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How Trauma-Informed Programming to Treat Social Determinants Unveils Challenges to Systems Alignment

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Abstract: Cross-sector collaboration and systems alignment to promote a culture of health can address social determinants of health (SDH), improve family well-being, and create a more equitable society. This paper documents our attempt to align Temporary Assistance for Needy Families (TANF) and Medicaid to promote health through a trauma-informed program, The Building Wealth and Health Network (The Network). The Network successfully integrated into traditional TANF and addresses SDH through peer-group programming where caregivers heal from adversity and build financial skills. We identify three challenges to alignment of TANF and Medicaid: 1) TANF's culture of compliance, 2) societal and systems-level forces including racism and discrimination, 3) misaligned partnerships (values, priorities, structure, and capability). For each challenge, we propose solutions including incentives for innovation and partnership, and promotion of racial equity initiatives, including reparations. By highlighting challenges and solutions we seek to strengthen current approaches to achieve health equity through systems alignment.

Key words: Systems alignment, challenges, solutions, trauma-informed, racism, TANF, Medicaid, social determinants of health.

Over the last several decades, public health researchers have drawn more attention to understanding and addressing a wide range of upstream factors affecting health, commonly known as social determinants of health. These include economic determinants, such as food insecurity and housing insecurity. More recently, practitioners are recognizing the roles that racism, adverse childhood experiences (ACEs), and community violence exposure play in determining health outcomes.[1,2] Social determinants affect family health long before a person enters the health care center, doctor's office, or emergency room. *Public Health 3.0* is a term for a new generation of public health practice and research that seeks to achieve population health across the lifespan.[3,4] Practitioners and policymakers adopting this approach recognize the need for cross-sectoral engagement and the integration and alignment of multiple public and private systems that are currently siloed. Cross-sector collaboration and systems align-

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ment to promote a culture of health where "placing well-being at the center of every aspect of our lives" is a chief concern in social services, health care, and medicine.[5[Pg.1]]

To benefit low-income families with young children, there is the potential for funding and programming alignment of Medicaid with Temporary Assistance for Needy Families (TANF). Medicaid is a public insurance program that provides health coverage for 97 million children, parents, pregnant women, seniors, and people with disabilities who are low-income. Almost all people who participate in Medicaid also participate in TANF. The goals of TANF are quite different from those of Medicaid. The Administration for Children and Families of the Department of Health and Human Services states that TANF is "to help needy families achieve self-sufficiency." However, none of the stated four purposes of the program* is focused on family well-being. Most TANF funds support childcare costs and education and training programs, ostensibly to address the issue of promoting job preparation and work. Other funds are meant to be provided as direct monetary grants, commonly referred to as "cash assistance," for people who have incomes below 50% of the federal poverty line (FPL).[6] However, over the last 20 years, states have been diverting TANF dollars to other state programs such as Earned Income Tax Credits, pre-K, or child welfare.[7] Additionally, since the grant amount was never adjusted for inflation, the grant amount has lost one third of its value since 1997. In Pennsylvania for instance, just $403 per month is provided for a family of three in most counties. This is less than 23% of the FPL.[8]

Although both Medicaid and TANF are crucial pieces of support for low-income families, both programs in their current iterations have significant limitations. Overall, most states have disinvested in cash assistance, and rely on a culture of compliance.[9] Medicaid has improved access to preventive and primary care for millions of Americans, protecting against and providing care for serious diseases, but has not traditionally addressed upstream causes of poor health and well-being.

To contribute to efforts to align siloed systems in which families participate, we use the program The Building Wealth and Health Network (The Network) as an example of a potential systems alignment opportunity. We highlight the successes of the integration of this trauma-informed financial empowerment program into traditional TANF programming to address the social determinants of food insecurity and adverse childhood experiences and to describe the difficulty in linking this TANF program with Medicaid funding to support the behavioral health and economic security improvements for families participating in TANF. Through this analysis, we identify and discuss three challenges to the integration and alignment of TANF and Medicaid: the surveillance culture of TANF, intersectional forms of racism and gender discrimination, and lack of opportunity for leaders and partners to make innovations. We then propose solutions to address these challenges.

