Dialogue4Health
TAKING ACTION TO PROMOTE HEALTH EQUITY SERIES: “SHOW ME THE MONEY – INNOVATIVE FUNDING APPROACHES TO PROMOTE HEALTH EQUITY”
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>> Laura Burr: Welcome to today's Dialogue4Health Web Forum, "Taking Action to Promote Health Equity Series: Show Me the Money -- Innovative Funding Approaches to Promote Health Equity" brought to you by our partner Trust for America's Health and sponsors, the Robert Wood Johnson Foundation, The California Endowment, and the W.K. Kellogg Foundation.

My name is Laura Burr and I'll be running today's Web Forum along with my colleague, Kathy Piazza. And now finally it's my great pleasure to introduce our moderator today, Dr. Nadine Gracia, executive vice president and chief operating officer at Trust for America's Health, where she's a senior adviser to the President. She has more than 20 years of leadership and management experience in federal government, advocacy organizations, academia, and clinical practice.

Prior to joining us, she served in the Obama Administration at the U.S. Department of Health and Human Services.

Welcome back, and thank you, Dr. Gracia.

NADINE: Thank you.

Let me first welcome you to the second in a series of four webinars on the topic of equity, innovative funding approaches to promote health equity.

For those of you joining us for the first series last month, we welcome you back. To those of us joining this webinar series for the first time, we're thrilled to have you join us for this important discussion. On behalf of Trust for America's Health, I'm pleased to be moderating this series. We are a nonprofit, nonpartisan, public health research advocacy organization based in Washington, D.C. We envision a nation that values the health and well-being of all, and where prevention and health equity are foundational to policy making at all levels of society.

In this webinar series, Trust for America's Health, with support from the California endowment, the WK Kellogg Foundation is focusing on the critical issue of equity because of its importance to the health and well-being of individuals, families, and communities across the United States and to our nation as a whole.

Specifically this series is intended to provide useful and constructive information to address that need. Each of the four webinars is focusing on an important aspect of efforts to advance health equity. The examples that we will highlight are more than promising practices. They also illustrate innovative initiatives that offer important lessons and key take aways that you may want to apply to your work throughout the nation.

Just as a recap, our first webinar held on September 18 was a wonderful panel discussion on a transformational effort to promote equity. The California Endowment's building healthy communities initiative. A community initiative seeking to transform the conditions in 14 communities in California devastated by health inequities in a manner never attempted on this scale.

Now, if you were not able to tune in for that, the recording is available at the Dialogue4Health website at Dialogue4Health.org.

As a reminder, these webinars are conducted as conversations. With those involved in the work of advancing health equity rather than as a formal panel with set presentations. This will allow us to more deeply explore the models. We'll strive to answer such questions as what was behind the success of the efforts, what challenges did our presenters encounter, and how did they overcome them and what elements of their work are transferable.

The theme for today's webinar is innovative funding approaches to promote health equity. As many of you know and experience in your day-to-day work, investments and funding for health equity promotion are a critical issue that is often top of mind for how we advance health and well-being of communities across the nation in a sustainable and meaningful way.

There are many considerations and concerns when we address the issue of funding. The availability of funding, the sources of funding, including from all levels of government, philanthropy, and the private sector. How funding streams can be used and for what purposes. The concept of improving community health. And what outcomes and return on investment are expected, just to name a few.

There are examples to promote community health and well-being, such as the Racial and Ethnic Approaches to Community Health, or REACH, funded by the Centers for Disease Control and Prevention.

Almost two decades, they have used community-based, culturally-appropriate approaches to identify, develop, and disseminate effective strategies for addressing health disparities. And it's noteworthy that there continues to be a great need for increased funding and commitment for programs and initiatives such as these that focus specifically on health equity.

There are innovative funding models with tangible outcomes and progress, and that will be the focus of our panel discussion today. We're going to hear about place-based initiatives, leveraging diversed funding, assets, and commitments of multiple sectors to do just that. These examples include the successful Health Equity Zones in Rhode Island, which is managing what seems to be the impossible task of converting categorical funding into community-driven equitable work.

We'll also hear about the Green and Healthy Homes Initiative model as well as other strategies they're using to advance evidence-based interventions that efficiently connect funding to meaningful health, economic, and social outcomes in order to promote health equity for people in low income communities.

To understand these etch forts, we have two great speakers I'll introduce now. First we have Ana Novais. She is the executive director of the Rhode Island Department of Health. Ana has led the department's efforts to achieve the goal of health equity by focusing in the areas of health disparities and access to care, chronic disease management and prevention, environmental health, and maternal and child health. And by developing and implementing the Rhode Island health equity framework, a plan of action for achieving health equity at the state and local level due to Health Equity Zones initiative.

Our second panelist is Ruth Ann Norton, President and CEO of the Green and Healthy Homes Initiative, a national nonprofit founded in 1986 dedicated to the elimination of childhood lead poisoning. A dedicated advocate for healthy housing, she wants to end childhood lead poisoning by designing a program built on a framework of cross sector collaboration to efficiently deliver green, healthy, and safe homes in communities across the United States.

And for our audience's awareness, you probably saw Dr. Nicole Alexander-Scott, the director of the Rhode Island Department of Health was also scheduled to be one of our featured speakers. She sends her regrets that she will unfortunately not be able to join us for today's webinar, but Ana will provide an excellent insight on her behalf.

So thank you to all of our panelists for participating in today's web forum.

Now, before we start our discussion, I want to bring up on your screen poll question 2. That question is: Is your organization using funding from multiple funding streams to address health equity?

Just a reminder that all of the audio and slides for this web forum will be available for download on the Dialogue4Health website following the forum. We'll provide that information at the end of today's webinar.

So we can go ahead and close our poll.

It's great to see most of you use health disparity funding.

With that, it is my pleasure to start our panel discussion and also at the end of the panel discussion, we'll have a question and answer session. So please do submit questions and we will do our best to answer as many questions as we can during the Q&A period.

