Some really great examples. In each of your examples, it really sounded like you really did work around the current system to make it work, which is what you have to do. I'm just wondering what your thoughts are, I'm thinking of all of you, but Anna in particular. How do we change the current system so you don't have to do those work arounds? I think that's the issue of policy at the State and Federal level. Some of it, you've mentioned already, that there was more flexibility in the HRSA and the MCH Block Grant. What other things in terms of the policy issues, what other things could we be doing to make things easier for you all and still be able to provide the funders, meaning both private and public, be the kind of accountability that they need? That's one question.

My other question is about a lot of folks get their care through managed care organizations and there is actually a lot of flexibility in terms of how they use their funding. I'm just wondering whether they were involved in the behavioral health work. So, those are 2 questions.

MS. ALEXANDER-SCOTT: So, from a safe perspective, I think some of the policies that would need to change were alluded at the beginning by the first panel. I think at the Federal level from a grants funding perspective to have more alignment in terms of time frames and the budget ear for every grant, which varies from agency to agency and sometimes we get the same agencies, about alignment in terms of reporting requirements to States and the creating that flexibility, because, for example, when they had the famous

nickname 1505 which was an integrated chronic disease grant, it was integrated, but it was not, because we needed still to report back by disease integrating the grant. So, having that alignment in terms of reporting financial, that will be a needed policy change at the Federal level.

But then at the State level, I think, if you truly look at the guidance, it has more flexibility than one thinks. Challenging back the Federal government by telling your story differently. We usually read the guidance and you think you are responding by saying "A", "B", and "C" exactly as it is, but if you truly read and tell your story, they don't approve it and you now have a framework and an approval from the Federal government to do that innovation that you need to do. So, it's challenging yourself as a State, but also, it's challenging and asking of the Feds the flexibility in terms of grant making and grant funding that needs to exist. They need to talk to each other the same way we are talking.

MS. BROWN: I think the Federal government is becoming more rigid in terms of what I see. One of the things that is an example of their rigidity is that now their request for time sheets for every piece of work that we do. So, if you think that most of my employees are funded by blended funding across 5 different funders, their time sheets become this nightmare of how do we make sure that they are correct to the funding source. I mean, just me sitting here, I have to think about where is this 8 hours going to do, probably into general fund because that's the easiest way to explain it, but more and more, it's not just Federal authorities but Federal authorities in particular asking for minutia in terms of how the money gets spent. I understand that's around protection of public funding, but it becomes that we are spending all of our time accounting for how we are spending the money, rather than spending the money for the public good. I actually believe that that's not what the Federal government means. So, I think that flexibility around funding is incredibly important. I just want to echo what Stuart said at the beginning about leadership. This is so much about leadership at a small and big level for those of you who run agencies, for those of you who have departments, this is a behavior of encouragement because we are discouraged from

collaborating. We are praised for what we do for our silo, with our section, with our department, with our State agency. We are not praised for behavior that is not that, that actually gives praise to others. So, I spend all my time trying to think about where is the enlightened self-interest for everybody that I work with because I've got to find a way for them to look and feel good about the work that we do. Leadership will figure out how to make the collaborative behavior, the praised behavior, the wanted behavior. That's up to all of us to do whatever level you're working at. I'm not going to answer the MCO question because I think I'll do a really bad job of it. So, I'm going to pass.

MS. DE BAISI: Thank you. I'm happy to answer the MCO question. We contract with the behavior health MCO that is very involved in everything we do. They understand that if we don't address housing and education and basic needs like utilities and food, that they are going to have higher bills. I mean, that's the way it is. So, they work very closely with us and as one example, they funded a program called "Helping Families Raise Healthy Children". Basically what this program was about, was when our early intervention birth, 0-3, staff went into homes and found that a mom or a dad was depressed, we developed this program paid for by the MCO where therapy staff and case management staff would go into the home and for the period of time that was necessary and work with that mom until she was able to go into treatment at an agency or with a practitioner or if she didn't need it any more. They paid for that. It was a huge success. In fact, if you just google Helping Families Raise Healthy Children, you can learn a little bit about it, but that's just one of many examples where our MCO was right with us, because they understood it's not just the mom. It's the kids. So, yes, they work really closely with us.

MS. DE BIASI: Thank you so much. I think unfortunately, even though I know I wanted to get to one more question, we are out of time, so I guess I would just ask our panelists if they would be willing to hang around at the end of the program at 11:00 today, so that we can have our one next panel. I know people wanted to ask you some questions. Please join me in thanking Anna and Pam and Pat. Thank you. I want to invite

Sandra to come back up.

MS. WILKNISS: While folks are getting situated, I'll go ahead and let you all know who our next panelists are' Following the real people is always very challenging, but these folks are going to share with us what innovative work is happening on the policy side, Federal, State and local, to support some of these braiding and blending efforts and hopefully some of the initiatives that you learned about today.

Okay, I'll go ahead and introduce our panelists as they get mic'd up, so we have plenty of time for Q&A. With us today from far right, I think we're in order, yes.

From the right is John Tambornino from the White House office of Management and Budget. He is part of the evidence team of Q&A where he helps lead efforts to promote evaluation and evidence-based policy making across the Federal government. He served in many, many roles in HHS previously. He was a director of economic support for families at the Assistant Secretary for Planning and Evaluation. He has had many senior career positions there and at the Social Security Administration covering safety net, health care, poverty and disability issues.

Next to him is Amy Clary from the National Academy for State Health Policy. She is a Senior Policy Associate at NASHP where she works on projects related to health system performance. Prior to joining NASHP she worked for the American Federation of Teachers in D.C., where she developed resources for Health Care Work Force on the implications of Health care delivery system reforms.

