Healthier Washington

Health Innovation Leadership Network Meeting

9 a.m.-noon Friday, April 27, 2018

Cambia Grove | Suite 250 | 1800 9th Avenue | Seattle
Webinar access: https://register.gotowebinar.com/register/4939284797158219779

Agenda

Meeting Objectives:

- Create a shared understanding of equity, health disparities and social determinants, and why they are important to health systems transformation efforts;
- Understand HILN's multisector leadership role in advancing equity as part of a multi-year action agenda focused on wellbeing; and
- Agree to collective and organizational commitments to equity to advance a healthier Washington.

9:00 a.m. Welcome and Introductions
Sue Birch & Bill Robertson, Health Innovation Leadership Network Co-Chairs

9:15 a.m. Spotlight On: Healthier Washington and Equity
Sofia Aragon and Winfried Danke, Communities & Equity Accelerator Committee Co-Champions
Aren Sparck, Seattle Indian Health Board
Lisa Segerstrom, Washington State Hospital Association

- Equity definition: Health equity exists when all people have the opportunity to attain their full health potential and no one is disadvantaged
- Opportunities for action alignment: data, community and workforce

10:00 a.m. Spotlight On Equity | Community Engagement and Supports
Allen Cheadle, Center for Community Health and Evaluation
Janet Varon, Northwest Health Law Advocates

10:40 a.m. Break

10:50 a.m. Spotlight On Equity | Workforce Considerations
Sofia Aragon, Washington Center for Nursing
Ali Jensen, Community Health Plan of Washington

11:25 a.m. HILN's Commitment to Advancing Equity
Sofia Aragon and Winfried Danke

- Individual and collective commitments to action
    - Data
    - Community supports
    - Workforce

11:50 a.m. Next Steps

Sue Birch & Bill Robertson

- Next HILN quarterly meeting 9 a.m.-noon July 20 at Cambia Grove
    - Next steps to advance the HILN action agenda focused on wellbeing

12:00 p.m. Adjourn

Health Innovation Leadership Network Roster

Name	**Organization**
Sue Birch, Co-Chair	Health Care Authority
Bill Robertson, Co-Chair	MultiCare
Chris Ackerley	Ackerley Partners, LLC
Peter Adler	Molina Healthcare Washington, Inc.
Teresita Batayola	International Community Health Services
Brian Bonlender	Department of Commerce
Doug Bowes	UnitedHealthcare Community Plan
Antony Chiang	Empire Health Foundation
Ann Christian	Community Mental Health Council
Eileen Cody	House of Representatives
Phil Colmenares	Premera Blue Cross
Sean Corry	Sprague Israel Giles, Inc.
Winfried Danke	CHOICE Regional Health Network
Regina Delahunt	Whatcom County Health and Human Services
Greg Devereux	Washington Federation of State Employees
Sue Elliott	Arc of Washington
Michael Erikson	Neighborcare Health
Andre Fresco	Yakima Health District
Nancy Giunto	Washington Health Alliance
Mike Glenn	Jefferson Healthcare, Port Townsend
Paul Hayes	Harborview Medical Center
Ross Hunter	Department of Early Learning
Nancy Johnson	Colville Business Council

Health Innovation Leadership Network Roster

Name	Organization
Mike Kreidler	Office of the Insurance Commissioner
Maura Little	Cambia Grove
Pam MacEwan	Health Benefits Exchange
Tom Martin	Lincoln Hospital and North Basin Medical Clinics
Jason McGill	Office of the Governor
Tammy Moore	Summit Pacific Medical Center
Peter Morgan	Family Health Centers
Martin Mueller	Office of the Superintendent for Public Instruction
Steve Mullin	Washington Roundtable
Diane Narasaki	Asian Counseling and Referral Service
Diane Oakes	Washington Dental Service Foundation
Richard Pannkuk	Office of Financial Management
Kathleen Paul	Virginia Mason Medical Center
Ann Rivers	Washington State Senate
David Rolf	SEIU 775 NW
Joe Roszak	Kitsap Mental Health Services
Bill Rumpf	Mercy Housing Northwest
Peter Rutherford	Confluence Health, Wenatchee
Joel Sacks	Department of Labor and Industries
Marilyn Scott	Upper Skagit Indian Tribe
Jill Sells	Reach Out and Read Washington State
Preston Simmons	Providence Regional Medical Center
Joe Smith	Kaiser Permanente Washington
Diane Sosne	SEIU 1199 NW

Health Innovation Leadership Network Roster

Name	**Organization**
Aren Sparck	Seattle Indian Health Board
Hugh Straley	Dr. Robert Bree Collaborative
Cheryl Strange	Department of Social and Health Services
Jurgen Unutzer	University of Washington, Department of Psychiatry
Joe Valentine	North Sound Accountable Community of Health
Lisa van der Lugt	Washington Commission on Hispanic Affairs
Janet Varon	Northwest Health Law Advocates
Ron Vivion	Washington State Council on Aging
Rick Weaver	Central Washington Comprehensive Mental Health
David Wertheimer	Bill & Melinda Gates Foundation
Caroline Whalen	King County
John Wiesman	Department of Health

Healthier
WASHINGTON

Dear Health Innovation Leadership Network:

We are writing to confirm your commitment to advancing health equity in Washington State. At the April 2018 Health Innovation Leadership Network (HILN) meeting, we request HILN members **commit to action** on equity to support and advance Healthier Washington's goals. We thank you for your efforts to create an equitable health system. In support of advancing a healthier Washington, we are asking you to use levers to promote health equity with an eye toward wellbeing.

Addressing health equity is crucial to creating a health and wellness system that works for *all* Washingtonians. In Washington State, as in the rest of the country, there are extreme variations in health outcomes impacted by social determinants of health. A few examples include[1]:

- Life expectancy and geography: Residents of Mercer Island have a life expectancy of 86.1 years while residents in South Auburn have a life expectancy of 76.6 years—almost a decade difference.[2]
- Infant mortality: American Indian and Alaska Natives experience twice the infant mortality as white Washingtonians. The infant mortality rate for babies born to American Indian and Alaska Natives in 9.8 per 1000 contrast to babies born to white mothers which is 4.3 per 1000.[3]
- Mental health: American Indian and Alaska Natives report significantly higher rates of poor mental health (20%) than all other racial/ethnic group (Whites 12%, Asians 7%).[4]

Without active intervention, significant health disparities between different populations will only grow as our state becomes more diverse. In 2010, the Office of Financial Management (OFM) estimated that 27% of the population (over one million Washingtonians) was a race other than white or multiracial; 11.2% (over 750,000 Washingtonians) were Hispanic.[5] By 2040, OFM projects that 28% of the population (over 2.6 million) will be a race other than white or multiracial and 18% (over 1.6 million Washingtonians) will be Hispanic.[6]

The Healthier Washington Communities & Equity Accelerator Committee was created as a sub-committee of HILN to help address and mitigate these disparities. However, we cannot do this alone.

The Communities & Equity Accelerator Committee relaunched in October 2018 and includes four workgroups: data disaggregation, equity and community engagement support for Accountable Communities of Health (ACHs), and workforce development.

While it has been helpful to organize ourselves in these workgroups to break down the rather daunting task of addressing health inequities, due to the pervasive and systemic nature of health disparities, our work cannot operate within the silos of these workgroups or the committee alone. Rather, with the vision of a healthier Washington in mind, we are reaching out to you to ask that you commit to one or

---

[1] http://healthequity.wa.gov/Portals/9/Doc/Publications/Reports/HDC-Reports-2010-Action-Plan.pdf

[2] https://www.kingcounty.gov/~/media/depts/health/data/documents/life-expectancy/life-expectancy.ashx?la=en

[3] https://www.doh.wa.gov/Portals/1/Documents/1500/MCH-IM2013.pdf

[4] https://www.doh.wa.gov/Portals/1/Documents/1000/SHA-MentalHealth.pdf

[5] https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin

[6] https://www.ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/projections-state-population-age-sex-race-and-hispanic-origin

more of the below equity domains and help to accelerate efforts in that area, collectively through the HILN and individually within your organizations. We recognize many of you are already engaged in this work, and we therefore ask you to take these efforts to the next level.

Equity Action Domains:

- ☐ Data: Collect, create, and analyze patient and/or client data that enables my organization to identify and respond to disparities relevant to my community. Examples include: race/ethnicity, language, client zip code, sexual orientation/gender identity, and veteran status.
- ☐ Community linkages: Incorporate community feedback and participation, especially members of vulnerable populations, into your organization's work. For example, provider organizational resources to solicit and operationalize consumer feedback into your processes and practices on an ongoing basis.
- ☐ Workforce opportunities: Assess recruitment and hiring practices to create a diverse workforce. For example, develop pipelines for entry level health care and social service workers to advance their careers and support the use of community health workers and peer support coaches into your organization's workflow and budget.
- ☐ Optional write in: ____

  ____

As you embark on engaging in the equity action domain(s) you identified, consider the following:

- What would have to change, both operationally and culturally, to complete this activity and how will you drive this change?
- What stakeholders in your organization are critical to successfully advancing this work?
- What enablers or resources do you have to help drive this work?
- What individuals or organizations engaged in the HILN could help you with his work?

Please email the Communities & Equity Accelerator Committee at healthierwa@hca.wa.gov with your commitment by **Monday, May 7.**

Thank you for your ongoing commitment to this work,

Sofia Aragon, Winfried Danke, and Antony Chiang
Healthier Washington Communities & Equity Co-Champions

Name:

Organization:

> *Health equity exists when all people have the opportunity to attain their full health potential and no one is disadvantaged. We will proactively pursue the elimination of health inequities and preventable differences in health among groups based on socioeconomic status, source of income, gender identity, sexual orientation, race and ethnicity, tribal membership, language, immigration status, age, religion, the job they have, education, disability, housing status, the neighborhood they live in or any other socially determined circumstances.*[1]

To create a healthier Washington, I commit to a specific action within one or more of the below equity domains to accelerate efforts in that area, collectively and at my individual organization:

☐ Data: Collect, create, and analyze patient and/or client data that enables your organization to identify and respond to disparities relevant to your community. Examples include: race/ethnicity, language, client zip code, sexual orientation/gender identity, and veteran status.

____

____

☐ Community linkages: Incorporate community feedback and participation, especially members of vulnerable populations, into your organization's work. For example, provide organizational resources to solicit and operationalize community feedback into your processes and practices on an ongoing basis.

____

____

☐ Workforce opportunities: Assess recruitment and hiring practices to create a diverse workforce. For example, develop pipelines for entry level health care and social service workers to advance their careers and/or support the use of community health workers and peer support coaches into your organization's workflow and budget.

____

____

☐ Optional write in: ____

____

As you embark on the action you identified above, consider the following:

- What would you have to change, both operationally and culturally, to complete this activity?
- What stakeholders in your organization are critical for successfully completing this work?
- What enablers or resources do you have to help?
- What individuals or organizations from HILN could partner on or help you with this work?

Please email the Communities & Equity Accelerator Committee at healthierwa@hca.wa.gov with your commitment by Monday, May 7.

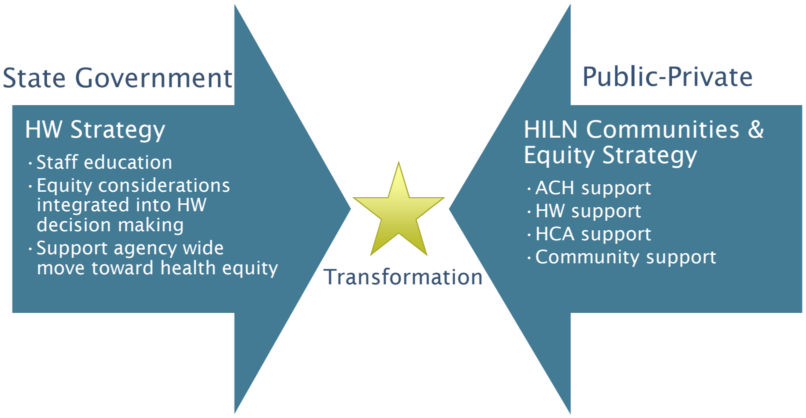
---

[1] Adapted from the Washington State Department of Health 2014-2016 Strategic Plan

Health Innovation Leadership Network Communities and Equity Accelerator Committee

2018 Strategy

The big picture



State Government

HW Strategy

- Staff education
- Equity considerations integrated into HW decision making
- Support agency wide move toward health equity

Transformation

Public-Private

HILN Communities & Equity Strategy

- ACH support
- HW support
- HCA support
- Community support

HILN Communities and Equity Committee

- What makes this committee distinct?
    - Supported by staff
    - Convened by HCA
    - Focused on health system transformation

HILN Communities and Equity Committee

- What is the scope of the committee?
    - Focus on state and community solutions
    - Not limited to Medicaid
    - Organize/respond to federal changes that impact the state
    - Leverage partner knowledge to forward statewide equity

HILN Communities and Equity Committee

- What is the scope of the committee?
  - Engage state-wide/local health organizations to support improved equity within their organizations (including coordinating with HILN leadership)
  - The committee serves as a team of health equity advisors to HW programs
    - Leads/ supports existing health equity efforts outside of HW

Committee workgroups

- Data
- Workforce
- Foundational community supports
- ACH community engagement

Healthier
WASHINGTON

Health Innovation Leadership Network: Communities & Equity Accelerator Committee Roster

Name	Organization
Antony Chiang, Co-Champion	Empire Health Foundation
Winfried Danke, Co-Champion	CHOICE/ Cascade Pacific Action Alliance
Sofia Aragon, Co-Champion	WA Center for Nursing
Bertha Lopez	Yakima Memorial Hospital
Victoria Fletcher	Washington Center for Nursing
Sybill Hyppolite	SEIU Healthcare 1199 NW
Lisa Segerstrom	Washington State Hospital Association
Aren Sparck	Seattle Indian Health Board
Shareka Fortier	MultiCare Connected Care
Janet Varon	Northwest Health Law Advocates
Jessie Dean	Health Care Authority
Leah Tuzzio	Kaiser Permanente Research Institute
Michael Itti	Washington State Commission on Asian Pacific Islanders
Nora Coronado	University of Washington Medicine
Paj Nandi	Department of Health
Rick Ludwig	Providence
Sam Watson-Alvan	Office of Rural Health
Sarah Kwiatkowski	Community Health Plan of Washington
Torney Smith	Spokane Regional Health District
Vicki Lowe	American Indian Health Commission

Staff:
Katharine Weiss, Health Care Authority: Katharine.weiss@hca.wa.gov
Kristin Villas, Health Care Authority: Kristin.villas@hca.wa.gov

GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

2018 State Policy Action Plan to Eliminate Health Disparities

TABLE OF CONTENTS

INTRODUCTION

The Governor's Interagency Council on Health Disparities (Council) is charged with creating a state policy action plan to eliminate health inequities by race/ethnicity and gender. This report outlines strategies to eliminate these gaps in health outcomes by promoting equity in state government. The background section of this report explains why the Council has chosen to focus much of its work on the social determinants of health. It also explains how promoting equity throughout state government can lead to equity in the social determinants of health, which can ultimately lead to health equity.

This action plan summarizes strategies that Council member agencies will commit to for the remainder of the 2017-2019 biennium to promote equity in state government. The Council recognizes that in order to be healthy, all communities should have equitable access to high quality early learning and education, affordable housing and healthy neighborhoods, safe working environments and living wages, and high quality healthcare services. Moreover, race/ethnicity and income should not be predictors of involvement in the child welfare or criminal justice systems. While state government cannot accomplish these goals on its own, it certainly has an important role to play. The commitments by Council member agencies are necessary steps toward obtaining a more equitable state government. The Council also recognizes that meaningful community engagement into state government decision making can help ensure information and services provided by the state are culturally and linguistically appropriate and accessible to all. Therefore, this report also includes recommendations to address important policy barriers that currently stand in the way of effective community engagement, particularly for communities facing health and other inequities.

BACKGROUND

Social Determinants of Health

The Council's primary responsibility is to create a state policy action plan to eliminate health disparities by race/ethnicity and gender. This responsibility is summarized in RCW 43.20.270, which states the Legislature's intent in creating the Council:

> *"The legislature finds that women and people of color experience significant disparities from men and the general population in education, employment, healthful living conditions, access to health care, and other social determinants of health."*
>
> *"It is the intent of the Washington state legislature to create the healthiest state in the nation by striving to eliminate health disparities in people of color and between men and women. In meeting the intent of chapter 239, Laws of 2006, the legislature creates the governor's interagency coordinating council on health disparities. This council shall create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition."*

The intent section of the Council's authorizing statute makes it clear that when identifying actions to eliminate health inequities, the Council must focus upstream on the social determinants of health. The Legislature defines social determinants of health in RCW 43.20.025 as "those elements of social structure most closely shown to affect health and illness, including at a minimum, early learning, education, socioeconomic standing, safe housing, gender, incidence of violence, convenient and affordable access to safe opportunities for physical activity, healthy diet, and appropriate health care services". To put it a little more simply—health starts where we live, learn, work, and play.

Health Disparities are differences in incidence, prevalence, mortality, or burden of disease and other adverse health conditions that exist between specific population groups.

Equity is fairness and justice, focused on ensuring everyone has the opportunity to attain their full potential without disadvantage because of social position or other socially determined circumstances. Equity is distinct from **equality,** which refers to everyone having the same treatment without accounting for differing needs or outcomes.

BACKGROUND (CONT'D)

The Social Ecological Model of Health (Figure 1) depicts how an individual's health has multiple spheres of influence. At the center of the model is the individual, whose health can be influenced by his or her knowledge, attitudes, and behaviors. Next is the interpersonal level, where social support from friends and family can work to enhance health. At the organizational level, policies, programs, and practices of institutions, such as schools and businesses, can have an impact on one's health. At the community level, health can be influenced by community-based organizations, coalitions, campaigns, and other partnerships. The outermost level represents federal, state, local, and tribal policies that can have impacts on health. At all levels of the model, health can be influenced directly or indirectly through the social determinants of health.

Figure 1: Social Ecological Model of Health

BACKGROUND (CONT'D)

The Council's mandate to focus on the social determinants of health is also clearly illustrated by the interagency makeup of the Council itself. While the Council does include members from key health agencies such as the Department of Health, State Board of Health, Department of Social and Health Services, and the Health Care Authority, it also includes representatives of non-traditional health agencies. These include the Department of Early Learning, Office of Superintendent of Public Instruction, the Workforce Education Training and Coordinating Board, Department of Commerce, Department of Agriculture, and the Department of Ecology. By having these agencies represented on the Council, it has the ability to address factors that indirectly influence health, such as education, employment, housing, poverty, nutrition, and environmental conditions. The work of these agencies predominantly influences health indirectly through the organizational, community, and policy levels of the Social Ecological Model.

The Council also includes representatives from the Commissions on African American Affairs, Asian Pacific American Affairs, and Hispanic Affairs, as well as the American Indian Health Commission and two consumer representatives. These essential members help to ensure the Council includes the voices of historically marginalized communities experiencing health inequities.

