VIEWPOINT

Bringing Global Health Home: The Case of Global to Local in King County, Washington

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Abstract

The article describes the experience of testing successful global health interventions in the cities of SeaTac and Tukwila, Washington—2 very diverse, underserved communities outside of Seattle that experience significant health disparities compared with surrounding areas in King County. Topics covered include an overview of the partnership that established Global to Local, the process of engaging Seattle-based global health institutions in identifying global health strategies to test, identifying communities experiencing health disparities that might benefit from global health—inspired interventions, engaging those local communities to understand the perceived drivers of poor health outcomes, tailoring global interventions to the local context, launching programs, and the successes and challenges that have emerged throughout this process. Global health strategies that were tested and are reported on in the article include the use of community health workers to support chronic disease prevention and management, partnering with and building the capacity of local organizations and institutions, linking public health and primary care by addressing the social determinants of health in a primary care and community setting, and using mobile phones to transform practices for managing type 2 diabetes. The paper concludes that based on the early learnings of this approach, there is value in looking to tested and proven global health strategies to address health disparities in underserved communities in the United States and calls for further exploration of this approach by other actors.

KEY WORDS global health, community health workers, mhealth, economic development, health equity, diabetes, reverse innovation, social determinants of health, community development, leadership development, public-private partnerships, diversity, innovation, disparities

INTRODUCTION

Global to Local (G2L), started as an initiative and now formalized as a nonprofit organization, was formed in 2010 in an effort to bring the learnings of global health interventions—many of which have their origins in Washington State—based global health institutions—back home to address health disparities in local communities. The initiative was formed through a partnership between Swedish Health Services (Seattle's largest hospital), Public Health Seattle & King County, HealthPoint (a federally qualified health center), and the Washington Global Health Alliance (a consortium that brings together a broad range of global health institutions working in Washington State).

The partnership came together based on the recognition that although billions of dollars from Washington State are being invested on an annual basis to identify innovative, often low-cost, approaches to addressing health disparities in low-resourced environments around the world, there are many under-resourced communities in King County—particularly South King County—that

experience significant health disparities. The partnership set out to answer the question of whether any of these approaches that have been effective overseas might be relevant to local communities.

This case study sets forth a detailed model of an organization designed to adapt proven global health strategies to vulnerable populations in the United States. The authors provide a detailed background of the genesis of the organization, its development and funding, several projects initiated by the organization, and an analysis of successes and barriers along the way. Although the creation of a "global to local" organization depends on multiple moving parts coming together toward a single goal, G2L stands as a model replicable in whole or part and an inspiration to public health advocates hoping to bring the world home to their U.S. location.

GETTING STARTED

In 2009, Swedish Medical Group, a Seattle hospital system,[*] committed to funding a pilot project at the level of $1 million over 5 years. With this significant commitment, the partnership group set about identifying communities where a pilot could be launched. Public Health Seattle & King County, working with the University of Washington's Institute for Health Metrics and Evaluation, a group well known for its Global Burden of Disease reports,[1] analyzed health outcomes at the census tract level for King County and developed a number of maps showing how different parts of the county compared across health outcomes. The findings—and in particular the visual representation of these findings—were shocking. Residents of the cities of Tukwila and Sea-Tac, just miles south of downtown Seattle, were found to have 1.5 times the rates of diabetes-related deaths compared with King County averages; obesity rates were also 1.5 times the county average, as were the number of people who reported no physical activity during the past month; teen birth rates were 3 times the county average and smoking rates were 200% higher. These cities were also found to have significant economic and social disparities, with twice the number of students on free and reduced lunch (76% in Tukwila, 66% in SeaTac, 35% for all of King County), more than twice the proportion of people living below the poverty line

(24% in Tukwila vs 9.7% for all of King County), and nearly one-third of people being foreign born (compared with 19% for King County). Life expectancy in these cities was found to be 2.4 years less than King County overall.[2]

Based on these data, G2L's founding partners approached the cities of SeaTac and Tukwila and presented the opportunity to work together on a pilot project. The cities, through the involvement of their human services departments,[†] were interested in participating and became integral partners both through the startup and implementation phases, as described later. At the same time, in order to move this concept toward action, the partners hired a program manager who was initially tasked with conducting an analysis of the opportunity and making recommendations on how to operationalize the conceptual model.

