Public Health Institute Web Forum
The View is Worth the Climb: Health-Sector Leadership Strategies to Address Social Determinants
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>> Hello and welcome to The View is Worth the Climb: Health-Sector Leadership Strategies to Address Social Determinants. My name is Joanna and I will be running the technical side along with Laura and Tanya. Closed captioning will be available today. Regina with Home Team Captions will be providing real-time captioning. The text will be available in the media viewer panel. Can be accessed by clicking on an icon that looks like a small circle with a film strip through it. On a PC, it's on the top right hand corner of a screen. In a Mac, bottom right hand corner of your screen. In the media viewer window, you'll see the show/hide header text. Click on this in order to see more of the live captioning.

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The recording and presentation slides will be posted on our web site. We encourage you to use social media before and after the event.

We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon, type your question in and hit send. Please send your question to all panelists. We will address questions throughout and mostly at the end of the presentations. We will be using the polling feature to get your feedback during the events. The first poll is on screen now. Select your answer from the available choices and click the submit button. I am attending this web forum A, individually, B, in a group of 2 to 5 people, C in a group of 6 to 10 people, or D in a group of more than 10 people.

Once you are done, click on the media viewer icon to bring back captioning if you are using it.

It is my pleasure to introduce our moderator, Matthew Marson with PHI. Founding moderator. And as usual, it is with pleasure I turn things over to him.

>> Matthew Marson: Thank you very much. Good afternoon and welcome to this rich Dialogue4Health web forum to discuss this critical issue of health to address the social determinants of health. Thrilled we can have a panel that's going to provide such informative information that will shape our understanding of the way -- the impact on health and life span and health outcomes is greater than ever. And such healthcare leadership is a critical partner to ensure success. Thank you for joining us. We're going to have a wonderful discussion. I want to thank the sponsors for on-going support for the series. We couldn't do this without all of these organizations. The American Public Health Association, Prevention Institute, Public Health Institute and Trust for America's Health.

I also want to thank those listed on the screen now. I won't go through all of them. We appreciate the support for this series and show casing the information with networks and members.

We're thrilled to have this really leading -- panel of leaders today to discuss this issue. I want to introduce now each of them. First, someone who is familiar to many of you who have participated in prior Dialogue4Health web forums, Dr. Kevin Barnett, who is a Senior Investigator at the Public Health Institute and workforce diversity for over two decades, hospitals, government agencies and Stakeholders across the country. Thank you for joining us, Kevin.

Dr. Bechara Choucair is Trinity Health's senior vice president where he works with Trinity Health ministries and impact the community based social determinants of health. Thank you for joining us. Look forward to hearing from you later.

Anne De Biasi is director of policy development at Trust for America's Health. General strategy associated with the organization's goal to create a modernized accountable public health system and integrate prevention into healthcare delivery and financing system. Thank you for joining us. We appreciate you being here.

And last but not least, John Lovelace has been President of UPMC since 2007 where he provides leadership, direction and administration. Provide -- non-profit care managed organization. Since 2012, he has been President of government programs for UPMC insurance division where he oversees Medicare, Medicaid and the children's health insurance program. Served as the chief program officer for community care behavioral health. A part of UPMC insurance division. Community care is a provider-owned federally tax exempt managed care organization in Pittsburgh. And managed behavioral health to 900,000 members across Pennsylvania. So thank you very much for joining us as well.

An incredible panel. Look forward to hearing from them all. Want to quickly summarize the agenda. We're going to hear from each of the panelists and then have a panel discussion that Kevin Barnett is going to moderate. The View is Worth the Climb: Health-Sector Leadership Strategies to Address Social Determinants. And additional Q and A where we'll have opportunity to hear from you, the audience. I do want to remind everybody about the hash tags. #leadinghealth and #communityprevention. So please join us online in social media as well.

Before we hand over to Anne, I do want to bring up poll 2. How would you rate the strength of existing leadership in your population health improvement efforts within your organization/community/area. The options are very strong, adequate, needs improvement or nonexistent.

Okay. Click submit.

Great. Thank you very much. I'm going to hand over to Anne De Biasi with Trust for America's Health to lead us through the next portion of this web forum.

>> Anne De Biasi: Thank you so much. So pleased to be here today to share with you all some key takeaways and lessons learned from a conference that was held in October 2014 entitled national forum on hospitals, health systems and population health: Partnerships to build a culture of health.

So about TFAH before I start out, most of you on the phone are familiar with us as one of the partners in the webinar series. We are an evidence-based policy and advocacy organization focused on prevention and public health. And for the past four years, we've conducted a series of convening around population health. That's going to inform what I talk to you about today.

And I'm having a problem advancing my slide. There we go. Sorry about that. Okay. So as I mentioned in October 2014, the Robert Wood Johnson foundation sponsored the first national population health conference. And TFAH had the opportunity help organize that conference. At that time, John Lovelace will talk to you today, he was there. As well as other industries including health plans which aren't noted on this bullet but should be. Government, public health and community-based organizations.

The bulk of the conference was organized as a series of moderated discussions where questions were posed to leaders to better understand motivations for prioritizing population health as a key strategy in their organization. So yes, that meant there were virtually no PowerPoints at this conference.

The focus of the conference, as I mentioned, was really asking leaders about what motivated them to do population health in their organizations. We also dug into a number of topics. The resources provided along with this webinar include an overview and highlights of the conference. In this summary, you can find the key takeaways from the breakout sessions that delved into these areas including partnerships that build bridges between public health, healthcare and social services. Innovations to address the drivers of health, otherwise known as a social determine in answer of health. New ways to use and share data, analytics and information technology, best practices for augmenting the workforce with nontraditional workers and connecting patients to social and community services. And emerging payment models to incentivize and sustain population health initiatives. But really, the key question and to the point of this webinar today, why did leaders shift their strategy in operations to address population health? The short answer is the triple aim. Let's unpack that a little bit and dig deeper. Executives told us stories about how they led a shift from the focus on the health of their patients to a focus on the health of their employees to broaden out even further to look at the health of their communities. We also know many hospitals, health systems are considering themselves anchor institutions and using their power and assets to invest in improving local economies. Because a healthy community is a healthy workforce is a healthy economy in the eyes of the leaders.