In fulfilling its primary responsibility to create a state policy action plan to eliminate health inequities (per RCW 43.20.280), the Council:

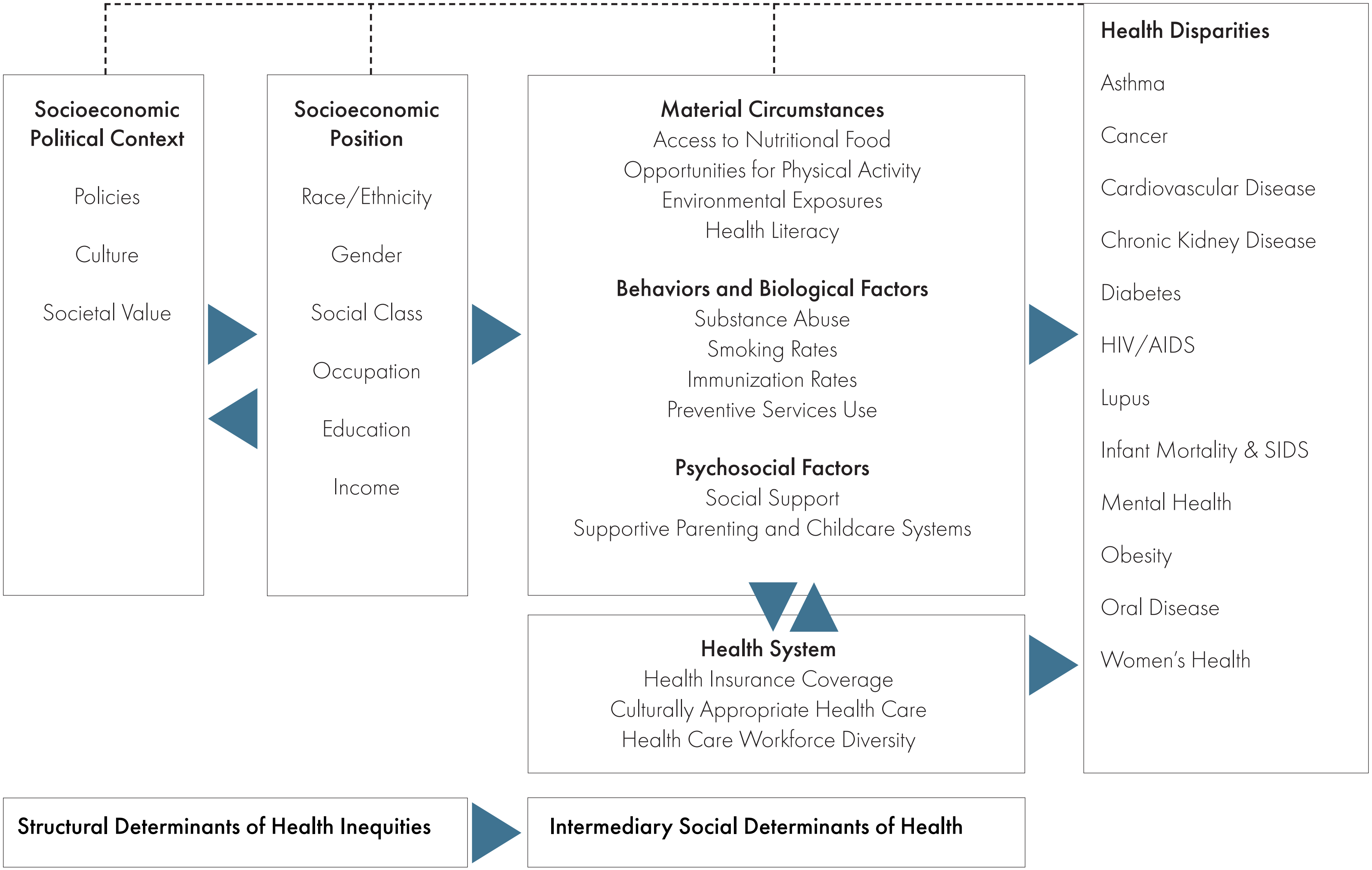
> *"...must address, but is not limited to, the following diseases, conditions, and health indicators: Diabetes, asthma, infant mortality, HIV/AIDS, heart disease, strokes, breast cancer, cervical cancer, prostate cancer, chronic kidney disease, sudden infant death syndrome (SIDS), mental health, women's health issues, smoking cessation, oral disease, and immunization rates of children and senior citizens. The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan."*

The Council recognized that the list of conditions and indicators listed in statute did not include many of the social determinants of health, so in its early years it sought community input about what else should be considered. The conditions and indicators listed in statute along with those informed by the community and added by the Council are included in the framework (Figure 2), which was formally adopted by the Council in 2007.

The framework was adapted from one developed for the Commission on Social Determinants of Health. It demonstrates how structural and social determinants ultimately impact health. The model assumes that those with lower socioeconomic position have less favorable material circumstances, health behaviors, psychosocial factors, and experiences with the health system. The unequal distribution of these social determinants of health constitutes the mechanism by which socioeconomic position generates health disparities.

In adopting the framework, the Council made an intentional decision to listen to the advice from community members and focus on the social determinants of health as a strategy to ultimately address all of the diseases, health conditions, and indicators listed in statute and added by the Council.

FIGURE 2: FRAMEWORK LINKING THE SOCIAL DETERMINANTS OF HEALTH WITH HEALTH DISPARITIES



Why Equity?

Equity differs from equality in that it assumes all communities are not starting from the same place. Achieving equity requires the systematic examination of policies and systems to understand where they may advantage some communities and unfairly burden others. Achieving equity also requires targeting programs and services to historically marginalized communities currently experiencing worse outcomes.

Washington State experiences some of the best outcomes in the nation; however inequities exist for almost every indicator by race/ethnicity, income, education level, and other demographics. For example, in some parts of our state, people who live within the same county may have a difference in life expectancy up to 13 years.[1]

The Council recognizes that our success in life is shaped by our opportunities to make positive choices—unfortunately, we do not all have the same menu of choices to choose from. Equitable policies and programs across sectors (education, transportation, housing, economic development, criminal justice, employment, environment, etc.) create opportunities for all communities to thrive.

Why Government?

Historically, governments and institutions have intentionally created policies to advantage some and disadvantage others.[2] Some of these policies may still exist in total or in part because they have not been systematically dismantled. Today, state policies, programs, and decisions may unintentionally create inequity for a variety of reasons. They may be created without recognizing unintended consequences. Limited public engagement in state decision making and a workforce that does not fully reflect the populations it serves can contribute to such oversights. As an example, Washington State employment applications ask for salary history information. Communities of color, women, and other disadvantaged groups have historically experienced inequitable pay gaps. By asking for salary history on applications, these groups are disadvantaged going into future pay negotiations.

Over the years, the Council has heard from its advisory committees and members of the public, particularly those from communities disproportionately experiencing inequities that we need to address the structural and institutional inequities in our state system as a key strategy to eliminate health inequities. While state government has an important role to play, it cannot reverse all of our state's persisting inequities on its own. Organizations in the non-profit, philanthropic, business, and local government sectors are also working to promote equity and there are opportunities to partner and align efforts.

---

[1] King County Equity and Social Justice Annual Report, December 2015

[2] Bailey et al., (2017). Structural racism and health inequities in the USA: evidence and interventions. The Lancet 389(10077): 1453-1463.

EQUITY IN STATE GOVERNMENT ACTION PLAN

In June 2016, the Council issued a recommendation[3] to promote equity in state government and in this report, it reiterates that recommendation.

Equity in State Government Recommendation: The Governor should consider issuing policy to create a comprehensive initiative to promote equity in state government. Input from diverse communities and Tribes should be gathered and used to inform the creation of the policy. Consideration should be given to lessons learned and recommendations from local equity initiatives and comprehensive frameworks. The Governor's Interagency Council on Health Disparities offers to serve as a resource. The policy should include but not necessarily be limited to the following actions:

- Ensure that diverse racial/ethnic communities, Tribes, low-income communities, and others are included and have a voice in state government decisions.
- Improve access to information and services for people who speak languages other than English.
- Increase the diversity of the state workforce at all levels to reflect the growing diversity of Washington State, including racial/ethnic, language, and disability diversity.
- Improve the cultural humility of the state workforce at all levels to better serve all people in Washington State.
- Assess potential impacts of policy, program, and budget decisions on equity and make necessary changes to maximize benefits and limit harms.
- Improve equity in grant and contracting practices, including increasing the percent of grants and contracts awarded to community based organizations serving diverse communities.
- Ensure that organizations that receive state support are also accountable for promoting equity.
- Promote the exchange of information and best practices to promote equity across state government.
- Collect, analyze, and distribute disaggregated data to uncover and raise awareness of inequities that exist within our state's diverse communities.
- Create performance metrics and track progress in making state government more equitable, such as through Results Washington.

Currently, there are state agency programs implementing best practices and others are testing new strategies to promote equity, however this work is fragmented and inconsistent across state government. The Council believes that a comprehensive, enterprise-wide approach to intentionally consider equity in government policies, programs, and decisions is needed for enduring change to occur.

By taking action to promote equity in state government, race/ethnicity, income, gender, and other demographics will no longer be predictors of state service delivery or outcomes. In other words, by promoting equity in state government we can create equity in the social determinants of health and ultimately eliminate health inequities.

The Council is committing to actions through the remainder of the 2017-2019 biennium in order to support coordination and exchange of information and best practices toward the implementation of its equity in state government recommendations (Appendix, Table 1). In addition, state agencies with representation on the Council have also committed to implementing strategies to promote equity. These commitments are outlined in Tables 2-7 in the appendix, which include the specific strategies to be implemented, performance measures, and the agencies that have committed to each strategy.

---

[3] Governor's Interagency Council on Health Disparities' June 2016 report (see pages 8-9)

COMMUNITY ENGAGEMENT

Over the years the Council has heard from advisory committee members or through comments at public testimony or community forums that the state could improve its efforts with community engagement. The Council has heard multiple suggestions for how the state could improve its outreach to the community and these suggestions have been documented in past reports. The Council has also heard about and experienced policy and process barriers that hinder meaningful community engagement, particularly as it relates to participation on boards and commissions and community advisory committees. At its May 2017 meeting, the Council directed staff to conduct an assessment to identify policy and process barriers, which might require policy change, and to develop recommendations for the Council's consideration.

Council staff reviewed relevant materials including statues, policies, procedures, forms, and websites. Staff reviewed statutes related to compensating members of part-time boards and commissions (RCW 43.03.220), reimbursing members of boards and commissions (RCW 43.03.050), and reimbursement for mileage (RCW 43.03.060). Other applicable documents reviewed included:

- Travel policies in the State Administrative & Accounting Manual issued by the Office of Financial Management.
- Engrossed Second Substitute House Bill 1371 (2011-2012), which places restrictions on allowances and travel for members of boards, commissions, councils, and committees identified as class one through class three and class five.
- The July 2011 memo from the Office of Financial Management regarding travel allowances for class one, two, three, and five groups.
- The Office of Financial Management webpage dedicated to travel expenses for boards and commissions.
- The Department of Enterprise Services webpage dedicated to receiving payment from the State.
- Governor Inslee's Executive Order 17-01—Reaffirming Washington State's Commitment to Tolerance, Diversity, and Inclusiveness.

After gaining an understanding of the current landscape, staff then engaged with staff in key agencies to better understand how these policies and procedures impact organizations in practice. Feedback was received from the Washington State Commission on Hispanic Affairs, Washington State Commission on Asian Pacific American Affairs, the Office of Financial Management, the Department of Enterprise Services, and the Governor's Office.

Community Engagement Recommendations

1. **Community Engagement Recommendation 1** (for the Governor's Office): Remove application questions for boards and commissions about an applicant's citizenship status and criminal history. Use these questions only as additional screening questions for successful candidates and only for those boards and commissions as required by statute. Some boards and commissions require by statute the consideration of an applicant's citizenship status in the appointment process. However, there are a number of appointments that do not require this information and stakeholders indicated that non-citizens have been appointed in the past. Stakeholders also indicated that having a criminal record does not necessarily disqualify an applicant from appointment consideration and staff work with applicants to understand the context of the situation. Therefore, in order to encourage diverse applicant pools and to ensure consistency with Executive Order 17-01, which prohibits state agencies from conditioning provision of services or benefits upon a resident's immigration status (unless required by law), the Council recommends removing questions about citizenship and criminal history from the initial board and commission application. Instead, the Council recommends that they be considered only on a case by case basis and only as required by statute.

2. **Community Engagement Recommendation 2** (for the Legislature): Ensure that reimbursements are provided for subsistence, lodging, and travel for non-legislative members of work groups or task forces that are created by the Legislature. When the Legislature creates a task force or work group, reimbursement for subsistence, lodging, and travel are not always provided for non-legislative members. This often leaves the burden of reimbursement with the agency or organization that the member is representing. Council staff heard from boards and commissions that due to budgetary constraints they are often unable to send representatives to all of the meetings that they are invited to participate in. The lack of dedicated funding can be a particular barrier for small boards and commissions with limited budgets, such as the racial/ethnic commissions, which are often charged with identifying representatives to serve on task forces and work groups. Moreover, these public representatives are often selected because they are primary members of historically marginalized groups, and by definition, may lack resources necessary to participate. Therefore, the Council recommends that the Legislature consistently provide funding for subsistence, lodging, and travel expenses for all public members appointed to work groups and task forces.

3. **Community Engagement Recommendation 3** (for the Legislature): Eliminate the prohibition of using State General Fund dollars to reimburse members of boards, commissions, councils, and committees identified as class one through three and class five for travel. Currently, members of class one through three and class five boards, commissions, councils and committees are not allowed to receive an allowance for travel and related expenses if the cost is funded by the State General Fund. However, there are processes in place that allow for exemptions if the expenses are related to the critically necessary work of an agency. The process for receiving an exemption is outlined on the Office of Financial Management's website and it requires most agencies and organizations to submit an exemption form for approval that is signed by the agency director or group leader. This process creates an unnecessary administrative burden and if an agency finds the work critically necessary, and has the budget to provide for their members, it should be standard of practice that a reimbursement may be provided. Staff from the Office of Financial Management indicate that they receive about 20 requests per year and they have yet to deny a request. Therefore, the Council recommends that the Legislature rescind the prohibition for using State General Fund dollars to reimburse travel expenses for members of class one through class three and class five groups.

4. **Community Engagement Recommendation 4** (for the Department of Enterprise Services): Investigate alternate ways to reimburse community members for participation that do not require a social security number. In order for a community member to be reimbursed by a state agency they must register with the Statewide Payee Desk at the Department of Enterprise Services by filling out a registration form, which requires either a social security number or an employer identification number. Requiring a social security number may prohibit meaningful engagement from individuals that are unable to provide this information and for whom the costs associated with participation, such as travel, are prohibitive. Moreover, it is not consistent with the intent of Executive Order 17-01, which prohibits state agencies from conditioning provision of services or benefits upon a resident's immigration status (unless required by law). The Council recommends the Department of Enterprise Services critically examine the necessity of requiring a social security number for reimbursement and explore alternate ways that reimbursement could be provided without this stipulation.

COUNCIL MEMBERSHIP

The Council has 17 members: a chair appointed by the Governor; representatives of 14 state agencies, boards, and commissions; and two members of the public who represent health care consumers. A list of current Council members is provided below.

Governor's Representative and Council Chair	Benjamin Danielson
Consumer Representative and Council Vice Chair	Frankie T. Manning
Consumer Representative	Vacant
Commission on African American Affairs	Sara Franklin
Commission on Asian Pacific American Affairs	Lori Wada
Commission on Hispanic Affairs	Nora Coronado Diana Lindner (alternate)
Department of Agriculture	Jill Wisehart
Department of Commerce	Diane Klontz Kendrick Stewart (alternate)
Department of Early Learning	Greg Williamson
Department of Ecology	Millie Piazza John Ridgway (alternate)
Department of Health	Paj Nandi Gail Brandt (alternate)
Department of Social and Health Services	Marietta Bobba
American Indian Health Commission[4]	Willie Frank Jan Olmstead (alternate)
Health Care Authority	Jessie Dean
Office of Superintendent of Public Instruction	Mona Johnson
State Board of Health	Stephen Kutz
Workforce Training and Education Coordinating Board	Patrick Woods

---

[4] The Governor's Office of Indian Affairs delegated authority to the American Indian Health Commission to appoint a representative to the Council.

APPENDIX

Agencies' Action Plan to Promote Equity in State Government

(Timeline – Through June 2019)

TABLE 1: COORDINATION AND EXCHANGE OF INFORMATION AND BEST PRACTICES: STRATEGIES TO BE IMPLEMENTED BY THE GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

STRATEGY	PERFORMANCE MEASURE
1.1 Compile existing information, tools, and resources to assist agencies in promoting equity and post to Council's website.	Number of resources posted to Council website
1.2 Create an equity work plan template with sample strategies and performance measures.	Date template created
1.3 Convene the Interagency Equity Workgroup to facilitate exchange of information, sharing of best practices, and identification of opportunities for collaboration across state government.	Number of meetings
1.4 Connect with organizations in the non-profit, philanthropic, business, and local government sectors who are also working to promote equity to identify opportunities to align efforts.	Number of organizations contacted

APPENDIX (CONT'D)

TABLE 2: COMMUNITY ENGAGEMENT

STRATEGY	PERFORMANCE MEASURE	AGENCIES
2.1 Adopt a community engagement guide aimed at creating opportunities for public input and feedback on programs, services, policies, and decisions.	Date community engagement guide adopted	Dept. of Commerce Dept. of Early Learning Dept. of Ecology Dept. of Health Workforce Board
2.2 Explore with Board members the establishment of an agency equity policy and adopt an agency manual on equity activities	Receive direction from Board on the adoption of a policy and development of agency manual on equity. If adopted share with other agencies.	Workforce Board
2.3 Increase staff time at community-driven events.	Number of events attended	Dept. of Commerce State Board of Health
2.4 Provide assistive community technology	Increase the number of locations that serve the public and clients with assistive listening systems from 140 in July 2017 to 200 in June 2018.	Dept. of Social & Health Svc. (Aging and Long Term Care)
2.5 Expand case management services	Increase the number of clients served by the Regional Service Centers of the Deaf, Deafblind, Deaf Plus, hard of hearing and late deafened from 500 in June 2017 to 600 by June 2018.	Dept. of Social & Health Svc. (Aging and Long Term Care)
2.6 Actively pursue actions to work in collaboration and consultation with American Indian tribes and American Indian organizations.	TBD	Dept. of Social & Health Svc. (Economic Svc.) Health Care Authority
2.7 Increase public safety by identifying and addressing policies and procedures that lead to racial and ethnic disparities in the juvenile justice system.	Decrease the percentage of youth of color in detention from 46% in June 2017 to 39% by June 2019.	Dept. of Social & Health Svc. (Rehabilitation Admin.)
2.8 Provide technical assistance to DSHS's Children's Administration, Behavioral Health Administration, Department of Children, Youth and Families, and tribes regarding coordination to update area agreements.	Develop or update Memorandums of Agreement with federally recognized tribes by June 2018.	Dept. of Social & Health Svc. (Svc. & Enterprise Support)
2.9 Assist the Economic Services Administration in developing and updating intergovernmental agreements with all tribes who operate TTANF Families.	Develop or update the number of intergovernmental agreements with tribes from 11 agreements to 16 agreements by June 2018.	Dept. of Social & Health Svc. (Svc. & Enterprise Support)
2.10 Embed racial equity into Early Childhood Education and Assistance Program expansion plan, develop a tribal framework, and promote culturally and linguistically responsive services.	TBD	Dept. of Early Learning (Early Childhood Education and Assistance Program)

APPENDIX (CONT'D)

TABLE 3: LANGUAGE ACCESS

STRATEGY	PERFORMANCE MEASURE	AGENCIES
3.1 Conduct a four-factor analysis to identify vital documents and needed languages.	% of programs that have conducted a four-factor analysis	Dept. of Ecology Dept. of Health
3.2 Develop a plan to prioritize and translate vital documents.	% of vital documents that have been translated	Dept. of Ecology Dept. of Health Office of Superintendent of Public Instruction
3.3 Conduct a language access assessment of all customer points of contact.	Date assessment conducted	Dept. of Health Office of Superintendent of Public Instruction
3.4 Develop and implement a plan to ensure all customer points of contact are linguistically accessible.	% of customer points of contact that are linguistically accessible	Dept. of Health Office of Superintendent of Public Instruction
3.5 Adopt a written language access policy and plan.	Date policy/plan adopted	Dept. of Ecology Dept. of Health
3.6 Increase awareness of available resources for communicating with Limited English Proficiency customers.	TBD	Dept. of Agriculture Dept. of Ecology Office of Superintendent of Public Instruction
3.7 Continue distribution of non-English translations of information.	TBD	Dept. of Agriculture Dept. of Ecology
3.8 Develop IT plan for compliance with Web Content Accessibility Guidelines.	Date plan completed	Dept. of Agriculture Dept. of Ecology Office of Superintendent of Public Instruction
3.9 Establish agency requirements for all staff completion of CLAS Standards training. Expand quality assurance policies and procedures administration-wide to incorporate CLAS. Develop training plans for onboarding new employees and existing staff on CLAS. Ensure communications from DSHS are ADA-accessible for the deaf and hard of hearing.	Complete all items by June 2019	Dept. of Social & Health Svc. (Aging and Long Term Care) Health Care Authority
3.10 Translate forms and instructions for fiscal vendors into multiple languages.	TBD	Dept. of Early Learning
3.11 Provide equitable licensing caseloads and compensation for dual language licensors.	TBD	Dept. of Early Learning (Licensing)
3.12 Develop Language Access Services training for agency staff.	Date of training completion	Dept. of Ecology
3.13 Develop and train staff on language data mapping tools.	Date of completion	Dept. of Ecology

