Clark County Commission on Aging
Webex Remote Meeting
Vancouver, Washington

MEETING NOTES

Wednesday, August 18, 2021
4:30 p.m. – 6:00 p.m.

Members Present: Chuck Green (Chair), Franklin Johnson (Vice Chair), Nancy Dong, Cass Freedland, Amy Gross, Meghan McCarthy, Larry Smith, Tanya Stewart, Pamela Wheeler

Absent:

1. **Welcome and call to order**
   Chuck Green opened the meeting

   Approval of agenda
   The agenda was unanimously approved.

   Approval of Jul. 21 meeting notes
   The meeting notes were unanimously approved.

2. **Moderated Discussion/ "Fireside Chat": Social Determinants of Health**
   Details on each presentation are available in the recording on the Commission website.
   Guests: Judy Zerzan-Thul, Washington State Health Care Authority and Gillian Feldmeth, NowPow

   Discussion highlights:
   What is your personal definition of social determinants of health?
   - Judy: the conditions in which people are born, grow, work and age. The terminology for both myself and the Washington Healthcare Authority is changing from "social determinants of health" to "health related social needs." Homelessness, employment, food, transportation, criminal justice, etc. are all examples. You could also include race/ethnicity, income level, etc. Or, whether you have a car, high school diploma, etc. The health-related social needs change over time depending on life stage.
   - Gillian: building off what Judy shared, one thing I would add is that I think often the assumption is that a social determinant of health (SDH) is a negative thing, but there can be positive SDH as well. Having a job can lead to improved health outcomes. Oftentimes in the communities we work with, taking the asset-based approach can be helpful when working with individual community members. In terms of life ages and stages, the idea that, and COVID exposed this, any of us at any point of time could enter a scenario where something that wasn't an issue before could become an issue. It's important to understand that as we age and circumstances change, the SDH are quite dynamic. There's a health affairs blog post talking about the importance of

precision when using the term "social determinants of health" and talking through the differences of a social determinant and a social need. The way we intervene could be different.

How can communities identify the Social Determinants of Health that are most relevant to their aging residents? And once identified, how can communities address these factors holistically?

- Gillian: NowPow is a health technology company. It's a play on words for Knowledge is Power. We provide people with the knowledge of resources in their community that may help address identified needs. Many of our partners, which involve health systems, community-based organizations, health departments, etc. use our tech to systematically assess need at the individual level by asking the individual if they are experiencing any challenges. The questions may differ depending on who we are working with. We put a large emphasis on engaging the individual on understanding what their priorities are. Community partners are asking their clients questions and then asking if they want support with that need. Putting the patient first can lead to improved outcomes.
- Gillian: Most of the time, this is an assessment so you can report on rates of need across a population. Commonly this is happening as part of routine care. NowPow comes in to serve up or suggest resources based on the responses to those questions. If I say that I'm interested in food and transportation resources, the technology queries a database of resources to match what we know about the person to what we know about organizations in the community. In some cases, we have partners who, with their client's consent, can work directly with those resource organizations to make sure there is follow-up with the patient.
- Gillian: We are also seeing an increased frequency of partners removing the "middleman" where the organizations are providing direct access to the resource directories to their clients to self-serve and understand the resources in their community. In our original research that lead to creation of NowPow, there was a high percentage of individuals who received referrals to organizations who shared that information with someone else (i.e. a neighbor, family member, etc.)
- Judy: I agree that asking the person is one of the best ways to do that. It can be a struggle on how to do that though. The University of California San Francisco is leading an effort called SIREN about what are the best practices and best wording of questions. We are following that and involved with that.
- Judy: One of the other things is that the universe can be quite vast when thinking about SDH and prioritizing can be useful. We as an organization focus on three main topics: housing, food, and transportation.
- Judy: There are some algorithms and databases that can give information by sub-zip code. The CDC has one resource called the Geographic Deprivation Index that helps you figure out what communities might have more need and how can you address that?
- Judy: The magic starts to happen when you connect the person in front of you and some of these tools to help figure that out. Some things we have done at HCA relevant to this include:
    - We had a grant starting in 2016 called Healthier Washington from the federal government. Accountable Communities for Health (SWACH is the acronym for the SW WA ACH). ACHs are organizations to convene community leaders and prioritize and solve regional health issues. This includes things like SDH. SWACH includes bidirectional interconnection of care: mental and physical health needs; community-based care coordination; opioid use; chronic disease

