# Housing is the Prescription We Need

Friday, June 12, 2020, 12-1p.m.

**[1:24] Jonathan Reckford**: Welcome. Thank you for joining us today. I'm Jonathan Reckford, CEO of Habitat for Humanity, and I'm thrilled you've joined us for our +You series, where we're talking about key themes around housing and how that is so crucial to both the individual and community success we all want.

I want to acknowledge this is happening at a time of great pain and suffering for our country and our world now. We are living in a historic time trying to address a global pandemic, and here in the United States, on top of that, we are having a national conversation around racial equity and justice sparked by the horrific killing of George Floyd on top of other incidences.

We picked today because it's the first anniversary of Habitat's first-ever housing advocacy campaign called Cost of Home where we are advocating for good housing policies locally, at the state level and at the federal level all across the United States. And we welcome your participation. So you can insert your own questions through the YouTube chat, and we will try to incorporate those.

Today's theme is housing and health and the deep interrelationship between health and housing. We are thrilled to have an amazing panel. We have Megan Sandel, who is an associate professor of pediatrics at the Boston University School of Medicine and co-director of the Grow Clinic at Boston Medical Center. Dr. Stephen Klasko, president of Thomas Jefferson University and CEO of Jefferson Health. And Lisa Gordon, president and CEO of Atlanta Habitat for Humanity and chair of Habitat's U.S. Council Advisory Committee.

So, Megan, Steve, Lisa, thank you for being with us today. Very excited about the conversation. And to kick things off, first to you, Megan, tell us about the dramatic event that made the connection between housing and health so real for you.

**[3:18] Dr. Megan Sandel**: Well, thank you so much for having me today. This is really a topic near and dear to my heart, and really Habitat has been an amazing partner over the decades around how to think about a stable, decent, affordable home as being really that foundation to being healthy.

I, in many ways, was blessed very early in my pediatric career when I was just studying to be a pediatric resident after I graduated from medical school. And I admitted a child to the ICU with

asthma. And I was kind of tearing my hair out. Why was this kid having such bad asthma? Why did she go from previously pretty well-controlled to now being at risk of having actually a tube put down her throat to help her breathe? And in that, I asked the family kind of a fateful question.

I asked them what had changed. And they talked about getting a cat. And in that, it was this moment where I asked them why they had gotten the cat, and it became clear that they had mice in the house. They had seen droppings in her bedding. And they got the cat, and it turned out that she was allergic to cats, and that's why she ended up in the ICU. And so for me, it was this like eureka moment where I was like, “Oh, the prescription I want to write is for a healthier home, and that's not stocked at the pharmacy at Boston Medical Center.” And so, how do we make a housing prescription available to everyone. Everyone. So that they have that foundation to be healthy now and in the future.

**[4:45] Jonathan Reckford**: Great. Lisa, thank you so much. And in our format, we really just want to have a conversation so we're not going to structure it too much. Steve, you bring a perspective both as a writer, policy-maker and running one of the great academic medical centers, talk from your perspective as you see community development and health.

**[5:04] Dr. Stephen Klasko**: You know in 1966, Dr. Martin Luther King said basically that the greatest injustice in the United States is health equities. And we represent three cities that probably between us have six or seven of the top 25 health systems in the country. And our three cities probably have the greatest inequities by ZIP code and the greatest difference in life expectancies.

And it starts not with the hospitals, it starts at home. It starts with housing. You can’t do anything else until you start with that. So, in a time where we're dealing with literally thinking about just about everything about our society — starting with race, starting with how this pandemic was handled in a presidential election — this is the time to do the “I’m mad as hell, and I’m not going to take it anymore” and say any health policy has to start with the house.

We spend 80% of our money on things that will affect 20% of health. And we have to stop talking about academic things of population health. We had the first college of population health. For years, we spent half of our time talking about, “Is there a 20-year difference in life expectancy in Philadelphia or 22 years?” And we stopped that.

In Philadelphia, we started the Philadelphia Collaboration for Health Equity. We’re partnering with Habitat for Humanity. We’re part of the CAPABLE program. So as part of the people that are saying things have to change, everybody needs to start with a house. And I have a book coming out in two weeks called *Un-Healthcare*, a manifesto for health assurance. And basically what it says is we need to move from hospital-centric sick care to health assurance at home. And you can’t do health assurance at home without a home.

**[6:52] Jonathan Reckford**: Thank you. Lisa, you see this every day in the community. How have you experienced this from the housing side?

**[7:01] Lisa Gordon**: Well, here in Atlanta, we are almost dead last in social and economic mobility by ZIP code. And also, the health disparities are being seen by ZIP code as well. So depending on what ZIP code you're in, there's a map that shows how likely you are to have some of the diseases that are most affected by housing or environment. So, we know we have a big challenge here in Atlanta.

On the ground for us at Habitat, we see it where we get homeowners getting, coming into our homes, and we see all of the health attributes of them and their children just improving over the year. And we do a survey annually with our homeowners to ask them kind of the before and after, so we just see that.

We have a Repair with Kindness program where that's really geared at seniors and veterans. And we find those folks are trying to age in place. And right now with COVID, they're the group that is being told to stay at home, but many of them are in unhealthy homes. And so, we have a partnership with National Church Residences to assess all of their needs and a lot of the health needs whether they have their prescriptions as well as food insecurity as well as all of the things that we will be repairing in their house. So on the ground, that's what it looks like for us here in Atlanta — and I know that's a representation of what it looks like for Habitats across the country.

**[8:31] Jonathan Reckford**: Absolutely, and I would say across the world. You know, it's always, how do you put a personal … The data is staggering, and I find how do you connect that and make it personal for people?

