North Central Accountable Community of Health

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Lessons Learned From Community Engagement

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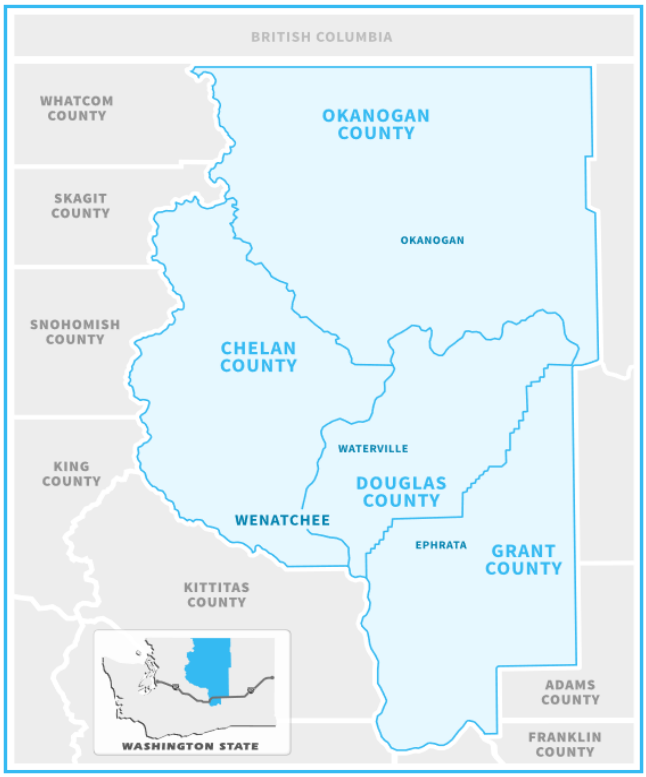
How have you engaged, convened, and maintained relationships with your community/communities?

The North Central Accountable Community of Health spans four counties (Chelan, Douglas, Grant, and Okanogan) (NCACH) and encompasses 12,684 square miles – or roughly 1/5 of Washington State. With 255,378 people, the population density for NCACH is an estimated 20.1 people per square mile (compared to the State average of 88.6 people per square mile) making NCACH the most rural of Washington's nine Accountable Communities of Health.



The rural nature of the region created a culture of cross-sector collaboration, which meant that many of our key stakeholders were already engaged in healthcare system delivery reform efforts before a formal organization was established. Prior to Healthier Washington's Medicaid Transformation efforts, the North Central region was awarded a State Innovation Model (SIM) grant in 2014, which eventually formed the region's Accountable Community of Health (ACH).

The SIM grant's original leadership group that convened the region's stakeholders became members of the Governing Board, who then went on to engage partnering providers, members of local community voice councils, and the Coalitions for Health Improvement (CHI). The CHIs were formed in 2014 to engage a wide variety of partner providers and stakeholders and provide input regarding the formation of NCACH. There are three CHIs, each convened by a local health jurisdiction (Chelan-Douglas, Grant, and Okanogan Counties) and supported with funding from NCACH. In April 2017, the NCACH Governing Board determined that the CHIs should be NCACH's primary means for community-level input and representation in NCACH's work. In July 2017, a voting seat for each Coalition was established by the Governing Board. The CHIs are open to anyone living or practicing in the North Central Region and are currently comprised of a wide range of community stakeholders and partners in health. Many events and opportunities for direct community engagement come from CHI member organizations, as well as connections to ongoing initiatives and events that are complementary to NCACH's work.

The CHIs are currently gathering community feedback through an online survey focused on opportunities and barriers to health and healthcare across our four-county region. The survey is being widely distributed until July 31, 2018, and will be used to create the three Coalitions' working strategic plan for the length of the Medicaid Transformation. NCACH also plans to use this feedback to identify areas of overlap, regional assets, and opportunities to address health equity with our Medicaid Transformation Project work.

The ACH's Project Workgroups, tasked with designing and implementing each of the six selected Medicaid Transformation Projects, are also a vehicle for community engagement. Comprised of local area service providers

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and community stakeholders, each Workgroup member is tasked with developing plans and funding strategies for the Board to approve, as well as informing and engaging partners about NCACH initiatives.

As much of NCACH's efforts revolve around process improvement and clinical transformation, it's been important to develop and maintain relationships with the clinical community. Through the efforts of our Whole Person Care Collaborative, (one of the Project Workgroups tasked with addressing Bi-Directional Integration of Primary and Behavioral Healthcare and Chronic Disease Prevention and Management) NCACH has successfully engaged and partnered with 17 different provider organizations who serve Medicaid beneficiaries.