Next to her is Sue Polis from the National League of Cities who is responsible for directing the Health and Wellness Portfolio for the National League of Cities as part of the Institute of Youth Education and Families. Her portfolio includes a wide range of issues, childhood obesity, building a culture of health through strong engagement of mayors and city leaders. She has also previously worked for the Trust for America's Health. There is a team here as well of psychology and has worked for AARP. So, she understands the whole life span. Feel free to direct life span questions to her.

Then finally, next to her is Lynn Nichols from George Mason University. He has there been the Director of the Center for Health Policy Research and Ethics and a professor of Health Policy since March 2010. He has been previously intimately involved in Health Reform debates and policy development. I'm sure this is a familiar name to those of you in the audience. And he has been doing that work for over 25 years. He was senior advisor for health policy at the Office of Management and Budget in the Clinton Administration. He has also worked at the Urban Institute and is currently on the Board of Directors for the National Committee for Quality Assurance which we all know is really important in deriving quality in the value-oriented work that we are all doing. He has also served as advisor to the Virginia Health Reform Initiative.

So, we have a very esteemed panel, a lot of deep expertise. I'll just note that they're going to provide comments from their deep expertise and lessons learned and not necessarily stating official positions unless they choose to state official positions. I'm going to sit down and join the group and we're going to similarly have a fireside chat discussion.

Okay. Thank you so much. Okay. I'm going to go ahead and open up with a very open-ended question for you all to answer as you see fit. What exciting initiatives are going on to facilitate braiding and blending? People have been stimulated by a lot of ideas of what's possible on State and local levels and we'd like to hear from you all about exciting initiatives underway that maybe we haven't heard about. I'd like to start, just really go down the row. State with you, John, on the Federal level and then we'll move down the row to hear about State and local initiatives as well. So, John, take it away.

MR. TAMBORNINO: Thank you, Sandra, a pleasure to be here and again, nothing I say is to be taken as official policy or views of the Office of Management and Budget or the U.S. Government. One important Federal initiative that I've involved with is the performance partnership pilots for disconnected youth, which still trips me up. It's the first time I've said it correctly, I think. It's known as P3. And P3, given this conversation, offers

lessons, but also some cautions, I would say.

P3 began under legislative authority that was provided in the labor HHS appropriations in 2014 and has been renews annually through 2019. What P3 does is allow States and localities and tribes to propose demonstrations for their pilot cost effective strategies to serve disconnected youth, young people not in school, not working, involved in criminal justice, homeless, that sort of thing.

The States and localities can propose to use funds under certain Federal discretionary programs more flexibly than they normally would if they commit to a greater focus on performance. Their flexibility includes being able to braid and blend funds, to broaden the range of use of funds, to simplify some of the reporting requirements. P3 allows Federal agencies to waive certain requirements, whether those that are rooted in Statute, regulation or other administrative policy.

P3 is administrated by a consortium of agencies. Q&A helps to coordinate it, but it's a superb group of staff at the agencies who really have made it happen. The underlying rationale for P3 was that States and localities kind of know what they needed, and that they were really being stifled by Federal requirements, at least in this program area, and that if we could relax these requirements, it would really free them to kind of flourish. To do what they wanted to do, to innovate, to integrate, to focus more on outcomes, to achieve better outcomes, to achieve better efficiencies.

Those were the expectations and they've proven a bit inflated actually, in terms of what we've learned. The uptake of P3 has been limited both the response to the call for proposals and those that we were able to select as sights. In many cases, in preparing an application and then presenting it to the Federal agencies, we realized that the barrier they were encountering was not rooted in Federal policy but rather in State and local policy where sometimes there was a perceived barrier, but not an actual barrier.

The waivers that were requested were modest, typically just wanting to make kind of a marginal change in the use of funds. We also discovered -- I think I most

want to emphasize this -- that waivers were not what was most critical. The inflexibility was not what was most inhibiting States and localities. They realized and we realized that often they needed more federal guidance, technical assistance, resources to be sure, evaluation capacity, that sort of thing.

So, once the waivers were granted, that was not sufficient to really empower them to often make qualitative changes and improvements. The Federal process for reviewing these flexibility requests and granting waivers was significant. We had to go through a thorough legal and policy review across all the effected agencies to negotiate with States and localities regarding the scope of the waiver, to develop new performance metrics and put in place more active performance management to insure transparency both the Congress as was required in the Statute and also to the public explaining why we're waiving this requirement which was put in place at least initially with good reason and to insure that various protections were in place, including the appropriate use of funds.

All of this was very staff intensive just to do a handful of sites across several rounds of P3 projects. So, that's the caution I'll emphasize at the moment, that P3 was an instance in which we had statutory authority for significant flexibility. We had genuine leadership commitment and staff engagement across multiple agencies. We promoted it actively to States and localities and still, the uptake was limited. The interest was limited. Where there was interest, it's been discovered that it was perhaps what was most needed.

Now, these are sort of preliminary observations. Most of these projects are still underway. The formal valuation is forthcoming. But we've learned a lot already. At least this initiative and other sorts of funding flexibility.

MS. WILKNISS: Thank you very much. Amy, do you want to talk a little bit about State and local connections?

MS. CLARY: Sure, I'd love to. Thank you. So, it's great to be part of this panel and this event today. One thing, in talking with the State officials that I have the honor to work with, that we hear frequently is that braiding and blending funds is seen by the State

officials that we work with as a strategy to build and sustain their programs and should not be seen as a replacement for adequate and robust funding of those programs. So, I just wanted to flag up front that that's something important that we often hear. That said, the idea of braiding and sometimes blending funds across sectors is critically important as we've heard from all the speakers today.