I remember, gosh, when I just started with Habitat, and this was the early beginnings, I was in Memphis in the Uptown neighborhood, a historically underinvested, tough part of Memphis. And the executive director took me to visit an African-American veteran in his early 80s. He was living in a house that not only had a hole in the roof, and you can imagine all of the issues with water coming into the house, he had a gaping hole in the floor of his bedroom that was just bare dirt underneath. And you can imagine the chances of staying healthy in those environments. And a relatively small investment would fundamentally change his health sustainability as well as ability to stay in those homes — and that led to our aging in place efforts.

Also, we are a global mission, and it is just breaking my heart when a country says "shelter in place." And for a meaningful amount of the population, that is a … that can be a death sentence, not a helpful piece. I remember talking to a beautiful young mom in Nicaragua. And she was carrying her baby, and she just had tears in her eyes. She said that the ability to move into a house with a cement floor meant that she could actually put her baby down for the first time — which meant that this little girl could develop properly because you could crawl, you can learn to walk, you could do. But without that, could not do. And we know that the most basic idea of having a dry place to live and a proper floor has a fundamental health impact.

Or last year, I was in Cambodia with a young family. They had two small girls, and they took out a loan with Habitat to be able to build a bathroom. And for them, you know, you think about all the implications for a girl who is maturing not to have privacy, not to have health, not, you know, and all that that means for their ability to go to school and all the rest that comes with that. So, this is something we've become so passionate about. I recognize that relatively small solutions can actually have a big impact.

Back from the health perspective, you've seen we're in the midst of a gigantic health crisis now to our doctors. How … what would be most helpful? And as you think about from a health policy perspective, what would make the biggest difference if we could do something?

**[10:55] Dr. Megan Sandel**: I mean, I think that from my perspective, and I'd be interested in Dr. Klasko's point of view as well, is that there almost is this kind of sense that there is an impending tidal wave coming of potentially people that will become homeless, right? The National Low Income Housing Coalition estimates that 1.5 million families are potentially at risk of becoming homeless — and that's on top of, you know, the 20 million that are spending more than half of their income on rent right now. And so when we think about this, I think that it is really important that we at least stabilize what we have, right, and be able to provide things like rent assistance so families don't become homeless and become evicted.

But I also think that we can't just be on defense. We have to somewhat be on offense and really start thinking about reinvesting in housing as infrastructure. And what are the ways in which we can do that and be able to move forward? And I really think that one of the things that I enjoy about being part of the Cost of Home cabinet is this idea that it's not just about rental, but it's about homeownership. How do you build equity? How do we, you know, address the racial wealth gaps in many of our cities and be able to do that in a more comprehensive way? And so, I think this is the time to work with government to be able to find new resources and not just step back from what we're doing, but actually lean in and do more.

**[12:23] Dr. Stephen Klasko**: And you know, look, Jonathan, you and I are both involved with the World Economic Forum and that whole issue of stakeholder capitalism. One of my talks there was, “Do we need a Greta Thunberg for health care and housing?” Because at the end of the day, if you think about climate change, that's been viewed as a global, global, global issue. Well, this is the second global issue.

You know, there is really two things that don't have borders. One is health equity slash housing. And the second is climate change. And the interesting thing about climate change is that it's not just going to happen from British Petroleum changing the way they do things. Everybody’s got to creatively partner. Bank of America has to lend them money at cheaper rates so that they can do recyclable fuels, et cetera.

The same thing has to happen in health care. We have to recognize that if we're going to have a long-term healthy society, that we have to start with homes. And you, you know, you look at our country, the United States, during this pandemic, you know some of the national insurers had

record profits, pharma had record profits. The next administration, whoever it is, needs to really say, “Look, you need to stop doing those 30-second commercials about how great you are and start investing in homes. You can't say you are a health organization.”

Let me give you one example. We made a decision at Jefferson. Everybody has galas, right? And you know this Megan, but in the traditional health care gala, it's “Give us money so we can get a bigger MRI than the competitor across the street. Won’t that be great?” We made a decision our last three years that we weren’t going to do that. That every one of our galas was going to be based on this collaboration for health equities: working with Project HOME in Philadelphia, working with Habitat, working with others. None of that … It doesn’t have a “J” in it. It doesn't start with Jefferson.

So to me, it's a combination of health policy that recognizes that people are not sick patients. 95% of people start out as people who want to thrive without health getting in the way, and those are the people that you have to support and send the money to — not, not the 5% that are sick. And by the way, if you do that, you will save a lot of money between food, education and housing.

I've talked a lot about food deserts. If Amazon, for all their talks about, “Hey, we're contributing a lot of money,” if they could contribute free drone delivery in Atlanta and Boston and Philadelphia, and we had a health policy that gave families 50% more food in electronic food transfers if they ordered healthy food, you wouldn't have food deserts. It wouldn't matter in my ZIP code that I can walk to five Whole Foods, and in Strawberry Mansion there's just a bodega selling Fritos and Cokes.

So, I think that we have the opportunity. I'm hoping that some of these protests in our country and some of these protests happening worldwide get past the — we talk about “stopping the bleeding” in surgery — get past the “stopping the bleeding” stage and the raw and the emotion stage and start to say, “Now, let's really make a difference for everybody. For African Americans — for or underserved people everywhere.”

**[15:43] Jonathan Reckford**: You know, Steve, you make such an important point. I remember being in a conversation with the health minister from New Zealand. And he was saying the best ROI for the government from a health investment perspective would actually be weatherizing housing for low-income seniors. But the way their budgets work, they can’t take the money out of the health budget and put it into the housing budget. We need to have this holistic conversation because there is a mismatch in the way that our budgeting structures work.

