Verdant Health Commission:
Community Health and Wellness Assessment

Executive Summary

Purpose, Team, and Method

The Verdant Health Commission asked for an assessment of the health needs of the communities served by the Public Hospital District No 2 to serve as an empirical foundation for setting investment priorities and defining future directions for its work.

The project team was led by Strategic Learning Resources and included George Kosovich of the Verdant Health Commission, The Gilmore Research Group, and staff from the Snohomish Health District, Snohomish County Human Services and the Snohomish Workforce Development Council.

The team collected and integrated data from four different data streams:
1. Quantitative Health and Socio-Economic Data
2. A Community Conversation with 39 local health and social service providers
3. A multi-modal survey which reached 400 residents
4. Focus groups involving 96 residents

Health Impact Pyramid

In Part II of the report, the key findings of the assessment are synthesized across the four data streams, and organized around a public health framework called the "Health Impact Pyramid." The Pyramid defines five different levels of community health interventions, and highlights the relationship between the potential impact of an intervention and the level of difficulty typically involved in implementation.

Interventions at the base of the pyramid create greater lasting long term improvements in community health, but can be most challenging and even controversial to accomplish. By contrast, interventions at the higher tiers of the pyramid are generally easier to accomplish, but they have less impact on the overall health of the community.

The clustering of assessment findings into the Health Impact Pyramid tiers allows the organization of information into actionable categories that relate to how effective a strategy may be, and how challenging it may be to implement.

Intersections and Implications

Part III looks across the health pyramid categories, and pulls out five over-arching messages which provide clues to where and how Verdant might invest to achieve its mission to improve the health and well-being of the community.

Message 1: Place and demography matters
- There are significant differences apparent by neighborhood and ethnic group, and these encourage Verdant to strategically focus its efforts on the neediest.

Message 2: The District is complex and social connection is hard to find
- The District is divided by major arterials and highways, and also by social divides in income, ethnicity, and language.
- Providers and residents, in different ways, expressed the belief that increasing social connectedness will support the health of families and communities.
- Spearheading the building of community and social capital could provide a platform for improving well-being across the diverse groups in the districts.

Message 3: The complexity of service systems is a barrier for both providers and clients
- System complexity, and the regulatory bureaucracies which accompany many service systems, create a disempowering environment in which both providers and residents frequently feel under-informed, misinformed, confused or just plain frustrated.
- There is considerable room for the development of new approaches and technologies for simplifying and bridging systems to support both providers and clients.

Message 4: Cost of care and lack of insurance are the greatest obstacles for adults seeking care.
- Many families find sliding scales and co-pays prohibitive even if they have some insurance, and many adults in the District choose not to seek services at all or to 'wait it out' until a health problem rises to the level of crisis.
- Flexible funding could leverage the ability of the people who 'fall through the cracks' because of a lack of insurance or under-insurance to receive care.

Message 5: Care-givers need support
- Family care-givers – including both single parents and care-givers of elder spouses or parents - feel isolated and have high support needs, irrespective of income level.
- Professional care providers also need support. They asked for venues to share information and learn from other providers, to increase connection and coordination, and work towards the common good of the community.
- Using the filter of supporting the people who do the work of care in homes, in the community, and in the professional sector may be another way to leverage investment in the community. Families and service systems can be made stronger by supporting care-givers in their efforts to support loved ones or clients.

Roles and Investment Opportunities

As Verdant sets priorities and develops a portfolio of short-term and longer-term investments in the health of the District communities, the assessment findings suggest five possible roles Verdant might play. These roles are not mutually exclusive and Verdant will undoubtedly have more than one role in the community. On the other hand, Verdant will have the greatest impact if it sets clear directions that can be articulated to, and supported by, the community.

The five roles, designed to spark further conversation within the Board, are:

Gap Filler	*Provide strategic and targeted assistance to a) help people gain access to services where cost is a barrier and b) support the development of new programs where there is an unfilled need in the District.*
Door Opener	*Help welcome the most vulnerable into systems of support, create bridges between systems, and assure that there are 'no wrong doors.'*
Convener	*Bring together private and public providers, policy-setters, and decision-makers to work together to solve system-level problems*
Community-Builder	*Create settings and experiences that foster social connection and a culture of health at the community level.*
Advocate	*Take a stand on issues which directly affect the health and well-being of residents in the Hospital District.*

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Recruited & Supported Attendees for Provider Conversation Café

- Arc of Snohomish County
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- City of Lynnwood
- Cocoon House
- Compass Health
- Domestic Violence Services of Snohomish County
- Edmonds Community College
- Edmonds Senior Center
- Evergreen Manor
- Little Red School House
- Lutheran Community Services Northwest
- MarkWell Health & Wellness
- Project Access Northwest
- Providence Medical Center
- Puget Sound Christian Clinic
- South Snohomish County Emergency Cold Weather Shelter
- Swedish Edmonds
- Volunteers of America, Western Washington

I. Introduction and Context

PURPOSE

The purpose of this community health and wellness assessment is to help the Verdant Health Commission identify the behaviors, perspectives, and economic and environmental factors that contribute to the current and future health status of the communities served by Public Hospital District No 2. This window into the health needs of the community is intended to support the Commission in setting investment priorities and defining future directions for its work.

APPROACH

The Project Team

The project was led and managed by Strategic Learning Resources, Inc. (SLR.) George Kosovich of the Verdant Health Commission partnered closely with SLR, helping to evaluate options and providing ongoing guidance to the project team. The Snohomish Health District provided data support, participated in analytical discussions, and helped to staff focus groups and the community conversation with local providers. The Gilmore Research Group[1] conducted the multi-modal survey, and Snohomish County Human Services Department and the Snohomish Workforce Development Council contributed quantitative socio-economic and health data.

Data gathering processes

The Verdant Health Commission requested an assessment process that:

- included both quantitative and qualitative data gathering;
- tapped the best available health, demographic, and economic data, and
- effectively engaged the communities served by the Hospital district.

The assessment process therefore included the development of four distinct data sets:

1. Quantitative Health and Socio-Economic Data
The Snohomish Health District updated a community health assessment conducted in 2010 for what was then called Stevens Hospital to reflect current data drawn from numerous sources including the 2010 Census, 2010 Behavioral Risk Factor Surveillance Survey (BRFSS), and the 2010 Healthy Youth Survey.

Other project partners – including Snohomish County Human Services and the Snohomish Workforce Development Council – contributed data resources and participated in meetings to review and discuss them.

2. Community Conversation with Providers
On April 10, 2013, Strategic Learning Resources, with support from Snohomish Health District staff, facilitated a Conversation Café that brought together 39 providers of health and social services in the Hospital district. In a series of lively conversational "rounds," participants defined success factors in connecting clients with services, shared perspectives on opportunities for positive change, and identified highest priority areas of concern.

Many providers expressed gratitude for the opportunity to meet, connect with, and learn from one another and voiced appreciation of Verdant's commitment to hearing their perspectives.

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[1] Gilmore Research Group closed for business as of May, 2013.

3. Multi-modal Survey of Residents
The Gilmore Research group conducted a phone and online survey of Public Hospital District No 2 residents, which was completed by 400 respondents. The survey primarily focused on issues of access to care, and also included questions about personal assessments of health status and participation in educational programs.

4. Focus groups with Residents
Strategic Learning Resources, with support from Snohomish Health District staff, conducted 12 focus groups, through which we heard from 96 residents. The groups were designed to elicit stories from selected populations that are otherwise difficult to reach due to language, cultural, or socio-economic factors.

We talked with:

- 3 groups of low-income residents, including single mothers who are currently homeless or were recently homeless, and a gender-mixed group of low-income residents living in low-income housing.
- 3 groups of Spanish-speaking parents, both mothers and fathers.
- 3 groups of young people, including homeless youth, participants in a YMCA youth development program, and students attending a college-based, high school youth re-engagement program at Edmonds Community College.
- 4 groups of family caregivers, primarily older residents caring for spouses with dementia, stroke, Parkinson's and other chronic illnesses.

Many focus group participants thanked us sincerely for the opportunity to be heard and the chance to hear others' experiences and perspectives.   Most were not aware of Verdant prior to their participation and many were genuinely interested to learn about Verdant's role in community health and wellness.

Challenges and limitations in data gathering

Limited number of focus groups possible
We could not directly reach all vulnerable populations through focus groups within the parameters of the project.

Challenges in Focus Group recruitment
It was difficult to ensure that all the focus group participants were district residents, though we were able to draw most participants from the immediate area.

Disproportionate Sample in Survey
Despite the efforts of Gilmore Research to over-sample minority populations, the respondent group they were able to reach were disproportionately White and higher income. This suggests that the sample may not be representative of the population in all aspects of the survey.

