

Transcript of the [Socially Determined Podcast](#)

**“Adapting Determination of Need to Serve Community Health”  
with Dr. Monica Bharel, Commissioner of the Massachusetts Department of  
Public Health, and Ben Wood, Director of the Office of Community Health  
Planning and Engagement within the Massachusetts Department of Public Health  
2019**

**ANNOUNCER:**

Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, board president of the National Association of Chronic Disease Directors. Dr. Gabriel Kaplan interviews Dr. Monica Bharel, Commissioner of the Massachusetts Department of Public Health, and Ben Wood, Director of the Office of Community Health Planning and Engagement within the Department of Public Health. Together they discuss Massachusetts’ unique approach to addressing the social determinants of health, especially their adaptation of the determination of need program. Thank you for joining us. Enjoy the program.

**DR. GABRIEL KAPLAN:**

Thanks for joining us. It is great to have an opportunity to have a conversation with you both and to talk about Massachusetts's approach to the root causes of health disparities. Can you tell us a bit about this approach and how Massachusetts thinks about these issues and sort of approaches the idea of what a public health department's role should be in addressing these?

**DR. MONICA BHAREL:**

Absolutely. So you know when we think about our Department of Public Health, I think in general about our role of public health individuals. And you know, if you think about our work as a department, it's really to provide opportunities to keep people healthy. And when we think about that—addressing and investing in safe and healthy communities—there's really a core part of our work in that area. And for me this is really developed from my clinical experience. I'm a primary care and commerce and doctor by training. And when I was doing my clinical work, I saw again and again examples where treating someone's chronic disease like their diabetes or high blood pressure was much easier than actually getting to the root cause of why, when they know what to eat, they're still eating the 99-cent pizza or not knowing where to store their insulin because they sleep under a bridge.

Those questions for me were the real essence to why the patients they were caring for couldn't treat their chronic disease and couldn't be healthy. And so here at the Massachusetts Department of Public Health, we're really focused on being outcomes-focused, data-driven, and with a focus on both quality public health and health care services. And our ultimate goal is an emphasis on social determinants to eradicate health inequities, and we do this through a framework that I call a department of public health house.

And that is by focusing on using the data that we already collect to underline and emphasize the importance of social determinants in all of our health. And then finding where our data disparities are and putting a laser focus on using our limited resources towards those health disparities to truly allow people that opportunity to be healthy.

**DR. KAPLAN:**

So it sounds like one of the challenges really is to raise the consciousness of the staff about the importance of these root causes, these health disparities, and the inequities that can exist across communities, and understanding that not all communities are the same. So have you consciously tried to incorporate that understanding, and education, and awareness in both the recruitment process and the onboarding process in Massachusetts?

**DR. BHAREL:**

You know that's an interesting question. I find in my work that the individuals who work at the Department of Public Health are truly invested in improving communities and making changes at the community level.

What sometimes can be challenging is that sometimes our partners or stakeholders don't have that same level of understanding or deep appreciation for the level of policy work and programming work that can be done in the community that then can help someone be disease free. So I come from our health care system. And as you've heard many times, health care can sometimes be called a disease care system.

And by the time we're seeing someone presenting with complications from their chronic diseases, it's often too late to make the changes that can truly give them help. And a lot of times our staff actually understand that, and many of them—as we've developed this framework of addressing disparities through data and with a focus and with a focus on social determinants—have been really excited to have the framework to do their work in that way. Our focus and attention on addressing health disparities has been really rejuvenating for a lot of us.

And I will say that one of the things that comes up a lot is really having the funding to do the upstream work. One of the areas we focused on here at the Massachusetts Department of Public Health is very closely looking at what leverage do we have within our department and what areas do we have where we can affect change with our existing programs. Policies are regulated.

**DR. KAPLAN:**

One of the levers that you have, I believe, is this determination of need program. So how is that used as a mechanism for addressing the social determinants?

**DR. BHAREL:**

Our determination of need programs, which in many states it's called the certification of need program, about half of the states roughly have it. Our determination of program has been around since the 1970s, and when we looked at the work that we were doing, and our vision

toward highlighting our work in the communities, we wanted to look at our work with the healthcare system and where we can make system level changes.

So the purpose of the determination of need program is really meant to look at the public health value of any health care improvement expansion program. And it really focuses on looking at the public health value and how we can promote population health, and look at innovative health delivery models and really thinking about equity. So looking at this determination of need program and what is meant by the determination of need program, we recognize that this could be a really significant tool for us to leverage. So in 2017, we underwent extensive reform of our determination of need program that really included a laser focus on how health systems can address the social determinants really from an upstream point of view.

