IC²
Innovating Well-Being

The Future of Health Equity
Conference Synthesis

IC² INSTITUTE
THE UNIVERSITY OF TEXAS AT AUSTIN

DIRECTOR'S FOREWORD

The Future of Health Equity conference convened a vibrant mix of thought leaders and health practitioners to explore the challenges and opportunities we all face in our efforts to advance health equity.

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No matter if you are an academic, a philanthropic leader, a medical or public health professional, or with the government, we have a lot to learn from the multidisciplinary perspectives and views that filled the conference room—and we will continue to learn from this conversation as it draws in other minds and ideas.

We designed the event with space for interdisciplinary conversations, provocations, and solutions—not merely a focus on the problems. While there is often contentious debate about why health inequities exist—from individual failures to structural failures—the fact that these disparities do exist is generally not in dispute. Some populations suffer higher rates of chronic disease, receive inadequate health care, and have shorter life spans. We deliberately chose to recognize disparities but not make them the singular focus of our dialogue. Instead, we highlighted the important work many of you are doing to reduce health disparities through pathbreaking research, clinical and social innovations, and funding efforts.

The IC^2 Institute has a long history of studying and catalyzing innovation. It's what we do. At this event, we brought together leaders and experts in varied fields and roles to catalyze new research ideas and health equity strategies. We learned about novel work by researchers to illuminate factors that drive health disparities. We heard how medical professionals, educators, and community-based organizations are standing strong on the frontlines of health equity. And foundation leaders shared reimagined funding strategies and purpose in the face of growing disparities. While there is always more to do and learn, cultivating strategic partnerships and opportunities across disciplines is certainly central to this work.

Dr. S. Craig Watkins
IC^2 Executive Director

The conference, more than anything, reminded us all why we care about health equity and brilliantly demonstrated the many different ways we pursue it. The ideas circulating during the event by our speakers and audience offered rich insights for a forward-leaning agenda of research, practice, and funding. We at IC^2 are buoyed by the conversations that will steer and refine our future initiatives and partnerships.

CONTENTS

On April 21, 2023, the IC^2 Institute convened nearly 100 experts and leaders for a one-day conference: The Future of Health Equity.

Through this invitation-only event, we hosted a diverse array of thinkers and innovators from public health, health care, research, philanthropy, and social services. It was the outgrowth of myriad strategic conversations IC^2 has been coordinating with community partners to advance health equity.

Since Executive Director Dr. S. Craig Watkins took the reins of the IC^2 Institute in January 2022, our team has honed its focus on the foundational pillars of a well-being economy. Health equity is one pillar. We acknowledge widespread disparities in the prevalence of chronic disease and persistent barriers to health equity; IC^2 has been rigorously exploring these issues with social and data scientists, healthcare professionals, and leaders in public health and other sectors.

Conference invitees included health practitioners (doctors, nurses, and other public health professionals), philanthropic leaders, workforce experts, researchers, and policymakers. The size of the conference was important: 97 attendees was large enough to facilitate cross-fertilization of ideas, but intimate enough to encourage authentic connection and space for honest dialogue.

Following the many dynamic conversations at the event, our team crafted this conference synthesis report to keep the dialogue going— adding in more voices and minds along the way to move our growing community of thinkers and doers toward targeted solutions to identified problems. This report offers a summary and reflections of the event, highlighting bold ideas and action steps we continue to define and pursue collectively.

Well-Being Economy

An economy in which improved quality of life for all—not GDP— is the measure of progress.

FOCUS & APPROACH

What Is IC^2 and What Is Our Role in Advancing Health Equity?

The IC^2 Institute was established at The University of Texas at Austin in 1977 as a think-and-do tank to study the drivers of economic development and shared prosperity. IC^2 has a deep legacy of academic research and real-world practice—connecting academic, business, and community leaders around bold ideas.

Currently, IC^2 is moving in new directions...

leveraging the Institute's history of community building and ecosystem creation. The Institute's newest strategic initiative, Innovating Well-Being, drives research and programming that advance equity in social, economic, environmental, and health systems. We believe that prosperity goes far beyond traditional economic measures; life-enhancing resources must be allocated equitably. Current systemic inequities—the digital divide, health disparities, the racial wealth gap, and social and environmental isolation of rural and poor communities—are areas that demand our attention and innovations.

Learn more about us:
https://ic2.utexas.edu/

View the full conference program:
https://ic2.utexas.edu/conference/

Watch our conference YouTube playlist:
bit.ly/3WzbSet

Convening the Experts: Five Conference Panels

The event included five moderated panels:

- **Uvalde and the Future of Health Equity Keynote** - Uvalde, Texas, is a microcosm of the social, economic, health, and demographic transitions underway in Texas and the nation. Panelists discussed their current, on-the-ground work to mitigate social and health inequalities in the aftermath of the elementary school shooting in 2022—and the ways in which discoveries can translate into solutions for other rural communities.

- **Rethinking the Social Determinants of Health** - There is widespread consensus that the social determinants of health—the conditions in which people are born, grow, live, work, and age—are key drivers of health disparities. In this session, we considered the real-world nuances and implications of these drivers and discussed inventive ways practitioners mitigate such social and environmental factors.

- **Shaping a New Healthcare Workforce** - The COVID-19 pandemic stressed state and local healthcare workforces. Panelists and the audience explored the challenges of rebuilding the healthcare talent pipeline, the implications of expanded telehealth, and how existing health inequities exacerbate recruitment and retention of healthcare workers.

- **Health Equity and the Future of Philanthropy Keynote** - The COVID-19 pandemic dramatically changed the way foundations view their work. Panelists highlighted their foundations' current strategic funding priorities in addressing health equity needs in target communities.

- **Well-Being Hubs and the Future of Health Care** - Trusted places and people have a pivotal role in advancing health equity by connecting diverse communities to essential services. A lightning talk illuminated research findings on a new multi-dimensional service model deemed "well-being hubs," a reference to the nonconventional places in communities that expand access to health services and reimagine the delivery of health care. Panelists then shared their pioneering work to create well-being hubs.

FOCUS & APPROACH

Synthesizing the Ideas Into Action

Throughout the day, we encouraged the audience to write down ideas and place them on our THINK / DO / FUND idea board. It was an opportunity for attendees to respond to the panelists and the big questions addressed by the conference, pose additional questions, and offer solutions.

To step from ideas into action, we've organized the many audience responses into subcategories. The full list of ideas can be found in the **Idea Board Section**.