NCACH also has formalized partnerships with several other provider and social service agencies as a part of their other project work, and through the three Coalitions for Health Improvement. Community engagement has been intentionally built into the design of our organization's MOUs – each partnering provider is required to perform some kind of consumer or broader community engagement as a part of their contract deliverables.

As NCACH continues to mature, we've learned that the most effective way to build and maintain relationships in the community is to better understand initiatives that are already occurring, and where our efforts can best support the goals of our community. A big part of our work as an ACH is to understand where our partners invest their energy and identify initiatives that are already happening and are complementary to the work we are doing to improve population health. One of the ways we engage with partners, and find complementary initiatives is by spending time in the community ourselves: NCACH staff frequently attend several community meetings and events that are not directly related to NCACH work. For example, NCACH staff are currently working to convene conversations and planning around a new jail transitions program being designed in Okanogan County aimed at reducing recidivism and successfully integrating justice-involved adults back into the community. NCACH staff have also been instrumental creating connections between law enforcement and mental health service providers as Wenatchee is set to open the region's first crisis-stabilization center in our four-county region.

How have you co-designed or co-created solutions with your community/communities?

The six selected Medicaid Transformation Projects currently being implemented by NCACH are co-designed with our community, as each Project requires community partners to design approaches and collaborative solutions to transform our current healthcare delivery system. The six projects were selected based on community feedback compiled from several sources including community forums and surveys conducted by NCACH in 2017. Based on community input, the NCACH region's top priorities were identified as: mental healthcare access, access to primary care, high school graduation rates, obesity, affordable housing, drug and alcohol abuse, access to healthy foods, and diabetes. As a result of the community feedback, the NCACH selected the following Medicaid Transformation Projects from the *Medicaid Transformation Project Toolkit*[1] released by the Washington State Healthcare Authority:

1. Bi-Directional Integration of Primary and Behavioral Health Care
2. Community-Based Care Coordination (Pathways Community HUB)
3. Transitional Care
4. Diversion Interventions
5. Addressing the Opioid Use Public Health Crisis
6. Chronic Disease Prevention and Management

Each of the projects are being implemented by a Project Workgroup (consisting of community stakeholders), which are responsible for the design and implementation of each of the selected Medicaid Transformation

[1] Medicaid Transformation Project Toolkit: https://www.hca.wa.gov/sites/default/files/program/medicaid-transformation-toolkit.pdf

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Projects (MTP). NCACH has also been very intentional about creating transparent decision-making processes that reflect the views and recommendations of as many community stakeholders as we can.

NCACH is able to ensure that our project approaches are appropriate and attainable for the region by using several decision-making bodies within the organization who make recommendations on funding disbursement and project design, as well as intentionally cultivating a diverse group of community stakeholders. For example, one of the required Medicaid Transformation Projects that all Accountable Communities of Health must implement is to "Address the Opioid Use Public Health Crisis." Our region already has several ongoing initiatives and groups who are already working to address the opioid use public health crisis. Instead of duplicating efforts, NCACH engaged several of the partners from the currently existing regional stakeholders group. The workgroup then decided to offer resources to the groups and providers already working to address opioid use and misuse across the region. In April 2018, NCACH's Opioid Project Workgroup designed and released a Rapid Cycle Opioid Project Application with up to $10,000 available in funding for small projects that are to be implemented between July – December 2018. In June 2018, the NCACH Governing Board awarded a total of $97,390 to support ongoing efforts in the region.

NCACH is also dedicating resources to addressing some of the social determinants of health (SDOH) that present barriers to health in the region. Using feedback from the *2016 Community Health Needs Assessment* [2] as an indication of community need, NCACH convened stakeholders to discuss housing and transportation as barriers to health. Participants identified common misconceptions they encounter, organizational barriers, and recommended suggestions on how NCACH could help. Suggestions included:

1. Help organizations acquire external funding
2. Provide technical assistance in capacity-building for housing and transportation agencies and organizations
3. Convene, coordinate, and advocate for housing and transportation at regional, state, and cross-sectoral levels
4. Coordinate and align information across organizations and the region
5. Provide direct access to funding

NCACH hosted its Annual Summit in April 2018, following the facilitated discussions, and asked over 200 attendees to rank the suggestions in order of importance. Based on the feedback gathered at the Annual Summit, NCACH has created a new position dedicated to building capacity and providing fundraising support to community organizations focused on housing and transportation. As a means of regional capacity development and equity work, NCACH is also planning to pay for local organizations to access data dashboards that depict a variety of current state assessments for the region (e.g. number of people living under the federal poverty line in each county, disaggregated by race.) Our belief is that by making these resources available to community partners, we can continue co-creating solutions to local health barriers together.

How have you addressed systematic inequities that affect health (such as power differentials or racism) as part of your community engagement work?