So Ana, let me start with you. And talk to you briefly about the Department of Health in Rhode Island and give our audience an understanding of the Department of Health and its priorities. Tell us briefly about the department and its priorities as it relates to health equity.

ANA: Absolutely. First of all, thank you so much for the invitation. It's truly an honor and a pleasure to be here and share what Rhode Island is doing.

The department currently has three leading priorities that are absolutely connected with equity. Our priorities are addressing social, economic, and environment concerns

regarding health. The second one, elimination of health disparities and promotion of health equity. And third one, issuing access to quality health services for all, including the state's most vulnerable population.

And we think this truly comes from the belief that no matter what you look like, what you sound like, where you live, your place of birth, everyone deserves the chance to be as healthy as possible. And to live in as healthy a community as possible. That is a decision we've carried for many years, that Dr. Alexander-Scott coming in as a director in 2015 was elevated to becoming department priorities. And that was the focus also in fact of our very recent third annual health equity summit that we just had in Rhode Island, where we had more than 700 community key stakeholders coming together to talk about health equity in the state.

So that's what's guiding our work, and that's what kind of also led, which I will talk about a little more later, about the Health Equity Zones. But internal examples of how we are implementing it at the department level, we have a health equity institute, we have a sexual orientation and gender equity work group, we have office of special needs. Those are the ways that we are doing this work internally.

NADINE: Excellent. Thank you, Ana. You highlighted key points about the leadership and leadership commitment as well as the infrastructure at the department and also setting key strategic priorities that specifically address equity. So really an important framework for the work that you do within your department.

Now, I know that Dr. Alexander-Scott is not only the director of the Rhode Island Department of Health but she is also the new President of the state and territorial health officials and she has issued a 2019 President's challenge of building healthy and resilient communities which she highlighted just last week at their annual meeting.

Can you talk about, on her behalf, that presidential challenge for her term and how that focuses on place-based initiatives and describe it a little bit more for us and how it also then connects to the work that you're currently doing in Rhode Island?

ANA: Absolutely. It comes from the belief, as I said before, that place matters. Where one lives matters. Your zip code matters. So we know that despite all of the money that we have invested in healthcare, in clinical settings, 80% of our health outcomes are determined by the socioeconomic determinants of health. Housing, our transportation, what happens in our neighborhood. That means that we need access to fresh fruits and vegetables, quality education, job opportunities, social supports, healthy housing.

So thinking about that, how do we shift? We must make a shift in our investments to the settings where they will have the most impact, which is in our communities.

And so the presidential challenge, the President's challenge is the first time, in fact, that we've been able to align with the national association of county and city health officials, and also with the general focus on community health and economic prosperity.

So we are basically calling on all state, territorial, local, tribal health officials to build healthier, more resilient communities by supporting investments in community-led, place-based approaches that address the health of our communities.

We have two goals: One, equipping health officials to mobilize those community-led, place-based collectives that are focusing on measurable outcomes and that also

support the U.S. Surgeon General model of better health to better partnerships so we can build stronger communities.

And the second goal is to connect with health officials to business leaders and policymakers who want to invest in this community-led, place-based approach and be able to advance economic development by reaching across sectors.

That's two additional goals that we have by doing this President's challenge that Dr. Alexander-Scott is calling upon her peers to implement in their states.

It's also to promote positive social connectedness and to improve community resilience. In areas of social isolation, promoting social connectivity and bringing community members together to build social capital is a public health strategy that will help advance those.

And then improve community resilience, making sure our communities can resist, can respond to, but more important, can recover stronger than ever from adversity and bounce forward to better economic, socioeconomic and environmental conditions.

How does that connect with the work we're doing? We're working in Rhode Island around the Health Equity Zones as a foundation for that President's challenge. That was what was in mind, to be able to scale up these community place-based approach such as Health Equity Zones or many others that we've heard in other communities, such as what we talked about in the first webinar, the work that happened in live well San Diego, California, for example, where it is happening.

NADINE: Excellent. Thank you, Ana. You really highlighted I think this important concept and notion certainly in public health of health strategies in which you're working across sectors and at a multi-level approach and seeing how you're connecting at the state level, the work you're doing, with the national initiative, building partnerships across federal, state, and local government.

And then as you well noted, really addressing it through place-based approach. So certainly really seeing how public health has such a critical and key role and you're using terminology that we'll talk about even more so as we proceed in this webinar of things like social capital and economic opportunity and economic well-being, how much that is really connected to our health.

So let's dive in a little more to the Health Equity Zones initiative. It's a fascinating model. But before we talk about that model, could you tell us more about the effort itself? What is it? How did it get started? Why did it get started? And to address what needs specifically?

ANA: Absolutely. So one of the little stories that I like to tell people about is how I'm from Rhode Island and I started in public health more than 33 years ago. One of my first jobs was working with folks in mental illness. And before I could even start talking about the system of care for those folks, I realized that I needed to work on housing, on employment, on a series of issues that were impacting their capacity to be healthy.

But 33 years ago, I wasn't talking about the social and environmental determinants of health. Fast forward, when I came to the United States, one of my first jobs was in addressing childhood lead poisoning prevention. I talked to parents about the dangers of lead.

To be able to, at the end of the day, see those parents go back to the same dilapidated apartments that were causing the problems, and realizing how much we needed to shift our approach in public health to move from telling people what to do to really address what's impacting the health outcomes.

So we believe that if you want to address the social and environmental conditions, you want to move to a place-based initiative. So these are community-led collaboratives throughout the state in Rhode Island where the community had come together to address the underlying sectors in their communities that have the greatest impact in health outcomes. We have asked communities to really draw a line on a map and say, this is my zone of influence, and then to build collaboratives that is representative not only of all key stakeholders within that community but also residents, to develop a local health needs assessment. We have data that we shared with them, but there is a story to be told of the community by the community. So we asked them to really do their own health needs assessment.