The ideas that emerged at the conference nudge IC^2 and our partners in certain directions. In the coming months, we will develop a set of redefined IC^2 research initiatives and programs for 2024 and beyond, fitting audience ideas with our knowledge, expertise, and strengths. Read more in **Reflections** and **Closing Thoughts From the Conference Chair.**

Keynote: Uvalde and the Future of Health Equity

Three distinguished leaders sat down for a fireside chat with conference chair Dr. Steven Pedigo and discussed the ways in which the tragedy in Uvalde, Texas—the elementary school mass shooting in 2022—put a spotlight on a variety of health equity issues affecting Uvalde and many other communities in Texas. This keynote session revealed how Uvalde, an isolated town of 15,000 just 50 miles from the U.S.-Mexico border and an hour west of San Antonio, represents some of the most significant social, economic, health, and demographic transitions underway in our state and country.

Amber Arthur, Chief Operations Officer for Community Health Development, opened the discussion by describing "Team Uvalde," a group of nonprofits pooling limited resources to provide needed health care services in their small town. UT social work professor and interpersonal violence expert Dr. Noël Busch-Armendariz added that the closest domestic violence shelter is in Hondo, about 40 miles away. Isolated communities generally struggle to provide health and mental health care, especially after a crisis when demand spikes.

"Our needs assessment revealed a mental health services desert coupled with widespread misunderstanding of what mental health is—stigma is a particular challenge in Uvalde,"

said Professor Busch-Armendariz. The community's capacity to integrate resources offered by people and entities outside of Uvalde is limited by "trauma shock," she added. The experts agreed that a citywide health communication strategy is needed to educate the community and its partners on the dynamics and impacts of trauma; such a strategy seems to be missing from the existing "recovery playbook" Uvalde has been using.

SYNTHESIS OF IDEAS
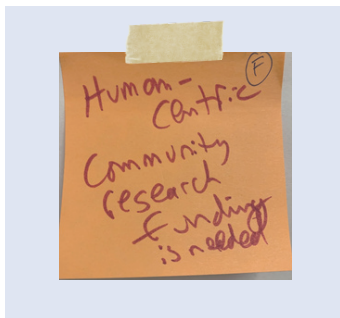
UT history professor and MacArthur Fellow, Dr. Monica Martinez, who was born and raised in Uvalde, pointed out that the town is 80% Hispanic with long patterns of discrimination, social injustice, and accumulated trauma. In this context, she said:

"People who are coming to town after the shooting from elsewhere to provide services to this community are having trouble building trust."

She also identified a lack of medical infrastructure, including broadband internet service, which is holding back community recovery: "Uvalde is a traditionally under-resourced town."

Arthur added that Uvalde especially needs housing infrastructure as well as digital literacy. As in other small communities, the housing stock is limited and aging, making it difficult to recruit professionals and young workers to move there. She added that her organization is trying to introduce telehealth services and guide the community in uptake. "One thing that we've done is to offer free Wi-Fi to all our patients...and show them how it works, orient them."

Above all, discussions during this keynote repeatedly emphasized how community decisions must be collaborative and participatory, with broad community buy-in. "Our community-based needs assessment involved talking with dozens of community members—to establish trust that we as researchers understood the community first, before making recommendations," said Professor Martinez.

Panel: Rethinking the Social Determinants of Health

Promising Programs and Initiatives

What are the real-world, nuanced implications of the social determinants of health (SDoH) on health equity? How do they play out across diverse populations? How do individual lived experiences differentially impact health conditions, including mental, cardiovascular, metabolic, women's, and respiratory health? And what practical solutions are in the works to identify and mitigate the impacts of these drivers of health outcomes? While much progress has occurred, much work also remains.

SYNTHESIS OF IDEAS

This panel featured Dr. Chiquita Collins with UT Health San Antonio; Dr. Aliza Norwood of Dell Medical School and Medical Director of Vivent Health; Dr. Matthew Kammer-Kerwick, a Senior Research Scientist at the IC^2 Institute; and moderator Dr. Mini Kahlon of Dell Medical School and Executive Director of Factor Health.
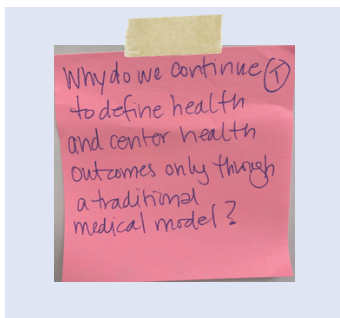
Rethinking Language

First, panelists led the audience in considering something more basic: How does the term "social determinants of health" land? While it's commonly used, is it accurate and fitting? The audience shared both positive and negative associations with the wording, such as: "determinants" sounds too technical and obtuse or "social" could be confounded with the loaded term socialism. Multiple attendees gravitated toward "non-medical drivers" as a better characterization to discuss such complex, intersecting, and nuanced ideas in ways that connect with policymakers and the public. Yet not all agreed. Panelists chimed in to give context on the rich 25-year history of scholarly and policy work behind the concept and phrase "social determinants of health." There is room to be flexible in how we talk to policymakers, community members, and others about these ideas, and we can adapt our language as appropriate as we continue to recognize and respect how each individual's day-to-day lived experiences impact their health decisions.

Resource Allocation

The conversation turned to resource allocation in clinical practice. The group agreed that health care leaders recognize the importance of being able to allocate more resources to patients with the greatest needs and barriers to accessing care—in other words, needs and barriers related to SDoH. The panel delved into an example of SDoH considerations in health care for the LGBTQ+ community and how some barriers can be addressed in primary care while others necessitate a larger shift in social norms.

One of the most powerful ways to achieve a shift in norms for positive health and health care outcomes, the panel noted, is to incorporate interdisciplinary care teams to facilitate deeper knowledge of the nuanced role of SDoH. This includes members of the care team who connect patients to needed community resources and can be an advocate for the patient as they evaluate and make decisions about those resources. This is one strategy to help patients see the clinic as a safe space to share information about discrimination endured, food insecurity, housing precarity, and other specific non-medical drivers of health.
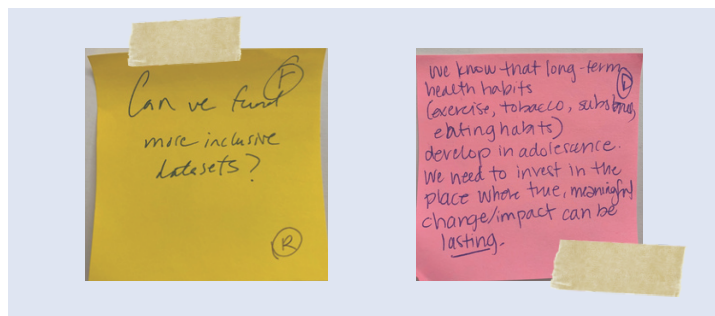
Data-Driven Advances

Ongoing research and analysis of existing data are key to further understanding about SDoH for specific communities and disease areas. The panel discussed the value of critical investments by the federal government, and pointed out how the All of Us dataset by NIH allows for examination of the moderating and mediating effects of non-medical drivers of health for individuals by social position, identity, and specific disease indications. Kammer-Kerwick noted how early results from a machine learning exercise have shown both the complexity and the nuance associated with such investigations. Through this research, we can improve our understanding of the impacts of SDoH and spur development of decision-support tools that improve diagnostic precision based on non-medical factors.