HEALTH IMPACT PYRAMID FRAMEWORK

Verdant elected to use the "Health Impact Pyramid," which aligns with their current priorities, as a conceptual framework to help organize data on the broad issues of community health and wellness into actionable information.
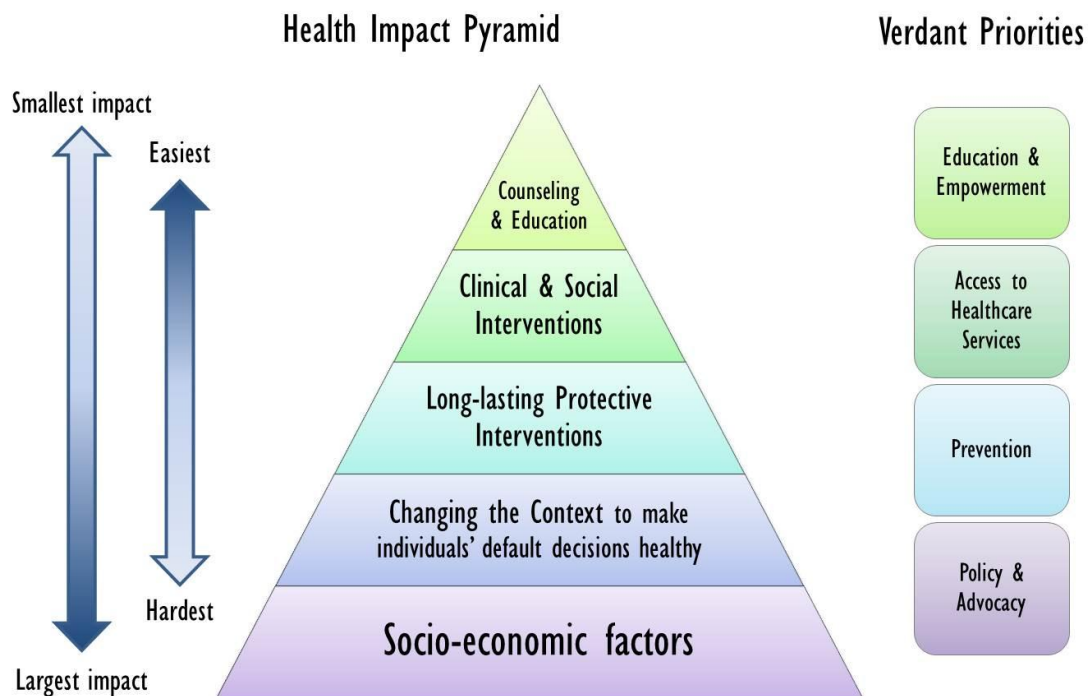
The "Health Impact Pyramid" is a public health framework developed by Dr. Thomas Frieden, Director of the Center for Disease Control and Prevention. It graphically reminds us that "public health involves far more than healthcare," and is useful for organizing and differentiating our thinking about types of community health interventions. The pyramid also highlights the relationship between the potential impact of an intervention and the level of difficulty often involved.   Interventions with the greatest potential impact are often the most challenging and controversial to accomplish, and require the highest levels of political will and perseverance.

The Health Impact framework illustrates the types of interventions that impact community and individual health:

- The socio-economic factors at the base, such as poverty and culture, have the largest impact on community health and wellness and are also the hardest to influence.
- The second tier of the pyramid focuses on opportunities to make it easier for individuals to make healthy choices (such as building sidewalks or reducing the cost of fresh fruits and vegetables). These are areas where government, business, and other organizations can often make an impact through policy and program, but which may also have political and substantial financial barriers.

- The third pyramid tier represents interventions and behaviors, which are required infrequently in the life of an individual but, can have long-term affect (such as immunizations.) Many public health and human service programs related to protective and risk reduction factors fall in this area.
- The fourth level relates to the direct clinical and social interventions that impact the health status of individuals and families. From a community perspective, this can range from the broad issue of access to care to best practices in the coordination of care for chronic diseases. This is the realm of medical, mental health, and other providers. While relatively easier to carryout than addressing the lower levels of the pyramid they generally have less of an impact on the community's health.
- The top level, education, involves expanding what people know about healthy living and managing their illnesses and is the easiest to achieve, but generally has the least impact on overall population health.

To say that social and contextual changes are more effective at improving public health is not to imply that other interventions should be ignored…Comprehensive public health programs should generally attempt to implement measures at each level of intervention to maximize synergy and the likelihood of long-term success.
– Thomas Frieden

"A Framework for Public Health Action: The Health Impact Pyramid" American Journal of Public Health, April 2010, Vo. 100, No 4

In the next section of the report, we have used the tiers of the Health Impact Pyramid as the organizing structure for presenting of the major findings of this assessment.

II.   What the Assessment Tells Us

TIER 1: SOCIO-ECONOMIC FACTORS AND THE HEALTH OF THE DISTRICT

Income and Income Disparities

Differences in health status are linked both to income and to income disparities across communities. To understand the health status and the health needs of residents, a deeper understanding of their socio-economic conditions is necessary.[2]

There are large variations across the Hospital district in age, income, household worth, home ownership and ethnicity. Highway 99 is a rough dividing line. West of the highway, residents are older and whiter and East of it they are younger and more ethnically diverse. Renters and low-income residents concentrate along Highway 99.

One way to understand the demographic range is to consider the story of two census tracts[3] representing two neighborhoods, one in Edmonds bordering the Sound, and the second at the north end of the District bordering Highway 99, just five miles apart.

> *"The complex, integrated and overlapping social structures and economic systems are responsible for most health inequities… Social determinants of health are shaped by the distribution of money, power, and resources in local communities…"*
> *- Commission on Social Determinants of Health, WHO*

	In Edmonds	North-99
% of residents living below poverty	6.2%	18.5%
Median Age - Years	57.6	30.4
Owner Occupied Homes	94%	24%
% of Households that are single parent	3.3%	9.9%
% of Households that moved into current unit within last 5 years (2005 or later)	38.6%	81.4%

As we think about the meaning of the socio-economic data, it is important to remember that the definition of poverty used by Federal and State governments reflects extremely low levels of income. In 2013, a family of four needs an annual income of $23,550 or below to be considered poor under Federal guidelines. In the focus groups, described later in this report, we heard that

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2 Appendix A offers maps that illustrate in detail the many ways that areas within the District differ demographically from one another. It also contains tables providing socio-economic data by census tract for the hospital District. Appendix B provides demographic and health status data by zip code from a variety of sources.

3 U.S. Census 2010. Census tracts roughly represent neighborhoods with populations typically between 3000-7000.

families who make more than this experience significant financial barriers to access and that their economic status can affect their health status in a range of ways.

A helpful concept that offers an alternative to "poverty levels" is the notion of "economic security." Economic security is defined as the level of income that allows a family to sustain itself without government support. In Snohomish County achieving economic security requires an annual income of $71,604 for a family of two workers and two small children.[4] Similar work has been done to assess economic security for people 65 or older, taking into account potential long-term care costs. For example, in Snohomish County a person over the age of 65, living on their own, in a house they own fully and requiring 16 hours of care a week is estimated to need an income of $45,052 per year. Many people in the District live below these income levels.

Health and Social Condition Indicators

The differences in socio-economic condition within the hospital district appear to translate into differences in health status and, as we will see, in access to care. Health status information is not available at a census tract level of detail, but was developed by the Snohomish Health District by zip code.[5] Related social and environmental data was developed by Snohomish County Human Services. In both data sets, a similar pattern of variation can be found as with critical demographic factors.
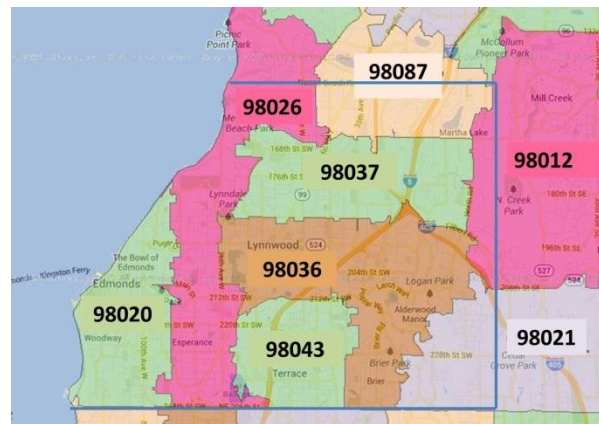
At first blush, the residents of Public Hospital District 2 appear healthy. When asked 60% of respondents in the multi-modal survey reported being either in very good or excellent health and only 12% reported being in fair or poor health. Mortality and morbidity rates are also lower in the District than for the rest of Snohomish County. But these aggregated data points do not tell the whole story. Within the district there are wide variations in mortality rates and other health indicators. For example:

- The zip code 98020, which encompasses Woodway and Edmonds, has the lowest mortality rate, but zip code 98037 - just a 15-minute drive away - has an age-adjusted mortality rate that is 60% higher and considerably higher than the County's overall rate.
- There is a two-fold difference in the report of smoking by adults between 98020 (9%) and 98087 (22%).
- 98087 has almost twice the rate of mothers who do not get prenatal care in the first trimester as 98021.
- 98043 has almost twice the rate of obesity as 98020.