We then asked them to do a community prioritization process, to identify what was important for them, what were the issues, the priorities that they needed, that they wanted to address that they felt needed to be addressed.

We asked them to focus possibly on chronic disease, improving birth outcomes, and definitely improving the social and environmental conditions on their neighborhoods.

And we asked them to implement evidence-based approaches that had a menu of interventions that could be selected from, depending on what they wanted to do, because we needed to be responsible back to our funders.

So basically the Health Equity Zones are drawing a line on a map to identify their geographic area, doing a local needs assessment, first building a collaborative of key representatives that includes all factors: Housing, education, faith based, residents. Do a community needs assessment and then develop a plan of action that is evidence based and is evaluated for outcomes, that have very strong outcomes.

Examples of how this is being done, for example, we have in Washington County, at a county level, they are working to address mental health concerns among residents, providing evidence-based mental health first aid. They've trained clergy members, police officers, parents, members, etc. Very different from, for example, in one city in Rhode Island where they're focusing on realizing dilapidated buildings need job training, market space with local fresh fruits and vegetables, etc. So there is a job training program and also income-generating activity.

So very different, the scope of the work, but what's common to all of them is the community-led process and the use of evidence-based strong specific outcomes interventions.

NADINE: Great. And so how many communities are funded and what are the grantees? Are they coalitions? Are they departments? Describe a little bit more.

ANA: Absolutely. We currently have nine Health Equity Zones. When we started, the fourth year of the project, when we started we had in fact 11. When we talk about lessons learned, we can talk about what happened with the two that fell off along the way.

The funding was issued through a competitive process. We did an RFP, a request for proposals. And every community collaborative, the funding goes to the collaborative through a backbone organization. So they needed to identify a fiscal agent that will have not just get the funding, but if it does get the funding on behalf of the community collaborative, with the funding needing to go to all of the participants at the agencies that are part of the collaborative. The backbone organization, in fact, is a key component or factor in the success of the Health Equity Zones, because they need to have the infrastructure to support and facilitate this collaborative process. And they are very different. Some are health systems. Like we have one health equity zone that is led by a health system, a hospital. We have Health Equity Zones led by qualified health centers. We have Health Equity Zones where the backbone organization is the city local government or an urbanization, like a community development kind of organization.

So they differ. And it will be interesting to see how much the backbone organization type will change the engagement and the outcomes of the collaborative.

NADINE: Great. So really a diverse array of funded entities. We're going to talk about that more. Specifically I know there's some questions about how to engage different sectors in this type of work. So that's very helpful.

Talk a little more about the funding itself. How much does a community get in its funding? How long is that funding for? And I know you well; this took some significant groundwork on your part to fund this approach.

Can you walk us through how you specifically have funded these communities and Health Equity Zones?

ANA: Absolutely. We used what we call a braided funding model. I can see the picture on the screen where you're showing the different funding streams that we used when we did our Health Equity Zones request for proposals.

So to take one step back, we used to have a very disease-focused siloed approach to investing in the community because that's what we receive as funding from the federal government. So we have our tobacco funding and so forth.

And we used to have a school community contract for schools to do tobacco prevention, or a community-based organization contract to do obesity, physical activity, and nutrition intervention.

We had state funding to target racial and ethnic minority populations. Very limited amount of funding that wasn't giving us the outcomes that we wanted.

So we took the time to, one, start developing -- when we developed the health equity framework, we wanted to fully embrace that equity was a priority for the department. If you look at any funding opportunity that comes out of the federal government, as you know, Nadine, being part of the office of minority health, they all ask the state to address equity, to address disparities, and to focus on the social and environmental determinants. They recognize that.

So we started counting the stories of the infrastructure building in every grant opportunity we responded to. When we responded and got a grant from the federal government, from CDC, for example, to address chronic disease and they ask us to

address issues of equity and social determinants and the community, we said we're going to do that to our Health Equity Zones.

When we applied for funding to do, for example, maternal health, and we needed to address maternal and child health priorities and infant mortality disparity, we said we would do that through these local health infrastructures that we were building.

So when we put the request for proposals, we first identified as part of the braided funding those funding streams that were more flexible such as block grants or state funding, and with that funding, we supported the infrastructure itself, meaning doing the health needs assessment, doing the building of the collaborative, maintaining of that collaborative. That was the community prioritization process with that flexible funding streams.

And then based on every health equity zone prioritization process and identification of priorities, we pulled from that the specific funding stream that could support implementation. So for example, if a community health equity zone said that they were going to be addressing maternal and child health issues, we could pull funding from maternal and child health and support that implementation.

If someone was wanting to do a diabetes prevention activity, we would be pulling funding from chronic disease to address that.

If someone, and you could see by what I mentioned before, wanted to work on dilapidated buildings and promoting healthy housing and do job training, we had no federal funding that could do that, but we could go back to our state funding and pull that state funding in doing that. That was one.

But we also could start having conversations with our sister agency for housing for the Department of Labor and Training to say how do we connect? Here is an infrastructure that has identified job training as a need; can you support this?

So it's really a combination, and when you ask about how much funding each one received, it varied because it depended on the work plan. So we had a base funding for the infrastructure which was around 100,000 for every one of the (inaudible) per year, and then their implementation varied a lot.

So so far we had invested around $10 million in the past four years.

NADINE: That's excellent, Ana. And clearly in doing this work, as you talked about being able to identify the specific funding streams, whether federal or state or other source, sometimes what the challenges may be is the timing of those grant opportunities, the reporting requirements.

Were there some barriers that you had as you were trying to do this work of the braiding, that you had to basically create some systems to align these funding efforts? And how long would you say it took you to getting to the point where you then had that flexibility and ready access to be able to identify how you would fund these communities?

ANA: Oh, absolutely. I think sometimes I'm still identifying some of those obstacles and overcoming them. But I think there were a few principles that we needed to keep in mind so we could successfully do braided funding.

