

WASHINGTON STATE'S  
ACCOUNTABLE COMMUNITIES OF HEALTH

*Promising Practices for Consumer Engagement  
in the New Regional Health Collaboratives*

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Northwest Health Law Advocates (NoHLA) is a Seattle-based non-profit providing education, legal and policy advocacy, and support to community organizations in the Northwest and across the country. NoHLA's mission is to achieve accessible and affordable health care and secure health care rights for all. [www.nohla.org](http://www.nohla.org)



With over 40,000 members, Washington CAN! is the state's largest grassroots community organization. Together we work to achieve racial, social, and economic justice in Washington state and our nation. We can only achieve our goals when people become involved and take action for justice. [www.washingtoncan.org](http://www.washingtoncan.org)

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## Promising Practices for Consumer Engagement in the New Regional Health Collaboratives

### EXECUTIVE SUMMARY

The creation of Accountable Communities of Health (ACHs) in Washington offers a watershed opportunity to actively include members of communities that experience disparities in health outcomes and access to care in health system decision-making. In a time when Washington State's health systems are undergoing major transformations on many levels, ACHs provide an opportunity to harness the unique experiences and insights of grassroots consumers to help health care institutions in identifying their communities' health needs and priorities and developing projects to address them.

ACHs have already embraced a number of promising consumer engagement activities. This paper highlights several of these and recommends a few others, to help illustrate to ACHs some successful engagement practices that they can adopt in their own regions. We also recommend practices that do not require great resources to implement but that support ACH engagement of grassroots consumers and enabling them to be accountable, transparent and equitable to the communities they serve.

As ACHs decide how regional health systems will act to improve their communities' health, they should offer meaningful opportunities for the involvement of grassroots consumers, including low income families, immigrants, people of color, people with disabilities, older adults, and LGBTQ individuals, among others. ACHs should include grass roots consumers in their governing bodies and operations both to ensure the success of these programs and as a matter of equity. ACHs' staff and governing bodies cannot hope to accurately identify and prioritize their communities' most serious health needs unless they make those determinations in partnership with individuals who experience those needs and who will most benefit from ACH-led interventions. Moreover, communities facing serious health disparities have traditionally been underrepresented in the executive decision-making ranks of health care systems. Rather than reproducing these structural inequities, ACHs should take a more equitable path by structuring their decision-making and operations to include grassroots consumers belonging to these communities.

## PROMISING PRACTICES FOR CONSUMER ENGAGEMENT BY ACHS

To help ACHs better understand the benefits of consumer engagement and choose the most effective means for engaging the grassroots consumers in their regions, Northwest Health Law Advocates (NoHLA) in collaboration with the Washington Community Action Network (Washington CAN!) have developed these recommendations for ACH consumer engagement practices. Our recommendations are based on our review of documents from the state and ACHs and other related literature, interviews with members of ACH governing bodies and staff, discussions with state agency staff, and information we obtained about practices in other states with similar regionally-based organizations. NoHLA and WACAN staff have also attended and participated in meetings of the four ACHs highlighted in this paper.

## PROMISING PRACTICES FROM OTHER STATES

Regionally based health system transformation organizations in Oregon, New York and Maryland offer some useful lessons for Washington's ACH program. In particular, we highlight the following promising practices:

- **Community Advisory Councils in Oregon Coordinated Care Organizations (CCOs):** CCOs provide Medicaid services to individuals in their areas in Oregon. Each CCO is required by law to have at least one Community Advisory Council, with consumer representatives constituting a majority of its members.
- **Data Dashboards used by Maryland Low Income Health Improvement Coalitions:** Maryland's State Health Improvement Process (SHIP) and the State's county-based Local Health Improvement Coalitions (LHICs) collaborated to gather and share data on a common set of health measures set by the SHIP. This data was made widely accessible through graphic data dashboards. The dashboards have helped the LHICs plan and measure the effectiveness of their health improvement programs, and they provide the public with clear information about community health needs and the impacts of LHIC programs.
- **Project Approval and Oversight Panel for New York Performing Provider Systems (PPSs):** Similar to Washington's proposed Medicaid Transformation Waiver, New York received a Medicaid waiver that designated regional organizations, called Performing Provider Systems, to propose and administer waiver-funded health projects. To provide public accountability and monitoring for the program, the State created a stakeholder Project Approval and Oversight Panel, to review and assess applications for waiver-funded projects and provide ongoing oversight to the waiver's programs. The Panel includes in its membership a low-income consumer and a consumer-oriented coalition representative.

## PROMISING PRACTICES IN WASHINGTON STATE'S ACHS

After reviewing these out-of-state programs, we lay out a set of principles for community participation that we recommend ACHs to adopt and use to guide their governance, community engagement and outreach. The principles are divided between five domains – racial/health equity, transparency, accessibility, community engagement, and accountable governance. For each domain, we list an overarching principle, as well as concrete ways for an ACH to integrate the principle into its procedures and activities. These principles are found in Appendix A of the paper. The principles may also be downloaded as a stand-alone document. One of the ways we suggest that ACHs promote racial/health equity is through the use of a racial/health equity tool to help in recognizing and addressing the impacts of significant decisions they make on racial equity. In Appendix B, we provide a sample tool of this sort (adapted from the City of Seattle's Racial Equity Toolkit), for reference, along with a discussion of the merits of using a health/equity decision-making rubric, and how it can be used.

In addition to explaining the benefits of adopting and possible ways to implement these principles, the paper highlights promising practices of four of the State's ACHs – the Cascade Pacific Action Alliance, the North Sound ACH, the King County ACH and the Pierce County ACH. The Cascade and North Sound ACHs were chosen in significant part because they were identified early on by the State Health Care Authority as being more advanced in their development. The King and Pierce County ACHs are the only two single-county ACHs in the state, and their regions respectively make up the State's most populous and second most populous counties.

Some of the highlighted promising practices of these four ACHs include:

- Allocating seats on ACH decision-making bodies to consumers
- Committing to including consumers in ACH work groups or committees
- Creating a Consumer Advisory Board
- Multi-tiered engagement – creating multiple opportunities for consumer engagement with different levels and lengths of commitment required
- Holding community meetings at which consumer participations was sought and encouraged
- Conducting presentations on ACHs at community organization gatherings
- Using local community forums to distill and report local perspectives to the ACH (particularly for geographically large ACH regions)
- Creating and operating a work group charged with addressing consumer engagement
- Creating a consumer engagement plan for the ACH

- Operating an ACH website that lists governing board, work group and committee meeting dates and offers links to download supporting materials
- Budgeting in advance for consumer engagement (at least 10% of the ACH’s annual budget)
- Distributing newsletters with updates on ACH activities and upcoming meeting dates
- Establishing health equity and combating health disparities as central values for the ACH
- ACH governing bodies employ consensus-based decision-making
- Translating ACH website content in prevalent non-English languages
- Opening ACH governing body meetings to full public participation

## CHALLENGES FOR ACHS

As the implications of the anticipated Medicaid Transformation Waiver loom large over ACHs, there are significant questions about the ACHs’ funding, mission and challenges in engaging consumers:

- 1. Financial pressures may inhibit ACHs’ interest in pursuing robust consumer engagement activities that are neither required by ACH funders nor likely to be required for the ACHs to participate in the waiver programs.**
- 2. Waiver funded projects run the risk of crowding out ACH work that serves the collaboratives’ original mission but that may be in tension with the waiver’s specific requirements.**
  - Regional priorities v. State Identified Project Types and Standards* - ACHs were created to move health planning to a regional level, identifying their most significant regional health needs and articulating their region’s unique priorities and plan for addressing those needs. However, the Health Care Authority is now considering requiring each ACH to have five waiver-funded projects each of which falls within a project category chosen (with public input) by the Health Care Authority. This may restrict ACHs flexibility to select projects that best address their regions’ priorities.
  - Social Determinants of Health vs. Medicaid Program Objectives* – ACHs were designed to improve health outcomes for their *entire* population by addressing the social determinants of health. Yet, projects funded through a Medicaid waiver must benefit primarily Medicaid enrollees and serve Medicaid program objectives. This may make it more difficult for ACHs to pursue projects that focus on addressing the social determinants of health rather than aiming at directly improving health care services and particularly health care delivery systems.

3. **ACHs must step up consumer engagement efforts as they make major decisions affecting their operation and programs. Otherwise they risk alienating their communities and making future engagement activities significantly more difficult.**

Given the need for ACHs to act promptly to engage consumers in their regions, and the limitations on funding that a number of ACHs are experiencing, in Appendix C, we provide a list and explanation of several consumer engagement practices that: a) ACHs should be able to implement relatively quickly; b) should not require significant expenditures for items or activities beyond the staffing and overhead for which the ACHs will likely have already budgeted; and, c) should have high value, regardless of an ACH's individual demographics and other circumstances.

## CONCLUSION

ACHs' ability to impact their communities' health and health care delivery systems is likely to expand quickly in the near future. Upon approval of the Medicaid Transformation Waiver, it will be more important than ever for ACHs to work quickly to develop consumer engagement plans and involve members of communities facing health disparities in ACH decisions and operations. We hope that this paper can serve as a valuable tool and call to action for consumers and policymakers alike to develop a strong partnership between ACHs and the low-income individuals, people of color, immigrants, persons with disabilities, older adults and LGBTQ individuals who make up the grassroots participants in their health care systems, so that they can successfully collaborate to improve the health of the communities in which they live and work.

## I. INTRODUCTION

In January 2014, Washington State proposed a State Health Care Innovation Plan (SHCIP) to broadly transform its health care system to achieve the “triple aim” of producing a better health care experience and delivering better quality care while lowering the cost of care for its residents.<sup>1</sup> One of the primary pillars of this plan was to divide the state into regions, each of which would form a public-private multi-sector collaborative – an Accountable Community of Health (ACH) – with the goals of increasing collaboration across the healthcare system, better coordinating and integrating care and social services, reducing costs, helping providers change their practices to increase the value of their care, and increasing equity in outcomes.<sup>2</sup> The two primary conceits underlying this program were simple. First, the social determinants of health – societal factors other than the quality of and accessibility of health care itself – are actually the prime movers of a population’s health.<sup>3</sup> Second, Washington’s health delivery systems, community supports, demographics and, consequently, its communities’ greatest health needs vary significantly across the state. The first of these factors counsels that the most significant improvements in population health can be achieved by improving the social determinants of a population’s health, rather than aiming exclusively to improve its health care delivery system. The second principle counsels that statewide one-size fits all health system innovations, while potentially helpful, cannot help but fail to address the areas of greatest health need in many communities throughout the State. These conclusions, taken together, formed the animating principle of ACHs, that regional collaborative cross-sector bodies composed of a diverse and broad set of stakeholders would provide the most effective means of improving population health overall statewide by identifying the most significant health needs in their respective regions and then seeking to address them through the social determinants of health in a way that reflects each region’s individual priorities.<sup>4</sup>

**This program presents an exciting opportunity for grassroots health care consumers** to assume an important and necessary role in the development and operation of their local ACHs. To be successful in identifying the most significant health needs in their communities and their constituents’ priorities for addressing those needs, ACHs must seek out the voices of their low-

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<sup>1</sup> Washington State Health Care Authority, Washington State Health Care Innovation Plan, January 2014 (“SHCIP”), [http://www.hca.wa.gov/hw/Documents/SHCIP\\_InnovationPlan.pdf](http://www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf) at iii.

<sup>2</sup> SHCIP at 30-31, 52-53.

<sup>3</sup> Washington State Medicaid Transformation Waiver Application (“Medicaid Transformation Waiver”), Washington State Health Care Authority and Department of Social Services, August 24, 2015, *available at* <http://www.hca.wa.gov/hw/Documents/waiverappl.pdf> at 6-7.

<sup>4</sup> Medicaid Transformation Waiver at 8-9, 15 fn8.

income community members who suffer from the health disparities that create those needs. Conversely, if ACHs fail to include in their deliberations and operations members of their communities who have traditionally been the subjects of public health programs but who just as often have been excluded from participating in those programs' design and delivery (e.g., racial and ethnic minorities, immigrants, older adults, LGBTQ individuals, and persons with disabilities), the ACH program will put itself on the path towards perpetuating the paternalism and biases endemic in the health care system.

Unfortunately, while the initial SHCIP, later updated as the Healthier Washington plan,<sup>5</sup> spoke of the need for consumer involvement in ACHs, neither of those plans stated with detail specific expectations for ACHs to engage the consumers who make up their communities, and particularly the low-income populations that most require and are likely to be impacted by ACHs' activities.

The stakes were raised significantly with the State's request to the federal Centers for Medicare and Medicaid Services (CMS) for a § 1115 Medicaid demonstration waiver (the "Medicaid Transformation Waiver"). Among other things, the State's waiver application proposes for ACHs to serve as regional "Coordinating Entities" (RCEs) that would select, monitor, and report on Medicaid funded projects to be implemented in their individual regions.<sup>6</sup> Like the Healthier Washington Plan and the SHCIP before it, the Medicaid Transformation Waiver application outlines very few requirements for engaging grassroots consumers and soliciting their perspectives in choosing and overseeing waiver projects to be administered by ACHs.

Recognizing the clear need to promote robust grassroots consumer engagement in the developing ACH program, Northwest Health Law Advocates and Washington CAN! have collaborated to create this report recommending principles for consumer engagement and public accountability for the State's ACHs to adopt and for consumers and allied advocates to promote (*See* § IV, App. A). The report summarizes the process through which ACHs were created and how they have subsequently developed through their initial planning period. It also looks to how similar regional entities were structured and function in other states, drawing what lessons can be learned from these out-of-state antecedents to Washington's ACH program. The report then outlines the justifications for its principles for ACH Community Participation along with concrete suggestions for how ACHs can develop successful consumer engagement plans and make their operations transparent, accessible and accountable to their communities. In discussing these recommendations, the report highlights some promising

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<sup>5</sup> *See generally* Healthier Washington – Better Health Better Care, Lower Cost – State Innovations Model Grant Application, July 2014 ("Healthier Washington Application"), *available at* [http://www.hca.wa.gov/hw/Documents/SIM\\_Grant\\_Application.pdf](http://www.hca.wa.gov/hw/Documents/SIM_Grant_Application.pdf),

<sup>6</sup> Medicaid Transformation Waiver at 8-9.

practices utilized by four of the State's ACHs -- the North Sound ACH, the Cascade Pacific Action Alliance (CPAA), the King County ACH and the Pierce County ACH. The North Sound and Cascade Pacific ACHs were chosen in part because they were identified as the State's two "pilot" ACH programs, both of which received a higher level of early funding than other ACH regions to begin to implement their programs on an accelerated basis.<sup>7</sup> Also, while one of these ACHs' regions contains a major local population center,<sup>8</sup> each of these ACHs' regions is comprised of multiple counties, the majority of the areas of which are relatively rural and geographically diverse. The King County and Pierce County ACHs were chosen in part to provide contrast to the pilot ACH regions and capture how regional needs and practices could be different in significantly different environments. The King and Pierce County ACHs constitute the only single-county ACHs among the state's nine ACH regions. Also, while both King and Pierce Counties have significant rural areas, they are the State's two most populous counties and include, respectively, the first and third most populous cities in the State.<sup>9</sup> The report concludes with an overview of the challenges that ACHs will face in engaging their communities' consumers, achieving sustainable support for their activities, and remaining true to their mission, as they make their way through their first year as fully operational entities and as their role and funding structure might change significantly under the provisions of Medicaid waiver program for which the State has applied.

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<sup>7</sup> Washington State awards \$300,000 in grants to two Accountable Communities of Health, Washington State Health Care Authority, January 2, 2015, <http://www.hca.wa.gov/Releases/ACH%20grants%20awarded%201-2-15.pdf>, last viewed on March 7, 2016.

<sup>8</sup> The City of Everett, the largest city in the North Sound ACH's region, was listed in the 2010 census as having a population of 103,019, making it the sixth most populous city in Washington State. This information is drawn from the Spokane Spokesman Review's website ("SSR website") that provides Washington State data from the 2010 census in various formats. See <http://data.spokesman.com/census/2010/washington/cities/>, last viewed on March 1, 2016.

<sup>9</sup> SSR website; information on the population of the State of Washington broken down by counties was retrieved from <http://data.spokesman.com/census/2010/washington/counties/>, and information about the States' cities' populations was retrieved from <http://data.spokesman.com/census/2010/washington/cities/>, both last viewed on March 1, 2016.