In addition, of course, there's a recognition of the social determinant model of health and the need for policy systems and environmental change to address those social determinants.

At the same time, with the shift from volume to value-based payment really starting to provide alignment of incentives for leaders to move population health forward in their organizations. And then, of course, for non-profit hospitals, there are the community benefit requirements both for needs assessment and an implementation, a strategy for moving that forward.

So now I want to share with you, given that this conference really brought together early adopters in the field and you'll see in the conference summary that was provided to you in the resources about 40 or more initiatives around the country. And from those early adopters, we learned lessons.

I want to share with you the five key lessons learned.

First, partnerships are all about it. It's definitely population health by the very definition cannot be done by one sector alone. So we have to work together. And while we know that's

not easy, it also has a benefit. And that was something that was interesting for me to hear CEOs by saying by working with other partners and sharing the responsibility for working toward a collective goal, they were actually mitigating their risk. If they were trying to convince their executive team or their board they should engage in something around population health, they could make their case better by talking about the fact they are collaborating with others and thus the responsibility for getting to the outcome wasn't only on the backs of the hospital or the health plan or whatever they led. I thought that was interesting. We know partnership is challenging. A lot of talk about collective impact. But what's important is there are a lot of early adopters out there. There are models of how it can be done.

For the second lesson. Executive leadership support is key to culture change. All the leaders of the conference talked about the fact support from the board and the CEO is necessary. And culture change is slow. It takes time. You have to change from a focus on short-term results to long-term results. Volume-based payment to value-based payment. Working inside your walls to outside your walls. To focus on healing and prevention. And from focusing on individuals to focusing on populations and systems. There is a lot of culture change involved. And every part of the workforce needs to be brought along. The clinical workforce is important, of course. But everyone from the people who work in environmental services in the cafeteria to the clinicians and the administration.

The third lesson was don't forget to evaluate right from the start. So the CEOs really emphasize that good evaluation plans are critical to building support, documenting progress, showing the value and the social impact of these investments, particularly now, when the business incentives might not yet be aligned in terms of the move to value-based payment.

They also talked about the fact that we should use metrics that make sense to people in the field including physicians and other clinicians. So there are a plethora of metrics out there for population health. One project I'm involved in recently looked at field testing communities across the country and found they were using hundreds and hundreds and hundreds of metrics.

So it's not a problem of what to measure. It's really what you want to select to measure. And selecting something that's meaningful to the people that you are working with and the people you are trying to show the value.

In terms of showing the value, it is important to sharing results. And importantly, you've got to share both what works and what did not work. And that's scary sharing what did not work. That was really emphasized by the leaders and the early adopters in the fields.

Another thing they said is the narrative is as important as the numbers. The stories of small success need to be shared along the way because population health takes a long time. We don't get there in a year or two years, usually. We also can use interim measures such as people eating more fruits and vegetables or being more physically active if we're looking to reduce obesity in our community.

The next lesson is that we've got to align the financial incentives to accelerate change. And this was a strong call from the executives at this conference. I think that call has already been partially answered in terms of secretary of health and human services, really putting a stake in the ground about moving to value-based payment systems and incentivizing to invest in prevention. Certainly, this is moving along. We know it's not there yet.

In addition, we need to sustain organizations that work across sectors. As we develop partnerships and multi-sector coalitions in the community and we start to implement population health initiatives, we are going to need to bring together various different funding sources to maintain these initiatives overtime. And even to get them started. So there was a real call for the federal government to be more flexible in regard to allowing states and communities to braid together different funding streams where it makes sense to support their population health initiatives.

That may also require funders to think about consistent outcomes across the various different grants that they give.

And finally, this isn't always about just looking at the needs of the community. We also need to look at the assets in our communities. So the last key lesson I want to share with you is that executives told us we have to tap into the assets that exist in our community and new workforce solutions to better link health and social services with other sectors. Examples of this are the increasing use of nontraditional workers such as community health workers to develop trust, engage patients, coordinate care, educate and connect patients to the services they need. These models are new. So the support systems around them and the policies to sustain them don't necessarily already exist. They are in development. How to train, reimburse and certification, for example. So this is complex and will take time.

Hospitals communicated that in terms of the needs assessment, they are starting to think about how they can map assets in the community so they can tap into those and not reinvent the wheel but build on what already exists. That's great because it promotes community engagement and empowerment of those local organizations and providers.

So tapping into these community assets and sharing data between them to better connect patients to social and community-based services outside of the walls of the hospital is really key.

And those are the five lessons I wanted to share with you. So I'll turn it back over to Matthew and look forward to the panel discussion that Kevin will lead.

>> Matthew Marson: Thank you very much. Really appreciate the overview and the lessons learned. And I'm sure they will be built into the conversation as we proceed. Just a couple housekeeping notes before we get to poll 3. First is a reminder to follow along on Twitter as well. We're using #leadinghealth and #communityprevention. Important we maximize the use of social media. And please do send in your comments and questions using the Q and A feature. This is the opportunity for you to ask questions and make sure that we can have your voice, if not directly but through our panel heard today. So please send in comments or questions through Q and A.

Let's bring up poll 3. What is needed to improve leadership within your organization? A, increased understanding among leadership of the importance of population health. B, best practices, models, examples of leadership approaches that are replicable. C or D. Or E all of the above. If you can please click on your poll choice and submit. We'll make sure we have an opportunity to hear your perspective. What is needed to improve leadership within your organization and community area.

