Abstract

This document provides findings and analysis to support short and long-term recommendations for structuring a health equity initiative.

SEED Collaborative, LLC

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Executive Summary

North Sound ACH engaged SEED Collaborative, LLC (SEED) to help develop a health equity initiative that incorporates principles and strategies of targeted universalism, while actualizing equity 2.0 and belonging broadly and racial equity specifically.

As part of the development process, SEED conducted stakeholder interviews and research that resulted in a set of findings and recommendations presented in this Report.

Summary of Consultant Recommendations

Based on an analysis of due diligence findings, supported by research and the principles of targeted universalism and belonging, SEED offers the following recommendations that are detailed more fully later in the Report:

Short Term – solutions that North Sound ACH can implement in 12 months or less.

- Continue to conduct Partner and community education, training and information dissemination to improve awareness and understanding of health equity and to guide development and implementation of strategies that incorporate targeted universalism, remove barriers experienced by communities of color, native nations and others, and promote structures, practices and norms that support healthy communities that are designed for each relevant community
- Expand training, education and information dissemination delivery vehicles and models to include new technologies
- Continue to incorporate health equity policies, requirements and incentives in Partner contracts
- Continue to measure health equity outcomes and create accountability mechanisms for all Partners, organizations and emergent strategies
- Work to strengthen community health initiatives led and supported by community-based organizations, people of color, indigenous people and other marginalized communities, including low-income white communities
- Continue to support community mobilization and health equity strategies of Native Nations and indigenous peoples in the region
- Use data and surveys to monitor the health climate of the community with over sampling of targeted communities

Longer Term – solutions that North Sound ACH can facilitate in the next 12-18 months.

- Facilitate creation of an independent Community Collaborative ("Collaborative") of healthcare activists that is focused on access to quality healthcare, strengthening of community and social cohesion, addressing social determinants

and preconditions, promotion of equity 2.0 and belonging, advocacy, and is inclusive and sustainable.

- Through contractual requirements and incentives implement policies to engage Partners in developing and implementing: 1) health equity plans/initiatives; 2) evaluation tools and systems that measure positive and negative feedback, which information is used to improve services; and 3) strategies that support community collaboration and Health in All[1] policies.

- Innovative Model – North Sound ACH to support development of a pilot project that improves healthcare access and a sense of belonging through the integration of technology, health information and consultation, culturally sensitive and responsive content and paid community health guides that is based on research and supports face to face interaction where possible. (For purposes of this Report, the term "TelaEQ" refers to the innovative model)
    - Support development of TelaEQ as a social enterprise owned by the Collaborative or other community organization or socially responsible entity.

Anticipated Outcomes

SEED proposes the above recommendations as core components of a North Sound ACH health equity initiative/strategy that drive the following outcomes:

1. Increase capacity of Partners to improve health outcomes for Medicaid consumers by expanding their understanding of equity 2.0 and belonging broadly and targeted universalism specifically.
2. Expand the number of Partners that develop and implement health equity initiatives, plans and strategies.
3. Creation of a collaborative movement of community wellness activists to advocate for structural and institutional change, challenge the barriers to universal wellness, promote affirmative narratives, ground the definition of health equity and resulting strategies in lived community-based realities, and address the social determinants of health as well as the preconditions.
4. Creation of a pilot project that improves health access and belonging, supports job development and creates a sustainable enterprise that can contribute financially to a healthcare movement.

[1] Health in All" is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. http://www.phi.org/resources/?resource=hiapguide

Background

North Sound ACH is a partner in the statewide Healthier Washington initiative, which includes an agreement between Washington State and the federal government to provide opportunities to support new and innovative approaches to transform health and community services for Medicaid users.

Consistent with the mandate to transform health and community services, North Sound ACH requires its Partners to commit to aligning their work with the vision of improved health, a transformed health system, and improved health equity for the region.

North Sound ACH has adopted targeted universalism as an operational and communication framework to ensure health equity is strongly featured throughout the lifespan of project planning and implementation.

Targeted universalism includes: 1) agreement on universal goals for all; 2) identification of obstacles, including structural, systemic and cultural, faced by specific groups; 3) implementation of strategies to address the barriers faced by those specific groups; and 4) measurement of results. It is a proactive approach that improves health for all and targets strategies to address disparities among groups while moving to a universal goal.

North Sound ACH has taken steps to ensure that gaps in health equity knowledge and skills are assessed and addressed including:

- Identifying target populations of individuals experiencing access, care, and utilization disparities
- Utilizing targeted universalism as an operational, organizing and communication framework to ensure that health equity is featured strongly throughout the lifespan of project planning and implementation

Key Interview Findings[2]

Based on stakeholder interviews, this Report is guided by the following key social determinant areas that emerged as barriers to universal wellness.

- Access to information and data and quality and culturally responsive and competent healthcare services, facilities and resources
- Access to affordable housing
- Homelessness
- Equity in education
- Living wage jobs
- Access to clean water and sustainable fishing
- Siloed providers, community organizations, systems and communication

[2] A more detailed analysis of interview findings is provided as Appendix I

Consultant Recommendations

The recommendations that follow take into consideration the impact of social determinants, as well as, the underlying structural barriers that create power imbalance and inequities. The recommendations are also informed by the principles of shared power and belonging.

Short Term Recommendations

Short term recommendations can be implemented within 1-2 years and are within the authority, scope and capacity of North Sound ACH to implement.

North Sound ACH has already taken the following actions toward increasing knowledge, understanding and awareness of health equity.

- Participation in the planning of a statewide health equity summit
- In the process of developing health equity measures for the regional implementation plan with support from outside consultants
- Identification of partner organizations that can augment learning and teaching about equity and racial and social justice; for example, education related to the strength and resilience of the region's Native Tribes
- Hosted a learning session in fall 2017 on equity and racism for approximately 100 staff and regional workgroup members
- Hosted a learning session on the Native Transformation Project, carried out by Upper Skagit, Lummi, and Swinomish tribes
- Required that the 70+ implementation Partners commit to key agreements, including participation in shared learning around equity and disparities and development of strategies to address underlying conditions that impact health and disparities.
- Conducted a Partner training in the spring of 2019 on issues and challenges facing Native Nations, the importance of belonging and began the process of identifying strategies to remove barriers and improve access

While committed to Medicaid delivery system reform, North Sound ACH is equally committed to health equity and believes to achieve improvements in health equity they must continually look downstream, midstream, and upstream, and engage in bold dialogue about class, privilege, and race. The following recommendations are grounded in this core North Sound ACH frame.

SEED recommends that North Sound ACH consider the following additional steps and actions toward realizing equitable health outcomes.

1. North Sound ACH Actions

    - Continue to conduct Partner and community education, organizing, training and information dissemination to improve awareness and understanding of health

equity and to inform development and implementation of strategies that incorporate targeted universalism and promote affirmative narratives/stories, including:
  - Hold trainings throughout the region
  - Implement train the trainer model for expanding educational outreach and reduce training costs
  - Consider inviting healthcare activists, professionals and organizational representatives to train, present innovative strategies and contribute to policy and strategic planning based on their lived realities and community-based experiences

- Ground development of health equity strategies in an iterative process that connects the best from the fields of health and community

- Support processes and activities that promote cross learning and buy in by Partners, health professionals and community

- Encourage utilization of processes and tools that incorporate community priorities and definitions of success and that support indigenous and Native Nations' models of care

- Expand training, education and information dissemination delivery vehicles, based on the specific needs of the various communities, e.g. YouTube,[3] Twitter, FaceTime, Zoom, etc. Implement technological solutions that increase access and reduce dissemination costs

- Continue to incorporate health equity policies, requirements and incentives in Partner contracts, including policies that look at health practices beyond the biological model of health (See suggested contract requirements in next section)

- Continue to measure health equity outcomes and manage Partner accountability
  - Establish baseline data
  - Evaluate positive and negative feedback
  - Identify problem and opportunity areas to focus on

2. Partner Contracts (see additional detail below on page 9)

   - Develop additional and innovative Partner contract requirements and incentives for contract years 2 and 3. For example:

[3] Change the Odds of Health/Anthony Iton/TEDx San Francisco, https://www.youtube.com/watch?v=0H6yte4RXx0; https://www.youtube.com/watch?v=j1WPV6Uf9mM; https://www.youtube.com/watch?v=ywQJGnzQKGs; https://www.youtube.com/watch?v=56ZKfSNkcJc

- Contract Requirements
  - Develop health equity initiative, plan and/or strategy(ies) that integrate and are strongly guided by engagement with people of color, Native peoples and other marginalized communities and incorporates targeted strategies for specific groups
  - Report on development and/or implementation of health equity plan
  - Develop and implement strategies/plans to diversify governing board and leadership, specifically to include people of color
  - Track and measure health outcomes, for example increased access to quality care, improved sense of belonging and improvement in social determinants.