## II. DEVELOPMENT OF WASHINGTON'S ACCOUNTABLE COMMUNITIES OF HEALTH

### A. ACHS' ORIGIN IN THE STATE HEALTH CARE INNOVATION PLAN AND IMPLEMENTING LEGISLATION

The State of Washington proposed the creation of ACHs in its State Health Care Innovation Plan (SHCIP), released in January of 2014, with support from the State Innovation Models (SIM) Initiative of CMS' Center for Medicare and Medicaid Innovation (CMMI).<sup>10</sup> Building on the SHCIP's framework, in 2014, Washington's Governor Jay Inslee signed into law E2SHB 2572,<sup>11</sup> a bill that established funding for "Community of Health" planning and the subsequent designation of two (pilot) Accountable Communities of Health (ACHs). That same year, Governor Inslee also signed ESSB 6312,<sup>12</sup> which laid the groundwork for the State to integrate how physical health and behavioral health services are procured and delivered in publicly administered health coverage programs.<sup>13</sup> This legislation directed the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to jointly designate Regional Services Areas (RSAs) that would together comprise the entire state.<sup>14</sup> In a move to shift Medicaid purchasing to a regional level, ESSB 6312 also required the managed care organizations (MCOs) with which HCA contracts to provide Medicaid, CHIP<sup>15</sup> and other safety-net health care coverage<sup>16</sup> to most enrollees in these programs to provide such services within one or more individual RSAs, rather than on a county by county basis, as had been done before.<sup>17</sup> HCA and DSHS announced the selected RSAs in November 2014.<sup>18</sup> Under the Healthier Washington proposal, each RSA was intended to be coextensive with area of operations for that region's ACH, although there are slight exceptions.<sup>19</sup> Two ACHs – the King

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<sup>10</sup> SHCIP at 52-54.

<sup>11</sup> Laws of 2014, ch. 223, § 4.

<sup>12</sup> Laws of 2014, ch. 225.

<sup>13</sup> Washington State Health Care Authority, Physical and Behavioral Health Integration, [http://www.hca.wa.gov/hw/Pages/integrated\\_purchasing.aspx](http://www.hca.wa.gov/hw/Pages/integrated_purchasing.aspx).

<sup>14</sup> Laws of 2014, ch. 225, § 2.

<sup>15</sup> The Children's Health Insurance Program, see generally WAC 182-505-0235.

<sup>16</sup> These programs are collectively referred to as Washington Apple Health. WAC 182-500-0120.

<sup>17</sup> Laws of 2014, ch. 225, § 3(3) (HCA and DSHS must use common service areas for purchasing public behavioral health and medical services);

<sup>18</sup> Laws of 2014, ch. 225, § 55(8). Washington State Health Care Authority, Notice of Regional Service Area Designation, November 4, 2014, <http://www.hca.wa.gov/Releases/RSA%20Announcement%2011-04-14.pdf>

<sup>19</sup> See Washington State Health Care Authority, Notice of Regional Service Area Designation, November 4, 2014 (RSA Designation), <http://www.hca.wa.gov/Releases/RSA%20Announcement%2011-04-14.pdf>. The Cascade Pacific Action Alliance, serves a region that combines two of the ten RSAs. Also, the Southwest Washington RSA includes Klickitat County, although the State contracts to provide Medicaid and publicly funded behavioral health services to that county together with the counties in the Greater Columbia ACH. Similarly, Okanogan County was initially placed in the Spokane RSA, but the state contracts to Medicaid and publicly funded behavioral health services

and Pierce County ACHs – consist of a single county each, while the other ACHs serve multiple counties, with the Greater Columbia ACH including 10 counties, the most counties served by a single ACH.

## B. 2015 – THE DESIGN AND PILOT PERIODS CONCLUDING IN FULL DESIGNATION AS ACHS

With a \$65 million SIM grant that the State received from CMMI to implement the Healthier Washington plan, and with funding approved by the Legislature through E2SHB 2572, in January of 2015, the State awarded two nascent ACHs grants to serve as “pilot” ACH programs.<sup>20</sup> The remaining seven regional groups seeking to create ACHs received “design” grants to bring together the sectors and create the infrastructure they would need to build successful ACH programs.<sup>21</sup> The pilot ACHs – the CPAA and North Sound ACH – received \$150,000 for a six month period; and, the design grant consortia received \$100,000 each for 2015, with the expectation that by the end of that time period the resultant regional health collaboratives would be able to be designated as fully functional ACHs.<sup>22</sup> Each ACH was required to have a “backbone” organization that would carry out the ACH’s administrative functions and serve as the fiscal agent for the pilot or design grant funds. Each of the pilot ACHs was also required to develop a plan for at least one substantive health improvement project that would be ready to implement by the end of 2015.<sup>23</sup> Unfortunately, the conditions of the pilot and design grant funding placed almost no concrete requirements on ACHs to include consumers in their governance and activities. The one exception to this was that grantees were admonished that their:

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together with the North Central ACH’s area. *Compare* RSA Designation at 4 with ACH Regions Map, available at <http://www.hca.wa.gov/hw/Documents/ACHRegionsMap072015.pdf>. It is anticipated that Klickitat and Okanogan Counties will rejoin their original RSAs for the purposes of public health program service delivery at some time in the future. Accountable Communities of Health,

<sup>20</sup> Washington State Health Care Authority, State Health Care Innovation Plan Annual Status Report, [http://www.hca.wa.gov/documents/legislative/schip\\_annual\\_statusReport\\_1.19.16\\_final\\_to\\_leg\\_compiled.pdf](http://www.hca.wa.gov/documents/legislative/schip_annual_statusReport_1.19.16_final_to_leg_compiled.pdf) at 8.

<sup>21</sup> Washington State awards \$700,000 in grants to seven design regions for Accountable Communities of Health, Washington State Health Care Authority, January 28, 2015, <http://www.hca.wa.gov/Releases/ACH%20design%20grants%20awarded%201-28-15.pdf>, last viewed on March 7, 2016.

<sup>22</sup> Washington Health Care State Authority, ACH Design Grants Awarded, <http://www.hca.wa.gov/Releases/ACH%20design%20grants%20awarded%201-28-15.pdf> (announcing grant awards). Washington Health Care Authority Grant Award Agreement, HCA Contract Number: K1391 (ACH Pilot Grant Contract), § 2.2, at 4 (pilot grant award amount). Washington Health Care Authority Grant Award Agreement, HCA Contract Number: K1433 (ACH Design Grant Contract), Schedule A, § 4(a) at 19 (expectation that awardees will submit proposal and application for designation as full ACHs)

<sup>23</sup> Building the Foundation for Regional Health Improvement: Evaluating Washington’s Accountable Communities of Health, Center for Community Health and Evaluation, January 2016, [http://www.hca.wa.gov/hw/Documents/ach\\_evalreport\\_year\\_1.pdf](http://www.hca.wa.gov/hw/Documents/ach_evalreport_year_1.pdf) (ACH Evaluation Report) at 7.

governance and engagement strategy should *strongly consider* the development or inclusion of the following functions and assurances as part of the ACH construct:...f. **Community/consumer engagement**, including authentic representation engagement of consumers and underserved communities.<sup>24</sup>

No definitions were provided for what constituted “authentic representation engagement of consumers and underserved communities.” In any event, as the developing ACHs were only asked to strongly consider this, none was sanctioned for failing either to include grassroots consumers in their governance structures or to develop meaningful plans to reach out to, educate consumers about the ACHs and support them in joining in ACH activities.

In June 2015, the two pilot ACHs applied for and the following month were designated as fully operational ACHs by the Health Care Authority.<sup>25</sup> Between November 2015 and January 2016, the remaining seven non-pilot ACHs were formally designated by HCA as well.<sup>26</sup> Just as with the pilot and design grants, ACH designation required no inclusion of consumers in ACH governance and oversight and did not require ACHs to have engaged in or commit to engaging consumers in specific ways.<sup>27</sup> ACHs received an additional \$150,000 upon designation by HCA.<sup>28</sup> In February of 2016, HCA renewed their funding contracts with the ACHs for FY2016, with slight amendments, providing each ACH with a further \$330,000 this year. Again, almost no concrete requirements for consumer engagement were included in the renewed contract.<sup>29</sup> In July 2016,

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<sup>24</sup>ACH Design Grant Contract, Schedule A, § 4(i)(2) at 20-21.

<sup>25</sup> Washington State Health Care Authority, State Health Care Innovation Plan Annual Status Report, [http://www.hca.wa.gov/documents\\_legislative/schip\\_annual\\_statusReport\\_1.19.16\\_final\\_to\\_leg\\_compiled.pdf](http://www.hca.wa.gov/documents_legislative/schip_annual_statusReport_1.19.16_final_to_leg_compiled.pdf) at 9.

<sup>26</sup>ACH Evaluation Report at 7.

<sup>27</sup> Regarding governance structure, the designation application template furnished by HCA requires that “Governing body membership reflects balanced, multi-sector engagement. At a minimum, balanced engagement refers to the participation of key community partners that represent systems that influence health; public health, the health care system, and systems that influence the Social Determinants of Health (SDOH), with the recognition that this includes different spheres of influence.” Framework for Accountable Community of Health Readiness Proposal (6.15.2015), Healthier Washington, [http://www.hca.wa.gov/hw/Documents/Readiness\\_Framework.pdf](http://www.hca.wa.gov/hw/Documents/Readiness_Framework.pdf), last viewed April 29, 2016 at 1. Notably, grassroots consumers (or even grass-tops consumer representatives) are conspicuously absent from this list. Regarding consumer/community engagement, applicants are asked to document that “[c]ommunity engagement activities are underway and additional community engagement activities are planned in addition to engagement that occurs through the governance structure (e.g., ACH governing body and committee meetings).” *Id.* It is easy to understand how the lack of requirements that these activities include outreach to grassroots consumers resulted in most developing ACHs primarily conducting their initial outreach to providers, advocates and other individuals whose interest in the ACH was principally professional.

<sup>28</sup> See, e.g., Washington Health Care Authority Contract Amendment, HCA Contract Number K1391, Amendment No. 1 (ACH Contract Amendment 1), at 2, No.2.

<sup>29</sup> Washington Health Care Authority Grant Award Amendment, HCA Contract No. K1390 Amendment No. 2 (ACH Contract Amendment 2), at 2 (additional award of \$330,000), 3, 5 (engagement requirements). The amended contract’s specific “engagement” requirements are “Engagement activities to include, but not limited to: Summary

HCA announced its giving each ACH the opportunity to apply for and receive a one-time award of \$50,000 to spend on activities related to developing and carrying out a health improvement project in its region.

### C. “MEDICAID TRANSFORMATION” WAIVER

On August 24, 2015 the State applied to CMS for authorization to implement a five-year § 1115 Medicaid waiver program<sup>30</sup> that would help to carry out many facets of the Healthier Washington Plan. The proposed waiver program is composed of three initiatives, the first of which is titled “Transformation through Accountable Communities of Health (ACHs)”.<sup>31</sup> Under this initiative, the State is charged with developing a menu of transformation project types. In each RSA, the ACH would serve as the regional “coordinating entity” (RCE) that could apply to HCA for waiver funding for projects to be implemented in the ACH’s region and that fall within the project type descriptions on the State-developed menu. The waiver application anticipates that ACHs will likely serve as the RCEs, given sufficient guarantees that the ACHs have the desire

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of current ACH communication and engagement activities and identified gaps that need to be addressed. - April 29, 2016. Plan and timeline to address gaps and implement other ACH strategies. – October 31, 2016.” *Id.* at 5. To be clear, ACHs are not required to spend the entire \$330,000 during the current year, and HCA has stated that it “anticipate[s] most ACHs will carry over a portion of the \$330,000 from the 2016 award, specifically those who have significant carry over.” ACH Budget Project: 2016-2018. As ACHs will be eligible to receive a further \$330,000 of SIM grant funding during the entirety of FY 2017 and 2018, some may be motivated to retain some of this year’s award for future years, in case the Medicaid Transformation Waiver does not provide the funding they hope, or to spend on activities that cannot be funded through the waiver. See Washington Health Care Authority Grant Award Amendment, HCA Contract No. K1432 Amendment No. 2 at 1-2 (increase of maximum contract amount from \$250,000 to \$580,000).

<sup>30</sup> The Medicaid Act contains a list of services that all State Medicaid programs are required to offer, as well as a list of services that states can choose whether or not to furnish to their Medicaid recipients and are listed in the State’s Medicaid State Plan. 42 U.S.C. §§1396a(a)(10)(A), 1396d(a). However, federal law also provides opportunities for States to “test new or existing ways to deliver and pay for health care services in Medicaid and the Children’s Health Insurance Program (CHIP)” not covered under the general list of mandatory and standard optional Medicaid services. Medicaid.gov, Waivers, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>. In return for the State’s agreement to provide these services to eligible individuals, CMS provides the State a “waiver” from applicable Medicaid requirements that might otherwise prevent the implementation of the proposed Medicaid service expansion. For example, while Medicaid services are generally required to be offered on a “state-wide” basis (42 C.F.R. §431.50), a waiver to this requirement might be provided to allow a State to implement a pilot program that offers additional services within a sub-region of a State. § 1115 of the Social Security Act authorizes States to apply to set up “demonstration” projects that test new approaches to delivering or financing Medicaid or CHIP services. See <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>.

<sup>31</sup> Medicaid Transformation Waiver at 13. See also Medicaid Transformation Waiver Development of Transformation Project List, December 8, 2015, at [http://www.hca.wa.gov/hw/Documents/waiver\\_tpwebinar\\_12-8-15.pdf](http://www.hca.wa.gov/hw/Documents/waiver_tpwebinar_12-8-15.pdf) at 7. The remaining two initiatives consist of a suite of changes to the State’s long term services and supports programs (e.g. home care for persons with disabilities and caregiver support), as well as the development and delivery of Medicaid supported employment and supported housing benefits to be offered on a state-wide basis. *Id.* at 7.

and infrastructure needed to do so.<sup>32</sup> Waiver funding could be made available both for approved regional transformation projects and for ACHs to carry out their administrative duties as RCEs.<sup>33</sup> With SIM grant funding for each ACH set to fall to an average of \$165,000/year in 2017 and 2018 and end after January 2019, the Medicaid Transformation Waiver provides the potential for significantly increasing ACH administrative and programmatic capacity at least over the projected five-year term of the waiver program.

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<sup>32</sup> See Medicaid Transformation Waiver at 14-15, 37, 51, Appendix 9. Although the waiver application originally referred to the bodies that would select and oversee regional Medicaid transformation projects as “coordinating entities,” the State Health Care Authority has eschewed the use of this term more recently, to describe these bodies; it is now generally expected that ACHs will fill this role. See, *e.g.*, Memorandum to Marc Provence, Washington State Health Care Authority, From Cathy Kaufmann, HMA, Recommendations on Essential Components for an ACH related to the Medicaid Transformation Waiver, March 2, 2016 (“HMA Memorandum”) at 2, available at [http://crhn.org/pages/wp-content/uploads/2015/06/03\\_HMA-Recommendations.pdf](http://crhn.org/pages/wp-content/uploads/2015/06/03_HMA-Recommendations.pdf) (last viewed June 22, 2016).

<sup>33</sup> Medicaid Transformation Waiver at 14-15, 37.

### III. STATE-BASED REGIONAL COLLABORATIVE HEALTH IMPROVEMENT PROGRAMS

Innovation in Medicaid and the safety net health care system more generally is taking place across the nation with a number of projects similar to Washington’s ACHs operating in several states. This paper examines three that are based in Oregon, Maryland, and New York that have features worthy of consideration for adaptation or emulation in Washington.<sup>34</sup> Some of these stem from CMMI’s SIM initiative.<sup>35</sup> Others have been created by § 1115 waivers through CMS<sup>36</sup>, as well as by grants from the Centers for Disease Control (CDC).<sup>37</sup> Much like Washington’s ACHs, the projects create regional organizations designed to create a better functioning health care delivery system and address local communities’ specific health needs.

#### A. OREGON: COORDINATED CARE ORGANIZATIONS

In 2012, Oregon began implementing Coordinated Care Organizations (CCOs) throughout the state. CCOs are local health entities that deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid).<sup>38</sup> There are sixteen regionally-based CCOs whose constituencies are defined by partial, single or multiple county regions.<sup>39</sup> CCOs receive and are designed to manage a global budget made up of funds that were formerly separated into different streams for providing healthcare, mental health and substance abuse services, and dental services to coordinate the Medicaid program.<sup>40</sup> CCOs may also choose to coordinate their enrollees’ social services together with their health care.<sup>41</sup> In determining what services to offer and how to provide them, each CCO must partner with local public health departments and hospitals to complete a community health needs assessment.<sup>42</sup> To assure that community voices are included in decisions about CCO operations, the Oregon Legislature adopted specific requirements for community member participation in CCO governance and advisory bodies. CCOs’ governing boards must contain representatives of a broad spectrum of “the major

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<sup>35</sup> Oregon

<sup>36</sup> Maryland

<sup>37</sup> New York

<sup>38</sup> Oregon Health Authority, Coordinated Care Organization Implementation, <https://cco.health.oregon.gov/Pages/AboutUs.aspx>, last viewed April 25, 2016. Thus, unlike ACHs (as currently constituted), CCOs are risk-bearing entities.