One of the areas in which we see this strategy coming to the fore is the intersection of health and housing. So one State example that I'd like to highlight, and again the experts on these topics are the State officials, the real people who are doing this work. In Louisiana in the aftermath of Hurricanes Katrina and Rita, they developed a permanent supportive housing program that was the beginning of a long and fruitful relationship between the State housing and health sector agencies. Through working together, they were able to build the kind of trust for one thing, allow the housing side to do health side to do the services part of permanent supportive housing. So, really working out how each sector can play to its strength and not get in each other's way. We've been braiding funds on the housing side, both HUD funds and State funds to do the vouchers and capital construction.

There's also a lot of braiding of funds on the services side through a variety of CMS waiver funds through the Medicaid program, plus some Sam Sess and some Ryan White, some other funding, also coupled with community development block grant funding in clouding some from the DBG disaster funds at the outset of the program and what we've heard from the State officials, in addition to the importance of making those relationships is that having those braided funding streams gives the program resiliency so that if a client, and of course, this is all about the person who needs the services and needs the housing to live a healthy productive life. If something happens to that person's paperwork to cause an interruption in one of their funding streams, in Louisiana the permanent supportive housing program can often work behind the scenes to temporarily use a different funding stream to keep the continuity going and so it's a lot of work and it sits an ongoing and really interesting

program to watch, but it really has a result for the people they are trying to serve. So, that's a fascinating example.

Another quick example, we've heard a lot about braiding and just an example of actually blending funds that I've heard of and we've got plenty of experts, I'm sure, even in the room here, is the Virginia Children Services Act initiative where in Virginia they are able to actually pull some State funds from State child serving agencies and use those together with braided federal funds and the thing that struck me about that program that the way it was explained to me by the folks again actually doing the work is that that system of pooling funds and then braiding some other plans that actually meets the need of the individual child or a family, instead of delivering the services that that funding stream wants to pay for and so that's for me a terrific example of how that can work, but that's not to say it's easy by any stretch.

Just quickly at the outset, another example -- and this came to my attention more recently. We just recently did a case study on Lawrence, Massachusetts, and now I'm with the National Academy for State Health Policies. So, you might be wondering why Lawrence, Massachusetts, but we have at NASHP a work group what looks at hospital community benefits investing and policy, and I heard from State officials in Massachusetts. I heard look at Lauren's and what's been going on in Lawrence is the city's mayor help pass course is breeding funds from a range of sources and forging this -- I mean, they are just a juggernaut of community partnerships doing all kinds of upstream prevention. They're using funds from the hospital in the area, philanthropic funds, State funds, Federal Funds, and braiding them to do this tremendous work, but the State policy angle is that you've got on the one hand, the Massachusetts AG's office, who recently came out with a new revamped nonprofit hospital community benefits policy guidelines that are in line with the State health improvement plan, State health priority guidelines, the Public Health Department in the State oversees the Certificate of Need requirements for hospitals and the State Medicaid program mass certifies Medicaid ACO's and rewards them and encourages them to reward

population health activities that are also in line with those State health priorities. All of those factors led to the hospital both making these really community guided investments that were identified through the community health needs assessment.

Also, the mass health ACO, there's an ACO now in Lawrence that involves the hospital, the Mayor's Health Task Force and other community partners. So, all of this is to say that braiding and blending is not just about breaking down silos across agencies. There's a big vertical component to it as well, where meaningful, aligned, thoughtful State policies can really be the catalyst for action on the community level.

And as we heard from our Federal partners thinking the same way, that Federal policy affects State policy as it affects local. So, really tremendous excitement and opportunity out there.

MS. WILKNISS: Terrific Segway. Go ahead, Sue.

MS. POLIS: Thank you.

MS. WILKNISS: Bring us to the local.

MS. POLIS: Thank you. We didn't really totally plan this, but I think our remarks hopefully you'll see as complimentary. Again, it's a pleasure to be here. I'm with the National League of Cities. We've been leading a series of conversations with mayors on social determinates of health, exploring housing, the link between education and health, opioids, just a whole myriad of issues. We keep encountering with our cities in this work these barriers, particularly getting funding working at the community level where the needs really are.

We approach this work in a broader framework. Braiding and blending is a strategy that we encourage our cities to use, but what we're really finding with our cities is we have to set a table. This is first and foremost about identifying the needs in the community, finding the shared value proposition, bringing partners together. That is really the first step. What we piloted it are now taking the scale is an effort that we're calling cities of opportunity and I'm mentioning this because while financing is a piece of that, if you don't

have the table set to really help cities work across their respective agencies, we're not really going to make the progress that we need to make.

Cities of opportunity is really about helping cities better leverage all of their assets across city departments. We've had 12 pilot cities working in this initiative. New Orleans is one and I want to just bird dog what Amy was saying in that New Orleans is benefiting from some of this. They are one of our cities that are further ahead with braiding and helping residents connect with services. The door there is largely through their low barrier homeless shelter. That has eased and I think that is an important story.

In contrast, Lawrence, Massachusetts, we just had Mayor Rivera with us as part of our mayors' institute on affordable housing and health. While there are some great things going on there, they just don't have enough housing. They have a very high immigrant population. While these things are working, it's not enough to just look at them in a narrow context. We have to help our cities with strategies across the board in this regard. I think Lawrence is a great example, but I'm trying to make the point that it's just not adequate for the needs as well. So that's why we take this broader context of cities of opportunity.

We have to be agnostic at the National League of Cities. We don't prioritize breeding and blending over community health needs assessment using community benefit, or other financing strategies. Our role is really to put all these considerations ahead of cities like pay for success, pay for performance. We try to lift up all the ways in which cities are doing innovative financing.

Boise is a great example of the city's leadership role in convening all the right partners, prioritizing homelessness, working toward pay for success, which actually ended up being paid for performance because they couldn’t quite get all the way there, but it set the table now in homelessness building more housing for homeless. Now, they're able to carry that through on other priorities like pre-K. We're really trying to help our cities work across these different issues.

