Production Transcript for Panel 2.mp4

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>> Raphael Bostic: For our next panel on housing and health, the moderator is Ali Solis from Enterprise Community Partners. Great friend, tremendous energy, she's injured. And so, we're going to-- so please be kind to her as the moderator.

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>> Ali Solis: That's the story I'm sticking with.

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>> Raphael Bostic: And, Ali, take it away.

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>> Ali Solis: Thank you so much, Raphael. Thank you. I want to thank Dean Knott and Raphael for allowing me to participate today. A very exciting conversation, I really look forward to the ongoing dialogue because I think there is much to discuss on all of these topics. Today's panel of renowned experts on health and housing are going to give us, I think, a range of perspectives on how we might think about housing and its connectivity to health around the alleviation of poverty. Growing research has really linked the social determinants of health, or many of them, to the growing needs on the affordable housing side. So, we're going to hear from two great professors, one that's going to talk about the access to health care, Dr. Wolfe and Dr. Olsen will speak about reforms perhaps to the housing system that will help expand access to affordable, safe and decent housing. And then, we'll have a lively discussion, I hope. We are pleased to have a great policymaker, a national leader who's also former Deputy Secretary at HUD and a renowned pediatrician and advocate for children who's doing a ton to address diabetes in our nation.

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So, I'm excited to be here. And with that, I'm going to turn it over to our professors to talk about their work a bit.

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>> Ed Olsen: And I'm delighted to be back, PowerPoint-less, to participate in a conference on poverty alleviation. So, the rapid growth of spending and entitlement programs for the elderly that will occur until there are substantial reforms will create pressure to reduce spending on programs whose budgets are determined each year by Congress. In this situation, we should be focusing on how to get more from the current budgets for these programs. Low-income housing assistance is fertile ground for such reforms. Most current recipients are sold by programs whose cost is enormously excessive for the housing provided. Phasing out these programs in favor of the system's most cost effective program would ultimately free up, release the resources to provide housing assistance to millions of additional people. Furthermore, the current system provides large, sometimes enormous subsidies to some households while offering none to others in the same economic circumstances.

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And it provides subsidies to many people who are not poor, while offering none to some of the-- to many of the poorest. So, avoiding these excessive subsidies and targeting assistance on the poorest families would contribute to poverty alleviation. And my paper proposes reforms of the current system of housing assistance that would produce substantial poverty alleviation without greater public spending. The reforms deal with all parts of the current system, public housing, existing privately-owned subsidized projects, active construction programs, and the housing voucher program. So, the public housing reforms would better use the funds and assets currently available to public housing authorities. They're designed to alleviate poverty by delivering better housing to the tenants who remain in public housing, by providing public housing tenants with more choice regarding their housing, and by assisting additional households. The reforms would give each housing authority the same amount of money, federal money, as the current system.

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They would require each housing authority to offer each current tenant the option of a portable housing voucher, or staying in their current unit, unless the housing authority decides to sell the project. The generosity of the voucher subsidy would be set to ensure that the housing authority could pay for the vouchers with the money available. The proposal would allow housing authorities to sell any of their projects to the highest bidder with no restrictions on its use so as to generate the maximum amount of money to provide housing assistance to additional families. When a project is sold, the remaining tenants in that project would be offered the choice between vacant units in other public housing projects or a housing voucher. By selling public housing projects on which the housing authorities would have spent the most money and providing their occupants with vouchers that have the same cost as the authority's average expenditure on its public housing units, the public housing authority would generate money to better maintain its remaining units or provide vouchers to additional households or both.

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When a public housing unit is vacated by a family that accepts a voucher, the housing authority would offer the unit to the next family on the waiting list. The family would have a choice of taking a voucher, to taking that unit, or the alternative of a portable voucher. If the family chooses a portable voucher, then the housing authority would be allowed to rent that unit at the highest rent that the market would bear. This would provide additional revenue to the housing authority without any additional government subsidies. So, the preceding reforms would benefit many current public housing tenants without greater taxpayer cost. I'm going to need to be briefer about my other proposals. What about, what to do about existing privately-owned subsidized projects? Well, my proposal is that the contracts with the owners of these projects should not be renewed at the end of their current use agreement and that the tenants of these projects should be given portable vouchers. This reform would yield savings. It could be used to assist additional families.

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The evidence indicates that the total amount paid for units and privately-owned subsidized projects greatly exceeds the rents of identical units in the private market. What about active subsidized construction programs? Well, the Low-Income Housing Tax Credit is by far the largest tax program. Unlike HUD's programs, the Tax Credit Program is poorly targeted on the poorest households. The poor targeting of its subsidies and the evidence on its cost and effectiveness argue strongly for phasing out subsidies for additional tax credit projects. So, my proposal is to divert the tax expenditures that would have been used on additional tax credit projects to refundable tax credits for the poorest homeowners. You might be surprised to know that 25 percent of unassisted households in the lowest decile-- real

income decile-- are actually homeowners. So, a lot of home-- very poor homeowners out there. Finally, HUD's Housing Choice Voucher Program provides very large subsidies to recipients while offering nothing to others in the same economic circumstances.

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In 2012, a household in L.A. with one adult and two children and no countable income was entitled to a voucher subsidy of over 17,000 dollars. From the viewpoint of poverty alleviation correctly conceived, it's surely better to provide somewhat more modest subsidies to a larger number of households than to put-- have such large subsidies for a few. So, I'm looking forward to getting your feedback both in the discussion and others on these proposals. Thank you.

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[Applause]

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>> Barbara Wolfe: So, I'm going to start in just in terms of giving a little bit of background about the differences in terms of health by poverty status. It's very clear that these are linked. The data I put up here are just for children and adults below 60. And what you can see is, regardless of which indicator you use, I chose here health limitations and self-report on the 5-point scale of fair poor health, that the differences are very clear when we look at the rates for those below poverty versus those at 200 percent of the federal poverty line or more. And second, that they grow, that for adults, the differences are bigger than children. But the important point here is that we see this clear link and then we know that the consequences of health are very important for all of the other components of life.