Rationale for TANF and Medicaid systems alignment. Aligning Medicaid and TANF offers significant opportunities to address both family health and economic

*The four are: 1) provide assistance to needy families so that children can be cared for in their own homes or in the homes of relatives, 2) end the dependence of needy parents by promoting job preparation, work, and marriage, 3) prevent and reduce the incidence of out-of-wedlock pregnancies, and 4) encourage the formation and maintenance of two-parent families.

security. Nearly all TANF participants receive Medicaid health coverage, an overlap that presents great opportunities for integrated approaches to address both income and health needs. However, the two programs rarely coordinate.[10] Due to the interconnected nature of a family's health and financial well-being, better coordination between programs such as Medicaid and TANF can provide families with substantial benefits. Currently, the only way that Medicaid funding might be able to be used to support a TANF participant is if a participant has an identifiable mental health diagnosis. However, conditions such as depression, sleeplessness, anxiety, and other mood disorders associated with exposure to adverse childhood experiences (ACEs) often escape diagnosis,[11] and formal diagnosis could also exacerbate stigma. Yet many people participating in TANF have major struggles with depression, anxiety, and adversity that go undiagnosed, underdiagnosed, or that are impossible to diagnose.[8] Though TANF programming does not receive support from Medicaid, in multiple states Medicaid dollars have been used to fund other public assistance programs that have been shown to promote health, including housing-first and food assistance programming.[12]

Again, few efforts have aligned workforce education and training programs with behavioral health. The Building Wealth and Health Network (The Network) sought to change that. The Network is a trauma-informed, healing-centered, financial empowerment program integrated into standard TANF programming in Philadelphia. It uses a peer-group format aimed to build the wealth and health of caregivers with low incomes. The Network simultaneously addresses mental and emotional health along with financial health, employment, and training. This approach represents a programmatic solution to social determinants of health. Despite the fact that The Network addresses the syndemic of depression, economic insecurity (including food insecurity, housing instability, and energy insecurity), and low job success, the funding for its operations has been primarily from philanthropic foundations, with some public monies from state TANF streams.

The Building Wealth and Health Network: Intervention and Outcomes

The Program. The Network began in 2014 as a randomized controlled trial, and since then has been adapted to a variety of formats to adjust to changes in funding, and a fuller integration into standard workforce development settings. The program consists of 16 three-hour, curriculum-based peer group sessions, and a one-year savings program, in which members open savings accounts and receive a 1:1 match of their deposits (up to $20 per month). Participants in The Network are referred to as "members" and members are enrolled in the program as peer group cohorts. The language and approach of the peer group curriculum is rooted in the evidence-based Sanctuary Model®, a trauma-informed approach to organizational and group processes that works to prevent re-traumatization and promote healing, recovery, and behavior change, which can lead to personal and group transformation.[13] Taking a psychoeducation approach, the healing-centered framework of The Network sessions helps members learn how exposure to violence can create trauma-related symptoms such as hypervigilance, loss of trust and emotional control, social isolation, sleep disturbance, anxiety, and disso-

ciation, all of which can limit employment opportunities and success, and potentially lead to a number of mental health problems including depression, alcoholism, and drug addiction. In addition, members learn about trauma responses that are normal and protective during traumatic events, but that can create problems when the original violent experiences are no longer occurring. The curriculum also helps members to acknowledge, understand, and practice new ways of building relationships, managing emotions, imagining a future, and participating in self-care by using the language of S.E.L.F. (taking care of Safety, Emotional management, Loss and letting go, and developing a sense of Future).[13]

The empowerment-focused curriculum also emphasizes a sharing of resources, ideas, and experiences among the group, rather than relying on a coach to "teach" curricula, and dialogues are fostered to strengthen social support. Combined with these group resource-sharing experiences are coach-facilitated learning modules on financial education that include strategies for banking, improving credit scores, reducing debt, and increasing income.

Research results from The Building Wealth and Health Network demonstrate that a workforce and training curriculum that combines trauma-informed peer support with financial empowerment education improves depressive symptoms, coping strategies, employment, income, and overall economic security, including food security.[14–17] The Network program also reduces TANF participation over time.[15] More details on the data collection procedures for the Network are found elsewhere.[18] These positive results suggest that improvements in mental health and economic security with concomitant reduction in TANF participation would reduce costs in both Medicaid and TANF.