TABLE 4: WORKFORCE DIVERSITY

STRATEGY	PERFORMANCE MEASURE	AGENCIES
4.1 Require that all hiring supervisors have gender and racial/ethnic diversity on interview panels.	% of interview panels that include gender and racial/ethnic diversity.	Dept. of Health State Board of Health
4.2 Require that all hiring panels complete "countering bias" training prior to interviews.	% of hiring panels that complete "countering bias" training.	Dept. of Early Learning Dept. of Health Health Care Authority State Board of Health
4.3 Require that position descriptions be reviewed to assess whether higher education requirements are necessary.	% of position descriptions reviewed.	Dept. of Commerce Dept. of Health Dept. of Ecology Health Care Authority State Board of Health Office of Superintendent of Public Instruction
4.4 Adopt an agency policy to encourage the formation of employee resource groups as a strategy to promote retention among diverse staff.	Date policy adopted	Dept. of Commerce Dept. of Health Dept. of Early Learning Health Care Authority
4.5 Implement coaching for hiring managers and panels.	TBD	Dept. of Early Learning Dept. of Ecology
4.6 Update and adhere to agency policy regarding affirmative action and equal employment opportunity.	TBD	Dept. of Agriculture Dept. of Ecology Office of Superintendent of Public Instruction
4.7 Continue adherence to agency policy regarding providing employees with reasonable accommodation.	TBD	Dept. of Agriculture Dept. of Ecology Health Care Authority Office of Superintendent of Public Instruction
4.8 Use targeted recruitments, outreach resources, and creative job announcements.	TBD	Dept. of Agriculture Dept. of Ecology Office of Superintendent of Public Instruction
4.9 Support hiring managers in thinking outside the box when advertising vacancies.	TBD	Dept. of Agriculture Dept. of Ecology
4.10 Adhere to agency policy and support diversity and affirmative action goals regarding recruitment for WMS positions.	TBD	Dept. of Agriculture Dept. of Ecology

APPENDIX (CONT'D)

TABLE 4: WORKFORCE DIVERSITY (CONT'D)

4.11 Continue to make developmental job assignments and leadership development available, and use processes such as job shadowing that provide diverse employees opportunities to serve in leadership roles.	TBD	Dept. of Agriculture Dept. of Ecology
4.12 Participate in job/career fairs and diverse employee resource groups.	TBD	Dept. of Agriculture Dept. of Ecology
4.13 Gather and analyze recruitment and retention data based on diversity and identify activities to address disparities.	Improve employee retention rate from 96.2% to 87% by June 2018	Dept. of Social & Health Svc. (Aging and Long Term Care)
4.14 Develop a Community of Practice that includes executive leadership and staff to identify gaps in Equity/Diversity/Inclusion (EDI). Establish a workgroup to explore collection of sexual orientation and gender identify data. Identify population shifts, services used, and the forecast for the future need for services by a diverse aging state population.	Embed EDI principles throughout the organization planning and operations as measured by completion of items by June 2019.	Dept. of Social & Health Svc. (Aging and Long Term Care) Health Care Authority
4.15 Develop a tangible and proactive EDI program that will lead to healthier outcomes for patients and a supportive, productive environment for employees.	Complete by June 2019	Dept. of Social & Health Svc. (Behavioral Health Admin.)
4.16 Initiate local conversations on EDI in the workplace through summits and establishing a community of practice. Provide a report to leadership that advises the state of EDI work in Children's Administration.	Develop a baseline understanding of Children's Administration's successes and barriers to better supporting fairness, difference, and inclusion in the workplace by June 2018.	Dept. of Social & Health Svc. (Children's Admin.)
4.17 Include a goal of completing cultural humility training in supervisor's annual performance plan.	Ensure 90 supervisors complete cultural humility training by July 2019.	Dept. of Social & Health Svc. (Developmental Disabilities)
4.18 Implement initiatives developed by the Administration's EDI community of practice. Provide clear and consistent leadership support to EDI events and initiatives. Support the Department's five areas of EDI focus and initiatives.	Increase employee responses of "always" or "usually" to the question "my agency consistently demonstrates support for a diverse workforce" by 2% on the 2019 DSHS Employee Survey.	Dept. of Social & Health Svc. (Economic Services)
4.19 Provide consultation on implementation of community of practice and EDI topic-specific resources and support to each Rehabilitation Administration program.	Establish a community of practice in each program within Rehabilitation Administration that will meet quarterly to access policies, practices, and procedures to ensure effective implementation of EDI by June 2018.	Dept. of Social & Health Svc. (Rehabilitation Admin.)

APPENDIX (CONT'D)

TABLE 4: WORKFORCE DIVERSITY (CONT'D)

4.20 Develop a workforce profile template. Create strategies for recruitment, retention, learning, development, and career mapping based on analysis of data in the workforce profile.	Create a workforce profile by December 2018.	Dept. of Social & Health Svc. (Svc. and Enterprise Support)
4.21 Identify committee members from each administration and develop committee work plan. Assist with development and implementation of the access plans.	Establish a language access plan and an American with Disabilities Act access plan by December 2018.	Dept. of Social & Health Svc. (Svc. and Enterprise Support)
4.22 Identify themes, develop best practice guidelines/manuals/ toolkits for agency-wide implementation. Assist each administration with implementation.	Integrate the results of the initial Certified Diversity Professionals and Certified Diversity Executives cohort EDI group projects into administrations by June 2019.	Dept. of Social & Health Svc. (Svc. and Enterprise Support)
4.23 Provide support and guidance for the communities of practice. Assist leaders with development of a communication strategy to plan and promote communities of practice. Provide leaders with a sustainability framework and assist with a plan for ongoing employee participation.	Establish EDI community of practice groups in every administration by June 2018.	Dept. of Social & Health Svc. (Svc. and Enterprise Support)
4.24 Develop an onboarding checklist to help new hires transition into their jobs and to engage with our agency and its mission, in coordination with the FSA Team Satisfaction Objective.	Complete a standardized onboarding program for new FSA employees by June 30, 2018.	Dept. of Social & Health Svc. (Financial Svc.)
4.25 Monitor and report attendance for basic supervisory trainings. Add trainings as an expected performance item in each supervisor's PDP.	Increase manager and supervisor attendance at basic supervisory trainings to 90% by June 30, 2019.	Dept. of Social & Health Svc. (Financial Svc.)
4.26 Conduct a brief diversity and inclusion survey of employees to serve as a baseline from which to measure FSA's progress on EDI.	Establish baseline EDI data by way of a FSA assessment by June 30, 2018.	Dept. of Social & Health Svc. (Financial Svc.)
4.27 Provide training and tools for supporting equity and inclusion.	TBD	Dept. of Early Learning Dept. of Ecology
4.28 Embed racial equity lens in the Workforce Council Compensation work group efforts. Target scholarships and hire bilingual staff.	TBD	Dept. of Early Learning
4.29 Develop apprenticeships for high school and college students and awareness and recruitment efforts focused on underrepresented people in state government, including women, veterans, and communities of color.	Number of apprenticeships established and filled.	Health Care Authority

APPENDIX (CONT'D)

TABLE 5: WORKFORCE CULTURAL HUMILITY

STRATEGY	PERFORMANCE MEASURE	AGENCIES
5.1 Incorporate cultural humility into staff performance and development plans (PDP) as a key competency.	% of staff with cultural humility incorporated into PDPs	Dept. of Health State Board of Health
5.2 Create requirements for staff to obtain initial and ongoing cultural humility training.	% of staff completing cultural humility training	Dept. of Early Learning Dept. of Ecology Dept. of Health State Board of Health Office of Superintendent of Public Instruction
5.3 Create requirements for staff to take government-to-government training.	% of staff completing government-to-government training	Dept. of Commerce Dept. of Ecology Dept. of Health Health Care Authority State Board of Health
5.4 Support select staff to obtain diversity certification through an accredited organization so they can lead cultural humility education and training efforts in the agency.	# of staff certified by an accredited organization	Dept. of Commerce Dept. of Health
5.5 Provide education and training to DSHS staff and providers to better serve residents and clients.	Increase the number of DSHS and service-provider sites where education and training in communication access modalities for people who are deaf and hard of hearing is provided from 4 in 2017 to 25 by June 2018.	Dept. of Social & Health Svc. (Aging and Long Term Care)
5.6 Increase the skills, awareness, and engagement of Behavioral Health Administration in EDI.	Increase the percentage of Behavioral Health Administration managers and supervisors who have completed training in EDI from 44% to 75% by July 2019.	Dept. of Social & Health Svc. (Behavioral Health)
5.7 Add a requirement to complete at least one DSHS EDI training during the biennium to Developmental Disabilities Administration employee performance plans.	Increase the percentage of Developmental Disabilities Administration employees who complete EDI training to 95% by June 2019.	Dept. of Social & Health Svc. (Developmental Disabilities)
5.8 Ensure all staff has the opportunity to attend Race, Power of an Illusion training to increase awareness of historical issues around institutional racism.	TBD	Dept. of Social & Health Svc. (Rehabilitation Admin.)
5.9 Provide technical assistance to the Department and partners as they develop capacity around government-to-government relations, especially around social services provision and contracting.	Fully integrate tribal/state consultation policy and capacity at Department of Children Youth and Families by June 2019.	Dept. of Social & Health Svc. (Svc. and Enterprise Support)
5.10 Provide ongoing training and opportunities for color-brave conversations.	TBD	Dept. of Early Learning

APPENDIX (CONT'D)

TABLE 6: EQUITY ASSESSMENT

STRATEGY	PERFORMANCE MEASURE	AGENCIES
6.1 Include questions about potential equity impacts on bill analysis forms.	% of bill analyses conducted that included an equity assessment	Dept. of Early Learning Dept. of Health Health Care Authority State Board of Health
6.2 Incorporate questions about potential equity impacts into decision package processes.	% of decision packages created that included an equity assessment	Dept. of Early Learning Dept. of Health Health Care Authority State Board of Health Office of Superintendent of Public Instruction
6.3 Incorporate questions about potential equity impacts into rulemaking processes.	% of rules adopted that included an equity assessment	Dept. of Early Learning Dept. of Ecology Dept. of Health Health Care Authority
6.4 Incorporate questions about potential equity impacts into project development processes.	Number of projects developed that included an equity assessment	Dept. of Early Learning Dept. of Health Health Care Authority
6.5 Incorporate questions about potential equity impacts into budgeting processes.	Number of budgeting processes that incorporated an equity assessment	Dept. of Early Learning Dept. of Health Health Care Authority
6.6 Explore with the Board the development of a presentation template that includes potential equity impacts into the decision making process.	Receive direction from the Board on adoption of presentation template	Workforce Board

APPENDIX (CONT'D)

TABLE 7: DATA

STRATEGY	PERFORMANCE MEASURE	AGENCIES
7.1 Complete a data inventory to identify client, service provider, and outcome data collected by the agency.	Date inventory completed	Dept. of Commerce Dept. of Early Learning
7.2 Identify opportunities and create a plan to enhance the collection of demographics data and the level to which data are disaggregated.	Date plan completed	Dept. of Commerce Health Care Authority Office of Superintendent of Public Instruction Workforce Board
7.3 Analyze data on clients, providers, and service outcomes by race/ethnicity, language, and/or other demographics to identify and address gaps and inequities.	Date assessment report completed	Dept. of Commerce Health Care Authority Office of Superintendent of Public Instruction
7.4 Report state-level student education outcomes for more detailed ethnic/race categories, as collected within its student data system. The disaggregated sub-ethnic categories can be found in the 2017 Race and Ethnicity Student Data: Guidance for Washington's Public Education System	Annual School Report Cards, Education Data System (Administration and Student Record Exchange), and Comprehensive Education Data and Research System (CEDARS)	Office of Superintendent of Public Instruction
7.5 Establish a 90 percent minimum graduation rate for each subgroup.[5]	Annual School Report Cards, Education Data System (Administration and Student Record Exchange), and Comprehensive Education Data and Research System (CEDARS)	Office of Superintendent of Public Instruction
7.6 Continue to add technology and other tools to offices statewide to assist individuals who are deaf and hard of hearing to have real time notification of incidents and emergencies occurring in their work area and common areas of state office buildings.	TBD	Dept. of Social & Health Svc.
7.7 Maintain and promulgate use of reporting standards to disaggregate published analyses by race, ethnicity, age, and gender.	TBD	Dept. of Social & Health Svc. Health Care Authority
7.8 Ensure Department of Early Learning collection and reporting data can be disaggregated by race and ethnicity consistently using the ERDC guidelines. Early Childhood Education and Assistance Program, Managed Education and Registry Information Tool, and Early Support for Infants and Toddlers now, and Working Child Care Connections is next.	TBD	Dept. of Early Learning
7.9 Embed racial equity lens into the Administrative Data Project and framework for performance-based contracting.	TBD	Dept. of Early Learning

---

[5] Washington's long-term goals in high school will place the focus on closing gaps in graduation rates by subgroup (gender, grade level, ethnicity, eligibility for free and reduced lunch, special education and English Language Learners (ELL). In 10 years, no subgroup within a school will graduate at a rate less than 90 percent. Schools and subgroups currently graduating at a rate exceeding 90 percent will be expected to demonstrate continuous progress toward all students graduating. Schools and subgroups not graduating at 90 percent will have annual, interim targets set toward reaching that goal.

striving to eliminate health disparities in washington state

HEALTH EQUITY

Governor's Interagency Council on Health Disparities

healthequity@sboh.wa.gov / www.healthequity.wa.gov / facebook/WAHealthEquity / twitter/WAHealthEquity

The New York Times Magazine | https://nyti.ms/2GRP4if

Why America’s Black Mothers and Babies Are in a Life-or-Death Crisis

The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.

By LINDA VILLAROSA APRIL 11, 2018

When Simone Landrum felt tired and both nauseated and ravenous at the same time in the spring of 2016, she recognized the signs of pregnancy. Her beloved grandmother died earlier that year, and Landrum felt a sense of divine order when her doctor confirmed on Muma’s birthday that she was carrying a girl. She decided she would name her daughter Harmony. “I pictured myself teaching my daughter to sing,” says Landrum, now 23, who lives in New Orleans. “It was something I thought we could do together.”

But Landrum, who was the mother of two young sons, noticed something different about this pregnancy as it progressed. The trouble began with constant headaches and sensitivity to light; Landrum described the pain as “shocking.” It would have been reasonable to guess that the crippling headaches had something to do with stress: Her relationship with her boyfriend, the baby’s father, had become increasingly contentious and eventually physically violent. Three months into her pregnancy, he became angry at her for wanting to hang out with friends and threw her to the ground outside their apartment. She scrambled to her feet, ran inside and called the police. He continued to pursue her, so she grabbed a knife. “Back up — I have a baby,” she screamed. After the police arrived, he was arrested and charged with multiple offenses, including battery. He was released on bond pending a trial that would not be held until the next year. Though she had broken up with him several times, Landrum took him back, out of love and also out of fear that she couldn't support herself, her sons and the child she was carrying on the paycheck from her waitress gig at a restaurant in the French Quarter.

As her January due date grew closer, Landrum noticed that her hands, her feet and even her face were swollen, and she had to quit her job because she felt so ill. But her doctor, whom several friends had recommended and who accepted Medicaid, brushed aside her complaints. He recommended Tylenol for the headaches. "I am not a person who likes to take medicine, but I was always popping Tylenol," Landrum says. "When I told him my head still hurt, he said to take more."

At a prenatal appointment a few days before her baby shower in November, Landrum reported that the headache had intensified and that she felt achy and tired. A handwritten note from the appointment, sandwiched into a printed file of Landrum's electronic medical records that she later obtained, shows an elevated blood-pressure reading of 143/86. A top number of 140 or more or a bottom number higher than 90, especially combined with headaches, swelling and fatigue, points to the possibility of pre-eclampsia: dangerously high blood pressure during pregnancy.

High blood pressure and cardiovascular disease are two of the leading causes of maternal death, according to the Centers for Disease Control and Prevention, and hypertensive disorders in pregnancy, including pre-eclampsia, have been on the rise over the past two decades, increasing 72 percent from 1993 to 2014. A Department of Health and Human Services report last year found that pre-eclampsia and eclampsia (seizures that develop after pre-eclampsia) are 60 percent more common in African-American women and also more severe. Landrum's medical records note that she received printed educational material about pre-eclampsia during a prenatal visit. But Landrum would comprehend the details about the disorder only months later, doing online research on her own.

When Landrum complained about how she was feeling more forcefully at the appointment, she recalls, her doctor told her to lie down — and calm down. She says that he also warned her that he was planning to go out of town and told her that he could deliver the baby by C-section that day if she wished, six weeks before her early-January due date. Landrum says it seemed like an ultimatum, centered on his schedule and convenience. So she took a deep breath and lay on her back for 40 minutes until her blood pressure dropped within normal range. Aside from the handwritten note, Landrum’s medical records don’t mention the hypertensive episode, the headaches or the swelling, and she says that was the last time the doctor or anyone from his office spoke to her. “It was like he threw me away,” Landrum says angrily.

Four days later, Landrum could no longer deny that something was very wrong. She was suffering from severe back pain and felt bone-tired, unable to get out of bed. That evening, she packed a bag and asked her boyfriend to take her sons to her stepfather’s house and then drive her to the hospital. In the car on the way to drop off the boys, she felt wetness between her legs and assumed her water had broken. But when she looked at the seat, she saw blood. At her stepfather’s house, she called 911. Before she got into the ambulance, Landrum pulled her sons close. “Mommy loves you,” she told them, willing them to stay calm. “I have to go away, but when I come back I will have your sister.”

By the time she was lying on a gurney in the emergency room of Touro Infirmary, a hospital in the Uptown section of New Orleans, the splash of blood had turned into a steady stream. “I could feel it draining out of me, like if you get a jug of milk and pour it onto the floor,” she recalls. Elevated blood pressure — Landrum’s medical records show a reading of 160/100 that day — had caused an abruption: the separation of the placenta from her uterine wall.

With doctors and nurses hovering over her, everything became both hazy and chaotic. When a nurse moved a monitor across her belly, Landrum couldn’t hear a heartbeat. “I kept saying: ‘Is she O.K.? Is she all right?’ ” Landrum recalls. “Nobody said a word. I have never heard a room so silent in my life.” She remembers that the emergency-room doctor dropped his head. Then he looked into her eyes. “He told me my baby was dead inside of me. I was like: What just happened? Is this a dream? And then I turned my head to the side and threw up.”

Sedated but conscious, Landrum felt her mind growing foggy. “I was just so tired,” she says. “I felt like giving up.” Then she pictured the faces of her two young sons. “I thought, Who’s going to take care of them if I’m gone?” That’s the last thing she recalls clearly. When she became more alert sometime later, a nurse told her that she had almost bled to death and had required a half dozen units of transfused blood and platelets to survive. “The nurse told me: ‘You know, you been sick. You are very lucky to be alive,’ ” Landrum remembers. “She said it more than once.”