As a rural Accountable Community of Health, many of our partners are small critical access hospitals. Through its current reimbursement and alignment structures, the current healthcare reform system promotes multi-care organizations as opposed to the small local hospital systems, which makes it difficult to engage and incentivize small partners over larger ones. The rural nature of the region means that providers and patients often have to travel great distances, or expend significant staff resources, to provide care across our region. In order to reduce

[2] 2016 Community Health Needs Assessment:
http://www.mydocvault.us/uploads/7/5/8/6/7586208/2016_central_washington_chna_final.pdf

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costs, care providers would also have to reduce the scope of their care – thus reducing access to care for NCACH residents. NCACH and other ACHs have had to champion for rural healthcare systems throughout the Transformation process, as many of the approaches and metrics are best applied to a more concentrated population. In an attempt to help our partnering providers in the Whole Person Care Collaborative (addressing Bi-Directional Integration and Chronic Disease Prevention and Control), NCACH has designed a funding model that offers financial support to offset the cost of staff participation in the Collaborative's process improvement efforts. Payment models were developed that fit both the small and large hospital systems, which has helped some of the region's smaller healthcare organizations to participate in process improvement along with the region's larger healthcare systems. Similarly, NCACH will be funding partnering providers through its work with Transitional Care and Diversions Interventions based on participating in a collaborative effort to reduce inappropriate emergency department use. By reducing the barriers to participating, NCACH is ensuring that smaller partners are able to make the changes needed so they can provide care to our most remote patients.

The nature of our work is very high-level and we often engage directly with an organization's leadership or executive staff. As a result, we typically have limited engagement with frontline staff, their clients (Medicaid beneficiaries), and the broader community. This means that we usually interface with a predominantly white professional class – the majority of whom are not eligible for Medicaid benefits and therefore are not impacted as end-users by decisions made within NCACH's Workgroups and Governing Board. We rely on our partnering providers and the Coalitions for Health Improvement to engage Medicaid beneficiaries and infuse their voice into our work.

NCACH has experienced difficulty engaging partners using the term "health equity." This is not to say that our region, or our partners, do not believe that everyone deserves a fair and equal opportunity to lead healthy and productive lives – they do. It's just that many of our conservative and rural partners associate 'equity' with opportunities for advancement that favor urban populations over rural populations. As such, we have learned that we can talk directly about advancing equity in our region by framing equity as "removing barriers to health" or focusing on "addressing the social determinants of health," all of which relate to creating more equitable conditions in our community. For example, our Whole Person Care Collaborative providers are being tasked with addressing the social determinants of health in their care services, including using screening tools and community referrals to ensure that people are receiving Whole Person Care.

In addition to our Transformation efforts, we (along with our other rural ACH partners) have also had to advocate at the State level for materials and education to be culturally appropriate. For example, three of our four counties became mid-adopters of Fully Integrated Managed Care (FIMC) in 2018. As a part of the FIMC rollout, the Healthcare Authority (Washington's Medicaid payer) provided a series of outreach materials to be sent to Medicaid beneficiaries in English, but not in Spanish (spoken by nearly half of NCACH's Medicaid beneficiaries.) NCACH and local partners championed for the outreach materials to be translated into Spanish, which significantly helped providers serving Medicaid beneficiaries as their managed care plans shifted with the regional adoption of integrated managed care.

What about your organization's way of working has made you successful? How has your organizational culture or structure changed to allow for authentic community relationships? Include examples of how your staff and your board (if relevant) contributed to the culture and values that enabled your success.

The collaborative nature of the work we do requires us to cultivate relationships and foster connections across the region. Convening is the core of what we do. NCACH is fortunate to have many of the community's trusted leaders and organizations as a part of their Governing Board and staff. Above all, NCACH values Whole Person Care. Whole Person Care recognizes that in order to address health, our health system must also address the

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social determinants of health. Successfully addressing the social determinants of health requires authentic community partnerships.

As conveners, our Executive Director often reminds us that we must be flexible in order to best support the region through the Medicaid Transformation process. Flexibility has allowed staff to spend time at partner-hosted events, community meetings, and other opportunities that create meaningful connections. Our Governing Board has also been instrumental in bringing in new partners, ideas, and innovative solutions. Our organization's staff include both a former State Legislator and former Group Health executive, which bring significant social capital and long-standing relationships to the organization. We also regularly attend regional hospital council meetings, which include executives from both private and public hospital systems. NCACH is committed to uniting partners regionally as we are able to so that even the smallest and most rural of our communities can be served through the Transformation.