So we're now going to move to the next portion which is a panel discussion and led by Kevin Barnett who I introduced earlier. The way this is going to work is we're going to hear from Kevin who will introduce Bechara and John and then we'll have an opportunity -- they will each introduce their work and organizations and talk about the work they are doing. And then Kevin and Anne will join them and Kevin will lead through a dialogue on these important issues. So that's the way this next portion's going to go. Please do send in comments and questions using Q and A as well. With that, Kevin, over to you. Reminder to unmute yourself. Over to you, Kevin.

>> Kevin Barnett: Good afternoon, everyone. I'm absolutely delighted to be participating in this webinar and have the opportunity to engage two dynamic leaders in this regard.

I'm going to offer a few initial comments to help frame the conversation that we're going to have. And I will start by noting when I started doing this work a little over 20 years ago, I had the real pleasure of working with a good number of people across the country in hospitals that are passionately committed to the kind of work we're talking about. But in most, if not all cases, they tended to be in fairly marginal positions doing good work but on relatively small scale. And generally disconnected from the core business from the hospital enterprise.

We're now at a special time in the history where thanks to the Affordable Care Act and the general recognition we have to change the way we do business. That increasingly our hospital and health systems are hiring people with the appropriate expertise and passion to be

a part of their senior leadership team. And many organizations are also bringing these kinds of individuals on their boards as well.

And I've experienced this in so many situations in the last year. The conversations are shifting. And there are challenges given the sheer scale and scope of the changes needed. Many organizations are drinking water through a fire hose. And recognizing they have to begin to change the way they do business.

Some of the kinds of areas the focus where we need to really take action and I'll summarize briefly. One of them is, as it relates to the work of community benefit is getting out of the compliance mind set, getting beyond the check the box. We did this and move on to the other thing. And really beginning to think of how we begin to integrate the work we're doing in the communities with political service delivery beginning to integrate into our data analysis and our guidance of our teams. Population health is not a panel of patients. We want to include panel populations in this but have to think about the community context and ways in which we work together to address these issues. This means we've got to think in terms of leverage. How do we build ethic of shares ownership with the full spectrum of Stakeholders? How do we get beyond the parallel play that is so common in our communities and come together to build a balance portfolio investments that address the real structural problems that we have in our neighborhoods and communities. How do we think in holistic terms how we act in forces for the good. How do we think in ways we do procurement hiring and as well as the broader care delivery enterprise and really produce that we see.

And how we begin to use influence among leaders in healthcare. How do we begin to bring about that kind of change?

It's important to note there are immense array of activities which leaders such as Dr. Bechara Choucair are engaged in. The governance and leadership in healthcare that involves bringing together senior leaders and board members together to do a deep dive into a population of community health and community development is about. How we begin to act in a more fundamental way. How we begin to engage our boards as think tanks in helping to design strategies that advance this work. We'll make available the information on that in the wake of this webinar.

I mentioned Stakeholder health. Folks should know Stakeholder health which released a monograph in April of 2013 is about to release a second -- in fact, I would call it a book, in essence, that is collaboratively written series of essays on advancing this work. That is about to be released.

There is another series of meetings going on. And I know Dr. Bechara Choucair will touch on this work. We are working with the public policy to bring together teams of hospitals, community members and community development financial institutions to directly advance strategies that link community development investments with hospitals and human service activities and local communities.

Then folks should be aware of the 100 million lives initiative and now has well over 700 organizations across the country involved in looking at ways to advance the network.

I would mention the formation of the cost coalition founded by a group at a regional health system in northern Ohio and southern Michigan. Launched this with an initial focus on hunger, food and security and are looking at expanding their scope of work to the broader social determine in answer of health. But that really looks at ways in which we leverage the influence that our healthcare leaders have at the community level and beyond. The policy changes that are needed to reinforce and sustain our efforts around health improvement.

I'm going to turn it over to Dr. Bechara Choucair and John Lovelace who will give summaries and move together in a conversation. Thank you very much.

>> Bechara Choucair: Thank you, Kevin. And I think we all agree that the marketplace is demanding fundamental change in how we operate and how we produce as health systems. Especially, after the ACA, we are seeing a shift from a fee for volume environment and fee for

value environment. What that means is if we are a producer center health system today, we need to be thinking about how do we become more of a people center system.

For us, a couple years ago, our board adopted a health systems strategy that looks at three key pillars in that work. The episodic healthcare management continues to be in our system. In addition to that, over the last few years, building a lot of capabilities around population health management. And our board was keen in making sure community health and wellbeing will be an integral part of our people center health system strategy.

So just briefly when you look at our footprint from an episodic perspective, one of the largest systems in the country. We have a network of 90 hospitals. We are one of the largest providers in the country. We employ around 4,000 physicians but 24,000 physicians in our system. And deliver 1.6% of all babies in this country. So our footprint is pretty significant in the country. The next slide shows population health management footprint. We've made a decision to significantly invest and build our population health capabilities. That's why we have 34 accountable care organizations including 14 -- in five of our markets. We co-own three health plans. Out of our 6 plus million patients who depend on us for healthcare services, 1.2 million are attributed lives through risk or value-based reimbursement program. Health plans cover 772,000 lives. We're investing a lot in population health management efforts.

And then the third pillar of our work is around our community health and wellbeing. And the way we look at it as a system is through a continuum. Starts with clinical services and a lot of focus on Medicaid and duly enrolled. People experiencing homelessness. Also it looks around community engagement and how do we make sure those patients of ours who are living in poverty, we are able to provide them with the right wrap around services to support their social services need. The use of community health workers whether it's through help models or community health workers within an infrastructure are key to ensuring that linkage between the health system and social services agencies. And that continuum really is also key within community transformation. And this is around engaging other sectors other than the healthcare system to really build on the policy systems and environmental changes that are important in our communities so we can be an integral part of those communities. So how do we engage the built environment, economic sector and other social determinants of health becomes an integral part of our core business of a health system?

