

Dialogue4Health Web Forum

Community Prevention and Multi-Sector Stakeholder Web Forum Series – Stepping up to Make a Difference: The Vital Role of Anchor Institutions in Community Health Improvements

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[Captioner standing by waiting for event to begin.]

>> Hello and welcome to Stepping Up to Make a Difference: The Vital Role of Anchor Institutions in Community Health Improvements. My name is Joanna. Star and I will be running today's forum. Closed captioning will be available throughout today's web forum. Regina with Home Team Captions will be providing real-time captioning. The closed captioning text will be available in the media viewer panel. The media viewer panel can be accessed by clicking on an icon that looks like a small circle with a film strip running through it. On a PC, this can be found in top right hand corner of your screen. And on a Mac, bottom right hand corner of your screen. In the media viewer window on the bottom right hand corner, you'll see a show/hide header text. Please click on this in order to see more of the live captioning. During the web forum, another window may cause the media viewer panel to collapse. Don't worry. You can reopen the window by clicking on the icon that looks like a small circle with a film strip running through it.

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Once the web forum ends today, a survey evaluation will open in a new window. Please take a moment to complete the evaluation as we need your feedback. We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon. To type your question in and hit send. Please send your question to all panelists. We'll address questions throughout and at the end of the presentation. We will be using the polling feature to get your feedback during the event. The first poll is on screen now. Select your answer and click the submit button. Are you attending this web forum individually, in a group of 2-5 people, in a group of 6-10 people or in a group of more than 10 people? Again, please click submit. Once you are done answering the poll question, click the media viewer icon to bring back the closed captioning. It's my pleasure to introduce our moderator, Matthew Marsom.

Matthew happens to be vice president for the public policy and programs of the public health institute. Domestic and global health programs. He is responsible for detaining and implementing strategy for monitoring and influencing public policy, legislation and regulations affecting PHI projects and public health policy relevant to PHI. He was a moderator and happy to turn it back over to him today. Please go ahead.

>> Matthew Marsom: Thank you so much and welcome to this valuable discussion we have scheduled for you today. Step Stepping Up to Make a Difference: The Vital Role of Anchor Institutions in Community Health Improvements. I want to thank the organizations sponsoring today to make sure we can bring this. The Prevention Institute, the Public Health Institute. I encourage you to go to the web sites for resources. I also want to thank critical support from co-sponsors. You can see the logos and names of our co-sponsoring organizations. We really want to thank them.

We have a wonderful panel of speakers joining us today to talk about the role of anchor institutions and promoting community health. I want to start by introducing each of them. First is Steven Standley who is the Chief Administrative Officer of University Hospitals Cleveland. Steven served in a senior leadership role since July 2000. A position responsible for system-wide master facility of planning, plan operations, biomedical engineering, system-wide sustain ability programs. Construction projects, et cetera. Including the construction of two new hospitals and 36 other major construction projects.

Amy Slonim is the Senior Program Officer with Robert Wood Johnson Foundation. Amy is working with the bridging health and healthcare catalyzing demand for healthy practices portfolios. She was the CDCA liaison as a consultant to the population health, Healthy aging program. And prior to 2007, Amy was the Director of Programs and Senior Public Health Advisor for the Public Health Institute. Thank you for joining us.

Tyler Norris is joining us, Vice President of Total Partnerships for Kaiser Permanente. Community vitality and prosperity. Currently in his role as the Vice President of Total Health Partnerships, anchor institution strategies applying all assets to improve population health. Thank you for joining us.

And last but not least, David Zuckerman who is the Manager for Healthcare Engagement at the Democracy Collaborative. He served as the manager for the healthcare engagement of the organization's anchor institution initiative. Embracing the anchor mission. Focuses on economic development strategies that build wealth in low-income communities with attention on hospitals and health systems can deploy the business size of the institutions to support community health improvement and strengthen local economies. All of the bios today will be available to download on the web site. So again, thank you and welcome. You'll hear from them all shortly.

So the agenda at a high level. We're going to have an opportunity to hear from Steven in a moment. And then a panel discussion and really grateful that Amy is going to moderate that for us today with Tyler, David and Steven. And then come back to a Q and A where I'll moderate where it's valuable that we hear from you, our audience. We have several hundred people who are logged in and listening to us today. And we want to hear from you. Use the Q and A feature to send in your questions for the panel. And we'll be sure to bring those up. And so with that, I'm going to start off by bringing up poll 2. If we can, on the right-hand side of your screen, you'll see poll 2. How familiar are you with the term anchor institutions? Are you very familiar, not too familiar or new to you? If you can please click submit, that will enable us to get a sense about your familiarity with the term.

So with that, it's my pleasure to hand back to Steven Standley who is the Chief Administrative Officer of University Hospitals Cleveland. And Steven is going to walk us through his presentation.

>> Steven Standley: Thank you, Matthew. Good afternoon to everyone. As was mentioned, my profile and bio is up. As you hear us talk about what transitioned and how we engaged, one

of the crucial factors in your organization to redirect resources and link together business strategy with community engagement and community development activities. I did not start out this way. As time went by, my portfolio fits very nicely for a lot of the strategies that I'm going to talk about as I go forward here. Really started in 2005. I won't spend a lot of time on the detail. There is a white paper on the vision 2010 projects that was put together by the democracy collaborative and also MIT. And I believe that will be available to people if they wish to review that. That project, in terms of scale included, as was mentioned, multiple major construction projects across northeast Ohio which occurred from 2006 through the middle of 2010. We did not realize the recession would happen while they were happening. Why that is important. That was the beginning of a journey. Prior to that, university hospitals would be like any other major health system in terms of how we engage the community for various diseased states. Our mission to treat nurses and those types of health system.

