DEMOCRATIZING LONGEVITY: HARNESSING THE ECONOMIC POWER OF HEALTH-CARE INSTITUTIONS

Dawn Carpenter 00:05

Good morning, everyone. How are you? Good morning. Welcome to "Democratizing Longevity: Harnessing the Economic Power of Health-Care Institutions." We meet here in Washington today, at a defining moment. Across town— everywhere in town—policymakers are, once again, debating how to fund the nation's health-care system amidst mounting costs, deep, structural inequities. The headlines tell a familiar story—strained budgets, hospital closures, workforce shortages, and a widening gap in both access and trust. And yet, even in this atmosphere of uncertainty, a new narrative is emerging, one that sees health care not just as a system of treatment, but as an engine for community renewal. That's the spirit behind today's conversation and behind our new Milken Institute report "The Longevity Equation: How Healthspan and Wealthspan Intersect." The data remind us that where we live remains the strongest predictor of how long we live, and that the gap between the healthiest and wealthiest zip codes and those left behind is now as much as 35 years. The paradox is that the very institutions that are witnessing these disparities every day, our hospitals, are among the most powerful actors capable of helping to remedy those disparities. With their capital, employment, influence, they can drive inclusive growth, create good jobs and build the kind of community wealth that translates directly into longer and healthier lives. So the question before us today is this: If longevity is a function of place, how can our health care institutions become anchors of prosperity and engines for equity? To help us explore that we're joined by five extraordinary leaders who are redefining what it means to care each from a different point along the health and wealth continuum. Dr. Omar Lateef, he is the president and CEO of Rush University Medical System for Health, whose anchor strategy on Chicago's West Side has become a national model for transforming hospital operations into community investment. Dr. Joe Betancourt, president of The Commonwealth Fund, a national leader advancing equity and governance reform in health systems. Kenya Boswell, senior vice president of community affairs for Highmark Health and president of the Highmark Foundation, bringing a perspective of philanthropy and payer innovation. Dr. Bobby Mukkamala, president of the American Medical Association, representing physician leadership and the face of care. And, at the end, David Zuckerman, president of the Healthcare Anchor Network, who has helped align hospitals

nationwide around a common framework for community wealth building. So let's get started. We're going to do a lightning round so we have a brief reflection from each of our panelists. So, we're ready? Where do you see the longevity divide showing up most starkly, and what is one lever within your reach that could help close it? Let's start with Omar Lateef.

Omar Lateef 04:23

I'm on a sandwich between a bunch of geniuses, and I'm on this chair where it's impossible to look cool like there's no way. I sat like this. I sat like this. My socks aren't the right socks. It's a bad start, and then Dawn calls me out as first so it's a real problem. The longevity divide is what we talked about, right? Like this is noncontroversial to say that if you born in one neighborhood, you live less than you live in another. Only we hide behind this nonsensical statements, like it's gun violence like so if you're born in the bougie avenue—bougie part of Chicago where all the stores are, like the Gucci and all those Prada and all those stores are, you live 16 years longer. Ten years ago when—Pastor Hatch and I started looking at this, you live 16 years longer than if you live on the West Side of Chicago. So then we all decided we were gonna fix it, and we got some new data, and now it's 20 years longer, right? We all started calling it out. You live 20 years longer than if you're born on Michigan Avenue and if you're born in our zip code. That's the gap, that's the divide. It's pretty clear. And the leading cause of death in that is not gun violence, it's hypertension, it's diabetes, it's people not taking their medications or not having access to care. It's breast cancer, where we have phenomenal treatments for all over the world, yet we have a three times higher mortality in that neighborhood than we do on Michigan Avenue. So that's the divide, if we need to explain it more. We have a real problem. Like we have to really go back and talk about this, right? So it's not controversial, it's factual. And so what are the levers you push? Hospitals are 5 percent of the total health-care ecosystem. Out of a 20 percent of every dollar of your GDP goes to health care, only five cents goes to hospitals. Yet that burden is on hospitals. We can't do it alone. So the levers we push are through partnerships. We have partnered with people in our community. We've partnered with community leaders and said, what are the problems you need to solve, and how can we do it? So we partnered with a person here. And one lever we have, as crazy as it sounds, is a basketball court. So Pastor Hatch is putting together a basketball court and one of the most violent zip codes in America, and that will save more lives than our liver transplant program. Another lever—to be really [inaudible], and I know I'm only allowed one in 90 seconds, and I'll be pulled soon—the other lever, I would tell you we would pull is around taking your medications. We partnered with a technology company called Nuna that uses games to motivate people to take their medicines. And, it turns out, if you take your blood pressure medicines, you're going to live longer and you're going to spend less. And so by using simple games in the community and getting out there and interacting with patients, we got them through a partnership with people with a lot more resources than us to improve outcomes. So my levers are a basketball court and taking your meds.

Dawn Carpenter 07:02

Kenya?