And a major part of that regulation and it changes in that regulation, we could look at our community health investment as part of our determination of need process health systems make a five percent contribution to community health initiative. And that process can result depending on how big that project is on a significant amount of money. And in the past before we made the reforms there was really no accountability of how those investments were made. To give you an example from when I was in my clinical time, a community health investment could go to a food pantry where my patient would receive several cans of soup. And that patient who was sleeping under the bridge had no use for that, although they had great need to have their food insecurity addressed. So what we wanted to do with the way we changed this was make sure that we were putting in place investments that made sense to the community that would be involved. I'd like Ben to just give you a little bit more information about this because I think individuals can learn a lot from the model we use there.

**DR. BEN WOOD:**

So hi everybody. I have the pleasure of providing leadership on the Kidney Health Initiative part of the deal end program at EPA and as Commissioner Burrell was saying the 2017 regulatory vision gave us a chance to take a step back and really try to make sure that we were getting what we wanted out of that program and make sure that it was aligned with the public health principles and priorities that Ms. Bharel has already laid out.

And just to give people just the real big basics of it, Ms. Bharel said that there's a five percent cost, essentially that relate that result in a community health project that a hospital needs to engage in so that can be a small amount of money. So if a hospital is coming to the department with a request to engage in some sort of new technology, buy an MRI machine or something like that, the total cost of that might be you know a couple million dollars and so five percent of that isn't a whole bunch of money, but it's certainly still significant. But there could also be really large projects, a billion dollar plus capital building project, so five percent can be a tremendous injection of critical health resources into communities.

So what we did when we took this sort of step back to revise the regulation was a couple of different things. First of all, we've codified for the very first time in regulations that a five percent contribution was required. Previous to that, it had been what we essentially called a customary contribution, but by fully codifying regulations we have now the ability to provide a lot more structure around the program.

And then what we also did with the regulation was we essentially said that hospitals to fulfill their Community Health Initiative requirements have to meet state defined health priorities. And by

putting that language into the regulation, enabled us to define exactly what we mean by state health priorities and through some regulatory guidance, really sort of as the commissioner was saying, laser focus in on our priorities around making sure that hospitals were identifying and addressing social determinants of health.

And so what we did was we created a framework first of talking about social determinants and we use six domains that we use: housing, employment, education, the built environment, the social environment, employment, and education as just the basic way in which we talk about what those health priorities are. And then we also identified a series of health outcomes and focus issues that we know are overriding issues in communities across the state.

So we look at mental health, substance use disorders, homelessness, and chronic disease with a focus on the chronic conditions that are real drivers of health outcomes and quality of life. And so by creating that regulatory guidance and structure around what we mean by those social determinants of health domains, and by asking hospitals to pay attention to these focus issues, where what we're in effect we're doing is allowing communities to identify what the needs are present in their communities and set their own needs, but to have this overarching state framework that ensures the dollars are being invested in actually effecting change at the community level.

**DR. KAPLAN:**

That's great. I think for those of our listeners in chronic disease who aren't as familiar with a Certificate of Need process, I mean the basic principle as I understand it is that to sort of have some influence and control on the expansion of the, of the health system, and to ensure that health systems aren't just expanding where the money is but are expanding in proportion to the needs of communities. There's a bit of a regulatory process, and health systems have to petition the state for permission to build a new wing, or as you've pointed out, to buy particular equipment that might be a revenue generator for them. And it tries to prevent the sort of phenomena of scarcity in some neighborhoods and then empty beds with too many hospitals sort of moving into other neighborhoods. And it tries to regulate that process. And so your response in Massachusetts is to say that that's fine as part of that process in assessing that need is to make sure that part of that investment also goes back into the community directly to address their particular needs.

How do you engage the community and involve them in decision-making? For those who don't know there's some similar stipulations in building, for instance when a developer needs to do a big development in a community. A lot of cities say well x percent of this money needs to go into artwork. And so the developer does it sort of as an afterthought. And sometimes communities end up with these artworks that are commissioned that don't necessarily conform to what their values are and can create some controversy in the community.

How do you avoid that in this space, and making sure that the community health initiatives that get chosen by health systems really meet community needs and reflect the interests and the voice of the community?