What really happened during the vision 2010 projects where we were spending \$1.2 billion to build the new assets, we made the decision to focus the investment in a completely different way in terms of investing in local businesses not following the tradition methodology of hiring the largest construction firm and everything comes in from out of market and really kept everything focused. And with intentionally looking at developing small businesses to do some of the work on the projects and inclusion and diversity. And this morphed for us as we started to see the connection between jobs and creating jobs and the communities that surround our largest campus which are some of the most challenged in the state of Ohio. About UH, I won't go through all the metrics here, but it is a large health system. 15 counties are now up to 26,000 employees. This slide's important because at this scale, our ability to redesign our workforce strategy is really making an impact now in some of the targeted communities where we know we can help with the way we spend money. We can help with the way we support housing development. But we can also help as an employer. And we can set up protocols and systems which I'll talk about in a minute which allow us to really go out and find residents from these tougher area inside terms of socioeconomic metrics and employ them within our health system.

The market I'm talking about sits in the eastern side of the city of Cleveland. We refer to it as the greater university circle. This slide is there to show you some of the socioeconomic challenges of this area. And I think for us, for a healthcare institution, some of these numbers really resonate. We have Rainbow babies in children's hospital which is nationally ranked. The idea of access location connects to the community for things like infant mortality is simplistic. The reality is it's about socioeconomic factors. That gets us to employment and stability for the residents of these areas. If you are interested in the anchor strategy, this is a really great document. I think it gets into all the cultural issues we had to overcome and the way we kind of changed in terms of approaching major construction. I'm going to spend time on this slide.

What I wanted to talk about is these factors on how we put this together. If you've worked in a major healthcare institution, buying local is not as easy as it sounds. A lot of the acquisition and procurement strategy comes from a 20 or 30-year-old philosophy of using group purchasing organizations. In our case, 6 to \$800 million a year and say no we're not going to do that. We're going to try to keep the money as local as possible. It's a real change in culture in terms of procurement strategy, contract and going things like that. Neighborhood revitalization for us through our partners. The other anchors in northeast Ohio really started with what we call greater circle living. This is a program where all the employers put up and pledge funds to encourage our own employees to reinvest and purchase homes or rent homes in these areas that we wanted to help revitalize. And that program has had excellent results over 302 employees have taken advantage of that opportunity. 104 homes have been purchased. And we've assisted over 160 people with rental assistance. This also has a subtle reward. Our CEO gets a letter from the employee thanking them and how it changed their life and this type of stuff. These are great because what this does is it keeps reminding your senior

leadership culture that we're doing much more than the traditional healthcare mission, which is dramatic and big here. This is a completely new space for us in terms of how we can impact people's lives. A lot of organizations do this. They do a very nice job at it. The difference for us is it's not just the traditional let's track our businesses and how many dollars we've spent. We track local the same way. We also encourage our large convenient for partners to document and provide us with reporting so we can extend our purchasing leverage beyond the traditional methodology. And third part is we are leveraging our contracts to encourage businesses that do not exist in our market to relocate to our market in return for long-term contracts. We have one project like that that finished last year. Where we brought in a medical contributor who built a \$15 million facility in the core city. Which was worth around \$750 million. Two more of those working on right now. It's a lot more than identify the MBE or female-owned enterprise or try to direct dollars there. Whole idea of sustainable purchasing through partners.

This greater university circle project which is over 10 years old. It's unique because it brings competitors to the table with a third party aggregator. In our case, the Cleveland foundation. At these meetings we have the Cleveland clinic and university hospitals which are traditionally competitors sitting and collaborating on community development, community health. Supporting some of the strategies that came out of this group. Which includes three evergreen co-ops which includes people from these neighborhoods where they have their own personal equity in the companies. The anchors buy the products and help seed them as they go out. They have the mayor's office. The various CDCs and the various communities we're talking about. The regional transit authority. And many others around the table. The CEOs of each institutions attend the meetings. This has been a real process for us in terms of making impact. Greater circle living which I mentioned earlier came out of this. The co-ops and creating all those jobs and three new businesses came out of this. And the creation of the new bridge center for arts and technology which came out of this.

Part of my role here is to say these are all good things to do but we are tracking results. And we're defining that by jobs in this first ten years.

Community investment. UH has the traditional community benefit report that all not for profits produce. As a traditional health system, we have close to \$70 million worth of charity care that we deal with every year. But in addition to that, we have taken what was traditional sponsorship dollars in the traditional sense of buying tables at events for the cancer society or the heart association or those types of things and added to that and said we're going to take dollars and directly fund these job creation strategies. That's a cultural shift for an organization from where we started from. And was not the norm ten years ago. From a cultural transition, I'm amazed as I look back. I've been at UH for 16 years. The way we now refer to community engagement and community development has completely been redefined.

Capacity building, obviously, as a large employer, we have the ability to employ people that, you know, may or may not think they have a chance of getting into an academic setting. And we have really exciting programs that are past pilot stage. One of them is called step up UH. Where we are engaging the community with partners, neighborhood connections and towards employment. And identifying people to come in to our entry-level positions. Once they come in to the organization, if they choose, they can join programs we have internally which develop them to take on higher-paying jobs or finish education. They have now affected 300 people's lives. We have the highest retention of those employees versus their peer level employees that are just traditionally coming in to the organization. We're excited about our focus. This is something we can directly control. As I mentioned earlier, we leverage vendors to come into the community, set up businesses. And as part of that, we ask them to do the same thing we're doing which is prioritize people from the surrounding community. That may mean they are going to have to go extra and take extra time and not use the traditional job descriptions when they are employing.

And community health is our newest area. As I referred to earlier, we have now taken on infant mortality. And led. It was alarming to all of us. Not just the study. Not just to do analytics but to call to action and take all the assets and deal with this situation once and for all. That's one of our newest focus areas.

My notes were to show results. This was the big impact of the large building program. We exceeded our goals with I believe a little challenge on trying to engage people from the city residency. That was harder than we realized. We're thrilled with the results. As we look back, if you remember the recession. It was a good thing we were doing this and kept plowing through.