SYNTHESIS OF IDEAS

How do we adopt a social determinants of health schema?

Several are already available with varying models and numbers of health determinant pillars included—but do the models reflect how these pillars interact and are comorbid? In a single person or community of people, many SDoH factors move together at once, and separating out the effects of each factor for personalized care is a challenge. Yet, we can ask patients to tell us more. Collecting and analyzing narrative qualitative data about the context of a person's lived experiences in concert with analysis of data from SDoH screeners is an avenue to understanding, especially if those data can be collected in a real-world setting outside of the clinic. Over time, this approach can reveal trends in the trajectories of patients.

The group continued by further examining how to operationalize SDoH, what themes and factors to measure, and how various factors overlap. Panelists also discussed how to determine the best framework for examining SDoH issues by population, whether we're primarily focused on race and ethnicity, age-related issues, or gender and sexual minority groups. While many questions arise, a healthy respect for data and models remains important; data elucidate and inform clinical practice, even in the face of ambiguity and nuance.

At the end of this session, the panelists reiterated the importance of:
- Educating future health care leaders about SDoH.
- Creating sustainable, grassroots programs designed in concert with the community to address gaps associated with non-medical drivers of health.
- Providing evidence-based decision support to policymakers who play such an important role in the allocation and prioritization of health care and social support resources.

> The one thing I would encourage us to do is to not set our sights too low....I want us to think of health, not just as the absence of disease, but the true target of health being living a joyful, dignified, and fulfilling life.
>
> Mini Kahlon, *Vice Dean for the Health Ecosystem; Executive Director of Factor Health | Dell Medical School*

SYNTHESIS OF IDEAS

Panel: Shaping a New Healthcare Workforce

Besides technical knowledge, skills, and abilities, the dialogue during this panel session pinpointed how future healthcare employees need the soft skills that lead to collaboration, empowerment, and advocacy. And it is paramount for healthcare professionals to be willing to learn continuously.

IC^2 convened this panel to discuss challenges and opportunities in developing a skilled, engaged future healthcare workforce. It featured leaders Dr. Nina Almasy with Austin Community College; Tamara Atkinson of Workforce Solutions Capital Area; and Dr. Ryan Sutton, Assistant Dean for Diversity, Equity, & Inclusion at Dell Medical School, and was moderated by Sherri Greenberg, Assistant Dean for State and Local Government Engagement at the LBJ School of Public Affairs.

The discussion centered on:
- **Diversity:** As populations in need of health care become more diverse in terms of race/ethnicity, language, disease prevalence, and social class, what impact will there be on the types of skills healthcare workers must develop?
- **Aging**: What specific issues facing the healthcare workforce are presented by an aging population?
- **Inequities in Workforce**: How are existing health inequities exacerbating recruitment and retention of healthcare workers?

Promising Programs and Initiatives
Numerous programs are being adopted to extend and expand the talent pipeline for a more diverse and equitable healthcare workforce, such as:

- **Dell Medical School** has new pathway development initiatives designed to create access, exposure, and opportunity for students to understand healthcare roles, to demystify the spaces or professions they might be dreaming about, and to allow them to re-envision themselves and their careers. These include high school summer camps and school-year programs as well as trips to the CDC, Morehouse School of Medicine, and a professional sports medicine facility.

SYNTHESIS OF IDEAS

- **Workforce Solutions** has been funding and implementing internships and apprenticeships, and also increasing childcare options for parents in the workforce.
- **Austin Community College** has dual credit programs with high schools as well as adult education programs. There are 14 credit programs in health sciences, covering nearly all non-physician staffing occupations in a hospital: radiology technology, occupational therapy, physical therapy, sonography, dental hygiene, and nursing. And the college's collaborative programs with two school districts are aimed at inspiring students from minority populations to pursue nursing.

Additionally, experts and audience members noted current trends that bode well for achieving a healthcare workforce that is increasingly similar to the patients being served:

- At Dell Medical School, an increasing number of candidates come from a career in another field, bringing rich and expanded experience to their studies. Also, there is an increase of diversity in students, making Dell Med more reflective of the communities it serves.
- In health policy, more students seeking graduate studies come from business and other non-health care backgrounds.
- And healthcare employers are seeing more applicants for entry-level positions coming from the hospitality industry and looking for the career growth they see in the healthcare industry.

> *"When it comes to lifelong learning, it should not be only on the shoulders of the workers who are carrying significant loads. There must be a partnership.... Workers should be able to ask for what they need to continue to learn. And then the employers, I believe, should pay them to learn those skills."*
> *—Tamara Atkinson, CEO of Workforce Solutions Capital Area*

Persistent Challenges
The discussion also touched on certain key barriers to achieving a more diverse workforce:
- Compensation is inadequate for many entry- and middle-level healthcare positions as compared to the cost of living.
- Supports, such as childcare, still are insufficient for the healthcare workforce.
- Few future healthcare workers have the luxury of being in school or another training program without simultaneously working, which limits their capacity to study and adds barriers to program completion. For instance, most community college students work and/or have family obligations.

SYNTHESIS OF IDEAS

Future Vision

How will the future healthcare workforce look different from today's workforce? A major portion of the discussion centered on this question—plus concrete strategies we as experts and leaders can use to shape that vision.

We know that the future healthcare workforce will be much larger than today's workforce. In the Austin region, for example, healthcare positions will surpass the number of new positions in all other industries combined. To meet that demand, staff recruitment and retention must improve. To support and sustain healthcare employees from diverse backgrounds, a more welcoming employee climate is needed in the field, such as these standout examples: Cherokee health models[1] in Tennessee and Nuka health systems[2] in the State of Washington.

To achieve a larger and more effective future healthcare workforce, the panelists and audience noted how:

- Future healthcare employees should expect continuous learning.
- Employers will need to recruit more innovatively.
- There is a need for more apprenticeship programs.
- Employers will need increasingly to put skin in the game by embracing the "earn and learn" approach.
- The discussion also touched on the impacts of artificial intelligence on the healthcare workforce, considerations around employee representation on healthcare boards of directors, and the transparency of pathways to becoming a healthcare administrator.

Earn and Learn Example

Some hospitals are recruiting nursing students for internships and paying them to fill patient care technician jobs during their training. The students can count those work hours toward their clinical hours needed for graduation, and then the employers hire the students for full-time roles upon completion of their training.