- Incentives/Penalties
  - Continue to provide for financial rewards and penalties to model behavior that supports health equity, targeted universalism and belonging
  - For areas where Partners have identified programmatic, operational or systemic deficiencies require Partner corrective action plan(s) that detail plans/strategies to correct deficiency(ies)

3. Health Equity Tools[4]

- Identify and make available a health equity and belonging toolkit accessible on the North Sound ACH website

- Develop user friendly health equity curriculum that incorporates the principles of targeted universalism and belonging that can be accessed from North Sound ACH website

4. Facilitation/Convening

- Facilitate creation of Equity Cohort for Partners that would:
  - Allow peer-to-peer exchange of best practices, tactics and strategies
  - Provide shared learning and mobilizing opportunities
  - Advocate for institutional and systemic change
  - Provide a forum for community to engage and collaborate with Partners
  - Require active participation with Equity Cohort by assigning designated representative, holding representative accountable for regular attendance and active participation

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[4] https://hcn.eu/wp-content/uploads/2017/12/1_Health-Equity-2020-Toolkit-Edition-1.0.pdf; https://www.allianceon.org/sites/default/files/documents/Health%20Equity%20Toolkit_Final.pdf; https://multco.us/health/community-health/health-equity-initiative; http://www.preventioninstitute.org/tools/tools-general/health-equity-toolkit; https://www.nap.edu/read/24624/chapter/10; https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf; https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/hia-map?sortBy=relevance&sortOrder=asc&page=1

- Convene community partners, stakeholders and organizations to: discuss barriers to healthcare; understand the power of affirmative narratives in influencing public perception and addressing social determinants of health on multiple levels, including structural, cultural and inter-personal; and discuss access to care and systems and institutional change

- Identify seed funding and support for facilitation/convening experimentation, learning and sharing

5. Expand capacity of Community Organizations

- Develop pathway(s) for community organizations to become Partners, especially agencies lead by people of color and/or represent people of color and indigenous peoples
  - Provide technical assistance that addresses among other organizational needs governance, leadership and building organizational and financial capacity
  - Offer training sessions for community partners on Partner requirements, including one on one consultations concerning organization's plan to meet requirements
  - Encourage Partner-community organization mentoring opportunities
  - Evaluate Partner-community based organization partner/subcontracting opportunities
  - Evaluate step program to Partner status for CBOs that supports an incremental approach to becoming a contract Partner

6. Provide Partner guidance and direction

- Continue to require Partners to support goals to advance equity and reduce health disparities, including:
  - Gather patient/client self-reported race, ethnicity, language, and disability
  - Screen for social determinants of health during intake and routine appointments
  - Refer patients to community agencies when concerns related to social determinants of health are identified.
  - Participate with North Sound ACH in addressing barriers to standardized identification and tracking of North Sound ACH target populations.
  - Participate in training and technical assistance sessions from the Equity and Tribal Learning Series

- Incent Partners to expand learning and education to:
  - Attend equity 2.0 and othering and belonging conferences, courses, workshops and seminars
  - Implement internal health equity training provided by Partner staff or outside consultants

    - Convene community partners around discussions regarding barriers to wellness and social determinants of health

7. Continue to support regional ACH collaboration, consultation and strategic planning

- Peer-to-peer exchange of best practices, tactics and strategies
- Shared learning opportunities
- Advocate for institutional and systemic change grounded in community-based data and priorities
- Co-create statewide tools, systems and strategies
- Support statewide goals to advance equity and establish "Health in All" guidelines for Washington

Longer Term Solutions

Longer term solutions and recommendations often require more than one year to develop and implement and may be beyond the authority and scope of North Sound ACH.

Health Equity Community Collaborative[5]

- Facilitate creation of a North Sound Health Equity Community Collaborative (Collaborative) that may incorporate any of the following characteristics:
    - Be composed of a coalition of healthcare organizations and organizations that represent people and communities of color and Native Nations
    - Be focused on access to quality healthcare, elimination of barriers to wellness, promotion of structural and cultural designs that proactively and affirmatively impact the social determinants of health, such as affordable housing, unemployment & homelessness
    - Willingness to look beyond the biological determinants of health to concepts of belonging grounded in Native American healing traditions
    - Capacity to isolate negative conditions in communities and create affirmative narratives that allow community groups to engage in culturally appropriate collective activities
    - Have a collective vision & voice for healthcare change
    - Advocate for structural, systems & legislative change
    - Utilize targeted approaches and strategies
    - Assess and prioritize health equity issues in the region

[5] Washington Health Coalitions, Networks & Alliances - Washington Healthcare Access Alliance, https://www.wahealthcareaccessalliance.org/about; Healthy Washington Coalition, http://www.healthywa.org/; Whatcom Alliance for Health Advancement, http://whatcomalliance.org/about/; http://www.coalitioncommunitiescolor.org/whoweare

- Develop “Health in All” guidelines, parameters and practices
    - Be a formal collaborative structure that is adequately resourced for sustainability & capacity to effect change

- Implementation steps
    1. Identify healthcare activist individuals and organizations, as well as, organizations that represent people of color and Native Nations
        i. Conduct opportunity and resource mapping
    2. Interview a sampling of identified individuals/stakeholders to determine
        i. Interest in collaboration
        ii. Innovative ideas and strategies for collaboration
        iii. Identify other networks/alliances, as well as, past collaborations
        iv. Determine organizational capacity and leadership
        v. Identify funding opportunities for Collaborative
    3. Convene group of organizing individuals to formulate, organize and launch the Collaborative, with responsibility for:
        i. Review interview findings
        ii. Evaluate and discuss opportunities and risks of collaboration
        iii. Evaluate and discuss the unique considerations in North Sound region
        iv. Decide on a structure and operating agreement
        v. Solicit funding
    4. Implement structure and operating principles
    5. Acquire funding
    6. Launch

<u>Partner Contract Requirements/Incentives</u>

- Year Two
    - Requirement
        - Develop health equity plan and/or strategy
        - Conduct internal equity and tribal learning trainings and/or attend external workshops, seminars and conferences
        - Participate with Partner equity cohort

    - Incentive
        - Develop three-year plan with strategies and projected outcomes
        - Begin to implement health equity strategy/plan
        - Develop and implement systems to track and measure results/outcomes
        - Partner with community-based organizations, communities of color, health equity collaboratives/coalitions and/or Native Nations to build capacity, improve organizational sustainability and support community-based health equity strategies

        - Support regional and statewide goals to advance equity and to establish "Health in All"[6] guidelines for Washington

- Year Three
    - Requirement
        - Implement health equity plan/strategy

    - Incentive
        - Documentation of positive health outcomes, including decreased emergency room, hospital and/or doctor visits, reduced use of Medicaid benefits and improvement in social determinants as defined by specific groups/communities
        - Develop and implement systems to track and measure results/outcomes

<u>Regional ACH Cohort</u>

- Facilitate formation of Regional ACH Equity Cohort to accomplish:
    - Build consensus and common language
        - Targeted Universalism
        - Health equity measures and outcomes
        - Partner expectations and objectives
    - Share best practices and strategies
    - Share data
    - Advocate for and mobilize around actions that decrease harm and increase community health and belonging
    - Develop common measurement tools and systems informed by community priorities and voice
    - Support regional and statewide goals to advance equity and to establish "Health in All" guidelines for the State of Washington

[6] "Health in All" is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. http://www.phi.org/resources/?resource=hiapguide

Measurement[7] & Accountability

Measurement

North Sound ACH tracks Partner performance by monitoring Partner planning, reporting and implementation of deliverables tied to goals for the region. Partners must demonstrate commitment to improving equity and reducing disparities.

