Conversation with Luke Shankland
Ashley Hopkinson
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Ashley Hopkinson: Can you introduce yourself, tell me a little bit about your background and what brought you to the work that you do today?

Luke Shankland: I'm Luke Shankland. I'm a Canadian-South African. My formal training was in math and philosophy, neither of which was really a viable career path, at least it didn't feel like it when I was 20. I went and worked with Doctors Without Borders for a long time and then switched out completely, worked with banks for about five years doing financing of small businesses, using machine learning for credit scoring. I've been back in the health space for the last 12 years or so.

My interest is primarily around how people can better navigate and access the right information at the right time and overcome barriers and achieve better health. There's lots of micro constraints and psychological constraints, and obviously, financial constraints play a massive role, especially when you're in places in Africa and other parts. There's always financial constraints to any service. That is a lot of what I've been doing. I've also become more and more interested in the social determinants of health.

What I've been doing in the past is using digital tools to help with navigation and communication. That's really important when you need to get certain medical services and there are constraints there. However, the other side of it is just that there's a lot of other things that come before medical service. This is where the social determinants of health come in. Housing, quality food, green spaces, employment, and just a steady income.

The math is persuasive. They say somewhere between 50% and 80% of health outcomes are linked to social determinants. Medicine is a major piece of health, but a lot of health actually is all these other things that lead up to a medical intervention. When you think a lot about trying to guide people through medical intervention and get them to where they need to go, you start thinking, there's only

so much you can do when a patient is at this stage, when all these other factors play a huge role in health outcomes.

A lot of time people in health just are like, "Yes, that sounds like somebody else's problem. What am I supposed to do about your housing? What am I supposed to do about your other issues?" It doesn't feel right or doesn't sit right at some point. On the other side, medical people have their training and their specialization — they have the things that they're good at. If you're good at doing certain things and you feel like you don't want to do other things, then that makes sense.

One of my real interests has been how can we work with people to improve social determinants of health *from a health perspective* without making a bunch of people in health feel uncomfortable so that they're going out of their lane, that they're not asked to speak about things that are not really in their expertise.

I think we throw around the word. It's easy to throw around, but there's an intersectional aspect of this, which is that health sees massive benefits to people having security and other social components like steady housing, regular food, employment. These things dramatically increase your health. But they're not things that the health system feels like they can provide. Then the question is what can health systems provide? Can you provide data? Can you assist with advocacy? Can you do better referrals? What else can you add to the pot since you're going to see huge benefits in your sector and know how to do it?

How do you get people from different sectors to collaborate when the problems sit at the intersection and nobody really feels it's their problem? Nobody really sees the full risk-benefit of taking it on completely themselves, but everybody benefits from improvements in those areas.

Ashley Hopkinson: What would you say has been something that has helped to move you forward in the work? Have there been partnerships or collaborations that have helped you?

Luke Shankland: We're pretty early in some ways. Let's say, I'm starting to get a pretty good handle on the problem. I don't know that I can confidently say that I know what the solutions are at this point.

Ashley Hopkinson: Can you tell me about something that has come up as a clearly defined problem in terms of finding a direction you would like to tackle first. Let’s start there.

Luke Shankland: When I started wading into this I had already done a lot of work around screening and navigation. Going through a program, helping people to screen for HIV, TB, and then navigating people to appropriate resources depending on the outcomes and determining how you make that

accessible. I'm working with a partner out of Harvard. She saw a lot of incentive and pressure around screening and navigation for social determinants of health. It seemed like a very natural thing for me to come into. To start the process we interviewed 100 different healthcare workers and many other people, and we realized very quickly that there's a pretty good understanding and a pretty good ability to screen and even to navigate for a lot of social issues in health systems.

If someone really is having food insecurity or they're unable to access appointments because of transportation there actually is a fair amount of resources in the U.S. to identify solutions and push them through. A lot of people are quite tech-savvy depending where you are. The one that we really noticed though is housing. People are spending an incredible amount of time and energy trying to secure housing for their patients when they're housing insecure.

That navigation support is the approach right now because there's this fear of going into an area that's not yours e.g. housing systems. As health experts, we're not supposed to provide housing. We're not supposed to get into the housing system. True. Fair enough. But then those same health experts end up doing things like setting up these big navigation programs aiming at the same limited supply .