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So, you think about how well children do in school, when you think about opportunities to work, health is going to influence these. The second thing, and the indicator that people look at all the time is the proportion without health insurance. And here on this diagram that looks at this from 1987 until last year, what you really see is that there's still a lot of children that don't have insurance coverage, even though this is the group that has been largely targeted in terms of the non-elderly. So, it's hard, I think, to think about innovations without thinking about what's already in place because many of the innovations that we think about are reforms, which is not all that different from what we just heard from Ed. So first, what I want to mention is a program not targeted at the poor but it's a huge program, it's the largest tax expenditure program in the country, and that is tax subsidies for employer-sponsored insurance.

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So, we have payroll taxes, we have the federal income tax. It's a program that in 2011 accounted for 268 billion dollars and it's very much pro-rich. This does not provide much subsidy and encouragement for the poor to buy health insurance. The next set of programs are very large programs-- Medicaid, Medicare and the Children's Health Insurance Program. Medicaid covered about 60 million in 2012. Just recently through the ACA, about 6.3 million have been added. This is the third largest domestic federal program and the second largest in most states. One of the problems with this, though, is both for Medicaid and CHIP is that we have differing eligibility and differing coverage across the states. The third large program, and one that is overlooked far too often, are community health centers that started out as neighborhood health centers.

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These are centers in underserved areas with a high proportion of poor. They offer a traditional primary care-based care, but some of the unique features is they offer case management, they tend to offer translation in areas in which the population does not speak English, they offer outreach, and health education. They are one of the primary targets to provide health care under the ACA within-- they served about 22 million last year and the hope is that they will add another 16 or 17 million, in terms of sources of care. The National Health Service Corps is a program that finances medical personnel to provide care in medically underserved areas. They provide two programs, loans and scholarships.

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And lastly, the Affordable Care Act provides subsidies for low income but starting at 100 percent of the federal property line, up to 400 percent. I have a set of proposals to try to provide increased access to the low-income population. And most of these have the following characteristic. The characteristic is to bring providers who are lower cost providers into communities where the poor reside. So, that's the core of almost all of these proposals. And so, they sort of go together. You can think of them as individual or you can think of them as a package. So, the first one is to increase medical extenders, and we tend to think of these as nurse practitioners and physician assistants. There's been a lot of study of these. The evidence is that the quality of care that nurse practitioners provide is excellent.

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On many indicators, when we look at for primary care, we find that they do better than traditional doctors. They-- bulk of them, 52 percent of the nurse practitioners do practice primary care. They are quicker to train than medical doctors. The two constraints we now-- facing now, one is that in a number of states, scope of practice laws restrict their ability to practice. So, one of my targets would be to make that a federal program and to reduce those restrictions. Second is to allow them to be paid directly, which would decrease the cost of health care and again, make it more feasible. The second idea here is a little bit more-- well, a little bit more revolutionary or innovative and that is to create a new category of providers, if you will, and I'm calling them primary care technicians.

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The easiest way to think about them is when an ambulance arrives, they have someone called an emergency medical tech. And those emergency medical techs, I don't know if you know this, generally are people with just a high school degree or at most an associate's degree. They are an example of the kind of individual that could be trained under the program we heard of on the-- in the first panel. So, they could care for patients with a particular illness and do so quite efficiently. The idea here would be to take people, give them specialized training just to provide care for a limited set of individuals. They would work under either a nurse practitioner or a doctor so they would be in constant contact. But they would be inexpensive. If you did this, you could have these individuals be from the communities, the low-income urban communities, so they'd also be able to understand the culture better and know the language. I have run out of time and I'm just going to quickly go through these.

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Expand the community health centers. They don't have to be independent, but they could be satellites of existing health care centers. But the important idea is to put them where the individuals who don't currently have access live. And to increase the numbers and have them at least have access to primary care provided by some of these medical extenders. And for people with chronic conditions, have them care for in part by these primary care technicians. The last was saving resources. I think the biggest one in terms of finding resources is to cap the tax subsidy for employer-sponsored insurance. We do that--

we've done that a little bit in the ACA but clearly there's a lot more funds that we could garner if we were to reduce that tax subsidy. So, let me end there and if I get a chance in some of the discussion, I'd be happy to talk about the other ideas. Thank you.

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[Applause]

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>> Francine Kaufman: I do want to also thank Raphael for the opportunity to be here. And, as a health care provider, I'd really like to take my 10 minutes make everybody get up and exercise, but I'll restrain myself. I have spent a lot of time I think thinking about access to health care, and we really should reframe that conversation to access to health. I think the focus when we talk about access to health care, and Professor Wolfe did a great job of focusing on the workforce, but they really only account for somewhere between 10 to 20 percent of our health outcomes. The rest is determined in part by our genetics and, you know, one day we'll be able to change all that for all of us and I'm not sure I want to be in a world when that happens. But until that point, we are confined in some roles by our genetics, by our community, by our education, by our poverty.

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And so, when we really talk about health, it's a much larger ecological model than just who may be providing it. But digressing just for a second, I would add to the health care providers, innovations and technology. And there is already a huge shift in how we get information, so there is improved decision support for the expanded workforce who may not have gone to medical school online, on tablets, on their person all the time that will improve their effectiveness. There's greater ability to move medical records around in real time in those emergency rooms, although we're not quite there. So, there's some innovation that really needs to happen and, of course, there's telemedicine. So, many people who don't have access to specialists are able to get it through being on one side of a phone or computer, perhaps with the health care provider and talking to another health care provider or on their own.

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I frequently now get pictures of my patients sent from their iPhone, what's this, what's that. Sometimes I need a little context of what body part are you pointing at. One of my patients actually sent something on her dog the other day to me, so I did have to pass. I think we also have to differentiate between acute care, which is really more about the workforce and about hospitals and community centers, versus chronic care. And as the baby boomers age, it is expected that they'll have four or five chronic conditions that will need some kind of management. And this is where I certainly agree a group of community-based, maybe even family-derived individuals who can be trained, and in some part supported by cost savings of not going into hospitals or clinics as much, would be able to help in this chronic care model of taking medications, assuring good nutrition, activity, whatever it may take, but I think that is a really community-based kind of event.

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And then of course, all this starts before the child is born, and we must focus on pre-pregnancy planning. The pregnancy time period is critical. There is more and more evidence that the diseases we are susceptible to are part of our epigenetics and that those are influenced by our intrauterine environment. There's clear evidence that obesity and diabetes are associated with the maternal exposure to diabetes or excessive even weight gain. So, we have to really focus on that if we're going to look at health in the future and maybe some of these community programs in the workforce, in the

home setting are really about improving pregnancy outcomes. We've reduced prematurity rate, which is great news but we've not-- actually, we're watching an increasing rate of gestational diabetes develop in those. So, I think for those technicians, I would call them health coaches. I would hopefully put in some technology and, of course, I put this in the communities in which they live.