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[4] From the Economic Security Institute, Basic Economic Security Tables and Elder Economic Security Standard Index.

[5] The eight zip codes selected for analysis include but extend past the District boundaries. The zip codes are large areas with most having between 20,000 – 36,000 residents. They are not tied to natural communities and are therefore only crude representations of geographic variation.

Indicators that relate to the need for services and access to care have a similar pattern:

- 98043, 98036 and 98037 have admission rates to outpatient treatment for publicly funded substance abuse that are two to three times the rate for 98020.[6]
- There is a five-fold difference between the percent of residents without health insurance in 98020 (4%) and 98087 (21%).
- Similarly, 42% of residents of 98087 report that they did not have a primary care provider, compared to only 9% in 98020.
- 98043, 98036 and 98037 also have the highest rates of homelessness, 5 – 7 times that of 98020.[7]

Demographic Trends

There are two critical demographic trends that influence health status, the types of supports the community may need, and the opportunities for improving the health of the community: aging and increased ethnic diversity.

Aging

Like much of the country, Snohomish County and the hospital district are aging. Today, 12% of the population is 65 or over and this number is expected to rise to 20% by 2030. According to the Family Caregiver Alliance, almost 20% of the US adult population already provides care for a family member who is over age 50 and more than 6% care for someone with Alzheimer's disease or other dementia. These numbers can be expected to increase as the size of the elder population grows.

Diversity

The increasing diversity of the District and the County is a countervailing trend that brings its own particular needs and opportunities. While the population of residents who are 65 and older is disproportionately White, the younger populations are more diverse. Overall, 73% of the hospital district's population is White, 14% is Asian/Pacific-Islander, and 9% is Hispanic. The Edmonds School District has more than 2,000 students who speak 82 different languages.

There are no reliable forecasts of ethnicity for Snohomish County, but the changes from 2000 to 2010 tell the story of recent shifts. The greatest growth has occurred in Hispanic and Asian/Pacific Islander ethnic groups. It is important to consider that within these large Census-designated groups there are many different countries and cultures represented.

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[6] This may not reflect a difference in the rate of substance abuse, as residents of 98020 are more likely to seek privately funded treatment.

[7] As measured by the number of people/10,000 who received homeless related services, and reported these zip codes as their last stable housing in 2012.

Snohomish County Growth 2000-2010			
	% Growth	Number[8]	% Contribution to Growth
Snohomish County	18%	107,311	
White	5%	23,050	21%
Black	74%	7,446	7%
Native American	10%	759	1%
Asian/Pacific Islander	79%	29,248	27%
2 or more Races	76%	11,149	10%
Hispanic	122%	35,299	33%

The pattern of large variations seen for other socio-economic characteristics across the Hospital district is also seen ethnicity, with census tracts having populations ranging from 7% to 46% non-White.

Data Come to Life

The impact of the differences in how people live and who they are was made visible during the study. For example during the Community Conversation, providers raised issues based on their lived experience, which were further illustrated by the quantitative demographic and health data.

Some issues raised by providers are likely to be outside of Verdant's scope. Immigration reform, for example, was seen as vital to improving access for both legal and undocumented immigrants to health services, social supports, education, and economic security. Economic development geared to increasing the number of local jobs that provide economic security and health insurance was seen as another high priority for helping low-middle class residents access mental health, dental, and basic health services.

> *"I think having a job is a big part of being healthy because a lot of the stress is removed when you can actually pay your bills, and that is also good for keeping the body and mind healthy."*
> *— Spanish-speaking resident*

However, providers also talked in-depth about how the wide economic disparities, the sense of Highway 99 and I-5 being geographic divides, and the presence of multiple ethnic cultures are all part of a puzzle that works against the experience of a common community. They shared the perspective that building a sense of community and belonging would lead to an improved health of the community.

The stories and views of the residents who participated in focus groups also confirmed and added depth to the picture painted by the quantitative demographic and health data. Youth spoke passionately about the need for more entry-level jobs suitable for young people.   Many of the caregivers spoke to having pensions and Social Security, but still not being able to afford health insurance co-pays, and being deeply worried about their financial future. The focus group facilitators noted that virtually all of the low-income focus group participants suffered from a serious physical and/or mental chronic illness, irrespective of their age. Some even came to the

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[8] This list of racial groups does not include "Other" which accounts for 360 persons.

group with untreated acute symptoms. Their stories and lessons are explored more deeply in the coming sections.

Health is Individual and Personal

In setting priorities for investment, Verdant should look at data at the population level, both quantitative and qualitative. But it is important to not lose sight of the fact that health is also related to individual behaviors, beliefs and experiences. We asked focus groups "what does it mean to live a healthy life?" and were surprised at the strong commonalities in ideas and views expressed across age, culture, and income:

- Being healthy means being well rounded and having a balance in life between work and play, and needs to reflect physical, emotional, social, and spiritual well-being.
- Exercise and good nutrition are understood to be critical to good health, but many find it difficult to align their behaviors and habits with their understandings.
- Lack of time due to the complexities of modern life is a barrier to healthy living – whether it is time for cooking, time for exercise, or taking time from work to go to the doctor.
- Lack of money is seen as a barrier to healthy living, in part because of perceptions of what is needed to support health, such as a gym membership, participation in school sports, shopping at Whole Foods, or having respite care for one's loved one so you can walk every day.
- Personal changes in behavior are seen as difficult, as they take self-discipline and motivation.
- Behaviors and practices don't match with people's knowledge.

TIER 2: CHANGING THE CONTEXT TO MAKE INDIVIDUALS' DEFAULT DECISIONS HEALTHY

When using the Health Impact Pyramid community health organizations typically focus their thinking in the area of "Changing the Context" to aspects of the context for health and wellness such as:

- social connectedness and community
- walkability and "playability"
- availability of transportation, and
- access to healthy food sources.

In addition to these considerations, the project team has elected to discuss in this section two other aspects of the environment that powerfully shape and limit the decisions individuals make:

- the complexity of systems of care, and
- categorical funding and the associated bureaucracy.

Social Connectedness and Community

As human beings, our sense of wellness, our mental health and our happiness are all tied to our sense of belonging and connection in community. Evidence is mounting that meaningful social connections and engagement in community, sometimes called "social capital," drive a "positive

upward spiral" that correlates with positive mental health, physical health, resistance to disease, and perceptions of happiness.[9]

Many factors weave together into the "fabric of a community," but a key element in community-level design, according to the Center for Disease Control & Prevention (CDC), is to expand the opportunities and the amount of time that is available for

- Extracurricular activities for children
- Recreation/rejuvenation time for adults after work
- Community involvement activities such as neighborhood improvement projects and neighborhood association events
- Time for family members to spend together[10]

> *"The fabric of a community and the community pool of human resources available to it is often called its "social capital." This term refers to the individual and communal time and energy that is available for such things as community improvement, social networking, civic engagement, personal recreation, and other activities that create social bonds between individuals and groups."*
> -   *CDC Health Topics*

Many participants in the focus groups spoke to their lived experience of this relationship between social connection and health. One young person said, for example, "Without support it's really hard to fight off an addiction," and adults we talked with described family connections and engagement in community activities as important elements of their picture of overall healthy living. One Spanish-speaking parent said, "I stopped driving for about three years, and I've been biking all the time and using the bus lines, and I have my kids all over the place, even raining, snowing, it doesn't matter. And now I just got my license back and I think I'm going to lose all the health and family time because of that."

Seniors interviewed as part of the Snohomish Health District's 2011 Report *Creating an Aging Friendly Snohomish County* echoed these sentiments, naming time with grandchildren and the freedom to volunteer and spend time with friends and family as the most positive aspects of aging, while isolation was a top concern. Interestingly, the family caregivers we talked with made little mention of grandchildren, and spoke about their adult children being too busy to help with the work of care. This isolation faced by caregivers is an important barrier to their experiences of health and well-being.

Providers also honed in on issues of community and social connection as a particular challenge in the hospital district. Wide economic disparities, geographic divides (I-99, I-5, waterfront communities), built environments developed to support commerce rather than community, transportation issues, and the transience of populations, all work against the experience of common community in the District area. Indeed, one of the priorities for action named by the providers, was to "emphasize community-building to expand social health and create a context that supports healthy living." They saw great benefits to cultivating formal and informal relationships throughout the community, and envisioned "family mentoring family: connecting one another to the community for support."