<sup>39</sup> *Coordinated Care Organizations*, OREGON HEALTH POLICY BOARD, <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx> (last visited July 10, 2015)

<sup>40</sup> Janet M. Corrigan, Elliott S. Fisher, *Accountable Health Communities: Insights from State Health Reform Initiatives*, THE DARTMOUTH INSTITUTE FOR HEALTH POLICY AND CLINICAL PRACTICE (Nov. 2014) (“Corrigan and Fisher”), 10, <http://tdi.dartmouth.edu/images/uploads/AccountHealthComm-WhPaperFinal.pdf>.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

components of the healthcare delivery system,” as well as “[a]t least two members from the community at large, to ensure that the organization’s decision-making is consistent with the values of the members and the community.”<sup>43</sup> Each CCO must also have at least one community advisory council (CAC), which is required to “[i]nclude representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership”.<sup>44</sup> Some CCOs have multiple CACs, in order to reflect their regions’ diverse populations.<sup>45</sup>

CACs are statutorily assigned significant clearly defined responsibilities. Notably, they are authorized and required to oversee:

“a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization;...”<sup>46</sup>

While Washington State’s ACHs have similar duties, the assignment of these tasks to a consumer-majority CAC in Oregon’s CCO system ensures that the community health assessment and health improvement plan will incorporate and reflect the knowledge and priorities of consumers from the CAC’s region. Also, each of Oregon’s CCOs is required to include on its governing board at least one member of the CCO’s CAC.<sup>47</sup> This provides a ready conduit for communications and collaboration between the CAC and its CCO’s governing board, ensuring that CAC recommendations and requests for information are able to receive the Board’s attention.

In addition to these consumer-friendly structural features, a number of CCOs and their advisory committees have taken it on themselves not simply to seek to better the coverage and health delivery systems within their region, but to more broadly improve their communities’ wellbeing through the social determinants of health. For example, the Eastern Oregon CCO’s community health assessment found that there were significant cultural and linguistic barriers to accessing health services, such as adolescent health checkups, in the CCO’s Latino community. To address

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<sup>43</sup> Or. Rev. Stat. § 414.625(2)(o).

<sup>44</sup> Or. Rev. Stat. §§ 414.625(2)(i), 414.627(a).

<sup>45</sup> Corrigan and Fisher at 9. For example, the Trillium Community Health Plan CCO has two separate community advisory councils, with one specifically designated to address the needs of the CCO’s rural population. *Rural Advisory Council Public Notices*, TRILLIUM COMMUNITY HEALTH PLAN, [http://trilliumchp.com/rural\\_advisory\\_council.php](http://trilliumchp.com/rural_advisory_council.php) (last visited July 10, 2015).

<sup>46</sup> Or. Rev. Stat. 414.627(2)(b). CACs are statutorily assigned other duties as well, including identifying and advocating for preventive care practices to be used by the CCO and publishing an annual report on the progress of the CAC’s community health improvement plan. Or. Rev. Stat. 414.627(2)(b).

<sup>47</sup> Or. Rev. Stat. § 414.625(2)(o)(E).

this need, the CCO arranged to place a community health worker in a local high school to help teenagers access not just health services, but also food and housing.<sup>48</sup> Another CCO, Primary Health of Josephine County, identified early literacy as one of the main areas on which to focus its activities.<sup>49</sup> To implement this service priority, Primary Health’s advisory council received funding from its CCO to purchase and distribute books to local children at places like food banks and community events.<sup>50</sup> Yet another CAC, PacificSource Columbia Gorge’s advisory committee, worked with its CCO to expand the population served by the local Meals on Wheels program to include patients of any age who were recently discharged from the hospital and were in need of nutritious food.<sup>51</sup>

As illustrated by Oregon’s CCO system, CACs can provide “an important mechanism for both consumer and community engagement, informing not only what consumers need for optimal health but what the community needs to support them.”<sup>52</sup> They also demonstrate the ability of consumer led groups within broader collaborative health collectives to drive improvements in population health through their knowledge of local social needs that contribute to health disparities and their motivation to develop and implement projects to address them. However, as discussed below, to succeed, CACs require significant resources and rules to insure that they are accessible and supportive to their participants and to give them the authority to obtain the information they need, as well as mechanisms to ensure that their feedback receives their host organization’s meaningful consideration.<sup>53</sup>

## B. MARYLAND: LOCAL HEALTH IMPROVEMENT COALITIONS

In 2012, Maryland launched its State Health Improvement Process (SHIP) with the aim of improving population health in every region of the state.<sup>54</sup> The SHIP encouraged the development of Local Health Improvement Coalitions (LHICs) in each of the State’s 24 counties and tasked the LHICs with addressing regional health needs. LHICs were initially led by local health officers and hospital systems and were intended to provide a space for health

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<sup>48</sup> Chris DeMars, *Oregon Bridges The Gap Between Health Care And Community-Based Health*, HEALTH AFFAIRS (Feb. 12, 2015), <http://healthaffairs.org/blog/2015/02/12/oregon-bridges-the-gap-between-health-care-and-community-based-health/>

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Meaningful Consumer Engagement – Consumer Advisory Committees, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/consumer-advisory-committees>, last viewed March 8, 2016.

<sup>53</sup> See §V(B)(1)(a) discussing Pierce County ACH’s proposed Community Advisory Committee.

<sup>54</sup> Local Health Improvement Coalitions, Maryland Department of Health and Mental Hygiene, Office of Population Health Improvement, [http://dhmh.maryland.gov/mchrc/Pages/chrc\\_support.aspx](http://dhmh.maryland.gov/mchrc/Pages/chrc_support.aspx), last viewed March 8, 2016.

departments, hospitals, and other community organizations and consumers to come together to identify, prioritize and address local health needs.<sup>55</sup>

To assist in planning and implementation of health improvement projects, LHICs applied for and received grants from the Maryland Community Health Resources Commission (CHRC).<sup>56</sup> At the same time, the SHIP identified thirty-nine metrics within five broad topical “vision areas” on which to gather data and which would be used by LHICs to measure the outcomes of LHIC projects and their coalition’s progress more generally.<sup>57</sup> These metrics ran from standard health measures, such as HIV incidence rate and life expectancy, to social determinants of health, like high school graduation rate.<sup>58</sup> These metrics are also aligned with the Healthy People (HP) 2020 objectives established by the Department of Health and Human Services.<sup>59</sup>

The SHIP and its LHICs focused particularly on collaborating to gather and share data regarding the common set of population health measures designated by SHIP.<sup>60</sup> Data tools and mapping technology were leveraged to create data dashboards that LHICs and the public could use to easily determine any region’s population health performance along the selected measures. This helped LHICs plan and review the effectiveness of their projects and provided a means of holding LHICs and the SHIP more generally accountable to their communities for achieving the health improvements at which their projects were aimed.

Building on this recognition of the importance of making population health data along a common set of metrics widely available, Washington State has undertaken two similar initiatives that enhance ACHs’ ability to plan their projects and monitor their success. To begin with, the statutorily established statewide Performance Measures Coordinating Committee was created and successfully completed its initial mission to select a common set of health-related metrics to be employed in various capacities to plan and measure the success of Healthier Washington initiatives.<sup>61</sup> More directly relevant to the ACH program, the State has contracted with the Center for Outcomes Research and Education “to support ACH community health

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<sup>55</sup> Maryland State Health Improvement Plan, Maryland Department of Health and Mental Hygiene, Office of Population Health Improvement, <http://dhmh.maryland.gov/ship/Pages/home.aspx>, last viewed March 8, 2016.

<sup>56</sup> *Id.* See also, Community Health Resources Commission, Maryland Department of Health and Mental Hygiene, <http://dhmh.maryland.gov/mchrc/Pages/Home.aspx>, last viewed on March 8, 2016.

<sup>57</sup> Maryland State Health Improvement Plan, Maryland Department of Health and Mental Hygiene, Office of Population Health Improvement, <http://dhmh.maryland.gov/ship/Pages/home.aspx>, last viewed March 8, 2016 (list of metrics is available by clicking the “Ship Measures” link on the page).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> Local Health Improvement Coalitions, Maryland Department of Health and Mental Hygiene, Office of Population Health Improvement, [http://dhmh.maryland.gov/mchrc/Pages/chrc\\_support.aspx](http://dhmh.maryland.gov/mchrc/Pages/chrc_support.aspx), last viewed March 8, 2016.

<sup>61</sup> Laws of 2014, ch. 223, § 6.

transformation by building a regularly refreshed, interactive dashboard tool.”<sup>62</sup> The tool will use data from the State’s Medicaid and Public Employees’ coverage programs, as well as de-identified aggregate data from the Department of Health.<sup>63</sup> In designing this tool, it will be important to ensure that some form of it is made available not just to ACH staff and decision-makers but also to the public at large. This will provide a valuable service to the community by helping consumers and advocates participate in ACH planning and hold their ACHs accountable for meeting their stated community health improvement goals.

### C. NEW YORK: PERFORMING PROVIDER SYSTEMS

Like Washington State, New York sought (and received) a §1115 demonstration waiver from CMS to build a system of regional health organizations that would select and administer waiver-funded Delivery System Reform Incentive Payment (DSRIP) projects.<sup>64</sup> Instead of ACHs, the regional entities created under the New York waiver to administer local health improvement projects are called Performing Provider Systems (PPSs). There are currently twenty-five PPSs throughout the State. Each generally serves a single county or multi-county region, with a few exceptions in areas such as New York City, where multiple PPSs were created because of the local population density.<sup>65</sup> Each PPS is required to have a public hospital system or other safety net provider as its lead organization to govern the system.<sup>66</sup> Many PPSs include other types of organizations like health homes, clinics, and community-based organizations.<sup>67</sup>

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<sup>62</sup> Using Data to Drive Health Transformation Healthier WA Funded-ACH Dashboard Reporting Tool, February 11, 2016, Nikki Olson, Associate Director (Tool Slides), at 3, *available at* [http://www.hca.wa.gov/hw/Documents/aim\\_core2ach.pdf](http://www.hca.wa.gov/hw/Documents/aim_core2ach.pdf).

<sup>63</sup> *Id.* at 3-4.

<sup>64</sup> Schuyler Center for Analysis and Advocacy, Overview of the Delivery System Reform Incentive Payment Program, May 2014, *available at* <http://www.scaany.org/wp-content/uploads/2014/05/DSRIP-Overview-May2014.pdf> at 1.

<sup>65</sup> A list of the PPSs with the counties they serve is found on the New York State Department of Health website at [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/pps\\_map/index.htm#top](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm#top).

<sup>66</sup> New York State Department of Health, DSRIP Frequently Asked Questions (FAQs) (“NYS DSRIP FAQ”), New York’s MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Program, August 2015, [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/dsrip\\_faq.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_faq.pdf) at 4; see also Partnership Plan Revised Special Terms and Conditions, October 15, 2015, *available at* [http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/2015-10-01\\_special\\_terms\\_and\\_conditions.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-10-01_special_terms_and_conditions.pdf), at 39-41. PPSs may have been designed to be based mostly around hospital hubs in part because a primary goal of the program is to reduce avoidable hospitalizations in the state by 25%. NY DSRIP Project Toolkit, *available at* [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/dsrip\\_project\\_toolkit.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf), at 2.

<sup>67</sup> See NYS DSRIP Project Toolkit at 10, 25, 37. NYS DSRIP FAQ. at 4, 6, 33. NYS

Similar to what is proposed under the Medicaid Transformation Waiver, New York State has approved a list of forty-four types of DSRIP projects.<sup>68</sup> PPSs then apply for funding to implement programs falling within the project category descriptions on the State list. Approved waiver-funded projects cover a range of issues, including several that focus on addressing various social determinants of health.<sup>69</sup>

New York State retained a contractor to review and make initial decisions about approving funding for PPSs' DSRIP project applications. Applications were then reviewed and partly rescored by a stakeholder group called the Project Approval and Oversight Panel (PAOP).<sup>70</sup> The PAOP is a unique feature of New York's DSRIP program, allowing stakeholder participation in a variety of activities concerning the approval of waiver funds for regional health system transformation and capital projects and assisting the State with DSRIP program oversight.<sup>71</sup> Significantly, PAOP members cannot have conflicts of interest regarding the project applications they review.<sup>72</sup> As a result, the PAOP's membership generally excludes individuals who are likely to have conflicts arise in the course of carrying out their duties, such as employees of insurance carriers, hospital systems or other healthcare provider groups. The PAOP includes a grassroots consumer member and a representative of the Medicaid consumer advocacy coalition, Medicaid Matters.<sup>73</sup>

In addition to its duties reviewing and rescored the initial set of PPS waiver project applications for DSRIP funding, the PAOP serves as a continuing advisory body to the State. In this capacity, the panel provides oversight and monitoring of the DSRIP program and meets with PPS lead organizations to get updates on how their DSRIP projects are progressing and on PPS'

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<sup>68</sup> Performing Provider System Projects: Tackling the Health Needs of the Communities, DSRIP Data Brief, Medicaid Institute at United Hospital Fund, January 16, 2015, *available at* <https://www.uhfnyc.org/publications/881032>, January 16, 2015, at 2.

<sup>69</sup> *Id.* at 3.

<sup>70</sup> DSRIP Project Approval and Oversight Panel (PAOP) Training (PAOP Training), Public Consulting Group, January 2015 at 10, *available at* [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/paop\\_mrt\\_presentation.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/paop_mrt_presentation.pdf).

<sup>71</sup> PAOP Training at 11.

<sup>72</sup> *Id.* at 12-13.

<sup>73</sup> DSRIP Project Approval and Oversight Panel Member List, [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/project\\_member\\_list.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/project_member_list.htm), last viewed on March 8, 2016. Notably, while it's certainly helpful to have a grassroots consumer on the PAOP, we strongly suggest that any ACH-related governing or advisory body allow for at least two consumer members. "Lone consumer advocates who sat on SIM tables reported feeling isolated or feeling that their position was more of a token gesture that was not intended to provide input or help shape the direction of the program." Evaluating State Innovation Model (SIM) Grant States: A Scorecard for Consumer Advocate Engagement, FamiliesUSA, September 2015, *available at* [http://familiesusa.org/sites/default/files/product\\_documents/HST%20SIM%20Scorecard%20brief\\_web.pdf](http://familiesusa.org/sites/default/files/product_documents/HST%20SIM%20Scorecard%20brief_web.pdf), at 5.

performance in meeting their goals.<sup>74</sup> Mid-way through the waiver's 5-year life-span, the PAOP convenes to assess and make recommendations for changes to PPSs and their projects.<sup>75</sup>

PPSs do not have specific requirements to include grassroots consumers in their governing bodies or to engage in particular types of consumer engagement activities. It should thus not be surprising that local advocates report that the PPSs often don't include grassroots consumers in their governance structures and that the PPSs vary significantly in the extent and nature of their consumer engagement activities. This counsels that Washington State decision-makers give strong consideration to promoting uniform statewide baseline requirements for ACHs to engage consumers in their governance and operations.

To recap, at least one feature of New York's overall DSRIP/PPS program is particularly worth considering for adaptation elsewhere - the PAOP. PAOPs are worth exploring as a means of bringing consumers and other stakeholders into the State's part of planning and implementing the Medicaid Transformation Waiver's regional Medicaid Transformation Project Initiative. While ACHs provide ample opportunities for including consumers in their governance and operations, the State has not so far indicated an intention to employ a panel or work group of stakeholders to assist with project approval decisions and ongoing monitoring and oversight of the program more generally. New York's PAOP offers an interesting model that could be easily adapted to enlist consumers and other stakeholders in guiding the Medicaid Transformation Project Initiative from the State level of the program, just as ACHs can do the same at the regional level.

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<sup>74</sup> Delivery System Reform Incentive Payment (DSRIP) Program Project Approval and Oversight Panel, Briefing for the DSRIP Project Approval Panel, January 11, 2016, (PAOP Briefing), January 11, 2016, *available at* [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/paop/docs/2015-01-21-22\\_pre\\_jan\\_briefing.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/paop/docs/2015-01-21-22_pre_jan_briefing.pdf), at 29.

<sup>75</sup> *Id.*

## IV. PRINCIPLES OF COMMUNITY PARTICIPATION AND PROMISING PRACTICES IN SELECTED ACHS

### A. INTRODUCTION

To promote consumer engagement and public accountability in ACHs, NoHLA and Washington CAN! propose a set of Principles for Community Participation for Accountable Communities of Health (attached as Appendix A). We have divided these principles into five primary domains -- community engagement, racial/health equity, accountable governance, accessibility, and transparency. Each domain is characterized by an overarching principle and includes a series of more concrete recommendations for ACHs to adopt. This section of the report reviews each of these domains, explaining some of the specific standards we ask ACHs to meet to demonstrate a commitment to these principles, and highlighting promising practices and policies adopted by at least one of the four ACHs examined in preparing this paper (Cascade Pacific, King County, North Sound, and Pierce County).