Challenges of system alignment. The Network currently works within the state TANF structure of employment and training. With support from the Robert Wood Johnson Foundation Systems for Action mechanism, we sought to provide evidence that the outcomes above would reduce the financial burden of Medicaid spending on behavioral health challenges and treatment, as well as the financial burden of TANF churn (in which people cycle on and off of TANF within short periods of time). The intent was to demonstrate potential cost savings, and, therefore, make a case for aligning the funding streams to support family health and economic security. We originally intended to work with city and state officials, as well as The Network members, to make the case for aligning TANF with Medicaid dollars to support healing-centered programming for families living in poverty that would simultaneously improve economic security and trauma-related mental health symptoms. Despite the promising successes that The Network has shown in improving a variety of social determinants of health, and despite the shared evidence of success through strategic communications such as policy briefs, webinars, in-person visits, and discussions with state agencies, there were several significant challenges that inhibited successful system alignment. We encountered three main challenges: 1) the culture of compliance within TANF; 2) larger societal forces that are built into existing systems such as racism, gender discrimination, and systemic violence; and 3) misaligned partnerships (values, priorities, structure, and capability) that stifle innovation.

Table 1.

OVERVIEW OF CHALLENGES TO SYSTEM ALIGNMENT AND PROPOSED SOLUTIONS

Challenges	Proposed Solutions
TANF's Culture of Compliance 'Work-First' policies create a punitive environment that does not attend to health and well-being, despite evidence that poor health and well-being are barriers to work; This makes alignment between systems such as Medicaid and TANF on the basis of health promotion and addressing upstream factors to health extremely challenging	1) Incentivize state programming (ex: through waivers) to integrate evidence based, trauma-informed programming 2) Shift focus from punitive, isolating 'work-focused' policies to ones that truly put health, well-being and human dignity at the forefront. 3) Implement the following 4 policy priorities: a) Increase cash allotment to reflect the percent inflation rate since its last increase, or to reach at least 50% of FPL, b) Develop a Cost of Living Adjustment (COLA) that adjusts the cash grant each year for changes in inflation, and c) Raise the Earned Income Disregard (EID). d) Raise or eliminate the TANF asset limit to allow for more opportunities for families participating in TANF to build economic security, ensuring future stability not only financially but also for their health and well-being.

(*continued on p. 643*)

Table 1. (*continued*)

Challenges	Proposed Solutions
Major Societal Forces: Racism and Discrimination Institutionalized racism major barrier to public assistance reform Racism/Discrimination within public assistance programs and policies perpetuate stigma towards participants in public assistance, creating barriers to participation, and restricting the state's ability to innovate	1) Acknowledge and address systematic oppression and discrimination as a form of trauma 2) Policies and programs that aim to improve family economic security and well-being should use trauma-informed language and practice 3) Programs and organizations should seek out opportunities to support community coalitions, racial equity initiatives, and direct-action organizations that are run by Black, Indigenous and people of color 4) Create incentives at all levels of government to deliberate on and commit to a reparations process
Misaligned Partnerships Academic institutions in charge leads to issues with time-sensitive nature of grants High turnover in both situations (academic turnover due to grant cycles; state turnover) Large social services organizations should be at the center but typically they are constricted/unable to innovate	1) Align funding sources for all partners to ensure continuity of project 2) Place population health promotion and thus system alignment as a top priority to reduce stagnation from staff turnover 3) Incentivize innovation for social service programming

Challenge #1: Temporary Assistance for Needy Families (TANF) compliance culture counteracts goals of the culture of health.

The goal of TANF is to: "help needy families achieve self-sufficiency." The primary outcome of interest in most states is evidence of entering and staying in the workforce and the overall reduction in welfare rolls. These are incentivized by funding streams through the Administration for Children and Families (ACF), who provide monetary rewards to states for increases in workforce entry and reduction in TANF participation rolls. There are also financial penalties if these goals are not reached.[19] Funds provided to the state for TANF are based on state reports of maintaining a "work participation" rate as a measure of how well states engage families in work activities. The statutory requirements for fiscal year (FY) 2018 are 50% for all families and 90% for two-parent families.[20] However, a state's individual target rates equal the statutory rates minus a credit for reducing its caseload. These policies, widely known as "Work First," do not consider the health and wellness of participants, despite knowledge that major barriers to work include physical, emotional, and mental conditions and other major social and behavioral adversities.[21] Participants in TANF with mental health challenges that limit their ability to work must have an established diagnosis and/or a doctor's note that then puts them into another TANF participation category, where few to no opportunities for building economic security are provided. Additionally, this placement into another category allows the state to not consider such TANF participants in their outcomes for work participation.