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1. Learn more: https://www.ahrq.gov/ncepcr/tools/workforce-financing/case-example-7.html
2. Learn more: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752290/

SYNTHESIS OF IDEAS

Keynote: Health Equity and the Future of Philanthropy

The second keynote session gave attendees a glimpse into the mission-driven strategic thinking of three philanthropic foundations actively funding health equity initiatives. Panelists Jo Carcedo from Episcopal Health Foundation in Houston, Regan Gruber Moffitt from St. David's Foundation in Austin, and Kevin Lambing from T.L.L. Temple Foundation in Lufkin kicked off the conversation by introducing each foundation and its relationship to health equity work:

- Chartered in 2013, **Episcopal Health Foundation** serves 57 counties of the Episcopal Diocese. "We see ourselves as philanthropic, but also as part of the communities we serve," Carcedo said. The organization is an outgrowth of the Episcopal Church, which in recent years "has made a conscious decision that their work, as it relates to health, would be outward-focused." Episcopal Health defines health equity as: All people should have access to opportunity, regardless of race and other characteristics and conditions. The foundation is moving from a global understanding of health equity to a focus on eliminating health disparities.

- The **St. David's Foundation** can trace its existence back almost 100 years when a group of congregants determined that Austin needed more access to health care. While the foundation remains focused on health, its leaders have recognized that an organization cannot fund health care without questioning the "why's"—examining social determinants of health. In recent years, health equity has become central to the foundation's mission.

- The **T.L.L. Temple Foundation**, which began as a family foundation in 1962, serves 23 counties in Texas and one in Arkansas. Lambing said its mission as it relates to health equity is to ensure that all East Texans are healthy and have access to quality health care. The foundation funds work in four areas: health, education, human services, and economic opportunity. Lambing described the intersectionality of social determinants in his work:

"A number of times, the person whose problem I'm trying to solve in health, my colleagues are also trying to make sure that the school that child is going to has what they need, that the parents of the child also have economic opportunities...and the human services are available for the family, for wraparound services."

Evolving Funding Strategy

Moderator S. Craig Watkins asked the panelists to describe how external factors–COVID-19, growing economic inequality, and social unrest–have changed their funding strategies. All three panelists agreed that the pandemic revealed the cruciality of place-based work. "Work that is proximate to communities is important," Moffitt said. Carcedo responded:

"We can't just look at the health status outcomes of virtually any community in Texas and not ask the questions about why these things exist. The data force us to go upstream in our work."

St. David's Foundation is more fully grounded in the communities it serves because its team is taking a hard look at what the data is telling them, and seeking to understand the people behind the data. While "healthcare funding and financing is a systems-level issue," the foundation also works aggressively through community health centers as "part of the promise of changing how the system works."
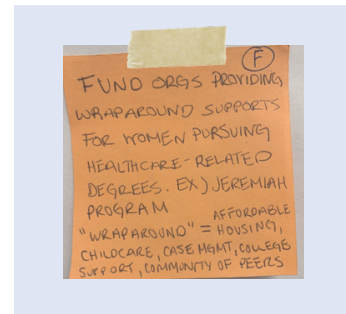
Moffitt explained that the pandemic provided a "reality check" for what the St. David's Foundation can and cannot do. Its new approach includes more funding for general operating support, more flexibility, and "more folks coming within our grant portfolio." Lambing added that the pandemic and other dynamics have made their team more strategic.

SYNTHESIS OF IDEAS

Balancing Limited Resources

To close the keynote session, Watkins posed this question to the panel:

How has your foundation narrowed its focus in a time of limited resources?

- Episcopal Health has moved from health equity as a broader conversation into a focus on specific health disparities as well as some new place-based initiatives. Three disparities have emerged as priorities: maternal health; food systems; and diabetes. In addition, Episcopal Health's approach to data is changing: "We've relied heavily on the data that comes out of the healthcare system and we're actually beginning to move in ways that incorporate the experience of what the community understands and knows for itself," said Jo Carcedo.
- Moffitt outlined five areas of focus for the St. David's Foundation: resilient children, healthy women and girls, older adults, aging in place, and thriving rural communities and clinics as community hubs.
- For the T.L..L.Temple Foundation, Lambing noted a few primary goals: access to providers and health services and access to affordable health insurance, in part based on an understanding that people in many rural communities must travel many miles just to reach health services. Beyond that, the foundation is focused on advocacy work around Medicaid expansion to broaden available resources and services.

As the panel ended, the audience conversation centered around the need for capacity building in rural communities and the need for an infusion of federal dollars to complement and reinforce the work that philanthropic foundations are doing to reduce inequities.

When we deal with issues of race and racial justice, I think [it starts with] building trust....people sitting at the table and having coffee and breaking bread and getting to know each other and understanding, "This is how I think about this."

Jo Carcedo, Vice President for Grants
Episcopal Health Foundation

SYNTHESIS OF IDEAS

Lightning Talk and Panel:
Well-Being Hubs and the Future of Health Care

The U.S. spends over 18% of its annual GDP on health care. This sector is also the largest private employer in our nation. Despite these dedicated resources, many people cannot access care and barriers are complex. Yet, trusted places and associated human mediators can play a pivotal role in advancing health equity and overcoming certain barriers by connecting diverse communities to essential services. This session catalyzed a research-driven discussion with thought leaders representing cutting-edge initiatives linking community institutions—such as public libraries, affordable housing providers, and faith-based organizations—with the delivery of much-needed health services.

Lightning Talk

Dr. Greg Pogue, Deputy Executive Director of the IC[2] Institute, presented findings from research illuminating a new multi-dimensional service model deemed the "well-being hub." Well-being hubs are trusted community anchor institutions that authentically engage the communities they serve by facilitating resource navigation, delivering life-enhancing services, and addressing salient needs. Hubs leverage existing community services and assets to meet individual and public health needs, expand health access, mediate and deliver care, and leverage technology to improve service delivery and effectiveness.

Libraries, Living Rooms, and Churches

Dr. Megan Weis, of the South Carolina Center for Rural and Primary Healthcare in the University of South Carolina School of Medicine, described the gaps in health equity in South Carolina in terms of maternal health, infant mortality, and specialty access. While 14 counties lack an OB/GYN physician, 95% of people live within proximity to public libraries and 37% of people who visit libraries are seeking health information. South Carolina has

successfully experimented with placing social workers and community health workers in libraries to facilitate information-sharing on housing and food and offer health care access.

Abena Asante with the St. David's Foundation has led the pilot of Libraries for Health, an initiative that is placing peer support specialists in public libraries throughout rural Central Texas for community mental health support. While stigma and a lack of trained providers are barriers, especially in rural areas, placing specialists into trusted, welcoming places promotes community access and engagement.

Jennifer Searles, CEO of Veritas Impact Partners, describes how her organization brings social and health services into the "living rooms of" 5,371 residents in participating affordable housing apartment complexes in Austin, Dallas, and Houston. With many working families lacking health insurance, Veritas offers free telehealth to residents 24/7/365 and saves families almost $500/month, thus freeing up funds for rent and "rainy day" savings. The well-being services also create new business models for the apartment managers through increased on-time rent payments, lower default rates, reduced resident turnover, and improved resident relations.