Wrapping up, I will say this is an alarming statistic. This is another driver. It's really shocking and for those of you looking for the morning et, it's an inner city challenge, socioeconomic area. It's a suburb of the city. More middle class, less social he can no, ma'am -- socioeconomic challenge. You can see in terms of all the factors. If you look at hospitals and part of our mission, this means a lot to us. It's not just infant mortality and not just horrible effects of lead. It's the overall life expectancy we're serving. This slide should say old on the left and new on the right. This is the transition UH has gone through. So many things that have happened to us. I talked to a lot of other institutions about this. This approach to the right really does have health impact and as you think of the intent and goals, our model is shifting to take risk. The reality is you have to build the relationship and have this type of infrastructure in place.

We are well positioned as healthcare reform came on that this now is going to be the vehicle for us to engage those people that are going to be responsible for.

This slide I won't go through but this is the Rainbow Babies Hospital. Just demographics on its scale. Why it's in here is -- we are -- we have just announced a few months ago that we are now going to place a \$25 million project right in one of the neighborhoods that we were talking about. And it will be an extension for children's hospital. So this is our way of saying most organizations wouldn't make this investment.

This is really important for us. We're about to break ground on this project. What's really good about this is the connection to rainbow and to our women's programs fits nicely with the type of impact and action steps we're going to take regarding infant mortality and lead poisoning in children. With that, I hope I didn't go too long here.

Little bit of lessons learned. Collaboration, these are all kind of logical. But the biggest one I would say on here is really figuring out a way to change the internal leadership culture around the issues with the peers and your leaders and your board. Because as you start to develop and mature in these, that's where you are going to end up when you are asking for dollars and focus of staff and things like that. I hope that was helpful.

>> Matthew Marsom: Thank you. Appreciate the remarks and the overview you are doing there in Cleveland and the incredible investments you are making in the community that underscore the importance of anchoring institutions and we'll hear more from our panel momentarily. I want to make a quick programming note. All of the audio as well as the slides including the slides that Steven presented will be available to download following the web forum. They are usually up in 24-48 hours or so. Be sure to look out for that.

Now, I'd like to bring up poll 3. Are you already working with an anchor institution in your community and if so, to what degree? Please respond yes, working well together, yes, but not working closely together, no, this hasn't been possible, interested but need more information. Please click the options and click submit so we can gather that information from you. And then I'd like to remind people to use the Q and A feature. We had a couple for Steven that we'll get to later on. Please do send in your comments. And with that, it's my pleasure to hand over to Amy, senior program officer. Over to you.

>> Amy Slonim: Thank you, Matthew. I have to second Matthew's appreciation of Steve's bringing to life the higher live local of university hospital in Cleveland. I am so pleased to be

part of this webinar today. And I hope that each of you on the phone is very aware of the Robert Wood Johnson Foundation. And for those of you that are not familiar, a culture of health is a mind set and actions around health as a shared value. That's everything from education to housing, to job creation to air quality and other things that you would think of. And the engagement of community members and sectors working and investing together to create healthier and more equitable communities for all. And we know the value and role of institutions that have deep roots in communities such as hospitals and healthcare institutions and the role they can play in the health and wellbeing not only of their patients but employees and the community at large. And it's through their business practices as you heard Steve reflect on and that you'll hear more from Tyler and Dave and taking on more full approach.

The conversation now continues with Steve being joined by Tyler and Dave. And Tyler and Dave will start out by giving more context about their organization in a very abbreviated way. Then we'll have a series of questions I'll ask them to bring to life. The comparisons and the contractions between university hospital that has been an established anchor and Kaiser Permanente whose work is really evolving. And then Dave brings a perspective and experience from across the country in his work with the democracy collaborative all across the country. He has a really good understanding of the current landscape. Both the trends and resources that support anchor institutions and the key partners.

So I would like to turn it over to Tyler who will be followed by Dave to give more context about their organization's commitment to anchor institution approaches. Tyler?

>> Tyler Norris: Thank you, Amy. And hello, everyone. Great to be able to participate in this. Again, my name is Tyler Norris. I'm vice president of Total Health partnerships. I get to be part of a team and help lead the way our entire organization steps up to being an anchor. And for me, having dedicated the bulk of my career the last 25 years to building healthier communities, the idea of the institutions that command 18% of our gross domestic products becoming part of the driving economic social and environmental drivers of health. Incredibly omission to me. Kaiser Permanente is an integrated delivery system as Steve talked about. Both our health plan and delivery system. We operate in ten states. We're about a \$60 billion organization with 200,000 employees. Amy, I think you said it beautifully. A couple thoughts about the evolving nature of being an anchor institution. As a \$60 billion organization, we are an anchor. Being an anchor is not what's new to us. What's new is the wide-spread awareness of our impact and potential to be much more deliberate about being the anchor institution that we are. We're the largest private employer in California. An anchor awareness, how do we think about our hiring, developing a workforce pipeline is not so much new. We direct that towards the health. One of the largest land owners in California. We were clear when we built the new facility in Downey in Los Angeles in 2008 when we opened it that our facility became part of what helped that community stabilize and stay relatively strong through a very difficult period. I'll get into some of the things we're doing. I think for most of us for health systems, it's a shift of mind set to recognize actually what we already are. And to be much more able to apply leadership to deploy our assets. We're fortunate to have a CEO who understands the more we lean into, we have the opportunity to address the upstream of health. It is possible to improve the health communities and reduce the preventable demand on our delivery system which therefore reduces cost and makes healthcare more affordable. That's our job. And for us, as you look at this slide, the movement is no longer about just trying to do good things. And couple billion dollars every year. We need to move from doing good things and measuring our impact to recognizing our accountability for our impact and being essentially on the line for the vitality of our communities in a much more robust way. That's the journey I'm looking for to describing as the conversation goes on.

>> Amy Slonim: Thank you, tie leer. That was a great intro. Dave?