There's one in Boston, there's another one in New York, with like 150 health workers that all they're doing is trying to help their patients navigate housing because their patients are having all kinds of bad outcomes because they don't have proper housing and then they're not staying on their cancer treatments or they're not doing other things to take care of their health. They're potentially covered, but they're just having really bad outcomes for e.g. in hepatitis treatment.

You don't really solve the supply constraint problem by just getting more and more people that are helping other people to navigate care. If there's no more houses, there's no more houses.

The insurance companies, they're not contributing to the building but they rather just contribute by putting energy and effort into getting their patients prioritized in queues — but then you're going to end up with another bunch of people who are housing insecure because there's limited supply. If you don't really step into the supply problem, you're not really going to solve it, and so that's really where we've been working.

We're working with developers because there are a lot of incentives for developers. It's one of those intersectional things. Developers really want to densify. They want to bring in new places. I was surprised by how many landlords and folks in New York and other places are really interested in getting support from health systems or at least having their inputs into their developments. If I know that I can get a steady stream of tenants that have been vetted from the health system, if I know I've

got data that I can put into my applications, if I can say I have a partnership when I'm writing up a funding proposal that says, “I have a partnership with the health system,” all these things can make a big difference to getting more units available. We’ve been looking at ways to improve these partnerships.

Ashley Hopkinson: Can you tell me a little bit about your project in the Bronx, a little bit about the thought process behind that?

Luke Shankland: What we've been working on there is an analysis of their program. What they're looking at is areas to improve and innovate in their program. Right now they've got 30 community health workers and they're going to go up to 150 and they're spending most of their time on housing issues. A lot of this was looking at all of the challenges that they have and what some of the solutions might be.

The supply constraints was one of the penny-drop insights because we were looking at a lot of ways to improve the processes for the community health workers. We're looking at different ways to help CBOs to deliver services. We're looking at different ways to get people to be able to navigate things on their own. We're looking at all these kinds of things and we just realized with almost all of them that it's not going to do much. At best, you're going to get a little like a 5%, 10% improvement in your processes and outcomes. If what you are doing is staying inside of your lane, and talking to the world, you're not fundamentally going to change it.

We're doing the same thing in Toronto actually where there's a community land trust and they've got a number of sites that are owned by the community. Community land trusts; they're a very interesting structure. Basically, they buy land with funding from philanthropic sources and then they hold it in perpetuity as affordable housing, and people can come and go on it. They've done a lot of that. There's a lot of support for a lot of really interesting models out there.

What they want to do is to densify, increase the amount of units that are available in each of the lots. It's really hard to get capital. It's just hard enough just to get money to do the capital repairs and keep the places up to speed. So how do you get the health system involved to improve the economics of the building? Again, it's the same problem. If it's a new building or a densification or a restructure of a building, this takes a lot of money nowadays. It has always taken a lot of money. If you're going to be making affordable housing at the end of it, there is very little margin in it.

Ashley Hopkinson: What is the next level of the work you're doing? You have the community healthcare workers around the project in the Bronx, and then you have this community land trust work in Toronto. What's the next step?

Luke Shankland: Personally, I don't spend much time on the medium term, meaning the next two or three years. What I'm going with is that I like to think I have a vision that's farther out and then I think there's a very narrow, "What are we going to do in the next 6 to 12 months?" The reason I'm saying that is because my drive to work on this comes from a lot of different places, and I'm really open to different ways to tackle the challenge.

When I was growing up, my mom had cancer and she had four kids and she was a single mom. We bounced around to all these different apartments and all that. She got onto the affordable housing wait list and we spent eight years in really not good conditions. Then she finally got affordable housing and it was a life changer for her for two years — until she died. Do you know what I mean? It always struck me as it was just the wrong way to do it. That was in Vancouver back in the '90s.

Then I went and traveled and worked overseas for 20 years, and when I came back, it was like just everywhere in North America was the way the West Coast used to be 30 years ago in terms of constraints on supply, in terms of the cost of housing. It used to be that Vancouver was like that, but then you would go to other places and they're like, "It's not so bad." You can get a house. But everywhere is like that now. It's not correct.

Will it have been worth doing all this work? I don't know. In 10 years, 20 years, it'll be worth it if we can get hundreds of thousands of units up for rent/sale. In Europe, 40% of housing is social housing. It is rent geared to income. Look, there's problems with cold/heating and other issues with the infrastructure but 40% of people are not worried about rent. That is not the case in New York City. In the Bronx 70% of people have rent that is unaffordable. Seventy percent!