### B. PRINCIPLES FOR COMMUNITY PARTICIPATION

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#### 1. CONSUMER ENGAGEMENT

*The voices of diverse members of the community served by the ACH and most in need of its services are included in every level of the ACH's governance, planning, and other activities. Representation of consumers by professional advocates in the ACH's work and decision-making is not substituted for giving seats at the table to low-income consumers themselves in these conversations and decisions.*<sup>76</sup>

It is hardly a new insight that health system programs, like ACHs, need to include the voices of the health care consumers they serve in decision-making and planning to ensure the quality of the decisions they make, to be accountable to the communities they are created to serve, and as a matter of simple justice.<sup>77</sup> To begin with, ACHs are charged with identifying their regional

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<sup>76</sup> The italicized text at the beginning of each part of the “Principles for Community Participation” is the overarching Principle for the domain in question, found in our Principles for Community Participation in Appendix A.

<sup>77</sup> See, e.g., Meaningful Consumer Engagement: A Toolkit for Plans (“Meaningful Consumer Engagement”), Provider Groups and Communities, The Transformative Power of Consumer Engagement, Community Catalyst, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>; Consumer Advisory Board Handbook, The Massachusetts Department of Public Health Office of HIV/AIDS, January 2011, downloadable at <http://www.mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids/advsvry-grps/statewide-consumer->

health needs and developing a plan to address those needs according to local priorities. But, a community's health needs and priorities are not determinable solely by experts using objective metrics on which all can agree. To the contrary, in carrying out its duty to assess its community's greatest health needs and priorities, an ACH must necessarily include the full range of voices, experience and perspectives of the individuals who make up that community. Indeed, members of groups experiencing the greatest disparities in health outcomes and health care access often have very different personal experiences related to health and the health care system than the government officials and health system managers who make up a large part of ACH boards. Those bodies simply cannot make fully informed decisions about how to improve their communities' health without the perspective of the members of their communities with the greatest needs for health improvement.

Second, while many sectors, such as local government, public health departments, Medicaid managed care organizations, and local hospitals (among others) will have a claim for representation within their local ACH, the group that all of these sectors have in common is the consumers they serve in their communities. Almost as a definitional matter, ACHs cannot be accountable to their communities in making decisions about how to address their communities' health if they don't include the voices of the individuals who comprise those communities and whom their programs are designed to help.

Perhaps most significantly, excluding grass-roots health care consumers from ACH decision-making, planning and oversight threatens to perpetuate systemic racism and other forms of discrimination that have been and continue to be endemic to the health care system. As discussed in more detail below, members of groups suffering from health disparities, such as racial and ethnic minorities, people with low income, immigrants, older adults, persons with disabilities, and members of the LGBTQ communities, have not historically been afforded the chance to participate on equal footing in decisions affecting them and their communities that have been made by other members of the health care system. ACHs must seek to avoid perpetuating these systemic inequities and include in their planning and in their decision-making bodies consumers belonging to groups that have often been excluded from participating in health system planning on an equal basis.

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[advisory-board.html](#) as SWCAB Handbook, at 7; UCSF Center for Excellence in Primary Care, Patients as Transformation Partners, <https://cepc.ucsf.edu/patients-transformation-partners> (last viewed April 27, 2016).

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a. ALLOCATING SEATS ON ACH DECISION-MAKING BODIES TO LOW-INCOME CONSUMERS

ACHs have a broad spectrum of options available to them in creating governance structures, and this paper does not seek to promote a particular governance format. However, to enable members of populations most in need of and impacted by ACH activities to have a meaningful role in ACH decisions and activities, ACHs must allocate specific meaningful numbers of the seats on their governing and other decision-making bodies to low-income consumers -- not just advocates who seek to *represent* the consumer perspective. Similar requirements are found in other health programs and systems serving low-income and vulnerable populations.<sup>78</sup> We recommend that at least 10% of the seats on an ACH's governing bodies and its committees and work groups responsible for making most substantive decisions and recommendations about governance, priorities and activities should be reserved for low-income consumers.

### Promising Practices

**CONSUMER PARTICIPATION IN ACH DECISION-MAKING BODIES** – The **King County ACH** and **Pierce County ACH** have specifically allocated seats on their governing bodies for consumers, and the **North Sound ACH** has one grassroots consumer serving on its governing body.<sup>79</sup> The **King County ACH** has allocated two seats on its governing body, the ACH's "Interim Leadership Council," to "[c]ommunity member(s) impacted by health/health-related inequities."<sup>80</sup> The ACH has also agreed to include such community members in its Community/Consumer Voices (consumer engagement) and Regional Health Improvement Plan (RHIP) Workgroups, which are both open to the public, although the RHIP has been on hiatus

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<sup>78</sup> For example, Federally Qualified Health Centers, which are funded to serve low-income populations, are required to have governing boards a majority of the seats on which are filled by "individuals who are or will be served by the center and who, as a group, represent the individuals being or to be served in terms of demographic factors, such as race, ethnicity, sex." 42 C.F.R. 51c.304(b). Managed Care Health Plans designed to provide integrated services to individuals who are dually eligible for Medicaid and Medicare services are required in several states to create diverse beneficiary advisory committees that offer a means of bidirectional communication with the health plan's Board. See *A Seat at the Table: Consumer Engagement Strategies Essential to the Success of State Dual Eligible Demonstration Projects*, Alice Dembner, Carol Regan, May 2013, at 3. And, each of Oregon's Coordinated Care Organizations (which offer Oregon Health Plan Medicaid coverage to local Oregonians) is required to have a Community Advisory Council, a majority of whom are low-income health care consumers from the CCO's region. Or. Rev. Stat. 414.625(o), .627.

<sup>79</sup> To be clear, this section focuses on the participation of grassroots consumers in ACHs' governing boards and committees, not just individuals who serve on an ACH body as a consumer advocate in a professional capacity. All four ACHs have consumer advocates on their boards and/or work groups or committees who participate in a professional capacity.

<sup>80</sup> King County ACH Interim Leadership Council Charter, <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~media/exec/HHSttransformation/ACH-Charter.ashx>, (King County ILC Charter) last viewed July 21, 2016, at 4.

for several months.<sup>81</sup> Until this month, the “Community” seats on the ILC remained unfilled. Two consumer advocates were recently appointed to fill these ILC seats on an interim basis, pending the anticipated development and implementation of a process to recruit, vet and select grassroots consumers to serve on the Council.<sup>82</sup> Like King County, the **Pierce County ACH** has allocated two of the 23 seats on its governing body, the Interim Board of Trustees, to Consumer/Community members.<sup>83</sup> Low-income consumers were appointed to both of these positions when most of the rest of the Trustee seats were filled by the Pierce County ACH. While specific consumer seats have not been allocated on the Pierce County ACH’s committees and work groups, there is no rule excluding the public from participating in any of these groups, and the ACH has affirmatively invited anyone interested to participate in some of its committee meetings, including in the Pierce County Health Innovation Partnership and the ACH’s ad hoc work group convened to recommend a health improvement project that the ACH should develop and pursue this year. The Innovation Partnership is the ACH’s Steering committee and served as a *de facto* governing body for the ACH until the Interim Board of Trustees was seated.<sup>84</sup>

Meetings of the **Pierce County** Health Innovation Partnership (the ACH’s steering committee) and the **Cascade Pacific Action Alliance’s** Coordinating Council (its governing board) are not only open to the public, but all attendees are invited to ask questions and make comments on all matters under consideration. Similarly, when these bodies make substantive decisions, as a matter of practice, participation is not limited to a static list of appointed or elected members.<sup>85</sup> Also, while the CPAA’s committees do not have specific seats allocated for

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<sup>81</sup> *Id.* at 4,7. The RHIP is currently on hiatus, while the ACH reassesses what the State’s requirements are for developing an RHIP and how community voices may be employed in this process. The CCV work group had been on hiatus for several months, but after meeting on July 7, 2016, it recommenced its activity.

<sup>82</sup> It should be noted that one of the consumer advocates who was appointed to fill the “Community/Consumer” seats on the ILC on an interim basis is an employee of Northwest Health Law Advocates (NoHLA), an author of this paper. The other interim ILC appointee to a Consumer/Community seat is an employee of the Puget Sound Advocates for Retirement Action (PSARA), which subcontracts with the paper’s other author, Washington CAN! to organize and promote engagement of older adults and persons with disabilities in ACH activities. NoHLA and PSARA staff agreed to these interim appointments to provide for a greater presence representing consumer perspectives while the ACH moves to recruit and seat grassroots consumers who would replace them with a target of seating such grassroots consumers on the ILC within three months.

<sup>83</sup> Accountable Community of Health Readiness Proposal (PC ACH Designation Portfolio), Tacoma-Pierce County Health Department and the Pierce County Health Innovation Partnership, <http://www.tpchd.org/files/library/589531489c725b3b.pdf>,

<sup>84</sup> PC ACH Designation Portfolio at 5 and 6.

<sup>85</sup> The Pierce County Health Innovation Partnership had a formal list of organizational members. PC ACH Designation Portfolio at 11. However, as a matter of practice, its meetings are open to the public, no one is excluded from participating in discussions, and anyone who has attended at least three of the Partnership’s meetings may participate in the group’s decisions. Similarly, the CPAA has a specified list of members for its governing council. See CPAA Council Roster at <http://crhn.org/pages/wp-content/uploads/2015/06/Copy-of-CPAA->

consumers, attendance is generally open to anyone interested, and listed members are encouraged to invite new participants.

**CONSUMER ADVISORY COMMITTEES** – Some non-ACH organizations have found it helpful to create advisory committees comprised mostly or wholly of consumers to provide a structured means of gathering and providing diverse consumer guidance to their decision-making bodies.<sup>86</sup> As discussed above, **Oregon’s CCOs** are each required to have at least one Community Advisory Council, the majority of the seats of which are allocated to consumers.<sup>87</sup> Similarly, the **Pierce County ACH** has indicated its intention to form a community advisory board, and it is currently in the process of creating the rules that will govern that body’s structure and operations and the solicitation and review of applications for membership in the advisory board.<sup>88</sup> The Principles for Community Participation in ACHs outlined in this paper (see Appendix A) do not recommend for or against ACHs creating a consumer advisory council (CAC). A CAC can provide a good means of bringing a more diverse set of perspectives to the table than can be represented by a couple consumers holding seats on an ACH board. It can also offer a venue for developing consumer leadership for members who might like to join their ACH’s board or take other leading positions in ACH functions. In creating the parameters for a CAC’s role and authority, it can be helpful to give the CAC some substantive responsibilities beyond simply providing feedback to the ACH when asked. This can serve to ensure both that the resource found in CAC members’ diverse experiences is put to best use and that CAC members understand that their perspective is valued and utilized in a substantive way by the ACH that is integral to the ACH’s role in their community.<sup>89</sup> On the other hand, in order to be effective, a

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[Council-Roster-20150817.pdf](#), last viewed on February 28, 2016. However, decisions are made by consensus. Cascade Pacific Action Alliance Designation, June 19, 2015, [https://crhn.org/Files/ach/CPAA\\_DesignationProposalPortfolio.pdf](https://crhn.org/Files/ach/CPAA_DesignationProposalPortfolio.pdf) at (CPAA Designation Portfolio) at 14. Also, the Council’s written decision-making procedure states that any interested party in attendance can participate in CPAA Council meetings, but only Council members may vote. However, as a matter of practice, we have not observed an attempt to exclude non-members from participating in votes. Nor are discussions cut off, when a consensus is not initially reached because non-council members raise concerns about a proposed decision.

<sup>86</sup> For example, Washington State’s Behavioral Health Organizations (BHOs), which are quasi-governmental managed care entities that contract with the State’s Department of Social and Health Services to administer some of its public behavioral health programs, are each required to maintain an advisory board the membership of which broadly represents the demographic character of the BHO’s service area and a majority of the members of which are individuals or the family members of individuals with lived experience with having a behavioral health condition, or who are recovering from behavioral health conditions. See WAC 388-865-0232 (generally describing BHOs), -0252 (describing BHO advisory board), *announced in* WSR 16-13-087, June 15, 2016, available at <https://www.dshs.wa.gov/sites/default/files/SESA/rpau/documents/103P-16-13-087.pdf>.

<sup>87</sup> Or. Rev. Stat. § 414.627(1)(a).

<sup>88</sup> PC ACH Designation Portfolio at 9, 12.

<sup>89</sup> For example, the CACs for Oregon’s CCOs are statutorily assigned the duties of “[o]verseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and

CAC must have the authority to get the information it requires to make informed decisions and recommendations and carry out any other duties assigned to them. Guarantees must also be made that the CAC's views will be communicated to and receive meaningful consideration from its ACH's staff and decision-making bodies. CACs can also be resource-intensive to staff and support. And, because participation in a CAC requires a substantial commitment from its members, it can be harder to fill out a CAC adequately than it can be to find handful of consumers to serve on a governing body or a work group or two.<sup>90</sup> CACs may thus provide an effective means of engaging consumers in ACH decisions and activities for some, but there may be other means that will serve the same purposes for other ACHs.

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b. MULTI-TIERED ENGAGEMENT

Community Catalyst<sup>91</sup> has noted that:

*Successful consumer engagement requires ... "delivery systems") to employ a "ladder of engagement" that acts to solicit and address the input of consumers who have varying levels of capacity and desire to make recommendations for delivery system improvement.*<sup>92</sup>

Although this recommendation was made with an eye to engaging consumers to work within health plan and provider group advisory bodies, its rationale applies equally to ACHs. Placing consumers on an ACH's governing board is certainly necessary, but is in no way sufficient by itself to capture the diversity of experiences and perspectives of low-income consumers whose voices must be included in ACH decision-making to make it fully informed by and accountable to the people it means to serve. By offering a variety of opportunities for consumers to get involved in and provide feedback to their ACH, with varying subject matter and required commitments, ACHs can best insure that a wide range of individuals can find a way to become involved that best suits their interests and capacity. To this end, ACHs should consider employing a broad spectrum of engagement strategies, from comment fields on their websites, to community meetings or focus groups, to ad hoc work groups convened to address specific issues, all the way to regular consumer participation on ACH Boards, work groups and other bodies.

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health care system service plan for the community served by the coordinated care organization." Or. Rev. Stat. § 414.627(2)(b).

<sup>90</sup> A Case Study on Collaborative Governance: Oregon Health Reform and Coordinated Care Organizations, Oliver John Droppers V, Portland State University, June 2, 2014, [http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=2824&context=open\\_access\\_etds](http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=2824&context=open_access_etds) at 145-146.

<sup>91</sup> Community Catalyst is a Boston-based national nonprofit health care policy and advocacy organization that advocates for quality affordable health care for all, including robust consumer engagement in health programs. Community Catalyst administers the grant that funded the research and writing of this paper.

<sup>92</sup> Meaningful Consumer Engagement Toolkit, The Ladder of Engagement, at 3.

## Promising Practices

**CASCADING ENGAGEMENT:** In its design grant contracts with the ACHs, the **Health Care Authority** states that each ACH’s governance model and engagement strategy should reflect, among other things, “cascading levels of engagement” to bring forward the voice of consumers/community members, in addition to multi-sector representation that exists within the ACH.”<sup>93</sup> This is similar to multi-tiered or “ladder of engagement” strategies that we and Community Catalyst call for to facilitate the involvement of the broad diversity of consumers who wish to become engaged in their ACHs.

**COMMUNITY MEETINGS:** The **CPAA, North Sound ACH, Pierce County ACH and King County ACH** have all held community meetings to provide information about the ACHs to members of their communities and to seek feedback to inform their community engagement and priority setting. It is important though to define the aims of these meetings in advance and be clear to the public about their nature. For example, in late 2014, the **North Sound ACH** held a series of public fora, in each of the five counties that comprise the ACH’s region (with one forum each in of four North Sound counties and two meetings in one county). Attendance by members of the community who were not participating in a professional capacity was actively solicited in at least four of the six meetings. Similarly, the **CPAA** sponsored a forum together with community allies on adverse childhood experiences (ACES) to which members of the general public were invited. But, even when members of the general public have been invited to ACHs’ public meetings, sometimes only a relatively small number of them have attended.

That does not mean that there is no role for meetings oriented primarily at professionals involved in the health care, government and social service sectors. At a **King County ACH “Roundtable” Community Meeting** that was aimed at these groups and held in early 2016, there was resounding agreement expressed by attendees that the grassroots consumers who make up racial and other minorities who experience significant health disparities should take the lead in shaping their ACH and that community organizing is required to engage such consumers to take action. If this meeting prompts a multi-sector collaboration in engaging grassroots consumers themselves to become involved, the effort will have been well worth it.