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And this gets to the housing issue of can we-- as we go to do these rebuilds of some of the low-income housing have health in focus so that the communities in which they live are much more apt to be health promoting than health deteriorating. So, I was going to show one slide but I-- forget it-- of the chronic care model, which really talks about being able to improve outcome from chronic diseases. And again, many people have four or five of them, heart disease, obesity, diabetes, hypertension, survive cancer, maybe some trauma in the past, have a cardiovascular implant, that that's about a pro-active patient in a health care setting that has faith in the patient's ability to manage their own chronic disease and the sector for the health care provider is small in that model.

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And it's all the surrounding space and sound that really makes all the difference in the world. So, I will end here and thank you very much.

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[Applause]

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>> Ronald Sims: I want to applaud the remarks of all the panelists and their incredible expertise and their wisdom, and I have nothing to say. But being a former politician, we never pass up a mic. So, I think that-- and trying to merge them, one is, I came out of an environment where we were able to predict health outcomes by zip code with an incredible accuracy. And in fact, we can do that by life outcomes. Long-term earnings of children are predictable by zip codes. So, let me kind of digress a little bit and talk about what those elements are, and you've heard them here this morning. One is I need to say this about housing voucher programs, please change them. I think that we're working off a model that was birthed in the-- I want to say the '50s, but it was the '60s, '70s, '80s, '90s. They are as old as I am and there comes a time when you're as old as I am that you need to make a change and they do. They are no longer a vehicle for a modern age, in my opinion.

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And I believe in fact that the changes will bring out really positive results. If you were in local government and you had this model, two things would happen to you if you are ahead of it. One, you would not get reelected. And two, people would find the government inefficient. I think there's time for the federal government to embrace the changes that were discussed this morning and are in your paper. And it isn't an issue of having time. There is a wonderful book that I read, and in fact, I got to meet the author and I said, I would only introduce her if she autographed it. It was a woman named Isabel Wilkerson. She wrote the book called "Warmth of Other Suns." She was the first African-American woman to get a Pulitzer Prize for reporting. She decided to go from her field into writing a book, but in her book, which talks about the great migration, she talks about what happened in that migration period. What resulted in the riots of 1910s, '20s, '30s and '40s, which were widespread and incredibly violent. And she talks about the two issues that were there.

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One is people that have long-term unemployment and two, they couldn't get housing. And so, I think that we're at a time when we had that at a scale unheard of in United States. And the depth of it is unheard of in the United States. And we've all believed that somehow, the people are going to be nice. But what happens is you're going to have a group of people who will come who-- unemployment start at most communities the second year approaching the Bush's administration. They've endured now for eight years. When president Obama gets out of his term, they will have been unemployed for 10 years. And they will be able to say to you that they have neither the skills to re-enter the market because there were no programs to address those skills. And two, that they have no hope. And when people have no hope, we have huge potential social disruptions that will occur. And so, I think that the speed of voucher changes and the other issues that have been talked about in this conference, we cannot wait for them to evolve over the next 10 years. There's an immediacy to that.

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So, I want to thank my good friend, Raphael Bostic for, you know, leading the-- helping lead the charge. And Richard, you as well, for having this conference because I think time is not an ally anymore for the change that must be undertaken. So, the voucher programs, please. On issue of health care, I think we're going to see the health care changes because we're going to have price transparency. And what price transparency means is that employers and health plans are also going to-- you will have in your hands, as will employers, the prices people are going to pay. And there's going to be a huge economic push for making things cheaper, because you're not going to want an inefficient health insurance plan. And so, you're going to see nurse practitioners being able to deliver services because they're efficient and they're cheaper. You're going to see physician assistants being more involved because they're efficient and they're cheaper particularly, because it's an issue in rural America. So, it's going to evolve very, very quickly, but it's also going to be an issue in urban America.

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The best person ever to have at your home is a nurse. And we don't know why, people love nurses. They don't love doctors. They do love nurses. And all the data that we've been able to accumulate so far, says that if you introduce nurses into your home or into your environment, you begin to see significant change. So, we're going to see a huge shift, I believe, into the issues that were also expressed in the paper in regards to the delivery of services. Now, I want to talk about the fact that people are sick in neighborhoods and we can determine that by zip code. And that is because of how neighborhoods are designed and how they look and all of us respond to them. And we talked a little bit this morning about epigenetics. And let me tell you what that means in many respects, it's how your genes are. Your genes do make adjustments molecularly, we know that. And you respond to them. For instance, if I were to take you down a dark alley, you would want more than one exit point.

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You would not want-- you would look behind you because the person is just behind you, you want to make sure they can't be in front-- somebody can't be in front of you. Not boxed in. If you climb up a hill or driving up a hill, you slow down when you get to the top. No matter whether you're on a highway or not, you slow down because our predators are always on the other side of that hill, that's where our enemies. So, we slow down. We don't go up really well in canyons because we evolved in the grasslands. And so, if you look at human function, we function much better in green spaces than we do where there are tall buildings. Wider sidewalks are a necessity for people who are older. They like the space. And so, if you want a walkable community, you have to have sidewalks, and they should be wide sidewalks. We like gathering points. Where there is a community garden or bulb streets because

people who are older like to know what is going on around them. If you ask about a community garden benefit, people would tell you, "I don't know, I grow weeds. But I at least know who else is in the neighborhood."

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That's incredibly important. But all of this is because of how we evolved as species. I hate to say it that way, but I don't want any debates on it. But as our genes, its genetic response in many respects, has turned into a behavioral one. So, how neighborhoods are designed. I can predict obesity rates by whether you have a park a quarter mile from you, a half mile from you, three quarters of a mile from you, or a mile. So, when we talk about obesity, if you are a three quarters of a mile or a mile from a park, I can tell you that as a mother, as a father, or as a child you're likely to be obese. The closer the park, the better the park. Everybody can be Michael Jordan at a park that's a quarter mile from your homes. But if you're a half mile, you're going to have a larger park, so we always say parks are incredibly important to be infused. Lighting is absolutely critical for those same neighborhoods. You have to have lighting. So, we're talking about the prevention of health outcomes. You want people to be mobile. You want them to walk. You want them to feel safe.