IDENTIFYING RELEVANT GLOBAL HEALTH STRATEGIES AND UNDERSTANDING LOCAL PRIORITIES

With the support of the Washington Global Health Alliance, G2L contracted with the Seattle-based global health organization PATH to research and write "Global to Local Landscape Assessment: Lessons Learned from Global Health," (PATH, unpublished study, 2010) which looked at broad global health strategies G2L might consider for SeaTac/Tukwila.[*] Topics covered included training and deploying community health workers, using technology to overcome barriers and transform community health practices, generating focused campaigns around priority health issues, mobilizing and empowering community-based organizations, linking health with economic development, and linking primary health care with public health services.

The group of partners felt strongly that, as global health learnings have found, solutions cannot be helicoptered in but must rather be formulated in

[†]Evie Boykan and Colleen Brandt-Schluter were and remain the human services managers in the cities of Tukwila and SeaTac, respectively.

[*]PATH looked for high-level, broadly applicable global health strategies that would have local relevance. So, rather than looking at a specific intervention that had worked in a specific environment (such as a text messaging program supporting medication adherence from South Africa), they called out the overarching approach of using mobile technologies to transform practices. As a result, the document reads like a selection of general themes and best practices from global health that have allowed multiple interventions to work in multiple environments.

[*]Swedish Medical Group has since strategically aligned with Providence Health and Services. As these institutions came together, Providence also joined in supporting Global to Local, also at a level of $1 million over 5 years.

partnership with the community that stands to bene-
fit. To this end, G2L's program manager spent
approximately 7 months engaging local groups to
understand what efforts were already underway in
the SeaTac/Tukwila area and what, from the perspec-
tive of those groups, were driving the poor health and
economic outcomes the data identified. Groups
engaged included health and social service providers,
school representatives, faith groups, and many repre-
sentatives of the cities' diverse cultural communities.

Using a combination of semistructured inter-
views, online surveys, community conversations,
and focus groups, several themes started to emerge
in response to the guiding question, What makes
it hard for people in this community to be healthy?
As highlighted in the *New England Journal of Med-
icine* article "We Can do Better Improving the
Health of the American People,"[3] the needs people
identified were not as focused on health care as they
were on the social determinants affecting their
health. The main issues in SeaTac/Tukwila were
identified as economic stability (including the need
for better jobs, the ability to pay for housing, and
transportation), challenges navigating various sys-
tems (such as health care and social services), lan-
guage and cultural barriers, and a sense that
people did not have a voice in how their community
and institutions were run. It was notable that in
pre–Affordable Care Act times—in a community
where nearly 1 out of 4 of people didn't have health
insurance[2]—access to health care was not at the top
of the community's list of needs in terms of living
healthy lives.

DEVELOPING PROGRAMS BASED ON COMMUNITY PRIORITIES AND GLOBAL HEALTH LEARNINGS

After the assessment period, the work shifted
toward identifying where the global health solutions
identified in the PATH analysis aligned with
community-identified needs and priorities—and
what initial funding levels could support. Through
this process, G2L opened the door to introducing
outside approaches not known to the community
and tailoring them appropriately with community
engagement. As Henry Ford said, "If I had asked
customers what they wanted they would have said
faster horses."[4] Although the community may say
that it needs support navigating the health and
social service arena, approaches that have worked
to address this problem may not be known. G2L
was well-positioned to pursue this 2-pronged

approach of introducing global approaches that
meet local needs and priorities.

