Group Health Foundation
Lessons Learned from Community Engagement

The success of the Better Health Together Accountable Community of Health (ACH) initiative comes from how it started and how it continues to support local community in leading the charge of transforming health. In our first two years as the backbone organization for our ACH (which encompasses Spokane, Lincoln, Adams, Stevens, Pend Oreille, and Ferry counties), we prioritized getting to know our communities. We asked about the biggest barriers for improving health and what promising bright spots were creating change. Now we have the opportunity to steward our community through a radical change in how Medicaid is delivered with the goal to increase access to and quality of care, while reducing costs. We have seized on this opportunity to move beyond talking about equity, to integrating equity into the system improvements we seek to make. This change is complex, and often disruptive, so it's been essential for our team to build strong individual relationships with our community members and leaders (often not the usual community leaders, but in some cases, it is the Hospital Commissioner, the Public Health nurse, or a County Commissioner) in order to be seen as trusted leaders in this work.

Using the Results Based Accountability method—a no-nonsense facilitation tool for helping groups develop goals, measurements, and strategies to overcome problems in their communities—BHT hosted over 75 focus groups and brainstorming sessions to identify a set of community strategies for improving health. We call these our Community Strategy Maps. These are living documents that outline our strategic priorities and guide our region as we select projects and seize new opportunities to expand our impact.

Although narrower in scope than the many audacious goals put forth by our ACH members, the projects that were selected for the Medicaid Transformation Toolkit by the Health Care Authority (from which ACHs had to select projects to take on) were well matched with the priorities of our community. The momentum for this work has been growing since long before the ACH. Now that we are here, we can leverage our roles of a convener and driver of a community health agenda along with the flexible dollars we earn from the state's 1115 Waiver, to catalyze large-scale transformation across the health care and social determinants delivery system.

In partnership with the Spokane Regional District Data Center, we "mapped" the different types of collaborative activities taking place in our ACH region and were able to measure the number of silos between different sectors. This work gave us data to inform where new relationships could have the highest impact on systemwide collaboration. There are a wealth of great services and providers in our region, but we kept hearing was that the lack of system level coordination between all of these agencies created duplications and gaps in services, that impact quality and cost of care. This led BHT to pinpoint and articulate our value as a strategic convener for the region, both in leading the Medicaid Waiver work and by impacting other priority issues on our Community Strategy Maps.

Our governance model is designed to ensure both community voice and sector representation is embedded in all decisions made. This helps our work stay community driven, translate across sectors, and foster collaboration. At the center of our structure are a series of Technical Councils representing key sectors that are critical to the success of our work. Each Council is co-chaired by a BHT Board member and community partner, to insure a bi-directional feedback channel between the council and the Board. Recommended actions generated by the community or BHT staff go through our Technical Councils for feedback and refinement before they go to the Board. Honoring this process, the Board has a policy of not going against a technical council recommendation without first going back to that council

for more discussion. Our Board members are a diverse group of community leaders, who expect equity to be a central goal in all the BHT activities. For the hour preceding every Board meeting, we host a community comment hour so that individuals can have their stories heard and make their concerns known. This is always attended by Board members and BHT staff and it has been wonderful for us to see more and more people attend and engage with the work that we are doing.

Our Provider Champions Council (comprised of primary care, behavioral health practitioners, MCO Medical Directors, and representation from Medical Society) have discussed and made recommendations to our stakeholders on healthcare and health systems literacy for patients, such as clear lay language in clinics and translation services. To our knowledge, this is the first collaborative effort of this kind between healthcare providers to discuss and develop aspirational goals towards equity.

Our Community Voices Council (comprised primarily of Medicaid beneficiaries and their advocates) are voicing their concerns, suggestions, and hopes for a health system that benefits their families, increases access to care, and is an environment that complements their cultural backgrounds. As our partnering providers complete transformation plans, this group will review and give input from the perspective of those who would be accessing and navigating services. We offer these participants a $75 stipend for each monthly meeting they attend, both to thank them and honor that many have childcare, transportation, and income barriers related to participating in this work voluntarily.