In addition to requiring Partners to support regional goals to advance equity and reduce health disparities, SEED recommends the following supplemental guidelines for building measurement tools and metrics that are gathered in a way that is sensitive to individual privacy.

1. Assess health determinants that are associated with social position
    - Gather educational level, income, wealth, and occupation

2. Assess social and structural determinants of health and consider multiple levels of measurement[8]
    - Education data
    - Income, employment and labor data
    - Access to healthy food
    - Housing data and specifically access to affordable housing

3. Provide reasons for methodological choices and clarify their implications
    - Define universal wellness as a refence point for rationale for methodology
    - Ensure that methodology and measurement integrate community driven priorities, include feedback loops with the community and encourage active community participation and input

4. Incorporate targeted universalism - North Sound ACH intends to use targeted universalism for selecting target populations, measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriate targeted interventions.

5. The need to communicate to a wide array of stakeholders can often be taken into consideration in the choice of measures and analytic methods

6. Assess what is necessary for different communities to practice belonging

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5845853/
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150121/

Accountability

SEED recommends that accountability mechanisms include participation of community leadership and inclusion of community priorities and provide necessary infrastructure for meaningful collaboration with community partners around design, implementation and on-going monitoring.

North Sound ACH should continue to include contractual goals to advance equity and reduce health disparities. SEED recommends that the contractual requirements be expanded to encompass promotion of affirmative narratives and steps taken to address social determinants of health.

The purpose of such contractual requirements and incentives is to ensure that Partner contracts are aligned with policies and strategies to improve health outcomes for all consumers in the region and Medicaid users specifically.

Innovative Partner contract provisions designed to promote the use of targeted universalism and affirmative narratives, reduce health disparities, eliminate inequities and encourage measurement and tracking of data are an important tool for modifying behavior and improving performance.

TELAEQ – Innovative Model

SEED recommends development of a pilot project within the North Sound region that merges aspects of telemedicine with targeted health strategies and concepts of belonging and that is evidenced based and supports face to face interaction and engagement.

TelaEQ is "Healthcare information, consultation & data delivered remotely via technology; with content that is culturally sensitive, competent and targeted; in environments that create a sense of Belonging; and by paid trained health guides from the communities they serve."[9]

The TelaEQ proposal is built upon the following concepts and assumptions.

- "Traditional indigenous systems of care provide a blueprint to model new healing strategies that have the potential to extend health promotion beyond the individual to the collective."[10]

[9] SEED definition
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913884/

- To adequately address the social determinants of health requires an analysis and evaluation of the preconditions and leveraging strategies that affect systems change. For example, student outcomes may be impacted by class size, quality of teachers and access to resources, but a precondition may be safety. Safe pathways to school and safety in school.

- "Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly."[11]

- Access to quality medical care addresses only about 10% of preventable mortality in the U.S.[12] For example, the medical response to opioid addiction is prescription drugs, but research shows that despair and isolation are the primary drivers of drug abuse.

- "The Centers for Medicare and Medicaid Services (CMS) is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries' access high-quality services in a convenient manner."[13]

- Telehealth is critically important, especially in rural areas and areas with large populations of the elderly and those with low incomes.[14]

- For hospitals, the promise of telehealth has spurred innovation across multiple service lines and led to the emergence of several new delivery models such as telestroke, teleradiology, telepsychiatry, telepathology, teleICU and remote patient monitoring.

- Technology platforms are used in a variety of efforts to improve access to healthcare. Yet, access will not transform health outcomes alone. There are several other ways that technology can expand beyond access to strengthen social relationships and cast a light on the systems that drive the social determinates of health.

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[11] https://www.careersinfosecurity.com/would-more-telehealth-bring-new-privacy-security-concerns-a-11208

[12] The Case For More Active Policy Attention To Health Promotion. J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman. Health Affairs, volume 21, no.2 (2002):78-93

[13] Seema Verma, CMS Administrator, https://www.careersinfosecurity.com/would-more-telehealth-bring-new-privacy-security-concerns-a-11208

[14] Mac McMillan, CEO of security consultancy CynergisTek

TelaEQ – Component Parts

Access – one objective of TelaEQ is to increase access to information, consultation and healthcare resources. TelaEQ is a robust extension of telemedicine.[15] The TelaEQ model would include the following characteristics:

- Information, consultation & data delivered remotely via technology
- User friendly hardware & software
- Healthcare information received locally at locations that are easily accessible by public transportation, bike or walk, and in environments that promote Belonging
    - Livingroom, backyard, community center

Technology

Technology platforms are used in a variety of efforts to improve access to healthcare. Yet, access alone will not transform health outcomes. There are several other ways that technology can expand beyond access to strengthen social relationships and cast a light on the systems that drive the social determinates of health.

North Sound ACH found that telehealth in behavioral health is working well.[16] A meta-analysis[17] of technology used by healthcare systems showcases the range of ways technology is used to improve access, including:

Mobile Health uses text messaging, mobile apps, avatars, and multimedia features to help people monitor their diet and exercise, provide education, motivation and mental health strategies.

Social Media apps such as Facebook or Twitter have been used to encourage use of condom and safe sex as well as smoking cessation. Social media in combination with other interventions such as text messages, coaching calls, and monitoring have also been shown to improve weight loss.

Consumer Technology - text messaging and computer-based education courses have been shown to support evaluation efforts. A text-based data collection tool was found to increase African American youth's adherence to using their daily asthma medication.

[15] See chart of technological solutions in Appendix II
[16] See Appendix III
[17] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304646

Case Studies

Community Information Exchange

Community Information Exchange (CIE) is a cloud-based platform that works to improve care coordination for vulnerable populations. The CIE works to intervene on two critical systemic issues. First, it works to improve care coordination. The service uses technology to enhance trauma-informed approaches, such as creating historical profiles so that patients don't need to revisit distressing experiences with each new provider.

The second intervention is anchored by a recognition that the roots of chronic disease and poor health often lie within larger social and economic systems. CIE monitors patient trends using a risk rating scale. The data gathered through their system helps describe where social systems are breaking down and inform the development of services such as, housing, senior services, transportation, early childhood development, post-incarceration, physical activity and nutrition, family caregiving, and others.

The success of the program has not been evaluated across the system; however, one hospital reported a steep reduction in readmissions and estimates that the return on investment is "roughly $17,562 per inpatient admission and $1,387 per ED admission, with higher ROIs for uninsured populations." [18]

Ada, Global Health Initiative

Ada[19] is an artificial intelligence based medical app that provides a health platform that helps individuals understand their health and navigate to appropriate care. Ada combines artificial intelligence, human medical expertise and the power of mobile technology to deliver access to healthcare and guidance at scale.

Ada's artificial intelligence led solutions are specifically targeted to the healthcare needs of lower and middle-income countries.

Technological Barriers to Consider

Researchers have pointed to several barriers or challenges technological platforms can create. Challenges include interoperability, questions of security and privacy, and storage issues.[20]

Researchers also note that platforms must be designed with careful attention to the *how* the user is going to engage with the technology. Using techniques such as participatory

[18] https://www.chcs.org/media/2-1-1-San-Diego-Case-Study_080918.pdf
[19] https://ada.com/
[20] https://ieeexplore.ieee.org/document/7030248

design, or user-centered design that lift the perspectives and needs of users, as well as create spaces for greater social cohesion, will create a stronger foundation for success.