**[16:14] Dr. Stephen Klasko**: And we also need to talk together. Megan, I don’t know how much — my guess is your CEO doesn’t spend every day talking to the CEO partners at Lahey, and you know, I mean, you know … What I told President Trump is that we need to literally get to a point where don’t give any money to Jefferson, Penn, Temple or Drexel in Philadelphia — give money for all of us to get together and make some of these changes and force us to talk at a different level.

**[16:38] Dr. Megan Sandel**: Yeah. I do think that at this point, because we are so aware now how social factors drive health outcomes that I think, if you think about it, no single health system is taking care of everyone in a given neighborhood.

So, you're never going to change … like Boston Medical Center, as kind of more of the safety-net hospital, is not going to change some of the inner-city neighborhoods that we need to be able to change alone. So we do need to partner with Boston Children's, with Mass General Brigham, with BI Deaconess and others. And I think the good news on some level is we started that by doing say a joint community health needs assessment that is required as not-for-profit hospitals. And guess what the number one need that came up in Boston? Housing.

And so, as a result, it's why my hospital put $6.5 million into a housing initiative. It's why Boston Children's dedicated some of their $50 million community health initiative into housing. I think this won't feel weird … I mean, it's why Kaiser put $200 million. It's why UnitedHealthcare now announced another $100 million on top of the $400 million. This will be a regular part of how health systems make you healthy — is by partnering.

But I want to be clear, we shouldn't be landlords. Right? Like we shouldn't be doing that. We should be partnering with people like Habitat, like other large housing organizations, like banks so that we can make people healthier.

**[18:02] Dr. Stephen Klasko**: So here's a suggestion for every health organization, if anybody in the audience is from a health organization. Take the real energy that happened during the pandemic. In every city, CEOs got together. I mean we had weekly calls with all of our quote colleagues and competitors. And just keep that up. But make the new pandemic — we're calling it at Jefferson the "pan-didn't" that we didn't provide housing, that these folks didn't get the care that they need — and continue those weekly calls around things like housing.

And here's one more thing that I think we all ought to do as a goal. We decided, there's a great quote I like to use from Upton Sinclair — it's hard to get somebody to do something when their salary depends upon them not doing it.

And a lot of times in health care, in our websites, we talk about things like food, education, housing, social determinants. And then you look at how the CEO gets paid, it's EBITDA, hospital census, do the doctors in my hospital like me, you know those kind — where we are in *U.S. News & World Report*.

So at Jefferson, 25% of my personal incentive is around food, education and housing in Philadelphia. So as you said, Megan, you said it exactly right: I have no control over any of those things. But I can go out to Esperanza, which is the Latinx group, or the African American groups or Project HOME and say, "How can I help — not in my hospital, but how I can help where you are?"

And we've done telehealth for the Project HOME folks, et cetera, well before the pandemic — so they were actually better prepared, some of the underserved communities at Jefferson through JeffConnect because they all had the app, than maybe some of our middle-class and upper-middle class patients that said, "Hey I'm not gonna do telehealth. I'm gonna go out to the office."

**[19:50] Jonathan Reckford**: You know, thank you for sharing that; I think it's so important. Honestly, I think Habitat was part of the problem, too, that, in a way, each sector said, "We're the answer." So we had health people saying, "Health will fix it." Housing people said, "Housing will fix it." Education people say, "Education will fix it." What we've really learned over and over is without all of it we don't get the outcomes we're looking for in terms of sustainable communities. We need all the different pieces.

I don't know if … we shouldn't take for granted … Lisa, can you talk a little more from the ZIP code perspective, the, it's not just health inequities but the way that we have segmented our communities. So, Atlanta thought of as a diverse city with a strong minority middle-class, and yet I think we were devastated as a fellow Atlantan to see how little social mobility was happening in Atlanta. And health is obviously one key component of that — but what have you seen in the communities?

**[20:43] Lisa Gordon**: I think what we've seen in the communities is there's been a disinvestment in some of the communities.

So, if you go back to some of Atlanta's history, you have where, at one point some of these communities were you know homogeneous — one race — and they were affluent. And then as segregation came in with civil rights and economically people were able to afford those neighborhoods, then you started to see people move out. And then over time, just those people that were there — what we call kind of the legacy residents — they were there when that was a thriving neighborhood, now all of a sudden, in the last 20 years there's been a tremendous amount of disinvestment in that community. And no investment.

And so you have vacant properties … you have … where landlords are some commercial company that you can't even find. So even when there's been revitalization efforts, it's been difficult to get control of property that's, you know, in some of these joint ventures or it's tied up in a legal entity. And that happened in the recession. And what we saw in the recession was really there was a little bit of a revitalization of homeownership in the African American community, especially here in Atlanta, but then as soon as the recession came, it wiped all of those families out and then even more. And so, you know, 7 to 10 years later, you're still trying to look for solutions to those communities being rebuilt and housing.

And then the other thing that I think is a pressure here in Atlanta is the rents are about $1,600 for less than 800 square feet, a 1-2 bedroom house. And most of the families we serve, which is 30-50% of AMI, is a single mom that makes $32,000 a year and has 2 or 3 kids. You're talking about a four-person household, and they have about $9,000 to spend on rent, and rent is

$1,600. So really, they're out of rent money in about five and a half months. And so, we see that huge disparity. But then for Habitat, we offer a home that's affordable in the mortgage and utilities and taxes and insurance. All-in is between $550-650 a month. So that family can afford that, and they can live, and they can get the things that they need.

But there are so many people that are paying more than the 50% of their paycheck to housing, and they're paying the much higher rents as opposed to being able to be in Habitat. And then at Habitat, we're trying to subsidize those costs, we're trying to raise money. And we have a waiting list. Here in Atlanta, about 350-plus, just people waiting to apply for the program.