We have a really strong instinct that these partnerships are the right thing, and we know developers. There are a lot of developers that are trying to put in applications to funders, whether those are big cooperative banks or social impact funders. Right now, I know that many of those go in without any concrete discussion of the health impact of their new developments. I know that those affordable housing developments they're putting out are going to have massive health impacts.

My goal very narrowly is just to be able to say and describe in those applications, this is the health impact and this is our collaboration with the health system. Then what I'd like is that within the year, if that works,then everyone's like, "Oh, well you can't do affordable housing if you don't talk about the

health impact." And if you do, you're going to get a lot more money because you are showing the impact. Then we can get a lot more affordable housing on the market, which has benefits for everybody because we just need more supply. That's the thing.

Ashley Hopkinson: What I'm hearing from you is that if we get to the point where developers are having health as a component of an application, then that's a marker that we're moving further along, because that's putting housing and health at the intersection. Am I hearing that right?

Luke Shankland: Yes, exactly. Every sector is very, very important, but sometimes when I think about it on some instinctive level, it's like the people building homes are in a very real practical sense building the future. Those homes are going to be there for the next 70 years. That's where people are going to live. It's the same with roads, water and other infrastructure, but the built physical environment it's a big deal.

What's always most interesting to me is the intersection. Where is it? Can I do something for you as a developer, just like with health. For a developer it may seem, what am I supposed to do? Call the hospital and ask for a partnership? Do you know what I mean? I wouldn't even know what to ask for. It's the same on the health side. They're willing to spend lots and lots of money on their community health workers and their nurses because they're like, "That's what we do."

Then you say, "Hey, do you want to get involved in a housing deal?" They're like, "I don't want anything to do with that. It's way outside of my expertise." But there is something there.

If you can get a nice vehicle that makes people feel like, "Okay, I don't have to learn about a whole new sector, but I can see some of the benefits for my contribution to it at a smaller level," it's a wonderful potential solution.

Ashley Hopkinson: Are you hoping that your work does become that vehicle for those two worlds to begin to talk so to speak and have it serve as a catalyst?

Luke Shankland: Yes. Very practically, I think that's what we want to do. We want to set up these partnerships and really help the developers to do it, but also more just to have case studies. But I find that you go to some talk shops and everyone just says partnerships, partnerships, partnerships, and everything's partnerships. I almost prefer a word like governance or something like that. It's like, what does your partnership mean?

Everyone has a different idea and actually just needs a templated MOU of this is how we collaborate. This is what you do. This is what I do. This is how we see the benefits. This is the thing. You know what I

mean? That's what I mean by partnership. It's boring. It's back office on some level. But it's not because it's the documented foundation for everything. If you're like, "Okay, this is when we're going to have meetings. This is what we're going to track. This is what we each commit to doing, and this is the expected benefits," and you have a template for that, that means that you don't have to make that up yourself. You can just say, "Oh, look, here's what this health system and the developer did in Boston…" For me, that's innovation. That's process innovation, which actually can be extraordinarily powerful.

Ashley Hopkinson: What has been something that you've learned through this process that you think could be valuable for the next person to learn something from? What's a lesson or takeaway from this process working with housing and health?

Luke Shankland: There's probably a few different lessons. One for sure is, talk slow. What I mean by that is partly the reason I feel comfortable with this problem is because I've spent the last 12 years at the intersection of health and technology and it's exactly the same problem. The way a medical person thinks, they have a whole set of acronyms and assumptions about what a proper outcome is, and about how to treat people and what the patients need and so on.

Then on the other side, you have technology providers which have a whole different set of measures, and they know about stabilization,or AWS, and all this kind of stuff. There's a whole world that's happening there.

You can just take a word, engagement. I always find that to be an interesting one. What it means to engage a patient is extremely different from what it means to engage somebody on a technology platform. It just is. It's one word with very deep different biases built into what it actually means. This is what I mean by talk slow. You need to talk slowly and carefully to translate between the 2 worlds.

Words have meaning and they have different meanings for different people. Housing and health is an interesting one — we just realized the other day in a meeting and I was like, "Oh, wait minute, two people are getting upset with each other because they're using a word and the way that they think about it; it's not the way that the other one thinks about it."