A few hours later, a nurse brought Harmony, who had been delivered stillborn via C-section, to her. Wrapped in a hospital blanket, her hair thick and black, the baby looked peaceful, as if she were dozing. “She was so beautiful — she reminded me of a doll,” Landrum says. “I know I was still sedated, but as I held her, I kept looking at her, thinking, Why doesn’t she wake up? I tried to feel love, but after a while I got more and more angry. I thought, Why is God doing this to me?”

The hardest part was going to pick up her sons empty-handed and telling them that their sister had died. “I felt like I failed them,” Landrum says, choking up. “I felt like someone had taken something from me, but also from them.”

In 1850, when the death of a baby was simply a fact of life, and babies died so often that parents avoided naming their children before their first birthdays, the United States began keeping records of infant mortality by race. That year, the reported black infant-mortality rate was 340 per 1,000; the white rate was 217 per 1,000. This black-white divide in infant mortality has been a source of both concern and debate for over a century. In his 1899 book, “The Philadelphia Negro,” the first sociological case study of black Americans, W.E.B. Du Bois pointed to the tragedy of black infant death and persistent racial disparities. He also shared his own “sorrow song,” the death of his baby son, Burghardt, in his 1903 masterwork, “The Souls of Black Folk.”

From 1915 through the 1990s, amid vast improvements in hygiene, nutrition, living conditions and health care, the number of babies of all races who died in the first year of life dropped by over 90 percent — a decrease unparalleled by reductions in other causes of death. But that national decline in infant mortality has since slowed. In 1960, the United States was ranked 12th among developed countries in infant mortality. Since then, with its rate largely driven by the deaths of black babies, the United States has fallen behind and now ranks 32nd out of the 35 wealthiest nations. Low birth weight is a key factor in infant death, and a new report released in March by the Robert Wood Johnson Foundation and the University of Wisconsin suggests that the number of low-birth-weight babies born in the United States — also driven by the data for black babies — has inched up for the first time in a decade.

Black infants in America are now more than twice as likely to die as white infants — 11.3 per 1,000 black babies, compared with 4.9 per 1,000 white babies, according to the most recent government data — a racial disparity that is actually wider than in 1850, 15 years before the end of slavery, when most black women were considered chattel. In one year, that racial gap adds up to more than 4,000 lost black babies. Education and income offer little protection. In fact, a black woman with an advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education.

This tragedy of black infant mortality is intimately intertwined with another tragedy: a crisis of death and near death in black mothers themselves. The United States is one of only 13 countries in the world where the rate of maternal mortality — the death of a woman related to pregnancy or childbirth up to a year after the end of pregnancy — is now worse than it was 25 years ago. Each year, an estimated 700 to 900 maternal deaths occur in the United States. In addition, the C.D.C. reports more than 50,000 potentially preventable near-deaths, like Landrum’s, per year — a number that rose nearly 200 percent from 1993 to 2014, the last year for which statistics are available. Black women are three to four times as likely to die from pregnancy-related causes as their white counterparts, according to the C.D.C. — a disproportionate rate that is higher than that of Mexico, where nearly half the population lives in poverty — and as with infants, the high numbers for black women drive the national numbers.

Monica Simpson is the executive director of SisterSong, the country’s largest organization dedicated to reproductive justice for women of color, and a member of the Black Mamas Matter Alliance, an advocacy group. In 2014, she testified in Geneva before the United Nations Committee on the Elimination of Racial Discrimination, saying that the United States, by failing to address the crisis in black maternal mortality, was violating an international human rights treaty. After her testimony, the committee called on the United States to “eliminate racial disparities in the field of sexual and reproductive health and standardize the data-collection system on maternal and infant deaths in all states to effectively identify and address the causes of disparities in maternal- and infant-mortality rates.” No such measures have been forthcoming. Only about half the states and a few cities maintain maternal-mortality review boards to analyze individual cases of pregnancy-related deaths. There has not been an official federal count of deaths related to pregnancy in more than 10 years. An effort to standardize the national count has been financed in part by contributions from Merck for Mothers, a program of the pharmaceutical company, to the CDC Foundation.

The crisis of maternal death and near-death also persists for black women across class lines. This year, the tennis star Serena Williams shared in Vogue the story of the birth of her first child and in further detail in a Facebook post. The day after delivering her daughter, Alexis Olympia, via C-section in September, Williams experienced a pulmonary embolism, the sudden blockage of an artery in the lung by a blood clot. Though she had a history of this disorder and was gasping for breath, she says medical personnel initially ignored her concerns. Though Williams should have been able to count on the most attentive health care in the world, her medical team seems to have been unprepared to monitor her for complications after her cesarean, including blood clots, one of the most common side effects of C-sections. Even after she received treatment, her problems continued; coughing, triggered by the embolism, caused her C-section wound to rupture. When she returned to surgery, physicians discovered a large hematoma, or collection of blood, in her abdomen, which required more surgery. Williams, 36, spent the first six weeks of her baby’s life bedridden.

The reasons for the black-white divide in both infant and maternal mortality have been debated by researchers and doctors for more than two decades. But recently there has been growing acceptance of what has largely been, for the medical establishment, a shocking idea: For black women in America, an inescapable atmosphere of societal and systemic racism can create a kind of toxic physiological stress, resulting in conditions — including hypertension and pre-eclampsia — that lead directly to higher rates of infant and maternal death. And that societal racism is further expressed in a pervasive, longstanding racial bias in health care — including the dismissal of legitimate concerns and symptoms — that can help explain poor birth outcomes even in the case of black women with the most advantages.

“Actual institutional and structural racism has a big bearing on our patients’ lives, and it’s our responsibility to talk about that more than just saying that it’s a problem,” says Dr. Sanithia L. Williams, an African-American OB-GYN in the Bay Area and a fellow with the nonprofit organization Physicians for Reproductive Health. “That has been the missing piece, I think, for a long time in medicine.”

After Harmony’s death, Landrum’s life grew more chaotic. Her boyfriend blamed her for what happened to their baby and grew more abusive. Around Christmas 2016, in a rage, he attacked her, choking her so hard that she urinated on herself. “He said to me, ‘Do you want to die in front of your kids?’ ” Landrum said, her hands shaking with the memory.

Then he tore off her clothes and sexually assaulted her. She called the police, who arrested him and charged him with second-degree rape. Landrum got a restraining order, but the district attorney eventually declined to prosecute. She also sought the assistance of the New Orleans Family Justice Center, an organization that provides advocacy and support for survivors of domestic violence and sexual assault. Counselors secreted her and her sons to a safe house, before moving them to a more permanent home early last year.

Landrum had a brief relationship with another man and found out in March 2017 that she was pregnant again and due in December. “I’m not going to lie; though I had a lot going on, I wanted to give my boys back the sister they had lost, ” Landrum said, looking down at her lap. “They don’t forget. Every night they always say their prayers, like: ‘Goodnight, Harmony. Goodnight, God. We love you, sister.’ ” She paused and took a breath. “But I was also afraid, because of what happened to me before.”

Early last fall, Landrum’s case manager at the Family Justice Center, Mary Ann Bartkowicz, attended a workshop conducted by Latona Giwa, the 31-year-old co-founder of the Birthmark Doula Collective. The group’s 12 racially diverse birth doulas, ages 26 to 46, work as professional companions during pregnancy and childbirth and for six weeks after the baby is born, serving about 400 clients across New Orleans each year, from wealthy women who live in the upscale Garden District to women from the Katrina-ravaged Lower Ninth Ward and other communities of color who are referred through clinics, school counselors and social-service organizations. Birthmark offers pro bono services to these women in need.

Right away, the case manager thought of her young, pregnant client. Losing her baby, nearly bleeding to death and fleeing an abusive partner were only the latest in a cascade of harrowing life events that Landrum had lived through since childhood. She was 10 when Hurricane Katrina devastated New Orleans in 2005. She and her family first fled to a hotel and then walked more than a mile through the rising water to the Superdome, where thousands of evacuees were already packed in with little food, water or space. She remembers passing Charity Hospital, where she was born. "The water was getting deeper and deeper, and by the end, I was on my tippy-toes, and the water was starting to go right by my mouth," Landrum recalls. "When I saw the hospital, honestly I thought, I'm going to die where I was born." Landrum wasn't sure what doulas were, but once Bartkowicz explained their role as a source of support and information, she requested the service. Latona Giwa would be her doula.

Giwa, the daughter of a white mother and a Nigerian immigrant father, took her first doula training while she was still a student at Grinnell College in Iowa. She moved to New Orleans for a fellowship in community organizing before getting a degree in nursing. After working as a labor and delivery nurse and then as a visiting nurse for Medicaid clients in St. Bernard Parish, an area of southeast New Orleans where every structure was damaged by Katrina floodwaters, she devoted herself to doula work and childbirth education. She founded Birthmark in 2011 with Dana Keren, another doula who was motivated to provide services for women in New Orleans who most needed support during pregnancy but couldn't afford it.

"Being a labor and delivery nurse in the United States means seeing patients come in acute medical need, because we haven't been practicing preventive and supportive care all along," Giwa says. Louisiana ranks 44th out of all 50 states in maternal mortality; black mothers in the state die at 3.5 times the rate of white mothers. Among the 1,500 clients the Birthmark doulas have served since the collective's founding seven years ago, 10 infant deaths have occurred, including late-term miscarriage and stillbirth, which is lower than the overall rate for both

Louisiana and the United States, as well as the rates for black infants. No mothers have died.

A scientific examination of 26 studies of nearly 16,000 subjects first conducted in 2003 and updated last year by Cochrane, a nonprofit network of independent researchers, found that pregnant women who received the continuous support that doulas provide were 39 percent less likely to have C-sections. In general, women with continuous support tended to have babies who were healthier at birth. Though empirical research has not yet linked doula support with decreased maternal and infant mortality, there are promising anecdotal reports. Last year, the American College of Obstetricians and Gynecologists released a statement noting that “evidence suggests that, in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor.”

In early November, the air was thick with humidity as Giwa pulled up to Landrum’s house, half of a wood-frame duplex, for their second meeting. Landrum opened the door, happy to see the smiling, fresh-faced Giwa, who at first glance looked younger than her 23-year-old client. Giwa would continue to meet with Landrum weekly until her Dec. 22 due date, would be with her during labor and delivery and would make six postpartum home visits to assure that both mother and baby son remained healthy. Landrum led Giwa through her living room, which was empty except for a tangle of disconnected cable cords. She had left most of her belongings behind — including her dog and the children’s new Christmas toys — when she fled from her abusive boyfriend, and she still couldn’t afford to replace all her furniture.

They sat at the kitchen table, where Giwa asked about Landrum’s last doctor visit, prodding her for details. Landrum reassured her that her blood pressure and weight, as well as the baby’s size and position, were all on target.

“Have you been getting rid of things that are stressful?” Giwa asked, handing her a tin of lavender balm, homemade from herbs in her garden.

“I’m trying not to be worried, but sometimes. ...” Landrum said haltingly, looking down at the table as her hair, tipped orange at the ends, brushed her shoulders. “I feel like my heart is so anxious.”

Taking crayons from her bag, Giwa suggested they write affirmations on sheets of white paper for Landrum to post around her home, to see and remind her of the good in her life. Landrum took a purple crayon, her favorite color, and scribbled in tight, tiny letters. But even as she wrote the affirmations, she began to recite a litany of fears: bleeding again when she goes into labor, coming home empty-handed, dying and leaving her sons motherless. Giwa leaned across the table, speaking evenly. “I know that it was a tragedy and a huge loss with Harmony, but don’t forget that you survived, you made it, you came home to your sons,” she said. Landrum stopped writing and looked at Giwa.

“If it’s O.K., why don’t I write down something you told me when we talked last time?” Giwa asked. Landrum nodded. “I know God has his arms wrapped around me and my son,” Giwa wrote in large purple letters, outlining “God” and “arms” in red, as Landrum watched. She took out another sheet of paper and wrote, “Harmony is here with us, protecting us.” After the period, she drew two purple butterflies.

Landrum’s eyes locked on the butterflies. “Every day, I see a butterfly, and I think that’s her. I really do,” she said, finally smiling, her large, dark eyes crinkling into half moons. “I like that a lot, because I think that’s something that I can look at and be like, Girl, you going to be O.K.”

With this pregnancy, Landrum was focused on making sure everything went right. She had switched to a new doctor, a woman who specialized in high-risk pregnancies and accepted Medicaid, and she would deliver this baby at a different hospital. Now she asked Giwa to review the birth plan one more time.

“On Nov. 30, I go on call, and that means this phone is always on me,” Giwa said, holding up her iPhone.

“What if. ...” Landrum began tentatively.

“I’m keeping a backup doula informed of everything,” Giwa said. “Just in case.”

"I think everything's going to be O.K. this time," Landrum said. But it sounded like a question.

When the black-white disparity in infant mortality first became the subject of study, discussion and media attention more than two decades ago, the high rate of infant death for black women was widely believed by almost everyone, including doctors and public-health experts, to affect only poor, less-educated women — who do experience the highest numbers of infant deaths. This led inevitably to blaming the mother. Was she eating badly, smoking, drinking, using drugs, overweight, not taking prenatal vitamins or getting enough rest, afraid to be proactive during prenatal visits, skipping them altogether, too young, unmarried?

At Essence magazine, where I was the health editor from the late '80s to the mid-'90s, we covered the issue of infant mortality by encouraging our largely middle-class black female readers to avoid unwanted pregnancy and by reminding them to pay attention to their health habits during pregnancy and make sure newborns slept on their backs. Because the future of the race depended on it, we also promoted a kind of each-one-teach-one mentality: Encourage teenagers in your orbit to just say no to sex and educate all the "sisters" in your life (read: your less-educated and less-privileged friends and family) about the importance of prenatal care and healthful habits during pregnancy.

In 1992, I was a journalism fellow at the Harvard T.H. Chan School of Public Health. One day a professor of health policy, Dr. Robert Blendon, who knew I was the health editor of Essence, said, "I thought you'd be interested in this." He handed me the latest issue of The New England Journal of Medicine, which contained what is now considered the watershed study on race, class and infant mortality. The study, conducted by four researchers at the C.D.C. — Kenneth Schoendorf, Carol Hogue, Joel Kleinman and Diane Rowley — mined a database of close to a million previously unavailable linked birth and death certificates and found that infants born to college-educated black parents were twice as likely to die as infants born to similarly educated white parents. In 72 percent of the cases, low birth weight was to blame. I was so surprised and skeptical that I peppered him with the kinds of questions about medical research that he encouraged us to ask in his course. Mainly I wanted to know *why*. “No one knows,” he told me, “but this might have something to do with stress.”

Though I wouldn’t learn of her work until years later, Dr. Arline Geronimus, a professor in the department of health behavior and health education at the University of Michigan School of Public Health, first linked stress and black infant mortality with her theory of “weathering.” She believed that a kind of toxic stress triggered the premature deterioration of the bodies of African-American women as a consequence of repeated exposure to a climate of discrimination and insults. The weathering of the mother’s body, she theorized, could lead to poor pregnancy outcomes, including the death of her infant.

After graduating from the Harvard School of Public Health, Geronimus landed at Michigan in 1987, where she continued her research. That year, in a report published in the journal Population and Development Review, she noted that black women in their mid-20s had higher rates of infant death than teenage girls did — presumably because they were older and stress had more time to affect their bodies. For white mothers, the opposite proved true: Teenagers had the highest risk of infant mortality, and women in their mid-20s the lowest.

Geronimus’s work contradicted the widely accepted belief that black teenage girls (assumed to be careless, poor and uneducated) were to blame for the high rate of black infant mortality. The backlash was swift. Politicians, media commentators and even other scientists accused her of promoting teenage pregnancy. She was attacked by colleagues and even received anonymous death threats at her office in Ann Arbor and at home. “At that time, which is now 25 or so years ago, there were more calls to complain about me to the University of Michigan, to say I should be fired, than had happened to anybody in the history of the university,” recalls Geronimus, who went on to publish in 1992 what is now considered her seminal study on weathering and black women and infants in the journal Ethnicity and Disease.

By the late 1990s, other researchers were trying to chip away at the mystery of the black-white gap in infant mortality. Poverty on its own had been disproved to explain infant mortality, and a study of more than 1,000 women in New York and

Chicago, published in The American Journal of Public Health in 1997, found that black women were less likely to drink and smoke during pregnancy, and that even when they had access to prenatal care, their babies were often born small.

Experts wondered if the high rates of infant death in black women, understood to be related to small, preterm babies, had a genetic component. Were black women passing along a defect that was affecting their offspring? But science has refuted that theory too: A 1997 study published by two Chicago neonatologists, Richard David and James Collins, in The New England Journal of Medicine found that babies born to new immigrants from impoverished West African nations weighed more than their black American-born counterparts and were similar in size to white babies. In other words, they were more likely to be born full term, which lowers the risk of death. In 2002, the same researchers made a further discovery: The daughters of African and Caribbean immigrants who grew up in the United States went on to have babies who were smaller than their mothers had been at birth, while the grandchildren of white European women actually weighed more than their mothers had at birth. It took just one generation for the American black-white disparity to manifest.

When I became pregnant in 1996, this research became suddenly real for me. When my Park Avenue OB-GYN, a female friend I trusted implicitly, discovered that my baby was far smaller than her gestational age would predict, even though I was in excellent health, she put me on bed rest and sent me to a specialist. I was found to have a condition called intrauterine growth restriction (IUGR), generally associated with mothers who have diabetes, high blood pressure, malnutrition or infections including syphilis, none of which applied to me. During an appointment with a perinatologist — covered by my excellent health insurance — I was hounded with questions about my "lifestyle" and whether I drank, smoked or used a vast assortment of illegal drugs. I wondered, Do these people think I'm sucking on a crack pipe the second I leave the office? I eventually learned that in the absence of a medical condition, IUGR is almost exclusively linked with mothers who smoke or abuse drugs and alcohol. As my pregnancy progressed but my baby didn't grow, my doctor decided to induce labor one month before my due date, believing that the baby would be healthier outside my body. My daughter was born at 4 pounds 13 ounces, classified as low birth weight. Though she is now a bright, healthy, athletic college student, I have always wondered: Was this somehow related to the experience of being a black woman in America?

Though it seemed radical 25 years ago, few in the field now dispute that the black-white disparity in the deaths of babies is related not to the genetics of race but to the lived experience of race in this country. In 2007, David and Collins published an even more thorough examination of race and infant mortality in The American Journal of Public Health, again dispelling the notion of some sort of gene that would predispose black women to preterm birth or low birth weight. To make sure the message of the research was crystal clear, David, a professor of pediatrics at the University of Illinois, Chicago, stated his hypothesis in media-friendly but blunt-force terms in interviews: "For black women," he said, "something about growing up in America seems to be bad for your baby's birth weight."

On a December morning three days before her due date, Landrum went to the hospital for her last ultrasound before the birth. Because of the stillbirth the previous year, her doctor did not want to let the pregnancy go past 40 weeks, to avoid the complications that can come with post-term delivery, so an induction had been scheduled in 48 hours.

During Giwa's last prenatal visit, the day before, she explained to Landrum that she would be given Pitocin, a synthetic version of the natural hormone that makes the uterus contract during labor, to start her contractions. "Will inducing stress out the baby?" Landrum asked. "I can't lie; I used to wake up and scream, when I'd be dreaming about getting cut open again. I know my body is fine, and I'm healthy, but I don't want to die."

"I respect how honest you are, and your trauma is real," Giwa told her, slowing down her words. "But my hope for you is, this birth can be a part of your healing. Your uterus is injured and has been scarred, but you've pushed out two babies, so your body knows what it's doing."

Now, lying on the table, Landrum looked out the window, smiling as the sound of her baby's heartbeat filled the room. A few minutes later, the technician returned and looked at the monitor. The baby's heart rate appeared less like little mountains than chicken scratching. He was also either not moving consistently or not breathing properly. A nurse left the room to call Landrum's doctor to get her opinion. The nurse returned in 20 minutes and gave Landrum the news that the baby would be induced not in two days but now. "We don't want to wait; we're going to get him out today," she said to Landrum.