So pretty significant. If housing is the foundation for health, then we are setting ourselves up for a really big crisis as well as with the unemployment due to COVID right now. We're expecting to see what they're calling is a tsunami of housing-related issues and … [inaudible] … 30 other providers in housing, and we were talking about solutions.

**[23:52] Jonathan Reckford**: Thank you, Lisa. Hopefully, we're not having technical trouble. It is … apologies out there if we are. As we come back … hopefully we're back. It is, I think as we connect those two pieces, I have just seen it comes down to two things. One, what's heartbreaking about COVID and would love for Megan and Steve to talk about this, is the disparate impact of COVID.

So we're seeing that it's not hitting everybody the same. And that reinforces the same issues Lisa was talking about. Which are, you know what we see is young, low-income children in mixed-income communities still have pretty good social mobility. Low-income children in concentrated poverty have virtually no social mobility. The American Dream is broken. And it ties to all these pieces — it's unlikely then they stay healthy, it's unlikely they have access to a good school, it's unlikely they have access to better jobs. All of those pieces come together.

There have been interesting experiments where hospitals are paid for outcomes rather than procedures. That has turned around and, much as you two have been at the vanguard of, made them think much more holistically about social determinants of health. What have you observed, and what is working in terms of making those shifts?

**[25:06] Dr. Stephen Klasko**: Well I — go ahead Megan.

**[25:08] Dr. Megan Sandel**: Well, I was going to say, I think that the Robert Wood Johnson Foundation has this amazing phase called, "Your ZIP code may be more important to your health than your genetic code." And I think as we look at what predicts to health, Dr. Klasko talked about it right, health care alone is probably 10 or 20%, and then you've got your genetics maybe 20%, and then you've got 60 to 80% that's social-behavioral related to where you live. And that's including green space to exercise, safety, being able to have access to healthy foods and other things. And so what I've often said is, "I don't know why we in health care are not in the ZIP code improvement business." Like why don't we think of it that way?

And I'll just use one really great example from Cincinnati Children's. They looked at the disparities, the health inequities that were talked about around asthma. And they showed that there were certain neighborhoods that had 4 to 5 times the hospitalization rate than other neighborhoods did. And they applied actually a neighborhood-level quality improvement program. This was published in *Health Affairs* last year where they showed that by doing a neighborhood-level intervention, they reduced the number of bed days by 20%. So, if you're being paid a certain amount of money, and you've reduced the bed days, that becomes an economic model. It's not a charity model; it's an equity model. And that is something that I think we need to be doing much more in the future.

**[26:37] Dr. Stephen Klasko**: Well, look, and I couldn't agree more. I would hope that everybody, everybody really concentrates on this, again, on this next election. It doesn't matter if it's your councilmen or your congressperson or the president. One of my professors at Wharton wrote a book called *Medicine's Dilemmas: Infinite Needs, Finite Resources* 40 years ago. Sound familiar? And what he said is, he was the first person to talk about the iron triangle of access, quality and cost. And if you remember ninth-grade geometry, you increase one angle, you gotta … He said if you're going to provide, you know, access, then you either have to increase the cost or decrease quality, et cetera. Unless you're willing to disrupt the system — and disruption is painful.

What he said 40 years ago, if anybody tells you they're going to increase access, increase quality and decrease cost, and it's not going to be painful, it's not truthful. So, if you just think about our last 16 years of health policy in our country, President Obama said the ACA is going to increase access, increase quality, decrease cost ,and it won't be painful. Well, that can't be true. I think President Trump said it's going to terrific, unbelievable and huge — but, you know, pretty much the same problem.

So, the issue is, health care is actually not that complicated, we just haven't had the profile in courage to do the things that Megan said. You know, we haven't had the profile in courage to say why are we paying — and I'm sorry dermatologists and orthopedic surgeons out there — but why are we paying dermatologists and orthopedic surgeons 10 times what we pay people like Megan and our family docs? And then tell the family docs that they have to go out to the community.

Why do we have guilds that limit nurse practitioners and others that really are doing the right thing of actually going to homes? Why do we pay a quarter of somebody doing a home visit versus somebody doing something in a hospital? You know, why do we pay $1,500 to somebody that comes to our ED? Why do we call something Medicaid so that the moment somebody calls and they say, "Oh, you're a Medicaid patient?" You know, doctors have this image whereas most civilized countries will just say, "Look, you're a patient that has insurance." Only the patient knows whether or not the government is subsidizing that insurance.

So I mean, it's really not that difficult. We spend twice as much as anybody in the world, and I'm a high-risk obstetrician so I'm on the other end of Megan's, and we have maternal morbidity and

mortality somewhere between Serbia, you know, and a few other countries. It's because maternal morbidity starts with, you know, “Are you healthy at home?” Starts with, “No, I can't come to the hospital three times a week to get a nonstress test if I'm an essential health worker because my job won't give me off. But if I don't have a job and, you know, my husband or wife is working, and I can just do whatever I want, I can do that.” So we know the problems.

And I just … every I talk to a congressperson or a presidential candidate, I say we need a 9/11 Commission for health care equities and social determinants. Just like we do with 9/11, the Republicans blame the Democrats, the Democrats blame the Republicans — at some time we say we failed to keep the country safe. We have failed to house this country and keep it healthy. And to me, that should be that 9/11 Commission.

**[29:59] Jonathan Reckford**: I would love to see it. It is, it’s been interesting. I've seen some really creative partnerships, but it's a challenge then to how do you get them to enough scale. And just like the health budgeting imbalance, I would say we have a housing budgeting imbalance in this same way. You know, if you're a good-hearted developer right now the math doesn't work. You cannot purchase land, develop it and build something that is affordable for a family making $32,000. The math doesn't, so we need subsidies. But, we still subsidize people in the top income brackets by giving them a huge tax deduction for purchasing a home. So, it seems, and if we have enough money to do that, that's great, but surely, we could then find subsidies.