Transient, that was the word. Transient homelessness. Very different from transient illness. The word transient is just a word. You're a journalist, you read or you write and you're like, "Transient means something else," probably different, but those have very technical specific meanings in the world of housing security and in medicine. They're not the same at all. They are the same in a sense that they indicate time limitedness, but it means something very different about motivations and how you

would intervene, how big of a scale a problem is, and things like that. Words matter and those translations really matter.

Getting the right vocabulary down early is super important, and getting people onto that vocabulary is hard work. That's why I'd say the second piece of it is, don't expect people to do the work. I think that comes back to what I was saying to you before. Once you have to learn a whole new language, and you're getting to all this, then you're like, "Okay, but I trained to do pediatric medicine. I can't learn about all this other kind of stuff too. I know that it's affecting a lot of my young patients, living in the Bronx, because they have asthma and they're having crises all the time because of the way that they're living and it's cold, and there's mold and all these kinds of issues. It's a major problem for me. I see it every single day in my facilities as a pediatrician, but now to learn about it and intervene, I have to learn about capital stacks, and LIHTC loans, and it's like, 'Oh, okay, I give up. I'm out.'" So first, I think you need to establish, borrowing from tech here, but it's an MVU, it's a minimum viable understanding.

If you're going to do cross-sectoral work, you have to have a minimum viable understanding, but you don't need more than that and you shouldn't want more than that. What do you absolutely need to know to do this? Then the second part is, set up structures that can work within that minimal viable understanding without asking too much of each of the people.

It's the same thing of a housing developer. You have to be like "Wait, here's what you could need to know to do an intersectional thing."

Ashley Hopkinson: What do you think is missing from the conversation that we are having about housing in the U.S. What do you wish people were talking more about, especially as it connects to equitable access?

Luke Shankland: I'm not American, I'm Canadian and South African. So let's just say North America.

There are problems that are not solvable by free markets, affordable housing being one of them. That's all I can say. Honestly, that's what I can say. Sometimes when you get so far into a pattern with these sorts of things, you really shoot yourself in the foot. What I mean by that is, the more you think, "free market, free market, free market, free market," the more it's the only solution. But you will pay somewhere.

It's either you pay for the housing now for these folks, or you're going to pay all their hospital bills later, or they're going to die on your front door. You don't have a choice. There are certain ways of solving these problems that create nice-looking environments and nice parks and safety and security

for people. And there are other ways of solving the problem that involve people spilling out of emergency rooms and coming and breaking into your house. You're going to pay. The question is how do you want to pay and when. That's maybe the 30,000-foot view.

But I also feel it's bad accounting. If you're just spending the same amount of money, but a lot more now is being spent in healthcare and justice systems. Bad accounting is: "Oh, well, this piece of infrastructure is the right one because it is by the lake," but you haven't accounted for the health impact of it and you haven't accounted for the other sector of the government that are going to be paying a lot because of the decisions you're making, it's not good.

Ashley Hopkinson: What's your process for working through some of the challenges that come up — if you have one yet — in terms of this housing health intersection?

Luke Shankland: I was just shouting at the government about what they should do. The flip side to that is intersectional is hard for them; these are complex things.

Usually, an intersection is two very complex systems now interacting and making it even more complex. My point is that you need humility and acupunctural solutions as opposed to, "Okay, we're going to do this, and then we're going to just jam it for as long as it takes to get it done." There's a lot of that.

Rather, just try something small and then it either works or it doesn't work. If the system reacts negatively, then don't do it. If you try this and all of a sudden, everybody's showing up at the meetings, then keep going. Humility and just pushing for a little intervention.

It's hard because you don't want to give up too early on some things. Everything takes work. It takes work just to get the needle in, but you know when things are working and when they're not working. Keep watching it, but just try and tweak things.

It's less intimidating. You're not asking people to do a lot, you just ask people to do a little bit "I'm not asking you to figure out the health and housing intersection. I've been spending a lot of time with that. I'm asking you to write me a letter. I'm asking you to deliver this data to me once a month. Then, I'm going to see if I can do something with that." Make the ask small and then try to monitor what comes out of the ask.

Ashley Hopkinson: Thank you Luke.

Ashley Hopkinson is an award-winning journalist, newsroom entrepreneur and leader dedicated to excellent storytelling and mission-driven media. She currently manages the Solutions Insights Lab, an initiative of the Solutions Journalism Network. She is based in New Orleans, Louisiana.

** This conversation has been edited and condensed.*