A key component is that every funding stream, you are able to maintain its own identity and able to report back to the feds. You're supposed to be able to report back to the feds in terms of, so if I'm using chronic disease and the expectation of the federal government is that I'm going to do X number of diabetes prevention programs, if I'm using diabetes funds, I need to be able to report back to the federal government, this is the number of classes that I did for the health equity zone in this area.

So the way we did that, we developed a financial model where we connected for every work plan, very specific, everything at the level of activity. So when they said they wanted to do chronic disease, they needed to be more specific than just chronic disease. They needed to identify if it was activity level, what was the cost of that intervention. So we could connect at the activity level a specific funding stream and be able to, at the health department, then collect that information and report back.

For our community partners, we did that at the department level. So to make it a little less confusing for our community partners, so these matchings of the funding streams with the activities was done at the department level and not at the health equity zone level. For them, we did let them know, I have X dollar amounts for activities that are connected with chronic disease. So people knew, this is what I can be fund. So we needed to be transparent.

Some of the challenges that we had, for example, with chronic disease, one of the funding streams that we used, midway there was a change in the federal government that would not allow us to any more fund one activity level that we had but even more important had asked us to make it a mandate to do something else.

So when we went back initially to the community partners, it was like, oh, you can no longer do this; you need to do this. It was like a negation from their minds. You are going back into your work. And the commitment to really let the power shift dynamic be at the community level and not the department telling them what to do.

We struggled with that for a while. Finally one of the things we did was, we said to the community, okay, this is what happened. We were transparent. This is what happened. This change happened. But you now have a choice to either stop doing the activity or to do these but we didn't mandate them to do it. We said, if you say to us through your community prioritization process this is not a priority and you do not want to do it, then we will work with you to see if we can continue to fund that, but so you know, we may not be able to.

So there is always that balance that you need to find in terms of staying true to your community process and to the model that you put forward where the power is within the community, where the community prioritization process is driving the work plans of the community. And the pressure that you get from federal government to do A, B, and C. Or even from your state legislature, I must say, to be very specific about the specific funding stream.

So I think being transparent from the get go and honest, that those things may happen, it's a critical component of the success of braided funding. And being able to still be accountable as I said initially at the activity level of every single funding stream.

NADINE: Thank you, Ana. That was really helpful. Really insightful. Thank you for sharing what some of those barriers are. You highlighted, for example, the key role that

you play at the department that many of those administrative and coordination functions as well as deciphering where the funding sources and streams are coming from and how they can be utilized for initiatives, that's a rule that the department maintained as opposed to placing that kind of administrative burden on to the communities but yet the communities still had leadership. And showing how, you know, you may anticipate what will happen but there are things that can change with regards to funding sources and funding streams, and your points about power shift and power dynamics was something that was also highlighted in our first webinar talking about building healthy communities, is that important notion of the empowerment of communities. So especially with the Health Equity Zones being community led, you really highlighted the important aspects of transparency and engagement and true meaningful partnership when you talk about community-led initiatives and community engagements.

Let's bring Ruth Ann into the conversation to talk specifically about the Green and Healthy Homes Initiative. I would like to turn to you to tell us a little bit more briefly about the history of Green and Healthy Homes Initiative, your mission and the work that you all do.

RUTH ANN: Sure. Nadine, I want to thank you and the wonderful presentation around the work that Ana just did in Rhode Island where we have one of our offices.

And as I begin, there's a funnel slide that I gave to you all that I hope -- there you go -- will be helpful in this discussion. But just to kind of build out of this discussion on the health equity and how are we getting to finding ways to advance the methodology of true alignment and finding resources to scale health-based housing, for example, is one of the major things in social determinants. I want to give you a brief history of where we come from and how we've gotten to the work in over 32 cities. That number, again, of health-focused social impact.

But GHHI grew out of the work of parents whose children were highly poisoned by lead. They set out to break the link between unhealthy housing and unhealthy children and families, effectively to address the twin tragedies of deteriorated housing stock, poor housing condition, and unhealthy people.

Over the course of our work, we began to understand that all of this work had to come from ground up, from listening to clients in the field, having conversations in their home as we looked holistically at the health of residents in housing instead of solely looking at lead as an issue. While we have reduced lead poisoning by 99% in Maryland and returned to $44.5 billion economic return to the state according to a study done by Duke University, we understood that we had an opportunity through the data provided through direct contact in the community through the data provided by empirical patient records and cost records, that we had to take a look at all of this. And instead, asking families to wade through 238 lines of funding that could address extreme heat and scream cold or mold, mildew, and moisture, those things that trigger asthma or lead paint or structural defects or other things that impact health, that we needed to find a way to better align those funds federally, state, local, but also to look at the role of philanthropic dollars and private sector dollars in how we could scale a more aligned system that took comprehensive holistic look sharing data across agencies, cross train the workers, everything from health educator to the environmental health assessor to the actual remediation specialist in the home.

And then what would we do in looking at the outcomes of those efforts. So what we decided to take a look at is the innovative social impact of models, especially around what were the cashable savings and what are the cashable savings being created in health systems such as Medicaid managed care, state Medicaid programs, hospital budgets, and how do we recapture those savings. We're also looking at this in the education field, in the housing field, so that by addressing healthy housing or unhealthy housing and anti-displacement efforts, how could we then take those savings back.

And if you want to go back to the slide on paper success, I can tell you how we have taken these standards and practices that have been adopted by 32 cities and with support from several foundations, as well as EPA and HUD, we have taken those outcomes from the work where we have worked with government, nonprofits, and health systems to align and coordinate, and we've especially looked at asthma as a learning tool where we have shown 66% reductions in hospitalizations in Baltimore, 70 plus percent in places like Philadelphia and similar results throughout the country on asthma. Emergency room visits and hospitalizations, for example. And how do we now then look at that and how are we looking at that and advancing the models of scale and reinvestment of dollars.