prevention and control. They convene tribes, hospitals and providers, community, and social service organizations.
    - Healthier Washington also includes foundational community support focused on health-related social needs. There is a pilot project, that has since expended with two tracks and has been successful in some ways: 1) supported employment and 2) housing. The project set-up a way for communities to use foundational support money and where some of the funding goes to individuals to help pay for housing, job training, etc. The housing track has been more successful than the employment track, decreasing hospitalizations and emergency room use. We think it's making people healthier.
    - Behavioral health has such a big impact, whether it's a mental health diagnosis or substance abuse issue. We have pushed an integrated behavioral health model. SW WA was the first region in the state to do this, starting in 2016. It has decreased unnecessary emergency room use and increased substance and mental health treatment. There are a few measures that have improved from this program, other measures have not. For instance, some screening and follow-up from emergency room visits have improved. Behavioral health, physical health and social needs are all important.

As we build or rebuild health care systems during and after COVID, what would you identify as the top policy priorities to combat disparities and inequity?

- Judy: First thing: alignment in definitions and how we collect information. If we ask things in aligned ways, as we move across communities and organizations, we will all know what we're asking and can better connect people. For example, at the Health Care Authority (HCA), we have five different ways to ask about race and ethnicity. You can't connect the categories because we are asking slightly different questions. The data isn't as helpful when it isn't aligned. We need to figure out on a community level how do we make sure we're asking the same question, so people don't feel like they're getting asked the same question repeatedly, and how we can translate the information across providers. We can't share data if things don't match.
- Judy: Second thing: healthcare payment. We have been thinking about social risk adjustment. Many times, in healthcare systems, things are risk adjusted and identify where the are people at higher risk for higher utilization. There is interesting work that some algorithms might have some racial bias and further disadvantage people. Social risk adjustment is about: how do you make sure you are not putting bias into your equation? North Carolina has a nice model where they pay more for primary care providers in high poverty areas. Providers ask questions and connect patients to resources and adequately reimburse people with enough money in system to connect people to resources.
- Judy: Third thing: HCA has applied for a rural grant to change rural care. This is an interesting place to work on assets, care coordination, and whole-person care and analytics. The rural healthcare system was set-up in the '60s and is hospital-focused. It's not set-up for in-home support or primary care. There isn't always internet structure for in-home communication. How can we do better with things like telemedicine in rural areas?
- Gillian: Considering broadband or internet access as a key SDH. It's amazing the progress made in past year in telehealth and the switch to virtual settings at a speed we couldn't do before. And yet, that left several communities behind. Even seeing a sample of all the screening questions our partners ask, they are all different. Very few of our partners are asking patients if they have reliable access to internet. Patient

portal access is lower than some health systems want it to be and this may relate to internet access. This has been a big challenge during the pandemic. With vaccines, for instance, people couldn't find out about vaccine appointments who didn't have internet access and the only way to schedule an appointment was online.

- Gillian: With community-based organizations, as part of our COVID-response, we quickly deployed a rapid resource verification process where we had to quickly reach out to all community organizations in our directory to understand if they were still open. Were staff members picking up the phone? Did they shift services to virtual or pick-up options? Some organizations went offline for a while because of the inability to switch quickly to a virtual model or update their website. There has been a lot of funding in the past year to improve broadband access. Virtual care is probably going to stay. Our ability to deliver requires us to connect people to services.

How can partnerships and community engagement be leveraged as a powerful force to address health inequities and social isolation?

- Gillian: At NowPow, how we think about community engagement is focused on where we can add value and knowing where we don't have a role. Judy mentioned different organizations or individual organizations doing things differently. We see that when we look at traditional healthcare organizations, they may or may not be communicating with community-based organizations outside of the health system walls. For us at NowPow, we add value at being able to add technology to human processes. There may be a case where health system A already has a few key partners in the community. They can leverage technology where data can be shared securely, and communication can be channeled. That can be beneficial.
- Gillian: We can support making sure a patient isn't lost in the abyss. Coordinated networks can ensure we don't lose people along the way and engaging people in the right way and with the right organizations. There may be someone down the block who can best support you with your nutrition need instead of waiting for your next annual doctor's visit.
- Gillian: Regarding social isolation, at NowPow we often get individuals asking us to add certain types of resources to the directory. In the pandemic, we saw requests around social connection. We saw hotlines or community-based organizations add calling clients to their service offerings to address this need. It was interesting to see in our data, where frontline social workers and community health workers were explicitly asking or sensing need to further support folks feeling isolated. That's always an interesting space for us to be in. The community organizations are doing this work. Tech can complement it and a community-based organization should use the best available tech and shouldn't have to rely on outdated methods to track things. This is like how health systems are investing in digital technology.
- Judy: The pathway I see is 3 parts: 1) need a screening protocol to collect info and ask questions; 2) need a resource directory; 3) need a way the clinics or social service organizations to have pathway to use the resource and close the loop with people get the services. The above may sound easy, but it's not.
- Judy: This came up during the last legislative session and will come up again. We are working on a statewide community information exchange. This would be like a statewide health information exchange. Currently, this doesn't exist for health-related social needs. Some communities are investing in this, but a community info exchange is needed so there is some alignment and not a different way to ask questions in different places.