"I'm very anxious," Landrum told Giwa on the phone as she walked to labor and delivery, a few floors up in the same hospital, "but I'm ready." An hour later, Giwa arrived, wearing purple scrubs, her cloth bag filled with snacks, lavender lotion and clary sage oil. She made sure the crayon-drawn affirmations were taped on the wall within Landrum's line of vision, then settled into a chair next to the bed, low-key but watchful. Though some doctors resent or even forbid the presence of a doula during labor and delivery — and some doulas overstep their roles and create conflict with doctors and nurses — Giwa says she and the other Birthmark doulas try to be unobtrusive and focused on what's best for the mother.

A medical resident, who was white, like all of the staff who would attend Landrum throughout her labor and delivery, walked into the room with paperwork. Right away, she asked Landrum briskly, "Have you had any children before?"

She hadn't read the chart.

"Yes, I've had three babies, but one died," Landrum explained warily, for the third time since she had arrived at the hospital that day. Her voice was flat. "I had a stillbirth."

"The demise was last year?" the resident asked without looking up to see Landrum stiffen at the word "demise."

"May I speak to you outside," Giwa said to the nurse caring for Landrum. In the hall, she asked her to please make a note in Landrum's chart about the stillbirth. "Each time she has to go over what happened, it brings her mind back to a place of fear and anxiety and loss," Giwa said later. "This is really serious. She's having a high-risk delivery, and I would hope that her care team would thoroughly review her chart before walking into her room."

One of the most important roles that doulas play is as an advocate in the medical system for their clients. "At the point a woman is most vulnerable, she has another set of ears and another voice to help get through some of the potentially traumatic decisions that have to be made," says Dána-Ain Davis, the director of the Center for the Study of Women and Society at the City University of New York, the author of a forthcoming book on pregnancy, race and premature birth and a black woman who is a doula herself. Doulas, she adds, " are a critical piece of the puzzle in the crisis of premature birth, infant and maternal mortality in black women."

Over the next 10 hours, Giwa left Landrum's side only briefly. About five hours in, Landrum requested an epidural. The anesthesiologist required all visitors to leave the room while it was administered. When Giwa returned about a half-hour later, Landrum was angry and agitated, clenching her fists and talking much faster than usual. She had mistakenly been given a spinal dose of anesthesia — generally reserved for C-sections performed in the operating room — rather than the epidural dose usually used in vaginal childbirth. Now she had no feeling at all in her legs and a splitting headache. When she questioned the incorrect dose of anesthesia, Landrum told Giwa, one nurse said, "You ask a lot of questions, don't you?" and winked at another nurse in the room and then rolled her eyes.

As Landrum loudly complained about what occurred, her blood pressure shot up, while the baby's heart rate dropped. Giwa glanced nervously at the monitor, the blinking lights reflecting off her face. "What happened was wrong," she said to Landrum, lowering her voice to a whisper. "But for the sake of the baby, it's time to let it go."

She asked Landrum to close her eyes and imagine the color of her stress.

"Red," Landrum snapped, before finally laying her head onto the pillow.

"What color is really soothing and relaxing?" Giwa asked, massaging her hand with lotion.

"Lavender," Landrum replied, taking a deep breath. Over the next 10 minutes, Landrum's blood pressure dropped within normal range as the baby's heart rate stabilized.

At 1 a.m., a team of three young female residents bustled into the room; the labor and delivery nurse followed them, flipping on the overhead light. They were accompanied by an older man Landrum had never seen. He briefly introduced himself as the attending physician before plunging his hand between Landrum’s legs to feel for the baby. Landrum had been told that her OB-GYN might not deliver her infant, but a nurse had reassured her earlier in the day that if her doctor was not available, her doctor’s husband, also an OB-GYN, would cover for her. This doctor, however, was not the husband, and no one explained the switch. Giwa raised an eyebrow. The Listening to Mothers Survey III, a national sampling of 2,400 women who gave birth in 2011 and 2012, found that more than a quarter of black women meet their birth attendants for the first time during childbirth, compared with 18 percent of white women.

“He’s ready,” the doctor said, snapping off his gloves. “It’s time to push.”

One resident stepped forward and took his place, putting her hand into Landrum’s vagina, feeling for the baby. Landrum gripped the side of the bed and closed her eyes, grimacing. “You’re a rock star,” Giwa said. The nurse, standing at her side, told Landrum: “Push! Now. You can do it.” After about 20 minutes of pushing, the baby’s head appeared. “This is it,” the nurse told her. “You can do this,” Giwa whispered on her other side.

Landrum bore down and pushed again. “You’re doing amazing,” Giwa said, not taking her eyes away from Landrum. The attending physician left the room to put on a clean gown. Landrum breathed in, closed her eyes and pushed. More of the infant’s head appeared, a slick cluster of black curls. The senior resident motioned to the third and most junior of the women, standing at her shoulder, and told her, “Here’s your chance.” The young resident took the baby’s head and eased the slippery infant out. Landrum was oblivious to the procession of young residents taking turns between her legs or the fact that the attending physician wasn’t in the room at all. She was sobbing, shaking, laughing — all at the same time — flooded with the kind of hysterical relief a woman feels when a baby leaves her body and emerges into the world.

The resident lay the infant, purple, wrinkled and still as a stone, on Landrum’s bare chest. “Is he all right? Is he O.K.?” Landrum asked, panicking as she looked down at the motionless baby. A second later, his tiny arms and legs tensed, and he opened his mouth and let out a definitive cry.

“He’s perfect,” Giwa told her, touching her shoulder.

“I did it,” Landrum said, looking up at Giwa and laying her hands on the baby’s back, still coated with blood and amniotic fluid. She had decided to name him Kingston Blessed Landrum.

“Yes,” Giwa said, finally allowing herself a wide smile. “You did.”

In 1995, a pregnant African-American doctoral student had a preterm birth after her water broke unexpectedly at 34 weeks. Her baby was on a ventilator for 48 hours and a feeding tube for six days during his 10-day stay in the neonatal intensive-care unit.

The woman was part of a team of female researchers from Boston and Howard Universities working on the Black Women’s Health Study, an ongoing examination, funded by the National Institutes of Health, of conditions like preterm birth that affect black women disproportionately. The team had started the study after they noticed that most large, long-term medical investigations of women overwhelmingly comprised white women. The Black Women’s Health Study researchers, except for two black women, were also all white.

What happened to the doctoral student altered the course of the study. “We’re thinking, Here’s a middle-class, well-educated black woman having a preterm birth when no one else in our group had a preterm birth,” says Dr. Julie Palmer, associate director of the Slone Epidemiology Center at Boston University and a principal investigator of the continuing study of 59,000 subjects. “That’s when I became aware that the race difference in preterm birth has got to be something different, that it really cuts across class. People had already done some studies showing health effects of racism, so we wanted to ask about that as soon as possible.”

In 1997, the study investigators added several yes-or-no questions about everyday race-related insults: I receive poorer service than others; people act as if I am not intelligent; people act as if I am dishonest; people act as if they are better than me; people act as if they are afraid of me. They also included a set of questions about more significant discrimination: I have been treated unfairly because of my race at my job, in housing or by the police. The findings showed higher levels of preterm birth among women who reported the greatest experiences of racism.

The bone-deep accumulation of traumatizing life experiences and persistent insults that the study pinpointed is not the sort of “lean in” stress relieved by meditation and “me time.” When a person is faced with a threat, the brain responds to the stress by releasing a flood of hormones, which allow the body to adapt and respond to the challenge. When stress is sustained, long-term exposure to stress hormones can lead to wear and tear on the cardiovascular, metabolic and immune systems, making the body vulnerable to illness and even early death.

Though Arline Geronimus’s early research had focused on birth outcomes mainly in disadvantaged teenagers and young women, she went on to apply her weathering theory across class lines. In 2006, she and her colleagues used government data, blood tests and questionnaires to measure the effects of stress associated with weathering on the systems of the body. Even when controlling for income and education, African-American women had the highest allostatic load scores — an algorithmic measurement of stress-associated body chemicals and their cumulative effect on the body’s systems — higher than white women and black men. Writing in The American Journal of Public Health, Geronimus and her colleagues concluded that “persistent racial differences in health may be influenced by the stress of living in a race-conscious society. These effects may be felt particularly by black women because of [the] double jeopardy of gender and racial discrimination.”

People of color, particularly black people, are treated differently the moment they enter the health care system. In 2002, the groundbreaking report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” published by a division of the National Academy of Sciences, took an exhaustive plunge into 100 previous studies, careful to decouple class from race, by comparing subjects with similar income and insurance coverage. The researchers found that people of color were less likely to be given appropriate medications for heart disease, or to undergo coronary bypass surgery, and received kidney dialysis and transplants less frequently than white people, which resulted in higher death rates. Black people were 3.6 times as likely as white people to have their legs and feet amputated as a result of diabetes, even when all other factors were equal. One study analyzed in the report found that cesarean sections were 40 percent more likely among black women compared with white women. "Some of us on the committee were surprised and shocked at the extent of the evidence," noted the chairman of the panel of physicians and scientists who compiled the research.

In 2016, a study by researchers at the University of Virginia examined why African-American patients receive inadequate treatment for pain not only compared with white patients but also relative to World Health Organization guidelines. The study found that white medical students and residents often believed incorrect and sometimes "fantastical" biological fallacies about racial differences in patients. For example, many thought, falsely, that blacks have less-sensitive nerve endings than whites, that black people's blood coagulates more quickly and that black skin is thicker than white. For these assumptions, researchers blamed not individual prejudice but deeply ingrained unconscious stereotypes about people of color, as well as physicians' difficulty in empathizing with patients whose experiences differ from their own. In specific research regarding childbirth, the Listening to Mothers Survey III found that one in five black and Hispanic women reported poor treatment from hospital staff because of race, ethnicity, cultural background or language, compared with 8 percent of white mothers.

Researchers have worked to connect the dots between racial bias and unequal treatment in the health care system and maternal and infant mortality. Carol Hogue, an epidemiologist and the Jules & Uldeen Terry Chair in Maternal and Child Health at the Rollins School of Public Health at Emory University and one of the original authors of the 1992 New England Journal of Medicine study on infant mortality that opened my own eyes, was a co-author of a 2009 epidemiological review of research about the association between racial disparities in preterm birth and interpersonal and institutional racism. Her study, published by the Johns Hopkins School of Public Health, contains an extraordinary list of 174 citations from previous work. "You can't convince people of something like discrimination unless you really have evidence behind it," Hogue says. "You can't just say this — you have to prove it."

Lynn Freedman, director of the Averting Maternal Death and Disability Program at Columbia University’s Mailman School of Public Health, decided to take the lessons she and her colleagues learned while studying disrespect and abuse in maternal care in Tanzania — where problems in pregnancy and childbirth lead to nearly 20 percent of all deaths in women ages 15 to 49 — and apply them to New York City and Atlanta. Though the study is still in its preliminary phase, early focus groups of some 50 women who recently delivered babies in Washington Heights and Inwood, as well as with doulas who work in both those areas and in central Brooklyn, revealed a range of grievances — from having to wait one to two months before an initial prenatal appointment to being ignored, scolded and demeaned, even feeling bullied or pushed into having C-sections. “Disrespect and abuse means more than just somebody wasn’t nice to another individual person,” Freedman says. “There is something structural and much deeper going on in the health system that then expresses itself in poor outcomes and sometimes deaths.”

Two days after the birth of Landrum’s baby, she had moved out of labor and delivery and into a hospital room, with the butterfly-decorated, crayon-drawn affirmations taped above her bed. She’d had a few hours of sleep and felt rested and cheerful in a peach-colored jumpsuit she brought from home, with baby Kingston, who had weighed in at a healthy 6 pounds 13 ounces, napping in a plastic crib next to her bed. But over the next hours, Landrum’s mood worsened. When Giwa walked into her room after leaving for a few hours to change and nap, Landrum once again angrily recounted the mishap with the epidural and complained about the nurses and even the hospital food. Finally, Giwa put her hand on Landrum’s arm and asked, “Simone, where are the boys?”

Landrum stopped, and her entire body sagged. She told Giwa that her sons were staying on the other side of town with her godmother, whom she called Nanny. But with children of her own, Nanny was unable to make the 40-minute drive to bring Landrum’s sons to the hospital to see their mama and meet their brother. “After they lost their sister, it’s really important that they see Kingston,” Landrum said.

“I understand,” Giwa said, stroking her shoulder. “You need the boys to see their brother, to know that he is alive, that this is all real.” Landrum nodded. She made several phone calls from her hospital bed but could find no one to get the boys, so I left to drive across town and pick them up. It took Giwa's attentive eyes, and the months of building trust and a relationship with Landrum, to recognize a problem that couldn't be addressed medically but one that could have emotional and physical consequences.

The doula consumer market has been largely driven by and tailored for white women, but the kind of support Giwa was providing to Landrum was actually originated by black women, the granny midwives of the South. Inspired by that historic legacy and by increasingly visible reproductive-justice activism, dozens of doula groups like Birthmark in New Orleans have emerged or expanded in the past several years in Brooklyn, Los Angeles, Atlanta, Dallas, Memphis, Miami, Washington and many other cities, providing services to women of color, often free or on a sliding scale.

The By My Side Birth Support Program in New York City, administered by the city's Department of Health, offers free doula services during pregnancy, labor and delivery and postpartum for mothers in central and eastern Brooklyn's predominantly black and brown neighborhoods where maternal and infant mortality are highest. A team of 12 doulas has served more than 800 families since 2010, and an analysis of the program showed that from 2010 to 2015, mothers receiving doula support had half as many preterm births and low-birth-weight babies as other women in the same community.

Interventions that have worked to bring down maternal- and infant-mortality rates in other parts of the world have been brought back to the United States. Rachel Zaslow, a midwife and doula based in Charlottesville, Va., runs a program in northern Uganda, where a woman has a one-in-25 lifetime chance of dying in childbirth, through her nonprofit organization, Mother Health International. In Zaslow's program, community health workers — individuals selected by the community and given medical training — link local pregnant women to trained midwives and nurse-midwives. Since 2008, a mother has never died in Zaslow's program, and the infant-mortality rate is 11 per 1,000, compared with 64 per 1,000 for the country at large.

Three years ago, when she became aware of high rates of infant and maternal mortality in pockets of Virginia, Zaslow decided to take her Ugandan model there: a collective of 45 black and Latina doulas in Charlottesville, called Sisters Keeper, that offers birthing services free to women of color. “The doula model is very similar to the community health worker model that’s being used a lot, and successfully, throughout the global South,” Zaslow says. “For me, when it comes to maternal health, the answer is almost always some form of community health worker.” Since 2015, the Sisters Keeper doulas have attended about 300 births — with no maternal deaths and only one infant death among them.

“It is really hard for American health care professionals to get their heads around that when you have an organized community-based team that connects technical clinical issues with a deep, embedded set of relationships, you can make real breakthroughs,” says Dr. Prabhjot Singh, the director of the Arnhold Institute for Global Health at the Icahn School of Medicine at Mount Sinai, who studies community health worker models and how they can be used in the United States. “In the U.S., doulas can’t do it by themselves, but based on work that’s taken place globally, they can help reduce infant and maternal deaths using what is essentially a very simple solution.”

An hour and a half after Giwa noticed that Landrum needed to have her sons with her, Caden and Dillon burst through the door of the hospital room. Holding Kingston in her lap, Landrum lit up at the sight of the boys. Caden, who is 4, ran to his new brother, gleefully grabbing at the infant. “Calm down,” Landrum said, smiling and patting the side of the bed. “Put out your arms, strong, like this,” she told him, arranging his small arms with her free hand. Gently, she lay Kingston in his brother’s outstretched arms. “It’s my baby,” he said excitedly, leaning down to kiss the infant all over his cheeks and forehead. “I luh you, brother.”

Dillon, 7, was more cautious. He stood near the door, watchful. “Don’t you want to meet your brother, Dillon?” Landrum asked. He inched closer, looking at the floor. “Come on, boy, don’t be shy. This is Kingston.” He sat on the other side of his mother, and she took the baby from Caden and placed him in Dillon’s arms. He looked down at the newborn, nervous and still hesitant. “It’s a real baby,” he said, looking up at his mother and finally smiling. “Mommy, you did it.”

"At that moment, I felt complete," Landrum said later, tearing up, "seeing them all together."

On a cool, sunny afternoon in March, Landrum led me into her living room, which now held a used couch — a gift from a congregant of her church, where she is an active member. A white plastic Christmas tree strewn with multicolored Mardi Gras beads, left up after the holidays, added a festive touch. Landrum handed me Kingston, now 3 months old, dressed in a clean onesie with a little blue giraffe on the front. Plump and rosy, with cheeks chunky from breast milk and meaty, dimpled thighs, he smiled when I sang him a snippet of a Stevie Wonder song.
Landrum had lost the baby weight and looked strong and healthy in an oversize T-shirt and leggings, wearing her hair in pink braids that hung down her back. There was a lightness to her that wasn't apparent during her pregnancy. One word tumbling over the next, she told me that the new baby had motivated her to put her life in order. She had been doing hair and makeup for church members and friends out of her house to earn money to buy a car. She had applied to Delgado Community College to study to be an ultrasound technician. "I love babies," she said. "When I look at ultrasound pictures, I imagine I see the babies smiling at me."

Latona Giwa had continued to care for Landrum for two months after Kingston's birth. The C.D.C. measures American maternal mortality not just by deaths that occur in pregnancy or childbirth, or in the immediate days afterward, but rather all deaths during pregnancy and the year after the end of pregnancy — suggesting the need for continued care and monitoring, especially for women who are most at risk of complications.

It was Giwa who drove Landrum and the baby home from the hospital, moving her own 2-year-old daughter's car seat from the back of her Honda and replacing it with a backward-facing infant seat, when Landrum had no other ride. It was Giwa who ushered the new mother into her home and then surprised her by taking a bag of groceries and a tray of homemade lasagna, still warm, from the back of the car. And it was Giwa who asked her, six weeks after childbirth, if she had talked to her doctor about getting a contraceptive implant to avoid pregnancy. When Landrum told her that her doctor had never called her about a checkup, Giwa was livid. "High-risk patients with complicated maternal histories often have an appointment two weeks after they've been discharged," she said later, after insisting that Landrum call to make an appointment. "Her life is hectic; she's at home with three children. Luckily she's fine, but at minimum someone should've called to check on her."

For Giwa's work with Landrum, from October to February, she earned just $600. Like the other Birthmark doulas, Giwa can't make ends meet just doing doula work; she is employed as a lactation consultant for new mothers both privately and at a "latch clinic" in a New Orleans office of the federal Women, Infants and Children Food and Nutrition Service that supports low-income pregnant and postpartum women.

"We need to recognize that there is actual medical benefit to having doula support — and make the argument that insurance should pay for it," says Williams, the Bay Area OB-GYN. "It is a job. People do have to be paid for that work." Insurance would mean some standardization; Williams notes that many programs securing public funding or grants to provide doula support to lower-income women can't match the kind of money that private doulas can command. These programs often have "all black women who are doulas," she says. "Yes, it's fantastic that these women are training to be doulas and supporting other black women — but they're not making as much as these other doulas." If, she asks, "doula support is important and can have this beneficial outcome for women, especially black women, how can we actually move forward to make that more accessible to everybody?"

In her home on that March afternoon, Landrum put Kingston into a baby carrier. He fell asleep as we walked five blocks to meet Dillon and Caden, who were due home from school at two different bus stops. The boys jumped off their buses, dressed in identical red polo shirts, their hair freshly cut, each dragging a large backpack, and ran to their mother. Dillon could hardly wait to pull out his report card and show his mother his grades; he had received four out of six "exceptional" marks. "He's smart," Landrum said, and he gave her a huge, gaptoothed smile.

Then he raced ahead, his backpack lurching as he leapt over bumps in the sidewalk full of pent-up little-boy energy; Caden was right behind him, doing his best to keep up with his brother's longer strides. "Hey, y'all, you be careful!" Landrum called, keeping her eyes trained on them. "You hear me?!"