In addition to our six selected Transformation projects, NCACH has also adopted initiatives to support the six selected Medicaid Transformation Projects including a Community Paramedicine model with 10 participating Emergency Services (EMS) providers across the region, a 24-hour nurse line, and a staff position dedicated to providing technical assistance and building capacity to address housing and transportation as regional barriers to health. We value community and authentic relationships, which is why we work hard to stay nimble and responsive to the needs our community and partnering providers. For example, based on feedback from our Governing Board, Project Workgroups, and the broader NCACH community, NCACH added two Project Managers, a Communications and Engagement Manager, and will soon be adding a Whole Person Care Collaborative Manager and a Capacity Development and Grants Specialist to our staff team.

What have been your most significant challenges, obstacles, and missteps? We know that we can learn as much from setbacks as we can from successes, so please don't hold back! (If you are concerned about sharing challenges publicly, just let us know and we will omit your response to this question from the version we share publicly.)

Because the nature of our work revolves heavily around clinical transformation efforts, NCACH has worked extensively to bring clinical providers on as partners. With a heavy healthcare focus, it has been challenging to engage non-clinical community partners, especially as the majority of NCACH's project funding is allocated to healthcare organizations who are implementing our six MTP projects. While we are proud of our clinical partner involvement, NCACH's work will not be successful without involvement from the rest of the community. As such, NCACH staff and partners have been working to engage the non-clinical community and the greater public, but it is difficult to incentivize participation from community-based organizations who are not eligible for the bulk of NCACH's funding. NCACH is retroactively trying to find ways for more inclusive community involvement and funding opportunities. In June 2018, the NCACH Governing Board approved a position committed to building capacity and providing fundraising support for local housing and transportation providers and agencies.

With such a large Hispanic population to serve, NCACH has relatively little representation from the broader Hispanic community in NCACH's decision-making groups. This is also true of the Medicaid beneficiary and Tribal communities. While we have a seat open on the NCACH Governing Board for a Medicaid Consumer, it has been challenging to fill as we hold several mandatory meetings that require both the ability to take time off of work and a personal vehicle to attend. As well, one Medicaid Consumer cannot speak on behalf of all Medicaid Consumers the way a Public Hospital District executive might be able to. Additionally, because of the high-level nature of the work we do, it can be hard for the broader community, and even our non-clinical Governing Board members, to get fully up to speed on the clinical improvement work that NCACH is embarking.

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Limited engagement with the Confederated Tribes of the Colville has also presented a challenge for NCACH, as we recognize that we cannot improve population health or address health equity without acknowledging the inequities and lower health outcomes that exist within tribal populations in our region. There are many reasons as to why this is, partially due to the historical trauma and agency redlining that created separate and disparate health care systems to serve enrolled tribal members, as well as different funding mechanisms for each health care system. We are fortunate to have a tribal member and health care representative on our Governing Board, but our attempts to engage and include the local Indian Health Service Providers have not been successful. While we recognize this as an area for improvement, especially in regards to advancing health equity for a traditionally underserved population, we continue to stay in contact with tribal partners, and have maintained an open seat at every one of our project Workgroups, Coalitions, and Governing Board for representation. Moving forward, we hope to continue conversations about how NCACH and our tribal partners could collaborate and benefit as partnering providers within the Medicaid Transformation Project efforts, including a formal meeting between the Healthcare Authority, the local Indian Health Services Provider, and NCACH in July 2018.

What changes have you seen that give you hope about a future that is more equitable?

One of the things that give us hope is the region-wide and cross-sectoral acceptance that addressing the social determinants of health are critical to ensuring good health outcomes. The willingness of our partners to come together to improve community health, including Managed Care Organizations (MCOs) who are willing to expand their benefits to cover things like traditional healing modalities (e.g. sweat lodges and acupuncture) has increased the availability of culturally-appropriate care. Though we have fewer resources than many of our ACH-counterparts, our communities have created some incredible community health solutions, including two drug courts, mobile service units, and transitional programs aimed at building more resilient communities. As more partners come together to address the social determinants of health, the region has seen some very creative initiatives, such as a community hiking challenge jointly supported by a local MCO and a land trust. The region's values are also shifting – more and more community partners are becoming invested in building healthy communities, which is resulting in more discussions around health and health equity.

As NCACH continues on in the Medicaid Transformation process, our hope is that our work to address barriers to health will create lasting impact on the region. Our vision is one of a region that is connected, integrated, and supports Whole Person Care in all facets of the community for those with Medicaid and those with private market health insurance plans. We believe that the improvements NCACH's partnering providers are working towards will result in a healthier region that can work together to address regional inequities and the challenges unique to rural populations. We are especially hopeful as we see more and more collaboration between private, public, clinical, and non-clinical sectors within the Transformation work that this will all lend itself to a more equitable future.

Through a five-year State Medicaid Transformation Project, North Central Accountable Community of Health is implementing 6 projects to address regional health priorities and improve care by providing high-quality, cost-effective care that treats the whole person and improves the well-being of the communities in Chelan, Douglas, Grant, and Okanogan Counties.