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You want their homes to be safe. But, a public that moves is a healthy one. So, when we talk about health care in America, it will collapse, if we do not do anything regarding neighborhood design. If you look at what we call-- what's the bulge in the boa or how you want to describe it, the big bulge coming down a hose pipe, if you look at the numbers and its cost, it collapses our system years from now. The only way to avoid that is to have-- we have smarter, better designed neighborhoods. And so, in the other aspects that we're also able to predict is, and I want to say this about education. It's very interesting. We're the only country that takes pride in ensuring that our kids only speak one language. We do, we work really hard at it. As a matter of fact, we test. We have a whole system of testing now to make sure they only speak one language. But I'll do the immersion schools in Seattle. Immersion schools in Seattle, neighborhood schools, you don't petition in.

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You're our neighborhood schools. Poor kids and kids of all colors can go to those schools. They score every test 20 to 25 points higher than the kids in other schools because the complex subject matter is taught in a new language. So, my granddaughter has to learn her math and all other things in Spanish or Chinese. She chose Spanish. Now, it's interesting talking to a fifth grader who is speaking to me in Spanish and suddenly she's-- her next language is going to be French. So, she can speak two languages when she graduates. But nonetheless, brain development and learning complex issues are much better when you are acquiring them in a foreign language. So, you can talk about all the school reforms you want but we're going to still see kids falling out. And we're not going to see the reforms we want because we have only wanted to teach them in English and not have used the side of the brain that handles complex structures, which is a new language and math and sciences. So in closing, what I want to say before is I think that we have the possibility of altering a lot of things from this conference.

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The issue is to get excited, to be really ready to go, to be determined that we are going to make a change. But time is not an ally in education. It's not an ally in health care. And I-- with the talent in this room, if you were to give me this kind of talent and you were an athletic team, I would have Super Bowl after Super Bowl after Super Bowl after Super Bowl because you are Super Bowl-caliber intellects. It's great to be here.

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[Applause]

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>> Ali Solis: As a nation, we have, we continue to fund programs that are addressing the same population. In this case, we're discussing here the urban poor in silos. Programs don't talk to each other and even, you know, obviously we can't have a panel where we're sort of describing all these things at once. But the integration of these issues are so, so closely related, particularly those on health and housing, from the neighborhood context, but also from the needs of those individual families. And so, with that in mind, as we're thinking through some of the reforms that have been proposed here, what are some ways that we can look at some of those best practices? Certainly, my experience is that they're not coming from Washington but very much are happening in communities across the country. I just came from New Orleans, a place where you have an opportunity as a clean slate to kind of redo things because of this terrible catastrophic storm. So, if we have the opportunity now to rethink some of these programs, what are some ways that we can be learning from the examples that you're proposing here?

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>> Ed Olsen: We should be talking about one program that's an important part of the welfare system we haven't talked about, and that's the food stamp program, especially the big part of the food and nutrition programs, because in a really-- it harkens back to the importance of obesity. And the fact that the food stamp program is poorly designed to promote good nutrition. So, I think redesigning the food stamp program in a way which especially subsidizes nutritious foods relative to other foods would be kind of important for better health outcomes.

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>> Ali Solis: Well, what's interesting about that, I'll just say the food insecurity issue, one of the largest problems that they're facing once they've sort of addressed hunger is housing, so I think your point that the, you know, or my point I suppose, that they're sort of interrelated as the solution should be. So, I think you're right, efficiencies in these programs is one-- certainly one thing that we need to be considering. Others have thoughts?

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>> Barbara Wolfe: Well, one of the things that struck me and actually would like to know more about when you say we should redesign the housing voucher, what you had in mind, because one of the positive benefits we find when we studied it is that families with children in fact move. And they move to areas with better schools and they move to areas in which there are other resources there. And so, they're using it as a tool not to stay where they were, but in fact to be able to move. So, I didn't know what you had in mind when you said you wanted to change the way that we do housing assistance 'cause right now at least the vouchers do let you move and by moving, you do, you know, take advantage and create other things, at least some movement to more integration and to getting better access to a whole set of resources.

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>> Ronald Sims: There are-- let me put it this way, there are a number of restrictions on the various voucher programs you have. Some people can move, some people can't, some people are locked into a-

- if you're in a public housing authority for instance, you may be locked into their property and not be able to move. Issues on market--
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>> Ed Olsen: So, you really weren't talking about vouchers, you were talking about housing programs generally--

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>> Ronald Sims: Generally, yeah. Yeah. I would--

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>> Ed Olsen: -- some of the housing programs place these restrictions.

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>> Ronald Sims: That is correct.

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>> Ed Olsen: You have to accept the location of that project--

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>> Ronald Sims: That is correct.

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>> Ed Olsen: -- is. Yeah. OK, good.

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>> Ronald Sims: The-- and the other is-- so yeah. The other is I believe that you need to allow the nonprofit and the profit-making market to participate more fully in neighborhoods. So the issue is who gets the money, sometimes I keep thinking-- you know, I will give you an example, I was-- when I was at HUD, we had a huge problem in Orlando, Florida where we had a rat-- a very actively infested how-- in metropolitan area, Orlando Housing Authority, though, was great. The one next to it had-- was infested by all creatures. And the issue was people shouldn't live with uninvited guests. And so, how to close them down, the cumbersome process of being able to close down a housing authority, transfer that property to the Orlando Housing Authority which was demanding more money and more upgrades and demolition of property, it was just so arduous and very, very expensive.

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So, what I was thinking this morning, I said, it would just been easier to get people vouchers and let them move in the free market. So, that's what I'm kind of talking about, that for your movement, you have to adjust some people going to be in higher-- you should have the ability to have to stay in place or go to another place but you may want-- it may cost you more but the benefits may be greater for doing that is that kind of flexibility I'm kind of talking about.

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>> OK.

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>> Ronald Sims: I didn't mean to-- yeah, I'm sorry.