Kenya Boswell 07:03

How do I follow that? Okay, I think I look cool, so that's good. You know, I want to start with the levers, and I echo everything that Omar shared. You know, for us, strategic philanthropy and anchor institution investments and community and economic resilience is a powerful lever. And let me explain. You know, if you think about philanthropy, people expect you to do all the things with access to care, community health, and we do that and more. We have an opportunity to take advantage of—you know, in the state of Pennsylvania, participation in tax credit programs that allow us to do direct investments in community and economic resilience. You might ask, why? No zip code should dictate if someone is going to be able to not only meet their basic needs but their poor health outcomes. We believe that that is horrendous for anyone. So by utilizing these programs, we're able to not even—not only leverage our own sort of dollars and looking at—you know, again, data is a real thing—seeing how we can invest in things like affordable housing, economic and, you know, economic development looking, at really, the true issues around poverty, that's how we can make systemic change. And I will provide, you know, specific examples on how we're doing all of that throughout this discussion.

Dawn Carpenter 08:16

Thank you. David?

David Zuckerman 08:19

Well, as Dr. Lateef said, this is an incredible, brilliant panel. And, just really, thank you to Milken for having this conversation. And I think two of the challenges that we really need to name or one around, kind of the spatial divide, around inequities within our society, and our approach has really been around social services and charity to solve that, and it hasn't recognized that if you look at how investment flows into communities, the community in central Chicago is receiving all the investment. And so if that continues, we are not going to solve the issues in the communities with the gap, if we are focused on just trying to not actually fix why investment isn't flowing into those communities at the same time. Similarly, with hospitals, though, we also are thinking about how to cut costs around those hiring work, supply chain, investment really the back office things, that in this conversation, I think what we're going to talk about are the most powerful levers that institutions have. So I want to focus really on how do we actually look at this idea of health systems as anchor institutions, as the innovation, really the mindset shift that's needed around the role of health systems going outside their four walls, how they can partner internally, differently, how Treasury—that is in control of investments that are on Wall Street can actually work with community health—to redirect some of those investments into Main Street and the communities that are not receiving investment and that there are other partners needed in the community that are going to allow a health system to deploy its resources more intentionally. And I think around the mindset shift that needs to happen, partnering differently internally, and then really being at the table externally, with community and other institutions, is the shift that's needed, and while that sounds simple, that's really not been the practice across our country.

Dawn Carpenter 10:17

Bobby.

Bobby Mukkamala 10:18

Thank you. It's great to be here. Hearing amazing opinions. One thing that I use is a lot of what Commonwealth puts out, and it's the first two slides. I traveled the country for 200 days this year as the Voice of the Physician the American Medical Association. Those first two slides are where we rank in the world, right? And so we spend more than anybody on the planet, right? We heard it this morning, $5 trillion dollars and you look at where we are, it's down here in the corner, right, relative to even people that spend half of what we do. And that's the first slide, for a reason, because it sort of tells us where we're starting. And the physician's role in moving this dot just to be mediocre among everybody else. That's a lifetime goal for me. Right? To get there is going to take a generation, and physicians, I think, have a critical role in that, because we are the front lines for where patients come, where there's a trust, where there's a question, where there's a concern, and right now, that's a challenge. When I think about being a physician in practice in Flint, MI, for the past 25 years with my wife, and the microscope I use to clean out my patient's ears is now 30 years old, because the new one that runs on LED is a huge investment that we just can't make right now. Right? That's the reality of being a physician trying to move us in this direction, right? And you know what I want to see happen, right? And then there's the whole misinformation thing. One of my business partners in Flint, at the age of 35 passed away from COVID, and he was watching me vaccinate people in my hometown, right? And misinformation is what leads to that consequence. More in the city of Flint than its wealthy, more red versus blue suburbs, right? That's the reality that we live in. But what I want to see happen is, I want to see us plant the seeds that will make my office run better in this community, so that then those seeds can be fertilized by our grocery stores, right? Where the patient after having a conversation with me, when they go to their grocery store, they're not walking by 50 cent cupcakes to get to $5 carrots. I want the carrots on the front of the store for 50 cents, right? And then law enforcement, right? I want law enforcement to be able to protect those people after their amazing dinner, when they want to go outside on a beautiful fall day in Flint, Michigan, and go for a walk and look up there at the trees in the sky and the sunset instead of looking down here, worried about getting shot. Right? That's the reality of Flint, MI. And so these are the things that we need to accomplish if we're going to make the city of Flint's lifespan closer to the suburbs of Flint.

Dawn Carpenter 13:03

And you may have the last word in this lightning round.

Joseph Betancourt 13:06

Great. Well, thank you. It's great to see everyone here, and I'm with you, Omar, my feet could barely touch the bottom with the chair here, so not a good chair for short guys. So let me just begin by saying two things. One is that I hope we can shift the conversation from lifespan to healthspan. And I'd say, second, this is deeply personal to me as a leader in philanthropy, a practicing primary care doctor, and someone who has lived experience where family members have died at 50, 62, and 65. There's no doubt that we are