I saw a friend of mine — Sister Donna Markham from Catholic Charities has a lovely partnership in five cities that I think is fascinating with the Catholic hospitals and the churches. Churches are providing land, and the hospitals are actually paying for supportive housing, and Catholic Charities is going to build and operate it because it will actually save the hospitals money. They are now spending a fortune re-treating very expensive people in the emergency room who don't need it, if they only had supportive housing at a tenth of the cost. But again, it's figuring out how do we reallocate the funds in ways that allow some of these things to actually happen. Have you seen other examples like that where partnerships are making progress on this?

**[31:12] Dr. Stephen Klasko**: Jonathan, I want to get back to something Lisa said and talk about those partnerships. I gave a talk and spent some time in Singapore. And I know you spend time there. But you know, you mentioned, Lisa, the homogeny. One of the things that Singapore has done very well — and that we're looking actually looking at in Philadelphia with our college of architecture and Habitat and others — is you know it’s getting the right money for the homes, it’s building them, but it's also doing that in a smart way. And doing that in a creative way.

We look at public housing, just like we label somebody Medicaid, we almost go out of our way — outside of Habitat, I love what Habitat does — but our government housing. We almost go out of our way to make it the ugliest thing it can possibly be, you know. And I think what Singapore did is two interesting things. They partnered with architects and others to see how can we build affordable housing and that looks just like a really nice condo, there’s not much difference. And what they did was they incented folks to actually have each condo be exactly

the makeup of the population — so if you're Indonesian, if you're Muslim. If one condo had less, they would actually say, "We'll charge you less rent if you're of Indonesian origin if you'll go to this condo." So, it's not all, you know, in our country it's all … OK, this one has all African Americans, this one has all Hispanic patients, this one has all …

So, to me, those kinds of things literally create not only cultural unity, but actually they're just much healthier environments. So, the concept of creativity, partnering with the folks that are coming up with smart homes for the wealthiest, you know, and figuring out how you can do that because it's not really that expensive and then literally trying to not get away from this homogeny of, because part of health is violence and the more that people understand each other, usually the less violence there is.

**[33:24] Dr. Megan Sandel**: Yeah, it's interesting. I sometimes think even the term "supportive housing" is so othering, and in a lot of ways I had a really nice conversation with Ingrid Gould Ellen at the Furman Center at NYU. And she was like, "Well, there's a lot of supportive housing in Manhattan — it's called having a doorman." Right? You have somebody that checks on you, that receives your packages and makes sure everything is OK.

And I think that this concept of mixed income is really important because I don't think you should have stand-alone supportive housing. I think you should have integrated housing with varying levels of supports. And I think that when you make it a stand-alone supportive housing development then you end up with people who are like, "Not in my backyard. I don't want that next to me," instead of thinking it as an integrated community. I think Atlanta has some beautiful examples of this from purpose-built communities and others. And I think, I applaud, I was in Greenville, South Carolina, where they're building Habitat housing and mixed-income rentals side-by-side so that you create a community. And I think that's the type of — we need to think beyond just a single home and really think on a community planning scale and be able to think of financing funding streams that makes a difference.

I'll end with just like one other statistic. So we were looking at supportive housing in a neighborhood close to Boston. And there were a bunch of sober homes and other homeless shelters and supportive housing units. But it turned out a third of the people living in that neighborhood were young women with young children making $12,000 a year. And so, as we thought about what supportive housing looked like, it probably meant putting a childcare center on the first floor of the new housing development and a job training center. And that was a form of "supportive housing" that we wanted to see happen.

**[35:12] Dr. Stephen Klasko**: And, Jonathan, getting back to your COVID point, which I don't think I ever answered is, in our hospital, we had the largest amount of COVID patients in our 14 hospitals. We had about twice as many COVID patients as Mayo and Cleveland Clinic combined. It's a combination of our demographic and others. But twice as many African American folks died of COVID than you would expect, and that's not because they're genetically predisposed to RNA-encapsulated viruses. It's because of those pre-existing conditions.

So, I think, you know, one of the things that I think technology, getting back to what could be a creative partnership that would be a game-changer. If everybody had a home and as I start to see creative technology, one of our biggest successes this year was creating a wearable. Where, you know, it will monitor your temperature, your respiratory rate, your AFib. It's called Ecofibre. And the concept of getting up in the morning and sending continuous data. I was kidding around for one of the Silicon Valley things, my car gets better care than people. Because I have a car, most cars now, even less-expensive cars, send continuous data while it's in the garage. When I start my car, it says, “Hey Steve, while you were sleeping, my right passenger tire got a little flat so before you get your coffee, could you go and fill it up?” It's not quite like that, but it's close. Think about health care in this world, let alone the United States, but all the money we have. I'm going to maybe, if I have the money, go for a physical once a year and have somebody tell me my blood pressure, my pulse, my temperature, et cetera, is this, and here is what I should do for the next year. That's archaic.

So the concept of having a home, having continuous data sent and then actually starting to also recognize that a physical doesn't start here [points to neck and below], that this [points to neck and above] is a big part of it also. Just calling it a physical is frankly a little bit asinine because by definition you're saying, “Let's start here [pointing to neck and below].” We've started to put nurse physiologists, especially in this post-pandemic world, into every one of our clinics, especially in the underserved areas. Because some of this, which we haven't talked about yet, is just the stress of that person that can only spend, that only has five and a half months of rent and what that does to drug use, and what that does to behavioral health issues. So, you know, getting people out and dealing with that above the neck is equally important.