This dynamic has created tendencies in many states to focus only on levels of so-called work participation to the detriment of health, wellness, or economic security where families can earn enough money to pay for adequate food, housing, and utility bills, nor is it meant to invest in long-term family health and well-being.[22] The emphasis on work participation by ACF continues despite the well-known fact that a large percentage of caregivers participating in TANF report high rates of work-limiting conditions such as depression, mood disorders, and exposure to trauma and adversity.[23] Additionally, research has shown that many caregivers return to TANF or become "disconnected" from public assistance supports due to poor health or lack of success in the workforce.[24,25] To compound these barriers, a high percentage of TANF-eligible families have low financial literacy, limited credit history, few or no assets, and are unbanked or under-banked.[26] Savings and other tangible assets help sustain families through unexpected financial hardships,[27] and building assets can improve health, increase civic engagement, and reduce stress associated with maternal depression.[27,28]

Similar lack of attention to health and economic security in TANF programming is also seen at the state level and in the interpersonal interactions between state County Assistance Office workers and TANF participants, as these relationships are primarily transactional to ensure individual compliance such as the collection of pay stubs, transportation receipts, and hourly reports of job search or work participation. A caregiver is considered a "case" to be managed, surveilled, or sanctioned, and participation is evaluated solely on attendance at trainings, hours in the workforce, or "good cause" for not showing up.[29,30] At the local level, this means that organizations that are administering TANF programming are under pressure to maintain a high participation rate, as well as a high job placement rate, so they can reduce their caseload and receive

a financial credit from the state. This leaves no time for people to address behavioral health concerns or to build soft skills necessary to succeed in the workforce.

This culture of compliance is incompatible with programs that focus on health promotion and introduces a pivotal challenge to aligning systems to address social determinants of health.

The compliance culture was so prevalent throughout all levels of TANF programming and administration that it took multiple meetings, research and program reports, and assurances on the part of The Network program staff and research teams to convince state officials that The Network could be a program to support with TANF with state monies, rather than a grant-funded program. Even the outcomes from The Network were considered almost perpendicular to the primary focus of mandated TANF outcomes. As an example, research results from The Network showed that members were slower to get into the workforce, because the focus of the program was to help caregivers of young children begin healing from trauma, set goals, gain social connections, and build financial skills, rather than immediately enter the workforce. This was considered as a potential weakness in the program. However, the results also showed that once Network members became employed, they were more likely to remain employed and have higher earnings when compared with people participating in regular TANF programming at the end of 15 months.[15] Despite the positive outcome, the more immediate-term outcome was the only metric by which the state could justify supporting the programming.

The length of time between TANF entry and entry into the workforce is the most important in the Commonwealth of Pennsylvania for determining participation rate. Since this requirement is by statute, redirecting the goal of TANF to one of health and well-being first will always have to compete with the statutory goal of entering the workforce quickly, regardless of a caregiver's health and ability to succeed in employment. The complexity of ongoing contracts in place with current Education and Training (E&T) providers and competition between providers for high-functioning TANF recipients have made the state and main contracting agency that pays for E&T reluctant to expand funding for The Network or implement its best practices in other counties. Additionally, there is tension between local E&T providers and state officials as both are striving to meet the work participation requirement, hence the health and well-being focus of The Network threatens the already precarious relationships between other organizations and state administrators.

Another challenge is that once a person leaves the TANF rolls (e.g., for a job) or if a person is sanctioned (e.g., cut off of TANF, or made a child-only case), the state cannot allow TANF funds to continue to support the health and well-being of caregivers through TANF monies. Hence, the Network's goal of supporting people as they work through emotional challenges, as well as matching savings accrual for a full 12 months regardless of whether they continued on TANF, was counteracted by the state's unwillingness to pay for Member's continued participation in the program up to a year. This was despite the fact that the state administrators knew that the program had positive impacts on health, social support, and economic security.

Proposed solutions. The infrastructure for TANF programming has the potential to provide additional opportunities to promote health, well-being, and equity. Incentiv-

izing states to provide innovative programs with a focus on the promotion of health and well-being will help to shift the culture within TANF programming away from one of compliance towards one of healing and longer-term transformation. This would also entail a shift in measurement of success. As was seen with outcomes in The Network, members were *slower* to enter the workforce (a current negative outcome under TANF's goals) but were more likely to *stay employed* in the long term, and also reported improved overall health and well-being (a standard for success for long-term TANF stated but not currently acted-upon goals). Understanding that substantive changes in the administration of TANF will take national advocacy and legislative reform, TANF can immediately adjust TANF goals to be more long-term and holistic, rather than short-term and narrow (such as immediate workforce entry). This change allows for entry of a culture of health and funding for health-related programs such as The Network.