And to advance the community transformation work, I'm excited about our transforming community initiative we launched last year where we're anticipating an investment of $80 million over the next five years and community health interventions. Those are evidence-based community health where we've identified six communities across our footprint and we are funding local community coalitions focusing tobacco, obesity. We've also engaged the local businesses, local public health agencies and own hospitals as part of this effort.

We've also engaged national partners like community catalysts to make sure we're bringing the community's voice there. Camping for tobacco-free kids, Georgia health policies, couple of the CDFIs to help support the communities in the transformation efforts. Maintain $40 million available in low interest or no interest loans to those communities to think about bridging more consciously the community development sector and the community health sector.

So I'm going to stop here, Kevin, so that we can have more time for Q and A section here in a little bit. Thank you so much for inviting me.

>> Kevin Barnett: Thank you. I'm going to turn it over to John Lovelace at University of Pittsburgh medical center.

>> John Lovelace: Thank you very much, Kevin. And thanks, Bechara. I don't have quite as many fancy slides but I'm going to give you a quick overview of UPMC. University of Pittsburg medical center. But major work in healthcare is local. We're in four divisions. About a $12 billion company of insurance, which is where I am. In insurance, we have 155,000 person medical advantage plan, 380,000 enrollee Medicaid plan. We have a behavioral health medical plan. Separate here with 950,000 members. We do health insurance, marketplace work and

commercial work. So we have 3 million members. Focused heavily on regional quality measures. 4.5 stars in Medicare. We're level 4 plan in Medicaid. The health system on quality improvements and population health. The health services division is where acute healthcare is delivered. We have 20 plus hospitals, hundreds of outpatient locations. 4,000 employed doctors and 2,000 more folks affiliated or regional presence in hospitals. I think we have a conversation with Trinity folks in Ohio.

The business innovations happen. It's really more of a technology investment platform and international services in other countries. The mission of UPMC to develop financing system. In that regard, about half of our insurances is with ourselves. And it gives us an interesting platform to move forward. We are multi payer and the provider for many of our enrollees and many of our patients. Creates a very different incentive. When you are the payer and the provider around your investments in health and wellness. The project we talked about in October of 14 was a housing project. The work we do around social determinants and we were looking at some high spending consumer members who had a lot of unplanned healthcare. Unplanned meaning repeated emergency room visits. And not so much primary care or medication. As we looked into cases with care managers people didn't have a stable place to live. We don't have any way of knowing where people live. Out of that conversation came a recognition among other ways. It's very hard to address people's cross I can healthcare issues if they don't have somewhere to live or living in a dangerous situation. As we embarked on a project with the hud, the local county association had developed. It's actually permanent supported housing now and lots of unplanned care and help to stabilize their lives. And learning from that moves into a place where we see positive impact of providing supports around whether it's in school in the child welfare system. In-housing where we fund housing supports for people almost in chronic conditions or home efforts in our own work where we do community team interventions. Addressing issues people wouldn't raise in the healthcare system like safety and foot security. Make a huge difference in people's lives. And why is this good business for us and why is this good business for the people we serve? Been able to build in that model successfully. As we look at the evaluation to see which things work best for folks. The ability to add services around acute and post-acute healthcare has made a significant difference in our own understanding. And affect the trends in healthcare and outcomes of healthcare. With that, I'll probably stop as well and move into discussion if there are questions.

>> Kevin Barnett: Thank you very much. Very impressive work that you are engaged in. I'm now realizing how broadly the breath of the work that you are engaged in as well. I'm going to move us to discussion. I'll let you catch your breath and start with Bechara. I'll ask you to consider the same question. We were engaged in colleagues a few weeks ago. Tends to be a perception that folks like yourself tend to be rather -- can do a lot of things. And how difficult it is to move this agenda forward. So I wonder if you can address the issue how you make the case. Who do you have to convince to move this agenda?

>> Bechara Choucair: When we have made the commitment as a system that we're going to move to payment models, 75% of our revenue will move to payment models by 2020. What we meant is we really actively need to be thinking beyond the four walls of our hospitals. That cleared the business decision to move to embrace payment models, made it a lot easy for me to make the case. When you think about a system like ours, really, it goes back to the mission of an organization like ours to the legacy of our founders when the nuns went to low-income communities, they went to try to meet the demand and respond to the needs of those communities. For us to continue the legacy of our founders made a lot of sense. It was a dual approach. Making the business decision to move and embrace alternative payment models. We need to be focusing beyond the four walls of our hospitals. But also being part of a very mission-driven organization makes the case a lot easier.

>> John Lovelace: We have between 40 and 50% of our current health insurance business is an alternative payment model which are value based and quality as well as savings. And that