>> David Zuckerman: Thanks, Amy. Good afternoon to everyone participating on the webinar. I'm going to spend a few minutes building on the idea we've already heard from Steve and Tyler

and Amy. And concept of anchor institutions or idea of anchor mission. An inclusive place-based approach to economic development that focuses on leveraging existing assets to expand community ownership. Our work really spans research and practice and illustrated here are several Public Relations. In the vision 2010 initiative. Purchasing, hiring investment to improve community health.

In addition, more background about the collaborative, we were partners in other Cleveland anchors to help design the cooperatives as Steve referred to as earlier, evergreen is really important strategy. It's an employee-owned business strategy. And work with institutions, hospitals, universities, community foundations and local governments to provide support on how to implement different strategies. Currently, with the foundation support, we're developing tool kits in the areas, local and diverse hiring and strategies for leveraging the investment portfolio of health systems. And these tool kits will get at some of the ideas about the steps taken internally to be better positioned to do this work.

>> Amy Slonim: Thank you. Now I get to dig in and ask my questions of the panel. I encourage each of you on the phone, if I don't ask the question you wanted to, send it in. Tyler, I'm going to start with you. I know the participants will benefit from hearing about how you would characterize the value of your work to both Kaiser Permanente and the community and how this is evolved. And what you believe to be the value to your organization and the city and the community as you advance this approach. How will that value increase?

>> Tyler Norris: Thank you for the great question and grateful for the dialogue here. Just to build on Steve's excellent point. The shifting of our purchasing, the redirecting of our hiring, the new allocation of our significant investment portfolio towards providing community capitol is, first of all, requiring a fairly significant leadership inside the organization. It is not easy when our purchasing people, their job is to get the best deal. That we want to be able to incentivize and reward our people for as part of the larger value equation. Whether that's in hiring practice, environmental stewardship, the use of our investment capital. It's a very significant journey that we are underway on. And the beginning of that is all the measuring. We measure everything anyway. We need to measure economic, social and environmental impacts. Good or bad and be able to look at the truth of that. That's at the beginning of the journey. A couple examples of what we've done. The energy use of our enterprise, 40 plus hospitals, 600 medical centers across the country, we decided to shift our energy away from carbon toward wind and solar. \$800 million investment last year to meet half of our energy from wind and solar. Not only the centerpiece of that is focused on health. Contribution to asthma and cancers and other disease. That's at the center of this. But by making an \$800 million investment over 20 years in wind and solar, we're not only creating hundreds of green jobs in the places where that's occurring. But we're actually growing the marketplace for wind and solar through the long-term purchase. By shifting the way we're using -- powering our facilities if you will. You can say that we're doing something that is directionally correct. But our bar reduction, climate change is deminimis. How are we bringing other healthcare systems of how we're then trying to expand that to be much more of an impact. The second example is work with national supply or diversity. Our procurement is about \$15 billion a year. Again, put it in perspective. Our charity care and coverage is \$2 billion a year. That's still a lot of money. Our spend on procurement, \$15 billion a year when you start thinking about the levers we can pull. A tenth of that is dedicate today purchasing from women in minority-owned firms. Hitting that kind of scale. But it was focused on women in minority-owned firms alone. Our big movement now have been a big help. How do we localize that purchase so that we're spinning the local economic fly well. Not only referencing those groups but how do we bring that home? That is changing everything internally about what we see our value being. It's really allowing us to engage with the community to additional levers and help us drive a local economy. Really changing what's happening externally. Gives us so many more levers. Grant making and confined things in a traditional way.

>> Amy Slonim: Thank you. I'm sure very few people expected to hear about reduced carbon particular in response to that question. That was really helpful and expansive for all of us.

Now I'm going to turn to Dave. Dave, you come from a perspective that has input from your work from various institutions all across the country where the anchor approach is working. Tell us a little bit about your perceptions of what has precipitated that work getting started in various places.

>> David Zuckerman: Sure. I want to step back though to talk a little about, I think, what has put the responsibility in the communities the way we're describing here. In this area, very mobile corporate capital. Need to be leveraged in a different way so they can be active partners in helping to adjust the issues. In hospitals, universities, local governments, they all represent this idea of sticky capitol. The non-profit and public ownership. And they are in our communities for a long-term. Overtime, many communities, they have become the largest employers and new economic engines of those communities. A lot really has changed and as health systems wrestle with the different ideas we've been talking about fee for service keeping people healthy, they also contend with this new responsibility that comes with economic clout and all of this within an era within communities and local governments are demanding more from local institutions. The key here is how to rethink how we do business. Not to spend more money in this endeavor but to be more intentional how we spend our money. That's not really where this idea started as you were asking. It started with first really coming from the university sector. And out of a more self-serving approach. And overtime, equity inclusion have become more of a focus recognizing the win-win that can come from that.

Now, health systems are adopting this. And I want to make a small side note in this. What we have up here, the 7 drivers of community wealth building that they have used. Anchor institutions can employ their resources in many ways. Without a focus on equity inclusion. The impact can be much negative as it is positive. So it's really exciting for me is I keep learning about new and innovative approaches to leverage the operational side of the organization in partnership with the communities they serve.

>> Amy Slonim: That was a really important perspective. I think you raised two great points about the equity impact and how we do business. I love the sticky capitol piece. Let me turn to Tyler and Steve now. If you wouldn't mind reflecting on your own anchor institution efforts. Your more recent work, Tyler and established work of university hospital. What enabled you internally and in the community to start this work? In areas that had not been done before? And how would you describe the short and long-term differences inside your organization because of this work? And also the impacts in the community. I know this is a long series of questions. I know you'll be able to answer them. So basically getting at how cultures have changed because of your anchor approach. Both internally and externally. Tyler, do you want to start and follow up Steve?

>> Steven Standley: Sure.