failing the American people and failing certain communities more than others. Doubling down on what Bobby said—you know, at the Commonwealth Fund, we spend a lot of time comparing ourselves to other countries, and as Bobby said, we spend the most and have the least to show for it. What does that mean? It means that we have the lowest life expectancy of our peers, highest infant and maternal mortality, highest burden of chronic disease, highest disparities by race and geography. And then we look at those countries and say, what is different, right? What can we learn? What is different between them and us? And fundamentally, we see three big things. Number one, they do focus more on investing in the social safety net and the social drivers, which is— is the root of this conversation, is the social context. That term has evolved from social determinants to drivers to influencers, but the end of day, where you live matters and what's available to you matters. And, by the way, the other side of the tracks was not created by chance. It was created deliberately, with some very significant policies around mortgage lending and housing and transportation and life. So I'll set that here. I'd say—so that's one big differentiator. The second is universal coverage, and we could argue about who runs universal care. What I like to boil it down to is "He who makes or she who makes the investment gets the return." In a fragmented system, where that isn't the case, investments in prevention and communities. When we're looking at the short-term financial gains don't work out. And so that fragmentation is a real problem. And I'd say third—and as primary care doctor, very important to me—our peer nations spend 15 percent of their—15 (one-five)—of their health care dollars on primary care [inaudible]. We spend less than 5 percent and primary care has been shown to give you the biggest benefit around health outcomes. So, as we think about policy, I think our biggest lessons are to take this time of incredible disruption and to think bigger about how we create a new vision for health and health care we'll be doing at the Commonwealth Fund, catalyzing a new effort to be on the ground with people across the country, to understand the trade offs. But, at the end of the day, if we can't learn the differences between our peers and us and not continue to say, "Well, they're different." Because at the end of the day, we also do it by states, and the states that are at the top of the country that relate to health outcomes do the same exact thing—greater investment system in the social drivers, greater investment in kind of connecting people to coverage, and certainly greater investment in primary care. And we are at a tipping point—I'll just end by saying—the anger and angst that will only grow around affordability and coverage and access." It's no longer a "Boy, if we do Canada's system, we're going to have to wait three months for a primary care doctor"—people are feeling that today in cities like Boston, New York and others, and this longevity gap persists. And this is not a medical issue, we have all the technologies to solve this. It's a financial and policy issue, and those are real, significant decisions that we could debate on how to get to perfect, but we certainly can do better.

Dawn Carpenter 13:07

Thank you all for those beginning frames. Alright, let's talk about these engines of economic—economic engines and health, human health. So—I like to call this the anchor imperative. So I'm going to ask first, Omar—how did Rush operationalize its commitment to the West Side of Chicago, and what lessons are transferable to other cities?

Omar Lateef 16:14

Yeah, so look, you could—it turns out, it's far more lucrative to write about problems in health care than it is to solve them, and—far more lucrative. So if I'm an assistant professor, and I graduate from a university, and I want to show that—I could pick a disease. So breast cancer we've known for 30 years is different outcomes, 50 years is different outcomes based on the color your skin. And I write that paper, I get it published, I get invited to one of the places where my colleagues work at like these, like fancy institutions, Ivy League schools, and I get to present it, then I get promoted, and then I could write a book, and then I can get invited all over. If I try to solve it, I'm putting a mammography studio in one of the worst payer mix zip codes in the city of Chicago, instead of a dermatology clinic along the lake. Are you with me so far? So it turns out I could pick a disease anytime I want to get into med school, get famous, and write an article about it, but if I the minute I try to solve it and buy this guy's ENT machine, I'm out—right? I'm out. You lose. So the more good you do financially in health care, the less money you make. So we decided there has to be a way to flip that narrative. So we know that the death gap is 20 years. So we said, operationally, everything we're going to do as a health center is to drop that by half. Without a strategic plan. We didn't have a plan. Here's what we knew. We knew, if we went in the community and said we're going to fix your death gap, they would throw us out and say, we don't trust you, get the hell out of here, you haven't done anything, you're not real. So we had to go talk and leverage our relationships with the community. And then how do you do it in a way that's not detrimental to you? You find partnerships. So I'll give you one example that shows that you could invest in your community, reverse the death gap, and then not get hurt. So it turns out that hospitals have a lot of laundry linen. Like the hotels you stay in have a lot of laundry. Some of those hospitals and hotels do their own laundry. It turns out, when I became CEO, I learned all kinds of words like EBITDA and operating margin and things like an RFP—that was one of the phrases I learned. So we did an RFP where we found out who could clean our laundry and give it to us for the cheapest price. And it turned out our laundry would get picked up every day, taken to Wisconsin, cleaned and then brought back. We didn't care. It was a cheap price, and we had good laundry. So enter a neighborhood in Chicago where there is high poverty, low jobs. We partnered with the foundation The Steans Foundation to provide almost a zero, very low-interest loan to go in there and build a commercial laundry facility. We gave them a loan, and then we gave them the business to pay back the loan, and we said the only rules are, everybody you hire has to be from your neighborhood. The CEOs of the laundry place are from that neighborhood. The people they hire are from that neighborhood, and they have a 401(k) plan, and for the first time in their life, they have a trajectory. And we took down decrepit buildings and put beautiful buildings. And anyone will tell you that changes the feel of the neighborhood. Anyone will tell you—so you have beautiful building with 300 jobs. And now it turns out they're cleaning our laundry in one of the most challenged neighborhoods in the country, and it's saving us almost a million dollars a year. [Applause]

Omar Lateef 20:05

If you live these values, it doesn't have to bankrupt you, but you need to be clever smart and work with partners that know how to do this work. And if you don't ingrain yourself in with the real community leaders, you'll fail. Nobody likes coming in pretending they're going to solve something, and you have to make those community leaders the leaders of the programs you start, otherwise there's zero credibility. And I will say this at the end—you know, health care is a human right. It's not a controversial statement. I've never met a person that disagrees with that. If you say, if a person shows up in the hospital and they have crushing chest pain, I've never met a person that says, don't take them to the cath lab. I think we

have to go back to recognizing that and then make that the basis, or the true north of health care, and have all of the partners in health care start to work towards that. [applause]

Dawn Carpenter 20:57

David, my question to you is, how does the anchor framework redefine what success looks like for health systems beyond the financial margins?