**DR. BHAREL:**

The way you analyze their determination of need process is spot on. It's about making sure that the public health value to expansions and improvements within the health care system. And we had an opportunity to reform that process, which by the way included streamlining it, modernizing it, making it easier for health systems to engage with this regulatory step, we also wanted to modernize and improve the way we think about the community health investments. So just to be clear the community health investments that Ben described were actually already part of the determination of need process here in Massachusetts. But what we wanted to do is we took a step back, we said this is millions of dollars and it's coming from the healthcare system to the community, it's already money coming in the community.

But we wanted to help with the health care system understand how to move those investments upstream, so they're really tackling the root causes of the diseases that they're seeing and providing communities the resources they need. But you have a really important question around how community health investments engage the community. And Ben's been a real lead in this. I want him to address that.

**DR. WOOD:**

It's a tremendous question and it is really one of the guiding principles that we took into the planning process and the stakeholder engagement process that we went through to revise the deal and regulations.

So we absolutely see that the engagement practices are a foundation of understanding how to actually think about why health inequities exist in communities and to ensure that the strategies and the solutions that are being raised up and that hospitals are going to be implementing come from come from a community voice and actually meet the needs of people.

So what we did do was through something like regulatory guidance create a series of guidance documents that we require hospitals to use as they're going through the determination of need process, the application process. And one of those guidance documents is solely focused on engagement. So we have set expectations and standards that ensure that the hospital is setting a vision for what they are hoping to accomplish in partnership with community stakeholders, resident, multi sector partnerships, and ensuring that the, again, that the voice of the community is of the overriding voice that is part of the decision-making process.

So we did some of some real simple things with that, with the guidance we use the well-known and well used public participation spectrum that is used in a lot of public health planning processes. We essentially ask hospitals to place themselves on the spectrum of do they go out and are they informing the public, are they consulting with the public, or are they actually moving toward a community-driven and community-based decision-making process. And we ask them to articulate how they can defend the processes that they're going through as part of the application process and to give DPH an opportunity to consider and look at that and provide feedback and provide requirements and conditions if need be based upon the standard that we have set forth.

**DR. KAPLAN:**

That's great.

**DR. BHAREL:**

If you don't mind Dr. Kaplan, I just want to go back to what Ben was saying. Well we set the guidelines for our health care system partnering around the social determinants of health. And talked about the six domains. We also, along with that, set state level health priorities and those state level health priorities were chosen based on data. I spoke to you about how our Mass Department of Public Health Foundation is using data to highlight the social determinants and then kind of disparities.

And one of the things we looked at with our data were the, what health priorities would be most impacted some changes at community level interventions? And so we came up with for state health priorities. I think it's important to understand and those include addressing homelessness in individuals with housing instability, those with substance use disorder, mental health and mental wellness as well as preventable chronic disease.

So when we engage with our health care system partners around the social determinants, it's a very important piece about engaging the community based on that framework of the social determinants, but looking at the Massachusetts state health priorities to be able to address one or more of those.

**DR. KAPLAN:**

Are there examples where a health system selected an initiative in consultation with their community that sort of aligned with those priorities but required them to bring in some non-traditional partners that public health doesn't often work with, like a department of transportation or office of economic development that you can sort of highlight for us?

**DR. WOOD:**

Absolutely. So we're, we're really starting to see some successes which is incredibly exciting to us. So as probably in lots of other parts of the state, housing is an overriding issue that communities are facing both in terms of quality of housing, affordable housing. So this has been an area where we've seen a lot of hospitals start to dig in lately.

And I would just back up and say that one of the standards that we have set forward in our communications guidelines is actually to ensure that there is a multi-sector partnership that is that the House was using as an advisory committee and we name specific sectors for this purpose of ensuring that you know the quote unquote influencers of the social in terms of health are really active participants in the decision-making process, so we do name that housing stakeholders, and education stakeholders, and employment sector stakeholders, are part of the advisory committees that half of the values drive decision-making.

I'm going to give you a real concrete example that's coming out of Boston right now. So we have one of our health systems that has been a real leader in thinking about the connection between housing and health, and they had an approximately 7-million-dollar community health initiative requirement that they had to implement. And they decided to go all in on housing, and they did that in a couple of different ways, in some more traditional, what I would call more traditional

public health housing and health related interventions but also in much newer and more innovative ways, including making investments in a social equity fund that is putting money into actual new, affordable housing development and also supporting a development of a new grocery store in a neighborhood in Boston where there was a lack of affordable options, which definitely relates to the, you know, one of the priorities that we've set forward, which is to influence chronic disease and the major risk factors the chronic disease being one of which of course being deficient in food access.