**PRESENTATIONS WITH COMMUNITY ORGANIZATIONS:** ACHs can also more nimbly participate in community meetings and increase the likelihood that they will garner an audience that includes health care consumers who are not participating in a professional capacity by sending out representatives to speak at meetings of community organizations in their area. The **CPAA** and the **North Sound ACHs** have both sent backbone organization staff and governing

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<sup>93</sup> Design Grant Contract, Schedule A at 20.

Council members to attend community organization meetings where they have provided information to local consumers about their ACHs and sought feedback on their health priorities.<sup>94</sup> Consumers who are already involved with a nearby organization may feel more comfortable and more easily able to attend a meeting there than they would going to an unfamiliar meeting location that is not near where they live, at a meeting staffed by people they don't know. As a result, sending ACH staff to present and participate at local community organization meetings can be particularly useful in ACHs with large geographic areas. An additional benefit is that presenting about your ACH at a meeting organized and convened by another organization is likely to require less time and other resources from the ACH, than are likely to be required for your ACH to organize and put on a community outreach meeting of its own.

**LOCAL COMMUNITY FORA:** In addition to hosting or presenting at community meetings on an ad hoc basis, ACHs should consider if there are existing community organizations or coalitions that meet on a regular basis and that are able and willing to provide a forum for regular public discussions of ACH matters. Such an arrangement has been built into the structure of the **CPAA**. Specifically, each of the seven counties that comprise the **CPAA** has a community "forum" that meets regularly to discuss local health concerns, including ACH activities.<sup>95</sup> The CPAA's backbone organization sends a staff member to the meeting of each of these bodies, and participants in the local fora send representatives to the CPAA's Coordinating Council. This provides a ready channel for communications between the two tiers of organizations and a method for representing the ACH's local communities' perspectives in the regional ACH Council. Particularly for geographically large, multi-county ACHs, employing local coalitions, health collaboratives, or similar groups in this way can provide a means of involving community- members in ACH planning that is more accessible to consumers and involves the local programs and institutions with which they are more likely to be familiar.

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### C. CONSUMER ENGAGEMENT WORK GROUP AND PLAN

A detailed multi-level consumer engagement plan requires significant preparation to create and implement. To this end, we recommend that each ACH creates and operates a committee, work group or other body specifically charged with addressing consumer engagement in the ACH. In doing so, the ACH must ensure that the group's mandate is clearly stated and that specific commitments are made to ensure that the group receives the information it needs to do its assigned job and that ACH staff and governing bodies give meaningful consideration to the

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<sup>94</sup> CPAA Designation Portfolio at 65; North Sound Accountable Community of Health ACH Readiness Proposal, June 15, 2015 (North Sound ACH Designation Portfolio), *available at* [https://crhn.org/Files/ach/CPAA\\_DesignationProposalPortfolio.pdf](https://crhn.org/Files/ach/CPAA_DesignationProposalPortfolio.pdf), at 38.

<sup>95</sup> CPAA Designation Portfolio at 65, 68.

work group's recommendations. ACH backbone organization staff for each of the four ACHs discussed in this paper have acknowledged the need for grassroots participation in ACH operations. But they have also uniformly reported that the level of funding they received (from HCA) for FY2015 made it challenging for them to commit significant financial resources to conducting robust grassroots consumer engagement during that year. Several ACH staff and Board members have also expressed a desire for assistance in gaining expertise and training to guide them in these efforts. With these adverse institutional pressures, it has been easy for ACHs to delay engaging in in-depth planning on how its intentions to include grassroots consumers in its decision-making bodies and activities will be realized. It is our hope that the significant increases in ACH funding provided by HCA in 2016<sup>96</sup> will relieve some of these obstacles to consumer engagement. Also, HCA has contracted to provide ACHs technical assistance in several areas, including consumer engagement. However, funding is still limited compared with the need for ACH services, and increased funding and technical assistance by themselves won't get the job done of creating and implementing a fleshed-out consumer engagement program. By clearly allocating to a specified ACH work group the responsibility for addressing consumer engagement within the ACH, you increase accountability for carrying out this mandate. Also, by assigning this task to a group, rather than an individual, you make it possible to leverage a wider set of resources to the task and enable the plan to be developed and implemented in a forum that is accessible to the public and that can easily include consumers.

Merely allocating responsibility to a defined body will not alone ensure that its work is done, especially when additional expertise and resources may be needed to complete this work. Consequently, we recommend that ACHs develop a written consumer engagement plan, with the input and participation of consumers from their communities, outlining concrete aims for consumer engagement, the ACH's intended strategies to reach those aims, the timeline for doing so, the resources required to carry out these strategies, and how those resources will be delivered.

### Promising Practices

The **King County ACH** has convened a **Consumer/Community Voices Work Group** charged with addressing the need for the ACH to engage members of the ACH's communities facing health disparities and likely to be most impacted by ACH activities. This group initiated discussions

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<sup>96</sup> As noted above, ACHs received \$100,000 - \$150,000 for FY 2015 under their design and pilot grant contracts. Design Grant Contract, § 2.2, at 4; Pilot Grant Contract, § 2.2, at 4. The first amendment to these contracts provided for an additional \$150,000 after each ACH was formally designated as an ACH. ACH Contract Amendment 1, at 2, No.2. And, the amendment to these contracts for FY2016 provides for ACHs to receive \$330,000. ACH Contract Amendment 2, at 2. No.2.

about creating seats on the ACH’s Interim Leadership Council specifically for consumers and including consumers in the ACH’s RHIP work group, resulting in formal recommendations to this effect, which were adopted by the ILC. The work group also helped to organize the Community Roundtable hosted by two ILC members representing consumer-focused coalitions, the Regional Equity Network and the Healthy King County Coalition. The **Pierce County ACH** has a similar community engagement work group, which organized a community “summit” that was mostly focused at and attended by individuals participating in a professional capacity, but that did include some other members of the public among its participants. The work group is also moving to create the infrastructure for the ACH’s Community Advisory Board.<sup>97</sup>

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d. RESOURCES AND SUPPORT FOR MULTI-TIERED ENGAGEMENT

i. **Provide support for and arrange activities to facilitate consumer engagement.**

A well thought out and informed consumer engagement plan will require specific strategies and resources to insure its success at making ACH bodies and activities inclusive of a diverse array of consumers. Daytime ACH meetings that require significant travel to attend may suit individuals participating as health system professionals who are paid to participate generally during their normal work day, and who may receive reimbursement for travel expenses. However, the circumstances of these meetings may pose significant obstacles to grass-roots consumers who would otherwise want to participate, but who would need to miss work or child care responsibilities to attend daytime workweek meetings, and who may be hard pressed to travel to meetings or pay for parking when required. To mitigate and overcome these barriers, resources must be earmarked and devoted to facilitating consumers’ participation in ACH meetings and other activities. Transportation and, when necessary, parking should be provided to or paid for to consumer participants. Food should be provided at meetings of significant length, as well as child care. Interpreters, translations, and alternate format (e.g., Braille or large type) materials should be provided for languages used by a significant population in the area in which ACH activities are being conducted, as well as for other languages when requested by an individual wishing to attend an ACH activity.

And, just as ACH members who serve in a professional capacity are paid (their salaries) to participate, a stipend should be provided at least to consumers who regularly participate as members of ACH work groups and Boards to reimburse them for their work and demonstrate that the ACH values their time and efforts. All of these supports will be of little use, however, if

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<sup>97</sup> Committees & Workgroups, Pierce County Accountable Community of Health and Health Innovation Partnership, March 31, 2015, at 2 (listing area of operation and co-chairs for the work group); PC ACH Designation Portfolio at 13-14 (discussing community summit).

consumers cannot attend ACH meetings that are scheduled when they must be at (predominately day-time) jobs or engaged in other day-time activities. This means that at least some ACH meetings and activities should be scheduled at times and places that are accessible to individuals who are not ACH professionals (i.e., on evenings or weekends).

Particularly for geographically large ACHs, meetings or other activities should not always be held in a single location, but at least sometimes rotated to promote facility of attendance by local consumers who might otherwise be unable to travel to attend. Focused outreach should be made to communities that may be more difficult to reach and that are not already regularly and tightly engaged with the ACH's backbone organization. ACHs may well be able to leverage partners' resources to supply or fund some of these supports (e.g., a partner organization might be willing to provide space for an ACH activity free of charge in a location where there is free parking, and/or donate food for the meeting). Indeed, a local community organization that serves a particular segment of the community (e.g., a concentration of immigrants from a particular country) may be best situated to conduct outreach to, offer an accessible space with which community members are familiar, and help run activities to engage the people with whom they work.<sup>98</sup> But, ultimately ACH's themselves bear the responsibility of ensuring that consumers receive the supports they need to participate in ACH activities and that those supports are adequately resourced.

**ii. Budget in advance for adequate funding earmarked for consumer engagement.**

ACHs should explicitly budget funds designated for carrying out needed consumer engagement activities each year. ACHs are required to submit to HCA a budget breakdown for their spending and anticipated income through FY2018,<sup>99</sup> but they are not required to break out a line item for consumer engagement within those budgets. The lack of a budget entry explicitly devoted to consumer engagement certainly doesn't preclude an ACH from spending its funds on engagement activities. For example, funds allocated under a budget line item for backbone organization or administrative staff could be spent on having staff organize and conduct consumer outreach and engagement. However, while resources like staff time and office supplies (e.g., for copying/printing consumer outreach materials) may be able to be funded from more generic budget categories, other consumer engagement expenses, such as payments for food for lengthy meetings and stipends for low-income consumer Board members, may not be able to be so easily shoe-horned into existing budget entries.

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<sup>98</sup>Best Practices for Meaningful Consumer Input in New Health Care Delivery Models, Elna Nagasako, September 2012, available at [http://www.communitycatalyst.org/doc-store/publications/meaningfulconsumerinput\\_healthcaredeliverymodels.pdf](http://www.communitycatalyst.org/doc-store/publications/meaningfulconsumerinput_healthcaredeliverymodels.pdf) ("Best Practices"), at 6.

<sup>99</sup> ACH Contract Amendment 2, at 2, No. 4.

Consequently, we urge that ACHs include a specific line item for consumer engagement in their budgets, to help ensure that such funds will actually be available, able to be spent on a broad range of engagement activities, and used to engage consumers in ACH governance and operations.

The funding that most ACHs devoted to consumer engagement in 2015 was understandably limited, given that the base funding they received from HCA for the year was \$150,000 for each of the two “pilot” ACH regions (CPAA and North Sound ACH) and \$100,000 for each of the remaining “design grant” region ACHs (including the King and Pierce County ACHs). However, HCA has since awarded each of the ACHs \$150,000 after their designation as full-blown ACHs, and made an additional \$330,000 available to ACHs in FY 2016, exclusive of any other funding sources. As a result, ACHs will generally have \$330,000 or \$480,000 of HCA funding available this year to fund their activities.<sup>100</sup> While not all ACHs may choose to spend the entire award in 2016,<sup>101</sup> this level of funding ensures that all ACHs should be able to find significant financial resources to devote to consumer engagement during 2016. Acknowledging that ACHs may vary in the specific size of their budgets for this year and the level of non-HCA funding they receive, we propose that each ACH spend at least 10% of its gross annual income on consumer engagement activities. This will provide ACHs the ability to fund significant consumer engagement activities while only modestly impacting their overall budgets.

### Promising Practices

**Budgeting for Consumer Engagement** - The **King County ACH**, which has elected to devote its entire \$480,000 award from HCA to expenditures during FY2016, has adopted a budget

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<sup>100</sup> See Best Practices at 6.

<sup>101</sup> Each ACH became eligible for a one-time award of \$150,000 upon their designation, which took place between July of 2015 and January of 2016, depending on the ACH. As a practical matter, most or all of this money was unspent before or not even received by most ACHs in the “design grant” region ACHs until 2016. Under their funding contracts for FY2016, ACHs are awarded an additional \$330,000, which represents half of the \$660,000 each ACH is due to receive over the remaining three-year period (FY 2016 – 2018) of SIM Grant funding. In the absence of further funding, ACHs will then receive from the HCA an average of \$165,000 during each of the last two years of the SIM Grant period. If the Medicaid Transformation Waiver is approved, ACHs that serve as regional coordinating entities for the Transformation Project Initiative, may receive significant additional funds to administer the Medicaid transformation projects they select for waiver funding. Medicaid Transformation Waiver at 14-15 (possible ACH role as coordinating entities). However, some ACHs may choose not to budget spending the entire \$330,000 or \$480,000 they receive from HCA this year, either to provide for a more gradual funding decrease in later years, in case they do not receive the expected level of waiver funding in 2017, or to maintain more of a cushion to continue to support activities that cannot be funded by the waiver.

allocating \$45,000 for consumer engagement activities and another \$24,000 for a consumer engagement consultant during that year.<sup>102</sup>

**Newsletters** - The **CPAA and North Sound ACH** distribute e-newsletters on a monthly basis to lists of interested parties. **King County** sends out a monthly “Health & Human Services Transformation Update,” which includes information about the King County ACH’s work. So far, these transmissions have been used primarily as an educational tool, to keep interested professionals and members of the public abreast of ACH-related activities and the dates and times of upcoming Board meetings. However, with the proper distribution base and format, newsletters can be used as a tool to engage community members to become more involved in ACH functions.<sup>103</sup>

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<sup>102</sup> King County Accountable Community of Health Interim Leadership Council Meeting Materials, January 29, 2016, <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/leadership-council/~media/exec/HHStransformation/ACH-Meeting-Materials-Jan-2016.ashx>, at 9-10.

<sup>103</sup> Meaningful Consumer Engagement – Effective Member Newsletters, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/effective-member-newsletters>, last viewed March 7, 2016.

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## 2. RACIAL/HEALTH EQUITY

*Inequities in health outcomes and disparities in access to health care in Washington State often break down along racial and ethnic lines, with health inequities also being experienced by immigrants, older adults, persons with disabilities, and members of the LGBTQ community. The ACH explicitly recognizes that identifying and seeking ways to remedy these inequities and disparities are primary purposes of the ACHs. When the ACH makes decisions about policy and funding priorities and how those priorities are implemented, it makes a principled and concrete commitment to considering how these decisions offer opportunities to remedy these disparities, as well as what impact those decisions will have on health equity.*

There is a growing recognition that racial and ethnic disparities infect many critical areas of our lives, such as income, diet, housing, education, treatment in the criminal justice system, health, and access to health care.<sup>104</sup> Racial and ethnic disparities in health outcomes are prevalent both throughout the country and within Washington State. While the State's overall population health is above average compared with the rest of the country,<sup>105</sup> racial and ethnic minorities experience disproportionately negative health outcomes under a variety of measures, and they have worse access to health care than individuals who identify as white.<sup>106</sup> Other groups, such

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<sup>104</sup> See, e.g., Where Health Disparities Begin: The Role of Social and Economic Determinants – And Why Current Policies May Make Matters Worse, Steven H. Woolf, Paula Braveman, *Health Affairs* 30, no. 10 (2011), available at <http://content.healthaffairs.org/content/30/10/1852.full.pdf+html> (illustrating how racial disparities in education, income, diet and other social determinants impact racial disparities in health); Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action, Ingrid A. Binswanger, Nicole Redmond, John F. Steiner, and LeRoi S. Hicks, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 89, No. 1 (2011), available at [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3284594/pdf/11524\\_2011\\_Article\\_9614.pdf](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3284594/pdf/11524_2011_Article_9614.pdf) (examining how racial and ethnic disparities in the criminal justice system could impact health disparities); Diet-Related Disparities: Understanding the Problem and Accelerating Solutions, Jessie A Satia, *J. Am. Diet Assoc.* Vol. 109, No. 4, April 2009, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2729116/pdf/nihms106651.pdf> (importance of understanding how racial and ethnic diet disparities contribute to health disparities)..

<sup>105</sup> The Washington State Health Care Landscape, June 3, 2014, at 2, available at <https://kaiserfamilyfoundation.files.wordpress.com/2014/06/8599-the-washington-state-health-care-landscape2.pdf>.