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>> Francine Kaufman: Yeah. I would-- so that these health coaches are very needed in our community colleges. So, if we want to-- we'll look at the health of young adults, teenagers are very difficult but then through college, those early years, they're really determined like they gain the 20 pounds, it's not even 20 pounds anymore, their freshmen 10 is now about freshmen 30, and these kind of health coaches or health workers could be a program actually in training in community college themselves of having some way to come back then and incentivize or help the college communities stay healthier. They come out and, you know, hopefully, they'll have better access to health care but there is some health services in some campuses and fewer in others but there's no real coaching and no real-- there's a gym but it's not really a coordinated effort. And then I would actually like to extend those kind of health coaches to maybe all schools. We, for a long time, you know, we haven't had a nurse.

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We designate a secretary as a health aide, but she's got no real health capability. And I think if we had a, you know, particularly for the young children and nutrition and some-- already chronic illnesses that we can't care for most of these schools, these health coaches, I guess you're calling health technicians and--

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>> Barbara Wolfe: The health coaches works for me.

[00:37:52]
>> Francine Kaufman: Yeah. Well, we could kind of expand those and then into the community as well. You know, I do-- I've always had this vision. I know there's a small program here of better schools, better neighborhoods where the school is the center of community vitality, and there is health care not just for the children there but for the community members, the schools or their gymnasium or whatever facilities they have are open longer time periods for the neighborhood and then there's a lot of, you know, community activity including even gardens and some of these, would be the way I think to help vitalize the schools again as well.

[00:38:30]
>> Barbara Wolfe: You know, on that, if I can just pick up, I'm going to go to the younger age child. One of the things that I had the opportunity to observe when I spent time in Australia is that they have programs that are geared for families with young children and what-- essentially what they do is they start with an infant program, and parents and their infants come together for two hours at particular times, starting at three months and then six months and they have an opportunity - one to meet with their parents which itself is very good. But they're run by pediatric dietitians and the focus in large part is to start it off while our children are really young and to expose these young parents and their children to notions about what's important in terms of their health and then as well, they develop into play groups and in low-income areas, these play groups have staff assistants provided through the public sector and so they have-- they have individuals with training who come.

[00:39:40]
They could be these kind of health coaches, and they work with children and they work with these young children and their parents while the children are in these play groups. So, they have the advantage of having space where they're playing, or they come together, and they're gaining knowledge

all in this kind of setting which is very-- it sort of provides a lot of the socialization and information all at the same time. So, this is-- it's relatively inexpensive. It's particularly if you use individuals who are trained as health coaches and, yeah, they could really help people start out in a much more positive space.

[00:40:15]
>> Ali Solis: We're talking about integrated services here, so one question in Professor Olsen's proposal to really voucher out many of the housing programs I think is one that we should consider and further talk about. Certainly given the fiduciary situation that we find ourselves in in Washington, the current program can't continue to-- the way we funded these housing programs can't continue to sort of exist. On the other hand, we have populations with severe service needs. So, we have 600,000 families, homeless families on the streets every night. Many of which a voucher alone is not going to be the answer to their solution and so, you know, how do we think about integrated approaches that bring these health services and the housing together. There are many of them that exist now in terms of supportive housing services that is where services are prodding directly. Now, that is for a chronic population. But to address some of the other issues that have been raised here around preventative health care options, can we look at some new approaches potentially to, you know, bring some of these preventative services through community-based health care faculties to these residents.

[00:41:21]
And I think, you know, so the question I suppose for Dr. Olsen is, how does your model in terms of vouchering out where there are needs of, you know, urban poor that actually, you know, need additional services or that come from generations where that community is sort of their home and so theoretically, access to opportunity may be found in providing a voucher but, you know, is that always the case?

[00:41:47]
>> Ed Olsen: I think that, you know, the voucher program actually has been successfully used with homeless people. Part of the problem is that the most severely or mentally disabled people who are on the streets is actually getting them in to get help. They are not willing to come in to home-- many of them are not willing to come into homeless shelters. And so, that's how the housing first approach but you can use that either with vouchers or with projects. But, you know, the vouchers have been used to serve the homeless, get them in off the streets, in a place where people can get in touch with them on a regular basis and help them. So, you know, in the most severe cases I mean, you're needing something closer to the mental hospital, really. Now if you're talking about that, then I don't think we're talking about vouchers. But that of course is a very small number of people. There're actually 600,000 as a number of homeless, most of them are actually in shelters every night. So, the number on the streets is much lesser, and so that's a really tiny fraction of all the people currently served. And in a tiny fraction of all of the additional people, I would like to get-- that I think could be served by the kind of reforms that I've been talking about.

[00:42:53]
>> Ali Solis: Ron?

[00:42:53]
>> Ronald Sims: You know, I don't think you can divorce homelessness from the need for the services. Whether they're child care services, mental health services, alcoholism services, I mean, it's really interesting because we-- the standard answer to a person who is poor in need of services is we can do

this but we can't do this. So, there isn't an integrated system in place to actually do much for them. Then when you say, "Well, why are you poor," and the issue is you-- we're not giving them enough tools to move out of poverty or to deal with the poverty they're in. And I remember in King County, we used to-- we used to tell alcoholics, you had to go into detox before you went into a homeless shelter. Then, we had a person who said, "No. Why don't we just let them come in drunk as they want into a shelter," which they did call the 1811 building. And they did, and it was really hard for people like me to say, "You're letting these people come in torched to the shelter?"

[00:43:59]
And the answer was yes, but what do they do? It was easier to stabilize them having them in that facility. It was easier to get them into counseling. They form their own alcohol X anonymous group. And they saved the taxpayers 4 million dollars a year just in not going to hospitals episodically. So, the-- I think the integration is probably the key. And this isn't only for the homeless. It's all aspects of people in-- who are poor needing more than one service solution and trying to figure out having a mechanism to address their various needs, because I think on the long run, it saves far more money.

[00:44:41]
>> Ali Solis: That's great. I think we're going to move to audience questions one second but go ahead and respond.

[00:44:44]
>> Francine Kaufman: I just wanted to add that for-- to pay for the health coaches, I would put a tax on sugar. You know, Mexico--

[00:44:52]
>> Ali Solis: A good innovative approach.

[00:44:53]
>> Francine Kaufman: Yeah, Mexico has done it. They are now taxing sugar. They're taking a little clearer. I was just down there talking to some of the politicians. It's going to be partly segmented to health care outcomes. So, we could perhaps do the same.

[00:45:08]
>> Ali Solis: I think that's great. We're going move to questions now.