Our Community-Based Care Coordination Council (comprised of social determinants of health providers, community-based organizations, and healthcare providers) is authentically and intentionally connecting the key social services necessary for patients to use and receive, in order to improve health outcomes. These key social services have historically been separated from the clinical setting and we are seeing movements to integrate key services such as housing, transportation, and food access to clinical settings for a true vision of whole-person health.

Our Tribal Partners Leadership Council (a consortium of six out of the seven Native American / Tribal health organizations in our six-county region) have engaged in catalytic, collaborative information sharing and learning on elevating Tribal health issues in our region. This council was created in direct response to a request from Tribal partners in the region. In hindsight, our staff would have benefited from more education—earlier on—around Indian Health Services, Tribal sovereignty, and Native history in our region, in order to have avoided some early missteps. We did not fully understand what it would take to build a trusting and collaborative partnership with our area Tribes and Native organizations, given the incredibly complex history of genocide, racism, and trauma resulting in Natives facing the harshest health disparities of any race in our region. The creation of this council, as well as hiring a Tribal Liaison (a role specifically dedicated to improving collaboration with tribes), has helped us ensure Native voice is part of all BHT decision making. In many instances, tribal partners have long been leaders for the kinds of change we want to see, such as integrated health care services that recognize the mind, body, and spirit as one, and the value of culturally relevant and trauma-informed care. So, we were pleased that our Tribal partners found enough value in these initiatives to participate, even with their resources already spread thin. In fact, one of our Tribal partners threw an appreciation BBQ for their staff, thanking them for the hard work and time they have been putting into the Medicaid Transformation work. They extended the invite to BHT staff, several of who attended. This opportunity to deepen relationships and shared learning gives us hope.

These technical councils have given community and health systems' voice to help understand, organize, and implement our region's health equity goals and gives us hope that a community-wide, collaborative approach will lead to lasting change.

The primary role of BHT staff is to synthesize the complex funding opportunities and health improvement strategies available to our region, and support community partners in collaborating to seize on those opportunities and make an impact. BHT is intentional in recruiting for diversity when hiring, and we benefit from a team with a mix of racial and ethnic backgrounds, lived experience, disability status, sexual orientation, age, and status. Although health is at the center of our mission, the majority of our staff do not come from health care backgrounds, but instead fundraising, community organization, and communication backgrounds. We have a team skilled in relationship building, who are passionate about influencing change in their community. We learn a great deal from each other's experiences which has deepened our team's commitment to accelerate health equity. The deeper our connections grow, the more we see this mission is about all of us; not any individual problem but building a whole community.

The BHT team puts a very high priority on clear, down-to-earth, and transparent communication. We have a robust public website, containing announcements, meeting schedules, partner lists, and more. We have also created additional private pages to support partners working directly with us, providing them access documents, calendars, contacts, and other relevant information to support their work. We aim for a casual and fun, yet concise voice in all of our communication. We respect that our readers usually have a lot on their plates and come from very different backgrounds. We send out a regular newsletter, with additional communications to targeted specific sectors as needed in the same style. Using MailChimp, we can track our open rates, and are consistently 10%-30% above non-profit industry averages, which helps us gauge that our approach helps us be accessible.

Our staff aims to be always responsive to our communities changing needs and capacity. For our 80+ partners, each ACH team member has an assigned set of contacts in order to provide a single access point for each of our partners. We have found it invaluable for every partner to know they have a human being they can call whenever they have questions. Additionally, we have three Program Managers dedicated to supporting the needs of our partners. On any given day, this could mean facilitating a rural health coalition meeting in Republic, giving a presentation to medical students in Spokane, or walking a provider through their Transformation Plan deliverable in Othello; we want all of our partners to know we are available to come to them as connectors and problem solvers. Which is why we refer to ourselves as *tenacious problem solvers.*

Deploying our staff in this way has helped to support collaboration within the natural network of partnerships needed to make system wide change. An important part of our brand is for the community not to see the ACH just as BHT staff, but instead as the entire network of partners working towards our shared health improvement goals. This keeps the heart of the work in the community and puts collaboration as a foundational element of how we work.