MR. NICHOLS: So, what makes life exciting for the private sector? I would

to say the truth is that so many people are talking about social determinates of health. In fact, I would say, so many people have finally discovered social determinates of health. I would go so far to say economists have even discovered social determinates of health, but of course, we're imperialistic enough that we think we invented this. We were the first to bring math to it, but anyway, we're doing this.

It turns out, of course, social workers and public health nurses have known this stuff for about 120 years. So, you know, who knew, but anyway, we're working on it.

I think the key learning opportunity actually in the health care sector was the readmission penalty and the Affordable Care Act because the readmission penalty is a very serious hit, like 3 percent of Medicare revenue which is big. It's going to hit you if you don't get your readmission rate down and of course, most of the country was pretty high. That had the effect of making 4,000 hospitals pay an awfully lot of money to a whole bunch of consultants to tell them the problem is not inside your walls. The problem is upstream. Upstream, what is that. So, they started talking with these social workers. Next thing you know, they're looking upstream and don't have refrigerators for their insulin. Right? People can't get to the appointments because they don't have transportation. People are eating real crap, if they're eating at all. So, there's a whole bunch of stuff we could do relatively cheaply, oh, my goodness, to save us real money.

On the second learning opportunity, health plans. Let's look at dual eligible. This whole business of expanding Medicaid also bright an awful lot of frail elderly suddenly and their managed care plans who are now at risk. What a concept. Economists did invent that and so this whole idea of now, oh, my goodness, now I'm supposed to manage these people and they're not like these people I've been dealing with before. I've got to go upstream. There's a tremendous amount of learning with financial incentives involved which gets me back to why all of these folks have led to me. That is, there is not enough money over there. You need the private sector too.

It turns out if you can link the self in trust of the major players and the

private sector with the social interests in reaching upstream, there's a collaborative win-win here. That's what we've been working on for some time now.

MS. WILKNISS: Thank you. I'm going to stick with you, Len, because you really set the table, as Sue actually said. People are eager to learn more about economic models that might be implicated here. I know you have been thinking about this a lot, the wrong pocket problem and writing about most recently, the pubic good strategy. I'm wondering if you can just, in a nutshell, try to frame that approach for people in the audience.

MR. NICHOLS: Okay. Thank you. Basically, there are 3 elements to what we brought to this conversation and I want to make it clear that I would not be in this conversation were it not for my co-author, Lauren Taters. The first trick is to find a really good co-author. Lauren, just to give you 30 seconds on her background. How many of you have heard of Elizabeth Bradley? Yeah.

So, Bradley did the original work showing that countries that spend more on social spend less on health. Lauren was her undergraduate research assistant. All right? Lauren was so smart; Betsy got her an MPH in one year. Lauren's boyfriend gets drafted by the Kansas City Chiefs. She goes to Kansas City, pretends to be an NFL wife while she edits Betsy's book. She did such a good job on Betsy's book that Betsy made her co-author, The American Healthcare Paradox, Taylor and Bradley.

Then Shane gets cut, but he lasted 2 years more than 3, so I'm still impressed. They come back to the East Coast. She goes to Harvard Divinity School because she wants to change the world. So, she finished Harvard Divinity School. She can marry you and bury you, but it turns out people who finish Harvard Divinity School don't actually preach. What do they do? They try to change the world. So, what does she are about? She cares about health policy. She is now in Joe Newhouse's program in the medical school doing health care policy. David Color is her advisor. The world Is a very small world. I met her at a conference 3 years ago and I said, oh, my God, she was speaking for Betsy. I've got to meet this one. So, I go up, and I say, hello, hello. I say, can

you teach me this stuff. She said, well, maybe. So, over a while. I said to her, you teach me social determinates. I will find us an economic model to incentivize and invest. I had no idea if I could do this but I knew she could teach me social determinates. So, it turns out.

There are 3 real key things here. One is thinking about social determinate social deficits as public goods. That is to say, if you solve it, if you invest in it, it will benefit more than one person at a time. That fact -- think about it -- if you actually help the person, not come to the emergency room a lot, it will help both the hospital and the health plan. Right? So, you've got multiple beneficiaries. That creates what we in economics call a free rider problem. Every hospital knows where the homeless are. They could put a nurse practitioner out there this afternoon and do a whole lot of good, but it would also help Hospital B and C. Therefore, they don't.

So, it's a free rider problem. Turns out, economics has a solution to the free rider problem. It was buried in highly mathematical General Equilibrium Theory in the 1970's, but also turns out that's when I went to grad school. I can read this shit. It's amazing.

So, I find this model and it's complicated, but it's got a little bit of gain theory, a little bit of observe theory. It's not that complicated. If I can understand it, trust me, it's not rocket science, but this model turns out to link the self-interest of those who would benefit from the intervention of the social interest of the intervention in such a way that they actually gain financially. Now, it's not going to solve every problem. It is not actually for every community, but go back to the readmissions crisis, add to it what we spoke about this morning, the opioid crisis. The key elements of making the model work is actually not the math. It's actually trust. It's actually a stakeholder coalition. These stakeholder coalitions have come to exist precisely to solve the readmissions problem because you can't solve it one hospital at a time. You've got to solve it together.

And the opioid crisis. The opioid crisis is like a poster child for social determinates of health. It's brought these sectors together. Therefore, all we need to do is to

get in the room and lately, with incredibly creative financing from the Commonwealth Fund, from the Episcopal Health Foundation, from Missouri Foundation for Health and now the California Health Care Foundation, we're going to get to teach this model to the country and we're quite excited about that.

Lauren will be right there by my side because she's the--

MS. WILKNISS: Well, we can invite her next time.

MR. NICHOLS: Yeah, you should. You should. But I promised David I would only take 15 hours a week. So, you've got to limit the time.