G2L presented several ideas to an ad-hoc Gover-
nance Group, which was made up of 50% represen-
tatives of community-based groups from SeaTac/
Tukwila and 50% members of the institutional part-
ners group. The recommendations included hiring a
team of community health workers who could work
with specific cultural communities to develop
culturally tailored approaches to addressing
community-identified issues, investing in commun-
ity leadership development, and developing a com-
munity health resource hub. Although initial
funding would not support the creation of a mobile
phone–based program to provide health promoting
information remotely, this was presented as a prior-
ity for when funding became available. The Gover-
nance Group unanimously supported this approach
and requested that G2L move to implement the
recommendations.

Through a very iterative process that emerged
over the following 2 years, G2L put in place several
different initiatives that aligned with these recom-
mendations. Although approximately 8 different
programs were piloted, the 5 initiatives that have
become the core of G2L's work to date are high-
lighted here. Table 1 outlines the approach and
the global health strategy that informed the program
design and how this approach was modified for the
local context.

Community Health Workers. The first program-
matic step G2L took in 2010 was to create a small
team of community health workers (CHWs) who
were initially brought on as AmeriCorps volunteers.
This work was prioritized because it allowed G2L to
further engage with communities, seeking input on
what sorts of solutions would best address their
needs and building on community assets. This
initial cohort included local members of the Somali,
Latino, Burmese, and Eritrean communities. G2L
currently employs CHWs from the Somali and
Latino communities, as well as a CHW working
with a variety of communities that can communicate
effectively in English.[*] Although the ultimate goal

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[*]Initially G2L sought to work with as many commun-
ities as resources would allow, and the organization
brought on CHWs from the Somali, Latino, Burmese,
Bhutanese, Eritrean, and African American communities.
As the organization's strategy evolved, however, it was
determined that it was better to focus resources in a couple
of communities, coupled with a more robust monitoring
and evaluation strategy that could demonstrate the effec-
tiveness of interventions.

Table 1. Localizing Global Health

Initiative	Global Health Strategy	Global Health Learning[*]	Local Need/Opportunity Addressed
Culturally tailored chronic disease prevention and management	Community health workers	Trusted community members, working outside of the clinic, can effectively provide health education, resource referral, and overall social support to promote healthy behaviors.	Language and cultural barriers, high rates of chronic disease, challenges navigating health care and insurance systems
Connection Desk	Linking public health and primary care	It is important to work across sectors and address the social issues that often drive poor health.	Challenges navigating systems, language and cultural barriers
Mobile phone–based diabetes management	Using technology to transform community health practices	Mobile phones can address access issues, improve information flows, and lower costs of providing services.	Access issues related to transportation, ability to pay for health care, fear of or unfamiliarity with health care systems
Food Innovation Network[†]	Linking health with economic development; Making catalytic investments to address market failures[‡]	Increasing wealth will often lead to improved health. By making investments in places where there are market failures it is possible to spur economic development.	Limited economic opportunity, challenges in starting businesses, poor employment options
Building local leadership to increase community voice and civic participation	Building local capacity[§]	An active and engaged community is necessary to ensure sustainability as well as to advocate for systems change.	Need for increased civic participation, role in decision making for under-represented groups

[*] *Global health learning* refers to the evidence from global health efforts that provided inspiration and guidance for Global to Local (G2L)'s local intervention.

[†] The Food Innovation Network, which supports diverse, low-income individuals to start food businesses, is not covered in detail in this paper because of space limitations but is an important part of G2L's work to link health and economic development.

[‡] Making catalytic investments to address market failures was not initially identified in the PATH landscape assessment, but this is another global health strategy that has proven relevant in G2L's work. This approach will be included in an updated version of the Landscape Assessment, to be available in late 2016 and available at www.globaltolocalorg.

[§] The initial strategy identified in PATH's landscape assessment focused on partnering with and building capacity of local organizations. Although G2L partners with many local organizations, the need has also emerged to build leadership capacity for individuals so as to increase community voice in local decision-making processes—a need identified during the initial community assessment.

of the CHW initiative is to encourage heathy behaviors that can prevent and support management of chronic diseases—particularly diabetes—the design of the specific interventions supported by CHWs has been a very collaborative process with community members and local partners. G2L's work with the Somali community provides an illustrative example.