Some providers expanded the concept of community-building to include consideration of a broader set of cultural beliefs about poverty in which people without income are blamed for their condition

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[9] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3455910/pdf/11524_2006_Article_44.pdf
http://www.time.com/time/health/article/0,8599,2006938,00.html

[10] http://www.cdc.gov/healthyplaces/healthtopics/social.htm

and considered not entitled to kindness and compassion. Providers envisioned the possibility that "through health-based community building, we could support a shift from individual to shared values, build kindness, and work against a culture that 'blames people for being poor.'" They were excited about the possibility that community-building efforts might offer opportunities for shared experiences among diverse community members, thereby increasing compassion and understanding.

Walkability

Walkability offers many benefits to community health, including direct impacts on obesity. For example, a recent University of Utah study shows that the average resident of a walkable neighborhood weighs 6-10 pounds less than someone who lives in a sprawling neighborhood.[11] Walkability is also linked to community connectedness and to mental health and happiness. A Sightline Institute study shows that for every 10 minutes a person spends in a daily car commute, time spent in community activities falls by 10%.

Some important variables that go into calculations of walkability include block size, the existence of sidewalks, and what is called "walkshed" (the connectivity of the street network – e.g. cross freeway connections). A fourth variable is the general environment, whether needed services are present, a lively streetscape, and a sense of safety.

The Puget Sound Regional Council (PSRC) has studied these variables along their North Transit corridor and found most areas along that corridor that fall within the hospital district to be not very walkable (on a four point scale, PRSC rated them C and D). Recent "Walkscore.com" walkability ratings rated most cities in the hospital district service area as "Somewhat Walkable." On a 100 point scale (100 being "a walker's paradise" Lynnwood has a walk score of 57 , Mountlake Terrace of 54 and Edmonds a score of 50.

Providers and residents did not speak directly to walkability challenges, though they did speak quite a bit about "playability" and transportation concerns.

"Playability" – Culture and Leisure

The health and social service providers, Spanish-speaking parents and youth we spoke with expressed concerns about a lack of affordable opportunities for children, adolescents, and families to play in South Snohomish County, particularly indoors.

> *"Many children are overweight or obese because it's not easy to go outside in this weather."*
> - *Spanish speaking parent*

Indoor play
Most of the Spanish-speaking parents we spoke with described playing in the park with their children as their primary "fun activity" and they expressed a desire to have more indoor places where they could play together as a family when it rains.

Teen activity
The Washington State Healthy Youth Survey found that only about one in four 6th and 8th graders report being physically active for 60 or more minutes per day. Those numbers decline in the later grades, so that by 12th grade, only 17% of young people report 60 minutes a day of physical activity. Almost half of the students in 8th to 12th grade reported spending 2 or more hours per day watching

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[11] http://switchboard.nrdc.org/blogs/kbenfield/utah_study_links_walkable_neig.html

television, DVDs or videos, and similar numbers reported spending 2 or more hours per day playing video or computer games.

The teens we spoke with said simply "we get bored…there needs to be innocent fun stuff for young people to do."   They identified the absence of "innocent fun" options as a key factor that leans them towards negative health behaviors including isolation and substance abuse.

"Little kids have stuff to do…but once you're 17, you don't want to do that stuff no more. Like 17 year olds still want to go Go-Karting and Paint Ball, but there's none of that stuff free for us to do. Everything costs money or you're not old enough or you're too young."
– Teen at Cocoon House

Many of the homeless teens we spoke with had previously lived in other parts of the country. They described community activity centers in other places they'd lived; places with activities ranging from ice-skating to gym equipment and dancing, and spoke passionately about a desire for a free or very low cost activity center with adult supervision, tailored to "innocent" fun for teens.

Community center
Participants in the provider conversation also envisioned a physical community center as one strategy for increasing people's experience of community, positive exposure to social diversity, and access to healthy activities.

Cost of sports participation
Both English- and Spanish-speaking parents with low incomes said that their children would like to participate in school and extra-curriculur sports activites, but the costs of participation were too high. They pointed out that the total cost for sports participation includes not only the financial cost of fees and equipment, but also the cost and time for transportation to and from practices and games.

Transportation
Lack of access to low cost or free transportation options is a significant concern for many residents of the hospital district. Providers, low-income parents, caregivers, and youth all spoke to gaps in the transportation network which make it difficult for them to access community activities as well as health care and other services. Options for mobility simply make healthy decisions and activities easier.

"It's ridiculous to try to get to a destination 2 miles from your house and it takes an hour and a half to get there, because you have to take 2 buses and wait a half hour in between."
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"My doctor wanted me to have a [medical test] a month ago, but I'm not eligible for Hopelink and I don't drive. It's a ways from here, so I haven't gone and taken that test even though they want me to take it."
- Low-income residents

Living without a car in South Snohomish County
The 2010 census shows that there is a cluster of three census tracts in the area bordering Highway 99 and 196th Ave. where 12% to 17% of households report having no vehicle available.

For residents who cannot afford the costs of car ownership, or who cannot drive, getting around in South Snohomish County can be quite challenging. We heard that buses don't come often enough, routes are not convenient, and that bus passes are difficult for low-income residents to afford.

Providers try individually to fill some of the transportation gap. Several said they often "go the extra mile – literally. We drive people to clinic, treatment, etc."

Special transport needs of medically fragile elders

The caregivers we spoke with raised a different set of transportation issues specific to the challenges of transporting medically fragile patients. Elderly spouses face a complicated and often expensive set of logistics when transporting their loved ones to medical appointments. For example, one focus group participant paid $150 to hire a cabulance and 2 men to help carry his wife downstairs every time she had a regular medical appointment. Another participant reported that she had been encouraged to call 911 and request an ambulance to serve as her spouse's transport to medical services, since she could not move him by herself.

Given the extreme difficulty of elder caregivers trying to move their physically immobile, fragile and sometimes mentally confused spouses, it is understandable that these participants advocated strongly for free or affordable home-based services. Home visits by doctors, dentists, physical therapists, and other providers would significantly lessen the financial and physical burdens they currently face.

> *"My greatest need is help with moving and transporting: I have 14 stairs to make with a man whose legs are gone."*
> *– Family caregiver*

Access to healthy food

We do not have much data on the existence of hunger or food insecurity in the district. Though a few focus group participants referenced having used a food bank, we did not hear from any that having sufficient food was an issue. We did hear, however, that low-income participants find it challenging to get *healthy* food, and those without a car said that getting to and from the grocery store was cumbersome (especially on the way home.).

Young focus group participants particularly said that they were more likely to reach for "junk food" and fast food because it is more convenient and quicker to access, and the Healthy Youth survey suggests that 16-19% (depending on grade) of young people reported skipping meals or cutting meal size due to lack of money.

The provider conversation also included discussion of food insecurity and the need for year-round food programs.

System complexity and silos

A defining feature of the broader American landscape of health is the presence of extremely complex and siloed sets of systems for delivery of health care and social services. These systems have their own funding streams, languages, rules and ways of operating. This complexity is, of course, also part of the environment within which individuals in South Snohomish County make health and wellness decisions.

> *"I think when they were making these programs; I don't think they understood what happens to put it all together. You know what I mean?"*
> *– Teen at Cocoon House*

Provider perspectives

Local providers spoke to the ways in which systems complexity and silos create a care environment organized around funders' needs first, then providers' needs, and patient/client needs third. As one provider said, "It is hard to learn the language and the landscape."

Providers said that one of the top success factors in effectively connecting clients to services was their ability to work together, and they named "Cultivating connection and team work among providers" as a top priority for local change. At the same time, they described how challenging it is

to forge partnerships in the context of siloed funding streams and organizational systems, and called for leadership to support them in developing coalitions of provider organizations and capacity-building in collaboration to promote continuity of communication across service agencies. They expressed a passionate desire for funding models that support agency collaboration, reduce red tape, offer long-term sustainability, and allow them to serve broader groups of residents.

One way to help consumers negotiate highly complex systems of care is to train "navigators" whose role it is to help guide consumers through the maze of systems. Providers articulated a need to expand access to case managers, navigators, advocates, and coaches to help clients access and use complex systems of care.

Resident perspectives

The challenges of this systems-level context for care were felt acutely by the residents who spoke with us. From client and patient perspectives, it is clear that the systems are often confusing.

This results in high levels of misinformation or misunderstanding of the systems, and sheer confusion about how things really work. Focus group facilitators observed across all groups examples of misinformation about the different systems residents must navigate, *whether* it is "Harborview won't charge you if you can't pay" or "Medicare only pays 20% for walkers" (its pays 80%) or "some places only give you services if you are Hispanic."