**[37:46] Jonathan Reckford**: That's a great point. And I wanted to pull back to Megan's comment because one of the big challenges on housing is the data is overwhelmingly clear: Mixed-income, mixed-use development where people can live close to their work and live is better for everybody. But it's not the way many of our communities have been intentionally designed, and it then becomes hard to change. It may be easier to design new ones than to tear down the barriers that stop.

But I think we ought to talk about the policy side of that, because one of the reasons Habitat did an umbrella of local campaigns is so much of these things are decided at the local level. There's a federal component, there's a state component clearly and those are critical from a funding perspective, but land use is often decided locally. And we all know NIMBY — Not In My Backyard. It's not really funny, but in California and coast, it's been BANANA — Build Absolutely Nothing Anywhere Near Anything — where people have basically said “no housing near me.” And communities who are otherwise liberal and friendly stop being so when it comes to this. Lisa, maybe you can steer us into the policy side of this. How should we be beginning to think about this?

**[38:57] Lisa Gordon**: I think with Cost of Home, for example, we wanted to raise awareness and we wanted to impact 10 million people over five years to provide access and opportunities for housing. And the reason we wanted to do that is it's not enough just to talk about it, we have

to have real scalable solutions to get that done. And I think the most important thing of everything our panelists have been talking about it is great solutions — but really how do we scale those solutions? And also, how do we have meaningful impact in these communities?

And, to Megan's point earlier, calling it “supportive housing” or “special housing” always creates just a physiological barrier and a barrier in those communities, and one of the goals is to really see more housing in communities of opportunity. So, we see communities of opportunities, it means there are already good schools there. We just need some more diversity in terms of the types of people that live there. And to your point about some of the issues where these communities are built, how do we start to make those changes and kind of make those pivots?

So, I think for us with Cost of Home, especially the advocacy committee, we've been doing several things. One, just making sure people understand about land, housing preservation. There’s a lot of affordable housing that’s expiring. Access to financing — you know, how do you get that access? And then how do we provide more opportunities? I think this whole year we've done a lot of different things and small little individual campaigns that roll up into the big umbrella for Habitat. And we've actually been keeping track and have impacted about 1.5 million people just this year in all of the different solutions. And I think it's really important to talk about with the panel, how do we in our different roles scale, and how do we break down the barriers? Because I agree with you, Mike, you said, “We have all of the answers.” Not Mike, I said the wrong name — I'm sorry. How do we get to the solutions? So, I'll pivot back to all of you.

**[41:12] Dr. Megan Sandel**: Yeah, I will just say one of the things that I have tried is to view that my position voice is a new voice in the conversation for policy. Even having now policy-makers quote back to me that housing is a prescription for health, to me feels like a little bit of a win.

And then starting to think about, just as I think Dr. Klasko talked about, right, we in health care chew up a large percentage of the budget, right? In Massachusetts, Medicaid is 40% of the state budget. And yet, we know that really large percentages of people — like for us it's our top 2 to 3% of our Medicaid users — use 40% of the dollars in our system. And guess what? Half of them are homeless. Right? And so, we're housing them — we're just housing them in our in-patient and emergency departments —

**[42:04] Jonathan Reckford:** Very inefficient.

**[42:05] Dr. Megan Sandel**: — at a very high expense. So how do we then use it where, again, we are going to the state government and say, “You need to start funding more vouchers. You need to start funding.” We showed up to the housing bond bill. Like what are the ways in which we say this is a good investment? And I think where it gets hard is we don't want to say it where it's like, “Oh, you're definitely going to save money on the other side.” It's more that you're getting better health — and that's in and of itself a value — and these are ways in which we can then do the prevention that needs to happen. And so, I think it starts with a lot of voices. It's

health showing up, it's education showing up, it's economic mobility showing up, with our housing brethren to speak in one voice about how we're going to make a difference.

**[42:51] Dr. Stephen Klasko**: And, Megan, you know I think that 5% and 50% is so key. And it doesn't take a lot of money. We started something called hotspotting. So, we took those 5%, now that we have the data to finally do that, and we have our nursing students, our medical students, our other students actually go out to the patient's home.

So, I'll give you one example. We had a patient that had been 16 times to our ER in four months. She's got some developmental disabilities, she's got some behavioral issues, and she has a colostomy. And when we start to hotspot her, so she had cost the system about $700,000 in six months. When we talked to her — and these students, she had an iPhone so they started to text her, and they came and visited her — she had trouble understanding how to care for her colostomy. And that's why she would go to the ER because she knew they would take care of it. She has not been in the ER or used the system in six months. And the students have loved it because they feel like they've made a major change. The patient's happy.

So not only, Megan, do we need to be a voice for health policy, but we as health systems have to have consumers in a voice in our board, in our advisory board. And by the way, it can't just be the donors. It's got to be those folks that live in Habitat houses and say, "What can I do at Jefferson to help you?" Because you'll get some answers that are very, very different than you'll get from the rest of your board.

**[44:31] Lisa Gordon**: Thank you, Stephen and Megan. And my apologies on my name slip, I was just so enthralled with the conversation. We're getting a few questions on our live stream from the different folks that are watching us. And there's quite a few — we have over 500 people who are live streaming with us right now — so this is great conversation.

And so, one of the questions we have here is: How can we change the budgeting structures — and all of you have mentioned this a little bit — so that some of the health money can go directly to housing in a way that we can measure and in a way that we can impact those communities in that partnership we've been talking about?