At a 2012 G2L health screening event in a local junior high, there were dozens of people in attendance but very few Somalis. G2L's recently hired Somali CHW, Aisha Dahir, had not had much time to do outreach, but she immediately walked over to the local mosque, which she had been involved with since it had opened. In talking with the imam and other mosque leadership, she was quickly able to gather a group of approximately 30 Somali men and women to get screened. This ability to quickly mobilize the community demonstrated the importance of hiring a CHW who is trusted in the community with strong relationships and a shared experience with the people she aims to serve. These should be the core elements of a job description for a CHW anywhere in the world.

Many of the Somali participants learned through the screening of high cholesterol, elevated blood sugar, and high blood pressure. The next step was for Dahir to engage her community in discussions about why, from the community perspective, this was the case. One of the things she heard from the Somali women is that they did not feel like they had a place where they could be physically active—that local fitness facilities did not accommodate their cultural needs related to modesty. With this information, Dahir approached the Tukwila Community Center (TCC) and expressed the need for fitness programming that women could participate in separately from men. In short order, TCC developed a women-only fitness program. More than 3 years later, and now having institutionalized this program, TCC was recently awarded a statewide award for culturally competent fitness programming.

Although CHW programming was initially designed to be highly responsive to community needs and priorities—which was crucial for getting community participation and buy-in—G2L reached a point where the organization was offering more

than 50 different activities each month and attendance in any given activity was limited. Since 2015, the organization has become much more focused on a small number of activities, with increased attention to measuring outcomes. A system has now been implemented through which G2L's health care partner, HealthPoint, can make referrals to CHWs who then work with referred individuals to get them into culturally tailored 8-week fitness programs G2L has co-designed with TCC and the local YMCA. In addition to organizing the classes, CHWs provide phone-based case management, working with participants to achieve the health goals they and their providers have identified.
Next Steps for CHW Program. One of the great challenges for G2L is to identify sustainable funding for CHWs, which is one reason the organization has started to focus heavily on measuring the impact of its work. Just recently, G2L, along with other local partners (Mercy Housing Northwest, King County Housing Authority, Neighborcare, and HealthPoint), was identified by the newly formed King County Accountable Communities of Health[*] to participate in a project to deploy CHWs in subsidized housing sites. Using newly integrated health and housing data,[†] the project partners see an opportunity to better target program participants and track their outcomes with the ultimate goal of identifying improvements in health-promoting behaviors, increased use of preventative health care services, and ultimately health care cost savings. By participating in this highly visible and rigorously evaluated project, G2L and the other partners hope to further demonstrate the value of CHWs while paving the way for a sustainable funding source.
Connection Desk. The G2L Connection Desk, inspired by the pioneering work done by HealthLeads,[5] was launched in April 2012 to help

HealthPoint patients and the broader community address the underlying social issues that affect health. Like HealthLeads, the Connection Desk recruits, trains, and deploys volunteer university students to serve as resource referral specialists. Different from HealthLeads, however, the Connection Desk operates in a suburban setting, far from the urban center of Seattle where the vast majority of social services are located. This is important because of the fact that there are now more poor people living in suburbs than cities in the United States[6] and as this population moves away from where services are located, accessing those services becomes increasingly hard. The Connection Desk aims to address this emerging issue in King County.

Each year G2L's Connection Desk manager recruits approximately 15 university students, each of whom volunteer 6 hours per week to staff the Connection Desk—a physical desk located in the lobby of the building where the SeaTac HealthPoint clinic is located. Since 2012, more than 30 volunteers have provided nearly 9000 resource referrals in areas including health care enrollment and navigation, housing assistance, food assistance, transportation assistance, job search, and application assistance. Approximately 45% of Connection Desk clients are referred by HealthPoint, whereas the others are either walk-ins or contact the desk by phone.