David Zuckerman 21:07

So I think one of the most important things that we just heard from Dr. Lateef is that you can work at the intersection of mission alignment and good business. These things don't have to be in competition. You can find these really powerful win-wins, and that's at the heart of the anchor frame, which we really see as aligning health care around this idea of their role in economic inclusion, supporting local economies, in support of improving community health. We know the root causes of poor health, our poverty, that poverty is concentrated, that poverty is linked to disinvestment in communities over a long period of time, and health care alone isn't going to address the longevity gap. As a consequence, we really need to think about, how do we bring every tool that we have at our disposal and deploy it within community? And that is why thinking about supply chain and what we purchase and how that can create good employment in our communities, which we know is the foundation of a healthy life, is so important. There are so many tools that health care has, but what the anchor framework really requires is actually considering all of them and not saying, oh, our investments are there to serve our institution only when times are bad. Instead of actually asking the question of we have all that this capital invested, can we redeploy a portion of it to sustainable investments in our community that also meet some of those fundamental needs that we know we have? Just as an example of this, I had the opportunity to small gathering a couple of weeks ago to hear Matt Desmond speak. He's a professor at Princeton. Many of you may have heard of him. He's an expert on on poverty in America, and what he said is that that from 40 years ago to today, the cost of bringing every American out of poverty has increased when adjusted for inflation. And at the root of that is two primary things. One is the cost of housing, and the other is that the wages at the lowest 25 percent have not kept up with the rest of wage growth for all Americans. So if hospitals hire a lot of people and can create career trajectories for them, if they have investments that they can leverage to invest in affordable housing in their communities, if they can shift their purchasing to create jobs on the West Side of Chicago that have 401(k)s and can help build wealth. These are all things that are core business operations that can contribute to addressing these fundamental root causes of poverty. And that's the shift that the anchor frame really requires of institutions. It's not an either or. It's not about saying that every dollar an institution invests needs to be invested in the West Side of Chicago. But if you just take 1 percent of the investment portfolios of health systems across the country, that's more than $5 billion. And those—again, not spending that money, but saying, how do we put it into low interest loans that help address the gap of affordable housing in our communities? Which we know is driving up the cost of wages in health care because our employees can't get housing. We know it's impacting our patients' ability to comply with medicine— with prescriptions, because they can't afford their prescriptions. And it's overall important for our community. And then if health care invites payers, if invites universities, invites foundations to the table and say, well, we all actually have this social capital. Can we all think together

collaboratively to invest it? It begins to really get the scale. And that's what I think, is the opportunity, especially in this moment in time. There's, of course, a tremendous amount of policy fixes that need to happen to better incentivize and regulate our health-care players to think broader than acute care. But, at the same time, right now, the solution is going to be local, and it's really going to require our largest institutions. Health care in almost every community is an economic engine. It's one of the largest employers. It has a nonprofit or public mission for the most part. It's linked to the that place in a way that other organizations aren't. And if we can't have our institutions lean in and be part of the solution even in this time. Let's acknowledge health care is under attack. It's under threat. That's true, but there's still so many resources that health care has more resources in the communities that we're talking about right that are disinvested. And so we need health care to remain rooted. We need it to remain resilient, and we need to stand by its communities even now, if we want to maintain that trust that's so fundamental for those partnerships that will allow for other strategies around health and well-being, and so just really encourage folks to think about these other resources in the institution. Even what Dr. Lateef was saying about we had this opportunity to leverage space to create a basketball court. That's thinking differently about the assets that institutions have and how those institutions can be better connected to communities. That's going to build trust, that is going to allow for really the kind of connective social fabric that we need to address the longevity gap. Because it's not going to be technology that it's going to solve it. It's really going to be a different way of working together, partnering, and leveraging our resources.

Dawn Carpenter 21:07

Thank you. Kenya, let's talk about payers. How do payer systems like Highmark mobilize capital for community regeneration rather than just cost containment?