> *"I am very very grateful for the childcare and food I get assistance with, but the paperwork is overwhelming. I am an intelligent person, I used to run 6 computer programs, and it's overwhelming."*
> — *Single mom*

In this context, it is perhaps not surprising that many residents named the ability to advocate for oneself as a critical part of good health. They also acknowledged that self-advocacy is hard work in the face of such "mysterious" and seemingly vast systems. As one caregiver said, "I just wonder how people manage who don't have the energy or perseverance – a lot of perseverance – to negotiate the system. I was just trying to get the things [for my husband] that I believed he needed. It was very daunting, that whole process for me."

In addition to support for their self-advocacy, some focus group participants also said "I need help!," expressing a wish for a navigator or advocate who could help them access the right combination of appropriate services for themselves or loved ones.

Across the focus groups we conducted, caregivers, women with low-incomes, youth, and Spanish-speaking parents all spoke to their awareness of the seemingly arbitrary categories, which get you into or out of service and the frequent shifts in eligibility. They were frustrated, exhausted, and sometimes angered by the time and effort required to find out about programs, deal with paperwork and navigate the eligibility maze.

> *"A lot of shelters and housing things, they have different requirements. Like some of them actually require you to be an addict, or require you to have experienced domestic violence. They'll ask you, 'Do you have a domestic violence case?' 'No.' Click. Really? Because I don't have a domestic violence case you can't help me? Its just limits."*
> — *Teen at Cocoon House*

Community members who are caregivers for the elderly or for young children are particularly bound up in multiple and sometimes conflicting systems of care. For example, caregivers we spoke with interacted with multiple systems, including the Veteran's Administration, Medicare, Volunteers of America,, Senior Services, and the internally complex healthcare system tied to their insurance.

Some young parents we spoke with interacted with an even wider network of services.   A homeless pregnant mom might, for example interact with Dept. of Social and Health Services programs (DSHS) programs such as childcare, WIC, Temporary Assistance for Needy Families (TANF), Child Protective Services, Supplemental Nutrition Assistance Program (SNAP), as well as housing agencies, substance abuse treatment, and WorkSource. Eligibility for receiving these services from particular agencies is tied to individual factors like substance abuse, domestic violence, pregnancy, homelessness, work status, and age, and changes in any one of these statuses can change the picture of available services.   Making one's way through the complexities of these systems is truly hard work.

TIER 3: LONG LASTING PROTECTIVE INTERVENTIONS

In the field of public health, long lasting protective interventions are considered those that occur at the level of the individual, but do not require ongoing clinical interventions.   Information related to this tier of the Health Impact Pyramid was gathered primarily through the CDC's Behavioral Risk Factor Surveillance System (BRFSS) and the multi-modal survey to determine how three long lasting interventions are faring in the hospital district: immunizations, prenatal care, and preventive dental care.

In addition to these three interventions, the tier of "long lasting protective interventions" was expanded to include housing, for the purposes of this report. It is known that stable housing for families living in chaos, or persons with mental illness and/or addictions is a critical first step in helping them achieve long lasting recovery and health.

Immunizations
Verdant has already shown commitment to a well-immunized community, as evidenced by its promotion of whooping cough vaccine last winter. Immunizations are a key protective intervention to improve or maintain the community's health.

Of the multi-modal survey respondents who were 65 years or older:

- 84% had received the flu vaccine this season[12]
- 67% had received vaccine for pneumonia in the past five years
- 46% had received the shingles vaccine.

The goal for whooping cough (TDAP) vaccine is that everyone receive it. Survey respondents were asked if they had received in it the past five years. Responses were as follows:

- Only 43% of adults 25 years or older thought they had received it.
- The likelihood of having received it was linked to income. Persons at or below 200% of poverty reported receiving it at half the rate of those above the line, and people whose income was $75,000 or more were almost three times as likely to report having received it as those whose income was $27,000 or less.

Teeth Cleaning
Preventive dental care reduces cavities and loss of teeth. Good oral health also contributes to nutrition, a person's self-esteem, and may even reduce the risk of heart disease and stroke in adults.

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[12] The influenza immunization rate for Snohomish County as a whole is only 70% according to the Health of Snohomish County Community Report Card, April 2013. The Healthy People 2020 goal is 90%.

The ability to have your teeth cleaned is clearly linked to income. 84% of respondents with incomes above the 200% of the poverty line responded that their teeth were checked and cleaned in the past year, while only 47% below the 200% of poverty responded affirmatively. People below the 200% of poverty were also less likely to have a private dentist. There may also be a link to race, as Whites were more likely to use a private dentist than non-Whites, and non-Whites were more likely to feel that they did not need dental care in the last year.

Prenatal Care

Prenatal care in the first trimester of pregnancy improves birth outcomes. It allows a clinician to identify possible medical problems and risk factors, and provide parental support and education about nutrition, self-care, and fetal development. Its greatest benefits are for mothers who are at risk for poor health outcomes, such as teen mothers, low-income mothers and Black and Hispanic women.

White mothers living in the hospital district are most likely to receive prenatal care in the first trimester (and at a higher rate than the rest of the county.) But Hispanic women - who have the highest fertility rate - are least likely to seek prenatal care early. Only 69% of Hispanic mothers receive early prenatal care compared to 84% of White mothers. Black mothers also have a higher fertility rate than Whites, coupled with a low rate of receiving prenatal care in the first trimester (75%).

The specific barriers to receiving prenatal care in the first trimester experienced by Hispanic and Black mothers are not clear and were not specifically raised by focus groups. It may be an area for further study.

Housing

Discussions with providers and low-income residents of the District highlighted the complexity of the housing system, and its gaps and benefits.

Providers identified gaps in the housing continuum and the absence of sufficient emergency and transitional housing with the District as a huge problem. They identified long wait lists as impacting people's ability to

> *"If it takes six to eight months to get in, it's not emergency shelter."*
> *- Previously homeless mom*

work, achieve sobriety or mental health, and provide stable settings for families. Providers spoke specifically to gaps in emergency shelters for people over 18, housing for homeless persons with advocacy and other services built in, and stable permanent housing for those with low incomes.

Residents' perspectives were very much in alignment with the providers' assessment, saying for example, that a "lack of stable housing makes it difficult when getting out of treatment to stay sober, to get a job."

Focus group participants are acutely aware of the different criteria and the regulations governing who is eligible for different types of housing assistance and often feel trapped or blocked by the requirements. A range of examples include:

- One described finding help from an Everett shelter where she lived for some time with her 5 children. She got a job in Bothell, but couldn't leave the children at the shelter after school or find other arrangements. Consequently she lost her job and then lost an opportunity to move to transitional housing because she didn't have a job.
- "I was supposed to go into housing but they shot me down because of my felony…it's 7 years old…I'm trying to change…but I always feel like there's that block there."

- "I feel like if I had a drug or alcohol problem …there are a lot more services for me, but…I don't, because I just have a housing issue and credit issue."

Lack of permanent housing units adds a layer of complexity to the picture, as people must periodically reapply and check in with agencies on an ongoing basis. One resident, who has been waiting for many years for a unit, described the Section 8 housing waiting list as "like the receding universe."

On the other hand, many expressed their thankfulness for the help and support they were getting and a sense that their situation was better because of the combination of housing and supports they were able to get. One woman, in her 50's expressed it this way:

"I'm on Section 8 housing. But thank goodness I do have that… because we have an apartment we're taken care of. There are many people out there who are living on the streets or from couch to couch, and it's our well-being that we have a place to call our own, we can decorate. We can have our friends or family and we can be ourselves. Despite our problems, you know. I'm poor. I don't have some of these things, but I still am happy because I have my animals. I have my family that can come to my home, and I have a place of my own."

TIER 4: DIRECT CLINICAL CARE AND SOCIAL INTERVENTIONS

In the Health Impact Pyramid, the tier associated with direct health and social interventions explores questions like: Can residents access ongoing clinical care? Are the services they need available locally? Can residents easily find out what services are available?

We've chosen to organize the findings related to this tier around three topics:

1. Barriers to accessing care
2. Availability of care
3. How residents use different types of care.

1. Barriers to accessing care

Cost of Care
The cost of care is a significant barrier to accessing basic medical care for those without insurance, and for people who have insurance, but who have high use of services and multiple copays. BRFSS data indicates high disparities across zip codes in the numbers of people without health insurance, ranging from Edmonds, in which only 4% are uninsured, to North Lynnwood, where about 20% or 1 in 5 people do not have health insurance.