An internal G2L evaluation of the pilot project conducted after 2 years of desk operations found that 87% of people who receive navigation services successfully access at least 1 service.[*] Focus groups with participants found that working with a Connection Desk volunteer allows clients to better navigate the health and human services landscape and access services that are important for their health. Interviews with HealthPoint providers, who make nearly half of all referrals to the Connection Desk, also found that being able to refer their patients to the Connection Desk increased confidence that they could meet the holistic needs of their patients; knowing that they had a reliable referral option to address social needs allowed them to focus on health-specific issues during medical visits. HealthPoint's clinic staff, who have also, historically, helped with postvisit social service navigation,

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[*]This is a group, initiated in response to health care reform, that includes health care providers, insurers, public health institutions, and community-based groups, all focused on supporting the move from fee-for-service to outcomes based health care. See http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach.aspx.

[†]For the past several years, Public Health Seattle & King County, Seattle Housing Authority, and King County Housing Authority have been working to integrate health and housing data. This effort has been boosted by a recent Robert Wood Johnson Data Across Sectors for Health (DASH) grant. The DASH grant creates an ongoing platform for annual integration of Public Housing Authority and affordable housing data into Medicaid 1 data through King County Public Health.

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[*]G2L defines a successful referral as one where a client connects with a referral resource provided at the Connection Desk and is able to benefit from at least 1 service that referral resource provides.

have been freed up to focus on enrolling people in health insurance available through the Affordable Care Act, something that clinic staff believe has led to a decrease in charity care and increased reimbursement for services—both good for the clinic's bottom line.

Next Steps for the Connection Desk Program. Strategically, G2L aims to develop programs that can eventually be adopted by sustaining partners and the broader health and human services system. In the case of the Connection Desk, G2L is in the process of transferring the management of the desk to Lutheran Community Services Northwest, which owns the building in SeaTac where HealthPoint and the Connection Desk are located. The organizations are committed to maintaining the approach developed to date, and G2L will continue to partner with them on data collection and evaluation. By handing this service over, G2L can free up resources to pilot new initiatives and devote energy to supporting other institutions that are interested in this model. At this point, G2L is providing technical assistance to 3 other local health care providers who are at varying stages of implementing a Connection Desk–inspired approach. G2L also recently joined with multiple partners to submit a grant to CMS that would allow for the creation of several more desks and collection of data relating to the effectiveness of integrating social service screening and navigation services into the health care system——something that could lead to a national-level policy change.

Leadership Development for Under-Represented Communities. Although more than one-third of the populations of SeaTac and Tukwila are now foreign born, local structures (government, schools, and other institutions) still look very much like they did when the cities were largely white, just 15 years ago. Institutions are struggling to engage with newly arrived communities and to adapt to the needs and opportunities these demographic shifts present. The G2L leadership program responds to the community-identified need to increase community voice in local decision-making processes so that systems can better understand and respond to the priorities of under-represented groups.

In 2013, the city of Tukwila realized that their traditional approaches to community engagement—things like town hall meetings and online surveys—were not reaching their newly arrived communities and other struggling groups. To find solutions to this challenge, the city contracted with the nonprofit organization Forterra to make

recommendations on approaches to improve engagement. Forterra, being aware of G2L's CHW program and ability to connect with new arrival groups, recommended that the city contract with G2L to identify and train community members who could serve as "connectors" between city staff and under-represented communities.

Selecting among active and interested participants in G2L's health programs, G2L recruited several individuals from diverse communities (Somali, Latino, Burmese, Bhutanese, Eritrean, and Ethiopian) to serve as connectors. Working with the city and Forterra, connectors received "City 101" training where they learned about the roles of city council, the mayor's office, city departments, the budgeting process, and the comprehensive planning process,* among other things. At the same time, city staff gathered input from connectors and their communities on issues of importance for the city's comprehensive plan update. Through outreach and engagement of the connectors, G2L, Forterra, and the city hosted multiple community events where the community could develop specific community recommendations—particularly in the areas of housing and economic development—to be incorporated into the comprehensive plan. Connectors attended planning and city council meetings to speak on behalf of their communities and the issues they hoped would be covered in the comprehensive plan.