Operational Barriers

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides that the same requirements for patient privacy and confidentiality that apply for in-person visits apply to visits conducted over video.[21] The provider has the identical responsibility to protect patient information. The privacy requirements of HIPAA[22], as well as the privacy and confidentiality requirements of the North Sound ACH Master Services Agreement[23], directly conflict with the concepts of collective healing and belonging that are critical components of TelaEQ.

Regulatory provisions provide:

- Electronic protected health information (**ePHI**) is protected health information (PHI) that is produced, saved, transferred or received in an electronic form.
- Only authorized users should have access to ePHI.
- A system of secure communication should be implemented to protect the integrity of ePHI.
    - unsecure channels of communication such as SMS, Skype, and email should not be used for communicating ePHI at distance.
- A system of monitoring communications containing ePHI should be implemented to prevent accidental or malicious breaches.

No federal agency currently has authority to enact privacy and security requirements to cover the telehealth ecosystem.

Culturally Competent and Responsive – content that addresses diverse histories, communication and cultures,[24] targets messaging to address barriers to wellness for individuals and communities that are situated differently and incorporates affirmative narratives, stories and communication.

Dominant narratives, the stories that we tell about ourselves and the broader stories in the culture, can have positive and negative effects on life and health in the present and future. "All stories are constitutive of life and shape our lives".[25] Affirmative narratives, which are supportive, hopeful and encouraging, can affect change on multiple levels, including structural, cultural and inter-personal.

[21] https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
[22] https://journalofethics.ama-assn.org/article/privacy-and-security-concerns-telehealth/2014-12
[23] NSACH - FEPortalMasterServiceAgreement2018 pdf
[24] Culturally and linguistically appropriate services, https://www.thinkculturalhealth.hhs.gov/clas/what-is-clas
[25] What is Narrative Therapy? An easy-to-read introduction, Alice Morgan, December 2000

TelaEQ content would include culturally competent and sensitive healing practices, prescriptions, communication, stories and images. Content would include, but not be limited to:

- General wellness and prevention – diet, exercise, etc.
- Physical health
- Mental health
- Belonging – how a sense of Belonging is created & measured
- Healthcare resources
- Medical consultation
- Healthcare data
- Cultural sensitivity and responsive – spirituality, earth, legacy remedies and affirmative narratives

Belonging – the creation of vertical health networks that connect people in ways that reduce loneliness, social isolation and trauma and improve access to resources, knowledge and power.

"Belongingness appears to have multiple and strong effects on emotional patterns and on cognitive processes. Lack of attachment is linked to a variety of ill effects on health, adjustment, and well-being."[26]

Pain, anxiety, stress and other health disorders have been shown to be correlated to the feeling of being disconnected, to our inability to see the full dignity of others, "… and the resulting culture of fear, distrust, tribalism, shaming and strife."[27]

In Native American culture there is a saying that "we are all related"; all things live in relationship to one another[28], which is foundational to the concept of belonging. john a. powell, Director of the Haas Institute and SEED Principal, articulated 5 components of the practice of belonging.[29]

1. *Expand the circle of human concern*: Focus on inclusive strategies that expand networks vertically as well as horizontally, especially for people who have been marginalized, disenfranchised, or cast aside.

2. *Determine points of intervention*: Focus on what systems or structures are *doing.* What is happening at a macro-level? How do systems relate to one another? What are the leverage points, i.e. the points/interventions that cause system change?

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[26] The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation, Roy F. Baumeister and Mark R. Leary, American Psychological Association, 1995
[27] https://www.nytimes.com/2019/02/18/opinion/culture-compassion.html
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913884/
[29] https://haasinstitute.berkeley.edu/othering-belonging-framework-and-analysis-fair-and-inclusive-society

3. *Frame conversations around unity and linked fate*: Focus on terminology that brings people together and understand the effects systems have on all people.

4. *Highlight deep shared values*: Focus on opportunities to underscore values such as fairness, mobility, redemption, and security.

5. *Create a culture of belonging*: Create spaces where people are truly seen and cared for.

Implementing the concept of belonging assumes engaging in an assessment of what is necessary for different communities to practice belonging.

Case Studies

CenteringPregnancy[30]

CenteringPregnancy is a prenatal healthcare model that brings small groups of pregnant people together for health assessments, group discussions, interactive education, and social support. The model has led to better health outcomes for both babies, reduced health care costs, and improved the well-being of healthcare providers.

Preliminary studies have also found the model nearly eliminates racial disparities for preterm birth between black, white, and Hispanic women.[31] The overwhelmingly positive research has convinced South Carolina Medicaid and the insurance providers to invest in CenteringPregnancy programs across the state and over 25 other states are working to adopt the model.

The success of the program points to healthcare providers putting pregnant people's sense of belonging and ability to care for themselves at the center of their services. As Dr. Amy Crockett, founder of CenteringPregnancy, South Carolina describes, "it's not about the latest surgery, it's not about the newest drug, what it's about is allowing women to have a space to connect with each other."

Dr. Crockett has seen a 47 percent reduction in preterm births in her South Carolina practice, along with higher rates of breastfeeding, lower rates of gestational diabetes, lower rates of cesarean delivery, and lower rates of admission to the neonatal intensive unit. The Georgia Health Policy Center is currently studying South Carolina's model to understand birth outcomes and cost savings,[32] and a team of researchers are

[30] http://www.ncmedicaljournal.com/content/77/6/394.full
[31] https://www.sciencedirect.com/science/article/pii/S0002937812001317
[32] https://ghpc.gsu.edu/project/south-carolina-centeringpregnancy-evaluation/

conducting a randomized controlled trial to understand how the model reduces racial disparities in birth outcomes. [33]

The CenteringPregnancy model showcases many of the core principles of belonging outlined by powell.

- The model is anchored by an approach that creates a space for people to be seen and cared for, in one of their most vulnerable periods in life.
- The small group format allows participants to listen to one another and deepen their relationships over time.
- By using a facilitation model that focuses and builds on the wisdom of the group, the facilitator can lift shared values, while building unity among participants.
- The program includes targeted interventions such as, participants completing portions of their own health assessments, and providing basic education on how to read medical charts to give them a sense of capacity and ownership over the process.
- Though the process reduces costs for healthcare systems, it is most impactful because it expands the circle of human concern by improving the quality of care, reducing racial health disparities, improving population health, and attending to the well-being of health professionals.[34]

Doctor on Demand App

Doctor on Demand is a service that connects users to board certified doctors in their area. The app does not provide comprehensive diagnosis; however, you can get quick help for things like the flu, depression, anxiety, skin irritations, heartburn, and other minor issues.

Health Effects of Loneliness & Isolation[35]

The adverse health effects of loneliness and isolation are well documented.[36] It is arguable that current technological and cultural trends are contributing to greater isolation and loneliness. In addition, it is often assumed that loneliness and social isolation are problems associated with aging, but research indicates that such problems are must prevalent among adolescents and young adults.