Kingston stirred when he heard his mother's voice. He lifted his head briefly and looked into Landrum's face. Their eyes met, his still slightly crossed with new-baby nearsightedness. Landrum paused long enough to stroke his head and kiss his damp cheek. The baby sighed. Then he burrowed his head back into the warmth and safety of his mother's chest.

Linda Villarosa directs the journalism program at the City College of New York, in Harlem, and is a contributing writer for the magazine. She last wrote a feature about the H.I.V. epidemic among American black gay and bisexual men.

Sign up for our newsletter to get the best of The New York Times Magazine delivered to your inbox every week. For more coverage of women and gender issues, subscribe to Gender Letter, a new newsletter, or follow @nytgender on Instagram.

Health Equity Summary of ACH Project Plans

In mid-November, all 9 ACHS submitted project plans. These plans represent preliminary ACH planning and strategizing around Medicaid transformation. As such, these documents focus largely on the big picture and do not include many details.

This project plan summary document is a broad overview of ACHs plans to address equity in their projects. The intent of this summary is to focus on the concrete actions planned or already taken by ACHs, rather than focusing on vision and values around equity. *This summary is by no means exhaustive.*

Throughout the project plans all ACHs articulate a need for addressing health equity and the social determinants of health within project transformation work. Some overarching themes and activities across ACHs include:

- All ACHs list health equity as a criteria for project plan development.
- All ACHs plan to look at data to help them determine which groups are facing the largest health disparities.
- Most ACHs plan to engage Medicaid beneficiaries in their project planning and development through the use of a Community Voice Council.
- Most ACHs plan to have a funding category dedicated to addressing the social determinants of health.
- Most ACHs plan to leverage the work conducted by community health workers to further equity.
- Most ACHs reference a plan to train their staff/board members and partners in issues of implicit bias/cultural humility etc.
- Most ACHs plan to support providers in providing resources and tools for them to be more culturally and linguistically appropriate.

Background

Project Selection by ACH

Project	BHT	CPAA	GCACH	KCACH	NCACH	NSACH	OCH	PCACH	SWACH
2A: Bi-directional Integration of Care	●	●	●	●	●	●	●	●	●
2B: Community-based Care Coordination	●	●			●	●		●	●
2C: Transitional Care		●	●	●		●			
2D: Diversions Interventions					●	●	●		
3A: Addressing Opioid Use	●	●	●	●	●	●	●	●	●
3B: Reproductive and Maternal and Child Health		●				●	●		
3C: Access to Oral Health Services						●	●		
3D: Chronic Disease Prevention and Control	●	●	●	●	●	●	●	●	●

Funding By Category

Funding Category	BHT	CPAA	GCACH	KCACH	NCACH	North Sound ACH*	OCH	PCACH	SWACH
Project Management and Administration	5%	4%	5%	15%	2%	10%	22%	8%	10%
Provider Engagement, Participation, and Implementation	32%	8%	32%	33%	60%	50%	2%	12%	0%*
Provider Performance and Quality Incentive Payments	23%	43%	28%	30%	23%	20%	50%	34%	26%
Health Systems and Community Capacity Building	30%	28%	17%	13%	15%	10%	19%	36%	48%
Other									
Health Systems and Community Capacity Building						10%			
Reserve/ Contingency		2%	5%	3%			3%		
Community Resiliency Fund	10%							10%	16%
Innovation Fund (CPAA); Integration Fund (GCACH)		15%	13%						
Social Equity and Wellness Fund (KCACH); Community/Social Determinants of Health Projects and Consumer Empowerment; Policy and Advocacy (OCH)				6%			4% (2% each)		

*North Sound ACH has two Health Systems and Community Capacity Building use categories: one is applicable to contractors and partnering providers and the other to the ACH. SWACH included provider engagement, participation, and implementation in the Health Systems and Community Capacity Building use category.

Highlights from Project Plans

Better Health Together

- BHT will disaggregate data by race and ethnicity to help inform target population selection for MTP projects.
- BHT is Launching a Community Voice Council made up of 50% Medicaid beneficiaries & 50% community advocates
    - Members will be nominated by the community and then additional members will be recruited from existing members
    - Group will validate the needs and expectations of the beneficiary in reference to plans
    - Advise on metrics to evaluate how project plans address health equity and then continue to monitor those metrics
    - Members receive a stipend for participation
    - Council meetings will be in the evening and or weekend and include childcare
- BHT is Creating an “Equity Accelerator Payment” for partners who serve a large proportion of high risk clients

- BHT plans to evaluate their funds flow using equity as one of the considerations
- BHT plans to create a Community Resilience fund using $600,000 of design funds to address social determinants of health
    - Over 5 years 10% of funds will be allocated to this fund
    - Will match these funds with community donations from other stakeholders

Cascade Pacific Action Alliance

- All project work groups are using mortality data by US Census Tract as a proxy for identifying health disparities and identifying sub-regions for focused interventions
- CPAA is developing an adaptation of health equity tools used by other organizations, such as King and Multnomah counties that will inform the methods behind finalizing target populations and implementing specific project area interventions.
- Training for clinical and community-based providers on trauma-informed care principles, population health concepts, and patient-centered care will be will be an integral part of CPAA's Medicaid Transformation projects.
- Community members/consumers/Medicaid beneficiaries are engaged at the local (community forums) and regional decision-making level (council and board), as well as in project work groups. Community member/consumer/Medicaid beneficiary input into project selection also has occurred through surveys, focus groups, local community forums, CPAA Consumer Advisory Committee, and council/board participation. We will continue to use these varied engagement methods going forward.
- CPAA has appointed two consumer representatives to its board and council, ensuring enhanced community and consumer voice in decision-making.
- CPAA will evaluate the following areas to measure their success in incorporating equity: the number of community members and organizations representing diverse community perspectives that actively participate in CPAA meetings, broad representation of community members and community organizations from across the region, and sustained, consistent participation. Another key indicator is the degree to which CPAA decisions and actions reflect the needs and interests of the community.
- CPAA is offering stipends and other financial incentives to support consumer engagement

Greater Columbia Accountable Community of Health

- GCACH will provide $900k in funding to Local Health Improvement Networks in support of their work to address social determinants of health on the local level
- GCACH is forming a Consumer Council with 6-8 current/former Medicaid Beneficiaries or their family members as well as Medicare, VA, Privately insured and uninsured individuals
- GCACH will do a regional assessment of providers to see if they have the tools necessary to support cultural competency in delivery of care for project 2A
- GCACH will develop educational materials that are culturally and linguistically appropriate for projects and use bilingual and bicultural facilitators
- GCACH has one consumer representative on their board who is a community health worker

HealthierHere (King County)

- King plans to leverage Medicaid providers in their county who specialize in best practices with the care of minority and foreign-born populations and have culturally diverse staff
- One of the major barriers noted in King's overall plan implementation is institutional and systematic racism
- King plans to use an Equity Impact Assessment Tool which was developed by their Community/Consumer Voice Committee. The ACH is using it to explore strategies to engage individuals impacted by health disparities.
- King plans to do in-depth trainings during the planning phase with the equity tool.

Olympic Accountable Community of Health (OCH)

- OCH will weigh DSRIP investments according to a community needs index and PRSIM score
- OCH has developed change plans for each partnering provider organization. These change plans will include a description of how the provider organization plans to address health equity within their practice. OCH will provide trainings and webinars to support this work.
- OCH integrated results from categorical analyses identifying health disparities for each project
- OCH has created a Community and Tribal Advisory Committee. The committee will include 12-20 members
- OCH plans to coordinate with MCOs in providing transitional care for people leaving prison/jail

Pierce County Accountable Community of Health

- Pierce plans to address equity in their project plan development in 6 overarching ways:
    - Use data to track disparities
    - Use CHWS in their pathway model
    - Embed equity in project and vendor selection
    - Provide community trainings in multiple languages at community sites across the region. Train staff and board in diversity, equity and inclusion
    - Applying an equity lens to ACH policy and procedures
    - Focus on cultural humility and trauma-informed care in work with community partners
- Pierce plans to incorporate equity questions into the Care Coordination Agencies (CCA) Request for Proposals (RFP) process for Pathways. They want to make sure that contractors have the tools to provide linguistically and culturally appropriate services
- Pierce plans to use "the Science of Improvement" to ensure that the opioid project addresses stigma and trauma informed care in all settings
- Community Voice Council will participate in the RFP process
- Pierce plans to look at disaggregated data of their Medicaid Beneficiaries to decide how to target their efforts
- Pierce plans to use the "Transformation Rules of Engagement" strategy which means working with providers to set expectations in terms of design, practice changes, tools, and performance expectations. Equity will be one of the requirements imbedded in this.
- Pierce is going to work with Planned Parenthood to broker relationship between partnering providers and planned parenthood to better serve their patient base and improve access and equity

North Central Accountable Community of Health

- North Central used identified disparities in health risks and health outcomes through analysis of data during project selection phase
- North Central is using the Robert Wood Johnson Foundation's "Key Steps for Advancing Health Equity" tool in identifying, addressing and evaluating and monitoring health disparities
- North Central will engage in three local CHIs during project implementation planning to have a local perspective on what providers see as the causes of health disparities in their communities
- North Central plans to analyze their data for discrepancies in socioeconomic status and incarceration rates as it relates to opioid use to look for underlying causes of health inequity

North Sound Accountable Community of Health

- North Sound ACH is implementing multiple annual learning opportunities on equity and reducing Disparities for partners. They are hoping to partner with other ACHs on this.
- North Sound will use "Target 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. This approach defines unisveral goals for all, then identifies obstacles faced by specific groups and tailors strategies to address the barriers in those specific situation
- Communities impacted by disparities will help inform selection of target populations and project development
- North Sound plans to incorporate their Community Leadership Council into their governance structure
- North Sound will provide 3-4 equity learning sessions a year
- North Sound is using the community engagement process that was outlined in Northwest Health Law Advocates ACH report on ACH community engagement
- North Sound plans to work with their Community Leadership Council to go beyond digital forms of public engagement and work to engage people on the grassroots level
- North Sound plans to train Paramedics and care coordinators in cultural humility, motivational interviewing and how to recognize implicit bias

Southwest Accountable Community of Health (SWACH)

- SWACH is working with community orgs to develop an equity lens. They plan to use the Center for Racial Justice Innovation's "Racial Equity Impact Assessment Guide" for decision making in the meantime. SWACH has secured $40k in funding from United Way to develop this work.
- SWACH is working with the Health Living Collaborative of SW Washington (HLC) on issues of health equity. HLC is a community driven coalition that works on upstream initiatives for promoting health equity and strengthening communities
- SWACH is using health equity to determine target populations by asking the following questions:
    - Does the target population disproportionately experience poor health outcomes?
    - Are the subgroups within the population that experience disparities?
    - Is there a gap in existing services that could effectively address these outcomes?
- SWACH's RFP process will include questions on equity. Additionally, community health workers were invited to the RFP process

- SWACH plans to have community trainings in multiple languages and across diverse cultural and geographical community sites
- Workgroups and community boards will receive trainings on diversity, equity and inclusion
- SWACH plans to use a trauma informed lens across transformation settings
- SWACH is partnering with the Center for Equity and Inclusion to support the development of their project planning

Community Health Worker Summary of ACH Project Plans

In mid-November, all 9 ACHS submitted project plans. These plans represent preliminary ACH planning and strategizing around Medicaid transformation. As such, these documents focus largely on the big picture and do not include many details.

This project plan summary document is a broad overview of ACHs plans to address workforce in their projects. The intent of this summary was to focus on the needs and planned use of community health workers (CHWs) ACHs described in their plans. *This summary is by no means exhaustive.*

Throughout the project plans all ACHs articulate a need community health workers within project transformation work. Some overarching themes and activities across ACHs include:

- All ACHs plan to incorporate community health workers in at least one of their projects and cited them as a workforce strategy.
- Several ACHs discussed the need for additional community health workers and to provide recruitment and training for them.
- Several ACHs plan to use community health workers a part of the Pathways Hub in 2b Community Based Coordination.
- ACHs recognized the value of community health workers to address the social determinants of health, health disparities, promote health equity, provide culturally competent and linguistically appropriate care, and bring their lived experiences to the position.
- Project plans suggest using CHWs in a variety of settings such as emergency departments, jails, health clinics, client homes, and other community forums.
- Several ACHs expressed a need to work CHWs into the clinical care team.
- A few ACHs discussed community health workers in the context of financial sustainability and moving to VBP.
- ACHs differ in specificity regarding the use of CHWs ranging from identifying organizations to use with CHWs and funding to broadly stating plans to use CHWs.

Background

Project Selection by ACH

Project	BHT	CPAA	GCACH	KCACH	NCACH	NSACH	OCH	PCACH	SWACH
2A: Bi-directional Integration of Care				●		●			
2B: Community-based Care Coordination	●	●			●	●		●	●
2C: Transitional Care		●		●	●				
2D: Diversions Interventions						●	●		
3A: Addressing Opioid Use		●	●	●					
3B: Reproductive and Maternal and Child Health		●				●	●		
3C: Access to Oral Health Services							●		
3D: Chronic Disease Prevention and Control	●	●	●	●		●	●	●	●

Highlights from Project Plans

Better Health Together

- Recruiting, training and providing Community Health Workers with a living wage may be a significant challenge for the region.
- BHT ACH is advancing the Pathways model and use of Community Health Workers with lived experience of health inequities to further our efforts. CHWs are critical to developing trust and culturally appropriate strategies to meet the needs of our target populations across the Transformation project areas.
- Project 3d: Chronic Disease Prevention- expect to leverage the Community Health Workers Network of Eastern Washington as well as our Community Voices Council to build a community level movement to encourage healthy behaviors.
- Stakeholder feedback to ACH through focus groups: Across all groups attendees indicated a significant need to have access to care coordinators or community health workers who could help them understand their coverage, access care, and gain referrals and approvals for services and medications.

Cascade Pacific Action Alliance

- There are similar capacity issues in the social services sector: too few community health workers are available to meet the multiple needs of Medicaid patients.
- Project 2b: Community Based Care Coordination Expanding number of community health workers. Employing Community Health Workers (CHWs) as care coordinators represents another important and effective strategy for addressing health equity by providing more culturally competent and linguistically relevant care. As CPAA implements the HUB, efforts will be made to hire individuals who reflect the diversity of the target populations served.
- Other projects CPAA has selected they noted: Expanding number of community health workers as a workforce investment.

Greater Columbia Accountable Community of Health

- GCACH has one consumer representative on their board who is a community health worker
- A Workforce Committee has been chartered to review the GCACH Provider system workforce needs and develop a recommended target state for the region.
    - Funding in the amount of $672K has been set aside for capacity development, recruiting, training and retention activities. GCACH will train and grow a workforce of community health workers, and cross-train existing health care professionals to meet project needs. Investments in workforce will also need to happen prior to project implementation in order to train new community health workers and have them integrated into care teams.
- There are many different types of community health workers already in the workforce, but with different titles; patient navigators, client advocates, community paramedics, school coordinators, outreach coordinators etc.
- Project 3a: Addressing the Opioid Crisis-Opioid Resource Networks will staff their services to fill in current gaps in local areas around the GCACH region, and may include Community Health Workers to conduct comprehensive assessments to identify support tailored to individual needs.

Community Health Workers will conduct outreach, connect individuals to services, and work within an established set of best practices for enrolling, assessing, and managing client cases, all while working with physician and MAT partners in the system. Project is designed to stabilize this relationship between providers and patients and thus to improve cross-team collaboration. By co-locating a Community Health Worker at the site of the clinical practice can help mediate the doctor-patient relationship, advocate for the patient in the moment, and help the patient adhere to treatment.

- Project 3d: Chronic Disease Prevention-This project will also utilize Community Health Workers (CHWs) who come from the communities being served. A challenge to improving outcomes and lowering costs is a Shortage of community health workers in smaller communities and/or rural areas.

HealthierHere (King County)

- After conducting an environmental scan of community-based care coordination, KCACH will develop strategies to support and make investments to improve it across all projects. This includes in development of the community health worker and peer support specialist workforce; and development of value-based payment models to support the long-term sustainability of community-based care coordination. These cross-cutting investments will benefit all projects.
- KCACH early workforce assessments across selected projects indicate a need to better integrate community health workers and peer support specialists into person-centered health teams and as a strategy to further community-based care coordination. Plan to use Public Health – Seattle & King County's curriculum for community health workers.
- Project 2a: Behavioral Health Integration-KCACH will work with consumers and community-based organizations to ensure that community health workers (CHWs) and/or peer support specialists are integrated as part of a multidisciplinary treatment team to assist with care coordination activities and linkages to services and supports. CHWs and/or peer support specialists will also help to engage clients who have an identified need but who have not, for a variety of reasons, accessed care because of barriers such as language or lack of understanding of how to navigate systems.
- Project 2c: Transitional care-Utilize community health workers (CHWs)/peer support specialists—peers with lived experience in the criminal justice system and/or behavioral health recovery—to work with individuals as they transition out of jail back into their community. This strategy will enhance the APIC model by including a "warm handoff"—CHWs or peers will meet an individual at release and accompany them to their first appointment to establish a relationship with a medical or behavioral health provider (a health home).
- Project 3a: Addressing the Opioid Crisis-KCACH is committed to developing a workforce that ensures access to recovery supports through peer support specialists and/or community health workers for ongoing care coordination and linkages to social services that help individuals achieve and maintain long-term recovery.
  - To ensure MAT treatment is expanded throughout the county in an equitable manner, receipt of MAT will be assessed by subgroup (e.g., by age, race/ethnicity, and geography).

  - The KCACH will collaborate with behavioral health providers and community-based organizations to develop a strategy to improve access to MAT in underserved communities (e.g., using peer support specialists, community health workers, and other community-based care coordination to facilitate MAT referrals as suggested in other projects).
- Project 3D: Chronic Disease Prevention-Looking at diabetes bundle. Bundles would include a range of services including self-management programs, CHW services, and activities outside the clinic walls that support prevention and effective management of the selected chronic disease conditions. Ultimately, the bundles would be part of value-based payment (VBP) arrangements aimed at achieving chronic disease quality and outcome measures.
  - KCACH will draw on the experience of the Community Health Worker Program of Public King County ACH Project Plan (November 15, 2017) Health – Seattle & King County (PHSKC) and partner with Federally Qualified Health Centers (FQHCs), housing authorities, and CBOs employing CHWs in clinical sites for lessons learned related to CDP implementation. The CDP will contribute to the MTP's long-term sustainability by Redefining the composition of the care team to include additional client supports such as community health workers.

Olympic Community of Health (OCH)

- During spring 2017, OCH requested information from collaborating partners during a letter-of-intent (LOI) and request-for-proposal (RFP) process for optional projects. Collected workforce information included current type and number of clinical and non-clinical employees. Budget line items included additional project workforce. This information helped inform planning of additional capacity and service. Examples of requested additional workforce included community health workers.
- Project 2D: Diversion Interventions-Upfront investments support provider organizations to hire workforce and invest in population health IT capacity. Workforce strategies will provide training for community health workers, community paramedics, decision support teams for population health management, and contracting teams for training in payer billing and reporting. Workforce strategy with CHWs is: Cross training and redefine role. Community health workers in ED or jail setting, working with social workers and nurses to identify and connect patients to primary care.
- Project 3B: Reproductive Maternal/Child Health-Coordinated, targeted outreach and engagement to increase well-child visits. Warm hand-off from Coordinated Care, an MCO, to PCHS (Peninsula community health services).
  - Through a pilot project with the Washington State Department of Health TCPI project, Coordinated Care contacts all new members to welcome them to the plan. During the call, Coordinated Care offers to initiate a three-way call to PCHS, to a direct line that is operated by a community health worker, to schedule the first well-child visit. This strategy has proven extremely successful, with 30% of those contacted scheduling a well-child visit.
- PCHS dedicates community health workers to calling rosters of patients provided by MCOs who have been assigned to PCHS but do not have a patient record or have not been seen recently.