In 2014, the city of Tukwila, along with Forterra and G2L, won the 2014 Washington Chapter of the American Planning Association and the Planning Association of Washington award in the category of Citizen Involvement. And in that same year, the city of SeaTac developed a similar contract with G2L to engage their diverse communities in city processes. Since that time, connectors have been involved in numerous activities including the creation of community gardens, resident satisfaction surveys, and hosting community safety events with the police and fire departments.

Next Steps for Community Leadership. Although the connectors program has allowed progress to be made, there remains a great need for increased community leadership and engagement, and in 2017 G2L intends to increase its efforts in this area.

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*The comprehensive plan is a long-term strategy document that guides the city's legislative and administrative actions. Topics covered include economic development, land use, transportation, neighborhoods, housing, and more.

G2L is collaborating with Restless Development, a leadership development organization that has worked in Africa and Asia, to bring their successful model[*] to SeaTac and Tukwila. As G2L's model evolves, it has become increasingly clear that investing in local leadership is core to the organization's ability to achieve change because we need new voices from communities to develop community-led solutions that align with community priorities.

Mobile Phone–Based Diabetes Management. mHealth, or the practice of medicine and public health supported by mobile devices,[7] has exploded around the world in the past decade. Although there remains a lot to learn about the effectiveness of the various approaches that have been deployed overseas, what is clear is that there is a tremendous opportunity to employ the tool that so many people now have—the mobile phone—to increase health information flows and access to services.

Although mHealth efforts overseas have focused on using mobile phones to address issues like maternal and child health, sexual and reproductive health, and medication adherence for HIV drug regimens,[8-10] G2L chose to adopt these approaches to a pressing local issue: type 2 diabetes. Working with HealthPoint, and collaborating on a 1-year research study with the University of Washington School of Public Health, G2L recruited 50 patients who were living with type 2 diabetes and gave them access to a mobile phone with a diabetes management app loaded onto it. Patients, most of whom had never used a smart phone before, were trained on how to use the app and how to share their app-generated reports with their G2L case manager. Using both the app and text messaging, participants were asked to share information on their blood glucose tests, diet, exercise, mood, and other things they felt they wanted to communicate with their case manager.

The mHealth program is managed by a physician/public health specialist and case managers. On a weekly basis, participants send their app-generated report to the case manager so their blood glucose and other information can be reviewed. Importantly, the case manager also sends personalized text messages to participants—largely focused on sharing encouraging words, reminders, and tips on diet and exercise. On average, a participant receives 2 to 3 messages per week.

After 1 year of the intervention, the UW-sponsored study was finalized, indicating very good results. More than one-third of participants improved their HbA1c value (an indicator used to assess improvement in overall glucose control) with an average reduction of 1.26%. These results are significant because a 1% reduction in HbA1c value translates into a reduction in the risk of eye, kidney, and nerve disease by approximately 40% and diabetes-related death by 21%. (National Institute for Coordinated Healthcare, unpublished study, 2016) Through the qualitative study, the researchers learned that participants attributed their success in the program to the fact that they felt accountable to someone they perceived as caring. So although the technology was a very important tool for enabling effective and efficient communication, the thing that reportedly made the critical difference was the personal relationship that was formed between the participants and the case manager.

In addition to the positive health outcomes stemming from the intervention, an external analysis conducted by the National Institute for Coordinated Health Care of G2L's mHealth project found, using data publicly available through the Centers for Medicaid and Medicare Services, that averted health care costs more than paid for the program just 6 months after the end of the program. The project yielded a positive return on investment of 10%, which equates to an average yearly savings of $556.5 per patient.[11]

Next Steps for the mHealth Program. Building on the success of the pilot, G2L is now working with both Swedish Medical Group and Washington State University to further test the approach in new populations. In the case of Swedish, the hope is that, if the intervention is again proven successful, it can be deployed across their entire health care system. G2L is also exploring other priority health conditions that may be appropriate for a mHealth intervention with issues like smoking cessation, maternal and child health, and mental health high on the list of options.