<sup>106</sup> Addressing Health Disparities Through the Marketplace an Action Agenda for Washington State, Washington CAN! Alliance for a Just Society, February 2015 at 1-2, [http://allianceforajustsociety.org/wp-content/uploads/2015/02/2015.02\\_Health-Disparities\\_WA-2.20.20151-2.pdf](http://allianceforajustsociety.org/wp-content/uploads/2015/02/2015.02_Health-Disparities_WA-2.20.20151-2.pdf). support Disparities in Care 2014 report, Washington Health Alliance, <http://wahealthalliance.org/wp-content/uploads/2014/07/disparities-in-care-report-2014.pdf> at 4; 2015 Disparities in Care, Aiming for Health Equity in Washington State, Washington Health Alliance, <http://wahealthalliance.org/wp-content/uploads.php?link-year=2015&link-month=09&link=2015-disparities-in-care.pdf> at 4; New report finds disparities in health care a continuing problem in Washington State, Washington Health Alliance, <http://wahealthalliance.org/new-report-finds-disparities-in-health-care-a-continuing-problem-in-washington-state/>; Cultural Competency in Health Service and Care: A guide for Health Care Providers, June 2010, Washington State Department of Health,

as older adults, the LGBTQ population and persons with disabilities also experience health disparities.<sup>107</sup> While indisputably unjust, these disparities have serious financial consequences as well. According to the Joint Center for Political and Economic Studies, health disparities and the deaths that resulted from them cost our country \$1.24 trillion from 2003 – 2006.<sup>108</sup> Also, a failure to receive adequate quality care when a health condition first exhibits itself can result in more expensive and avoidably more intensive care later on.<sup>109</sup> And, as our population becomes more diverse, the consequences of health disparities are only likely to grow.

ACHs provide a unique and powerful vehicle for addressing racial and other disparities in the health care system on a regional basis throughout Washington State. We strongly urge ACHs to make addressing these disparities the polestar of their efforts to improve their region's health. To demonstrate this commitment, ACHs should explicitly establish health equity or addressing health disparities as a guiding aim for their activities (e.g., as part of the ACH's mission statement).

However, recognition of the problem posed by health inequities and a general commitment to combat them only takes you so far. State and local governments have begun to realize that an effective way to fight disparities and biases inherent in our society's social systems is to require public agencies to investigate and report on the impact of policy proposals on minority populations experiencing disparities.<sup>110</sup> Washington State has been a leader in this area. In 2006, the Legislature authorized the State Board of Health to complete a health impact review of any proposal for legislative and budgetary change, in collaboration with the Governor's

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<http://www.doh.wa.gov/portals/1/Documents/Pubs/631013.pdf> at 5 (list of racial disparities in health outcomes in Washington State).

<sup>107</sup> See, e.g., Invisible, Unequal, and Forgotten: Health Disparities in the Elderly, Monique M. Williams, Notre Dame Journal of Law Ethics & Social Policy, Vo. 21 No. 2, available at

<http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1145&context=ndjlepp>; Disability and Health, <https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health>, last viewed April 28, 2016 (individuals with disabilities are less likely to receive specified preventive health services and are at higher risk for poor health outcomes); Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S., Jen Kates, Usha Ranji, Adara Beamesderfer, Alina Salganicoff, and Lindsey Dawson, Issue Brief, Kaiser Family Foundation, July 2015, available at <http://kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/> (LGBT individuals face unique health challenges and increased health challenges, including worse physical health compared with heterosexual and non-transgender individuals).

<sup>108</sup> The Economic Burden of Health Inequalities in the United States, Thomas LaVeist, Darrell J. Gasking, Patrick Richard, September 2009, available at [http://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden\\_of\\_Health\\_FINAL\\_0.pdf](http://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden_of_Health_FINAL_0.pdf) at 1.

<sup>109</sup> Disparities in Care 2014 Report, Washington Health Alliance, July 2014, at 4, available at <http://wahealthalliance.org/wp-content/uploads/2014/07/disparities-in-care-report-2014.pdf>.

<sup>110</sup> Health Impact Reviews Procedures, Washington State Board of Health, at 1, available at <http://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/Procedures.pdf>.

Interagency Council on Health Disparities.<sup>111</sup> The focus of these reviews is “whether the proposal is likely to exacerbate or ameliorate health disparities, as well as to impact the social determinants of health.”<sup>112</sup> Similarly, the City of Seattle has created a Racial Equity Toolkit,<sup>113</sup> and King County has created an Equity Impact Review Tool,<sup>114</sup> that staff employ to determine the impact of proposed policy decisions on racial and other minorities experiencing inequities. These tools are particularly useful, not just to combat disparities, but also to promote diverse consumer engagement, as they require policymakers to actively engage members of communities impacted by disparities in discussions about the relevant decisions and how policy choices can be structured to undo broader inequities. To this end, we recommend that ACHs use a similar structured set of priorities and procedures to determine the impact of significant decisions about the ACHs’ policies and activities and when selecting projects to fund or undertake. To provide an example of how such a tool could be structured to be more useful to ACHs seeking to combat racial and other disparities, we have adapted Seattle’s Racial Equity Toolkit into a tool that employs the same methods, a number of the same questions, method, and some definitions listed in Seattle’s Toolkit, but that: a) focuses in parts more directly on health related issues and ACH activities; and, b) is applicable to a regional body’s policies and practices. See Appendix B. Individual ACHs may prefer to use the original Seattle Toolkit, King County’s EIR, or another similar rubric,<sup>115</sup> or to develop their own, which might be more or less detailed according to their individual needs. The bottom line is, for ACHs to succeed in improving their region’s population health and make progress in dismantling biases inherent in their regional health system, ACHs must consciously engage in a structured process to attack

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<sup>111</sup> RCW 43.20.285; *see also* Health Impact Reviews Procedures, Washington State Board of Health, at 1, *available at* <http://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/Procedures.pdf>.

<sup>112</sup> Health Impact Reviews Procedures, Washington State Board of Health, at 1 (emphasis added), *available at* <http://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/Procedures.pdf>.

<sup>113</sup> Racial Equity Toolkit to Assess Policies, Initiatives, Programs and Budget Issues, Seattle Race and Social Justice Initiative, [http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit\\_FINAL\\_August2012.pdf](http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf). A video explaining how the Seattle Racial Equity Toolkit has been used, why it has been embraced by the City of Seattle, and how its use has yielded benefits to the City and its communities is found at the Local and Regional Government Alliance On Race & Equity website at <http://racialequityalliance.org/2015/03/15/using-a-racial-equity-toolkit/>, last viewed on March 7, 2016.

<sup>114</sup> King County Equity Impact Review Tool, King County, revised October 2010, <http://www.kingcounty.gov/~media/elected/executive/equity-social-justice/documents/KingCountyEIRTool2010.ashx?la=en>. Examples of how the King County EIR Tool has been used may be found in Using Equity Impact Review Toolkit, February 2012, <http://www.kingcounty.gov/~media/elected/executive/equity-socialjustice/documents/KingCountyEIRToolExamples.ashx?la=en>.

<sup>115</sup> See, e.g., Housing Development Consortium Racial Equity Project Toolkit, downloadable at <http://www.housingconsortium.org/2014/12/17/racial-equity-project-toolkit/>; Racial Equity Toolkit – An opportunity to Operationalize Equity, Julie Nelson, Local and Regional Alliance on Race & Equity, September 2015, [http://haasinstitute.berkeley.edu/sites/default/files/gare-racial\\_equity\\_toolkit.pdf](http://haasinstitute.berkeley.edu/sites/default/files/gare-racial_equity_toolkit.pdf).

health disparities and engage historically disempowered minority groups when making significant policy and financial decisions.

### Promising Practices

Several ACHs have adopted policies or value statements establishing health equity and combating health disparities as core values. For example, the **North Sound ACH** begins one of its six “Guiding Principles” with the statement: “To improve overall community health we need to address upstream determinants of health and health disparities, and strengthen the system of home and community based supports that stabilize the health of our most vulnerable members.”<sup>116</sup> More explicitly and comprehensively, the **Pierce County ACH** has established health equity as the overarching “lens” through which all of its proposed substantive activities should be considered.<sup>117</sup> Perhaps the clearest assertion of an ACH’s intent to embrace health equity and combatting disparities as a central tenet of its vision is found in the **King County ACH’s ILC** charter, which includes the following in its list of core values:

**EQUITY.** Work intentionally to eliminate racial, ethnic, socio-economic and geographic disparities in health and well-being. Without this focus, there is a risk that current power dynamics and structural racism in health care and governmental entities will drive toward roles and governance structures that perpetuate rather than eliminate inequities. For any given issue, this requires looking at who decides, who provides, and who benefits or bears the burdens.

**ENGAGEMENT OF THOSE MOST AFFECTED.** Populations and communities in King County who are most impacted by health and health-related inequities (i.e., neighborhoods, low-income groups, communities of color, and people with disabilities, among others) should be among those who are influencing ACH development and associated strategies for improving their health and the health of their communities. Putting this value into practice will entail intentional development and resourcing of capacity and mechanisms that support two-way communication so that on-the-ground context expertise shall be included in ACH development, governance, decision-making, and initiatives.

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<sup>116</sup> North Sound Accountable Community of Health Common Agenda and Organizing Committee Roles, Responsibilities & Expectations at 2, *available at* <http://www.nsach.org/wp-content/uploads/2015/08/NSACH-common-agenda.pdf>.

<sup>117</sup> Confirmed Priorities for Pierce’s Accountable Community of Health, *available at* <http://www.tpchd.org/files/library/a4eb153cc06beec4.pdf>, last viewed on July 15, 2016.

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### 3. ACCOUNTABLE GOVERNANCE

*The ACH adopts a transparent identifiable set of procedures that lay out its conception of its role, how its bodies are constituted, how it makes decisions, and how it identifies and addresses possible conflicts of interest.*

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#### a. WRITTEN ACCESSIBLE GOVERNING DOCUMENTS

Each ACH will be best equipped to act in a way that is predictable, accessible to, and considered fair by members of its community if it has a written charter, bylaws, or similar documents laying out its structure, how members of its governing board and other bodies are chosen, and how its decisions are made. ACHs that incorporate as nonprofit corporations or other independent legal entities will generally be required to adopt governing documents that include much of this sort of information as a condition of their creation and/or application for tax exempt status.<sup>118</sup> Such documents must be made freely available to members of the public.

#### Promising Practices

**All of the ACHs** examined in this paper have some form of governing documents, although they vary in detail and the extent to which their parts are integrated together. The **King County ACH's Interim Leadership Council Charter** provides an example of a well-integrated governance document including everything from a brief history of the ACH, a detailed "Values" statement, a list of the ACH's initial work groups and their areas of operation, and the structure of the ACH's governing board, its composition, and how it conducts meetings and makes decisions. The **CPAA** also has a well-integrated set of governance documents; the charter for the CPAA's governing Council includes much the same types of information, including a detailed conflict of interest policy.<sup>119</sup> The **North Sound ACH** has a detailed set of governing provisions, which are distributed between several documents. All of these materials are posted on the **King County ACH, CPAA and North Sound ACH** websites.<sup>120</sup>

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<sup>118</sup> See, e.g., RCW 24.03.025, .070 (respectively laying out requirements for articles of incorporation and bylaws for Washington State nonprofit corporations); RCW 25.15.018, .071 (laying out respectively statutes governing company agreements and certificates of formation for Washington State limited liability companies); Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code, Rev. December 2013 (Form 1023), <https://www.irs.gov/pub/irs-pdf/f1023.pdf>, at 2, Part II (requesting copies of applicant's articles of incorporation, articles of organization, articles of association, trust agreement, and/or bylaws).

<sup>119</sup> See Cascade Pacific Action (CPAA) Council Charter at [http://crhn.org/pages/wp-content/uploads/2015/06/CPAA-Charter\\_201603.pdf](http://crhn.org/pages/wp-content/uploads/2015/06/CPAA-Charter_201603.pdf) (CPAA 2016 Charter), last viewed on July 19, 2016.

<sup>120</sup> The King County ACH Interim Leadership Council Charter is found at [http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~media/exec/HHStransformation/ACH-Charter.ashx/](http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~/media/exec/HHStransformation/ACH-Charter.ashx/). The CPAA Council Charter is found at

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## b. DECISION-MAKING

The ACH's governing body's operational procedures should provide consumer voices with a meaningful role in decision-making that supports them in participating in the body's discussions and decisions and that cannot be easily overruled by other stakeholder participants. For example, inclusion of a single consumer representative on a governing body can make that individual feel isolated and squelch their desire to express their perspective in discussions.<sup>121</sup> Also, even if more than one seat on a board or work group is allocated to grassroots consumers, consumers are unlikely to command a significant plurality (much less a majority) of voting members of a body (at least, based on current ACH practices). As such, bare majority rule **should not** be the means by which the ACH's governing body makes decisions. Conversely, consensus-based decision-making strategies by their nature require the meaningful consideration of all parties' viewpoints and their general agreement. Some might suggest that use of consensus-based decision rules runs the risk of making it inordinately difficult for ACHs to make some needed controversial decisions. However, this has not borne out in practice, as three of the four ACHs considered in this paper have successfully used some form of consensus-based decision-making.<sup>122</sup>

### Promising Practices

The **King County** and **CPAA ACHs'** governing bodies both employ some form of consensus-based decision-making to good effect. The **King County ACH's** Interim Leadership Council uses a "consensus minus 1" process through which the ILC attempts to reach a consensus on each matter under its consideration, but if that proves elusive, a decision can still be made if only one Council member who is present opposes the consensus in favor of the decision. If more

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[http://crhn.org/pages/wp-content/uploads/2015/06/CPAA-Charter\\_201603](http://crhn.org/pages/wp-content/uploads/2015/06/CPAA-Charter_201603), last viewed July 19, 2016; other CPAA governance materials are listed and can be downloaded at [http://crhn.org/pages/choice\\_projects/cascade-pacific-action-alliance/cpaa-council/](http://crhn.org/pages/choice_projects/cascade-pacific-action-alliance/cpaa-council/), last viewed July 19, 2016. The North Sound ACH governing documents are found on the North Sound ACH Resources web page at <http://www.nsach.org/resources/>, last viewed on July 13, 2016.

<sup>121</sup> See Meaningful Consumer Engagement – Consumer Participation Within the Governance Structure at 4.

<sup>122</sup> Each of the three ACHs that we examined that employ or have employed a form of consensus-based decision-making use(d) a similar process for determining consensus. Participants are asked to express a thumbs up (approval), thumbs sideways (having questions or concerns, but not willing to block the decision in the face of broad support for it), and thumbs down (rejection of the proposal). Participants are polled to determine their positions from among these three. Questions or concerns from participants who voted with a "thumbs sideways" are discussed, and amendments may be made to address them. At the conclusion of the discussion, a new "thumbs" poll is taken of participants and only a "thumbs down" vote will be deemed to negate a consensus. See Cascade Pacific Action Alliance Designation Proposal Portfolio, June 19, 2015, [https://crhn.org/Files/ach/CPAA\\_DesignationProposalPortfolio.pdf](https://crhn.org/Files/ach/CPAA_DesignationProposalPortfolio.pdf) at 18. Backbone organization staff for the King and Pierce County ACHs and the CPAA indicated that in each ACH the fallback procedures in place for when consensus was not possible were invoked at most once in each ACH since the body employing consensus-based decision-making began meeting.

than one Council member objects, the decision is rejected, or more time must be taken to reach a broader consensus. In reality, a full consensus has been reached in every formal decision made by the ILC. The **CPAA**'s governing body's charter mandates that the Coordinating Council will attempt to reach a consensus on each matter under consideration and, if one cannot be had, a subgroup of council members will meet to discuss the matter and make a new recommendation to the Council in an attempt to reach a new consensus. The **Pierce County Health Innovation Partnership** has used full consensus as the means for making its decisions.<sup>123</sup> As noted before, the Partnership was designed to be the ACH's Steering Committee and served as its *de facto* governing body until recently. The new Pierce County ACH's governing body, the Interim Board of Trustees, has adopted a Decision-making Process that retrenches somewhat on the Innovation Partnership's consensus-based decision-making. While this Process calls for the Trustees to attempt to reach consensus on matters up for decision; after an initial vote, if no decision meets with consensus, an additional attempt will be made to change dissenters' views or make changes to the decision that will command a new consensus. If no consensus is reached at that time, a bare majority vote will control the decision.<sup>124</sup>

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#### C. CONFLICT OF INTEREST POLICY

All ACHs have been required to develop and submit to HCA Conflict of Interest Policies.<sup>125</sup> This is a timely and critical mandate. This year, for the first time, the seven ACHs that did not receive "pilot" grants last year are required to develop and implement a substantive project as a condition of their SIM Grant funding.<sup>126</sup> The substantial bump in funding provided to most ACHs by HCA in FY2016 provides a better opportunity for ACHs to devote financial resources to substantive health improvement activities.<sup>127</sup> If ACHs become regional coordinating entities, under the proposed Medicaid Transformation Waiver, as is now anticipated, they will likely be

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<sup>123</sup> While this has been the general practice, there is no process for how this body makes decisions that is laid out in the ACH's and the Partnership's governing documents. Accountable Community of Health Readiness Proposal – Tacoma-Pierce County Health Department and the Pierce County Health Innovation Partnership, available at <http://www.tpchd.org/files/library/589531489c725b3b.pdf>, last viewed February 28, 2016, at 4-27.

<sup>124</sup> Pierce County Accountable Community of Health (ACH) Interim Board of Trustees, Roles and Responsibilities, Sec. IV(d) Decisionmaking Process.