- Project 3C: Access to Oral Health-Create a more explicit connection between community health workers in ED (see Diversion Project Plan), and/or IT e-referral system (see Domain 1) to connect patients in the ED for a dental reason with a dental site accepting referrals
- Project 3d: Chronic Disease Prevention-Utilizing community health worker and peer navigators as a trusted link from clinic to community. Planned sharing of skilled workforce and trainings across the region. Shared staff positions across agencies may include Community Health Workers.
- The Board has also authorized the formation of a steering committee comprised of clinical and non-clinical partnering providers from each NCC (natural communities of care). NCC provider and steering committee meetings will be as frequent as requested by partnering providers, likely frontloaded in 2018 during the planning phase. OCH will convene communities of practice (e.g., community health workers or decision support specialists) across the region and, where appropriate, across ACHs, to share best practices and host group trainings.
- Specific to workforce, several Tribes expressed an interest in autonomy in selecting, hiring, and managing the equivalent of a community health worker, which historically Tribes have termed "community health representatives".

Pierce County Accountable Community of Health

- Community members have expressed the need for more culturally competent care. Suggestions include community health workers.
- Part of workforce is to support coordinating agencies that employ community health workers (CHWs) who have lived experience working in communities disproportionately impacted by poor health outcomes.
- Project 2B: Community-Based Care Coordination- Our adoption of the Pathways Model for Community Care Coordination includes a robust set of supports for leveraging and expanding the use of CHWs as part of our systems of care. Care Coordination Advisory Workgroup is comprised of a broad set of stakeholders and partners including hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, CHWs and the criminal justice system.
  - The Pierce County Pathways Community HUB will be implemented as an initial pilot targeting 200 pregnant women in DY 2. This pilot includes an anticipated cohort of seven community health workers (CHWs) serving as care coordinators across four contracted CCAs. During this initial pilot, HUB partners will build experience with budgeting, value-based payment methodologies, tracking outcomes, and building sustainability as we prepare to expand scope in DY 3.
  - Expansion will necessitate an estimated 50 CHW care coordinators. Sea Mar will dedicate up to 2.0 FTE (CHWs) to the Pathways Community HUB.
- Project 3D: Chronic Disease Prevention- PCACH's Pathways Community HUB is expected to be a critically important asset for the successful pursuit of improved health outcomes for individuals at risk for or experiencing chronic disease. Our approach to community-based care coordination through the Pathways Community HUB Model represents another opportunity for addressing health equity for individuals with chronic disease. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, Community Care

Coordination model will deepen beneficiaries' access to culturally and linguistically responsive care

- Pierce County Community Health Worker Collaborative (CHW Collaborative): PCACH is in the final stages of entering a formal relationship with the CHW Collaborative to mutually benefit and further each organizations' work.
    - The intention of the relationship is for the CHW Collaborative to connect community health worker's voice to system reform and further PCACH work, communication and feedback into communities otherwise inaccessible to PCACH due to reasons of trust, lack of knowledge or cultural appropriateness.
    - The CVC will work closely with representatives of the Community Health Worker Collaborative, trusted CBOs, and faith communities to include people who are often distrustful of mainstream organizations and systems in these listening sessions.

North Central Accountable Community of Health

- Workforce strategies will be heavily focused at the state level, however local investments (e.g., community health worker trainings), may need to be developed at community colleges with initial funds to get the program started. This will be better refined as we develop our project implementation plans during quarter 2 of 2018.
- Charter Colleges and Community Colleges – NCACH will work with them in quarter 2 of 2018 to develop programs and training to address the workforce gaps in the region for: chemical dependency staff, medical assistance staff, community health workers, and nurses.
- The Pathways Coordination HUB – This business opportunity will create an opportunity for training community health workers who can help fill the gap that is currently being addressed by more highly skilled professions such as nurses and EMTs.
- Project 2B: Community Based Care Coordination-the Care Coordination Project will help develop a regional platform, through the Pathways Community HUB model, that can coordinate the services of the current care coordination agencies in the region.
    - This will prevent duplication of services to clients and place clients with the most appropriate level of care coordinator (i.e. community health worker, nurse, social worker, etc.).
    - The Pathways Community HUB will directly address a portion of Domain I workforce development strategies by training community health workers in the region to provide community-based care coordination services.
    - NCACH plans to partner with Pathways Community HUB care coordination agencies to approach our local community colleges to develop a community health worker training program that meets Pathways Community HUB standards.
    - NCACH is advocating for an effective collaborative of ACHs working to implement the Pathways Community HUB and values the opportunities that would afford to organize some activities at the state level rather than separately in each ACH (e.g., IT arrangements, community health worker training capacity). This collaboration will help enhance the efforts NCACH has made toward the Pathways Community HUB model at a local level.

- Project 2C: Transitional care-Our preliminary selected approaches dovetail with some ideas specific to our Transitional Care Project that one of our healthcare partners recently shared. Specifically, they suggested that social workers/community health workers placed in EDs would allow for direct intervention with frequent ED utilizers, who often have complex social needs. This would improve follow-up, education and scheduling while proactively addressing social determinants of health driving ED utilization

North Sound Accountable Community of Health

- Preliminary planning in workgroups for each of the areas of the Project Toolkit identified anecdotal reports of workforce capacity gaps, such as Chemical Dependency Professionals in the area of Bi-Directional Integration and Opioids or Community Health Workers in the area of Care Coordination.
- Project 2a: Behavioral Health Integration Specific to bi-directional integration, opportunities for sustainability include exploring billing practices capable of supporting additional activities in clinical environments and leveraging the Pathways framework to sustain the activities of community health workers to improve care coordination systems among their own communities.
- Project 2b: Community based Care Coordination-the North Sound ACH embraced the Pathways Care Coordination model and its use of Community Health Workers (CHWs) as a means to address these commonly voiced barriers to care.
- In the bi-directional integration project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from within the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).
- North Sound ACH will pursue a Care Coordination project using the Pathways Community HUB model. Establishing a Pathways Community HUB in the North Sound region will ensure that patients in the target populations receive robust, patient-centered care coordination through community health workers who can help them navigate resources: in the Pathways model, community-based care coordinators go to where patients are and work with them and their families to overcome social and economic barriers to managing their health.
- In the Care Coordination project area, the North Sound ACH has a broad level of engagement from stakeholders across the region for the Pathways framework including Tribal Nations, community-based organizations and others able to leverage community health workers into the effort and the clinical and other partners able to serve as referral sources.
    - Workgroup leads in this area include a representative of a local FQHC: Sea Mar Community Health Centers, as well as a large health system partner: PeaceHealth. There is a robust existing workforce of community health workers and care coordinators based in the Community Service Organizations and Federally Qualified Health Centers across the North Sound region, including:
        - Health Home Care Coordination Organizations (CCOs) that provide care coordination services to high-risk Medicaid Enrollees. MCO and CCO partners may be able to support cross-training of Health Home care coordinators to also serve as Pathways community-based care coordinators.

        - Community health workers (CHW) who are employed throughout the region, at Community Based Organizations and at Federally Qualified Health Centers.
        - Other community based organization staff who serve in CHW-like roles but have not yet completed CHW training. Capacity building through training opportunities is an essential component for individuals and organizations which play a key care coordination role, but are not currently reimbursed for playing that role.
- In the Pathways HUB model, community health workers serve as care coordinators, and the North Sound ACH intends to leverage this existing workforce capacity to successfully engage the target populations where possible, and expand the workforce, especially among communities experiencing disparities, where CHWs with lived experience play a critical role as community liaisons.
- Project 3b: Reproductive Maternal/Child Health-While there is opportunity for workforce expansion in this area (especially around pediatric behavioral health care providers), there is a robust existing clinical, and nonclinical workforce across the North sound region, including Community Health Workers
- Project 3D: Chronic Disease Prevention-Asthma Home-Based Multi-trigger, Multicomponent Environmental Intervention (Healthy Homes): Healthy Homes targets persons with asthma or COPD and provides a holistic housing assessment coupled with environmental health education that includes:
    - a home education visit to help families take action to create a healthier home
    - inventory to support households in improving indoor air quality
    - comprehensive home assessment to identify indoor air health and safety hazards; referral to weatherization and home repair programs to improve indoor air quality, reduce asthma triggers and increase energy efficiency; one year of follow up service, both in-home and via phone.
    - Community health workers can become certified to conduct environmental assessments and refer to Healthy Homes.
- Already have a Community Leadership Council (CLC). Provided Education for Community Health Workers from Snohomish County Community Health Center on the work of the North Sound ACH, including invitations to both CHWs and engaged patients to participate in the CLC and project area workgroups

Southwest Accountable Community of Health (SWACH)

- Community members have highlighted the need for more peers and community health workers.
- SWACH's RFP process will include questions on equity. Additionally, community health workers were invited to the RFP process
- Workforce strategy- Community Health Worker training and practice integration; Support care coordinating agencies that employ community health workers (CHWs) who have lived experience working in communities disproportionately impacted by poor health outcomes;
- Project 2B: Community Based Care coordination- The HUB infra-structure provides tools and strategies necessary to ensure at-risk individuals in a
- community are served in a timely, coordinated manner, and utilizes a trained and expanding community health worker (CHW) workforce to do so.

    - As implementation continues, the Community Care Coordination Workgroup will evolve into a Community Advisory Council, which will include at least one representative from Community Health Workers serving the region.
    - The SWACH CCC Workgroup also finalized the Care Coordination Agency Application, which was recently released through an RFA process, to engage potential Community Care Coordination Agencies (CCAs) in the region who may be interested in contracting with SWACH to implement the Pathways model.
    - Additional points were also awarded to those applicants who currently employ Community Health Workers (CHWs) and Peers.
    - Building confidence in the Community Health Worker workforce is imperative to the potential growth of the workforce, as well as the success of the Pathways Community HUB. As previously highlighted, each of these CCAs are committed to health equity and currently provide culturally and linguistically responsive services to meet the diversity of PCACH resident's needs. Every one of these organizations already utilizes CHWs as part of their workforce structure and are adept at integrating CHWs into their overall team.
- Project 3D: Chronic Disease Prevention- seek to break down barriers to utilization of community health workers as part of a treatment team
    - SWACH's community engagement strategy stems from our merger with the existing Healthy Living Collaborative of SW Washington. HLC's Community Health Workers (CHWs) and Community Health Workers and Peer Support (CHAPS) networks are in communities and neighborhoods, working within our most vulnerable and marginalized communities across the region.
    - SWACH has incorporated HLC as the community outreach and engagement arm for our work under the MTP and more broadly across the region.

THE KING COUNTY HOUSING-HEALTH PARTNERSHIP

MAKING HOUSING A PLATFORM FOR HEALTH

BY BILL RUMPF AND TAVISH DONAHUE

LESSONS LEARNED

Much of what impacts health happens outside the doctor's office. Public and affordable housing organizations are uniquely positioned to partner with the health system to develop population health strategies that promote health and wellness in the communities where so many low-income Medicaid beneficiaries live. The evidence base for supportive housing programs serving the chronically homeless and other people with complex needs is already well established. Less known is whether health interventions for the broader family and senior populations in affordable and public housing communities improve health status, whether such programs can demonstrate ROI, and how the housing and health sectors can come together to sustain upstream population health interventions in a financially sustainable way.

This report shares the lessons learned from Mercy Housing Northwest (MHNW) and the King County Housing-Health Partnership's (KC Housing-Health Partnership) three-year experience testing Community Health Worker interventions and attempting to build a business case for using housing as a platform for health. Our hope is that the affordable and public housing sector will continue toward this objective by learning from our experience, as well as other innovative models for housing-health partnerships. We identified the following lessons from this three-year pilot:

1. *Biggest success: Engagement of underserved, vulnerable households.*
   The initiative was based in communities with very low-incomes and poor health indicators. Our Community Health Workers (CHWs) were quite successful in engaging residents who face significant language and cultural barriers to health with healthy lifestyle improvements. Data (shown on page 7) from seven of the sites shows 3,200 (duplicated) residents engaged in regular health promotion efforts, with average annual frequency of five times or more in health education and risk reduction, organized physical activities and healthy eating classes. The full profile of participating residents across 12 sites showed that roughly 90% were people of color; a majority were recent immigrants with quite low-incomes. Thus, CHWs are a potent tool to achieve equity and overcome health disparities.
2. *Biggest aspiration: More formal partnerships with health providers.*
   The KC Housing-Health Partnership identified relevant metrics from the Washington Health Care Authority's Common Measure Set—gender and age appropriate annual visits, immunization and prevention measures; however, we were unable to create the kind of relationship with Federally Qualified Health Centers (FQHCs) or other providers to coordinate community health efforts with clinical treatment plans, and to document relevant non-clinical activities in electronic health records. With more time, we had hoped to coordinate the type and frequency of CHW interventions with clinical care teams, particularly for persons with chronic health conditions.

   Our recommendations to expand housing-based population health efforts going forward:
3. *Housing-health data integration. Integration of Medicaid claims data (Washington's ProviderOne dataset), which provides comprehensive cost and clinical treatment information for all Medicaid users, with the individual and household-level data collected as part of affordable/public housing compliance could greatly spur collaboration between these two sectors. An integrated housing-health database (or broader "social determinant database") will show baseline health data on housing residents that will identify areas of need and shape more focused interventions, and creates capacity to measure the success of interventions.*

   Affordable and public housing is home for more than 250,000 people in Washington State, a large share of whom meet the income and/or age criteria for Medicaid and Medicare. In hindsight, it was a disadvantage to try to prove a business case before an integrated housing-health data system existed to evaluate the health system costs of these efforts. We strongly believe for both equity and financial reasons that housing- and community-based health work should not be limited only to the costliest clients of the health system. However, the most promising preventive and upstream health measures that can also bend the cost curve will focus on populations with an above average cost profile: seniors, pregnant women, children or persons that already have chronic health conditions such as asthma, diabetes, or obesity. We strongly support continuation of the public housing-Medicaid data integration effort in King County and expanding the housing-health data integration to a state level, using data already being collected.

A blood pressure screening at Appian Way's onsite clinic space.

4. *State-level institutional support for Community Health Workers. Community Health Workers (CHWs) are widely valued "philosophically" by health system stakeholders, but system supports (common standards for roles, reimbursement and training) are needed for this workforce to be stable and effective.*
   Health partners express interest in seeing more CHW activity, but the lack of standards for roles and training and intermittent grant funding creates major barriers from both the employer and employee perspective. The 2015 statewide Community Health Worker Task Force made a number of useful recommendations that have yet to be acted on by the Washington Department of Health and Health Care Authority. Oregon has established a CHW certification and a substantial training program, and much more extensive investment of hospital community benefit resources and use of Community Health Workers has resulted there. Similar progress has been seen in New Mexico, Minnesota, and other states where CHWs are paid a living wage and Medicaid managed care plans pay for a share of the work.

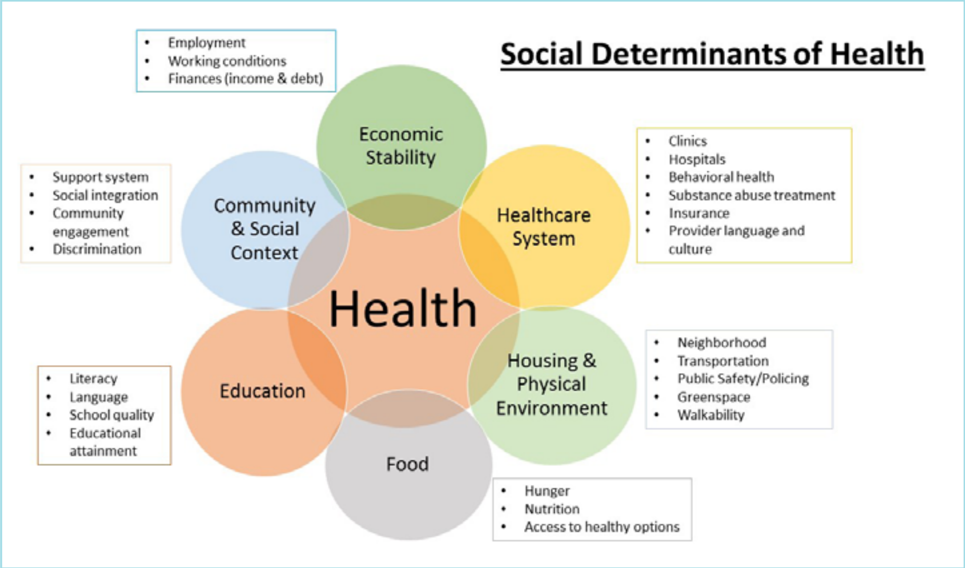
5. *Synchronize non-clinical health resources. A key strategy to expand upstream health efforts is to coordinate and braid funding and other resources across the social determinants. Washington State could leverage state purchasing power to mitigate fragmented health payment incentives. Local philanthropic, governmental, and housing entities could braid resources and make community investments in a more systemic and coordinated fashion.*
   Washington State purchases health coverage for over 2 million residents through Apple Health and Public Employee Benefits (PEBB) plans. The state would benefit financially from upstream measures that have a long-term payoff. By contrast, Managed Care Organizations (MCOs) have no financial incentives to pay for preventive health measures for persons insured by other plans, or to pay for activities promoting "healthy living" that produce savings long after the term of a current Medicaid contract. The HCA could change the "you get what you pay for" calculus to reward MCO's or primary

care providers for using CHWs and other interventions to promote healthy living among vulnerable sub-populations. Having funds dedicated specifically to prevention such as the Massachusetts Wellness Trust would support the evolution of activities with long-term ROI and health benefits. King County has embraced health transformation and devotes more resources than most jurisdictions to support community-based, non-clinical health promotion. These are flexible grant sources that are operated somewhat independently of each other for one to three-year grant terms. Community-based health and housing providers will need more stable multi-year support to undertake and document the effectiveness of health-housing partnerships. Best Starts for Kids, Communities of Opportunity and the Pacific Hospital Preservation and Development Authority (PHPDA) are King County-specific grant sources with roughly $34 million per year. Affordable and public housing owners also bring community facilities, resident service funds and relationships that could serve compatible goals: overcoming economic, racial, and health disparities with a strong vision of equity. If planned and allocated collaboratively, these flexible resources could change the map of health disparities.

Note: Pages 5 — 14 of this report serve as a case study of MHNW's three-year experience piloting an innovative housing-health partnership. The experiences detailed in the coming pages informed the lessons learned you just read. Page 15 lists the key partners referenced in the narrative.

CASE STUDY: HOUSING IS PART OF HEALTH TRANSFORMATION

As the Affordable Care Act was implemented in 2013-14, there was renewed interest in population health at the state level as part of the Healthier Washington plan and King County's Health & Human Services Transformation Plan to enhance the Medicaid delivery system. Health policymakers sought to engage other sectors that affected major social determinants of health. Leadership from the housing sector included strong work by Washington Low Income Housing Alliance and Corporation for Supportive Housing in advocating for a supportive housing benefit and from Mercy Housing Northwest (MHNW) representing the broader population of seniors, families and individuals living in affordable and public housing. As a result, the affordable housing community has been at the table for the implementation of health care reform in Washington State.



Health and wellness has been a longstanding part of Mercy Housing's resident services model - along with financial literacy, out of school time, housing stability, and community involvement. MHNW was inspired by the opportunity the ACA presented to expand health coverage for residents, and by an equity analysis done by King County. "The Public Health data mapping showed distinct correlation of disparities on many health indicators, income, and education," says MHNW's President, Bill Rumpf. "We hoped by engaging residents in improving health, we could reverse that map on other indicators as well."

MHNW looked for ways to supplement the health policy advocacy with specific interventions that could respond to the central premise of the Affordable Care Act—reducing high medical costs by expanding primary care and healthy-living choices. With over 250,000 residents in Washington living in public and affordable housing and a large majority of those falling within Medicaid and Medicaid expansion income guidelines, Rumpf and project consultant Betsy Lieberman saw an opportunity for housing to be a stable place to engage low-income residents "where they live."