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[*]Restless Development delivers a leadership development model based on community engagement. Young leaders are placed in communities and work to organize various stakeholders around local priorities with the ultimate goal of improving community health.

SUCCESSES, FAILURES, AND EVOLUTION OF THE MODEL

From the authors' perspectives, G2L's successes can largely be attributed to 4 things. First, and most

important, the founding partners were willing to invest in a lengthy, year-long community engagement process and were guided by community priorities. Hearing what the community wanted, the partners were willing to move past early assumptions about what solutions might be needed. For example, before the community engagement process got started, there was a sense among the partners that immunizations might be an appropriate place to start as an initial approach. This thinking was abandoned after the community engagement process as other priorities emerged.

Second, and connected to the first point, is that G2L has benefited from flexible funding made possible through creative partnerships. The initial funding of $1 million from Swedish was entirely unrestricted, allowing programs to be built around community priorities. Since that time, additional partnerships have been added, again with very few restrictions on how funding can be used.[*] Although G2L sought and received grant funding, in most cases grants have supported existing activities that were initiated with unrestricted funds, meaning that the organization seldom had to shape programming around funder priorities.

Third, the fact that G2L was founded through a partnership set the course for working across sectors, allowing the organization to focus on issues and solutions that often fall outside of traditional health care interventions. As described earlier, partnerships with the cities of SeaTac and Tukwila, local fitness facilities, community colleges, workforce development agencies, private companies like AT&T and Starbucks, HealthPoint, and Seattle's global health sector has allowed G2L to borrow competencies and leverage resources well beyond what would be possible if working alone.

Last, G2L leadership and staff have embraced a process of testing ideas—some of which will succeed and some of which will fail—learning, making modifications, moving forward, and redefining what success looks like when appropriate. For example, G2L initially hired as many CHWs as the budget would allow to reach as many people as possible. In addition, CHWs were encouraged to be as responsive as possible to community needs, and what resulted was a very large number of programs with few participants in any one of those, and therefore a very limited ability to determine

what was working and what was not. After planning discussions with the Board of Directors, a decision was made that rather than reaching as many people as possible, it was more appropriate to think of the organization as an incubator that could model different approaches and that by sharing our learnings we could lead other institutions with greater reach and potential for scale to take similar approaches.

NEXT STEPS FOR GLOBAL TO LOCAL

One of the big questions G2L has continually wrestled with is, What does success look like? Is it seeing improved health outcomes in the communities we are working in? Is it influencing the health care system to adopt different approaches that meet the needs of underserved groups? Is it seeing greater community ownership over local health and development efforts? As staff and the Board of Directors wrestle with these questions, one thing remains clear: G2L's ultimate customer is the community we serve, and our hope is to promote a new approach that puts the community in the driver's seat. Our goal is to create a movement that turns conventional thinking on its head, where ideas and priorities come from communities and best practices come from poor countries around the world.

In order to prove this approach, G2L recognizes that it is important to demonstrate that it can work in multiple environments, and as a result, the organization is planning to expand to 2 new communities in Cle Elum, WA, and Spokane, WA. With more rural populations and very different health and social issues, working in these environments will allow G2L to demonstrate that its approach can be effective, even though it will likely lead to very different sorts of activities.

G2L recently received funding from the Robert Wood Johnson Foundation to host a national convening in early 2017 on the topic of using global health strategies in local communities. Thought leaders and cross-sector groups from around the country will come together to hear about the G2L experience and explore how similar work might be done elsewhere. We at G2L look forward to hearing how this approach can be adopted to environments that are very different from where G2L works and to establishing a learning community where groups with similar aspirations can share what they find through their work, further helping to shape the global-to-local model.

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[*]Other unrestricted funding partners include Providence Health and Services, Bartell Drugs, and Washington State University.

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