"There are many different ways to look at access, but when it comes in the health realm, it's two questions for us and for our residents: How do I get to a doctor when I need one? And how do I pay for that care?"
—Jennifer Searles, CEO of Veritas Impact Partners

SYNTHESIS OF IDEAS

Angela Bigham from the People's Community Clinic partners with UT Austin's School of Nursing in the AMEN Program to offer mental health services. During the COVID-19 pandemic, nurses offered "check-in" services for mental health, food, water, and the COVID-19 vaccine, first at churches and then extending to congregant residences. The program also offered support to church ministers who were on the frontlines for their communities while also grieving pandemic-related losses themselves.
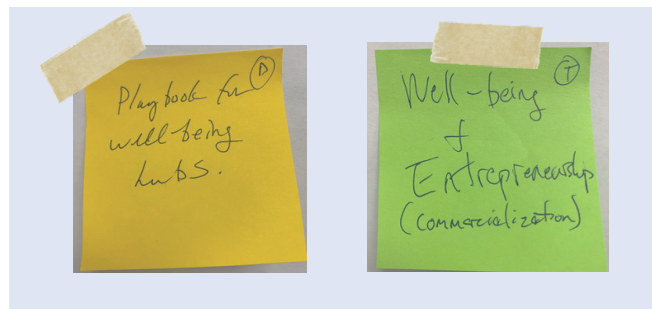
These creative and responsive solutions put the community at the center of the health care conversation and essentially bring health care to the underserved in non-traditional places, or what IC^2 refers to as well-being hubs. The session concluded with agreement that we must collectively "create greater public awareness of how each of these respective well-being hubs is functioning and why we need to begin building models, policies, and interventions to help sustain this work."

> We know that there are certain locations, populations...where the health impacts and all the great work that we're doing is still not being realized. It continues to be a critical crisis and we need to keep our attention on that.
>
> Dr. Megan Weis, Director, Connecting Communities
> SC Center for Rural and Primary Healthcare
> University of South Carolina School of Medicine

Human-Centered Disruptions
by Gregory Pogue, IC² Institute

We live in a world of constant disruption; one where the "makers" and the "made" compete for future dominance, or maybe just for mutual survival:

- The investment bank Goldman Sachs predicts that AI can replicate some or all of 66% of existing occupations, replace 25% of all jobs in the U.S. and Europe, and simultaneously enhance GDP productivity by 7%.[1] Talk about a faster, better, cheaper model!
- Automation and robotics are predicted to transform industries as disparate as mining and food preparation, manufacturing and medicine, ushering in an economy by the mid-2030s where 375 million existing jobs are unnecessary and a world with 600 million new people in it.[2]

A pessimist may ask, "What do people offer anymore?"

The recurring themes that arose during The Future of Health Equity conference give a strong and optimistic answer to that question.

We often think about health care in terms of system navigation, diagnosis, treatment, recovery, insurance, costs, and payments. The conference asked deeper questions about the theme of "access." Before a person can benefit from available health care, they must be aware of and know how to engage the healthcare system.

Access proved a complex topic, integrating physical proximity and transportation, time off work and financial resources, native language and health literacy, internet access, and digital literacy.

Digital Literacy
Some parts of access are technology dependent, but most are people-centric. Take, for example, digital literacy: There are almost 8 billion people on our planet; 5 billion use the internet and 93% of these are on social media.[3] Yet, digital literacy remains a need,

1. https://www.goldmansachs.com/insights/pages/generative-ai-could-raise-global-gdp-by-7-percent.html and https://www.bbc.com/news/technology-65102150
2. https://techjury.net/blog/jobs-lost-to-automation-statistics/#gref
3. Statista Research Department, "Internet Users in the World 2022," July 26, 2022, https://www.statista.com/statistics/617136/digital-population-worldwide/.

REFLECTIONS

especially among individuals in rural areas, greater than 60 years old, with a disability, or with income levels near the poverty line.[4] And digital literacy is central to health care considering how electronic health records and portals are becoming the norm to access lab results, doctor's notes, and more.

Public libraries are often tasked with closing the digital literacy gap in the U.S. We learned through a recent IC[2] Institute study of Texas libraries that this effort surprisingly and predominantly occurs through one-on-one, just-in-time meetings between people. The ineffectiveness of online training and group classes amazed us. The chief way a person learns to use the internet and associated tools does not require a robot or generative AI, but a patient and skilled human.[5]

Human Touch

Likewise, the conference emphasized the importance of the human touch, the human mind, and the whole human being in understanding and solving problems associated with health equity through themes like:

- Move beyond the data to see the people behind the data.
- Build trusted relationships before seeking to deliver a solution or service.
- Have community resource guides in print or on the web, but offer warm introductions and a hand-off to keep from losing people in the "cracks" between organizations.
- Receive people with respect to reduce stigma and shame.
- Meet people in their lived experience to both understand their needs and offer a path to healing.
- Approach solutions and services with cultural humility, prioritizing native language and customs.

The human touch goes hand-in-hand with the need for data and systems to solve pressing and prevalent problems. Indeed, the conference attendees made a compelling case that we need more data, greater analytical capacity, and more automated capabilities to understand societal problems and deliver solutions at a meaningful scale. But emotional intelligence is required to fit a solution to those in need and deliver it with kindness. Such offerings keep people at the center of health care.

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4. National Telecommunications and Infrastructure Administration. (2022). The Digital Equity Act: State capacity grant program, planning grants, and competitive grant FAQ. https://broadbandusa.ntia.gov/sites/default/files/2022-06/DE-FAQs.pdf.

5. Texas State Library and Archives Commission. (2023). Public libraries: Serving communities to enhance digital literacy. https://www.tsl.texas.gov/digitalliteracy

REFLECTIONS

Without human connection, health suffers. The U.S. Surgeon General recently issued a sobering analysis of the current state of our country's health.[6] We are a country where:

> *"Social isolation (an objective measure of lacking connection to families, friends, and community) and loneliness (a subjective measure of feeling disconnected) contribute to a person having a higher risk of heart disease, stroke, anxiety, depression, and dementia, and make people more susceptible to infectious diseases."[7]*

Our conference highlighted human-centered health care solutions for both physical and mental health as a potent antidote to social isolation and loneliness:

- People—residents as opposed to institutions—are at the center of strategies for violence prevention and community recovery in Uvalde, TX, as it builds a more unified and healthier community in the aftermath of the Robb Elementary School tragedy.
- With deep awareness and empathy toward the impact of social determinants of health, we can be compelled to engage, create connections, share resources, and develop policies to meaningfully resolve inequities.
- Engaging and mobilizing new partners to participate in health care delivery outside the traditional clinic setting provides relational pollinators throughout a community who offer a listening ear, lived experience, proximal health care, and fitting recommendations and referrals.
- Funders see return on investment from their social philanthropy as necessary—and realize that these returns must be measured beyond purely economic terms and consider change and enhancement to lives and community well-being.
- Well-being hubs offer communal spaces where social and health needs can be met through community-embedded solutions. Indeed, cultures of connectedness can be built through libraries, affordable housing centers, faith communities, schools, and elsewhere to monitor health, respond, and deliver needed services right where people are already.