TelaEQ seeks to incorporate collective healing and belonging practices to reduce the negative health effects of loneliness and social isolation. Mary Koithan, PhD, RN-C,

[33] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1295-7
[34] http://www.ncmedicaljournal.com/content/77/6/394.full
[35] The Surprising Effects of Loneliness on Health, Jane E. Brody, December 2017, https://www.nytimes.com/2017/12/11/well/mind/how-loneliness-affects-our-health.html
[36] Social Relationships and Health, James S. House, Karl R. Landis, Debra Umberson, July 1988, https://www.math.utah.edu/~lzhang/teaching/1070spring2012/Daily%20Updates/examples/feb1/Social%20Relationships%20and%20Health.pdf

CNS-BC and Cynthia Farrell, MSN, FNP-BC, the authors of Indigenous Native American Healing Traditions, noted that "The inclusion of family and community in treatment plans, decreases the isolation often found in allopathic care."[37]

TelaEQ creates belonging in the following ways:

- Inclusive – the model is designed to be inclusive and contribute to building health networks. Health guides are part of and trained to reach out to marginalized populations and create health networks, i.e. networks of Medicaid users, family, community and healthcare professionals
    - Intentional diversity based on age, gender, sexual orientation, disability, income, education or religious affiliation.
- Framing/Language – TelaEQ supports a common health terminology and shared language around unity and systems change
- Familiar/safe space – Sharing of wellness information with family, friends, neighbors and community in safe and accepting environments that help create a sense of connectedness and Belonging (Health Socials).
    - TelaEQ is delivered in neighbors' homes or other third spaces. Such spaces are familiar and considered safe, and are local and easily accessible via walk, bike or public transportation
        - Third space - is separate from the two usual social environments of home ("first place") and the workplace ("second place"). Examples of third places would be environments such as churches, cafes, clubs, public libraries, or parks.

TelaEQ combines the principles of belonging with a healthcare product, service or activity. Book clubs utilize a similar model, which includes a book review shared with friends in a safe/familiar environment. There are several business models that combine activity/product + community.

Case Studies

Groupmuse App

Groupmuse brings live chamber music to living rooms. Groupmuse Founder, Sam Bodkin, noted, "Despite our many technologies, there just aren't enough opportunities to gather in the real world around something meaningful…"

CityBlock Health[38]

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[37] Indigenous Native American Healing Traditions, June 2011, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913884/

[38] https://www.cityblock.com/

CityBlock defines its concept as being where health and community converge.

Cityblock Health brings together primary care, behavioral health care, and social services and meets the patient wherever and whenever works for the patient. Their tools and care teams are designed to support the patient and make it easy for the patient to meet all their health and daily needs. Innovative components:

- Where possible, the hubs will be built within existing, trusted spaces operated by its partners and staffed with local hires.
- The neighborhood hubs will be designed as visible, physical meeting spaces where health and community converge. Caregivers, members, and local organizations will use the hubs to engage with each other and address the many factors that affect health at the local level.
- Cityblock envisions offering a range of health, educational, and social events, including support groups and fitness classes.

Cityblock health hub innovation is motivated by three key health inequities related to underserved urban populations.

1. Disproportionately poor health outcomes
2. Interventions coming much later in the care continuum
3. Significantly higher cost of interventions in urban areas as compared to other populations

Health Guides – are paid health liaisons and conveners that connect their neighbors and community members to healthcare information and resources. The TelaEQ health guide program includes:

- Health Guides are local community leaders/influencers/connectors with the following attributes
  - Trusted member of the community
  - Intimate understanding of the community's social networks
  - Aware of community's health needs

- Training includes:
  - Set-up and use of technology
  - Facilitation of health meetings/socials
  - Providing resource referrals
  - General grounding and training in wellness, Belonging and Targeted Universalism

- Management of the TelaEQ process including:
  - Sourcing venue and scheduling meetings
  - Invitations and communications
  - Planning agenda, speakers and content
  - Follow-up communications

- Health Guide Supervisor
    - Resource for health guides
    - Trainer, mentor, supervisor and support person

- Compensation – supplemental income, e.g. Lyft, Amway
    - Part-time - primarily working in the evenings
    - Minimum base income plus incentives based on:
        - Number of TelaEQ presentations
        - Attendance at presentation
        - Number of healthcare referrals

Variations of the health guide model include Community Health Worker, Promotoras and Dental Health Aide Therapists.

Community Health Worker/Promotoras

"The cornerstone of Community Health Worker programs is the recruitment of community members who possess an intimate understanding of the community's social networks as well as its strengths and its special health needs."[39]

A community health worker is defined as "… a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[40]

With the appropriate resources, training and support, Community Health Workers improve the health of their communities by linking their neighbors to health care and social services, by educating their peers about disease and injury prevention, by working to make available services more accessible and by mobilizing their communities to create positive change through advocacy and culturally appropriate education and support.

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[39] http://www.orchwa.org/wp-content/uploads/2013/04/ORCHWA-CHW-Statewide-Needs-Assessment-Report_FINAL.pdf; Rosenthal, E.L., Wiggins, N., Brownstein, J. N., Rael, R., Johnson, S., & Koch, E. et.al. (1998). The final report of the National Community Health Advisor Study: Weaving the future. Tucson, Arizona: University of Arizona, Health Sciences Center.
[40] https://www.apha.org/apha-communities/member-sections/community-health-workers

Dental Health Aide Therapists Program[41]

The Dental Health Aide Therapists program (DHAT) has the following components:

- DHAT students are recruited by their tribal communities.
- The students complete a rigorous education program that is the equivalent of three academic years delivered in two calendar years.
- Students complete preceptorships with dentists.
- Students are then certified to work offsite under general supervision, consulting with their supervising dentists via telemedicine or phone and referring treatment services outside their scope to dentists.
- DHAT services are eligible to receive federal funding up to 100%.

DHATs practice in underserved communities like those where they grew up. They understand these communities' customs and needs and have the trust of community members. They are adept at providing culturally competent care, which is part of their training, and serve as role models to younger community members.

On February 21, 2017, the Governor of Washington signed into law authorization to have DHAT in Washington. The new law allows federally recognized tribes to use federal funding for DHATs, who provide preventive care and procedures such as cleanings, fillings and oral exams.

Financial Model

Financial sustainability is a crucial element of any program design. SEED recommends evaluating the following financial strategies to capitalize start-up activities and operations and achieve long-term sustainability.

Start-Up Funding

It is assumed that initial funding for the pilot project will be provided by a philanthropic health foundation(s).

The factors that will influence the ask are:

- Identification of community within the North Sound region that has the following characteristics
  - Identified barriers to access quality healthcare
  - Substantial Medicaid population
  - Reliable access to internet
  - Stable community organizations and institutions
- Commitments of support from pilot Partners
  - Healthcare provider, academia, community organization, local government

[41] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497887/

- Proposal that establishes that the pilot will address healthcare access and awareness among primarily Medicaid users and utilize targeted universalism to address the needs of specific groups and incorporates the concept of belonging to integrate collective health solutions, which will result in improved health outcomes.
- Budget
  - 2-3 years of operations, primarily health guide costs, measurement systems and administrative costs
  - Hardware & software
  - Content/curriculum/tools development
  - Video production

On-going Funding

Federal and State reimbursement must become the primary source of revenue. North Sound ACH identified the need to communicate health outcomes and cost-savings to payers to inform changes to reimbursement policies.

The strategy to justify modifying reimbursement policies will be grounded in the results of the pilot program that shows that TelaEQ reduces health costs by improving individual health through access to information, consultation and resources and collective health practices. Specifically, less emergency room, hospital and doctor visits and less use of Medicaid services.

There is already substantial research documenting the benefits of targeted universalism as a tool for achieving universal goals for all groups and the benefits of belonging and collective practices in reducing trauma and generating healthy outcomes. TelaEQ builds on this research by combining targeted strategies for specific groups, connectedness through local groupings of neighbors and friends in safe and familiar environments and such groupings facilitated by trained local influencers.

The funding objective is to present a compelling case pilot backed by evidenced based research to drive financial support for the pilot.