>> Tyler Norris: Sure. Be happy to. First of all, we came out of the shipyards. Kaiser Permanente started as an industrial organization and the health plan came out of Henry Kaiser's commitment to make sure his employees had healthcare. So we've been an anchor institution in partnership with labor since the beginning and paying a living wage and being an anchor is part of our roots. The first recognition is this is not corporate social responsibility for us. This is not something we do at the margin. In order to have a better CSR report at the margin. For us, the opportunity to provide a health plan and coverage. And provide high-quality care. And wrap community assets around that given what we know. That are so tied to chronic disease. Coverage and community and the enterprise. That all of those together is our value proposition, as an organization. When we've been trying to, and the investments have been ground breaking in helping shift help. Working for a long time. Unless we are deep in our communities, deeper than the grant-making side or reach intensity and duration, at least 7 to 10 year commitments, we're not actually seeing sustained behavior

change. That's on the community health improvement side. We need more dose. Longer, stronger, more intensive, not three year glance and half-baked efforts. It doesn't add up the behavior change. That's the challenge we're seeing around so much of what has passed this healthy community in the way. So from the dose perspective, if we're going to have a measurable impact on population health, we need to move everything we've got. Not just the \$2 billion that's community benefit. The other \$58 billion is the rest of the enterprise. That is a distributed ownership. It takes leadership at the top. We've got that with Bernard Tyson. We have to change the way a couple hundred thousand people operate where we think everything we do as being part of our role.

So just a simple example, let's say that we know that scaling access to healthy food is essential to making our contribution to health. We all know that. We can use grants, a mechanism we've long used. We do that well and so do many of you on this call. Multi-year purchasing like we do in partnership with other school districts and dignity health. One of our favorite competitors, if you will. To do multi-year contracts that are bankable. So we can use our procurement lever and turn around with our investment portfolio and make capitol available like we've done through the California fresh works fund. We start to see that grant's a lever. All at the same time. If we're seeing with the slide up right now, all assets for health. The executives are on the line by saying how do we bring HR to bare? The 28 labor unions to bare. All on the health bar community so this no longer is a community benefit strategy. It's an enterprise-wide strategy of what it means to be a generate I have company. I think it's kind of an approach is asking the question of what is business for and what is business capable of helping drive our country particularly as Dave pointed out for vulnerable populations. We are much more powerful than we've recognized. I'm going to talk about Kaiser Permanente health sector universities overall. And I think it's reflecting a new way. Steve, your turn.

>> Steven Standley: That was well said. I think you covered the overall. I would say in a local level, in a region like we are, there are so many business drivers to this way of thinking. It's shocking more people haven't picked this up. Or to get traditional bottom line thinkers beyond the community benefit or social responsibility lens. What's happening in healthcare is consumerism. In markets where like Cleveland where we have fully consolidated market of two large health systems, the reality of the future is the patient experience and all those types of what would be traditionally viewed as for-profit types of business drivers. The challenge is to take this way of thinking and put it into that lens. That's what resonates with people that you are trying to get them to see.

That's what our journey has been. Started out as 2005, we're going to spend a billion-two in Cleveland. Are we going to spend it in Cleveland or the United States? We chose to keep it local. And we could attribute that we kept a lot of people employed. Here, the big change was to define success in terms of jobs. There are so many other amazing programs. There are so many aspects to this. But the reality and some of the lessons we learned is if you give people meaningful jobs at a meaningful wage and health benefits, you're making a major change. And it's one person at a time. One family at a time. And then it starts to catch on. And our peers and our for-profit corporations hear all the success stories. And it's really not just the right thing to do. It makes sense.

I heard somebody say the other day, if we're not going to deal with the minimum wage issue, the reality is the people building the products can't afford to buy them. It's the same thing with our space; right? If we expect people to take care of their health, they don't have a job and other types of chronic diseases, they don't have the money for the medications. They get in our emergency room, they go home and they are back in 15 days. And every episode they get worse and they get worse and they get worse. So our numbers aren't as big as -- makes a direct correlation to our health mission. On the inside, as you recruit younger people to replace employees and professionals in our organization, they come to the table with a whole new set of expectations for you as a large employer. They expect you to have sustainability. They

expect you to be diverse. They expect you to have a presence in a community that's beyond your traditional product or mission. And we've seen that in our recruitment. Our CEO does open forums across the system which takes him a couple months because of our scale. And he tells us in the senior management, he talks about all the really cool stuff that's going on and the new technology and the new programs and all that stuff. When he asks employees for questions, they repeatedly prioritize and ask him about the programs we're talking about today. So we know it resonates with our employees and we think it drives a really good internal culture for our organization.

The other area is really the whole concept of managing and leveraging. You can do this heavy handed. And when we first started out, we thought well if we tell vendors to do this, we'll do it. We learned through time that you just can't dictate this stuff. You have to build meaningful partnerships. They have to see your vision, they have to share your values. So I think that's what's changed with us. And these days, we don't even talk about the traditional social community stuff we used to do. We still do it. Those disease state 501(c)3s expect us to be focusing on them.

>> Amy Slonim: Thank you, both. Really practical and invigorating wisdom about the assets, the tearing of investments and business drivers. I know it was a benefit to hear that. Dave, I'll turn to you and share your perspective on the landscape, meaning the institutions like hospitals and universities pursuing that anchor approach and how things have changed in the last five years. Where you think it's headed. And what, in particular, are you optimistic about.

>> David Zuckerman: Thanks, Amy. And I think what we've heard on this webinar is really insightful from Steve and Tyler. I want to thank them for sharing those thoughts. I want to say that the landscape has changed because where many of the efforts started from at the beginning was because of something was built into the culture of the organization overtime or the right champion or a specific trigger in the community that fends from mounting racial inequities. Now the shift is a more holistic view of health across the country. It's good jobs along with an entity such as grocery stores and affordable housing that get us to that end goal. And so, as the largest employer you see more health systems, you also see these regulatory triggers that Steve mentioned to keep people healthy. I do think that the community health needs assessment. While not having a lot of teeth has been a tool for framing a new conversation. When you see poverty, unemployment, housing affordability are issues that rise to the top to voice their health needs. Those need assessments have been an opportunity to build new relationships and also increase collaboration. Something that we can be optimistic about. As these different areas of the community work together in a way to take a his or her holistic approach to keeping people healthy.