**[45:15] Dr. Megan Sandel**: Well, I sometimes will talk about, there's kind of three different health care dollars that we can talk about leveraging to try and improve housing. I think the first is, most of us are not-for-profit systems so we have to do a certain amount of what's called community benefit. And I think as I mentioned, right, the academic medical centers in the Boston area did a joint community health needs assessment to help drive our community health improvement planning, our community benefit. And within housing, we have started to talk about what are ways in which we would use dollars not just I think to support housing but also potentially invest in housing. And I think that that becomes, I think, a really important tool.

There also is this concept of us paying for services. A lot of housers tell me that they wish they had a community health worker on-site at a public housing development or at another housing

development. And that's something that squarely we in health care could deploy. Instead of putting that community health worker that's on-site at our hospital, let's have that person report to a housing development. And we've started to pilot some of that in the community.

And then the third is many hospitals have investment portfolios and honestly could become impact investors doing program-related investing to provide that cheaper capital that becomes the glue that catalyzes things. You're already seeing this across the country. Kaiser devoted $200 million. UnitedHealthcare. And I think that there are ways — even making a 1% pledge, which is what the Democracy Collaborative is calling on us as health care anchors to do. Just among 15 hospitals, 1% represented $700 million that could be put into affordable housing. And so I think those things, again, won't feel weird soon. They'll feel like that's just a normal part of how a health system operates is being a social impact investor in housing.

**[47:09] Dr. Stephen Klasko**: And I think we have to defragment the system. I mean, we have this weird system where there's providers over here, there's insurers over here, there's pharma over here. We have to defragment the system. I often talk about banking. We've democratized banking, and, but what's interesting about it, we don't look at one thing. I don't think anyone gets up in the morning and says, "I think I'm going to telebank." It's just that banking moved from 90% at the bank — and if you're my age, you know it had to be by 4 p.m. unless it was Friday — to 90% at home.

And part of the reason we didn't have a banking crisis, 30 years ago, we would have been talking about, "Oh my god, during the pandemic what are we going to do about the people lining up at the bank to deposit their checks." They can now do that at home. And more people have been able to get into the finance system that are underserved because of things like Vanguard and some of these kinds of funds. So, I think that if we defragment the system and start to recognize that the system should start with the patient and start to put more money into those things, then I think it will make a huge difference in where the money gets spent.

**[48:18] Jonathan Reckford**: That's great. Hey, Steve, just to follow that up. I've heard amazing anecdotes, but do you think if it was mainstream that federal Medicaid/Medicare reimbursements to hospitals were based on health outcomes, not on procedures — is there anything wrong with that idea? And is that likely to go mainstream? Should that go mainstream?

**[48:39] Dr. Stephen Klasko**: Well, it should go mainstream. It also, look, there's two things that have to happen. We all have to be held accountable for health. We are health systems — but that includes insurers. That's why we have to, look, the reason we talk about places like Kaiser and the reason we talk about places like Intermountain is not that they're better than Boston Children's or Jefferson, it's just that they've got the insurer and the provider together. We do an amazing job in all this stuff with our 35,000 employees. Because I'm the employer, I'm the provider and the insurer. And health care starts at home, it's efficient. But I have seven different insurance companies with different rules about telehealth for the rest of the folks.

So I think the, and let me say one other thing, we have to get real about what we call folks. Payers are not payers -— they're insurers. The only payers are CMS, which is the largest payer, employers and people. They're the people that pay the bill. Insurers are great people, but they're the middle.

Pharma is not pharma — it's drug companies. They supply the drugs. And we have to get over paying retail prices for pharmaceuticals because that 20% that increases means that Megan and I can't invest back into the thing. There's no other country that pays retail price. We have to recognize that expanding the middle, after the Affordable Care Act, Jonathan, after the Affordable Care Act the first thing you should have done is sold all your for-profit insurer stocks, I say, gosh, in retail and everything else. What left? The middle. Those stocks have gone up 10-15 times since the Affordable Care Act. So, and it's not to pick on them. We're just as bad.

You know Warren Buffet called the providers the tapeworms of the system. If health policy was, “You know what Steve, you know what Megan? Your organizations are now going to be based on how healthy the ZIP codes you serve are.” We would spend a lot more money on food, education and housing.

Here's another thing: Some places would have to go under. That's the other thing we haven't been willing to do. The places that don’t get it? Every other industry, that's happened. If you’re Sears and Penney's and the retail world is changing, you're in trouble.

So, to me, I wrote an article actually for World Economic Forum called “There's No Such Thing as Non-Disruptive Disruption.” And the fact is, if you're going to disrupt the system, which would be exactly what you're talking about, Jonathan, we have to recognize that the people who don't get it are not going to do as well. Right now, the people that are the most vulnerable are the ones not doing as well. We need to get the people that are just raking in profits and not taking care of them not do as well.

**[51:22] Lisa Gordon**: You know, I'm so glad you said that, Stephen, because we have another question here that I know people are really wanting to hear an answer to from this panel. And that is, we have been hearing that there is going to be a second wave on this pandemic. We know how we've done on the first wave, and if we gave ourselves a grade we know we would get a failing grade for how communities black, indigenous, people of color, how those communities fared in terms of their representation in those communities and the rate at which they got COVID and the rate at which they died and are no longer here because of the different systems and the disparities.

So, the question we got from the audience is: How can we address these issues, whether they're institutional, they’re systemic, and what factors do we really feel are leading to those numbers that we have that are continuing to grow so that if we get this second wave, how can we make sure our report card looks much better?