Kenya Boswell 25:05

I appreciate the question, and we're a little bit different because we are a payer and a health-care provider, and as David was sharing, we are an anchor institution, if you will. I can give some concrete examples, but if there's any takeaways for the things that we really focus on is cocreation. It is understanding and respecting the lived experience of the individuals in our communities that we're trying to serve. And it's really looking at, how do we get at the root cause of poverty, i.e., SDOH, i.e., social health, or whatever the new terminology is. I have a couple concrete examples, one of them being right where our flagship hospital is. It is a very impoverished community. And you know, we could sit there and look at it like, how can we sit there and look at cost containment for ED usage, or we can say, what can we do to uplift the community? We know that this community is struggling. So we did just that. We partner with a nonprofit organization, Thrive 18, who has the trust. "We are the big bad health-care system"—not really, but that could be the perception, right? But we went to a trusted entity and said, how can we work with you to create something that's really going to be systemic change? And the result of that was Thrive 18. We were able to partner with other local funders in our community, leverage a build challenge grant, so additional dollars, and created this model in which we were able to hire local, trusted members of the community in a role of community health workers, provide the training for them to literally go and knock on 3,000 doors in this community. What was the result of that door knocking? Over five year period, we were able to address 1,430 different issues that these families were experiencing, one of them being evictions. We

were able to decrease the eviction rate for 60 percent of the population that was facing that and connect others with the resources that they needed. We were able to do things that was thinking outside the box that people may not necessarily see as a health-care provider. Another example I mentioned earlier taking advantage of our neighborhood, partnership tax program. Another hospital within our catchment area—again, we're looking at a neighborhood that is severely impoverished. So we were able to partner with a nonprofit organization, Mon Valley Initiative, and leverage dollars. And this is key making a long-term commitment. We had to show from a trust standpoint—we're not just here for one grant, one year, one cycle—where we made a 10 year commitment in this community to provide this flexible funding so they can sit there and allocate it where they need it most. One of them is creating a grocery store where there is fresh, fresh food available, and the resources to make sure that everyone have access to this grocery store. Another was providing that flexible capital so they can rehab housing and put new affordable housing out there on the market. These are things that are non traditional that we were able to do, and I am proud to say, during the duration of these investments, the poverty rate in this particular community, and we still have work to do. I'm not going to claim victory, but it went from 30 percent now down to 20 percent poverty rate. If we're looking at home ownership, it went from 50 percent to over 60 percent so we're trending in the right direction. That is how serving as an anchor institution and putting these strategic investments can really move the needle.

Dawn Carpenter 29:56

Yeah, okay, let's take us to place then. And I think what I'd like to do is ask Joe a question. Joe, what policies or accountability frameworks can close the gap between communities of abundance and those of abandonment?

Joseph Betancourt 30:16

You know, I think on this panel, we've already heard that there is a graveyard of incredible ideas that aren't supported by policy and financing. That's really what this amounts to. I mean, I find it fascinating—I wrote an essay in the power of ideas that talked about food as medicine and how that's the new thing. And Jack Geiger was talking about food as medicine back in the 50s, and probably people before him. So not only do we have a short memory, we don't acknowledge those whose shoulders we stand on. But on top of that, you know, we bring back these ideas that are evergreen and really, really critical, but the health-care system doesn't support, you know, their integration in real ways. So Omar has got to be like, okay, how can I be creative here within these constraints? And how can I, how can we invest so it's incredible, and these are heroic efforts by incredible leaders who are trying to do the right thing. But ultimately, I think I want to draw us back to covid, because I think covid is a phenomenal example of a time where hospitals that often had to compete were stripped away from the things that they need. They were competing on and work together to solve a common problem. And so I often say, working during covid as a caregiver and leading our equity work back at Mass General, that it was the worst of times for all the reasons we know, but it was the best of times. It removed red tape. It allowed for collaboration, it allowed for creativity. It allowed for in a place a series of hospitals, to not compete, but to collaborate around their community health with a singular focus being covid and why? It's because everything else was shut down. So they're like, well, this is life or death, and we have to lock in. And I think there are real lessons to be learned here.

Can we, at a much bigger level, think about fundamentally changing how we finance health care? Because I think that is the root of these challenges. Again, this is not the lack of resources that we have in the US. We have incredible hospitals who do incredible work, but it's how we deploy all those resources and the returns we get. But at a place based level, can we create a policy environment that isn't just hospitals that, as we've called out, is a series of partners, but there's policy incentives for collaboration around community health, and we finally move past these gaps, which have been there forever, and I would argue, are many ways getting bigger. And many people see the maps of subway lines, and whether it's one part of DC compared to the other part in a 30 year gap, or Boston, you name the city they exist, we haven't been able to move that needle. And while we have these creative things that are happening, sadly, they're not happening at the scale we need. And so that's the conversation we need to have, and I do believe it's leveraging these anchor institutions and all that you do, and investment wise, but also thinking about a population health, a community health approach where allow that allows for collaboration, not competition.

Dawn Carpenter 33:02

Bobby, let's talk about the physicians. How can physicians lead efforts to rebuild trust? We've heard that theme here today and access in communities where health-care systems have failed for generations.