In a world that needs data and technology solutions, how do we respond to the question: "What do people offer anymore?" We answer it simply: People offer human insight, compassion, and touch.

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6. U.S. Surgeon General. (2023). Our epidemic of loneliness and isolation. The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf
7. Scott, D. (2023, May 3). The Surgeon General says loneliness is as deadly as smoking. Vox. https://www.vox.com/policy/2023/5/3/23707936/surgeon-general-loneliness-epidemic-report

The Frontlines of Health Equity: The Impact of Well-Being Hubs
by S. Craig Watkins, Executive Director of the IC² Institute

One solution to health inequities discussed at length at the conference is the rise of what we call "well-being hubs," or community institutions that are stepping up to address health needs and disparities. During the conference, we showcased researchers and practitioners who are developing expertise and experience in the well-being hubs space. Largely unknown to the public, well-being hubs are increasingly on the frontlines of addressing our nation's health care crisis. Our libraries, churches, and affordable housing apartment complexes, for example, are routinely confronted by downstream impacts of social determinants of health (SDoH) because they are the places where people are born, live, age, work, and play. These places and the conditions that define them are not equal, thus neither are health outcomes.

SDoH are generally proximal, social, environmental, and durable—and therefore challenging to address. Even as more traditional health care professionals like doctors and nurses recognize the importance of SDoH, they also understand that they have limited capacity to address a patient's non-medical circumstances. This is precisely why well-being hubs and their staff are emerging as critical assets on the frontlines of health equity.

Here are three reasons why well-being hubs are poised to address health disparities:

- **Well-being hubs already exist** in urban and rural communities. You don't have to build a library or a place of worship, and these are common sites for community gatherings, refuge, and healing. Similarly, affordable housing developments exist in many parts of the country and are being designed smartly with wraparound support for residents.

- **Well-being hubs are trusted** community-based resources. One of the most serious barriers to equitable health care is the fact that many people in underserved populations struggle to trust formal health care providers and institutions, perhaps due to power differentials, perceived stigma, or past injustices. Consequently, people may not seek out or have high confidence in available care. Yet, patrons trust their librarians and faith leaders, thus they may be more open to a health service or intervention in these settings. Similarly, residents are more likely to trust a housing developer with wraparound services like education, broadband, or telehealth because these amenities associated with their home signal a commitment to providing support, comfort, and community.

REFLECTIONS

- **Hubs are embedded in communities** and can deliver health services directly where people are. This fact mitigates some of the most salient health equity barriers, including inadequate transportation and mobility, time poverty, and lack of access to health care facilities and services. The ability to offer expert mental health services, digital literacy, or vaccine education in places people routinely inhabit is a game-changer for health equity.

During one Q & A session, an audience member asked: Why are libraries becoming first responders to the health needs in their communities? The reply: Because they have been called to do so based on community needs. The effects of health inequality—despair, desperation, and dislocation—are forcing community-based institutions to step forward. While well-being hubs already exist on the frontlines of health crises as varied as mental health, food insecurity, and opioid addiction, they operate in the shadows of our health care delivery system.

Thought leaders at the conference suggested two calls to action to bring well-being hubs out of the shadows and spotlight their potential. First, we must collectively study, strengthen, and scale the capacity of well-being hubs to deliver effective health services—and recognize how well-being hubs leverage community assets to enhance community resiliency and outcomes. This includes research and strategic partnerships. Second, we must create greater awareness to highlight the important contributions—social, financial, and clinical—that well-being hubs are making in their communities. We must ensure that the public, media, and policymakers know about the impacts of well-being hubs. Both research and awareness campaigns can build a stronger appreciation for well-being hubs, increase publicity, and ideally boost funding that can make the great work of these community resources more sustainable and impactful.

In the months ahead, the IC^2 Institute will continue on this path with research and stakeholder engagement that illuminates how well-being hubs have emerged as transformational community assets and a catalyst for health equity.

CLOSING THOUGHTS
From the Conference Chair

As Goes Texas: A Well-Being Economy for the Future of the Nation

As conference chair, I was excited to help the nearly 100 attendees develop new perspectives on economic development and community building and unpack why health equity is an important foundation for both. Much of the discussion at the event was about the disparities in the prevalence of chronic diseases, the delivery of health care in Texas, and the impact on the well-being of Texans.

As I wrote in The New York Times in October 2021,[8] Texas is a big, diverse state, and as such is the perfect laboratory in which to isolate and understand challenges and opportunities facing the nation.

That diversity can be seen across our economy, our environment, and especially in our rapidly changing demography. White, non-Hispanic Texans make up less than 40% of the population. For every White person who has moved to Texas in the last 10 years, there have been three new Black residents, three Asians, three people with multi-racial backgrounds, and 11 new Hispanic Texans.

Texas' industrial mix is no less volatile and diverse. Houston and Dallas are global gateways; Austin has become one of the fastest-growing technology and innovation hubs in the country; El Paso anchors a binational mega-region; and San Antonio is a leader in life sciences. Oil extraction, ranching, and agriculture play much smaller roles than they used to; the share of high-skill, high-pay professionals, techies, scientists, educators, and artists in the Texas workforce has grown by nearly 30% since 2010. But at the same time, fewer than 30% of Texans hold bachelor's degrees, and two out of ten Texans lack health insurance.

Steven Pedigo
LBJ School of Public Affairs Urban Lab

As the conference discussions made clear, those disparities are reflected in the uneven impacts of the COVID-19 pandemic across Texas communities and in the social, educational, and economic divisions that both contributed to the 2022 tragedy in Uvalde, Texas, and are complicating its recovery. It is clear that Texas stakeholders can do more to build a place that is increasingly resilient, sustainable, and inclusive.

8. See: https://www.nytimes.com/2021/10/05/opinion/texas-census-united-states.html

CLOSING THOUGHTS

Indeed, the IC^2 Institute's emergent exploration of the "well-being economy" gives a new conceptual framework for people-centered community building in which health equity is a key pillar. This is a shift from the traditional model of regional economic development solely focused on business attraction, expansion, and development. More important still, IC^2 can develop the tools, best practices, and a practical playbook that governments, advocates, activists, philanthropists, and businesses can use as they work to address Texas' challenges, and the Institute can create networking and gathering opportunities for the exchange of ideas in a robust community of practice.

Complete community building is the future of economic development and health equity. The insights that IC^2 and its stakeholders develop and pursue will substantially impact the well-being of Texas communities and help to chart a new path for other states and cities across the U.S. and the world.