Current Reimbursement Policies

Washington Medicaid reimbursement policies are:

1. Medicaid reimbursement

   - Washington Medicaid reimburses for telehealth services through both their fee-for-service and managed care programs if the healthcare service is medically necessary as determined by the provider

- Medicaid can be charged a facility fee for the originating site, which can be a home

2. Recommended State Policies

- Allow reimbursement for telehealth services to low-income consumers in collective groups for non-medically necessary procedures and information as a preventative/proactive health solution
- Provide clear guidance about a range of ways to pay for Health Guide (HG) services. This should include approval of a robust list of billing codes for HGs, both to allow fee for service billing when appropriate, and to serve as a basis for calculating the value of HG services within value-based models. The guidance should emphasize capitated and Alternative Payment Model (APM) options, as those most likely to support HGs to play a wide range of roles.
- Provide for social impact bonds to fund TelaEQ services throughout Washington
- Provide contracts and grants to community-based organizations to support development of TelaEQ programs that cannot be supported through health system reimbursement.
- Support TelaEQ programs to include funding for on-going HG training and professional development, including costs of traveling to attend training and professional conferences.
- Mandate an equitable level of compensation and benefits for HGs in state-supported programs. Salaries should be commensurate with the complex, self-directed nature of HG practice
- Direct Managed Care Organizations (MCOs) to emphasize quality over quantity in value-based payment systems, and to de-emphasize short-term, individually focused incentive metrics in favor of longer-term, community-level metrics.

Measurement & Accountability

Health equity involves a complex system of interrelated social, physical and mental determinants. The TelaEQ model would incorporate the following measurement elements:

1. Establish a systems theory intervention that combines healthcare information, consultation & data with technology and community and track the resulting health outcomes and community connectedness.
2. Establish baseline data and link with other healthcare interventions to track results and evaluate positive & negative feedback.
3. Measure the unique and specific contribution of HGs to achieving positive health outcomes and increasing health equity.
4. Utilize a community-based participatory approach to program design and evaluation.

Social Enterprise

SEED recommends that TelaEQ be developed as a social enterprise owned by the community collaborative or some other community entity. Such an entrepreneurial enterprise could reinvest net revenues in strategies to improve the social determinants and close the health gap for Medicaid users.

Once the TelaEQ program has a demonstrated revenue model and a record of improving health outcomes at a reduced cost, then the sponsoring entity can access capital to build out TelaEQ statewide. With quantitative and qualitative research results, the innovative model would be attractive to health plans, health foundations and socially responsible investors.

For example, Pivotal Ventures, a Melinda Gates company, partners with organizations and individuals who share an urgency for social progress and expand participation, encourage cooperation and fuel new approaches that substantially improve people's lives.

Local ownership by a community-based collaborative or organization further advances equity goals of self-determination/community control and sustainability.

Items for North Sound ACH Board Consideration

- Partner contract requirements year 2 and 3
- North Sound ACH to provide technical assistance for community organizations, especially organizations led by or that represent people of color, that create pathways to becoming Partner Providers
- North Sound ACH support for Community Collaborative
- North Sound ACH support for TelaEQ solution

Next Steps

<table>
<tr><td><u>Internal - North Sound ACH</u>

Training and Education
• Continue to conduct Partner and community education, organizing, training and information dissemination
• Continue to expand educational, training and informational delivery platforms to include current technologies
• Select a health equity and belonging toolkit to be accessible from the North Sound ACH website

Partner Contracts
• Continue to include health equity requirements and incentives in Partner contracts

• Continue to measure Partner performance and monitor compliance

Facilitation
• Continue to support an iterative process that brings health professionals and advocates together with community to share knowledge and experiences, build consensus and buy-in, and support indigenous models of care

• Facilitate the creation of Health Equity Cohort for Partners

• Continue to support regional ACH collaboration, consultation and strategic planning

Technical Assistance
• Develop pathway(s) for community organizations to become Partners, especially agencies lead by people of color and/or that represent people of color and indigenous peoples</td><td>

Sept-Mar 2019-2020

Oct-Dec 2019

Jan-Dec 2020

Mar-Sept 2020

Mar-June 2020

July-June 2019-2020

Jan-Nov 2020</td></tr>
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External	
• Develop appropriate benchmarks and pathways toward targeted universalism guided by community input and feedback	Sept-June 2019-2020
• Support the creation of a North Sound Health Equity Community Collaborative	Sept-June 2019-2020
• Support development of TelaEQ pilot	Sept-Mar 2019-2020
• Support participatory research on best and next practices to improve healthcare access, create belonging and address social determinants, including preconditions	Oct -Mar 2019-2020

Conclusion

This Report supports the following conclusions:

- Targeted Universalism is the appropriate strategy to move toward a universal goal of wellness for diverse groups that are differently situated
- Issues of access to healthcare for marginalized communities are best addressed by technological innovation and strategies to take health care to the user as opposed to requiring the user to go to the provider
- Health equity narratives, priorities, solutions and assessments must be developed in partnership with the community and informed by lived experiences
- Strategies that connect people, systems and organizations reduce social isolation, bridge siloed organizations, systems and groups, and improve health outcomes

APPENDIX I

Barriers	Solutions
Access • Ability to access resources • People do not know how to access services or that services exist • Lack of access to culturally appropriate Medicaid services and resources • Access to health care • Lack of access to primary care • Lack of access to behavioral health • Access to dental health • Department of Health- difficult to access services • Challenges accessing home therapy • Slow access to care for veterans- authorizations are slow • Wrap around care not readily available, challenges accessing wrap around care • Racial differences in access to pain medication • Lack of access to health services due to lack of access to transportation • Bureaucracy poses barriers to accessing services, therefore unaddressed mental health issues • Access to data • Lack of public transportation and Disabled people have less access to public transportation • Equitable access to mental health • Lack of pediatric mental health (ACES) • Lack of access to affordable childcare and preschool **Information Systems** • Knowledge of resources to access • People do not know what they have a right to ask for • Addressing myths about the healthcare system via creative and culturally responsive messaging	**Institutional-Systems** • Whole Family Medical Leave Act- paying parents to stay home with their babies • Parent Mental Health Act- parent can have child involuntarily detained if professional cannot make it to see their child on the Island • Pass legislation to bring about more home visiting, case management programs- this is important for rural areas, will provide post-visit follow up supports • Support efforts that bring more accountability to how county funding decisions get made (could be a policy, a piloted process that leads to a structural policy, or revisiting current equity analyses methods or policies • Whidbey Health Medical Center's connection to a jail diversion program- alternative to incarceration • Patients informing care Whidbey partnered with county stakeholders on funding distribution methods • Whidbey Hospital's change plan focuses on 6 initiatives- Opioid Work, Reproductive Health, Chronic Illness, Education and Jail Diversion, Immunizations, and Integration of Physical and Mental Health • Power players step up including hospitals, Schools, City/County government and Universities • Advocacy via WA Physicians' Association • Waiver funding for organizations serving diverse patient population • Peace Health making intentional efforts to address HE Verdant Health Commission develops a stronger equity lens and prioritization process in relationship to $10 million they will put out in grants • Verdant Health Commission strengthen the "targeted" component of Targeted universalism

APPENDIX I

Barriers	Solutions
Information Systems (cont.) • Develop a more expansive understanding of health equity, i.e. communities defining the types of services and structures that will lead to the health that they need, political participation in their experience of the social determinants • Holistic definition of health as a mechanism to build legitimacy for addressing negative mental health due to structural racism and other oppressive structural realities • Increase people's understanding of the difference between positive mental health and negative mental health at the community level vs the experience of mental illness • Uplift local models that are working but not acknowledged • Discussion about race and health and yet not leading change with race lens • White progressives recognizing the need for systemic change and yet struggling with it • Must have TU lens-i.e. left all boats • Put forward ways to build collaboration across geographies and cultural groups • People working low income jobs to secure housing; however, supply is low • Many housing developers not taking advantage of 4% low income tax credit due to risk • Gentrification • Low supply of housing • Substandard housing • Inequities as a result of zoning • Work on housing for homeless Lummi, especially those with mental health needs and addiction	**Institutional-Systems (cont.)** • More flexibility in fashioning the resources to meet the needs of community- i.e., who can be admitted and treated, esp for those with Medicaid • WA filters to measure health success, fund health needs to shift from # of people seen to # of people seen and # of people with improved health • Adequate staffing and therefore focus on the process of transforming the system • Whatcom Alliance for Health Advancement as a mechanism to provide local services and foster public participation, meaningful system change • Clinical integration, wrap around services for Medicaid clients • Telemedicine as an innovation to address transportation issues • Reduce providers' caseloads • More regular, effective, and integrative ways for legislators to support and build relationships with key health partners in the North Sound region; this will lead to more supportive policy, economic distribution, and health shifts **Community** • Operate as a collective community • Subsidized maternity leave for all parents • Identify and prioritize taking care of each other • Collective Health is Community based participatory research (cbpr)- i.e., tribes identify their issues and solutions • Collective Health is tribal individual, family, community, and spiritual strengths and resiliencies • Many housing developers not taking advantage of 4% low income tax credit due to risk • Discussion about race and health and yet not leading change with a race lens and (2.) White progressives recognizing the need for systemic change and yet struggling with it