So we began by looking at what is commonly referred to as pay for success. It's the graphic on the right-hand side of your slide. And we used pay for success not only as one tool in the financial toolbox that we wanted to pursue to redirect health savings back into housing investment and housing healthcare, but to learn from that process, which I'll explain in the other tools in our 30-plus health systems, hospitals, health departments, and Medicaid administrations managed care that we're working with today.

But in the pay for success model, what we're looking at is taking evidence-based practices around issues such as asthma triggers in the home, being able to get referrals from Medicaid managed care and health systems over to community-based practitioners trained to use those evidence-based practices, and to effect a reduction in key outcome metrics, such as reductions in ER visits, reductions in hospitalizations, reductions in reliance on emergency meds or use of urgent care.

And in the pay for success model, those sections on outcomes, we've used actuarial analysis in over 20 studies to look in places like Houston, Texas, and Memphis, Tennessee, and the Bronx in New York and Utah and other places, including Baltimore, and where we have investments coming from either program-related investments from foundations, private sector investors who care about the fact that if we lower asthma, we're improving health, we're improving health systems, but we're also getting kids in the classroom because asthma is the number one reason kids miss school, preparing them better for the future or improving housing stability, they will put the capital up to lend effectively those dollars needed to go to scale. So if you looked at east Baltimore, for example, where we looked at with priority partners, we were looking at the 600 children a year who needed, who were hitting the emergency room on multiple occasions or being hospitalized, and where we could, instead, take dollars, do assessment, get in after the first emergency room visit for asthma, and address those triggers.

The outcome that we aim for then is what triggers payment back from the Medicaid managed care in that instance, and this is what we're working on with United in Houston, with University of Utah, that we had worked on in Utah with Affinity Healthcare in the Bronx and others. We're also working with the state of Rhode Island to look at this on a more statewide basis with their three entities.

If the outcome of emergency room visits and hospitalizations are met, that would then trigger an outcome payment out of the savings accrued for managed care flowing through a Medicaid managed care provider, and if that is met, a payment is made.

That's the baseline where the risk moves to the borrowing side and the intervention is evidence based, and when it works, it's the repayment for the outcome that becomes that countable medical payment.

But what we have learned in doing this work is that by doing the actuarial analysis, by doing our own economic modeling, looking at patient records and so forth throughout the United States but also, for example, the state of New York on a statewide basis, Connecticut, Maryland, and others, is that we have found a couple of things that have advanced.

In Salt Lake, where we looked at using the pay for success mechanism, between the University of Utah and Salt Lake County, the provider of the community-based service and its nonprofit network, the University of Utah health plan decided that the outcomes were compelling and instead are moving forward to pay for these directly.

In Baltimore, another health plan from which we had done a number of studies of around the evidence-based work that is producing the pay for success model, Ameri Group took the same stance, looking at the outcomes of a study where we had taken 240 families, 139 children who were chronically missing school, repeatedly going to the ER, to the hospital. And for the cohort of those children from that study, they saw a 30% per patient per month savings. And that compelled them to say, let's just fund this.

So that is the outcome there.

In Chicago, the Presence Health System decided that the analysis done was compelling enough that they have started to fund this work through hospital community benefit dollars and are now aligning that to move with other health systems to scale that work.

In the Bronx, in Tennessee, and in Houston, we are still looking at a more traditional pay for success model. But with some of the larger-scale managed care organizations, we're also looking at those managed care organizations, funding some of that work out of administrative dollars, and moving forward with state Medicaid programs to allow for the outcome payment or to look at the outcome equivalently as a med payment or the individual actions such as removing carpet, fixing roofs, removing mold and mildew and moisture, and moving that policy framework as medically necessary interventions for which state programs such as Texas are looking at whether or not to allow that as a potential payment.

So we're doing this work through lots of different ways. We have some hospital systems that are doing that through Children's Hospital in Tennessee, Medicaid managed care systems throughout the country, and then health districts such as in Richmond, state programs that are looking at it in Rhode Island, Connecticut, and New

York. And I would be more than happy to answer questions around that, but for us, what we saw in our work over time was that we were doing the interventions necessary to look holistically, right, to repair the issues that were causing ill health, in addition to lead, that we needed to do. And if we didn't do, we would have significant displacement.

The challenge for us became, while there is federal dollars and state dollars often available for lead hazard control, far less dollars available for the environmental interventions that are really necessary to do the root cause remediation around asthma, around fall prevention, all of which contribute, those two alone, to over $100 billion in avoidable costs in Medicaid state programs.

We've expanded this to look at fall prevention, doing programs around seniors. And I'll stop there so we can have more questions around this.

NADINE: Thank you for that history, Ruth Ann, and talking about some concrete models and places where, you know, this work and the interventions are happening.

As you described it, what I really appreciated too was that you talked about the outcomes and the agreed upon outcomes in order for there then as you're seeing these outcomes come to fruition, there is actually then that payment.

I'm sure over the years if you look globally, while you can have this anticipated outcomes of the interventions themselves, but I think the initiative more broadly, there are also surprises and anticipated outcomes, either some that show interventions and investments that you weren't expecting to have the result that they did, and others where it may not have been.

Can you share some examples of where there were some unanticipated outcomes and how potentially the model may have had to change over time?

RUTH ANN: Sure. So extremely good question.

Let me start with one baseline, right? We incorporated over time. As we started to look holistically and with the community of housing outcomes. So we were investing millions of dollars in lead hazard control. We then expanded that to look at asthma triggers and injury triggers in the home. And then really, we still were having unnecessary and costly displacement of families because of energy efficiency.

As we began to incorporate energy efficiency into the work, we found not only were we improving net income for families and stabilization of families because of that, but we were having a dramatic impact on indoor air quality and reduction of asthma.