Implementation of the Affordable Care Act Health Insurance Exchange in January, 2014 will expand the number of people covered by Medicaid and/or eligible for subsidized health insurance. This should be a significant step forward in reducing cost as a barrier. However, the Act will not affect undocumented residents. Legal immigrants who have been in the US for more than 5 years will have the same benefits as US citizens. Those

> *"I'm supposed to go to the rheumatologist for my Lupus, but I was told that I had to pay $600 up front. I can't do it so I haven't gone. No rheumatologist has a sliding scale."*
> *-Previously homeless mom*

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who have been in the country less than five years can purchase insurance, but will not be eligible for Medicaid expansion benefits. The upcoming efforts to educate and enroll members of the community through the Health Insurance Exchange will be critical to reducing barriers to care.

For now, cost of care and/or lack of insurance was the second most mentioned factor for focus group participants in weighing when whether or not to seek medical care for themselves or their children (after transportation.)

Focus group participants told us that even the sliding fee scales intended to increase the affordability of care are often too high.   One Spanish-speaking parent said, "at times we don't go to the doctor because we actually don't even have the $25."

Low-income residents described a number of different strategies for coping with the financial barriers to accessing medical care, including:

- Forgoing care.
- Waiting until a medical issue is incapacitating before seeking care.
- Getting care for their children (who are more likely to be insured) but not for themselves. One resident spoke eloquently about the limits of this strategy, "A lot of times they cut out adult health care things to focus on children, but if you are not well, how do you take care of your children?"

> *"When it comes to my grandkids, I will take them, but if it comes to myself, I don't have health insurance so I have to wait… usually I end up in the Emergency Room."*
>
> *- Low-income resident*

- Getting care for their loved ones but not for themselves (caregivers).
- Seeking alternative treatments and home remedies (we heard this most from Spanish-speaking and low-income focus group participants, and the survey echoed this finding, indicating that those below the 200% poverty line appear to visit alternative care providers more often than those above the poverty line.)

Filling prescriptions is not always possible for people with fewer financial means. The survey found that three out of five residents of the district have prescriptions (63%), and 18% of those residents with prescriptions have difficulty getting their medications filled. These difficulties are mostly caused by high cost (53%) or lack of insurance coverage (28%), though some encountered a shortage of their medication (13%).

Having insurance does not guarantee affordability of care. In the focus groups, caregivers of spouses with complex or chronic illnesses told us they find the cost of care prohibitive, since copays are required at every visit, and many of their loved ones require multiple daily and weekly visits to specialists. As one focus group participant put it, "After my husband's stroke … we had to take him to physical therapy, occupational therapy, and speech therapy. It was $35 a copay per one, and he has three of them a day. We did them 2-3 times a week."

> *We are living on Social Security and we have a certain amount of money per month. So then you take him to the neurologist, it's a $35 copay for him to go and see him, and then he wants to see him in two more days. So then there's another $35 copay. Then we're doing this vicious cycle where we've got 6-8 copays, and all of a sudden we have no money left.*
>
> *- Family Caregiver*

Other services that support caregivers, like home health agencies, respite care, and handyman services,

are also prohibitively expensive for many. The financial drain of copays and other services creates tremendous anxiety and concern for aging caregivers: "I've used a lot of my finances and that's a constant worry to me now and looking into the future...I've had to close out 2 IRAs and a regular savings account...not everybody has the money to do the respite care and all the other things."

Specific Insurance Coverage Gaps

We've seen that basic medical services are often out of reach for those with no insurance, and the providers we spoke with echoed that primary care is a coverage gap for many. But there are other specific health needs that are not covered by Medicare or many other insurance plans that both providers and residents described as real gaps, including:

- Mental health
- Podiatry
- Dental (Roughly 1 in 3 residents do not have dental coverage[13])
- Dentures
- Hearing aids
- Glasses

Language barriers

Residents who do not speak English as a first language experience a layer of additional barriers to accessing health and wellness services. Spanish-speaking residents said that it was difficult to find Spanish-speaking MD's, and they reported encounters with medical interpreters who they felt did not accurately translate the doctor/patient conversation. They also associated quality interpretation with higher-priced health providers, "Sometimes you end up going where it's more expensive because they do have

> *"Most everybody here has enough English to actually make appointments. They know enough to do that, but they need additional information to communicate and they don't have that.. Even if there are [health] centers, they just don't go."*
> *– Spanish speaking resident*

the most experienced interpreters. Other times, people may say 'go to this one because it's a lot cheaper,' but you get there and nobody is communicating in your language."

Providers sensitive to these issues named "cultural and linguistic fluency" as a top success factor in successfully connecting clients with services, and said that culture and language-appropriate services and informational tools were a priority for improvement.

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[13] The 2010 BRFSS survey indicated that 31% did not have dental insurance. The multi-modal survey indicated that 34% were without dental insurance.

2. Availability of Quality Care

Specific Gaps in Services Available Locally

Distinct from the question of gaps in coverage is the issue of services that are not available at the desired level in the hospital district. From provider and resident perspectives as articulated in the focus groups and the provider Community Conversation, the list of missing or inadequate local services includes:

Services	Providers	Residents
Specialist care for children	X	X
Services for youth	X	X
Mental health services	X	X
Legal services	X	X
In home supports	X	X
Emergency housing	X	X
Dental care	X	X
Legal services	X	X
Emergency childcare		X
Adult day care		X
Respite services for caregivers		X
Trusted language translators		X
Urgent Care options/Alternatives to ER	X	
Integrated Mental Health and Substance Abuse Treatment	X	
Family Planning	X	

Mental health services

BRFSS data suggests that a striking 35% of adults living in the hospital district experience poor mental health, defined as stress, depression, and problems with emotions. In the Healthy Youth Survey for the Edmonds School District 25-28% of youth (depending on grade-level) report having been severely depressed and 14-18% report having seriously considered attempting suicide.

> *"You need to be not only healthy physically but mentally so you're not depressed or stressed all the time. Just being happy is my image of health."*
> *- Young person*

The stories of focus group participants reinforced this data picture. Many of the young focus group participants spoke about being depressed themselves or having concern about depression in their family, and several Spanish-speaking parents expressed concerned about the mental health of their children.

Low-income participants emphasized that poverty itself, and the struggles and insecurities it brings, is a trigger for depression and anxiety, and caregivers spoke to the anxieties that trouble them as they face the challenges of caring for loved ones and the insecurities they face in their own lives.

Providers and residents both said that mental health services are difficult to find locally and hard to afford. Specific concerns raised by residents included:

- Non-crisis mental health services are only affordable for the very rich or very poor – "basic" middle class insurance does not cover enough mental health.
- Mental health services are only available for those in extreme crisis
- Whole-family counseling is not affordable

- Lack of mental health specialists in gerontology
- Lack of mental health specialists in child and adolescent counseling
- Lack of Spanish-speaking mental health/substance abuse providers. "I had a friend who they had to take all the way to Wenatchee to get some help [with substance abuse] because there is more Hispanic community there." "I haven't found help for depression because there is not enough Hispanic population that's looking for help for mental illnesses, and I don't speak English so I can't get help through the English side."

Providers echoed these concerns, naming expansion of mental health options and integrated mental health/substance abuse care as a priority area for change. Providers also named some additional specific local needs:

- More psychiatric beds
- Programs to address opiate abuse and overdose deaths
- Psychiatric medications management
- Mental Health providers for autistic people
- More diversity in Mental Health providers
- Flexible and accessible mental health treatment, both preventative and crisis.

Substance abuse

Substance abuse is seen as a major health concern by young people, and many of the young people in focus groups were not aware of what resources are available for substance abuse help. According to the Healthy Youth Survey, half of 12th graders in the Edmonds School District perceive risks associated with drug use, but more than a third have a favorable attitude towards or an intention to use drugs.

More than 20% of 10th graders and 37% of 12th graders reported current alcohol use, with 22% of 12th graders reporting current binge drinking and 12% describing themselves as having problem drinking. More than 20% of 12th graders also reported that they had recently ridden in a car driven by someone who had been drinking.

Marijuana is also commonly used with more than 18% of 10th graders and 29% of 12th graders reporting that they currently use marijuana. Marijuana is easier to get than alcohol. Roughly twice as many students reported Marijuana, as compared to alcohol, to be relatively easy to get.

Methamphetamine and cocaine use is reported at much lower levels (4-5%) but 19-29% of high-schoolers reported the use of any illegal drug to get high in the last 30 days. Both drug and alcohol use increase substantially as students move through the higher grades.

Quality of care issues

Across the focus groups, we heard many examples of good experiences with health care providers. However, we also heard that many residents without insurance have experienced poor quality care, which they directly attribute to the fact of their inability to pay for services. One focus group participant summed it up this way: "When you are uninsured or underinsured they Band-Aid things. They don't completely fix a problem."