Bobby Mukkamala 33:17

Yeah, I guess one thing came to mind related to the finances of health care that you kind of started with the question. I went to the Chamber of Commerce in our state capital in Lansing, in Michigan, about prior authorization. And the traditional response of the Chamber of Commerce was always, you know what this is going to save money. The insurance company says prior authorization saves money, it's going to decrease the cost of care. My personal premium for health insurance has never gone down, right despite this goal of prior authorization process. And what I told the Chamber of Commerce was that when you think about it from an employer employee perspective, just purely numbers, not ethics, not some moral obligation, but just the numbers. And I have somebody that has a lump on their tonsil that was a Stage I tonsil cancer, and that patient has to wait a month to get prior authorization for their PET scan. That thing's going to grow. In fact, this patient ended up with a positive lymph node ended up with Stage II tonsil cancer while waiting for a prior authorization. So when you look at it from a finance perspective, and you can keep that patient working, not leaving their occupation, leaving their job early, because now they have a survival issue or even just in pain, waiting for testing, you're going to lose that employee for who knows how long, right? Two, three weeks, while waiting for a test for the rest of their life with Stage II cancer consequences versus Stage I cancer consequences. This is something that, from an economic perspective, it's going to improve the finances of our country. This business will do better, right? And this is the kind of thing that physicians want to do, right? When I'm sitting in my office and I see that patient. We're at the emotional level of dealing with the tears of him and his family, and then I leave the room, and then I have to put on all this armor to have my medical assistant, try to get that prior authorization. That's something that burns us out, right? 50 percent of physicians in dealing with this environment are like, you know what? I can't do this anymore, right? And then on top of that, again, the physician interaction with all of us to improve the health care of this country or to improve the future of this is, in one component, an

important component of that entire process. And when we have to deal, like with things like prior authorization, deal with the finances of keeping our own practice open. My wife and I, she's an OBGYN. We're struggling, but we do it, but it shouldn't be a struggle, right? I want to focus on the patient in the room and not the bills that sign that land on my desk, right? But that's what we're dealing with. Then the patients now in Flint, MI, 50 percent of my of my patients are Medicaid. We're going to lose a lot of them, right? And I don't want somebody waiting to come in to see me, because now they don't have Medicaid, and their early tonsil thing ends up being Stage IV, where they know they can go to the emergency room, right? EMTALA will cover that or force them to cover that. But that's bad for the health of my community, and when you look at the survival rate and the life expectancy of where I live, we live in the city of Flint, when I put in my zip code, it freaked me out. 68 years my parents lived, seven exits down. I-75 in Grand Blanc, Michigan. 81 years, right? Seven exits down, I-75, 68 and 81 and that's the reality that we're dealing with. But the other thing that comes to me, so the physician's role in this is critical, I think, right, to help to take care of those patients, and not have to deal with the hassle factor to be able to do it, make it help me, to help you. Right? Wasn't that what Jerry Maguire said, right? I feel like Jerry Maguire sometimes at this moment. But the other thing that is concerning to us at the AMA and to me, we mentioned the nonprofit nature of hospital systems, right? And that's something that I think would be admirable, but it's not always admirable. We have three hospitals in the community where I work, when I walk into a hospital, I'll see new marble flooring, right? Pianist playing on an amazing grand piano, an amazing chandelier, right? That's the reality of what a nonprofit hospital looks like in my community, right? But their ability, their willingness to take care of patients to prevent disease is pretty minimal, right? I never see that. It's a great place to go. I myself had a brain tumor less than a year ago, right? I went to Mayo Clinic. I had this thing operated on. It was an amazing experience when the blank hit the fan. But how about preventing it from hitting the fan? How about improving 68 years of life expectancy in a city that's 10 miles from that hospital, right? An amazing new MRI scanner isn't going to get that done. An investment in a clinic in downtown Flint, which you rarely see—let alone on the North Side of Flint, where you can't even get healthy food—is a problem, and so this is where I want to focus.

Dawn Carpenter 38:20

You had me at hello. Okay, let's go to act three of the conversation that should last all day long, but we don't have all day. So here we are. Let's think about sparks of innovation. Remember, we talked about changing the narrative. I'm going to ask each of you very briefly, because I want to leave time, because I'm certain that there are anxious folks in the audience that would like to ask all kinds of questions. So just very quickly, let me ask you to respond to this question. If we were to design a health care system of the future around the principle of democratizing longevity, where every community has the conditions to survive. What's one innovation we could start with today, just briefly, you don't have to explain how it works, but one innovation, let's ask, who wants to start? I'll give it instead of Socratic. There you go, Bobby.

Bobby Mukkamala 39:18

Sure when I go home, I'll drive up the same I-75 that I mentioned, and there's always a billboard saying gold star for hernia surgery, right? You will never see a billboard that says, do you have pre diabetes? Call

us. We'll help you never get diabetes, right? I want to see those billboards change. So that's one thing that I would do when I go home. I'm going to say, You know what? Let's put up these billboards. We had a billboard just for about a month that said that 68 to 81 life expectancy, right? That's, that's what I want to see to improve things. The other thing that I want to see, I want to see everybody united with that goal, right? We have a physician community that wants to do that. We have a hospital system that we're—it meets to do that—but we need our teachers. We need our city officials. We need the mayor. We need City Council. We need the physicians. We need the hospitals. We need to sit around the table and think about: what does North on that compass look like? How do we prevent the stroke? It's an amazing place to go rush if you have a stroke, right? But what about what happens in the community before it even gets to that point. I think there's a—I'm looking forward to setting up that table when I get home and talk to the mayor and say, this is what we need to do to be better than 68 years.