I want to touch on one other thing. We talked about hiring purchasing. And a little on the role of investment. There's a tremendous amount of opportunity and while there have only been a few institutions to date that really explored how the tremendous investment portfolio and individual health systems can have several billion dollars, there may be \$500 billion. Could be unbelievably significant. Hospitals have really been leaders in this area. And one powerful example as in dignity health which has \$100 million loan pool. And it's another way to get at this community impact in a way that takes these resources and doesn't necessarily compromise in when you talk about these topics is no margin, no mission. I don't think it has to be either. You can definitely compliment the two. And what we're seeing in that one example, it started off in the culture is increasingly being aligned with the community investment and being realized as an important part of diverse portfolio. Very much from that business perspective and during the great recession, that loan fund outperformed the overall portfolio. There's a number of different ways to get at this. And seeing how all of the resources can be leveraged. I would just add that one last thing we're hearing is it's becoming an investment of time rather than spending resources. That's something to take home from this. Is that we're just talking about using resources in a more strategic way. I think that concept is really starting to sink in across the

country. The approach is growing.

>> Amy Slonim: I really appreciate that. Any barriers as we think about implementing an anchor approach?

>> David Zuckerman: Yeah. I think Steve talked about this culture. We need buy in from the top. How this conversation trickles down through the large institutions that are made up of many thousands of people. And one person can easily derail institutions and practices. And people get comfortable this way. As we rethink how systems should be operating in their communities, I think that the biggest barrier is less resources and the culture of the organization to go out of its way and putting these opportunities front and center as priorities for the organization and making sure that everyone down through all parts of the institution are brought into the process.

>> Amy Slonim: Thanks so much. And I really hear you reiterating the importance of those core relationships both in the community and internally. So thanks so much.

Before I turn to the final word, I'm going to ask Steve and Tyler for a quick reflection on how your institution -- has position -- positioned itself or viewed differently by the city or community by virtue of your anchor institution work and approach?

>> Steven Standley: Yeah, I think there's a lot of ways to respond to that. I can tell you that we have -- and we didn't do it for this but we've gotten several awards from different parts of the community, foundations, the city, the county, those types of things. Which is great because it just reinforces with our employees and leadership team that this stuff is meaningful and it's being recognized. We don't tend to -- we get criticized for not talking about this stuff enough. We don't want to make it into that. I think the other thing is we have built with our other anchor institutions this amazing circle of trust. We can compete on different issues outside this circle. But when we're together and we're working on these projects, because we've done so many together, everybody's kind of got everybody's back. And we can move faster and we can do more dramatic things which is what we're starting to do now. Those are really intangibles and really hard to monetize. As I look back at it and I reflect, I still call this stuff pilot. I think we are ready to go to scale now and have 10 and 15 companies in northeast Ohio that are tied to the anchor in different ways. I think the other is really, as I mentioned, I'm a senior leader here. We have to deal with budgets and have all these pressures that any big organization does. We have so much need. But I do see that this has become a priority. And it's now in our values. It's now in our compensation discussion. It is something that's become very important to this organization. We think it distinguishes us. In our focus groups, we are viewed as an organization here that is high touch. High quality, high touch engaged. I can run all the TV commercials I want but I think if you do real stuff like we're talking about today that people feel, then I think that really gets through. I think that helps us all.

>> Amy Slonim: Thank you, Steve. Tyler?

>> Tyler Norris: Wow. Steve, I think you nailed it who are we -- the depth not just the petina that comes out from our marketing. And you've put your finger on it beautifully. I know when we on shored jobs into downtown Atlanta and put those jobs between two Marta stops, that was more exciting than a lot of the grants we were making. As we're growing in Freddie Gray's neighborhood, if we're trying to make an impact on the fundamental issues that is hurting this country so much that we can't just put a medical office building there and flip grants. In a distinct way so that if we're going to bring the clinical and nonclinical living-wage jobs, we need to create that pipeline with Johns Hopkins, with Under Armor. So we're building a pipeline from high schools to community colleges. So the community can take advantage of those jobs. That's a different kind of role than we've been focused on. I appreciated what Dave said about the community health needs assessment. We're beginning that season now. That is giving us a focus on the housing needs. The transportation needs. We are shaping investments tied to what we're learn nothing the dialogue around the community health needs assessment. We're part of 50 of them around the country and giving a real focus. And finally, I wanted to pick up

with what Steve said about the goals. We've essentially treated our anchor strategy, what we call total health as a movement, a special movement inside the organization. So with an invitation. And next year, our goals for the executives will all be tied to how they are stepping up to deliver on total health. And in a big organization. That kind of goal and incentives and rewards helps move an organization in a way. So just a few things that I think are changing us internally and externally to walk the talk and make it real.

>> Amy Slonim: I must say I feel quite honored to have been able to moderate this panel. It was very potent in terms of all the nuggets I shared. I want to give each of you the final word. And I really mean just a few words you want to leave the participants with to ignite them about these possibilities or something that you wished you had said that I didn't give you an opportunity in the questions. But really just a few words. And then we'll turn it over to the participants to ask their questions. So why don't we start with Dave and Tyler and then Steve.

>> David Zuckerman: Sure. Thanks, Amy. Really great conversation here today. And I guess where I want to leave it is creating healthy communities is hard work. We all realized that. The core of it is the wanting to problem solve and bringing creativity to the issues we face. There's no logic model for that. It is important that what is measured gets done. And there is some way to evaluate the investment you are making. It's more of a learning and revising practice rather than to say we can't make indentation on poverty. Can't address good jobs. We can't create affordable housing. Maybe there is a way that health systems and other institutions can be part of those institutions. Maybe not the entire thing but part of them. So I really think there needs to be a sense of there's no failure throughout this process. There's feedback and trying to continue to move forward.