That compelled a whole series of work that we're doing, for example, for New York State with their energy research development authority, along with Department of Health, and having to look at how we could take multi-agency alignment and coordination to get this to not only be more efficient and more effective and more holistic for families as those health, social, and economic outcomes we're focused on, but it has an incredibly high return on investment. So we are working now in pilot design in the state of New York to explore energy efficiency dollars and health dollars to support also the Medicaid managed care that exists in the state of New York where managed care organizations are now mandated to invest in organizations that do work like our GHHI, direct service programs in the field to reduce asthma, for example. And they're

mandated to be investing in that work. And by aligning all of that, we have a much better shot of long term sustained funding.

Now, on the pay for success side, when we were going at a strict model, some of the things we came to encounter were trying to change culture, mindset, and revenue models on managed care organizations who are consistently in a whirlpool of change as to whether or not they will have the same patient population a year from now. How long will patients stay on a plan? And how do we account for that when we're looking at funding mechanisms that go out 5-10 years to allow scale?

So we had to really do some deep regression to the mean analysis. We had to look at other alternatives by utilizing value-based purchase contracting mechanisms that exist today that will allow us to hit 1-, 2-, 3-year metrics and get within the financial models to where in the change that's happening, we're happy to take people through this. We do a lot of training on this.

It also helped us to do baseline work so that we help to inform states that are now utilizing children's health insurance program dollars to do lead hazard control and asthma reduction as an aligned resource.

So it's also spurring a look at potential sort of bonds that we can do that are built on performance outcomes for issues like lead and to look at how do we better align together things like hospital community benefit investment with other resources in the community and with managed care or value-based payment outcomes.

I think yesterday at the Atlantic festival here in D.C., the administrator, CMF, was very clear what they have seen over the past administration and current administration is that you have to find ways to redirect health dollar if you want to move from volume to value in order to get better health outcomes. So I think we are on a research advance kind of process here, and we're starting now to see a move from the trickle to much more flow in the investment and reinvestment of health dollars into housing.

NADINE: Great. Thank you for that, Ruth Ann.

You know, your organization has decades of experience in doing this work. There are organizations and communities really thinking about embarking upon trying to utilize these types of innovative financing and funding models to advance equity and improve health and well-being in their communities. What kind of advice would you give them? Where should they start? What should they be aware of if they're embarking upon such initiatives?

RUTH ANN: Well, I think there's a couple of things. I would tell you that common sense and what we see is often the answers to many of our problems. There's a lot of programs at the ground level that we know work. The picture that you have on the leadership here in the upper left was launch of a program for public housing authorities in the United States where we knew that there was lots of excessive cases of asthma that were coming because maintenance workers hasn't been trained to the same level. And it was community-based organizations listening to families and looking at data both that came to design a program that did a better job of training the maintenance workers to have quality intervention, have quality assurance outcomes, and to look at the dollars saved.

So you have to have -- you know, we can't look alone at return on investment as the only answer, but it's a driver in making the case. So I think if you are at a community-based level, doing work that you see enormous success, either invest in or team up with local university programs or programs that can help collect hard data, embrace data in terms of the cost, the time, and the outcomes, both in survey data and patient data and actual cost data. All of it matters. Because once you get to the boardrooms of managed care, you get to the boardrooms of hospitals, you get to the level of talking to state Medicaid directors and health directors who have budgets to realign around those things that work, you're making that case.

But I think it doesn't stop there. Part of what has been enormously important for us is we've looked at those secondary and tertiary outcomes. So as we reduced hospitalizations for asthma in our study in Baltimore, for example, we also looked at school attendance. We took those 139 children who were chronically missing school, and we reduced greatly their hospitalizations, but we tracked the net result of that, which was a 62% improvement in school attendance.

We also tracked the ability of parents to get to work, which showed an 88% improvement. And we tracked the housing stability factor, which went from 36% a year of families turning over to 6%.

That displacement, that instability, that turnover, has a lot to do with other aspects of health and is a precursor to better retention rates for health plans.

So you have to be able to look at that as well as look at your own organization to say, we're doing something that works. Are we prepared for scale? Do we have the talent, the structures, the resources, and the right advisory services to go to scale? Because if you are a managed care organization in New York State, for example, or in Rhode Island, and you're looking to have community-based organizations do interventions, they're going to want to know who they're contracting with, who they are supporting, can actually achieve the projected results, do that with quality, and have faith in that work.

So we are concentrated a great deal on the service provider side to create a large pool of asset resources for this convergence between health and housing.

NADINE: Great, thank you, Ruth Ann.

And Ana, I think I'm getting a cue that you wanted to add to this point as well, is that right?

ANA: Yes. As I was hearing, I wanted to talk about scaling up and how do we sustain and grow this kind of initiatives, and how even we start with these kinds of things.

When I first talked about it, I focused on the funding of what we needed to do at the department level from a funding perspective. But I think it's also important to recognize some of the other critical components of this work. And one of them was really for us to move from the top down public health traditional approach to much more of, as I was talking about, the community-driven one.

But also important part of doing that job was breaking down the silos. Not just also within the health department, but across and outside of the health department. Sitting with, getting people from different sectors to sit at the same table and discuss what were the shared values and goals, but also what did we want it to achieve.

And the other thing about building our efforts was how we were thinking about bringing the private funders and the business as partners. We talked about the community benefits for the hospitals and that is absolutely something we've been working on. How do we use our regulatory framework, our regulatory tools to help move forward with this kind of agenda.

We heard Ruth talk about the accountable entities or accountable organizations and Medicaid, and we've been partnering with Medicaid in Rhode Island and with the accountable entities to challenge them, in fact, to move further down. And traditionally, there's a reinvestment of the savings into the healthcare systems. We want to have a conversation about how do you use some of those savings not to continuously reinvest in services and in the healthcare system, but also on those place-based initiatives that if you totally address the conditions at a neighborhood level, you are improving all kind of different health outcomes.

Also creating alignment of measures. We talked about measures and how that is important. So as we did with our because we had a state innovation plan, as we came up with a health system quality measures and if there were for diabetes, whatever is the measure, AC1, we made sure that the clinical measure we were doing for the health system was a comparable one at the population level, community level, so we can start aligning also the measures of success and outcomes.