Dawn Carpenter 40:29

Okay, Kenya, how about you?

Kenya Boswell 40:31

Okay, I'll do it fast, lived experience. We talk about it, we say it, we invite people in, but we really don't execute it so we can actually follow—I mean, focus on a lived experience of people in our community, take it serious and be okay that it may not sit in a box that you can check.

Dawn Carpenter 40:50

Okay. David, how about you?

David Zuckerman 40:52

So our social institutions, with their investment reserves or endowments, you can think of that should have more than just a financial return goal, it should have a social return goal as well, and that would allow us to begin to solve some of these challenges that we're seeing. Health care, I think, looks at the world as everything is a technical problem. There's a surgical intervention, but that's not going to allow us to get good jobs, healthy housing, safe communities. It's going to require using all of our resources differently, and I think how investment can do that, not grants, but actually investment in a sustainable, patient way, the way Rush has done on the West Side of Chicago. AMA has been a partner in that, using some of their own endowment and reserves, or in rural communities. Dartmouth Health working with other large employers to solve affordable housing issues in rural New Hampshire. That's how we're going to solve some of these problems long term.

Dawn Carpenter 41:50

Excellent, okay, Joe.

Joseph Betancourt 41:53

Yep, we're not going to change lifespan or healthspan with sparks, and I love innovation, but it's not going to happen at the end of the day. We need to have the hard conversation of, how do we spend our money, and what are the outcomes we get? And until we wrestle that down, we're going to see great models here and there and continue to fill the graveyard with all these great models, but we won't move the needle.

Omar Lateef 42:14

Dude, I'm dying right now, like, I have to say, like this, just about every question around here hits at something so deeply emotional. We're talking about health care for human beings. And the question is, like, what's one innovative thing that's going to change this? You know, there is not one innovative tool that's going to change this. What we have is a tremendously fragmented health care system. We're putting a tremendous amount of pressure on one part of the system and leaving everything else out. Bobby's getting at this when he's saying, let's get everybody at the table. Imagine a world where, with the 20 cents out of every dollar spent on health care, was all working together to try to improve outcomes. If I said, what's an innovative model, I would say, how about some bringing back some kindness in health care? Think about this. Bring back some common sense and kindness. If everyone deserves a chance to be healthy, we would change fundamentally how we practice health care. You wouldn't be waiting for a month while a tumor grows trying to fill out the right paperwork. We would have all the right people at the table. People would answer the phone when people called, and you wouldn't be alone. We're talking about health care. We're talking about actually saving people's lives like I've never met anyone who's gone into health care and said, I don't want to make an impact. Everybody is a hero. Everybody who walks in that door to take care of patients is a hero. They feel tremendously alone right now, and they feel like they're a target because they're not doing enough and they're not supported, and that's driving burnout. So what is the innovation? I'll tell you we went back to covid, sometimes the simplest things are the most important innovations we're running as a country out of personal protective equipment. People are getting burned out and we're scared. A nurse at NYU puts a Tiktok together, where she puts the most innovative thing that probably saved more lives during covid than anything else, long IV tubing. She took really long IV tubes outside and put the pump on a chair outside the room and took a picture of it and put it on Tiktok. So that meant every time an IV tube went off, you didn't have to put on new equipment, you didn't have to walk into the room, you didn't have to go there. You could just go change it. It probably saved millions of dollars of equipment and clothing and cost and expenses, and it was an innovative tool. And thank Tiktok. Think about this that saved more lives. So we're sitting here talking about, let's bring this tool in this high level, integrated internal medical record. The simplest thing is, we know how to take care of people. We know how to save people's lives. We have to do it earlier. We have to not spend more than every country in the world, for the 19th best outcomes, we have to be confident in calling it out and have these conversations with all due respect in bigger rooms at the main time of the conference. You want to talk about how to change health care. Bring this crowd at a large conference and say, this is what we're

going to talk about. What are the real problems and how do we change them? Don't put us in a small room at the end of the day and say we're going to talk about a couple goodwill things, because that's not the audience.

Dawn Carpenter 45:04

Okay, we have a big room in here today, and they want to ask us a lot of questions. I want you to answer their questions instead of mine. So I'm going to look at this iPad here. We actually—I want to call out, I think Omar, you did—Dr. Reverend Hatch, who's here with us from Chicago, who organized that West Side, so I think you owed some acknowledgement. So thank you very much. Okay, now I can't tell you how I would prioritize all of these questions, because there are a lot of them. So I'm going to just start with one here. How do you convince health-care systems that investing in the community and the social determinants of health provides ROI to their hospitals? I think we've talked about this, but the audience wants to know a little bit more, and we have just 10 minutes here for all of the questions. So let's go.

Omar Lateef 46:02

ROI could be in the laundry linen. It actual cash, or ROI could be social capital and changing outcomes, right? So if what is absolutely critical, if you embark on this journey to become an anchor hospital for real, is to clarify the mission for everybody that works in the organization, from the person that works in the front line to your board. If everybody is in agreement, the ROI is actually getting the better outcomes. The ROI is decreasing the death gap, right? So the ROI is not just revenue, but that comes from clarifying what the goal is, and that goal has to be clarified very publicly, internally and externally. So you'll make money, and you do many of these programs, but if everything that you do is for the community, ROI comes in achieving your mission,

Dawn Carpenter 46:47

Excellent. And Bobby, this next question is for you, but I know you want to add on. So if you want to answer that question while answering this one too, sure that would be great. The first one that I want to make sure that is heard, because I think there are young people online that are watching this, what advice would you give an individual graduating from medical school today?