Though we heard quality of care concerns across low-income groups, Spanish-speaking parents were particularly likely to report feeling not heard or seen, and felt that their concerns were often dismissed or ignored. The instance of kidney disease treated as depression (in the text box) was just one of 12 stories we heard from different individuals in the Spanish-speaking focus groups involving serious missed diagnoses.

> *"My husband felt tired, and was treated for a year for depression. Then he started having nosebleeds, which they just plugged. Finally, they discovered that his kidneys were not working and needed dialysis. We lost faith with the doctors, because this doctor that finally did the blood test, he had seen my husband for one entire year, and he never thought, 'Why are you throwing up? Let's do some tests. Why are you depressed or tired? Why are you having these symptoms?'"*
> *- Spanish speaking resident*

Participants across all low-income focus groups described long wait times for short and rushed appointments, and felt that the Community Health Clinic model of short appointment times in which only one health concern can be raised or addressed is not an effective or efficient treatment model. Participants said, "At my annual checkup I was talking about my problem and then I started to talk about another thing, and the doctor said, "Oh no, we don't have time for that. We are only going to talk about this one thing." "I wish doctors would change the way they examine kids. When I take my child it's half an hour waiting outside, 5 minutes inside, and they don't do a complete check. I have to tell them to listen to his lungs or maybe you should do a urine test and they come back and say 'Oh yeah, he had an infection.'"

3. How Residents Use Care

Primary and Specialty Care access

The multi-modal survey shows the unsurprising fact that District 2 residents with insurance are more likely to visit a regular personal doctor than those below the 200% poverty line or without insurance. Nearly all residents age 65 and older do have health care insurance (99%). Most homes with a household income of $75,000 or more per year also have healthcare insurance (98%).

For those who do have access to a personal doctor, 92% saw their provider in the past year, and this same group were more likely to report healthy behaviors, fill their prescriptions regularly, and avoid trips to the Emergency Room.

Those with less income and no insurance are far less likely to have a personal doctor and are more likely to rely on community health centers, urgent care, ER, and alternative care providers. One out of five residents reported having some difficulty seeing a doctor in the past year. A lack of insurance (28%) or being unable to pay (25%) were the top two difficulties that prevent residents from seeing a doctor routinely.

The multi-modal survey also described that:

- In the past year, half of respondents have visited a specialist (51%)
- As expected, older residents (65 and older) are more likely to visit a specialist than younger residents, but younger residents (below 65) are more likely to visit alternative care providers.
- Very few residents (8%) have difficulties obtaining referrals or follow-up services. The issues are generally expense related with 26% having cost barriers, 22% with insurance issues, and half with unique difficulties.

Emergency Room Use

Approximately 40% of survey respondents said they had used an Emergency Room in the last 2 years, either for themselves, or with a friend or family member. It is common wisdom that low-income residents without a primary care physician or insurance use the Emergency Room more than others. The survey data shows a weak correlation (because of the sample size) between income and ER use. The survey did not show a difference in ER use by age. However, the use of 911 and Emergency Room services was a topic of extensive discussion within the caregiver focus group and by older participants in the low-income groups.

TIER 5: COUNSELING AND EDUCATION OPPORTUNITIES

One of Verdant's current priorities is to support programs that educate and empower residents to live healthy lives. Questions were asked of both focus groups and the survey respondents about how they get health information and what they have sought out. Without prompting, this also became a focus of provider discussion during the Community Conversation.

Knowledge and family culture related to healthy living

Most focus group participants demonstrated a high awareness of the foundational connection between health and good nutrition. They described a vision of a healthy lifestyle that includes fruits and vegetables, water instead of soda, and home cooked meals instead of fast food. Two of the young people we spoke with expressed concern over the broader politics of food production in America, including the production of "fake food" that is "nutritionally dead."

Some participants of the low-income focus groups had perceptions that equated healthy food with organic food, and several shared that they couldn't eat healthily because they shopped at Walmart rather than Whole Foods, Trader Joe's, or PCC. A number also indicated that education about specific ways to eat healthily on a low budget would be helpful to them.

Spanish-speaking women were in general much more aware of specific ways of eating healthily than other groups, but spoke to resistance by their husbands to change nutritional habits. Other women, both low-income and not, spoke about how the way they were raised made it a challenge to change and cook differently: "You had lots of potatoes, gravy, macaroni and cheese…because that's what you could afford to feed your children." One Spanish-speaking recent immigrant said, "…most of us didn't grow up knowing how to eat healthier…I know a lot of American women they go and buy their food at Trader Joe's and it's all organic, but we didn't have that knowledge since the beginning, and nobody ever explained to us how big of a payoff it was going to be. So, we'll go to Walmart and buy our kids whatever they want…"

> "We're almost trained that if you're impoverished, then you are to be a certain way…Like a lot of people think they cannot afford to eat healthy, when they just haven't been shown that they really can."
> - *Low income resident*

Where people find information about health

The 'digital divide' appears to be an issue of the past. When asked where they got information virtually all focus group participants said the Internet or Google. Low-income participants used their phone or accessed computers through the library. Older participants also tended to reference their provider, books or family and friends more often.

Education program participation

Survey respondents were asked if they had attended any education programs about health topics in the last year, and if they had what its focus was. Only 20% had attended an educational program and people who were either low-income or female or under 65 years old were most likely to have gone. People thought they would be more likely to attend a program if the location was convenient, their physician had told them to so (this was particularly true for higher income respondents), and it was scheduled on the weekend or evening. Respondents mentioned interest in a wide range of topics from brain health to pre-operative classes, with no one area standing out.

Resource information

Before clients/patients can benefit from available clinical care and social services, they first need to know what services exist, whether they meet qualifications to receive the services, and how to access them. Providers suggested that it is difficult for both providers and clients to have a full picture of the available resources, and advocated for a system that makes it easier to get the information.

Spanish-speaking focus group participants added an important layer to the picture of access to resource information: "Many immigrants are afraid to seek out information because they are afraid they will be asked for documents or immigration status information. So they don't ask, and the information is not provided."

> *"Everybody lacks information as to how to go about getting assistance for health, so sometimes we get health [care] where we pay very little, and other times there is no discount."*
> *– Spanish-speaking resident*

Providers emphasize usefulness and importance of education

Providers raised self-care education as a means of preventing crisis and increasing clients' ability to live stable and healthy lives. Some proposed a holistic community education model that would help normalize good health practices. Topics proposed included: nutrition, hygiene, exercise, alternative medicine, budgeting, independent living skills, family planning, information about how the health care system works, supports for mental health and prevention of substance abuse.

Providers also approached the need for education from the perspective of what they needed for their own uses, and called out culturally and language-appropriate services and informational tools as particularly desired. Education for providers on working with clients with diverse languages, cultures, and abilities was also seen as a way to decrease barriers to access due to culture, language, or disability.

III.   Intersections and Implications

The Health Impact Pyramid allowed the organization of information into actionable categories that relate to how effective a strategy may be, and how challenging it may be to implement. But there are also themes that cross these categories, and their intersections provide clues to where and how Verdant might invest to achieve its mission to improve the health and well-being of the community. Some of the key over-arching actionable messages that emerged include:

Place and demography matters
- As a whole, residents of the District are healthy and this provides a great platform for making improvements. The task of improving the health of the community does not need to be over-whelming.
- The differences apparent by neighborhood and ethnic group encourages Verdant to strategically focus its efforts on the most needy.

The District is complex and social connection is hard to find
- Many residents experience where they live as fragmented, divided by major arterials and highways, divided by income, ethnicity, and language. The most vulnerable are isolated by poor transportation, family responsibilities, and the daily struggles to make do and find their way through multiple bureaucracies. The experience of gathering together in a focus group, for example, was for some a social event and a welcomed time to be heard and part of a group.
- Many residents and providers we spoke with seek community-based services, whether it is a day program for persons with dementia, a place for children to play, or a place to learn.
- Providers see the lack of community as a critical gap and believe that increasing social connectedness will help build resilience and recovery. They would welcome a community-building process, both to help them work more effectively together and to provide a sense of community for clients.
- Spearheading the building of community and social capital could provide a platform for improving the well-being of the community.

The complexity of service systems stands as a barrier to both providers and clients, often working against the people the systems are trying to help.
- Both providers and consumers share the desire for "navigators" to walk along with and guide consumers through the different systems.
- Residents across all focus groups raised the need to be a strong self-advocate in order to get what you need, and said this role does not come naturally or easily; it takes learning and practice to become an effective advocate.
- The idea of 'one-stop' for accessing information about resources and services is also shared. (Many don't appear to know about the 211 telephone helpline or, if they do know, don't find it useful.) There is a need to have better actionable information, but how to achieve that is not clear.
- The study team was struck that no one raised the question: "How do you make these systems less complex so navigators are not needed?"
- There is considerable room for the development of new approaches and technologies for simplifying and bridging systems to support both providers and clients.