definitely makes a huge difference in terms of the incentive of population health. Here, like everywhere else, I'm sure, there are some people who it's very easy about housing is healthcare. Or safety as healthcare. For others, it's difficult. Being able to point to the value and to the extent, point to the value and saying the people who are in this housing program. Shifted from 70/30 to 30/70. Not necessarily spending less. But they are getting more appropriate healthcare. That's something you can demonstrate with facts. Those are things that I think it's a data, if you will, that help you convince people this is not just me being a social worker. It's actually good business.
>> Kevin Barnett: Just a quick follow up on that. Are you having these conversations among your board members? And what role do they play to help support that change?
>> John Lovelace: We do. We have 8 licensed insurance boards. The Medicaid company which is a 501-C3 has its own board. One-third subscribers to the plan. They are much easier to convince. Low income people who families of struggles. And a pretty easy sell, honestly. Very social awareness focus on most of our boards. And those people -- those are people who are a little more sympathetic to this idea coming out of the box.
>> Bechara Choucair: They are sort of inclined this way anyway.
>> Kevin Barnett: For the folks that are listening in on this that are struggling themselves and without asking you to identify individuals per se, I'm wondering if you can both identify among the people of the leadership, what would you identify as the easy qualities or skills about leaders in your organizations?
>> Bechara Choucair: Kevin, I would clearly say the role of the board and the CEO is tremendously important in advancing this work. Board leadership is so critical. Hands on. The board at Trinity Health as an organization is so engaged in the space. Part of the regular agenda for the board meetings. We have these discussions regularly. We have board committees that discuss these issues on a regular basis. The personal engagements of our CEO is tremendously helpful. I also want to highlight the leadership we see at a local level. Having the community health voice being heard and a loud supportive voice at local level is so helpful. I know we are all doing community health needs assessment as a result of the IRS requirement. But we've been doing health needs assessment for a long time. So having that community excitement, the community engagement with community coalitions at a local hospital level is tremendously important to advance this work at Trinity Health and other health systems as well.
>> John Lovelace: One of the things that's changed in the last five or six years is in addition to the work the boards do, there's an insurance division. My boss is supportive of this. As the boards organize, they've structured a lot of external advisory groups that work on diversity and inclusion and community needs. And those are people who aren't mostly employees. They don't have formal affiliations with us. And they are people who are eyes and ears as well as attributors in terms of understanding how issues have on things like school health, public safety. Very different take on issues. That integration is supportive. If you talk to people in the school health business. Whole different way of thinking about the world than other people think about the world.
>> Let me shift a little bit. I know all of the dynamics around this are wrapped up in the fact that these organizations that have to meet their bottom line and think about how to keep their doors open going forward. And as we begin to move into these areas, a lot of folks who express concern about hospitals and health systems getting into this population health arena. Particularly as we're talking about it, which are the populations in the context of the geographic communities in which they live. What can you both say about what are the expectations that are being raised for you and engaging this work and supporting this work? What do you feel like you have to deliver in order to continue to get the kind of support going forward?
>> One big piece of this is the results. One of the things focused on, helps us think through the short-term and long-term impact of a particular project or health in a particular community. And

able to produce data that supports this is a huge help. Always an issue for us, we're a big organization with largest employer in Pennsylvania. Sort of always a temptation to think UMC could pay for this. And you can still pay for lots of things. So trying to build partnerships is a better focus as well. We're collaborating with the house and urban development department. So kind of leveraging money has been a good talking point.
>> I want to also echo what John mentioned. Being able to evaluate. We've partnered with Georgia health policies to be our key evaluator so we can show we're making a difference. I do want to reference, TFAH issued a report on the [inaudible] community prevention to work effort. This was a three-year investment from the CDC that showed a $2.4 billion savings on healthcare costs. $9.2 billion savings on productivity. And that type of data that's helpful in making the case and continuing to invest in efforts. So our $80 million is based on those same strategies evidence-based strategies that the CDC community putting to work were based on. So having to be able to prove would be tremendously important to continuing this work moving forward.
>> That speaks to Anne point about evaluating the start.
>> Kevin Barnett: Uh-huh. You both have referenced how do we leverage our internal resources. Wondering if you can address this a bit more and specific examples you might share and building ethic of shared ownership. Building this understanding of complex problems that require the resources and engagement and others in your local community.
>> Bechara Choucair: Sure. Kevin, when we think about a lot of this work, think about community benefit. And this is a great resource that we have with health systems and should absolutely leverage the resources in a way to transform the communities. As a system, we invest a little over a billion dollars a year. But in addition to that, what's really important is to look at what are other assets we have as a system or the communities have and try to leverage those. One example is where leveraging our investment portfolio. We've invested $32 million in finance institutions to focus on mixed income housing, focus on food access. And doubling down on the effort through initiative by adding another $40 million to that pot. And those will be available to communities of no interest or low interest loans that would allow that community development that bridged the gap in a very thoughtful way. And this is a resource we have as a system and excited to use it as transforming communities.
>> Kevin Barnett: Great. John?
>> John Lovelace: Our community benefits for last year was $890 million in a variety of research as well as being in the community. One of the vehicles we found is we found helpful here anyway. The state has neighborhood partnership tax programs in which organization like ours can invest in community-based effort around community wellness, community redevelopment in communities. And an opportunity to invest in those efforts with the organizers to create things we wouldn't normally be able to do like rebuilding housing, refinancing schools. Creating social improvement programs. And those are things that are contributors. We are using assets to enhance the charge whether it's community health workers or job development. In job development, we hire a lot of people. 10,000 people a year. We love opportunity to not only support job programs but reap the benefits by hiring the people they train. Nice wheel of synergy in that regard.
>> Kevin Barnett: Sure. John, I wonder if you can talk about your relationship to the university. The universities have been identified as the institutions as well that have an important role to play in supporting work in the community whether looking at ways to support investing in low-income communities. Two ways in which they leverage the resources in procurement and related activities.

Since you have this integrated model, ways in which you are engaged in the university and some of this work.
>> John Lovelace: Sure. Lots of opportunity. The particular focus is on community relationships and doing what you are describing. He's been here about two years now. Very

successful chancellor. About 20 years with a similar kind of focus. The university is separate from the UPM health system. They were related but not owned. A lot of our community benefit money supports research efforts and faculty research. And a lot of our joint work is around things like participating in a project training of social workers to work in a community health settings. Training students to move successfully to finish high school and move into college. So a lot of opportunity to collaborate on applied research. Clinical translational innovations. Taking what you learned in laboratory and apply it in the real world. In a particular way, we self-insure of course. 52,000 employees. We ensure PITT, 15-20,000 beneficiaries. We can do work around changing wellness and try to assess the impact.

So one is the direct impact on the community. A second is in making practical translations of research findings. And the third is supporting the research itself.