**[52:24] Dr. Stephen Klasko**: I'll start with that real briefly, and I'm sure Megan has some great thoughts on that. Our last Dr. Martin Luther King Day we brought in Dr. Dana Bowen Wilkes who is now the head of law at George Washington. She talked about we, in essence, we've gotten rid of redlining in banking you know, where it was, we're not gonna, you know, these ZIP codes, predominantly people of color. We, in some respects, still redline in health. If you look at — you know, I can't speak for Atlanta and Boston — in Philadelphia, where were we doing testing, by and large? You know, Citizens Bank Park where people could drive in from the suburbs, get their test. Most of them were worried well. And the people that were dying of COVID … It wasn't, now we had one of our doctors really went out to the African-American churches — we just had a big webinar on that — and made sure that people there could get it.

So, we have to start there. We have to start, if there's a wave, what we should all commit to is saying, "OK, where we are going to put our resources in the next wave?" No, not at our hospital, because a lot of people won't be able to get down there, you know. Where do people go? Hopefully, the people that have homes — the Habitat homes, the affordable housing — but also the churches. Because you know what? The people that have unlimited means, they'll figure it out. They'll figure out where to go, and they'll go on the web and figure out which one has the easiest way to get. So, let's not worry about them. They'll worry about themselves. Let's go right to the source.

**[54:03] Lisa Gordon**: I think that's really good advice. And I'm waiting to, dying to hear from you, too, Megan, about your suggestion. So, we're going to hold everybody to that. So, everybody in the audience, you heard that. Make sure in your communities that the resources go to where the problems are, where the needs are and where the trends are. Great, great point. Megan, please share some other ideas.

**[54:25] Dr. Megan Sandel**: No, I think what Steve said, I think it starts with testing. And I think we know there was huge disparity in every city around where the initial testing sites were and then where the testing sites needed to be. So, I think number one is testing.

I think the second is where do you isolate and quarantine when you have a positive test or you're waiting for your test results? Because what we ended up with was a lot of homeless congregate shelters, you couldn't wait there, right, you needed to go somewhere else. We actually reopened a hospital we shuttered to actually become a COVID recuperation unit and isolation unit because we needed to be able to do that. And so, many of our black and brown communities are in overcrowded settings right now where you can't quarantine and isolate. So, we need to get a lot better about not just testing, but where are you going to isolate and quarantine safely.

And then lastly, we have to do contact tracing. And I think that as we do contact tracing we need to make sure we have linguistic and cultural diversity in that workforce. This is an opportunity for us to give people jobs. And we need to be able to lean into those communities that right now in Boston many neighborhoods have 50% unemployment rates.

And so, it's about testing, isolation and quarantine, and contact tracing — and we should do that with an emphasis on our neighborhoods of color because they were left behind in the first round.

**[55:52] Dr. Stephen Klasko**: Hey, Lisa, one more thing. I think we've been talking a lot about systems and hospitals and government. You know, let's use this weird time in history for individuals. Some of it is just caring about your brother or sister that doesn't look like you. Some of this is, honestly, don't do stupid stuff. Since none of us is from New York, we'll pick on New York. You know the, “I'm going to go out to the Hamptons and buy all food,” so that the essential health workers, which again are the essential workers in those areas which tended to be folks of color, et cetera, couldn't get food. That's just stupid stuff. So, if we start to use this time to do self-reflection also of, “What am I doing?” Not what is Jefferson doing? Or what is Boston Children's doing? Or even what is Habitat doing? But what am *I* doing to care about somebody that I don't know? And what am I doing unconsciously that might be making their life more difficult? And you can start by giving some money to Habitat for Humanity because that will make you feel good.

**[56:58] Lisa Gordon**: Thank you. And with that, let me pivot to you, Jonathan. And we've had a lot of great conversation, and I'm getting other questions on the screen. How do we reach the decision-makers to put this information in action? And I know you have reach across the world in terms of talking to and connecting with decision-makers. So will you take that? And, Megan and Steve, feel free to chime in as well. You know, how do we really get this into action? If this second wave is coming in a few months. Which people do we reach out and touch so that we can really make an impact here?

**[57:33] Jonathan Reckford**: You know, thank you, Lisa. And it does matter. And this is one where we want people to use their voices and act. So we want, you know, we need prayers, we need thoughts, but we also need action. This is an election year, and so people are listening. And it's so critical at the local level, it's critical at the state level, and it's critical at the federal level that you let your representatives know that this matters.

It is … pulling back to the pieces that you may not have … Megan mentioned it, but the genesis of our advocacy work was the fact that we have 18 million households paying over half their income on rent. How can you afford food and medicine and all the other needs of life if you're that cost burdened? And 38 million families. And that was *before* COVID, so we know it's going to get much worse. More people losing income, so the problem is actually going to expand. So our view is, we need, it’s an “and,” not an “instead of,” but please reach out. If you want to learn more, if you go to habitat.org/costofhome you can learn about resources. You can learn about policies, and we can help steer you to both specific ideas and how to reach out. But we would love for people to actually take action.

The other thing — and I love what Steve said — which is, we need to make this personal. And so how do you get personally connected? Listen to stories, reach out and actually build relationships because I do think sometimes we have become so economically segregated and,

in some cases, racially segregated, but particularly economically segregated. I sometimes feel like housing got on the agenda finally only because it got so bad that middle-class families' children couldn't afford housing, so then it became an issue. But it's been a long-standing, growing crisis, and the piece goes together. I'm so grateful for our medical experts because they have really put a light on the deep inner-relationship between the two.

So, we are out of time, which I'm sorry about. We look forward to more of these +You conversations. Keep posted. We want to dig into some of the other pieces around race and justice and housing, around some of the other themes that will be coming up. But this conversation of health and housing is one that is so important. And so, Megan, Steve, Lisa, thank you for participating. For those of you who have joined in, thank you and don't stop being personally impacted, go share this story with somebody else, and let's do something together to make it better.

**[1:00:01] Dr. Stephen Klasko**: Don't stop believing, as Journey said.