- Judy: The other thing I want to give a nod to is providing these services/the workforce. COVID is straining the workforce and there's a lot of burnout. This also exists in different service organizations. We are in super stressful times in our society and it doesn't seem to be getting better. We are thinking about how to build a lay workforce and how to build a workforce to provide medical assistance to help call and screen people or a behavioral health workforce to council people who are isolated or maybe depressed.

Q&A with Commission:

- **Franklin**: you touched on something that is a pet project of mine about access to internet and telemedicine. Could you share any models you are aware of that would be able to provide economic internet access to seniors? **Gillian**: I participate in a group that works at the intersection of technology. I can share this information which includes available resources. The FCC put a lot of money into the issue recently and we are seeing some local resources. Beyond programmatic opportunities, we have seen that SMS technology, or the ability to text, is a more widely accessible communication method than internet in some communities. The ability to share and engage in text communication could feed another system. We are seeing a need for tech companies to be able to support text-based approaches.
- **Franklin**: do you see technology as an effective way to address isolation? **Judy**: potentially. Personally, most of my family lives in OR and we've made waves connecting with Zoom weekly. I talk to my family and extended family way more than I used to. I think it can be helpful, but it's also not sufficient. There is a difference between remote connection and being in the same room as each other and having that human connection. We need to figure out how to make the best of both worlds. The need for senior centers doesn't go away. My mom who is 76 is not at all satisfied with internet-only communication. It's a path and it's good to have options. With telemedicine, for instance, some people like it and some don't.
- **Amy**: Comcast contacted us and said they're going to give us faster internet service for free if we replace our modem for $100. Judy, you mentioned a program called SIREN, can you remind me what they do? **Judy**: they have federal dollars to figure out what are the best questions to ask to get at SDH. They created a repository of all the ways you can ask some things. They are trying to reach consensus on: if you want to ask someone about their transportation needs, ask this. And, they're also working on the tech that's required so it can be shared and linked with common formatting so easier to share that data. **Gillian**: "interoperability" is a term we use in the tech world. This is the way to capture the info and the standard way to share that info. Electronic medical systems do that. Community based organizations are largely left out of that. It puts a framework of how to exchange data in the same language (tech code).
- **Pam**: I heard you both say that through your guided surveys and assessments, you help the participant/client identify what their needs are and they drive the connection to your resources, which is refreshing to hear. Is NowPow used in communities outside of Chicago? **Gillian**: NowPow started at the University of Chicago and in the past several years has spread out across the country. We are in at least 16 states right now based on requests from organizations. We don't have a national presence. We go deep in the communities who ask us to come in. In WA, we work with Ideal Option, Ideal Balance and ESD 105. Some of our larger geographies include NYC, NJ, and Minnesota. I can follow-up with more info.
- **Tanya**: for those who love podcasts, SIREN Coffee & Science. SIREN = Social Interventions Research & Evaluation Network. The Gravity Project is also a good