>> Kevin Barnett: Uh-huh. That's great. I'm going to shift to a related question with Bechara. The history of hospital community engagement is mixed in the sense that often the engagement communities may be limited to seeking preliminary input during the assessment phase. And obviously seeking a much deeper form of engagement. For you, as part of the transforming communities initiative that you have referenced, you are engaging community catalyst as a partner and helping to look at ways to deepen those kinds of working relationships. And then your own history in leading a large FQHS. The issue of community engagement is absolutely critical. I'm wondering if you can share a little bit in your thinking about how do you see this work going forward and ways in which we can have community partners.

>> thanks, Kevin. The way we're approaching is a funder going to communities to do this work. 5 out of the 6 transforming community partners think about our role in the community engagement. And we are making it clear. This is about what the community needs and wants. That's why we're funding community coalition so they can decide on their priorities and the area they want to focus on and we're here to support them in that effort. Which is slightly different when a funder would come in and bring in resources to the community.

We're realizing this goes beyond our traditional healthcare partners. While we're really excited about engaging the medical community, the nursing community, the healthcare community, we're really excited about engaging the faith-based community. We're getting engaged much closer with the business sector. We're talking to non-traditional public health partners and building those relationships. To support what that community thinks they need and like to work on. So I just wanted to highlight the effort. And with partners like community catalyst and change of absolutions and like the CDFIs will be able to provide some assistance at every one of our communities at advancing this forward.

>> John Lovelace: I think we're much more focus on being participant and a collaborator. We bring health resources to the table. Technical resources. Maybe IT techniques. We have a pretty strong analytics department. But we're more interested in finding constructive partnerships and synergies, if you will, than we are on being funders. We do fund some things. But not a key role of ours.

>> Kevin Barnett: My question was strategy around more deeply in engaging community Stakeholders. Anything you would want to share about what has been successful for you in deepening that kind of engagement. Moving beyond simply asking people for -- beyond the focus group mentality to say how do we do this as partners and what are others putting on the table to move this.

>> John Lovelace: Something I was talking about earlier and that is the creation of these large standing advisory committees has been one of the key ways we've done this. On a call sending the patient engagement committee. 30 or 40 people that are not employees who have their -- they represent health needs or FQHCs and having that dialogue around every couple months. Are we doing better or worse? Focused on, on-going consultations with people with disabilities. They all have board members on them. And collect large standing group of people who convene periodically. Comment on how we are doing. Rolled up to the board and

incorporated into the strategic plans.
>> Bechara Choucair: One other example engaging community partners is our Trinity Health challenge we launched last week. We know dual eligible patients, seniors living in poverty and people with disabilities living in poverty. The deep dive into the analytics on the population, they've had significantly higher readmission rates than folks who are not dual eligible. We're asking partners help us identify ways and strategies to empower these patients who are the seniors living in poverty and people with disabilities living in poverty so the readmission rate goes down. We would love to promote that challenge. And this is one way that we're bringing innovative ways of thinking or engaging community partners in our work that we're excited about.
>> Kevin Barnett: I'm going to ask the last question before we move on. There's a good number of folks on the phone thinking to themselves this sounds good. You got to this stage of work in each of your organizations. What would you identify that's needed to sustain this work? What kinds of internal adjustments that are needed to sustain this work going forward? Any lessons you have to share that helps inform this work that helps others that are trying to move this agenda. What helps to sustain this work internally?
>> John Lovelace: One thing that comes to mind, I sound like I'm repeating myself. Continual production of information about this. Yes, this is still working. This is successful or not successful or change it. Keeping a front of mind. The things we do are kind of relatively speaking small projects. So they slip from mind. And if people are cruising around through the budget, $100,000 we can save. So we do a lot of internal work around with our board and with our staff reminding people what we're doing. Costs and results. And that's certainly a big piece of help.
>> Bechara Choucair: I would also say the way I look is you really create a movement and keep building the movement and keep building the momentum about the importance of this work. In an organization like ours that's really focused omission, this is such a great way of exciting across the system. But in addition to that, having regular dash boards, what's the impact with this work? So helpful and so important. This is why we were so excited with the dash board for our system overall. And also for every one of our communities, looking and trying to say look at metrics that might not have been part of metrics that health systems look at. Our community and wellbeing dash board look at metrics like what percentage have seniors living alone in the communities? What percentage of graduation from high school in your communities? What's the median income in your community? What percentage of kids are living in poverty? I'm putting them as part of a regular dash board that your local leaders are looking at on a regular basis. Really help build and continue to sustain that momentum and the importance of this work.
>> Kevin Barnett: I want to thank you both for your leadership in the field in moving this agenda forward. Back over to Matthew.
>> Matthew Marson: Greatly appreciate you leading that panel and the comments from the speakers and panelists. It was really rich conversation. We had a number of questions that come in on the Q and A. Just a reminder we are following the conversation on social media as well as here on the web forum. Encourage you to go now, if you can, but also in the days and weeks to come to social media to share this important conversation. We're using #leadinghealth and #communityprevention.

We're going to bring up poll 4 momentarily. For the remaining Q and A for the time we have left, I want to bring back in Anne as well so she can participate in this discussion. And if we can bring up poll 4. And listening to the conversation so far, what do you feel are the most significant opportunities to expand work and population health improvement in your organization/community or area? And select all that apply. A, b, c, d, e or f.

I do appreciate you responding. It's important to hear from you as well.