[00:45:11]
>> LaVonna Lewis: Good morning, I'm LaVonna Lewis and this is the first time I've appreciated this cast. You can actually see my hand going up. There's a very common tagline in health right now. All policy is health policy. And clearly, what we're talking about is policy solutions for poverty. And I guess what I'm struck by is the need clearly for integration, right? So Fran was talking about schools or centers of health. We're doing that in L.A. but we're-- they are telling us that we-- people have to be fingerprinted and go through Department of Justice clearance in order to come on the school campus. And so, you want to have this integration but how do we kind of answer those questions for people that are interested in risk management, who are fearful of, kind of, the unintended consequences of bringing all of those resources under one tent. Because right now, people want to work as far as their grant works. And so, we're doing a lot around, kind of, subsidizing business-as-usual but not being willing to fund risk takers.

[00:46:17]
And what do we do to kind of say, we don't know all the answers, but we're willing to take a risk and see how it goes.

[00:46:23]
>> Ronald Sims: All right. But this is a discussion that has to happen with foundations and the government, because everybody funds by segment. They do not fund in an integrated fashion because everybody wants to believe that their proposal is the best idea ever. And so-- but integration is the most effective approach for communities of poor or individuals that are poor, that's just my--

[00:46:48]
>> Ali Solis: We surely see some early examples of that integration through programs like the Choice Neighborhoods and Promise Neighborhoods. But to the earlier panels' discussion, they are not necessarily tested and proven yet. And so, how do we start to shine a light on some of those really innovative integrations where they're happening, which is in local communities to then sort of further these kinds of new policy ideas, Erika?

[00:47:09]
>> Erika Poethig: Sure. Thank you. Erika Poethig from the Urban Institute. So, we talked a lot in the first panel about the importance of social networks, especially for the working age population, which I think touches on the families that we've spent a little bit of time talking about in this conversation. And social networks are important for accessing opportunities. At the other end of the population spectrum, age spectrum if you will, we have really good research that for successfully aging you want to retain your social networks. You want to keep those in place. It becomes part of how you age successfully in an engaged kind of way. So, I want to go to Ed. So we, you know, we have really interesting evidence and emerging innovations in some states like Ohio and Vermont, that are successfully integrating housing for the elderly and health care reform. Where, in the case of work in Ohio, we're saving 50 percent of Medicare costs by aligning up the services with the housing.

[00:48:12]
So Ed, over 50 percent of HUD's assistance serves elderly and disabled. I'm wondering how your voucher model works to successfully support that part of the assisted households. And whether there are other opportunities that you see to really support and engage in this place-based interventions, which allow us to capture savings on the health side, which I know are also important to you.

[00:48:41]
>> Ed Olsen: Well, in-- if you're-- in the private sector, you have assisted living-- or you're talking about sort of assisted living facilities that kind of combine medical care and housing. As if-- we have nursing homes at the extreme. We have--

[00:48:55]
>> Erika Poethig: And that's the cost, right? So, the alternative is if you don't have an intermediate way, they go to nursing homes when they don't need to.

[00:49:04]

>> Ed Olsen: So, I mean, you know, that-- I would allow the housing voucher to be used for that and then we also have health insurance programs that pay-- can pay the medical care part of it. So, I don't see any reason why you can't have the cost of those kinds of things paid from these multiple sources.

[00:49:20]
>> Erika Poethig: It's taking advantage of all the people being in one place in order to deliver the services.

[00:49:25]
>> Ed Olsen: Well, but I say, that emerges in the market. These assisted living facilities have emerged in the market to satisfy the demand for the kind of thing, you know, I think it does make sense to have this combination and that's why we actually observe it in the market. And, you know, my proposals would just give more people the opportunity to do it. They have the resources to do it.

[00:49:47]
>> Ali Solis: So, you're suggesting that the vouchers could be used at assisted living facilities?

[00:49:51]
>> Ed Olsen: Yes, why not?

[00:49:52]
[Inaudible Discussions]

[00:49:54]
>> Margery Turner: So, Ed. You know, I'm a big voucher advocate also, and I think giving people the choice to decide where they want to live, where is the place that offers the best combination of services in neighborhood conditions, all, I'm all totally in favor. But I think the framework that you've outlined, which I think focuses sort of one dimensionally on the housing sector. In an effort to spread the existing resources more broadly, which I also, you know, support in principle, your voucher is going to be too thin, it's going to be too thin for people to get into neighborhoods where there are parks and walkability and safety. It's going to be too thin to get people into assisted living facilities that are any good. So we've-- the principles are all right, but the supply side of the housing market doesn't align with the resources that would be made available by your solution.

[00:50:58]
So, we got to make this work. We got to think beyond that part of resources and how to use it more effectively. We got to think about how to get, I don't know. I'm surprised that I'm person talking about the private sector all the time today. How do we get the housing market to produce those quality housing models with care for the elderly in healthy communities at a price that lower-income people can afford, at a price that our, you know, subsidy resources can support?

[00:51:34]
>> Ed Olsen: Well, you know, for, you know, for given amount of money, if you may, you can make the vouchers more generous and that will enable people to live in better neighborhoods you're talking about, but with a given amount of money that means serving fewer people. Putting a lot of subsidy on a few people rather than spreading it thinner, I favor spreading it thinner but, you know, I think the proposals I make are really, they are not really key to the particular amount of money we're spending now. I mean I'm saying this is the way you want to go no matter how you do it, because it's the more

cost effective approach. You just get more for your money, no matter how much money you're spending.

[00:52:11]
>> Ali Solis: So, the Bipartisan Policy Center has sort of taken that concept in some ways and made a proposal to look at vouchering and I'm not sure if you're familiar with this, Ed, but really targeting to those populations of most need, that is the ELI.

[00:52:26]
>> Ed Olsen: I am for it, I am for it.

[00:52:28]
>> Ali Solis: OK. Other questions from the-- here we go.

[00:52:33]
>> Kevin Rodin: Hi, my name is Kevin Rodin with The Michaels Organization, we're coincidentally the-- part of the master development team for Jordan Downs redevelopment in Watts. And I just wanted to take a second and say we're particularly honored to have USC with us at the hip on that as a research and innovation partner, so I think that's a really exciting opportunity. This has come up -- a couple of times in the panel. So, I wanted to drill down a little bit, regarding housing choice vouchers, so not project-based rental assistance, but the actual choice vouchers. Anecdotally around the water cooler, our experience in core urban markets, Los Angeles, Chicago, places in Florida and on the East Coast, when you give someone a voucher as they leave a public housing project, they move to a place that is equally poor or poorer, you know, to Los Angeles [inaudible] this would be. If you give someone a voucher in the center of the city, they don't move to Pasadena or Santa Monica, they move to Palmdale or San Bernardino. And I was wondering what-- is there actual research on this? You know, the vouchers have been around for a while.