<sup>125</sup> Framework for Accountable Community of Health Readiness Proposal (6.15.2015), Healthier Washington, [http://www.hca.wa.gov/hw/Documents/Readiness\\_Framework.pdf](http://www.hca.wa.gov/hw/Documents/Readiness_Framework.pdf), last viewed April 29, 2016, at 3.

<sup>126</sup> ACH Contract Amendment 2 at 3, No. 6, at 8, No.8.; King County ACH ILC Meeting Materials, January 29, 2016, at 12, <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/leadership-council/~media/exec/HHSttransformation/ACH-Meeting-Materials-Jan-2016.ashx>.

<sup>127</sup> Indeed, some ACHs have received substantial funding from sources other than HCA, further increasing the amounts they may be able to devote to these activities. That said, ACH and HCA staff have indicated that, even at current funding levels, they expect that most ACHs will not feel they have significant financial resources to fund substantive health improvement activities and will instead leverage existing resources and collaboration opportunities that are made possible by their ACH partnerships to support the health improvement initiatives required of ACHs by HCA.

in a position to propose regional projects that, if approved, could receive substantial funding to support their implementation. Conversely, the majority of ACHs currently have no independent legal status, although several are exploring or actively making plans to seek such status.<sup>128</sup> Even if some or all of the other ACHs become independent legal entities this year<sup>129</sup> (e.g., by incorporating as a nonprofit), it seems unlikely that they will employ in significant numbers the kinds of provider staff who will generally be used to carry out these health improvement projects. This makes it likely that ACHs will have to contract with organizations in their regions to carry out the substantive projects the ACHs propose to support through the waiver, giving rise to the potential for more conflicted transactions than they've had to deal with thus far. Also, given the wide variety of sectors represented on each ACH's governing board, there is a substantial likelihood that at least one board member at any particular ACH will be employed by an organization being considered to receive ACH funding to implement a substantive project supported or proposed by the ACH. This all counsels that ACHs develop and implement conflict of interest policies that require broad disclosure of conflicts by ACH staff, as well as members of its work groups and governing body. The policies should also require that identified conflicts be avoided or addressed in a way that is at least as robust as how charitable organizations must address potentially conflicted transactions, even if an ACH does not formally incorporate as a nonprofit and seek IRC § 501(c)(3) status.<sup>130</sup>

### Promising Practices

The conflict of interest policies adopted by the various ACHs often vary in detail and the rigor of their reporting requirements. The **King County ACH**, **CPAA** and **North Sound ACH** have all

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<sup>128</sup> Seven of the nine ACHs have an independent backbone organization that carries out the administrative functions of the ACH, and two are operated entirely by non-profit organizations, the governing boards of which serve as the boards of their ACH as well. See Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health (Building the Foundation), Center for Community Health and Evaluation, January 2016, [http://www.hca.wa.gov/hw/Documents/ach\\_evalreport\\_year\\_1.pdf](http://www.hca.wa.gov/hw/Documents/ach_evalreport_year_1.pdf), at 10-11

<sup>129</sup> Although HCA has not yet released what its specific requirements will be for ACHs to propose, oversee and report on regional waiver-funded programs, a memorandum prepared for the State Health Care Authority by Health Management Associates recommends that "[t]o act as a fiscal agent, critical for managing federal transformation investment funds, each ACH must be a legal entity." HMA Memorandum at 2. It is not clear, however, whether this recommendation remains entirely sound, as the assumption on which it is based – that coordinating entities will serve as fiscal agents for waiver funding -- was called into question by HCA staff who indicated that they now believe that a state-wide entity will likely handle the waiver project funding in some capacity. Medicaid Transformation Waiver Update, April 26, 2016, <https://attendee.gotowebinar.com/recording/946633706221765124>.

<sup>130</sup> The IRS includes a sample conflict of interest policy in the instructions for its application for tax exempt status, to give applicants an idea of the types of procedures that will help tax exempt organizations avoid certain kinds of inappropriate transactions, although applicants are not required to adopt the sample policy. Instructions for Form 1023 (Rev. June 2006), Department of Treasury Internal Revenue Service, <https://www.irs.gov/pub/irs-pdf/i1023.pdf>, at 9, Appendix A at 25-26.

adopted conflict of interest policies. The **North Sound ACH** and **CPAA** policies offer detailed descriptions of actual and potential conflicts of interests and the procedures to be used by the ACH's governing body in making decisions about such transactions. The **CPAA** and **North Sound ACH** policies have the significant benefit of explicitly requiring the disclosure of situations in which the Board member's employer would stand to gain from a Board decision, and not just when the Board member may reap a "personal gain" from a transaction on which (s)he is called to decide.<sup>131</sup> These policies have the kind of detailed framework that will be helpful to ACHs to use in considering the terms and propriety of decisions to ask for waiver funds to be awarded to organizations that are actually represented on their governing bodies or that have business relationships or close alliances with them.

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#### 4. ACCESSIBILITY

*To fulfill its commitment to health equity, the ACH makes best efforts to provide persons with disabilities and persons whose preferred language is not English equal access to the ACH's operations, activities, and services.*

An ACH cannot identify and seek to mitigate health disparities in its region without giving substantial consideration to the health issues faced by and priorities of persons with disabilities and individuals with limited English proficiency.<sup>132</sup> The largest set of U.S. health data for people with disabilities, DATA2010, reveals that persons with disabilities experience numerous health disparities compared with the general population.<sup>133</sup> Similarly, immigrant populations experience significant disparities in coverage and access to health care in our country.<sup>134</sup> Unsurprisingly, limited English proficiency (LEP) plays a major role in those disparities for many immigrant populations. *Id.* An ACH cannot hope to engage consumers with disabilities or with LEP if the ACH's materials, meetings and other functions aren't accessible and understandable to members of these populations. To ensure that this doesn't occur, ACHs must develop written

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<sup>131</sup> See CPAA 2016 Charter §3.1 at 9, North Sound Accountable Community of Health Governing Body Conflict of Interest Policy §3.1 at 1.

<sup>132</sup> The federal government uses the following definition for Limited English Proficient individuals: "individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or 'LEP.' These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter." <http://www.lep.gov/faqs/faqs.html>.

<sup>133</sup> Disability and Health, March 3, 2016, <http://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health>, referencing Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. DATA 2010, September 30, 2010, available at <http://wonder.cdc.gov/data2010/focus.htm>.

<sup>134</sup> See, e.g., Immigrants and Health Care: Sources of Vulnerability, Kathryn Pitkin Derose, Jose J. Escarce, Nicole Lurie, Health Affairs, 26, no.5 at 1259 (2007), available at <http://content.healthaffairs.org/content/26/5/1258.full>; Why Immigrants Lack Adequate Access to Health Care and Health Insurance, Leighton Ku, Migration Policy Institute, September 1, 2006, <http://www.migrationpolicy.org/article/why-immigrants-lack-adequate-access-health-care-and-health-insurance>, last viewed April 28, 2016.

policies outlining their commitment to, their methods for, and any substantive limits on their affording persons with LEP and individuals with disabilities equal access to the ACH's operations and services. These policies must ensure that oral language interpretation, written translations, alternately formatted documents (e.g., Braille, large type, etc.), and accommodations are made available to persons with disabilities or LEP at no cost to them. These policies should be made widely available at no cost and posted on the ACH's website, and the cost-free availability of these services should be announced in notices, newsletters and other public materials distributed by the ACH. Under the ACHs' equal access policies, interpreters and translations should be made available both on request and when the ACH has reason to believe that a significant number of individuals to whom an activity or document is directed use a particular primary language other than English. Fortunately, ACHs need not invent accessibility policies and practices from whole cloth. Numerous resources are publicly available to assist ACHs in designing a plan to offer culturally and linguistically competent services and make their activities and materials accessible to persons with disabilities.<sup>135</sup> There are also national and in-state organizations and in-State government agencies that can assist or offer resources to ACHs regarding designing policies and training staff and partners in offering accessible and culturally competent services.<sup>136</sup> With the help of such resources, ACH staff can and should educate themselves about and embrace best practices for offering equal access to all community members regardless of the barriers they may experience to gaining that access.

It is also important for the ACH's outward facing communications, including those in the English language, to be written or delivered in "Plain Talk" or plain language. ACHs and the health systems with which they engage are pretty complex. Members of the public are likely to misunderstand and possibly be put off by communications meant to engage them in ACH activities, if ACH staff doesn't make a conscious attempt to relate information about the ACHs in a readily understood manner and format. State agencies are already required to use simple

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<sup>135</sup>For example, the National CLAS (Culturally and Linguistically Appropriate Services in Health and Health Care) Standards provide offer assistance to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities U.S. Department of Health and Human Services Office of Minority Health website, last viewed February 28, 2016, at <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>; additional information on implementing the CLAS standards is available at <https://www.thinkculturalhealth.hhs.gov/>. The W3C Accessibility Initiative offers standards and resources to help organizations of all kinds make their online presence accessible to persons with disabilities. See generally W3C Accessibility Initiative, Introduction to Web Accessibility, at <https://www.w3.org/WAI/intro/accessibility.php>, last viewed February 28, 2016.

<sup>136</sup> See, e.g., the Cross Cultural Health Care Program, <http://www.xculture.org>; National Center for Law and Economic Justice, <http://www.nclaj.org>; Washington State Department of Health, Cultural Competency in Health Services and Care, A Guide for Health Care Providers, June 2010, available at <http://www.doh.wa.gov/portals/1/Documents/Pubs/631013.pdf>.

and clear language in communications with Washington State residents.<sup>137</sup> “Plain Talk” guidelines issued by the State and county governments, as well as by a host of other governments and civic organizations, offer a ready resource to ACH staff.<sup>138</sup>

### Promising Practices

ACHs have been relatively successful in making their governing board meetings physically accessible to persons with disabilities. The **King, Pierce, North Sound and the CPAA ACHs** generally hold their governing body meetings in government buildings which, by necessity, are designed to meet physical accessibility standards. The **Pierce County ACH** generally holds their committee meetings in the same buildings as their governing board meetings, making such meetings physically accessible as well.

ACHs have a longer way to go, however, to reach the goal of achieving full accessibility for their LEP populations. The **North Sound** and **Pierce County ACHs** are notable exceptions in showing a growing recognition of the importance of ACHs offering access to persons who speak a language other than English. Notices to the North Sound ACH’s 2014 Whatcom Community Forum were translated into and made available in Spanish. Spanish language interpreters were provided for members of the public at that forum. Also, both the **North Sound** and **Pierce County ACHs offer alternate language versions of their websites**. On the **North Sound ACH’s website**, Spanish and Russian translations are available, with a click of links marked “Español” and “Русский” near the top left corner of each North Sound ACH web page.<sup>139</sup> Similarly, each page of the **Pierce County ACH’s** website each has a small orange tab in the lower right hand corner.<sup>140</sup> When you click on the “Translate” tab, five small icons depicting the flags of the U.S.A., Spain, Vietnam, South Korea, and Russia. When a user clicks on any of these flags, the

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<sup>137</sup> Gov. Christine Gregoire issued Executive Order 05-03 (*available at* [http://www.governor.wa.gov/sites/default/files/exe\\_order/eo\\_05-03.pdf](http://www.governor.wa.gov/sites/default/files/exe_order/eo_05-03.pdf)) on March 24, 2005, requiring State agencies to adopt “Plain Talk” principles. Gov. Jay Inslee continues to support this Order and has issued complementary Plain Talk Guidelines. See <http://www.governor.wa.gov/issues/issues/efficient-government/plain-talk>, last viewed on April 28, 2016.

<sup>138</sup> See Washington State Plain Talk Guidelines, [http://www.governor.wa.gov/sites/default/files/documents/All\\_guidelines.pdf](http://www.governor.wa.gov/sites/default/files/documents/All_guidelines.pdf), last viewed on April 28, 2016; King County plain-language writing guide, <http://www.kingcounty.gov/exec/styleguide/plainwriting.aspx>, last viewed on April 28, 2016. King County also offers a list of links to other “Plain Talk” resources that are available online. Other plain-language resources, <http://www.kingcounty.gov/exec/styleguide/plainwriting/otherresources.aspx>, last viewed April 28, 2016.

<sup>139</sup> See, e.g., <http://www.nsach.org/>, last viewed July 18, 2016. Most of the pages within the North Sound ACH site, with the exception of downloadable documents that were prepared for other purposes include the “Español” and “Русский” links in the upper left corner of the pages, which offer translated versions of the pages when clicked.

<sup>140</sup> See, e.g., [www.achpiercecounty.org](http://www.achpiercecounty.org).

web page currently being viewed is rendered in the language of the country associated with the flag the user clicked – English (U.S.A.), Spanish, Vietnamese, Korean and Russian.

Like other services to assist ACHs with engaging members of their communities, ACH staff reported a desire to offer translated materials to members of their community not fluent in English, but that a lack of resources and, in some places, the relatively small size of the LEP community at least partly limited the priority to which obtaining translations was given. With the influx of additional funding from HCA this year (at least for the seven ACHs that were initially design-grant regions), it is hoped that ACHs will feel better able to offer these equal access services.

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## 5. TRANSPARENCY

*ACH activities are accessible to the public and transparent to the diverse communities to which the ACH is accountable throughout its region.*

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### a. Public Access to and Participation at ACH Meetings

In order for an ACH to engage and activate low-income consumers, and to maintain its accountability to the community from which it is drawn, the ACH must make its meetings open to the attendance and participation of the general public and disseminate critical information about the ACH to the public in a free and convenient manner. Most ACHs, including the four examined in this paper, make their governing bodies' meetings open to the public. It is also very important, however, to make ACH committee and work group meetings open to public attendance as well. ACH work groups and committees do much of the heavy lifting required to gather the information based on which ACH decisions are made. Typically, they develop policy recommendations for Board consideration and, in some cases, they set the agenda for governing board meetings. Generally opening these meetings to the public is a necessary step to making the real work of ACHs transparent and accessible to the communities they serve. There may be certain circumstances where there is a clear need to keep some meetings or parts of meetings confidential, such as those listed in Washington State's Open Public Meetings Act as grounds for holding closed executive sessions of public agency meetings that are otherwise presumptively open to the public.<sup>141</sup> However, those exceptions must be strictly cabined to ensure that they do not significantly undermine the public's ability to observe and, to the extent reasonably possible, participate in ACH deliberations and discussions.

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<sup>141</sup> See, e.g., RCW 42.30.110 (laying out the circumstances under which governing bodies of public agencies may executive sessions that are not open to the public and the procedures for holding such private meetings). For example, meetings to evaluate complaints brought against agency officers or meetings with legal counsel to discuss representing the agency in litigation can be held in executive sessions from which the public is excluded. RCW 42.30.110(1)(f), (i).

To be clear, allowing the public to attend ACH body meetings is a necessary but not sufficient step to enable ACHs to benefit from the diverse perspectives of the residents of their region and be accountable to the communities they serve. Members of the public must be given a reasonable opportunity to give meaningful written and oral input to ACH bodies at their meetings regarding **each significant issue** addressed by the body **before a decision is made** about that issue. There are many ways of doing this, but whatever method is chosen by a particular ACH, token opportunities for consumer feedback, such as offering a perfunctory 5-minute period for all public comments at a specific time during in an ACH board meeting, will not be sufficient. A brief comment period like this has two significant flaws. First, it deprives the public of the ability to have its input given meaningful consideration by the ACH body's members on any decision that was already made during that meeting. Similarly, the public can't comment in an informed matter on anything to be considered in the meeting after the public comment period.

### Promising Practices

The **King, Pierce, CPAA and North Sound ACHs** all allow the public to attend their governing body meetings. None of these ACHs has a formal policy regarding public attendance of their work group or committee meetings, although each ACH allows its work groups and committees to include members who do not serve on the ACH's governing body. The **CPAA** does not specify that its committee meetings are open (or closed) to the public, but committee members are encouraged to invite anyone to attend and, in practice, any individual who contacts the ACH or the work group chair to ask to attend is allowed to do so.

The **CPAA Coordinating Council** and **Pierce County (ACH) Health Innovation Partnership** both allow any member of the public who is present to ask questions and provide feedback on any matter being considered before a vote is taken. The **Pierce County ACH Interim Board of Trustees** recently voted to preclude members of the public from freely asking questions and offering feedback in its meetings, unlike the way in which the ACH has successfully allowed the public to participate broadly in the Innovation Partnership.<sup>142</sup> Instead, a general public comment period is provided at the start of each meeting of the Trustees, with additional public comment taken "prior to any decisionmaking during the course of [the Trustees'] meetings."