APPENDIX I

Barriers	Solutions
Homelessness • Homeless as a result of I5 corridor and related issues, including mental health, difficulty living on SSI or SSDI supports, lack of economic resources; low vacancy rate; Seattle being gentrified and subsequent high rents, people being pushed in to NW • Emerging homeless population is seniors • Homeless in dire need of behavioral health, primary care, and legal aid • Homelessness- lack of compassionate response, lack of affordable housing, other barriers to affordable housing- gentrification • Work on housing for homeless Lummi, especially those with mental health needs and addiction **Economic** • People working low income jobs to secure housing; however, supply is low • Lack of affordable childcare • Jobs- Low wage/low skill jobs for adults 18-21 • Lack of big employers • Low pay for behavioral health providers • Fair distribution of financial resources • Relationship between education and poverty • Economic inequity; Wealth disparity • Growing gap in wealth distribution • Lack of economic benefit to serve/treat Medicaid patients **Wrap Around Services** • Wrap around care not readily available • Challenges accessing wrap around care **Systems Change** • Safe and competent providers • Insufficient resources for mental and physical health • Weak patient-provider relationships • Silos within health Lack of mental and behavioral health providers	**Community (cont.)** • Must have a TU lens- i.e., lift all boats frame • Develop regional strategies; Organize at the 5 county, 8 tribe level; Continue to build collective impact • Collaborate with non-traditional partners; Build trust among diverse partners • Focus on how to collaborate and build trusting relationships with people in power • Put forward ways to build collaboration across geographies and cultural groups • Generations Forward process- large coalition, building health communities for families with young children initiative • Banning the box/criminal designation on job applications led to applicants getting through the hiring process • Greenways Levy • Develop a collective vision for action • How can the work be done smarter • Support established initiatives • Understand that building shared language re: health is beyond services and access to services • Listen to agencies doing the work • Include people doing the real work- not just talking a good game • Empower people • Ensure that there is integrity in terms of how an equity plan gets expressed and implemented, building ownership and supporting meaningful and strategic collaboration now and early • Leaders supporting each other and having a common agenda, with good coordination • People feeling empowered, with knowledge and power • Put forward community-driven standards of care and seek to implement and integrate into health systems • Promoting diverse nursing leaders to work on an equity agenda

APPENDIX I

Barriers	Solutions
Systems Change (cont.) • Medical team communication Silo-ed and overwhelmed health care delivery system • Lack of hospitals to treat behavioral health issues • Health care system's apathy • Low pay for behavioral health providers • Department of Health- difficult to access services • Department of Health- difficult to access services • Difficult for veterans to get in to a Veterans Administration • Bureaucracy poses barriers to accessing services, therefore unaddressed mental health issues • Mistrust of providers • Many providers do not want to do chronic pain management • Health system has not kept up with the opioid epidemic Disconnect between people and health care providers • Lack of providers in rural areas • Mistrust of MCOs Organizational sustainability, under new managed care system MCO's contract obligations versus provider's creativity on how to meet client needs • More hospitals to treat behavioral health issues • A hospital system in rural areas of North Sound	**Community (cont.)** • Ensure that there is integrity in terms of how an equity plan gets expressed and implemented, building ownership and supporting meaningful and strategic collaboration now and early Representative decision makers; Include people doing the real work- not just talking a good game • Local POC of power • Culturally appropriate care, including trusted peer counselors and community health assistance providers (CHAPs) that go to home • Advocacy for people suffering the deepest and needing the most support: pediatric mental health services for all young people • Rural voice at the decision-making table; People at the decision-making table need to reflect the community served • Acknowledgement of smaller voices, clinics, community-based organizations • Increase people's understanding of difference between positive mental health and negative mental health at the community level versus the experience of mental illness • Addressing myths about the healthcare system via creative and culturally responsive messaging • Representative decision makers; Include people doing the real work- not just talking a good game; Local POC with power; Those impacted should have a voice on how to pool resources and make a difference in their region and WA

APPENDIX I

Barriers	Solutions
Resource Allocation • Fair distribution of financial resources • Knowledge of resources to access • Resources to intervene quickly when a family is struggling • Lack of resources for opioid addiction • Lack of access to culturally appropriate Medicaid services and resources • More flexibility in fashioning the resources to meet the needs of community, i.e., who can be admitted and treated, especially for those with Medicaid • Increased training funds to support full integration • Lack of providers in rural areas • Real time technology inter-face for community health workers will facilitate connection to needed health resources • Offer resources on health equity-based community assessment basis • Those impacted should have a voice on how to pool resources and make a difference in their region and WA	**Tribal** • Collective Health is sharing tribal strengths and resiliencies with greater society • Tribal collaboration regarding mental health, drug addiction, and traditional healing • Samish purchasing referred care • Samish' government health grants; Samish health fair that provides on-site testing; Samish's culturally competent, health services • Tribal collaboration via pooled funding • Samish's culturally competent, health • Samish health fair that provides on-site testing **Housing** • Cordata's change in zoning, leading to more varied housing, mostly for seniors • Bellingham's 2 successful property tax levies and residents' self-tax to provide more supportive housing • Bellingham affordable housing fund • Bellingham set up an office to hold landlords accountable • Newest supportive housing program, in partnership between Opportunity Council and Northwest Youth Services

APPENDIX II

Study	Hypothesis	Results	Notes	Article Link
Pediatric Telemedicine Use in US Emergency Departments	Surveyed all 5,375 U.S. EDs to characterize emergency care in 2016.	Most widely reported use was for patient placement and transfer coordination. the most frequently reported challenges were process concerns (30%), such as concerns about slowing or interrupting providers' work flow and technological concerns (14%) Few EDs receive telemedicine for the delivery of pediatric emergency care nationally. Among EDs that do use telemedicine for pediatric care, many report process concerns.		https://onlinelibrary.wiley.com/doi/abs/10.1111/acem.13629
Urban telemedicine enables access to acute illness care	increased utilization reflected improved access among impoverished inner-city children to a level experienced by more affluent suburban children.	At baseline, overall acute illness utilization of suburban children exceeded that of inner-city children. Overall utilization for inner-city children increased with telemedicine to that of suburban children at baseline. Without telemedicine, however, inner-city use remained substantially less than for suburban counterparts. **Conclusions:** Health-e-Access Telemedicine redressed socioeconomic disparities in acute care access in the Rochester area, thus contributing to a more equitable community.	This observational study compared utilization among children without and with telemedicine access, beginning in 1993, ending in 2007, and based on 84,287 child-months of billing claims-based observation	https://www.liebertpub.com/doi/abs/10.1089/tmj.2016.0098
Telemedicine in the Cloud Era: Prospects and Challenges	What are the benefits and challenges of telemedicine?	**potential of telemedicine:** more affordable and higher quality healthcare **challenges:** how to achieve high assurance, interoperability, security		https://ieeexplore.ieee.org/abstract/document/7030248