[00:53:35]
In the core places, where are they actually moving?

[00:53:37]
>> Ed Olsen: Well, I mean among the research, we know that the poverty rates of people who live in public housing projects are much higher than the vouchers and actually the private projects are more similar to the vouchers than they are to public housing, but still the poverty rates of voucher recipients on average, not for about each and every place but on average across the country are lower, they live in lower poverty neighborhoods than people in the privately-owned subsidized projects and especially the people in public housing projects.

[00:54:11]
>> Greg Spiegel: I'm sorry. I'm Greg Spiegel with Inner City Law Center. And you have to forgive me, I'm located on skid row so I see very up close and maybe not have the big picture, but this seems the housing choice voucher is a very important subsidy to very low-income people. And as we talk about as you raised, as we want to make it more cost effective, if the analysis is how many people can be helped, we're going to be helping higher-income people. And from our perspective, that's not innovation. That's something that's been going on for about 35 years, shifting away from public housing and housing for very low-income people and moving it up to subsidizing more median income homeownership. And so, that's a continuation of what we've seen for last 35 years, using our public subsidies to go to higher-

income people and shifting more to the private sphere. So, that's what tenant-based vouchers are. They're also a landlord subsidy, which is great and they do good things. But it's-- we are shifting that money and we're continuing to do so. This is not an innovation in our perspective.

[00:55:09]
>> Ed Olsen: Well, a couple of things about that. The average income per capita income of voucher recipients is less than that of public housing and much less than in private projects nationally-- you can go on the HUD website, that's true. I don't favor the type of ships that you're criticizing. I definitely don't want to serve more people by just going up higher into the income distribution and giving smaller subsidy. I'm really talk-- I really want to focus the assistance down on the very poorest people and I want to make sure that every one of those people is offered the option of a voucher. They don't have to take it. So, I completely agree with your sentiment about how we should be moving the system towards who we should be serving, but right now even in the current system, right now, the voucher recipients are poorer than people on the other types of programs and especially the private projects.

[00:56:00]
>> Ben Robinson: Hello. My name is Ben Robinson and I'm a student here at USC. I work with Dr. Bostic. So, there's a quick comment and then a question, short comment I promise. So, I think we should be weary of the lessons of moving to opportunity. I'm not sure if that was what you were talking about professor, but the-- yeah. So, I think that maybe it touches on what you were saying.

[00:56:21]
>> Ed Olsen: Well, you know, there's an example of that and you're thinking there's all [inaudible]--

[00:56:25]
>> Ben Robinson: Yes. And I think it's one of the best examples we have--

[00:56:28]
>> Ed Olsen: -- people who are in these [inaudible].

[00:56:30]
>> Ben Robinson: Yes, that's not what my question is about. But I just want to say we should be worried at the lessons of moving to opportunity. My question is for Professor Wolfe and I think that Professor Olsen might be able to answer this a lot better than I can. But when you're talking about expanding the first part where you're expanding nurse practitioners and physicians assistants, at the same time that you're proposing this, we're seeing a hollowing out of the middle skill positions in health care, in part due to pressures on cost containment, among other things. So, I kind of want to know what you think about your proposal in light of the hollowing out of the middle skill associates' positions that you could get in the health care field. Thank you.

[00:57:25]
>> Barbara Wolfe: Well, I guess I have a couple of concerns. One is that I think in order to get recognition, the nurse practitioners are proposing being called doctors and increasing the training that's required. So, I think that what you see is that some of the, what I would call middle professions, think that in order to succeed, they have to look like they are more professional. And I think that that's something that we ought to be concerned about and then pay attention to and try to prevent that from actually coming about. And it should not be that these individuals have to have a doctorate degree because that will undercut a lot of the advantage we currently have with in terms of training and having

them being lower cost professionals. If we would directly pay these individuals, instead of undercutting them, we would give them much more power. And as we have more and more pressure to try to save resources and through-- whether it's through exchanges or through employers looking for less expensive packages and as well if we cap the deductibility of employer-sponsored insurance, I see it as opportunities for all of these individuals.

[00:58:53]
So, there're lots of opportunities for less expensive medical extenders to practice and to really improve health care, not just actually for the poor, but for the rest of us as well. Anyone with a chronic condition will certainly do better if they have access to either a health coach or, you know, more trained nurse practitioner. So, I think that the forces to try to reduce health care expenditures, you know, could go two ways, right? One, it could be to cut out the number of people providing care and only have it be the super specialists, or the other, which would be the better, is that there's more people who are providing care and that can be directly compensated. They don't have to be under -- an MD. And so, that the MD gets, you know, or their organization gets part of those resources. And we really want to change that model.

[00:59:23]
[Inaudible Remark]

[00:59:24]
>> Ronald Sims: I just-- just quickly. I just got out of a retreat with the Pacific Northwest's largest healthcare provider, insurance provider and with employers and every employer was basically talking about issues of nurse practitioners, physicians assistance because they are looking at the bottom lines and realized you can get the same level of service and better. You don't have to go to a doctor or a specialist, you can go to people who can provide the service and they were demanding it. I mean it was one of the-- it was a wonderful meeting for the employers. It was interesting looking at some of the providers sitting in angst, where it was very clear that the direction is being set. And I think it's going to continue, people begin to look at health care cost. You're going to see these fields emerge much more strongly than they are even present now.

[01:00:11]
>> Ali Solis: OK, a couple of those that I think some of the innovations and technology that Fran was talking about, you might have a pair of really, you know, both to just in cost and expending services. The gentleman in the back was waiting for [inaudible].