>> Amy Slonim: Thank you. Tyler?

>> Tyler Norris: I think that this is really allowing us to live up to our value proposition more fully. Not only mission to the communities we serve. But to improve the quality of care for less money. And one, we know clinical quality alone is not going to improve health. We have to wrap these community assets we need to invest in through community strategies alone. We're trying to reduce diabetes rates, we can't discharge people back. We need to invest in those core. If we do that as integrated delivery system at risk for the health of the community. That we believe that if we do this together with our friendly competitors, with school districts and universities and other anchors, that we can improve the health in a way that reduces preventable demand on the delivery system. Therefore, lowering our cost basis and helping make healthcare more affordable overtime. We think this is the ultimate cost containment strategy that makes healthcare not only improve the quality of care for more people but also to have a healthier nation in the first place.

>> Amy Slonim: Thank you. Steve?

>> Steven Standley: Tyler, that was excellent for the healthcare. I would take this up one notch just cause I haven't talked much on this. But I think this is another example of where the not for profit sector can set a new standard of expectations for all major employers. And that's what I think is happening here. A lot of the work we did turned into a much more sophisticated hybrid community benefit agreement for the city of Cleveland for developers and other for-proper it businesses if they want to engage here. But I think we are -- events like this today and thank you for inviting me. Moving this along and getting people with any community within the United States to think of their anchor institutions, their large universities, their major employers way beyond what the traditional expectation has been. And we really are anchors. We can't pick our business up and go. Communities should view us that way and hold us accountable that way. I think if the actual public sentiment and expectation shifts, many more institutions will begin to think this way. A lot of us are not for profit. We don't pay property tax. We are mostly in cities that have school systems that are needing dollars. We better do something to replace that position in a meaningful way so we're not taking care of the children but providing jobs for their parents so they can afford to take care of their children and go to school and our next

generation is that much better off. There's a lot of forces that play here. As general consumers, it's not just about products and services. It's really what are you doing? You are a large employer. Half our city works for you.

>> Amy Slonim: Well, thank you all. My final word is to say a special thank you to Steve and Tyler and David for sharing their reflections about anchor institution work and all the dimensions associated and making the opportunities very real. So Matthew, I am turning it over to you for the Q and A session.

>> Matthew Marsom: Thank you. And likewise, I want to thank the panel as well as you for that rich conversation. I couldn't stop scribbling notes and all the follow up I'm going to do. In terms of the value of the dialogue. So thank you. All of that conversation is going to be available as audio download. So really incredibly rich resource moving forward. And I encourage people listening to share with your partners. Share with your anchor institutions so you can see what incredible leadership is happening so we can replicate and sustain it as well. And on that note, I'm going to start with a question in the final 50 minutes we have, I'm going to go back to the panelists and ask questions. And Amy, feel free to interject if you want to add a thought as well. Steven, I'm going to come to you. One of the questions came in from Chris Paterson who is listening today. You mentioned in your presentation the importance of leadership. How can we make the case to existing healthcare leaders who may not see the benefit of value or feasibility? How can community partners reach out to leaders to say how can we replicate this?

>> Steven Standley: Yeah, I think the biggest issue is really to show examples from other markets that have accomplished things. Once you start to display the evidence that this is meaningful and not just the right thing to do, it's pretty compelling. Who hear snippets of doing. Once we finish with them after about an hour, they are all excited and they want to do this. It's logical and doesn't require, you know, huge change. It's really just a new way of thinking about how you are going to spend your dollars and who you can recruit into your organization.

The other point I'd add is economic forms are at play. Where are tomorrow's employees? We have shortage of doctors. Shortage of RNs. We need to attract people to this space into this sector. If we redefine the standard of the culture, it's much more attractive. Even the hardest core leader who is totally -- bottom-line oriented will realize that I have to attract employees to this organization for me to do my business. So there are forces out there that are happening anyway.

>> Matthew Marsom: And follow up question to that which has come in who is one of our listeners today. University's leadership based on social determinants in answer of health. She's been in conversations for several years without success. I think we know from experience that beginning a conversation can be new to people and challenging. How do you begin a conversation beyond just the immediate economic benefits? How can you start that dialogue around social determinants in answer around management?

>> Tyler Norris: It's a fabulous question. Part of social determinants of health, education and human substantiation are all the same. When we invest in the underlying drivers with populations in communities, that we're helping make the country healthier, wealthier and wiser that works for everyone. We need to take a look at what it is that we're talking about. Part of this conversation that's been so powerful is we have the assets that we're using them. We're already buying things and hiring people. So how do we use that power in ways that actually live up to our missions? That are much more authentic to who we really are as hospital systems or non-profit universities, et cetera.

And third, I think that we need to engage our board members and our physicians to really be thinking about what is the investment strategy for the health and prosperity for our community to that. So we're not saying we do this or do that. But what is the combined strategy by which we're trying to create prosperity and really shift a conversation starting at the board level in some cases.

>> Matthew Marsom: David, one of the questions come in from several listeners. I think it's

reflective we have a very diverse audience of several hundred people that's correct includes people in local health departments across the country in state and local health departments. The question is how can the local health departments and health department leadership get involved? They are not coming from the healthcare sector and from the community side of other employers or city government or community municipality government. How can local health departments engage?

>> David Zuckerman: I think there's Stakeholders on depending on what they hold. From a community benefit individual at a hospital in South Carolina who said it was really her health department counterpart that brought her to see the light of what they needed to be doing at the hospital. And so I think there's different ways to begin the process of the conversation. Health departments needed to do assessments. And so do a number of other organizations within communities. Those are great opportunities to begin to build those relationships and thinking about how to push some of these more upstream determinants higher in terms of priorities for the organization.