MS. WILKNISS: Okay. Fantastic. Thank you all so much for your reflections. My next question was going to be that people often refer to braiding and blending as just an accounting problem. What's holding us up for doing it more routinely? I feel like through all of our panels, we have a really good appreciation for what's holding us up. It's people, places and things essentially. We're going to try to digest that more and come up with some more policy strategies going forward.

What I want to do instead, with, I think we have a little bit more time going forward for our panelists before we open it up for a Q&A is just again, with an open-ended question. With all the lessons we've learned and the comments you've made in all of your areas of expertise, what is the next step? What can we be doing on the Federal level, State, local level, private sector, to take the next step, to really allow some of these braiding and blending initiatives to flourish, to really invest in a productive way in the determinacy of everything? Anyone want to take first stab? John?

MR. TAMBORNINO: Sure, thank you. Well, regarding P3, we've had discussions with the field regarding how something like that should have all given the lessons that we've learned, the potential for scaling it, to a greater number of slides, potentially nationally or scaling it to new areas outside of disconnected youth, and doing so, with realizing what I was emphasizing that capacity is equally important, sometimes more important than the issue of flexibility.

Another new initiative I'd like to note that is building on lessons and will provide many lessons, hopefully, is new legislative that I'm helping to implement the Social Impact Partnerships Result Act, SIPRA. That was enacted last year. SIPRA allows us to pilot a pay for success funding model that was referred to earlier. For those not familiar, on a pay for success funding model, the government is waiting to pay for whatever the program or service is until the end, when it's clear that the program or service has been successful in achieving the desired outcome.

In the original model, there was a crucial emphasis on government savings of implementing whatever government service that would lead to improved social and health outcomes, but also produce government savings through avoiding the sorts of things we want to avoid. In doing that, providing a surplus, and that surplus would be providing the funding that would allow paying for the initial expenditure. That up-front funding would often be provided by private funders, whether philanthropic or investors.

SIPRA provides flexible funding to supports these kinds of models across states and localities. It provides 100 million dollars available over a 10-year period. For projects across twenty areas effecting low income and disadvantaged persons, many of which would be amendable to the sorts of focus and strategy with helping whose funding's, many sorts of focus and strategies that we've been. Cipro is administered by the Treasury Department in cooperation with 9 other agencies and O&B is involved. Again, we are awaiting responses to a funding availability announcement that's pubic right now.

What I would want to emphasize for this panel is that SIPRA provides a unique opportunity to have very flexible funding, to have a much longer period of time for our project and to observe outcomes. Therefore, to be able to think longer term and to observe outcomes over a longer period.

In particular, it allows us to test the proposition that we've all been emphasizing, that we can improve health and social outcomes by being able to more flexibly and strategy use resources and in doing so, not only achieve these outcomes but produce

government savings. So, SIPRA requires rigorous evaluation and accounting of the outcomes of these projects and very carefully costing out where the savings accrued across federal, state and local levels of government and allows us to just recognize those savings across perhaps 12 different domains, whatever, 20 domains and then have this flexible funding that's used to pay for the service, sort of in a way that reflects the savings that were realized in this scattered fashion across silos without having to capture them. So, it's a real opportunity to test what's been emphasized. The statute is very specific. So, there's all kinds in ways in which it wouldn't fit a community or particular project, but nevertheless it's a real opportunity to innovate and evaluate in this space.

MS. WILKNISS: Thank you. Amy, you want to jump in?

MS. CLARY: Sure. Just a couple of thoughts on where things are going, we've been seeing a lot of exciting work in states unaccountable health entities and that's a term we use to describe a whole spectrum of different efforts in states where Medicaid and public health offices along with some other state partners are working together to really listen to the needs of communities and address them in a variety of ways. Some states are taking a pretty, kind of Medicaid concentric approach. Other states are working from the communities up and building those, but it's a lot of the issues we've heard about already today, the need for strong community partnerships for, data and data sharing, understand across sectors. I think those kinds of entities are -- they lay a really important groundwork for this kind of braiding and blending work.

Also, just thinking ahead, I wanted to note that we had recently done an analysis of some governor stated that state and inaugural addresses, so with the support of our partners at the Beaumont Foundation and in addition to hearing governors address things like education and jobs and all these really important determinates that one might expect. We heard a lot of governors talking about climate change and a lot about housing. I think all that is to say that as we're thinking out the future of improving health by addressing social determinates through braiding and blending. I think starting to think outside the panela

of social determinates of addressing and thinking more globally literally about things like climate change, I think will be on the horizon.

MS. POLIS: And just to piggyback again off of Amy's comments. At the local level, a lot of our emphasis in the work with cities across, again, opioids, housing. A lot of our emphasis is helping them be in more conversations with our relationships and some great examples, those are the exception, not the rule of why we can work with cities on things like healthy housing and of lead and asthma trigger remediation. To really ease those burdens, they have to be more in connection with their State Medicaid agencies. That's really where the relationships don't exist at the city level, so we've been trying to be much more intentional about our work with the National Governors' Association, the National Conference of State Legislators.

We have to help our cities build more of these connections and partnerships because they are often feeling like they're left out because when those decisions are made at the State level. It's hard sometimes for our cities to get the funds where they're needed and the community to address the needs. So, without those relationships, it's very hard to navigate that. Our quest here is to help facilitate those partnerships for cities. I think the last point about health care entities, a lot of our small and mid-sized cities don't have health departments. They have to work with the county on those efforts, but they also are oftentimes overlooking the other health stakeholders in the communities, the hospitals, the health plans. And so that's another big emphasis for us is really helping ease those conversations, getting those partnerships in place and so, as we think about cities of opportunity, a lot of our early emphasis has been on inviting a lot of our health stakeholders into those conversations with our cities to really begin to ease and build those relationships.