[01:00:21]
>> I just got a-- Ron, I really appreciate your comments earlier and I want to just underscore them a little story and ask a question. So, how many of these well meaning programs today become indirect forms of corporate welfare, keeping down wages for the people who have jobs? And at the same time, corporations have been criticized for offshoring jobs. And a lot of corporations are bringing back manufacturing to United States. But it's not going to jobs; it's going to automation. Around the country, there's a mass scale of automation, in ports, in distribution centers, in delivery areas. Formerly, you know, good middle class and low-class jobs are now being automated by robots. And those jobs are not coming back because the machines that build the robots are other robots. And we're facing, I think, a really urgent situation in America that we're totally unprepared for because the jobs that we need today are the people who build robots. And they're not the people who are doing welding. They're not the people who did former other types of jobs.

[01:01:21]
And what are we going to do about that looming storm of automation and mass unemployment in the situation we're in now?

[01:01:29]
>> Barbara Wolfe: Mine more positive is and this is not going to talk to the building of robots of which I have no knowledge whatsoever. But that one of the reasons that it's been really hard to reduce some of the increasing cost in the health care area is just one of the areas in which there's been growth of employment. And a lot of that employment has been amongst lower skills. And so, the same push that wants to save resources and reallocate them from the health care also would mean a problem probably similar to the one that you have in mind, in which we would potentially be reducing job opportunities.

[01:02:08]
>> Ed Olsen: Yeah, so I mean-- and so maybe part of the answer is just getting more children from low-income households to higher levels of education. And that seems to be the way to go. You know, there was a study done by Caroline Hoxby and Sarah Turner, my co-author, which was about that a lot of children from these households don't recognize and they can go to top schools and that much-- that all of the tuition would be paid and this is just by giving them information, you can get more of them at the top schools, so that's the way I would go.

[01:02:42]
>> Jennifer Blackwell-Trotter: Good morning, my name is Jennifer Blackwell-Trotter and I oversee the nonprofit arm of the county's housing authority. So, I really appreciate this conversation. And I have a couple of thoughts to share in regards to housing policy and specifically portability, section 8, housing choice vouchers. And for me, the thing that sticks out in my mind as one of the biggest barriers for housing policy isn't the portability factor, but it's the negative incentive that's built into this system that keeps residents less likely to obtain employment to become more self-sufficient-- economically self-sufficient. Because right as soon as they get a job, then rent increases, their SNAP benefits go down. And this kind of tug-of-war keeps a lot of residents in place. It doesn't matter if it's section 8 or public housing. And the other negative incentive that I see with the new-- excuse me-- neighborhood revitalization initiative in choice neighborhoods is that's a great idea of about way to bring different aspects in a holistic model to public housing.

[01:03:51]
But there's a negative incentive for housing authorities like the county of Los Angeles that do a great job on maintaining the properties, and their properties don't qualify even though there is that need and that desire to still improve the situation for those residents. So, I'm not sure if your research, Dr. Olsen, or anyone else's on the panel have addressed these issues, but I want to bring them forward.

[01:04:17]
>> Ed Olsen: Yeah. So, this is a-- a problem you're mentioning is the feature of all forms of housing assistance. Basically, the more the family earns, the lower is the subsidy and that's true in all of it-- all of the programs. We have evidence about the effect. And it's not only true for housing programs, it's true for most other welfare programs, you know, a food stamp program, TANF, it's all-- all of these programs are like that. And then you have the cumulative effect because people are participating in all of the programs. So, you know, with respect to have-- what we can do about that, I mean I think the first issue you have to face is, which people do you expect to work and which don't? There may be some people-- you know, heavily disabled people, you don't have an expectation to work. And so, you might treat

them one way. And then there's a people you expect to work. And I think the solution to the-- an economist solution to this is we provide-- we provide a lower subsidy to people who don't work at all. But then we wouldn't phase out the subsidy as fast as we do now under the current system. So, I mean there-- I think there are solutions but I don't know that anyone-- I haven't seen anyone who study-- who's tried to estimate what would be the effect of particular solutions on how much people work.

[01:05:29]
>> Ali Solis: Just to answer that last question that you had around the choice. And I think it's an issue of both resources, but also which is why they were-- they're limiting to the most distressed public housing authorities. We also don't have enough time to sort of prove out these models, but I think it's worth continuing to advocate for such kinds of more comprehensive approaches.

[01:05:48]
>>LaDonna Pavetti: The research that has been done shows that the disincentives to work really are not there in the way people generally think they are. It's true that that's the way the programs work, but when you look at the research of the impact on work, the research does not show that people don't work because of the-- because there's an incentive not to work in the program. So, I think there's a new paper out by Robert Moffitt that really looks across this and sort of arrives at the conclusion that the general sort of perception that there's a lot of non-work because of our public benefit programs is just not borne out in the research.

[01:06:29]
>> Ed Olsen: Oh, as opposed to working less?

[01:06:31]
>> No, but both.

[01:06:31]
>> Ed Olsen: You're focusing on-- Oh, I think the evidence is very convincing with respect to housing programs. And we have a co-author of what the paper sitting next to me.

[01:06:40]
>> Barbara Wolfe: We do find that there's--

[01:06:41]
>> Wait, I'm having this small--

[01:06:43]
>> Barbara Wolfe: -- disincentive but that over time it's reduced. It's not that it continues forever.

[01:06:47]
>> Right.

[01:06:47]
>> Barbara Wolfe: But when you have the dis-- when you first move, you also have the fact that you need a whole new set of networks and so you're looking for jobs. And so, it's not surprising then and-- as you first move, that you're going to reduce your work effort.

[01:07:01]
>> Right, but I think in general, that just the research is not sort of as strong on the public benefits program being a disincentive to work as people generally think, I think that's just what the evidence says and I think that's important. And I think what we really have to think about is the difference of where we are now versus where we were 10, 15 years ago in terms of the labor market. There are so many fewer opportunities. So, I think when we call for more requirements to work, what we don't think about is where are the jobs going to come from and who is going to be displaced to put new people into work. So, I think we need to sort of expand the conversation that really does include more about where will the opportunities come from, so that if we want people to work and people often are desperate to work, where will those opportunities come from.

[01:07:52]
>> Ali Solis: Well, that's a great way to end what was on the-- I think a fantastic session. Thanks to all of our panelists and I look forward to continuing the dialogue at lunch and later on at dinner. Thank you.

[01:08:01]
>> Raphael Bostic: So, the interconnectedness of these issues is critical and that's why it's important that when we talk about poverty as a policy issue, we talk about all of it together and bring as many experts on-- as many fields as possible together. And so, thank you again. And we'll continue the conversation.