Cost of care and lack of insurance are the greatest obstacles for adults seeking care.
- Families have their children enrolled in state insurance programs and report that their children can get health care when they need it.
- Caregivers, low-income mothers, and Spanish-speaking parents, on the other hand, find sliding scales and co-pays prohibitive even if they have insurance, and often choose not to seek services at all or to 'wait it out' until their need rises to the level of crisis.
- Gaps in services are often gaps because the service is not low-cost – rather than that it doesn't exist in the community. The greatest concerns - raised in all focus groups, as well as by providers - were dental services and mental health, but other needs such as eyeglasses and hearing aids were also noted. Many are under-insured and early interventions seem unobtainable to many in the most vulnerable populations.
- Flexible funding could leverage the ability of the people who 'fall through the cracks' because of a lack of insurance or under-insurance to receive care.

Care-givers need support
- The care we receive from one another in our families, our communities, and our professional services is foundational to our experience of health and wellness.
- Family caregivers, irrespective of income level, feel isolated and have limited community resources.
- The lack of adult day programs in the District, problems with transporting medically fragile and confused family members, and managing extensive paper work were all repeatedly mentioned by elder caregivers.
- At the other end of the age spectrum, single parents expressed similar concerns. They cited the need for emergency day care for when they are ill or seeking work and wished for help in wending their way through the rules and regulations governing the kinds of services for which they are eligible.
- Professional care providers also need support. They, too, are frustrated by red tape that gets in the way of their ability to foster the relationships and warm connections that produce the best outcomes for clients. They asked for venues to share information and learn from other providers, to increase connection and coordination, and work towards the common good of the community.
- Using the filter of supporting the people who do the work of care in homes, in the community, and in the professional sector may be another way to leverage investment in the community. Families and service systems can be made stronger by supporting caregivers in their efforts to support loved ones or clients.

IV.   Roles and Investment Opportunities

As Verdant begins its deliberations about how best to invest in the well-being and health of the hospital district communities, the study team thought it would be helpful to frame the priorities and opportunities in terms of five possible roles Verdant might play.

The intent of identifying different roles is to provide a structure or framework for the Boards discussions and work in setting priorities and investment strategies. Before looking in more detail at each of these roles, it is important to note that these roles are not mutually exclusive, and Verdant will undoubtedly have more than one role in the community. On the other hand Verdant will have the greatest impact if it sets clear directions that can be articulated to and supported by the community. We are proposing these roles as a way of providing that focus as well as a decision filter for future priority setting.

Contained within the description of each role is an array of possible activities or interventions. Verdant can develop a portfolio of investments within a role or across roles, with an eye toward finding a good combination of:

- near-term investments that produce early visible successes and meet acute needs and
- long-term strategies that are more likely to create substantive change at a community level.

The roles are not tied in a linear way to the Health Impact Pyramid, but some roles will support longer term, probably more difficult strategies while other roles will be better at supporting nearer term and direct service investments. How they may align is illustrated through the Health Impact Pyramid graphics attached to each of the five roles:

<div align="center">

Gap Filler

Door Opener

Convener

Community Builder

Advocate

</div>

The following describes the roles, with some examples of different ways they might be carried out in action.

Gap Filler

Provide strategic and targeted assistance to a) help people gain access to services where cost is a barrier and b) support the development of new programs where there is an unfilled need in the District.

The assessment showed that there are groups of residents with acute needs for care and support which are unmet by either public or private organizations. Examples of immediate investments, which Verdant could make to fill known gaps, are:

- ✓ Establish a fund to support preventive dental care for adults
- ✓ Fund a respite program for care-givers
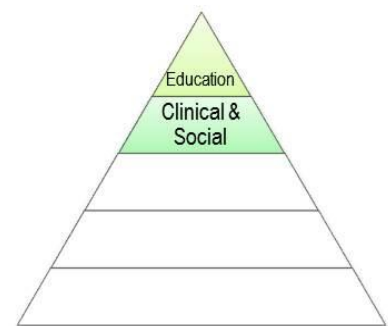
- ✓ Provide targeted transportation assistance in areas where it would make the most difference
- ✓ Sponsor or subsidize hearing aids, glasses, and dentures
- ✓ Fund local Adult Day programs
- ✓ Partner to provide episodic child care when parents or children are sick or parents are interviewing for jobs
- ✓ Support approaches (such as Project Access) to make available referrals to providers willing to donate their services

Door Opener

Help welcome the most vulnerable into systems of care and support, create bridges between systems, and assure that there are 'no wrong doors.'

The assessment showed that the complexity and regulation requirements of systems of care and support can be barriers to receiving service from those same systems. Culture and language also serve as barriers. Beyond the filling of gaps there is an opportunity to help residents find it easier to learn about and use existing services effectively, whether it is prenatal care or diabetes education.
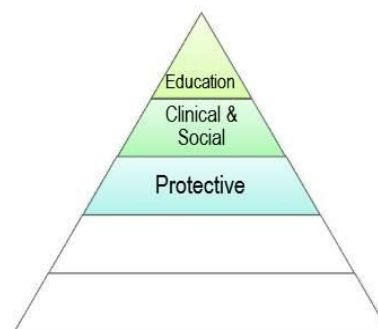
Examples of how the types of investments that might be represented by this role are:

- ✓ Reducing language barriers by supporting the development of culturally and linguistically sensitive tools and materials
- ✓ Partner with others to provide trainings that increase understanding of the different cultures present in the district, and the impact of culture on health beliefs and practices
- ✓ Increasing access to information about resources
- ✓ Advocating for individuals
- ✓ Work with partners to recognize and address the specific ways in which systems work against the people they wish to serve
- ✓ Supporting holistic approaches to service and care.

Convener

Bring together private and public providers, policy-setters, and decision-makers to work together to solve system-level problems.

In the long term system and community change is needed to improve and strengthen the health of the community. Verdant is well positioned to bring together both public and private entities to creatively address systemic issues.

Examples of possible investment strategies include:

- ✓ Build capacity of community organizations to work together across systems through training, coaching, and modeling of collaboration and partnership skills in the context of issue-focused work.

- ✓ Inspire and support innovation by making local innovation visible, hosting cutting-edge experts, and bringing forward national and international examples of creative and effective health interventions
- ✓ Support collaborative assessment and solution-development around specific complex issues such as housing, respite, or transportation.
- ✓ Advocating for policies, measures, and technologies, which would improve quality of care and provider education and accountability within the District.

Community-Builder

Create settings and experiences that foster social connection and a culture of health at the community level.

The assessment illuminated the desire on the part of both residents and service providers to experience stronger social connections and community based supports. Such experiences of community are, in of themselves, linked to mental and physical health. Socio-economic disparities, such as those demonstrated within the hospital district, erode social connection and health status. On the other hand, the evidence is strong that building social capital over a period of years changes the context in which people live and work for the better, and improves the overall health and wellness of a community.
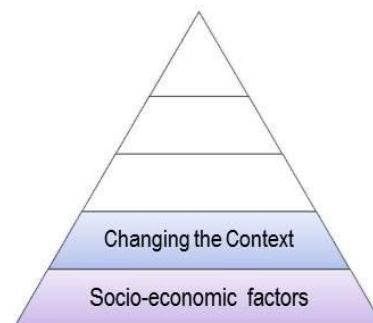
Examples of ways in which Verdant might carryout this role includes:

- ✓ Offer programs and supports, which develop a culture of healthy living within the community and bridge cultural differences
- ✓ Provide a place or places where residents can gather to play, socialize, and learn together
- ✓ Participate in built-environment design processes as an advocate for health-promoting design solutions.

Advocate

Take a stand on issues that directly affect the health and well-being of residents in the hospital district.

Ultimately, the most enduring changes in the health and wellness of communities comes from changes in the socio-economic landscape and the opportunities residents have to make healthy choices in how they live their lives. The development and implementation of policies, which change that context, could, over time, have a huge influence on the health and wellness of the hospital district.
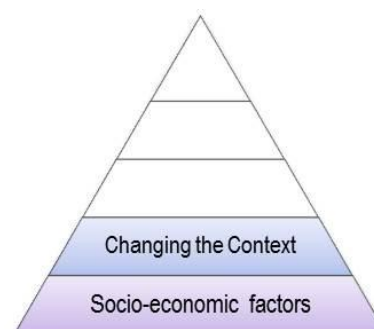
Ways in which this role could be carried out include:

- ✓ Policy assessment and development
- ✓ Advocating for an approach to public policy development that always take community health into account
- ✓ Advocating for specific policies to improve service systems, the economic environment, or the built-environment.