MR. NICHOLS: And the good news is those conversations are paying off. I would have to say there are a number of policies of this administration, I'm not a fan of. The ones that I am a fan of are the flexibility they are granting to Medicare advantage plans, to MCO's and to States. I look at what's going on in North Carolina right now. This is the best

1115 in the history of 1115's now. Jenny will yell at me. I probably shouldn't have said that. She knows about all 1115's. I just know the ones I like, but I do like this one a lot. I like it a lot because they basically are going to allow Mindy Cohen in North Carolina to actually spend money on housing.

MS. WILKNISS: Can you say a few words about what they're doing in that waiver?

MR. HOTCHKISS: So, essentially, the idea is they are giving North Carolina unprecedented involving freedom to direct resources through their new MCO's. Why not? Let's do Medicaid managed care at the same time. But anyway, that's useful because it has the vehicles of plans who know what they're doing in this space, as opposed to some other people. So, the plans are allowed then to petition for and actually spend money on a number of domains that we would call to be determines That we would call social determinates in ways they have never been allowed to before.

Mandy has a process in place and I will just say that the amount of freedom that she's got is unique in nature and everybody's watching, because just like John said, we've got to evaluate this in a serious way. We've got to make sure that we learn what works and what doesn't work and why it did and didn't. But even that doesn't go far enough. Yes, she can spend money on housing, but she can only spend deposit in the first month, which is nice, but what we need to do is a little bit more freedom and let's let Medicare Advantage do the same thing. By the way, what about fee for service Medicare? That's where you think about where we really need is for this creativity and this vision to spread and then hold us accountability at the local level to show exactly what the outcomes were. Not every experiment is going to be perfect. Not every experiment is going to pay out, but we're going to learn stuff in those experiments and we've got to have that experiment. We're so close. Why not let it go all the way to let what people at the local level thing? The key to our model, the key to all of this stuff, in my opinion, is the local stakeholder coalition of -- I love that management group they've got over there at New Hanover with the British accent.

How did they pull that off? But anyway, the local people have to decide where's the best way to spend our money this money, our total pot of money, whatever braided, blended thing you've got up.

We've got to figure out how to do this ourselves on a project we care about with people we trust. That's the way this is going to work. We're so close and we're making progress. A little more freedom will make it happen.

MS. WILKNISS: Any other reflections on that? What can we be doing? Even if you want to shoot back, instead of saying in your domain what you think is on the horizon, what should your partners be doing? So, from this State and local, what should the Feds be doing and vice versa?

MS. CLARY: You know, I worked primarily at the Federal Level for a really long time. So, being at the local level is a whole different view of this world. I think as we talk to mayors and city leaders, these issues are in front of them every day. They don't have the distance that we have here in Washington, D.C. While I think there's a lot of good things happening that we can build off of, it's only as good as people knowing about it, and it's only as good as people being able to operationalize it. I think more opportunities to help local communities set the table. I mentioned that earlier, but I think don't assume folks always know these things. We spend a lot of time on technical assistance. City folks are pretty busy. So we boil this down to pretty nutsy bolts research briefs.

Once they're aware of it, you can begin to operationalize it, but I think awareness is still lacking and I think that's part of all of our jobs, not assuming that we do want the locals talking to our states and we do want to facilitate that, but I think it has to work both ways. Some better collaboration around bringing state and local leaders together is something that we've been talking about within CSL because I think we're assuming too much. Folks are busy and have day jobs and I think that's part of what we need to do, is facilitate those relationships because they don't happen automatically.

MS. CLARY: I think one thing I would say for partners to consider is just to

first of all, to recognize the importance of Medicaid's core mission, the social determinates part is super important but also the fact that Medicaid with the budget they have in every State has to provide care to all the people who qualify for it. I guess just being sensitive to, when you're talking to your colleagues in State Medicaid offices, being sensitive when they have to protect their core mission while still doing a lot of really innovative work to address social determinates. So, acknowledging that Medicaid is important and also taking the time when you're speaking across sectors and across levels of government, to take the time to explain what you're talking about when you say data sharing, if the other person doesn't really understand the elements in your data dictionary, just acknowledge that it's okay not to know those things. If you have those trusted relationships and the time and capacity to engage in that kind of learning, that's an important step.

MR. NICHOLS: I spend most of my time thinking about the feds should do, actually, right at the states' locality, so I view much more sympathetically. I think the one thing I would emphasize is when you're dealing with Federal policy and many of you well know this, you really are having to think on that level, a national level, thinking about what good policy would be overall and often there might be a request by some locality to have some flexibility that in isolation makes sense, but at the federal level, you need to be thinking about precedent essentially and the extent to which that would make good policy, nationally, and not just thinking about the ways in which that would be conducive to a better performance in that instance, but the way in which it can cause problems in other instances. Of course, the point of a waiver is to be able to do something in a more isolated way so that's an important mechanism, but just that. There is necessarily a different vantage point at the federal level that has to be thinking beyond that particular project that even though it may very well make good sense there. I think also I'd just make the point that I appreciated the earlier panel was emphasizing the initiative that States and localities were taking. That's good. Continue with that. Often, as I said, barriers are not actual. They're perceived often. It just takes the initiative and creativity to really press something. It's the responsibility of the

Federal agencies to respond as constructively as possible to that. Again, keeping in mind a larger set of concerns, that inherently extend beyond the concerns of that particular locality.

MS. WILKNISS: Thanks for revisiting that notion of perceived versus actual barriers. I think that is a real challenge on all levels of this conversation and something that we should revisit, but I want to make sure that we have time for folks in the audience to ask questions. So, let's go ahead and open it up and we have microphones coming around. We have 2 people over here in this section. Thank you.