In our five rural counties, Rural Health Coalitions were already established and working towards their own local health improvement goals. BHT staff began attending those meetings at first to learn more about the communities in our region. The Coalitions were built off volunteered time from the member organizations. BHT saw we could add value by offering staff time to support the development of the work, such as providing a briefing on key elements of Medicaid Transformation, helping coordinate meetings, and providing a connection to region wide strategy. Recognizing the momentum

already built by these groups, we positioned them to be the backbone of our rural Transformation planning work, and they now make up our Rural Community Health Transformation Collaboratives who are responsible for designing and implementing the plan for their county to meet Medicaid Transformation goals.

To be officially recognized as a rural Collaborative, each group had to complete their own charter (which had to include a governance model) and establish a lead organization who could be the point person between the group and BHT. Upon completion of the charter, BHT will issue $50,000 to the Collaborative to expend in alignment with collaborative goals, this could be for staff time to coordinate or other community needs. We also required the charter to include an equity statement with the expectation to move it forward in their Transformation work. Another $50,000 will be issued to the rural Collaborative as a whole, to spend at their discretion to support the work of integrated health care. Each rural County collaboratives was given the option of giving over the $50,000 to BHT to pay for a BHT staffer to serve as a project manager, however none of them selected this option. We feel that in creating the flexibility to let each county Collaborative come up with their own distinct governance model, suited to their own leadership and communication style, gives them the best chance of setting up sustainable partnerships that will continue to function when they can no longer access dollars and support from BHT. This was also a way to build localized leadership in the community.

Our Spokane Community Health Transformation Collaborative represents a much more urban, populated, and resourced county. This Collaborative has 43 member organizations (our largest rural Collaborative has 12). The process of convening and developing a governance model has required a large amount facilitation by BHT because there are so many more partners, however it has been incredibly rewarding to see new partners step up to help drive the work. BHT has been hosting meetings for the Spokane Collaborative since March of this year. Each meeting takes place from 1-4pm, with a 12-1pm hour for an optional networking lunch. At the first lunch, BHT staff helped make introductions between organizations, and folks were very vocal about how valuable it was to get to hear about all the different services and agencies they didn't know about and have them all in one room. We realized that creating this space for organizations to get to know each other was a huge value add in breaking down silos and building relationships, and we've now made it a standard practice at these meetings. In one example that gave us great hope, these networking opportunities gave the American Indian Community Center in Spokane the chance to spotlight some newer behaviorally health services they were offering, that many folks in the area didn't know about. The Collaborative created a space where they could connect with other partners to increase AI/AN referrals to their programs.

As BHT earns 1115 waiver dollars by meeting pay-for-reporting and pay-for-performance milestones laid out by the Health Care Authority, we distribute these flexible funds to our Collaborative partners to incentivize and support the transformation activities. Our Technical Councils helped to create a clinical and community systems framework for the projects, synthesizing the key setting requirements that providers need to have in place to achieve health transformation and therefore earn performance incentives. These requirements include addressing key components of a chosen evidence-based model, creating alignment with greater community efforts, and promoting health equity.

Providers are asked to develop Community Transformation Plans for how they will meet these setting requirements and achieve overall community project goals. BHT will not view these Plans as pass/fail, but rather an iterative process to align individual Partnering Providers strategic plans for whole-person care in a changing value-based payment environment with a region-wide Transformation Plan that ensures access and quality delivery systems linked with the other things that keep us healthy.

We are clear that these plans will require woven together funding sources and investments beyond the ACH, but we are confident that the Collaborative structure and these plans will aid the region in improving health outcomes and securing more diverse funding and partnerships to achieve this. As partners achieve milestones, they earn incentive payments from BHT and are free to spend funds to further their plans. We know our partners often are constrained when funding can only be allocated for certain services, and we imagine these dollars to be highly leveraged.

Our first round of payments were awarded for activities such as signing an MOU with the ACH, completing an assessment, and submitting a transformation plan. We also offered Rural Accelerator, Volume Equalizer, and Health Equity Accelerator payments to offset some of the systemic challenges and reward the partners who are addressing already them. The Rural Accelerator paid out $50,000 to each rural Collaborative, recognizing the unique challenges of offering health care services in rural areas, that are often very isolated, resource starved, and stark with poverty. The Equity Accelerator gave additional dollars to Medicaid providers who were serving more than 10% of ethnically/racially diverse patients. This payment recognized that fact that patients of color have a higher probability of struggling with poor health outcomes (largely because of systemic barriers) and incentivize and support providers who are prioritizing access for these populations.