I do think, though, the other role the health department can play is thinking about who are the other allies in their communities that can be -- that can reach different people at the health system. We've found that community foundations have been very strong partners in this work in setting a neutral table that competing institutions can come to. Or they might have a level of relationship where they have these conversations with different -- those in higher leadership. And the third option is -- local health departments don't want to take this route. As Steve was talking about, communities need to hold institutions accountable. That can take very different forms from political or community pressure. We've seen some of those examples in varied locations from Pittsburgh with holding a health system there accountable. And most recently where the community organized to make sure its largest employer was hired from specific zip codes. I think there's a number of strategies.

>> Matthew Marsom: Roberto has a question that I think applies to the full panel. I'd like each of you to give a response if you can. His question is whether or not -- this is a question from Rudy, I'm sorry. University Hospitals Cleveland and Kaiser Permanente are big anchors. What about this concept in smaller rural hospitals in communities like the community he lives in Southwest New Hampshire? Perhaps we start with you, Steven.

>> Steven Standley: Yes, I'd think the strategy does work in smaller markets. I have talked to people in smaller markets. The reality is the smaller market could be easier to do this because there is a more direct connection between the anchor institution and the local business and if you will, the quote, unquote, Chamber of Commerce.

And what happens quickly is once the anchor institution says this is a priority, we've analyzed what we can buy locally, it only accounts for this much money, they can now engage the Chamber of Commerce or whatever it is and say these are the types of businesses we'd like to help attract to the community. We're going to fund -- we're going to give them a guaranteed business relationship if they'll do it. And I think in a smaller community, it's more targeted but can be more dynamic and probably faster than what we have to deal with in major urban areas.

>> Matthew Marsom: Tyler?

>> Tyler Norris: I think Steve said it beautifully. It probably is not only easier but in some ways more important than ever in a small community hospital sees itself as an anchor. At the end of the day, who is creating the jobs? Maybe there's a small business or two there. But that really is the core of the community. And if a small community hospital where you are really under cutting the potential of a rural community. Where a hospital is more important than ever. We need to see it -- size is not the issue here. It's the role.

>> Matthew Marsom: David, any thoughts?

>> David Zuckerman: The one last comment I would add is one of the advantages we've been hearing and dog a lot of our research is that the relationships are often stronger in smaller communities. So it's easier to get things done more quickly. You don't have to take the time to

figure out who you need to take to. That's a real advantage if everyone aligns towards the same end goal.

>> Matthew Marsom: We had a question that I think is absolutely critical to this. Does anyone on the panel have information or data on the impact of the anchor strategy on actual health outcomes? We talked about a lot of the benefits and the impact and value of these efforts. Perhaps I can start with you David. What is the evidence this is improving outcomes in these communities?

>> David Zuckerman: Well, I think we have to trust data that shows social and economic -- are key factors. Obviously, creating a good job with and along with the other communities are going to help create the conditions for better health. But I think that trying to create a logic model for some of this is frankly a full errand. Those that have not had the opportunity begin to have those abilities both for the benefit of the institution sitting in that community over the long-term and for the community residents who have been not had the opportunities in the past.

>> Matthew Marsom: Other members of the panel? Thoughts on that question?

>> Tyler Norris: I'll weigh in saying the question that was asked is the question our CEO is asking. He's leaving it the way Dave's saying. But let's prove it. I don't know if the slide I've got right now is showing. We're working with PricewaterhouseCoopers to measure the impact of everything we're doing. The hiring and facilities, all of it. What we're doing is created pathways through the economic, social and environmental impacts of all of those activities and are essentially tracing it. What we're in the middle of is a major measurement process to make that demonstration and to teach us which of the levers have a significant impact and which of them might be sexy and have curb appeal but aren't having the impact. So we're pulling the levers. We have a very significant measurement process underway to help us target what levers we pull and which ones are flesh in the pan.

>> Matthew Marsom: I think you win most impressive slide of the day with that.

[Laughing]

It should get an award. It really is amazing.

>> Spaghetti for everyone.

>> Steven Standley: I know we measure impact of various different programs and things that we do. It is very complex and especially in the types of markets we're talking about where there is constant movement. People moving out, people coming out of incarceration. So in a traditional baseline analytic, it's difficult to measure this. But I know the literature says employment is a key factor in being able to manage chronic disease and things like that. We have hundreds and hundreds of anecdotal stories. And lots of letters and lots of people that would make anyone on this call cry when they tell you what this meant to them in terms of impacting their life. As I said earlier, health outcomes is what we're all about. We have over 300,000 live inside that ACO. For where we are in that venture, we've done this with our own employees and we can see what we can do in terms of measured health outcome there and bent our cost curve back cause we're self-insured and taking all that knowledge and that learning and we're taking it out to our consumers, our patients and all those. Our targeted anchor institution strategy right now is we think very logical and really just about let's count how many jobs we create, let's count how many people we employ. Those are things we can keep our hands on and we know we're making a difference.

>> Matthew Marsom: Wonderful words to bring us to a close today. I want to thank all of our panelists. A rich dialogue and you've proven that to be the case. Steven Standley, Chief Administrative Officer, thank you so much. Amy Slonim, Senior Program Officer for your input and moderating a rich conversation today. Tyler Norris, Vice President of Total Health Partnerships and David Zuckerman manager for Healthcare Engagement.

Such an incredible amount of resources. We're going to make sure all of our audience today that the information for you where you can go for more information, for more resources to learn more about this. The reports, the white paper the policy to be sure you can get access to

those as we move forward. Certainly go to the web page and you'll be able to download the materials that have been mentioned including the slides and other resources as well.

I want to thank, again, our sponsors. The American Public Health Association, Prevention Institute.

And I also want to thank our co-sponsors for their support for the whole series as well. You can see the logos and names on the screen at this time. So thank you to everybody. This has been Stepping Up to Make a Difference: The Vital Role of Anchor Institutions in Community Health Improvements. And we look forward to seeing you on the next in the series. Thank you and have a wonderful afternoon. Good-bye.