APPENDIX II

Study	Hypothesis	Results	Notes	Article Link
		and privacy, and storage adaptability		
Behavioral Interventions Using Consumer Information Technology as Tools to Advance Health Equity	Literature and case examples are summarized to demonstrate the use of mHealth, telehealth, and social media as behavioral intervention platforms in health disparity populations, identify challenges to achieving their use, describe strategies for overcoming the challenges, and recommend future directions	Future directions include (1) improved design methods, (2) enhanced research reporting, (3) advancement of multilevel interventions, (4) rigorous evaluation, (5) efforts to address privacy concerns, and (6) inclusive design and implementation decisions	Cell phone ownership is higher among African Americans and Hispanics than among non-Hispanic Whites, and smartphone ownership is at least 75% for all three groups.1 Rural residents continue to lag behind those who live in urban and suburban areas in technology ownership, but about two thirds now have desktop computers or laptops and smart phones.2	https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304646

APPENDIX II

Study	Hypothesis	Results	Notes	Article Link
			A 2012 review of 125 CIT studies focused on health and wellness in historically underserved populations characterized the types of technologies involved, types of users, health topics covered, and evaluation focus, including outcomes measured. These included tailoring the CIT-enabled intervention to the intended population, contextually situating the CIT-enabled intervention to increase likelihood of behavior change, and increasing the use of mobile health (mHealth) and social media. They also called for explicit reporting of design processes to promote development of best practices and to standardize evaluation processes to create benchmarks for culturally informed use of CITs for health. Another descriptive review highlighted the promise of CITs for supporting health education and behavior change in underserved populations.	

APPENDIX III

North Sound ACH Findings

Communication & Engagement

- There is an opportunity for North Sound ACH to help translate messages to the community
- Engage stakeholders across all organizational levels, from leadership to frontline staff
- Focus on beneficiaries with behavioral health needs, co-morbid physical and behavioral health needs, SUD, ACEs, high-risk pregnancies, children and families, and high utilizers
- Need to focus on individuals experiencing health disparities such as homeless and transitional youth (ages 16 to 21)
- Shortage of behavioral health providers that accept Medicaid
- High need for oral health and SUD services, particularly in rural communities
- Telehealth in behavioral health is working well
- Need to increase number of behavioral health providers accepting Medicaid
- Opportunity to leverage the ACH's relationship with the behavioral health organizations
- Need to communicate health outcomes and cost-savings to payers
- Use and invest in resources such as local care coordinators and existing relationships
- Need to better coordinate services across partners, including state-level agencies with local organizations
- Need specific coordination for people experiencing homelessness
- Need to build on existing collaborations and momentum
- Identify ways to capture savings and invest in sustainable solutions
- Build evaluation into program plans
- Start small and find ways to expand
- Funding is critical to access and quality of care
- Manage expectations with early and frequent communication
- Be focused on the work and action oriented
- Regional CBOs exist throughout the North Sound, and these community care providers will be critical for successful project implementation.
- North Sound ACH has identified the following regional assets by organization type and focus area:
    - 32 Behavioral Health Assets
    - 9 Educational Assets
    - 33 Food/Nutrition Assets
    - 30 Transportation Assets
    - 25 Social Service Asset

APPENDIX IV

Process

From January 30 to February 12, 2019, three team members from SEED interviewed 25 stakeholders in confidential, hour long sessions. Of those interviewed, 23 were interviewed in person. We originally sought to understand the perspective of North Sound ACH stakeholders on the following specific to Northwest Washington:

- The meaning of health equity
- Definitions of personal and community wellbeing
- Barriers to health equity
- Regional social determinants of health
- Opportunities to build on work being done and successes to bring about greater health equity in Northwest Washington
- Others we should interview

After the first week of interviews, SEED realized that a scope revision and thus an interview guide revision was necessary. Interviews with the North Sound ACH staff were pivotal in this shift; it was after these interviews the consulting team realized that a consultant written health equity report informed but a steering committee may not be as effective as hoped. Areas of impact needed to be identified, and opportunities to bring together diverse stakeholders needed to be explored. As a result, the interview guide was revised to explore some of these ideas. Analysis derived from interviews using both guide versions is included in the below analysis.

An estimated 250 pages of interview notes were analyzed by question or category and themes were identified[42]. From there, intersectional analysis was conducted by consultants focusing on the intersections of barriers and solutions.

Methods

SEED used the qualitative research tool phenomenology[43] to conduct the stakeholder interviews. This method focuses on the lived experience of the person experiencing a

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[42] These themes are reflected in the Raw Analysis Microsoft Excel file that accompanied this memo.

[43] "Phenomenology is based on the academic disciplines of philosophy and psychology and has become a widely accepted method for describing human experiences. Phenomenology is a qualitative research method that is used to describe how human beings experience a certain phenomenon. A phenomenological study attempts to set aside biases and preconceived assumptions about human experiences, feelings, and responses to a particular situation. It allows the researcher to delve into the perceptions, perspectives, understandings, and feelings of those people who have actually experienced or lived the phenomenon or situation of interest. Therefore, phenomenology can be defined as the direct investigation and description of phenomena as consciously experienced by people living those experiences. Phenomenological research is typically conducted through the use of in-depth interviews of small samples of participants. By studying the perspectives of multiple participants, a researcher can

particular phenomenon. Phenomenology holds experience, perspective, and feelings of the person experiencing that phenomenon as the sough after data set. We used this method to ground our analysis of the day-to-day experiences with health and health equity from the perspective of a small sample of those living in and working on these issues in Northwest Washington. The method works well with one-on-one, in depth, confidential interviews of a relatively small sample size, which is the profile of the interview pool being discussed. This method fits wells with the project and helps directly respond to our initial thoughts and questions[44]. It gets to the center of the question: how is health experienced by the community and how can it be made more equitable?

Interviews were conducted by either one, two, or three consultants with one consultant leading the interviews and others also asking questions while taking notes[45]. The interview was structured such that it started with consultants making the interviewee aware that the interview is confidential, voluntary, one hour-long, and seeks to understand experience and perspective[46]. The interview guide was used as a tool to facilitate the interview, and it was designed to ground the interviewee in their personal experience and understanding, so they thought and felt from the personal prior to responding to questions about community health, barriers and opportunities. Questions from the interview guide were asked in order written, with predetermined probes used to draw out more full responses. Unplanned questions were also asked to follow up or dig deeper on information shared by the interviewee.

Limitations

As with any data collection and analysis process, there are limitations. The consulting team would like to note the following 4 limitations:

- Of the 25 stakeholders interviewed, no more than 20% of interviews were conducted by phone or Zoom rather than in person. In person interviews tend to draw out richer, more transparent responses from interviewees than those conducted remotely. Interviews conducted via phone or Zoon were done so due to inclement weather or challenging scheduling logistics.
- Interviewee pool lacked some diversity.
    - Just under half interviewees were internal stakeholders of North Sound ACH. The 25 interviewees are made up of 13 partners, and 11 North

begin to make generalizations regarding what it is like to experience a certain phenomenon from the perspective of those that have lived the experience."
https://cirt.gcu.edu/research/developmentresources/research_ready/phenomenology/phen_overview

[44] See the bullet point list on page one of this memo.
[45] In cases where there were more than one set of notes for a particular interviewee, those versions of notes were synthesized into the raw analysis found on the accompanying Raw Analysis file.
[46] See Attachment One to view the interview guide.

  Sound ACH internal stakeholders made up of 5 board members, 4 staff, and 2 members of North Sound related committees.
  - To the knowledge of the consultants, representatives from all 8 tribes in the region were not interviewed, only individuals from 3 tribes.
  - 24% of interviewees were non tribal people of color.
- Throughout the two weeks consultants were in Northwest Washington conducting the bulk of the interviews, the team experienced some technology challenges that made facilitating the interview not as smooth.
- Some questions from the interview guide were not answered due to the interviewee and flow of the interview.