We're going to ask our panelists -- we're going to have an opportunity to hear from audience questions. A whole variety of different comments come up. Data is obviously invaluable in evaluating this type of work and such work is creating outcomes. If the speakers -- and I'd like to make sure we have all of our panels address this as well. Is there any value or room for non-data evidence like community voices, human rights or such things along those lines? Who would like to take the first dive in that question? The value of non-data evidence as well as data.
>> Bechara Choucair: The data and non-data evidence are important. The non-data evidence brings that story and excitement. Building on the momentum that's equally important and continuing this work and advancing this work. I would go with both data is extremely important. Storytelling and looking at things that might not have been data backed or data evidence is important as well.
>> John Lovelace: We had a conversation this morning about this, actually. It really was in lots of ways, the anecdotes, the stories are much more compelling than the data. Mrs. Jones saved her leg and got off the street. A lot of riskiness to the content of the emotional part of the story. You need both, of course. The story makes it much more meaningful to lots of people.
>> Matthew Marson: Kevin or Anne? I know they do a great deal of work to lift up the stories particularly in Washington DC with decision makers. Wondering if you have thoughts on this.
>> Anne De Biasi: Yes, I couldn't agree more with the other speakers. The only thing I will add is that one of the earlier polls asked a question about what was important to convince leadership to move ahead on population health. And I think it was the most popular answer, please correct me if I'm wrong. It was having models to emulate. I think the stories can lift up the bright spots. That's what we try to do at the Trust for America's Health.
>> Matthew Marson: Absolutely. It's critical. Any final thoughts?
>> Kevin Barnett: Yeah. I would offer this. We have an interesting public dialogue going on out there. I think it's the core recognition across the country and across the political spectrum. That the profound economic and social health and equities are unsustainable. And frankly, unacceptable for country. And it's beginning to driving campaigns. But it presents a real opportunity for our health peer leaders in this regard. Because they are coming to grips with the fact that addressing the issues is closely tied to the future economic wellbeing. So it behooves us to build on the movements in our communities and at the national level that are demanding quality housing, water, food, transportation and living wages. These are all fundamentally tied to health. So you likely have these kinds of organizations or groups 234 each of the local communities where these hospitals are located. And behooves us to look at ways which we can engage and support their voices.
>> Matthew Marson: We've had a number of other questions and rather than go through all of them. I do want to highlight a number of our listeners today have asked that question about how are we engaging with the residents. Jodie Mitchell spoke to how do we ensure the lived experience is being built into the agenda and priorities determined by the hospital or health system and shaped the agenda for investments. We did already hear from both John and Bechara in terms of examples of the way you engage whether it's through participation in your boards. But are there other examples of the way you are engaging with community residents to shape the agenda and decision making?
>> Bechara Choucair: One way we're looking around advocacy and policy making. One area that we've been excited about as a system is around tobacco 21 which is raising the minimum wage of selling tobacco from 18 to 21. If you look at leaders across the country, many have participated in community coalition have engaged consumers and residents and went with them to city Council hearings. And that way of engaging around policy making has been a great and fighting way for us especially around tobacco 21 across the country.
>> John Lovelace: We have a similar experience. The health department director is relatively new. Been there a couple years. She's been a very straight forward broad effort to engage lots

of Stakeholders in several health systems and community around thinking of health and wellness in much more the social determinant way as well. Participating with equals in terms of voice with other hospitals and other consumer groups. The people who do the biking and public safety and much more robust dialogue around sidewalks and health.
>> Matthew Marson: We have another question here around social determinants. As you assess the return on investment, what metrics do you use to value impact on social determinants and how much time do you allow -- how does it rank as a priority with regard to business decision? Very important question. The first section again was specific metrics you use to value impact on social determinants.
>> John Lovelace: Large part so far we've been looking really at healthcare cost trends. I think over a time, we want to look at more broad data sources around broader satisfaction of personal impact senses. Not so much cost but how are people spending healthcare dollars? Our goal is to get planned healthcare. The metric is around the planned to unplanned healthcare.
>> Matthew Marson: Bechara, more on that question? Happy to list the question again as well.
>> Bechara Choucair: No. One way we're looking at that is through our partnership with a corporation for national and community service with the use of members. So we have this partnership with the national corporation for national and community service to hire and train and deploy 50 members as community health coordinators and placing them within our organization specifically focusing on our patients enrolled in Medicare and Medicaid. Our seniors living in poverty and people with disabilities living in poverty. And by attending to the social needs of those patients and making sure they have ways to get back and forth to the doctor's offices, they have ways to pay their medical bills, electric bill and water bill. And they have ways to enroll in food access issues. When we address that, and because these patients are part of our savings program or ACO, we will be able to track how these patients are performing when it comes to the triple aim. Is the healthcare outcome better? And equally as important as their healthcare utilization is going down. So this is an example of how we're trying to use data to look at these types of impact on cost of care as well as care experience.
>> Matthew Marson: Thank you. I think we should come back to this as we look at the role that health systems -- healthcare providers are having as both advocates and leaders around the impacts on social determinants. What we should begin to measure as well as noticeable changes in the environment of the community. So we could identify all theories that would measure, for example, what is the access to healthy food. A number of grocery stores, for example, that is in a community. What are the active transportation networks, for example, that the patient population that the health system is serving. Measurable improvements in those environmental community influences which have a tremendous impact on people's ability to be healthy. Those sorts. And also looking at other social and economic policies within a specific jurisdiction or area that the health systems operating. Shift in tack policy and other issues. Interesting for us to have a shared indicators and impacts that others could contribute to. And measure together that would influence patient behavior but also patient reported response as well. Just a thought my own I wanted to contribute in what we're collectively measuring.
>> Kevin Barnett: I was just going to build on your comment and note that we are currently conducting a study collaboration with the CDC funded with the ARP organization where we're looking at the issue of food and security among older adults with chronic disease and conducting an economic burden analysis looking at the relationship between those factors. So I think to a significant degree, part of this is looking at the -- not these indicators but issues of cost and utilization and focusing on seniors because they tend to be the highest utilizers. For making the case for increasing strategic investment of healthcare institutions. Dr. Bechara, you were going to add. Go ahead.
>> Bechara Choucair: Yeah, I wanted to add a reference to the community health and wellbeing dash board that we started here. And I'll be happy to share it with participants on this webinar.