Challenge #2: Racism and gender discrimination as broader, stronger societal forces. Another challenge to the successful integration and alignment of systems to address social determinants of health lies in the related but broader barriers of racism and gender discrimination, and lack of attention to intersectional forms of oppression where race and gender are considered together.[31] These dynamics are present in our society as a whole but are specifically relevant here as public assistance programming has been known to suffer from an overlay of racist and sexist views of women of color and their families.[32] Many authors have written at length about the history of public assistance programming and the systemic, institutional racism interwoven into the fabric of these policies.[33–35] As an example, the TANF grant amount is lower and more punitive in states that have a higher than average percentage of Black residents; Pennsylvania is one of those states. In 2017, 51.9% of the state's TANF recipients identified as Black, significantly higher than the 28.9% national average.[36] Pennsylvania spends less of their block grant on basic assistance than do other states with fewer Black recipients.[37] Additionally, states that did not expand Medicaid also had higher rates of poverty among Black, Indigenous, and other people of color.[38] Most adults participating in TANF are women, and because of the work-first approach, all are encouraged to enter into low-wage work quickly, such as in retail and caregiving, which are notoriously low-paid positions, often at minimum wage.[39,40] This practice keeps women in low-wage work, where they have little control over schedules, limited job security, and even more limited opportunities for career growth. These intersectional forms of discrimination based on race and gender[31] can have serious effects on the health and well-being of Black women and their families including maternal and infant mortality,[41] increased depression and poor health,[42] and food insecurity.[43]

Without acknowledging and then addressing these larger societal forces, especially on the part of state and federal administrators who can change the way programs are administered, challenges will continue to arise that will inhibit systems alignment meant to address critical social determinants of health such as adversity and discrimination.[31]

Proposed solutions. First, we should acknowledge and address systematic and intersecting forms of oppression and discrimination as a composite experience of trauma faced by millions of people who are Black, Indigenous, or members of other groups of people of color. Poverty can exacerbate and reproduce this trauma and trauma-

related behavioral health challenges.[44] Secondly, with this understanding, all policies and programs that aim to improve family economic security and well-being should use trauma-informed practice. Officials in TANF are beginning to recognize their importance but progress in adopting such programs is slow.[45] Third, programs and organizations should seek out opportunities to support community coalitions, racial equity initiatives, and direct-action organizations that are run by Black, Indigenous, and other people of color who are often underfunded and overlooked in their efforts. Fourth, there should be incentives at all levels of government to deliberate on and commit to a reparations processes (such as restorative or reparative justice[46]) that facilitate the economic, social, and emotional healing needed from generations of exploitation and discrimination. Finally, organizations and policies should use an intersectionality lens to better understand and help to alleviate institutionalized disadvantages experienced by Black, Indigenous, and other women of color in the United States.[31] Even if we were able to align the systems of TANF and Medicaid, these built-in forms of oppression might still prevail.

The Network addresses this societal challenge in several ways. One of the central approaches in The Network is to work with members to create their own individual and collective goals, rather than agree to what the State counts as an "Agreement of Mutual Responsibility," which is usually based on compliance with working in a low-wage job simply in order to receive a TANF grant amount that is less than 25% of the federal poverty line. Secondly, The Network's trauma-informed approach is not clinically focused with a required diagnosis of a mental health challenge or complex post-traumatic stress disorder (PTSD), but is rather, emotionally, socially, and politically focused. Much of the adversity that the members experience is related to gender discrimination and racial oppression, and should not be medicalized with a diagnosis, but rather explored as a way to understand and heal individual and collective suffering. The Network's focus is healing-centered, hence the curriculum works with members to acknowledge their social and political position, and seek ways to defy the odds against them. This emphasis that goes beyond a clinical understanding of trauma demands a political approach rather than a clinical one, and people participating in such healing-centered engagement who have experienced trauma are "agents in restoring their own well-being."[47[p.6]] For instance, in The Network, members open bank accounts, learn about saving, and have their savings matched, as they also explore why Black and Latina women have the least amount of wealth in U.S. society.[48] They have opportunities to start to overcome these barriers through opening a bank account, saving money, maintaining healthy relationships, and negotiating with their bosses for higher wages. Additionally, by emphasizing health and well-being rather than work participation, The Network provides a space where members are acknowledged for their full humanity, rather than as a "case" to push into a low-wage job.

Challenge #3: Misaligned partnerships: values, priorities, structure, and capability. When attempting to align or evaluate the alignment of systems in order to improve population health, the teams involved in the partnership have priorities, timelines, and funding sources that are sometimes incompatible with the goals of system alignment. When The Building Wealth and Health Network began, it comprised a university team

in public health and medicine that worked with state agency administrators along with an advisory board constituted of leaders in community behavioral health, public health, policy analysis, and lived experience.