MR. DATUK: Hi, my name is Alex Datuk. I work for a group called FAHE which works in central Appalachia in 6 states. We are based in eastern Kentucky. I wanted to ask-- and this kind of goes on the preceding conversation as well, with Pamela Brown. I don't know if she's still here, but that conversation about how there's sort of culture and policy of compliance where we spend and we see in lower capacity areas like in parts of some of the smaller towns in Appalachia for example, or communities that have lower capacity, just less ability to kind of thread the needle on all of these complex things. So, I'm wondering for the folks up right now -- I was going to ask this of the last folks too. How can we get more back to a values of where we want to invest in people and places, rather than exacting compliance on community health and social determinates which tends to be sort of bringing up the people with the least resources and lifting up their health? So, I raise it more as a values conversation, rather than a policy conversation which I think we probably should be talking more about. Thank you.

MS. WILKNISS: That may be a tough one to respond to, but what are some of the policy strategies to get back to, to values. Is that a fair --

MR. DATUK: I guess what I'm thinking is I would like for folks to think about what they see needing to happen in terms of whether it's a political conversation, like in my -- we work on housing, for example, as part of our group, just to clarify it, and it's 1.1 billion for this housing program or 1.3 every year. That's just really not enough. Right? So, social determinates are not being invested and so we can fight about 1.1 or 1.3. We can fight

about the funding strategies. I'm just asking you, I guess, to take a step back and think about the values conversation behind the policy a little bit.

MS. WILKNISS: And maybe realign policy and financing, funding approaches to reflect those values.

MR. NICHOLS: I'll just jump in as Thomas jumped in, anything. I would say, look, I think what you're talking about, at least what I heard, is how to make outcomes relevant to the compliance activity. You can't skew the need to have oversight and accountability. We both agree to that, but your point, they're filling out forms -- and Pam made the point too. They're filling out forms and doing all this stuff, terrified of being arrested when in fact -- so, I think it has to do with being very precise about what we want to measure, about what we want to hold results accountable for and just focus on that and focus less on a lot of stuff that we have to do. I think that's the key to under resource organizations. It's also the key to much better, I would say, alignment between values and actually the way we're spending our money, but it has to do with being precise and creative at the highest level of what outcomes do we care about. That's what I would say.

MS. WILKNISS: I'm sure this is not a new balance that we're trying to strike, so anyone else want to weigh in? Yes, go ahead.

MR. NICHOLS: Yes. If I could, I think I'm respectfully disagreeing with the economist perspective there, though on other grounds. Also, in response to the question, I think I would reformulate what I'm understanding the question to be, and that is to contest the -- refocus on values and focus on compliance itself is inherently antithetical. It's clear, I felt before I arrived this morning. I'm even more persuaded now, that excess requirements and a focus on monitoring and compliance can be stultifying and you lose sight of the purpose. That's true, but compliance and requirements and restrictions means a number of things. It means the targeting of funds appropriately and categorically as we were talking about earlier. It also means protections, whether protections for individuals, it mean thinking about the constitutionality and the legality of the means being used. This is front and center

in President Bush's faith based and community initiative where the argument there, the initiative there was to make it easier for a faith based organizations to provide social and health services, the argument given -- part of it was a free exercise argument, but partly the argument given was that they often achieve these excellent results, and therefore we should become more agnostic regarding the means used.

You had programs like the Prison Ministry Fellowship that involved worship. They're saying, look, we reduced recidivism. Ignore exactly what goes on in the program. Well, what was going on in the program was religious worship. That's not to say that shouldn't be going on in the program or in the prisons, but the question is should federal dollars be used for that. The objection that largely prevailed was to say no, even if that gives results and excellent outcomes, those aren't inappropriate means for the government to be funded, given the constitutional prohibition on establishment of religion.

Perhaps that's a more extreme example, but it's by no means unique. I can think of other kinds of instances where these restrictions and requirements in some level of compliance and monitoring is partly in the name of values and partly in the name of very important moral principals that need to be limiting what we do and an inclusive focus on outcomes, I think, is very problematical. I really appreciated the nuance and all the discussions this morning. Often, I come into these kinds of discussions where there's a focus on outcomes and it becomes quite simplistic, I feel.

There is this argument that we should be fully agnostic regarding the means used to achieve the ends and just focus on the ends. Just on basic philosophical grounds, that's problematical really, to only be concerned with the answers that any means to achieve them are justifiable.

The final thing I want to note, and this is again just more of a government perspective, in terms of the need for ongoing compliance and oversight, some of which is going to be fairly extensive, is responsible public stewardship of funds involves using them appropriately, of course, but appearance matters. If funds are being used in a way that

appears to be frivolous, that can really undermine the public's confidence in a program and we see examples of hat. When GSA notoriously had a staff training and they brought in a comedian and a juggler and a bicycle mechanic and a clown and some other sorts of things -- is that our next panel? That was seen as an outrageous abuse of funds. It could very well have been an excellent way of producing a higher staff morale and therefore performance, but it was seen as so egregious from the public's point of view that it was an unwise use of funds. I could go on and on.

Again, I'm absolutely recognizing my colleagues and I recognize the need to shift to more of an outcomes focus, but when I could simplify to the point of saying can't we just dispense with so much of this monitoring and oversight and so many of these constraints, I think that becomes problematical.

MS. WILKNISS: You've clearly hit a very important topic that I think deserves a lot of exploration. Maybe the time is right maybe to revisit these conversations and also figure out practically what the implications are. Let's just take a couple more questions though too before we have to end.

MS. HOLLANDER: Great. Thank you. I'm Cheryl Hollander from the American Hospital Association. I spent most of my grad school days reading things you wrote, Len, so don't sell yourself short. You're a celebrity in your own right.