This is exactly why we built this community health and wellbeing that looked in our own communities. But look at health behaviors in that community but also things related to social determinants of health. Poverty, transportation, education. So it's an integral part in the way we look and interact with those communities where we're in.
>> Matthew Marson: That would be wonderful resources to share. If there are resources and materials to share, we'll post those online both with the audio and the visuals and materials shared on today's web forum. That will be available along with the recording in a day or so. So please do share resources we can post.

As we look at the final few minutes, a couple other questions come in from a number of the listeners about the role of local health departments and the impact of the work on city and county health departments. You have a critical role across the country. And wondering if the panel have spoken to how they are collaborating and working with health departments in your work.
>> Bechara Choucair: For somebody who served as a local health department commissioner in the city of Chicago prior to joining Trinity Health, I see a lot of value in that partnership between health systems and local health departments. So much potential there. That's why when we've launched our community initiative, we made sure that every application that we accepted had to have three signatures. The local health departments, the top official's signature, local hospital CEO signature as well as the community coalition that we'll be administering. Because without that three partners, it's going to be difficult to transform communities. And local health departments play a significant role in that effort in anyone of our communities.
>> Matthew Marson: John, anything to add on that?
>> John Lovelace: Can play a key role in keeping it movement. Air quality monitoring and a bunch of things that are much more population based. Key place to see data in a different way and rally the troops in a different way. You need to have leadership support from the local leadership to make this work.
>> Bechara Choucair: Not the last one but the one before was the role of healthcare providers. And we also recognize the importance of other key influences. And that's employers and businesses. And I'm wondering if the panel can talk about other sectors. This is a question we had about other Stakeholders engaging in this work. Whether that be corporations, faith institutions and wonder if there's other examples you might be able to speak to through the work you are doing. Feel free to jump in.
>> Certainly schools are a good source of this. A pretty captive population of lots and lots of kids.
>> Matthew Marson: Uh-huh. Absolutely. I also want to show the example of California that hospitals are really important in local chambers of commerce. Many times the state Chamber of Commerce may be an obstacle which can improve health. The local city or local community Chamber of Commerce, the hospital has an influential voice to help support policy changes which can improve healthcare for patient populations. So from my perspective, really influential role that health systems can have healthcare providers on the local chambers of commerce. And I don't know if anyone on the panel, if that was your experience working in the city.
>> Bechara Choucair: I was going to jump in and say how important it can be. And remember, what local Chamber of Commerce wants, vibrantly community, they need healthier communities. One example of just what happened recently in Kansas City, the Kansas City Chamber of Commerce led the way to raise the minimum wage of selling tobacco from 18 to 21. The Chamber of Commerce was the driver behind the significantly important policy change in Kansas City. So those types of relationships are extremely important.
>> Matthew Marson: This has been a very rich conversation. We had a number of other questions from the audience we weren't able to get to. We'll make sure we capture those and share those as well with the panelists. And if there are other resources and answers to questions, we'll be sure to post those online. As I thank each of our panelists, I could ask you

to address in one sentence what you think the future of this work will look like as we look ahead for the coming years on what you think the shape will come. And I'll start with you Dr. Kevin Barnett, Senior Investigator at the Public Health Institute. Thank you to you and your thoughts on what the future holds.
>> Kevin Barnett: So I'm quite excited about the future. I see movement not only among health systems as you were talking about -- corporate leaders are thinking beyond simply beyond whether or not they have people on the workforce but really beginning to think about the communities in which their workforce is engaged. I think the question about the rules of public health agencies is critically important and we need to make sure that they have the funding and support so they can play the kind of appropriate role they are generally not able to do currently. Which is around monitoring and evaluation of the more comprehensive intersect approach to health improvement.

So there's a missed potential but a lot of moving parts to this. So it requires all of us to stay engaged.
>> Matthew Marson: Thank you for your participation today. Dr. Bechara Choucair, who is the Trinity Health senior advice President of Safety Net Transformation and Community Health. Your thoughts on what the future will lead to.
>> Bechara Choucair: From my perspective, we've always treated illness and so excited to be part of a health system that's not just treating illness but being part of creating health and look forward to a future we're all being part of creating health movements in our communities.
>> Matthew Marson: Thank you. Anne De Biasi, I know your organization along with PHI and others, as we look into uncertain times ahead with a new administration maybe shift in congress, what do you think the future for supporting this conversation from our leaders in Capitol Hill will look like in the coming next four years?
>> Anne De Biasi: I'm optimistic. That's regardless of who is in this seat. Who is leading the administration. Because I think regardless of political party, there's broad recognition about the need to breakdown the silos. As the title and topic of this webinar is about leadership, leadership is integral to being able to breakdown the silos and bring together funding and programming to address the social determinants.
>> Matthew Marson: Thank you. And last but not least, John Lovelace, President of UPMC for you. Thank you for joining us and I'd love to hear your thoughts. You get the last word. What do you think the future will hold?
>> John Lovelace: I'm very optimistic on the idea of moving into finance delivery systems, ACOs in which your successes are -- that's the move we are embarking on and very positive signs of that continuing to move forward as a way of improving health and saving money.
>> Matthew Marson: Thank you, again. And thank you to our audience for the questions and comments you've provided. The web forum series you can view the presentations online. And on your screen now is information on where you can get those at the web site.

I want to thank our presenters today. I also want to thank our sponsors. And the co-sponsoring organizations that have done so much to share this important web forum with this audience.

This has been The View is Worth the Climb: Health-Sector Leadership Strategies to Address Social Determinants. I do want to say very quickly to thank Joanna who has been the star support for today's web forum. She's actually leaving Public Health Institute. But hoping she'll continue as a consultant to support our work in the coming months and years. But she's actually leaving us as an employee. So thank you for all of your support over the last 8 years. And we look forward to working with you in a new way in the years to come. So thank you to you. And thanks to everybody. This has been The View is Worth the Climb: Health-Sector Leadership Strategies to Address Social Determinants. We'll see you next time.