This engagement and governance structure has helped us overcome some systemic barriers that often hinder these sorts of collaboration. With an extreme provider shortage, agencies have limited availability and resources to take on this very time intensive transformation work. We have to move fast, and our structure put a heavy emphasis on incorporating community and sector voice to make sure no decisions happen with blind spots to vulnerable or marginalized populations.

A big focus in our region is on inequities that stem from generational poverty, ACES, and family and historical trauma, which is why we put a heavy emphasis on creating linkages between clinical and social services to support a whole-person care system. While our improvement goals are mostly based in the health care setting, they cannot be achieved without collaboration between the entire continuum of services it takes to support health. Additionally, we believe that until we start paying for value, equity improvements won't be made because we are producing units of health delivery not improved health. We won't achieve population level health improvements until providers share risk with payers on the health of patients, and a new level of accountability is created to ensure patients have a safe place to live, access to a stable source of healthy foods, and adequate transportation to attend their medical appointments. From that perspective, we see the Value Based Care as a critical milestone to improving health equity. However, pay-for-value models haven't yet caught up with emerging practices on care—ACES and trauma informed care training still aren't standard despite the evidence base. Plus, there isn't enough research being done on culturally appropriate care to translate it into a billing code.

This work has not been without its challenges. ACH opportunity has narrowed over time, both as projects were put forth in the toolkit, and when funds were cut. Even though completely out of our control, BHT's credibility took some hits as folks realized we could not be all solutions for all people. To overcome this, we believe there will need to be a balance of early wins, with long term investment in the most vulnerable and/or prevention activities.

It's an ongoing challenge for the ACH staff and Board to manage the diverse opinions regarding what's needed to move the needle. We've worked exceptionally hard to acknowledge good work in the community and to note that we're champions for this work, even if it's not in the Medicaid toolkit (palliative end of life care, smoking and marijuana education and cessation, reducing unintended

pregnancies, and more). We need to create new muscles for how we work together. BHT has worked hard to not position ourselves as the single answer or an added level of bureaucracy but more of a herder of cats. This is challenging as we work through inevitable conflicts between sectors and yet if we can help pace this work and build on both short term intervention needs with preventative efforts, we may frustrate all, but make progress.

Additional challenges arise on the political front. Eastern Washington is a full spectrum of political ideologies. The Spokane city council and state legislative district leans towards Democrat while our rural county commissioners and legislators are Republican. It's been incumbent on BHT to develop language that isn't politically charged. One of the challenges we've faced in bringing the conversation of equity forward in way that is respectful of our diverse staff members and Board members, while not alienating people with different world views. Equity is such an overused word now that it doesn't mean as much. The challenge to respectfully define actions while not making it feel tokenistic.

In May, BHT hosted a two-hour meeting on how we use a health equity lens in our work and what it means for our stakeholders and public, with small group discussion facilitated by our staff. One staff member later shared with our team the discussion at her table around some discomfort with the term "Equity Lens." The group felt it almost seemed to imply that equity was a pair of magic goggles that we could just take on or off. Shouldn't equity be the foundation, embedded into everything we do? Why do we pull it off into a separate conversation? Finding balance of talking about it, not in a philosophical but actionable way is a challenge. If you aren't calling it out all the time then you aren't keeping it top of mind, but if you call it out without action it doesn't feel authentic.

This prompted a very rich staff discussion, and ultimately, we felt that yes, we *are* working towards a world where equity is such a fundamental part of every process and decision that we don't have to talk about it anymore. However, the data shows we are not there yet. We need to have this conversation and keep it front and center in our work to exercise the muscles it will take to get us to that equitable future. What gives us hope is seeing the good that has come out of creating space for these conversations, and to allow collaboration and shared learning to happen. With BHT providing support, where there would otherwise have not been community capacity for, we are watching agencies really seize the chance to collaborate for change.