For MHNW, Community Health Workers were a promising form of intervention. The communities with highest health disparities had significant income, language and cultural barriers. The CHW role is similar to Mercy's resident service model, with a particular emphasis on having cultural connections that seemed essential for families to engage and make changes on a topic as personal as health. The American Public Health Association defines a Community Health Worker 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."

Resident leaders from KCHA's Windsor Heights community proudly display their certificates after completing the Department of Health's Community Health Worker training program.

MHNW hoped to have more lasting impact than a local Community Health Worker pilot project could have. To pursue more systemic impact, MHNW convened a Housing-Health Partnership that has met for the past three years. The group was initially statewide and then focused in King County and brought together a cross-sector set of leaders with the goal of creating a replicable, scalable model for delivering housing-based health promotion. In addition, MHNW helped facilitate and supported efforts at the county and state level to create an integrated housing-health database. This report is meant to share the results and reflections of key participants from this housing-health approach.

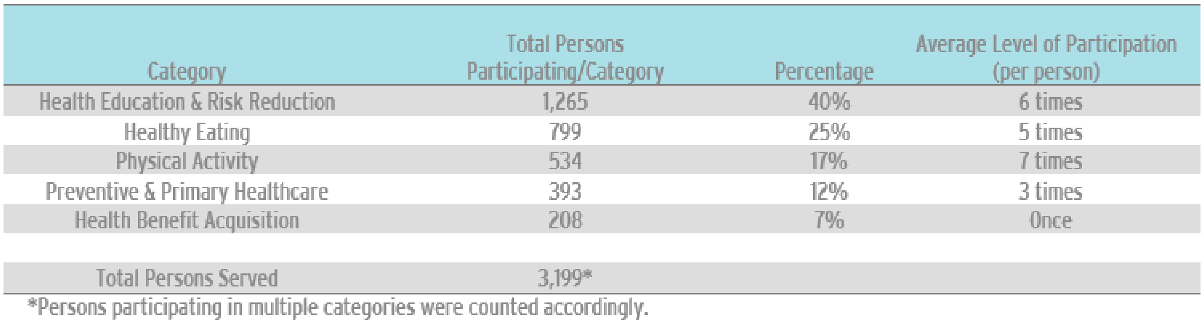
"Bringing Health Home" Community Health Worker Pilot Project

A three-year grant from the Pacific Hospital Preservation & Development Authority gave MHNW the chance to pilot an initiative known as "Bringing Health Home" that focused on health and wellness, embedding Community Health Workers (CHWs) in public and affordable housing communities in Southeast Seattle and south King County. Bringing Health Home ran from 2014 through 2017, with a team of CHWs and a CHW manager working in 7 affordable and public housing buildings across South Seattle and the cities of Kent and SeaTac in South King County. Interim Community Development and King County Housing Authority made housing sites available for the effort. Similar, informally affiliated community-based CHW efforts were operated by NeighborCare Health in Seattle Housing Authority properties and by Global to Local in targeted south King County communities. These CHW efforts were sited where the greatest health and income disparities exist in our region and where many new immigrants and refugees live. The partners wanted to reach residents with the most to gain from culturally and linguistically compatible CHWs with shared lived experience.

The program was based on a preventive population health approach that was provider and payor neutral-working across health systems rather than only serving residents from one clinic or health plan. Participants were not pre-selected based on health status. All residents in the community were eligible to participate, not just residents in the building but those from the surrounding neighborhood. Programs were free and the CHWs formed local partnerships with health providers to offer free or low-cost services on site whenever possible. Each month the CHWs created an activity schedule to keep residents engaged, including healthy eating/active living programs, enrollment assistance, health fairs (and other on-site primary care like mobile medical and dental), care coordination, and chronic disease self-management.

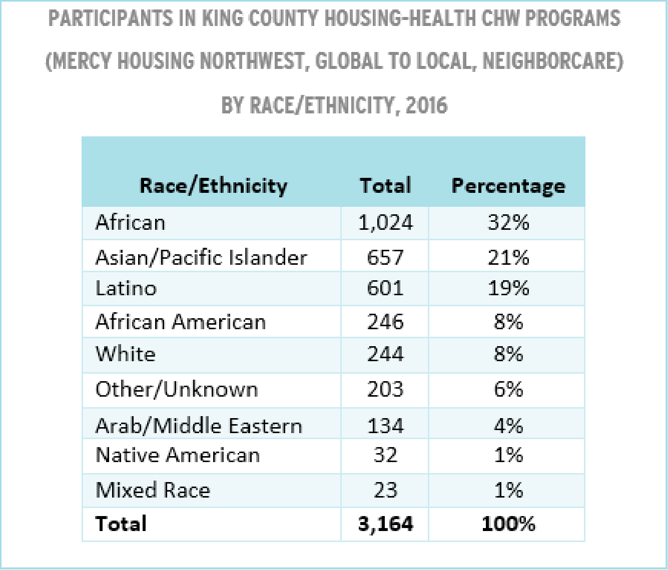
MHNW, Global to Local and NeighborCare Health CHWs all had strong success at engaging underserved residents. Residents engaged in repeated health promotion activity. The areas of higher activity were in health education and risk reduction, organized physical activities and healthy eating classes, with average annual frequency of five times or more among participants in those categories. The profile of unduplicated participating residents across MHNW, NeighborCare, and Global to Local showed that roughly 90% were people of color; a majority of whom were recent immigrants with quite low-incomes.

MERCY HOUSING NORTHWEST CHW PROGRAM PARTICIPATION BREAKDOWN, 2016-2017



Category	Total Persons Participating/Category	Percentage	Average Level of Participation (per person)
Health Education & Risk Reduction	1,265	40%	6 times
Healthy Eating	799	25%	5 times
Physical Activity	534	17%	7 times
Preventive & Primary Healthcare	393	12%	3 times
Health Benefit Acquisition	208	7%	Once
Total Persons Served	3,199*		

*Persons participating in multiple categories were counted accordingly.



PARTICIPANTS IN KING COUNTY HOUSING-HEALTH CHW PROGRAMS

(MERCY HOUSING NORTHWEST, GLOBAL TO LOCAL, NEIGHBORCARE)

BY RACE/ETHNICITY, 2016

Race/Ethnicity	Total	Percentage
African	1,024	32%
Asian/Pacific Islander	657	21%
Latino	601	19%
African American	246	8%
White	244	8%
Other/Unknown	203	6%
Arab/Middle Eastern	134	4%
Native American	32	1%
Mixed Race	23	1%
Total	**3,164**	**100%**

Building Trust

CHWs were recruited with two primary priorities- language skills and a passion for community engagement. MHNW hired staff with shared language and lived experience to the dominant immigrant communities in the 7 sites where the program was launched. Along with being fluent in English, MHNW's CHW team spoke Amharic, Oromo, Russian, Somali, Spanish, and Vietnamese. Most did not have a health background. A lack of technical health knowledge was not an impediment to success; what made the MHNW CHWs effective was their cultural competence, experience working in the community, and proficiency in nurturing partnerships with health partners.

Despite their common language and culture, it took time for the CHWs to establish trust. The program was new and some residents were suspicious. A large community of Russian/Ukrainian seniors had been targeted by a health insurance scam and were hesitant to engage with MHNW CHW Natalie Kotar. What worked was taking the time to get to know the residents and their areas of interest. Engagement included 'community cafes' to learn what residents wanted and needed from on-site health and wellness programs, and a simple health survey that gave baseline information about insurance, use of primary and emergency care, physical activity and food access. CHWs identified and engaged resident leaders who had earned the trust of their neighbors. Ultimately programs were designed in response to community needs and the resident leaders helped build up excitement and encourage participation.

Residents enjoy their weekly yoga class.

Overcoming Language Barriers

While the CHW teams had a notable level of cultural competence and language skills, it still required creativity to reach all backgrounds. At some housing communities 17+ languages were spoken. The CHWs developed an effective method for engaging residents when they could not rely on a common language- reaching out to community leaders (many of whom spoke excellent English) to help with translation. This proved more effective and personal than hiring a translator, "we've learned that working with the community leaders serves the community better," says CHW Hodo Hussein. This approach fostered cross-cultural participation and allowed more residents to participate in the programs.

The Power of Accessibility and Presence

MHNW's model of embedding CHWs in housing communities has made them effective in ways that a clinic-based CHW doing home visits with large numbers of clients may find difficult. By virtue of being in the same place every day the residents got comfortable with the presence of CHWs and adapted to the routine of daily programs and office hours. It was easier to connect with residents, follow-up, and give reminders. They knew the CHWs were there for them and were more likely to reach out for assistance with health needs and other social determinants like transportation, housing, and employment since they were comfortable with their CHW and had already established a trusting relationship. "You connect on a deeper level," says Hussein. "It's a lot easier to develop trust when you're working with someone every day. They see you as a family member. Someone who is there to serve them and to help them. With that trust, that's what keeps them coming back to the programs."

Confronting Stigma and Changing Habits

The cultural know-how of the CHWs had another clear benefit; they understood the stigmas around health that exist in their communities and how to work through that with residents. The CHWs reported a lot of stigma around immunizations in several of the cultural communities; they feel that it makes them sicker. The CHWs pair free flu shot events with health education to help overcome some of that stigma. The CHWs are also effective at encouraging residents to use primary care, an unfamiliar concept for many of the newer arrivals who won't use services unless they are in severe pain and think they really need it. The CHWs take the time to listen to the resident's concerns and address them, building on the trust and connection they have already established.

HOUSING-HEALTH DATA INTEGRATION

Public Health Seattle & King County (PHSKC), partnering with Seattle Housing Authority and King County Housing Authority, has made notable progress in creating an integrated housing-health database for King County. This work was supported by the Robert Wood Johnson Foundation's Data across Sectors for Health (DASH) initiative. PHSKC secured a data-sharing agreement enabling them to use housing data on residents of public housing and all recipients of Section 8 vouchers, and they are integrating this with the state's Medicaid ProviderOne claims records. This integrated data will provide a profile of health costs, demographic and income information and health diagnosis information for over 50,000 residents.

This data integration work has potential for wide replicability because both the public housing/voucher dataset and the Medicaid claims data are collected in relatively standard formats in states and jurisdictions all over the country. Washington State's DSHS Research and Data Analysis Division has undertaken similar data integration of housing, health and other social service and education data at a state level. An important additional housing data-set is held by the Washington State Housing Finance Commission and Department of Commerce which collects annual report data for state and city-funded affordable housing in the Web-Based Annual Reporting (WBARs) system.

Initial PHSKC analysis shows that roughly 80% of the 65,000 KCHA and SHA residents receiving federal housing subsidies are enrolled in Medicaid, validating the hypothesis that there was significant overlap between the Medicaid and public housing populations. The combined database will contain de-identified data that can provide key information about the health issues residents' face. Confidentiality will be maintained at the household level, but when fully functional, the integrated data will be a great resource for analyzing needs by geography and sub-populations, and for evaluating the impact of prevention efforts.

This work builds on the groundbreaking 2016 CORE/Enterprise study from Portland that demonstrated how housing paired with health care services increases access to primary care and reduces emergency department visits, lowering Medicaid costs by an average of 12% for the residents included in that study.

For the Bringing Health Home initiative, MHNW tracked program metrics in terms of points of service and intensity of engagement in various categories (ie. attending exercise classes, nutrition counseling, getting a screening at a health fair). MHNW CHWs were not able to access resident's health information or report community-based health promotion efforts in clinic Electronic Health Records (EHR) systems. During the pilot, CHWs relied on anecdotal evidence and self-reported health and wellness survey data to get a better sense of the health needs and utilization patterns in the selected residential communities. Mercy Housing assessed the cost of becoming HIPAA compliant to enable more data-sharing, but HIPAA compliance carries one-time and on-going costs, which far outstripped any revenue potential for a housing organization engaged in non-clinical health promotion.

MEANINGFUL METRICS FOR COMMUNITY-BASED HEALTH WORK

The KC Housing-Health Partnership was selected in 2016 as the King County Accountable Community of Health's state innovation model (SIM) project. Washington State required each region to select a SIM project to practice working across sectors on a regional health improvement project. As part of the SIM, the KC Housing-Health Partnership partners constituted an implementation advisory group with public health, hospital and Medicaid managed care representatives who provided useful guidance in choosing meaningful metrics for program design and evaluation so that community-based programs could produce a Return on Investment (ROI) and results that are responsive to the broader goals of health reform.

The group identified a mix of promising health measures that are included in Washington's Common Measure Set- a list of health metrics used in the state's Medicaid contracts. Promising measures were age- and gender-appropriate annual primary care visits, immunizations, as well as broader indicators touching on social determinants like housing stability and food access.

Adam Taylor, Executive Director of Global to Local has been wrestling with the issue of metrics for some time. "Let's look at some of the metrics that are important to health payors and we'll work on those, but at the same time we're going to continue to do the preventive, coaching, physical activity, nutrition; those things are supplemental to the measures that the clinic uses," Taylor says of his experience negotiating this tension. "We're trying to show a value to the health system but also hopefully pull along some of the upstream preventive activities." Currently the upstream preventive activities are possible only for the purposes and duration that can be supported by grants, and are not part of a clinical reimbursement model. Taylor would advise a level of alignment with clinical measures even though his heart is in the community. "We're still a ways out from the healthcare world buying in from a funding perspective. Many have bought in psychologically and emotionally but they're not there with their financial modeling," he says.

Dr. Marguerite Ro, Chief of Assessment, Policy Development, and Evaluation at PHSKC says, "there are population level measures in the Common Measure Set that CHWs in low-income housing developments absolutely can effect. Well child visits, immunizations, those are big ones. Even oral health visits, primary care visits, these are things we know we can help to effect on the health side." Ro is an advocate for finding ways to work at the intersections of the social determinants and her department at PHSKC has been a key ally for organizations developing innovative community-based models. She sees a lot of opportunity for success with a longer term, multi-year intervention focused on particular segments such as pregnant women, children, seniors, etc.

SUSTAINING POPULATION HEALTH AND PREVENTION EFFORTS

National housing intermediaries, such as Enterprise Community Partners and the National Housing Conference and the Federal Reserve Bank of San Francisco have held conferences and provided financial support for experimentation in affordable and public housing communities as a potentially cost-effective platform for activities that improve health access, wellness and healthy communities.

Bringing Health Home and the KC Housing-Health Partnership illustrated great potential for housing-based Community Health Worker and other housing-based healthy-living and prevention initiatives, during its 3-year grant funding period, but financial sustainability proved to be the most difficult challenge. Research by Joy Lee, University of Washington School of Public Health, on behalf of MHNW, found that grant funding is the most prevalent resource model for community-health worker programs.

An impromptu soccer game on the grounds of Windsor Heights.

Cost savings from a resident making incremental lifestyle changes after participating in healthy eating/active living programs at their housing complex may take 5-10 years to bear fruit. The same resident may change health plans and medical homes multiple times over the same time period, making it challenging to apply the cost savings to whoever made the upfront investment. Adam Taylor of Global to Local notes: "We have 5 Medicaid managed care organizations (MCOs) in Washington. I've heard MCOs ask, why would I invest if I don't know if that person will be on my rolls 5 years from now? Whose responsibility is it to make those investments? That's one of the big challenges." As the current political environment, exemplified by threats to Medicaid and the Affordable Care Act, becomes more stable, population health does have low-cost, long-term payoff potential.

Stable funding is not the only requisite for progress. States that have taken steps to create system supports for Community Health Workers have seen much stronger evolution of a CHW workforce and population health initiatives. Oregon has established a CHW certification and a substantial training program, and much more extensive investment of hospital community benefit resources and use of Community Health Workers has resulted there. Similar progress has been seen in Minnesota, New Mexico, and other states where CHWs are paid a living wage and Medicaid managed care plans pay for a share of the work. California, which doesn't have a statewide CHW certification program, is testing the large scale efficacy of CHWs and peer support specialists as a component of its Whole Person Care initiative. Massachusetts has a Wellness Trust that provides stable support for a variety of community-based health interventions.

Washington's Department of Health and Health Care Authority convened a Community Health Worker Task Force which produced a report after five months of convenings in 2015 that explained the variety of CHW roles and competencies in Washington. Most likely due to larger challenges in implementing Washington's Medicaid waiver at the state and regional levels, there has not been much follow-up yet from the Task Force report. King County has a number of local governmental and philanthropic initiatives that support cross-sector population health efforts, like Best Starts for Kids, Communities of Opportunity, and the Pacific Hospital Preservation and Development Authority. These funding sources could coordinate their efforts to maximize impact and lift up community-based population health efforts that struggle to remain financially sustainable. In addition, affordable and public housing owners bring community facilities, resident service funds and relationships that could serve compatible goals: overcoming economic, racial, and health disparities with a strong vision of equity. If planned and allocated collaboratively, these flexible resources could change the map of health disparities.

MOVING FORWARD

In closing, we want to express gratitude to all of the funders and partners that have been part of Bringing Health Home and the KC Housing-Health Partnership. Many of these entities are listed on the back pages of this report.

Mercy Housing is strongly committed to continuing to pursue and expand linkages between housing and health. Shifting the predominate pattern of health expenditures on acute and specialized care to more primary and preventive care is a long-term challenge. Aside from the complexity of health expenditures, the distinct correlation between lower-incomes and poor health outcomes is unacceptable and there is a strong equity case for continuing to remedy this.

A group of residents prep vegetables during a healthy eating class.

A key takeaway from this project is the importance of investing in diverse communities by bridging culture and language. Embedding culturally competent CHWs in housing communities was a very effective way to do this and allowed us to nimbly respond to needs and empower community assets like the resident leaders. Investment in data was another important lesson, particularly how to work around localized challenges with a systems-change approach that can have broader impact. A county-wide housing-health dataset will be a major win for our community, particularly if it is replicated at the state level.

As an affordable housing provider we are well aware of the role of housing as a key social determinant of health. We were also often humbled by our limitations in terms of expertise, health regulatory issues and specialized funding, so this truly has to be a cross-sector undertaking. The recommendations made on pages 2-4 of this report present our suggestions for how to move this type of intervention beyond pilot programs. Please direct questions and suggestions to Bill Rumpf at brumpf@mercyhousing.org

ABOUT MERCY HOUSING AND MERCY HOUSING NORTHWEST

mercy
HOUSING

Mercy Housing creates stable, vibrant and healthy communities by developing, financing, and operating affordable, program-enriched housing for families, seniors and people with special needs who lack the economic resources to access quality, safe housing opportunities.

Mercy Housing's core values guide decision-making at all levels of the organization:

- Respect – A basic perspective and behavior which is attentive, considerate, and shows special regard for the inherent dignity of persons
- Justice – The fair and impartial treatment of others
- Mercy – The ability to see need and respond with compassion.

Mercy Housing Northwest (MHNW) is a regional arm of Mercy Housing, one of the largest nonprofit affordable housing organizations in the country, owning and operating more than 20,000 affordable apartments in 24 states. In our two decades in Washington State, MHNW has developed and preserved over 2,000 units of affordable housing in 48 properties across the state, and now provides approximately 5,000 low-income individuals each year in our community with an affordable place to call home.

KING COUNTY HOUSING & HEALTH PARTNERSHIP PROJECT PARTNERS

GLOBAL TO LOCAL
neighborcare health
King County Housing Authority
Public Health Seattle & King County
Seattle Housing Authority
HealthPoint
Somali Health Board – Peace, Unity, Life, Health
INTERIM CDA

THANK YOU TO OUR PROJECT FUNDERS

BILL & MELINDA GATES foundation
PHPDA PACIFIC HOSPITAL PRESERVATION & DEVELOPMENT AUTHORITY
Communities of Opportunity – Seattle Foundation – King County
BOEING
Enterprise
Public Health Seattle & King County
Washington State Health Care Authority

mercy HOUSING

6930 Martin Luther King Jr. Way S. | Seattle, WA 98118 | mercyhousing.org/northwest