resource. Judy, you spoke about the community information exchange, which seems like an important need. I've seen some communities create these volunteer banks where you can collect hours and at some point exchange your volunteer hours and receive help from organizations. Is that something that has come up? **Judy**: I haven't heard of it. I do think it sounds good for building social connections and building community. **Tanya**: as I look at databases out there, the data always seems to be lagging, like 3-4 years old. How do we look at organizations like yours who partner with entities like school districts or hospital systems, to collect data and incorporate it so that it's live and actionable in the moment? **Gillian**: that is the best question and hardest question. It reminds me of a call with a trauma surgeon who helps connect people to resources in their community. She is shocked that NowPow even exists because she is from Canada where the federal government would keep the data accurate and up to date and incentivize community organizations to do the same. In an ideal state, we wouldn't have to have multiple sources of truth and different organizations trying to chase down the right information. We can't just rely on tech to scrape info and put it somewhere else. We have real people picking up the phone and making a call so that we have confidence in our information. If we can't get ahold of an organization, how can a community member? Flipping the power script, a community organization should want their data to be accurate and up to date. How can we make it easy for a community organization to do that? I think in this case, tech is our friend. Organizations have mailed us binders with printouts of resource info that could have been 10-yrs old. It's the details that are out of date. There is value in digitizing this space. If we make an update, then 80000 users get that update. The federal government should have a large stake. There are a lot of interesting legislation and congress people talking about SDH now. There's now a SDH congressional caucus. **Tanya**: it's clear we need to think outside the box. There was a child in our school district who was living with a grandparent. The grandparent had a need and the only reason they got it addressed was because the child was in a school with a family resource center. Where are the connecting pieces and connections?

Q&A with Public:

- **Christina Marneris**, Area Agency on Aging of SW Washington, Community Services Manager: wanted to echo the work being done with SWACH and building out partnerships and exchange of info. This work includes SWACH, AAADSW, Kaiser, and UniteUs. I also wanted to raise that in addition to access to internet and resources is the access to education on how to use this info. SWACH has created some learning videos which I can share with Jacqui.

3. **Commission Download: What have we heard? Potential recommendations? Request(s) for more information?**
    - Franklin: one thing that stuck out to me was Judy mentioning the Healthier Washington grant and another foundational health support grant. It would be nice to hear more about those grants and if funding sources are still available. ACTION ITEM: staff can do some follow-up.
    - Chuck: emphasis on the technology conversation. My wife is caregiving for a community member and trying to get an appointment for that first vaccination was hard. We need to be able to train each other and do that remotely.

4. **General Public Comment**

- **Bob Housley**: Thank you for having me here. I have a concern about senior property tax exemptions leaving seniors behind. As you see on the screen there, there is a process/procedure for determining the amount of property tax and who is eligible. In some cases, taxes are rising faster than inflation. One example was a difference of 6.5% annually. Tax relief is in order. I have an example here of threshold 3. If you look at the table, it explains how it works. In 2018, the exemption limit was $40,000. Threshold 3 was based on 65% of median household income. The actual percent was 52%. The legislative goal is 65%. The following year we fell further behind. Seniors are being left out because the $40,000 threshold is not updated, and yet median household income is increasing year after year. One problem I see is the targets the legislature laid out aren't being met. The more we go along the timeline, the target of 65% gets worse and worse. The solution to that is to update the income limit annually. There's a backlog. Seniors are waiting to qualify, but we don't update the exemption limit for every 5 years based on statute. I would like to see income limits updated annually so we can keep up with the median household income. **Chuck**: have you had some communication with the county assessor? **Bob Housley**: I did have some conversation with him. The first part of the original proposal was removed based on conversation with the assessor. It was too big of a change and politically probably not doable. **Chuck**: have you had any discussion with any of the local legislators? **Bob Housley**: yes, I have been discussing it with legislators, both local and non-local. Some are very interested and want to continue the conversation. I was hoping we could discuss it here and see if there is any support. **Chuck**: I think we can add an item on our next month's work session agenda to discuss further. If you get any updates from local legislators, we would be interested in seeing them. Typically, if we decide to pursue an advocacy item or a major change in legislation, we would put it on our work plan.

5. **Communications and Announcements**
    - COVID-19 update: Amy Gross provided an update based on the Public Health notes from Monday, Aug. 16. Numbers are not going in the right direction. COVID cases and hospitalizations are accelerating across the state. Statewide case rates are increasing across all age groups. Hospitalizations are skyrocketing. Highest rates are among young adults 20-39 years old. Low vaccination rates, more contagious variants and increased group interactions are contributing to the cases. There are now recommendations for people who are immune compromised to get a third dose of an mRNA vaccine. People should talk to their healthcare provider. CDC also has info on its website. The COVID vaccine continues to be highly effective at preventing serious reactions or death.
    - Clark County Housing Options Study & Action Plan update: Jacqui let the group know the project advisory group is continuing to meet and is evaluating strategy options before moving towards development of draft recommendations.

6. **Adjournment:** The meeting adjourned at 6:07pm.

The Clark County Commission on Aging provides leadership and creates community engagement in addressing the needs and opportunities of aging.