Learn more and join the dialogue at: https://ic2.utexas.edu/

CONFERENCE ATTENDEE AFFILIATIONS

The University of Texas at Austin

- Center for Health Communication
- Cockrell School of Engineering
- College of Fine Arts
- Dell Medical School
- Department of History
- Department of Mechanical Engineering
- Human Dimensions of Organization
- LBJ School of Public Affairs
- Moody College of Communication
- Office of the Vice President of Research, Scholarship and Creative Endeavors
- Population Health
- School of Design and Creative Technologies
- School of Nursing
- Steve Hicks School of Social Work
- UT Development, Corporate Relations
- UT Development, Foundations Relations

Health Equity Stakeholders

- 512 Asset Management
- Ascension
- Attune, LLC
- Austin Community College
- B1 Bank
- Central Health
- City of Austin - Austin Public Health
- Community Health Development in Uvalde
- Deloitte
- Episcopal Health Foundation
- Every Texan
- Jeremiah Program – Austin
- Memorial Hermann Health System
- Northwest Arkansas Council
- People's Community Clinic
- Rice University
- St. David's Foundation
- T.L.L. Temple Foundation
- Texas 2036
- Texas A&M University
- Texas Health and Human Services Commission
- True Wealth Ventures
- United States Departure of Agriculture
- University of South Carolina School of Medicine
- University of Texas at Arlington
- University of Texas Health San Antonio
- Value Institute for Health and Care
- Veritas Impact Partners
- Vivent Health
- Wellness Equity Alliance
- Workforce Solutions Capital Area
- Yumlish

IDEA BOARD

Throughout the conference, attendees added their ideas to the Think, Do, Fund idea board to respond to big questions, pose more, and offer solutions.

THINK

Social Determinants of Health
Texas statewide community needs assessment
Temporary + permanent shelter for people experiencing homelessness that doesn't isolate them from the communities they formed while living in homeless camps.
I like Matt's idea to study SDoH according to when, where and how they matter
You should research the impact of childcare support. How do these programs work?
Language of taxonomy for discussing SDoH outside of payer/provider/patient finance
Why do determinants need a preface? Call it "determinants of health"
How to incorporate trauma informed approach to healthcare, education, policing etc.
Rural health-landscape analysis of structured financial barriers caused by fed red that impugn financial stability of rural health centers & lead to clinic/hospital closures
What is health? What that means to people/community may be different and how do we get those to align/how do we understand what that is?
Why do we continue to define health and center health outcomes only through a traditional medical model
What does a health equity model look like if it doesn't treat a person like a patient?
Where is the APD health equity work
Workforce
Use research/data to develop approach/strategy to recruit members of low-income/ underestimated communities into the healthcare field. From personal experience, I will say that access to a healthcare professional at home changed health outcomes for my whole kinship network
Change compensation practices to increase pay for front-line healthcare workers including environment services staff, checks etc. + rethink healthcare executive path (equalize)
Why women are disproportionately interested in equity + wellness + life coaching - and how do we make well being important to make lawmakers and industry executives?
You should research the impact of solution life workforce development
Research why healthcare employment loss? Find solutions that prevent it
Barriers / Access
Are there barriers to underestimated communities attending UT or Dell Med? If so, how is this addressed? What could UT or Dell Med learn from ACC about Equity in access to education? Are there pipelines in place to support students?
Access is a problem: Distance, Services, Stigma
Rural doesn't equal White, Urban doesn't equal Black/Brown, We need to know the people

THINK (continued)

Systems
Trauma and childhood trauma is linked to disease. How do we address this even beyond healthcare?
Identify community level indicators beyond health outcomes. What are the other important outcomes
Non profit organization started that offers services identified as restrictive related to how people qualify. Clients can be referred from other organizations of the qualifier being that they were seen by other qualified program + referred.
Climate and health equity
What can IC2 do to earn sufficient trust to work with HC org data?
Brainstorm with staff at clinic on ways to be more nimble and agile in how we serve patients and their families. Site flexibility? Peer support? Etc
How to prioritize relationship building as a vital part of infrastructure building
Entrepreneurship
What are the business models that align the incentives for stakeholders to offer equitable services?
Research and apply other lessons from outside the healthcare industry
Well being + entrepreneurship (commercialization)
Hubs
What number of people represent critical mass to support a wellbeing hub? Can that number change through altering service delivery methods?
Identify pops or communities that have funding & services to establish a hub (e.g. foster care funding)
Understand effective health communication methods
Data
Do more intersectional research
Research the breakdown of where healthcare dollars are spent ins/ benefit/ providers/ mgmt/ hospitals /clinics /meds
Celebrate assets (joy + justice) & not only focus on disparities
Is there opportunity to explore processes to generate synthetic HC provider data? Where do we start?
Why aren't rural residents considered marginalized?
Expand the conversation on how racism also hurts White people (not to center White experiences) but highlight we are in this together
Recent news report - Single/divorced mothers are 60% more likely to suffer heart disease than mother's married (noted by a single mother)
Longitudinal study of a healthcare pipeline econ impact/ effectiveness
Gun violence as public health
Research gun violence as public health crisis
Comprehensive demo data
How do you limit responder burden in assessments? How do you ensure your tools are culturally & linguistically appropriate?
Why must communities or anyone else "opt-in" to resources instead of automatically receiving them especially if their 100 million just left
Rural needs assessment in Texas
AI create access in rural areas
Research how to keep unused public funds in TX?
AI conversation best practice

DO

Communications
Training community leaders on health communication
Health equity collaborative w/ a SDOH sub-committee, Multi- sector
Unified dashboards for tele-health platforms that facilitate access in languages other than English
What kind of partnerships do we need to better understand SDoH?
Advance sleep health equity for underserved populations in central Texas using innovative technologies to transform healthcare access and delivery. Connect with Dr. Azizi Seixas at UMiami SoM (https://draziziseixas.com), Director of Media Innovation Lab. Happy to make introductions - Jahanett Ramirez (behavioral sleep medicine- BSM pride program cohort 9), Research assistant professor, Steve Hicks School of Social Work - jahanett.ramirez@austin.utexas.edu UMiami Miller School of Medicine: The Media and Innovation lab - https://med.miami.edu/mil
Collaborate with TX counties to form an easily replicable repeatable well-being hub template model
Partner responses for non-traditional sites of care + resources to make new ones.
The unexpressed idea…
Business need to be socially conscious to appeal to new generation
Out of Clinic/Hub
The clinic shouldn't be the center of health - if 80% health is SoDH, have those services in the community, not based out of clinic (or require clinic referral)
Mobile Health clinic in neighborhood.
We know that long - term health habits (exercise, tobacco. substance, eating habits) develop in adolescence. We need to invest in the place where true, meaningful change/impact can be lasting.
Database to support open hubs.
Community health workers on school bus
Use research/ input from those with lived experience to create inclusive/trauma - informed approaches to interfacing with patients.
Collaborate with TX counties to form an easily replicable repeatable well-being hub template model to be used by others
Partner responses for non-traditional sites of care + resources to make new ones.
School/ districts populations. How to engage schools?
Contact library associations because our hub idea helps save their institutions
Schools as well-being hubs, inc. teachers, nurses
Group based care: Pre natal care, Diabetes etc.
Playbook for well-being hubs
Wellness hub @ academic institution
Tenant + apt owner benefit match. Reduce community ER visits
SB 1966: School based health clinics
Grants
Re: Federal gov rep saying rural communities don't apply for fed funding. We have to intentionally invest in developing the community members to learn how AND reduce the barriers that exist in the federal RFP process
All city, county state govts. should be required to have community advocates in the decision making + governance
Figure out how to create a clearer path towards venture capital + other investment in innovative ideas for health equity
Take action large org seek small org to partner
Idea for collaboration & a solution: Create grant/resource to development hub leverage the grant unity resources of some institutions for small less privileged entities that could benefit from grants
Assist institution in grant writing implementation & reporting