A change in the Pennsylvania Secretary for Human Services who oversees TANF and Medicaid funding and programming in 2016 marked a change in expertise and priorities for Medicaid and TANF spending. This change in senior leadership brought about additional administrative staff changes and disrupted the flow of dialogue, information exchange, and conversation about shared values, with the result that the research team had to explain and re-explain the intended goals of the program to a new set of staff in the midst of the partnership. Further challenging the program, the head of behavioral health for the City of Philadelphia left their position, making it difficult for the existing team to stay informed and engaged. Beyond the changes in state and local staffing, and a lack of familiarity with ways to align systems, the incentives (or lack of incentives) to shift systems when both Medicaid and TANF funding were in flux made it difficult to identify areas for alignment and to remember the potential value of that alignment.

Additionally, as the researchers and program team attempted to lead an alignment effort, they did so without being able to incentivize or promote state and city support and attention. Hence, the ability to align funding streams faltered. Due to lags as a result of state staff transitions and delays in legal processes to share administrative data, analysis to determine cost savings based on modeled changes in depression, employment, income, and economic security were impossible to carry out. The state was only able to share the data on the final day of the grant cycle, nearly two years after the start of research meant to identify ways to align systems through The Building Wealth and Health Network. For the university team, the end of a grant cycle meant the end of the contract cycle and financial support for project researcher with expertise to analyze administrative data. Simultaneously, the RWJF Systems for Action mechanism shifted its own priorities for funding, making a reapplication for funding impossible. This meant the end of the time allotted for the data analyst, and the team lost the staff with the skillset needed to clean and analyze the data from the state in order to make a financial case for Medicaid and TANF alignment.

Despite multiple in-person and phone meetings with state health agency leaders and income maintenance agency administrators, and despite the enthusiasm from both, there seemed minimal interest in finding a way forward to identify new funding streams that brought Medicaid funding in to the TANF education and training space. This was despite the fact that gainful steady employment—addressing which is a primary goal for the income maintenance agency—is a known social determinant of health,[49] addressing which is a primary goal of the state health agency. This can be interpreted as both a misalignment in priorities as well as capability: even though the values were explicitly stated to be the same for all partners, the priority was not placed on carrying out this stated value and/or there was no capability to carry it out.

These challenges involved a constantly changing workforce at multiple levels of the state and city, and the research institution. The project was also subject to the limitations of foundation funding. Additionally, there were misaligned values and priorities, structure, and capabilities that could not be overcome.

Proposed solutions. For systems alignment to occur, the effort must be led by innovative leadership within government entities that have the power and incentive to bring about such change. States can apply for an 1115 waiver so that Medicaid funds could be used for health-focused Education and Training (E&T) programs that promote healing, social support, and long-term economic security. There is also room for larger demonstration studies that could be funded through the Administration for Children and Families within the Department of Health and Human Services (DHHS) along with larger, well-resourced research entities. Finally, the renewed interest on behalf of U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation in the centrality of social capital to promote economic mobility suggests positive government involvement in addressing upstream social determinants of health through TANF programming.[50] However, the statutory requirements of work participation may still pose a challenge to promoting health first instead of work first.

Conclusion. By outlining these three major challenges to systems alignment among two federal safety-net programs that reach some of the poorest and most vulnerable families in the United States, we demonstrate that addressing the social determinants of health will not fully succeed unless we seek to undo the punitive culture of compliance, halt the financial undercutting of programs meant to help people with multiple forms of oppression, and create financial and legal incentives to promote cross-sector partnerships, state innovation, and leadership. Specific solutions we identified are 1) incentivize states to provide innovative programs with a focus on the promotion of overall health and well-being to shift the culture within TANF programming away from one of compliance towards one of healing and longer-term transformation; 2) engage in systems-level approaches to address institutionalized racism and discrimination within public assistance programming, including reparations; and 3) place population health promotion (and thus systems alignment) as top priority for state and federal programs, and incentivize leadership from within state entities to forge alignment.

Effective systems alignment and the integration of trauma-informed, healing, and human-centered interventions (such as The Building Wealth and Health Network) into public assistance programming can address social determinants of health, foster wealth, and promote well-being among families, potentially leading to a more equitable society. How such program innovations can occur through current efforts at systems alignment still remains to be seen.

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