But then they've also through their leadership they brought in two other Boston hospitals to participate in some of the housing-related work that they've been doing. So they've brought in all three of those hospitals are pooling together some of their determination need required investment into one initiative, which is called the innovative stable housing initiative, the ISHI initiative, that has three different strands attached to it, one of which is a Flex Fund though a national pool of significant resources to address the real immediate housing stability issues that people are facing in Boston, and in a particular neighborhood in Boston where there has been disinvestment and where there is a lot of displacement happening.

And also in what they call an upstream fund to identify innovative policy solutions to the housing crisis in Boston and then also a, what I would consider to be them on the most exciting thing a real resident led fund that is designed essentially to leave in some ways leave the hospital out of the decision-making process and to put money into the hands of Boston residents who identify their own creative solutions to the housing crisis.

So through this type of investment we're seeing the creativity, the creativity that we're super excited about to understand how to really dig in on some social determinant of health issues and actually move farther upstream and really understand the root causes of those issues, which takes the hospitals into talking about thinking about issues around structural racism and historical patterns of why disinvestment is happening in particular neighborhoods and really try to understand those and work with residents and stakeholders to sustainably create solutions.

**DR. BHAREL:**

Dr. Kaplan, if you don't mind if I just really emphasize the example that Ben gave around the use of community health investments for housing, should you take a step back and look at this, this is this has been in Massachusetts. This has been transformational. When you look at this is money that was already going from the health care system into the community that now is being used in a way that we know impacts our public health goals of allowing communities to live healthier.

And we've never had this before where the health care systems are investing this community health resources to directly impact those and it really is exciting to us as a department, as a state because when we think about, you know this thing that we all know, about how zip code contributes to health more than our genetic code, and here is the health care system contributing to the response and the improvements that we need for health equity.

So we're really excited about that example that Ben gave is one example. And in Boston where many times health systems are competitive with each other here we're seeing them working collaboratively to improve health in a community.

**DR. KAPLAN:**

That's great. It's fascinating. Any thoughts on how other states can bring this work into their chronic disease portfolios if they haven't previously worked with their certificate of need programs or if they don't have access to those kinds of things, are there aspects of this program that are easily translatable to other states?

**DR. BHAREL:**

Certificate of Need programs is one example that worked here in Massachusetts. What might be more generalizable is that since the ACA every state has community benefits that go from health care system to the community. And there are ways for example in Massachusetts we've aligned our work with the community health investments with our attorney general's office and that is one area where I believe a lot of what can be done, and Ben will say a couple of things about that as well.

**DR. WOOD:**

Yeah, I think that that is one of the big successes that we've seen is to ensure that the DON, the determination of need program in Massachusetts is aligned with some of these other state initiatives and really give us an opportunity to see things work in a more sustainable fashion. So DON or certificate of need would be, would be in any other state if they had something similar to what Massachusetts had, episodic investments right, they only happen when the hospital is going into the DON process but the community benefits process that nonprofit hospitals have to go through to meet their affordable care act requirements are routine, they have to do community health need assessments every three years, they have to define implementation strategies that relate to those community outreach assessments. And so state health authorities in our opinion really need to figure out a way to dig into these systems that are happening at the community level led by health care systems and to figure out how to layer on their state health priorities to those processes so that there is a more systematic and sustainable way of addressing community level conditions.

And again I think from our perspective, ensuring that those regular and ongoing processes is prioritized diagnosing and understanding social determinants health and their root causes so that implementation strategies and investments are really upstream investments and moving away from [inaudible] health system which is of course downstream work.

**DR. KAPLAN:**

I'm sorry we don't have more time to continue this conversation, it has just been fascinating and I really am grateful to you both for being able to share your experiences in Massachusetts with our audience of listeners across the country. I hope that this has proved valuable and provides opportunities to export these wonderful ideas to other states. Commissioner Bharel and Ben we thank you very much for talking with us today.



**DR. BHAREL:**

Thank you for having us.

**DR. WOOD:**

Thank you.

**ANNOUNCER:**

Thank you for listening to Socially Determined, a podcast brought to you by The National Association of Chronic Disease Directors. Please visit [www.chronicdisease.org](http://www.chronicdisease.org) to listen to more podcast like this one.

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