I wanted to just revisit that Medicare fee for service population, a question for all of you, but John, maybe you have a little bit of insight info on CMS's primary care initiative announcement and especially the geographic population-based payment model that they're looking for comment on. I'm just curious whether you think, some model like that, incentivizes the total cost of care risk, will actually or can actually create space for addressing social determinates, whether through braiding or blending or some other means or what you think about what sort of levers need to be pulled to really set that model up for success.

MR. NICHOLS: Well, do you want to talk?

MR. TAMBORNINO: No, please.

MR. NICHOLS: Great question. It does continue to raise the debate between John and I which will probably go on for the rest of our lives, which is good, but I think the model does have great promise I would observe that at some level you can trace that geographic version of the variant of it to a proposal that came through PTAC which I happen to sit on from the American Association of Family Medicine Hans. So, there are people really thinking hard about how to incentivize the ability to go and empower, the ability to spend upstream. Both God and the devil live in the details, as I think we are debating here. You got to have both present to make this work. You've got to make sure that there's enough money and that total cost to care bundle to actually do something n a serious way, but it is absolutely the right level in my view of focusing on accountability and outcome so that we can accomplish the objective. It's the right vehicle through which to drive it.

MS. WILKNISS: John, any thought?

MR. NICHOLS: Obviously he had one.

MR. TAMBORNINO: I'm no longer sort of active in the Medicaid space, so I don't want to speak to that. I'll get something wrong.

MS. WILKNISS: Okay. We have time for one more quick question. Go ahead.

SPEAKER: Thank you. I represent the dreaded Federal government here, but not an entity that works on the health care issues at all, except for funding facilities. We fund hospitals and with the Royal Development Missionary of the U.S. Department of Agriculture. I have one comment and one question.

To what the representative was saying, I think we're talking about improving health care by addressing housing and education and clean water and those sorts of needs, it almost seems like we're trying to hold our nose the other way around at the post advocating for adequate funding for housing and education and clean water and so on. I think that's kind of what I heard from the FAHE person.

My question is in the rule context. How did these models work? I heard folks say engaging hospitals and helping meet the housing needs and so on to make them more affordable. As you know, there is a crisis in rural America with hospitals closing. How does it work to have the community --?

MS. CLARY: I think we just did a convening with the HH office of faith-based neighborhood services on recovery around opioids and trying to figure out this. For folks in substance use and mental health and homelessness, experiencing all these things. These things are often connected, as we know, and from the values standpoint or question, I just wanted to sort of say again, these issues converge in communities. I think we were talking about Huntington, West Virginal a little bit when we met. Where we have really strong local leaders, this is a mayor in Huntington who was in finance in Chicago and went back home because he left like he could do something about it and has been able to really bring a variety of funding streams into the community to try and make some progress on this issue of opioids. These things don't live in isolation in cities. They are all connected, but I think three's also limits, to what cities can do with these Federal funds because they don't stretch to meet the needs of their communities. There has to be better recognition of that. Again, it's not all about outcomes to your point, but there has to be some better recognition that these are the same people experiencing these different things. I think that's just often overlooked. World communities, we've been talking to the world health association trying to figure out where we have some common interests to bring local leaders from rural communities to gather, noting the hospital shortages. We are hopeful that there is more that can be done with community health workers and social workers and things of that nature, but it is at the end of the day, like with the faith-based office and that conversation. Who is in the community? And so, a lot of time it is churches and it is that community that will bring in homeless people and take on that population

But how are they reimbursed for some of those services? So, with the HHS convening, I think we're hopeful that there can just be more collaboration between faith-

based leaders and city leaders to meet some of that need, but it is the same population experiencing these things and the funding storms that is sometimes needed to adjust these issues.

MS. WILKNISS: Thank you. I just want to acknowledge that we are a little bit over time, so we're going to have to cut it short, but I am happy to follow up with you with what's happening in rural frontier states. We're doing a lot of work there and I am happy to share that information with you off line.

I wanted to thank our panelists for a really dynamic conversation and obviously more to come. Thank you all for your attention and for your great questions.

MR. BUTLER: Let me also thank the panel and just say that when you raise a question, why don't agencies just work together to make things happen. I think we've learned today; this is easier said than done, but there's a lot of real interesting things going on around the country to actually make that happen. There's a lot of policy steps that need to be put into place and to be improved upon to make it happen even better. I work in this area in Brookings continues as does the work of other people around the City and around the country, some of whom you've met today who are working in the same areas. So, it's an ongoing thing. You've got a sense of the flavor of the kind of conversations we've had here at Brookings over many, many months about these same issues. This meeting is being webcast now and you can look at the panels later on if you wish and go back and relive some of the moments by going back on our Brookings site and looking up event. On that events page, you will also see a link to a web site here at Brookings which also contains the publications, including blogs that we've been doing in this area. I certainly encourage you to have a look at that.

I want to thank everybody who made this possible. I want to thank particularly the Johnson Foundation who did make this whole event possible and also the work we've been doing at Brookings and I know the work of a lot of people in this field. The Johnson Foundation is very active in this area, as I think many of us know, not just in terms

of the policy work, but actually helping to start up some of the things around the country that is happening. I know they are the leading edge. It's been very important to that work.

I also want to thank all the panelists who took part too and also the working group. The working group included the moderators and some others on the angels that helped pull his together and help us together. As we end, I'll ask you to do 2 things. One is as you leave here today, go tell other people about this issue. Get this excited about braiding and blending. It's probably not at the top of their immediate areas of gratification, but it's something they should know about and be aware of, particularly in the policy field. If you know somebody who works for the government, people who work for the agencies, please direct them to that events website that I mentioned, that will allow them to look at this and also allow them to see the other work that we're doing.

Finally, I just want to ask you to join me in applauding everybody who took part in this today. They will be around for a few minutes, so if you had questions, you'll have some of those answered. I'd just like to ask you to give a round of applause for everybody who took part in this. Thank you very much.

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