RUTH ANN: Ana, you got me excited and I apologize for that. The point you were making is so good because what we have found, two things, Nadine, that I think are important, when Ana was talking about multisector.

For example, in the state of Maryland, the Public Service Commission, which oversees utilities, invested $38 million into green and healthy homes across the state because they saw the opportunity of what are called nonenergy benefits, i.e., health benefits that they could reinvest to move that framework and support the health systems.

But I think the work Ana is talking about, being done by really good organizations, we are doing some work with Integra and with the state and others, is the opportunity to take some of these savings and the reinvestment and also from hospital community benefit fund that can do this work but also create jobs.

So we can create, when we do this work, for example, people who are underemployed or unemployed in the community, train them as energy health assessors. And those are jobs that will earn somewhere between $55,000-75,000 a year once they get to a 5-year level. That's a real salary that can be done to support this work but also give transportable tools.

The same on contractors, when we saw as we cross train the contractors doing the work and adding in the health framework and the cross work around lead, asthma, injury, energy, we took workers in Buffalo in a study from Cornell University and the center for employment opportunities, and we took their baseline wages up $4-8,000, which is significant. So there is an opportunity to build strength in communities through health equity assessments, and I just thought Ana was making that point so well. Sorry I got so excited.

NADINE: We love excitement and we love when our panelists are bouncing great thoughts and ideas and experience off of each other. So that is the point of engaging in this conversation in this way.

And I'll say that we've been actually, as you all have been speaking, are we've been addressing several of the questions that we have been receiving from our audience members, both in the registration as they were submitting questions as well as we've been going through the webinar. So that's been really great, that as you're discussing these, we are addressing several of their questions.

And I do want to move to answering some additional questions from the audience in our remaining time.

And this one in particular is focused to Ana, but certainly, Ruth Ann, if you have additional input to add.

But Ana, there's some interest in hearing more about the processes that were used for the community health assessment for Health Equity Zones. How did the communities actually conduct those community health assessments in order to identify the areas that they were then focused in?

ANA: Absolutely. When we did the RFPs to the community and we asked them to delineate the geographic area, we had some data at the state level, but we asked communities to do their own local health assessment. We provided community collaboratives with a series of needs assessment tools that they could use. We created one of the key components of our Health Equity Zones. It's a learning collaborative where we brought them all together so we could identify not only areas where technical assistance was needed and be able to provide that but help each other.

So they did a variety of different assessment tools, but all of the community Health Equity Zones, every single one of them had established a baseline of core data, and we wanted them to do it both from a disease perspective in terms of priority and disease outcomes, but also in terms of the community environmental conditions that they felt needed to be addressed. So the community profiles. We have community profiles for all of them. They needed to address, needed to have established disparities, outcome perspectives, but also environmental conditions that needed to be addressed.

We provided them with tools and support to be able to do that. And funding to be able to do that.

The other thing that we did, also trying to align with the hospital's community needs assessment. Because that also overlaps with some of those Health Equity Zones. So we asked where there was an overlap, for that alignment to have in terms of leveraging resources, and that was very successful also.

NADINE: Great. Excellent. Thank you.

We also had a question that's specific to geographic area, which is how to really engage and do this work in rural counties that often lack funding and staffing to be able to administer and oversee this kind of work successfully. And I know both in Rhode Island and certainly with the Green and Healthy Homes Initiative, that you have some examples of that. Are there lessons we can learn or some tools or strategies

specifically for rural communities and rural organizations to be able to do this kind of innovative work?

ANA: Absolutely. One of our Health Equity Zones is in a rural area. And it was, they had a coalition, and existing coalition, that was focusing on rural health that merged into a health equity zone.

And I think the importance on that perspective, identifying a partner that can play the role of the backbone organization and be able to provide the infrastructure to the collaborative at that area.

So in our case, we had a health system, a hospital, that wanted to -- that was engaged by the community and agreed to play the role of the backbone organization.

But we recognized that we needed to do support, part of the investment from us was supporting the build out of the infrastructure and give the community enough time to build a collaborative, to build the relationships needed to maintain that collaborative, and that identification of the backbone organization.

RUTH ANN: Yeah, I would just add on the rural, the housing question, there's a couple of -- there are some key resources that can be leveraged through the USDA housing preservation grants. Energy dollars are now looking more and more at health outcomes and can become a leveling resource at some level for rural. But the ability to capture Medicaid managed care or state Medicaid savings that may be reinvested also becomes a leveler in access to resources.

So I would tell the folks sitting in, because we are invested in Mississippi, and it took us six years of laying track in Hinds County in Jackson, which is not entirely rural, to start to build out to the rural communities and get the state engaged in aligned funding. So it has taken some time, but the idea of building in the health dollars starts to advance and accelerate the access to resources that have been a bit of a struggle on rural communities. And we're happy to talk about that more.

NADINE: You both talked about braiding. A question about state or federal programs being diverted to other programs with a similar intent or activity and still being able to meet the expectations as outlined in the state and federal funding as it relates.

ANA: In our perspective, in Rhode Island, we were very clear that we needed to maintain the integrity of the funding stream. And so we used in our rated model, we used the disease specific funding to support the functions at the level connected back to that funding stream. But we also, part of that was more of the broad grant funding such as the mental health block grant, such as prevention and public health fund grant. Those are more system building kind of language that allows us to use it for more of the infrastructure building along with state funding.

But I think on a braided funding model, it's critical to be able to pass an audit, which we did successfully, that you are able to keep the funding stream identity intact.

RUTH ANN: So let me just say no on diverting. I don't think anybody is suggesting there's diverting, and there's no blending.

The concept of braiding, GHHI wrote the standards around this which are now incorporated in HUD's notice of fund's available for all of their programs. It really is

around the fact that you can align and sequence programs that are going to look holistically.