Bobby Mukkamala 47:08

You know, I was I went to med school because my parents are immigrants from India, and that was the only way they would let me go, because that was their success route in this country. I told them I wanted to be a journalist, and they basically grounded me until I changed my mind. So what would I say to a medical student now, I mean, I would be excited that they're even asking somebody like me that question, versus just getting the good grades and moving on to a residency. But I would tell them is that, you know,

the AMA contributed to this in their medical school curriculum, right? So the health system science. That's literally a textbook that the AMA puts out, and it's one that I'm not proud that our country needs to do it. I would love to be able to just focus on the biology, but the fact that a medical student now has to be aware of how the health system works, how to deal with things like prior authorization, is a problem. But what I would tell them, unfortunately, right now, read this book, right because it helps us to navigate and be those people that are on the front lines for the best of our patient outcomes, right? And then the other thing I would say about the ROI is that I think that that's critical. I mean, one of our hospitals, a nonprofit hospital, invested, I don't know how many millions on a proton beam therapy for rate for cancer, something that the science really hadn't even been out there yet for long enough to say, is it going to be useful? The thing didn't work for three years, and then finally they got it working. Maybe they're treating some people with prostate cancer. They're marketing it as big, but this is easily tens of millions of dollars that could make that 68 a little closer to 81. None of that changed. That's a failure, nonprofit or for profit.

David Zuckerman 48:48

Can I connect those two questions briefly? So I think one of the things that we've seen is that physician leaders are some of the most powerful advocates for helping change the narrative at health systems. I think of it at Rush with Dr. David Ansell. I think of it with Dr. Thea James, Boston Medical Center. And they because they have the credentials of understanding the science and medicine and what the limitations of medicine are. I think they're really powerful communicators around the need for having this broader mindset, and this this way of working differently with the institution, and I think they can help communicate the ROI that can come from expanding this focus. I mean, if you talk about physician burnout, a lot of that is coming from the fact that physicians are being asked to deal with treating all of these social issues, and they don't have the tools and resources. So there is an ROI to thinking about, how else are we dealing with addressing these social needs by leveraging other parts of the institution? And I think that's where the culture change comes. Physicians can help lead that culture change if they're learning about it at med school. If they're being shown and experiencing this within the four walls of the hospital, and then other leaders within the institution can also pick this up, so that it really does go from the front lines up to the board. And I think that's a powerful piece that's necessary to expanding the definition of ROI so that it's both the immediate return in one specific intervention, but it's also understanding the multiple returns. This is a social return. This is a return for saving us money on laundry. This is a public return in terms of building trust with community and kind of adding those up to get the equation that you need to make the commitment. Obviously, there's going to be scarce resources. We're entering a time of lots of cuts, we're going to need to make hard choices. But that doesn't mean we should take off the table the opportunity to think creatively and out of the box and to partner differently, because that's how we're going to stretch our resources in this coming period. And I think leaving here saying like, how can we work differently internally? How can we be at different tables and be open to leveraging our resources differently, and how can leaders across the entire institution be empowered to make this case for this broader vision of the institution is really going to be important in this coming period.

Dawn Carpenter 51:16

Well, thanks for getting to just a few of the questions in the cadre of them that are on this little iPad. But I'm going to ask you all, because we have just maybe three minutes left, I want you to finish this sentence. Democratizing longevity means, Bobby, what does it mean?

Bobby Mukkamala 51:37

I want a table in my community to have everybody there. We're democratizing it so that we can improve on 68 year life expectancy. I don't want it to be just the C-suite of the hospital system. I don't want it to be just me as the President of the American Medical Association. I want all of those people there so that is North on our compass.

Dawn Carpenter 52:01

Joe, what does democratizing longevity mean to you?

Joseph Betancourt 52:05

It means absolutely democratizing longevity means building a health-care system that's held accountable for improving quality for everyone, no matter who you are, you where you're from.

Dawn Carpenter 52:17

Kenya, what does it democratizing longevity mean to you?

Kenya Boswell 52:20

It means cocreation, and everyone is created equal in that process.

David Zuckerman 52:26

It means intentionality. These things aren't going to happen unless we intentionally focus on creating those tables. Focus on co creation, focus on reorienting the system.

Dawn Carpenter 52:37

Omar, you get the last word.

Omar Lateef 52:40

We collectively have to have the courage to call out the problems we know exist, and we collectively have to have the courage to work together across a fragmented health-care system to solve those problems. We know what they are, and we have to solve them.

Dawn Carpenter 52:55

The promise of longevity must belong to everyone when we anchor our institutions, and when those institutional anchors invest in the places and the people that they serve, they turn health care into not only community, but also into true and robust health. So thank you all for joining us. Thank you all for investing your time with us here. Enjoy the rest of your concerts.

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