DO (continued)

Community Services
Contact Bev Wilson @Foodshare SC to see how they feed so many people - https://foodsharesc.org - https://foodsharesc.org/about-us/our-team/
School based/health kitchen partnership with local farmers
Re Uvalde project- Additional partnerships with agencies focused on substance abuse should be included as part of mental health strategy.
Give people unrestricted fund and let them decide how they want to spend that.
Create a database of projects or programs that have worked so people don't need to reinvent the wheel everytime.
24/7 free (no question asked) unrestricted grocery at clinics/hospitals
Take over National coalition of sale schools + get professional management involved.
Partner responses for non-traditional sites of care + resources to make new ones.
Paid community advisory board for grant funded projects/mmc development
Database for programs & projects that work, use AI to navigate database
Require 211 to follow through / follow up on community resource (did it work)
Support/build intermediaries to work with & build capacity of communities to address community defined issues
Paid community boards
Work with rural communities to take action on priorities that will make a difference
Mental Health service for whole family including grandparents with school as conduit
Workforce / Education
Career development internships for people of color is great and we also have to persuade employers to pay a livable wage for "entry level" positions as these positions are/will be careers as not everyone can take advantages of those career growth opportunities
Has Dell Med considered providing healthcare career mentorship for high school students to help create natural pipelines into the field?
Use social work students. They have training in assessing and helping (not choosing) decisions for others.
Invest in social workers as critical team members
How to avoid librarian concerns over workload
Get healthcare to pay for community health workers
USC SOM + other Med schools to create service corp of psych + SU residents/students to help trauma communities + create multiple university research + results.
How can ACC, Dell Med + UT leverage . ongoing research and today's discussion/findings to encourage healthcare institutions/ providers substantially increase wages/benefits for entry/mid-level healthcare workers
Career test drive in middle school
Collaborate with Dept. of Defense to find vets leaving services to find jobs in healthcare
Integrate equity principles into our work more deliberately.
Pipeline activities for students underrepresented in the health professions
Ways to introduce medical students to community health needs
Recruiting people of color in the medical field.
Health Care
Money in healthcare is in the wrong place in healthcare. It needs to shift to primary care not specialist care of end of life
Promote black matsral health through disruption - get provider to see patient as an individual
Balance the scale. Healthcare revenue provides to public health organizations across the US
Data
Make data more available and usable for providers. Shouldn't have to dig through notes for single data points.
Can we in the next meeting identify what efforts, successes have been made due this meeting.

FUND

Strategy
Paid community advisory board to regulate funding for educational institutions
Legislator/policy people collaboration
How to convince state policymakers to pass legislation for health equity
Provide low barrier funding sources
Funders: offer unrestricted funds directly to people (organization such as up together is doing that work)
Human-centric community research funding is needed
How do we plan and engage in a 20 year think - do process?
Research unused public funds health infrastructure, orgs who need to be informed to make use of previous returned funds
Fund community initiated projects vs. investigator projects. Community brings ideas to us
Funding for small orgs and others for funding health projects https://www.healthyplaceshealthypeople.org/immigrant/
More private funding to be trust based operational + fed funding needs lower barriers to access (less complicated apply compliance)
Are cities/earning funds on the table or is it primarily a need concern?
Affordable health screening
Return on Investment
What time frame(s) do funders want or expect to show/demonstrate results?
Increase community healthcare workers, Decrease specialists
ROI models for hubs like Veritas
Business models must enable scaled + sustainability
Divert grant funds from high level admin & psych to peer support specialists
Funders want intervention approach. Service delivery orgs are not set up to work like this.
Communications
Ensure community leaders fund or who health communication in a community

Outside of Clinic
Libraries seem to be a great idea in most communities trusted
Fund orgs providing wraparound supports for women pursuing healthcare related degrees (eg. Jeremiah program) "wraparound" - affordable housing, childcare, case mgmt, colleges, support, community of peers
Find funding partners for community/public mental health training
Is there any capacity of funding entities to mentor/support areas of need if & haven't been attained in the past
Create a database of projects or programs that have worked so people don't need to reinvent the wheel every time.
Funders- support building wellness economy of CHWs that can provide services at clinic + bill healthcare providers - pilot to policy change
We need to "fund" required field placements for SW + psych students Most need to work full time while in school
How to fit hubs for libraries
Fund the pipeline for MH providers. Programs and students are severely underfunded
Free apps + devices for populations to access healthcare
Keeping grocery stores open in food dessert
Fund mobile material health clinics to access communities lacking care/docs/L+D
Can we think about funding for systems change wrap around care similar to the HIV model for primary care/other chronic conditions?
Telehealth - connect provides that speak patient language
Trauma informed care for researchers as the connect to communities + build trust
Community trust is critical. How to build + maintain + not lose it + become in effective
Services are siloed along funding lines + proximity + access
Jennifer's telehealth concept + tutoring through multifamily settings. Apt. owners must subsidize to be sustainable
Collaborations with food delivery orgs to link grocery + food insecure
Data
Can we fund more inclusive datasets?
Fund direct payment programs & measure impact of this method
Workforce
Fund leadership coaching for students and employees in health related fields with orgs like Doerf institute, this can help grow students & employees who are focused & are initiators of great things
Enhance ties between home to Texas program and health equity initiatives in underserved areas - help tie UT to rural funders
Physician burnout - convert to purpose, build healthcare workforce
Fund income experiments
Support CHWS, education + employment (well-pay), pipeline at community colleges
Partnership
Collaborative funding foundations + federal
Matthew McConaughey to help make connections to assist Uvalde. Be specific in ask.
Promote partnerships with large orgs and small orgs (large org has fiscal agent)
Create rural healthcare collaboration hospital, RHC, unusual suspects - e.g. military

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Kelley Shrock   Vershanjali Chauhan

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