For example, if you go into a home and you have a comprehensive health and housing assessment, there may be a need for roofing and integrated pest management, lead hazard control. There may be a need for moisture control. There may be a need for a structural defect. And they all come from different areas.

But the same contractor can, in fact, perform the work. You just have to on the scope of that work delineate which grant pays for it. Some may have to be sequenced but can't be done within the same work stream. And so it's not difficult, but it is an exercise like, you know, doing 10 leg lifts a day or eating right. It's a discipline of how to do this but, as Ana said, still meet the grant outcomes, still meet the measures. And actually we find people are more successful in meeting their measures when they align these together.

That doesn't mean you can't also look at the lines of funding and really look down at the statutes and the regulations and potentially remanage, repurpose, or redefine within those legalities. We find that quite often when we go in and do asset gap analyses. There are programs that actually allow you to do housing remediation, for example, that people may not be using those dollars for. And staying within those guidelines, but it's the alignment and braiding, not blending or diverting that works.

ANA: And from a public health perspective, it's what I was referring to aligning at the activity level on the work plans and being able to connect every activity line with a line item very clearly.

And also being able to challenge the status quo a little with the funding organizations and asking the question back of them, being transparent of what you're doing and clear about what you're doing. And so it comes on with an approval. When I say on a grant application we are going to be doing implementing the diabetes prevention program from the 1505 disease prevention grant to the health equity zones and I got approval to do that, I'm clear. I'm being transparent.

So that's important, to also go back to the funder and say, this is what I have in mind, because if I said all grant applications talk about equity, talk about community, clinical linkage, and talk about addressing the importance of addressing the social determinants. So you can connect it back to what the grant guidance is telling you.

NADINE: Thank you, both, for that response in particular. Certainly myself as a former federal official, the notion of yes, there is that program integrity and ways to do this work that still aligns absolutely with the intent of the funding but also to work in collaboration with the funders as you implement these initiatives.

Another resource I want to point out to our audience members is last month there was an issue brief issued on this topic of community health improvement and braiding funding. So in addition to the resources that both Ana and Ruth Ann have talked about, you can also go to the Trust for America's Health website and click on the funding area and find that issue brief that offers some examples and compendium of resources on braiding and blending funds.

We are just to our final minutes of the webinar. Before I move to some closing comments and also highlight for our audience the upcoming webinar, Ana and Ruth Ann, let me turn to you just very briefly for a quick couple take away messages that you would like our audience to have based on our discussion today.

ANA: I think I would say for sure that community leadership is critical to ensure that our change at the community level is measurable, it's sustainable, and it's culturally and socially relevant to them. And that if you challenge the status quo and you are transparent about what you do, there is much more flexibility in our federal funding streams that one thinks of and we just need to be able to engage and push the envelope some more.

RUTH ANN: And first of all, I commend Ana how great you've been. And thank you again for us joining this conversation.

I want to offer to your audience a toolbox that we are creating around funding and scale. It's built around health-based housing but is translatable. So if people contact us at GHHI, we will be happy to do that.

I do think that I want to stress that community engagement, community opportunity, listening to the community, and showing the ability to invest in people and in our work in housing really pays off. Return on investment does, in fact, matter if you can show how that works, but having the tools at hand and engaging communities with those tools, we will be able to improve those health outcomes, those economic and social outcomes.

For us, it is the trajectory of our children and seniors that we're serving. So if we engineer from where we want those outcomes to be and then do our kind of process to that, that will always come out on the north side of the graph.

And I do want to say, if people want more information about how we can work with their hospitals, their managed care, their state Medicaid on this engagement work, Ana is an unbelievable resource. Go there. And if she's not available, the Green and Healthy Homes Initiative, we work throughout all 50 states and are happy to help and very happy to partner.

ANA: Thank you. We also have a position paper that we can share around the health equity zones, because, as you said, place matters when it comes to health and if we work together and invest together and shift our investments to the place where health happens the most, our communities, our outcomes will change.

So thank you, Nadine, and everyone for engaging with us.

NADINE: Absolutely. And I hope our audience can tell we've got two great champions for community and community engagement. As we do this work towards advancing health equity for the nation, I would like to move to our final poll question, which is, as a result of today's webinar, what are you taking away.

As you complete that question, I thank everyone again for participating. Ana and Ruth Ann, university been wonderful presenters and panelists and really colleagues in this work in advancing health equity.

I also want to thank our cosponsors as well as the Dialogue4Health staff and Laura Burr for your work behind the scenes in helping to host this web forum.

And certainly to all of you who have participated and tuned in. We really appreciate your participation and the great questions that you've had.

So we'll pull up the results of our final poll question. And while that's coming up, I just want to say again that this has been part two of our taking action to promote health equity series, specifically focused on innovative funding approaches to promote health equity. Wonderful to see that 92% of our audience participants have really gleaned useful information in this webinar and you've heard some of the resources as well that both Ana from the Rhode Island Department of Health and Ruth Ann from Green and Healthy Homes Initiative have shared with us.

You'll be able to download a recording of today's web forum and the first one as well in the series and other materials at the Dialogue4Health.org website as well as at TFAH.org.

The next in our series, breaking outside of the box, innovative collaborations, will take place on October 16 at 2:30 p.m. eastern or 11:30 Pacific. It will focus on the important work of the WK Kellogg Foundation to advance health equity through non-health sectors such as criminal justice, education, and community investment.

We'll hear from an incredible organization in Mississippi, the Mississippi roadmap to health equity, which has obtained impressive results with a wide range of activities, job training for young adults, tutoring students, and running an affordable exercise facility for people of all ages.

And we'll also hear about the healthy heartlands efforts that seek to improve health outcomes for low income communities and communities of color by engaging and educating select Midwestern organizations in the process of racial healing and collaboration.

So stay tuned, and we will send out the registration information for that web forum very soon. We certainly hope that you can join us and help us in spreading the word.

So thank you again to our incredible panelists, and thanks to all of you.

This concludes today's web forum.