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#### b. ACH Websites

One of the easiest ways to make information about ACH governance, meetings and activities freely available to the public is for ACHs to post it on the internet. Access to ACH information,

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<sup>142</sup> Pierce County Accountable Community of Health (ACH) Interim Board of Trustees Roles and Responsibilities, §IV(f) at 2.

such as ACH meeting and activity dates and locations, ACH governance structure, and meeting agendas, minutes and supplementary materials is necessary to support and facilitate consumer involvement in every phase of ACH life. While ACHs must take additional steps to make their materials available to individuals for whom internet access poses an impediment,<sup>143</sup> a website is likely to be the most efficient and cost-effective way of making a broad range of information about its structure, meetings and other activities widely accessible to a wide swath of the community. Eight of the nine ACHs have web presences on the internet.<sup>144</sup>

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<sup>143</sup> Although disparities in internet access have narrowed over the last two decades, there are still significant disparities in use of computers and internet access based in income, race, age, and ability. See Digital Differences, April 13, 2012, at <http://www.pewinternet.org/2012/04/13/digital-differences/>; Internet Connectivity Gap Narrow, But Disparities Still Exist Across States, June 25, 2013, at <http://www.governing.com/blogs/by-the-numbers/internet-connectivity-disparity-census-data.html>.

<sup>144</sup> Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health, Center for Community Health and Evaluation, January 2016, [http://www.hca.wa.gov/hw/Documents/ach\\_evalreport\\_year\\_1.pdf](http://www.hca.wa.gov/hw/Documents/ach_evalreport_year_1.pdf), at 18. The exceptions are the Greater Columbia and Olympic ACHs. *Id.*

TABLE 1 – LIST OF ACHS AND THEIR WEBSITES

ACH	URL
<b>Better Health Together</b>	<a href="http://www.betterhealthtogether.org/bold-solutions-content?category=ACH">http://www.betterhealthtogether.org/bold-solutions-content?category=ACH</a>
<b>Cascade Pacific Action Alliance</b>	<a href="http://crhn.org/pages/choice_projects/cascade-pacific-action-alliance/">http://crhn.org/pages/choice_projects/cascade-pacific-action-alliance/</a>
<b>Greater Columbia ACH</b>	<a href="http://www.greatercolumbiaach.org/">http://www.greatercolumbiaach.org/</a>
<b>King County ACH</b>	<a href="http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach.aspx">http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach.aspx</a>
<b>North Central ACH</b>	<a href="http://www.mydocvault.us">www.mydocvault.us</a>
<b>North Sound ACH</b>	<a href="http://www.nsach.org/resources/">http://www.nsach.org/resources/</a>
<b>Olympic Community of Health</b>	<a href="http://www.olympiccommunityofhealth.org/">http://www.olympiccommunityofhealth.org/</a>
<b>Pierce County ACH</b>	<a href="http://www.achpiercecouny.org">http://www.achpiercecouny.org</a>
<b>Southwest Washington Regional Health Alliance</b>	<a href="http://www.swrha.org/">http://www.swrha.org/</a>

### Promising Practices

The **King, Pierce, CPAA and North Sound ACHs** all have websites, as do four of the other five ACHs.<sup>145</sup> The **Pierce County ACH** site is currently under development and thus may not yet have the full range of information and materials posted there that it will eventually include.

Information and materials that are found on each of the other three ACHs’ sites include basic descriptive and historical information about the ACH, ACH governing documents, dates of and agendas for past governing board meetings, and the ACHs’ applications to HCA for their designation as full ACHs. What other material is included in ACH websites varies significantly, as does how easily identifiable and accessible this information can be to a user who is not familiar with the ACH or the site.

**MEETING DATES:** The **King County ACH** and **CPAA** not only have past governing board meeting dates but also upcoming meeting dates posted on their sites. The **CPAA** website lists both its governing board (Coordinating Council) and its steering committee (Support Team) meeting dates in advance. The **King County ACH** website has separate web pages for its Interim

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<sup>145</sup> See Table 1.

Leadership Council (governing board) as well as for each of its work groups, on which the work group's charter, roster, and past and future meeting dates are listed.<sup>146</sup>

**MEETING MATERIALS:** The **King County ACH** posts on its website materials that are identified as having been distributed at past council meetings, including meeting agendas. Materials for upcoming meetings of the **King County ACH's** ILC are generally posted on its site prior to the governing body meetings. The **CPAA** and **North Sound ACH** have miscellaneous ACH-related resources posted on their websites, which include some of the materials distributed at past governing body meetings, although they are not always identified as such. The **CPAA's** list of resources posted on their site is quite rich. The **King County ACH**, the **CPAA**, and the **North Sound ACH**, post minutes/summaries for their governing body meetings, although the latter's are not entirely up to date. The **CPAA** also posts meeting summaries of its Support Team (steering committee) calls. The **North Sound ACH** Coordinating Council meeting summaries contain links to some of the materials distributed at the meetings that the summaries document. The **Pierce County ACH** posts the materials distributed at some of its past Health Innovation Partnership Meetings, as well as the agendas and minutes for those meetings.

**OVERALL:** The **CPAA** and **North Sound ACH** both provide a broad range of materials related to their activities, bodies and meetings. As noted before, the **North Sound ACH website stands alone in offering at translations of its internal web pages**. The heft of these ACHs' sites is notable, given that each of these ACHs uses a modest-sized nonprofit as its backbone organization and thus cannot rely on extensive pre-existing in-house IT resources for these purposes. Perhaps for this reason, the **King County ACH** website provides the most comprehensive, organized and transparent set of materials and features of any of the ACHs examined. It offers a wide range of materials to which individuals are likely to want access to understand the workings of their ACH and prepare to attend and participate in ACH meetings and activities.

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<sup>146</sup> Links to information about the King County ACH's ILC and work groups are found at <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/leadership-council.aspx>, last viewed on March 7, 2016.

## V. CHALLENGES FOR THE FUTURE

During their design phase and pilot periods, ACHs focused predominately on developing their infrastructure and governance. This narrow focus likely resulted in part from ACHs' need to build out a truly new program for which they were provided few concrete requirements, as well as partly because ACHs' funding levels limited the ability of most of them to do much more than bringing together the people who would make initial decisions for the ACHs and setting the rules for making those decisions. As ACHs proceed through the first year of their full implementation, those parameters have changed significantly. With initial governing and administrative structures in place and substantially increased funding available, ACHs have a real opportunity to begin to collaborate in earnest with grassroots consumers in their communities to identify those communities' health priorities and implement projects to address those priorities through the social determinants of health. To succeed in doing so, it will be critical for ACHs to recognize, monitor and address potential challenges to achieving this vision.

### A. FUNDING LIMITS

HCA's FY2016 effective award of \$480,000 to most ACHs expands their ability to fund other critical activities, like consumer engagement and substantive health improvement projects. However, this is only a single year funding uptick, with SIM grant awards falling by an average of almost a factor of three in both of the next two years, after which they will terminate. That hardly means that ACH budgets have to shrink or disappear in three years. To the contrary, ACHs are required to engage in sustainability planning to develop a roadmap to enable them to continue to support their activities after the SIM program ends.<sup>147</sup> Nonetheless, with the reduction of predictable funding, ACH leaders may feel pressure to limit support for activities outside what they consider their key mission. It will thus be critical for advocates and grassroots members of ACH communities to move quickly to demonstrate to ACH governing bodies the benefits and necessity of promptly adopting a robust consumer engagement program. Moving to a collaborative model of ACH governance and operation will require substantial work and the outlay of significant resources to succeed. If these structural changes are not made this year, it may be considerably harder to prompt ACH decision-makers to commit dwindling funds to change a system that they may see as working only because they are not used to and consequently do not see the full benefits of genuinely working together with grassroots consumers.<sup>148</sup>

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<sup>147</sup> Medicaid Transformation Waiver at 9.

<sup>148</sup> Meaningful Consumer Engagement Toolkit, Creating Buy-In and Making Consumer Engagement a Top Priority, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/>, last viewed April 28,

Also, even if ACHs are able to sustain their current funding levels after the expiration of the SIM grant, they may well be hard pressed to achieve their vision of bringing about substantial region-wide improvements in their communities' health by supporting programs that address their communities' slate of health priorities.<sup>149</sup> That isn't to say that ACHs are incapable of creating and supporting projects that result in significant health benefits, even with their current (or perhaps a somewhat reduced) level of funding. For example, the **CPAA** designed and has begun to implement a promising youth behavioral health screening program with virtually no funding provided by the ACH, by leveraging their members' and allied organizations resources and willingness to collaborate on a project that promises to yield significant health and financial benefits.<sup>150</sup> Similarly, the **North Sound ACH** has funded its Long-Acting Reversible Contraception program with private donations and a Community Benefit grant from the Group Health Cooperative, a Washington State health insurance carrier.<sup>151</sup> That said, creating a regional health improvement project, or even developing a plan to scale up or implement in a new location an already existing project, supported primarily through in-kind resources, takes a great degree of work and creativity and cannot be expected to be the model for all or even most of the ACHs' health improvement endeavors. And, while HCA's recent offer to each ACH a one-time grant of \$50,000 to help carry out a health improvement project should assist ACHs in getting these programs off the ground, this is still fairly modest funding for what is hoped to be a multi-year sustainable project with a significant community impact. So, while there is much that ACHs can do with the level of funding they currently receive, they may be hard pressed to fulfill the promise envisioned in their original design of substantially improving their overall population's health without a substantial change in their financial resources.

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2017 (noting the need to create buy-in for consumer engagement with organizational staff and management who may not understand its benefits).

<sup>149</sup> Discounting the one time grant of \$150,000 that ACHs were awarded upon their designation, ACHs are slated to receive an average of \$220,000/year of SIM grant funding from FY2016-2018. But, most of that will likely be unavailable to support substantive health improvement programs, with a large chunk likely going towards ACH administrative staff. For example, the King County ACH budget for 2016 allocates \$175,000 for 1 FTE Program/Project Manager, \$120,000 for 1 FTE Administrative Support, and \$60,000 for 0.4 FTE communications specialist. See <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/leadership-council/~media/exec/HHStransformation/ACH-Meeting-Materials-Jan-2016.ashx>. One may suppose that ongoing ACH personnel expenses required to carry out duties unrelated to the ACHs' possible responsibilities as regional coordinating entities, may well be lower by FY2018 in most ACH regions. For example, ACHs' staffing needs might be higher this year (ACHs' first post-design year), to help the ACHs build out their infrastructure; and, personnel expenses can probably be expected to be somewhat lower in other parts of the state with lower costs of living. However, the bottom line is that, even accounting for reasonable efficiencies, under current funding levels, the financial resources available to ACHs to spend on substantive health improvement projects seems relatively limited compared with what might be required to move the needle significantly on region-wide population health.

<sup>150</sup> Collaborative Care Teams for Youth Behavioral Health Improvement Proposal *available at* [http://www.hca.wa.gov/hw/Documents/waiver tp proposals/waiver tpprop p102\\_011516.pdf](http://www.hca.wa.gov/hw/Documents/waiver_tp_proposals/waiver_tpprop_p102_011516.pdf).

<sup>151</sup> See [www.nsach.org](http://www.nsach.org), last viewed July 18, 2016.

## B. MEDICAID TRANSFORMATION WAIVER

For reasons such as these, ACHs are strongly attracted to and are generally making plans to become regional coordinating entities for local transformation projects funded by the Medicaid Transformation Waiver. However, this path carries with it other risks for ACHs.

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### 1. REGIONALLY IDENTIFIED PRIORITIES VS. STATE IDENTIFIED PROJECT TYPES

ACHs were created as a vehicle to move health planning to a regional level.<sup>152</sup> Accordingly, they are directed to develop a Regional Health Needs Inventory (RHNI), as well as a Regional Health Improvement Plan (RHIP) that addresses the needs delineated in the RHNI and that is based on regionally established priorities.<sup>153</sup> Conversely, RCEs will be required to apply to fund transformation projects that fall within descriptive categories to be listed on a menu of project types that is currently being created by the State Health Care Authority and that will be used by RCEs across the state.<sup>154</sup> It is not clear how long the menu will be or what level of specificity the listed project types will have, although the most recent draft had a total of five categories of programs across two more general domains.<sup>155</sup> A longer list of project types with more relatively broad descriptions will make it more likely that individual ACHs will be able to find a home for projects that advance their regionally developed priorities within transformation project categories applicable to all ACHs statewide.

There is also a concern that a menu of transformation project types created by State policymakers may not always match well with regional priorities that (hopefully) arise from a strong collaboration with the regions' grassroots consumers. In its Medicaid Transformation Waiver application, the State assured CMS that a stakeholder work group would be created to help develop the transformation project menu.<sup>156</sup> This has yet to occur, and it seems likely that meaningful consumer stakeholdering of this process will become infeasible if the State is able to reach its hoped for soon date for reaching an agreement with CMS to approve the waiver

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<sup>152</sup> Washington State Health Care Authority, Accountable Communities of Health at [http://www.hca.wa.gov/hw/Pages/communities\\_of\\_health.aspx](http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx) last viewed July 18, 2016.

<sup>153</sup> ACH Evaluation Report, at 2, 19.

<sup>154</sup> Medicaid Transformation Waiver, at 14-15.

<sup>155</sup> See Healthier Washington Medicaid Transformation Waiver Framework for Project Toolkit, Last Updated 4/21/2016, [http://www.hca.wa.gov/hw/Documents/waiver\\_tpframework\\_042016.pdf](http://www.hca.wa.gov/hw/Documents/waiver_tpframework_042016.pdf), (Waiver Framework) at 2-9. The Waiver Framework outlines three domains into which proposed projects would have to fall – health systems capacity building, care delivery redesign and prevention and health promotion. *Id.* at 1. However, the HCA anticipates that “all projects in Domain 1 must demonstrate a direct connection to Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion), or must support providers in developing the capabilities necessary to operate in value-based payment models.” *Id.* at 2.

<sup>156</sup> *Id.* at 137.

program, with the Special Terms and Conditions (STCs) to be worked out relatively quickly thereafter.<sup>157</sup>

This is not to imply that no public feedback has been sought or considered by HCA in drafting the transformation project category list. HCA solicited and received proposals for approximately 180 project types, as well as comments from the public on these ideas, from which the initial draft Waiver Framework was synthesized.<sup>158</sup> However, the initial project template application requested quite detailed information on a range of technical subjects, making it an unlikely vehicle for obtaining feedback from consumers about priorities in their communities for subjects to be addressed by regional waiver projects.<sup>159</sup> That said, subsequent calls for stakeholder feedback on the proposed projects submitted by the public and the State's draft Waiver Framework were certainly appreciated. But, these outreach initiatives were announced and explained primarily through electronic media (e.g., email, agency website and webinars), and through meetings with organizations such as ACHs that were generally not attended by many grassroots consumers. As such, these attempts to harvest public feedback on the development of the transformation project toolkit seem much better designed and delivered to obtain the perspectives and input of the health systems likely to be administering and delivering services through these projects than the individuals in communities that would benefit from and will likely receive those services.

The State would thus do well to consider modestly extending its timeline for developing a toolkit of Medicaid transformation project categories to allow stakeholders, including grassroots consumers, to work with State policymakers to ensure that the transformation

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<sup>157</sup> HCA had previously projected that it would receive CMS' approval of the waiver by April 2016. *Id.* at 49. Then, HCA staff then indicated a likely May date for obtaining the waiver's approval. Medicaid Transformation Waiver Update, April 26, 2016, <https://attendee.gotowebinar.com/recording/946633706221765124>. In more recent conversations with HCA staff, they conveyed an inclination that the waiver would be approved before the end of the summer.

<sup>158</sup> See Washington State Health Care Authority, Medicaid Transformation, Transformation Project Ideas, [http://www.hca.wa.gov/hw/Pages/mt\\_i1\\_tp\\_ideas.aspx](http://www.hca.wa.gov/hw/Pages/mt_i1_tp_ideas.aspx), last viewed July 18, 2016; Washington State Health Care Authority, Comments on Transformation Project Ideas, [http://www.hca.wa.gov/hw/Pages/trans\\_project\\_comments.aspx](http://www.hca.wa.gov/hw/Pages/trans_project_comments.aspx), last viewed July 18, 2016. Public feedback was also sought on the draft Medicaid Framework.

<sup>159</sup> For example, the project submission template asked applicants to include or describe "(s)upporting research (evidence-based and promising practices) for the value of the proposed project," the "financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline" for the project, and "(k)ey process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured." See, e.g., Healthier Washington, Medicaid Transformation Waiver, Guide to Development of the Transformation Project List, Washington State Health Care Authority and Department of Social and Health Services, December 1, 2015, [http://www.hca.wa.gov/hw/Documents/waiver\\_project\\_template\\_guidance\\_120115.pdf](http://www.hca.wa.gov/hw/Documents/waiver_project_template_guidance_120115.pdf), Attachment A – Template for Transformation Project Suggestions at 6-7.

project menu provides a comprehensive and sufficiently broad list of project types to accommodate most regional priorities for attacking health disparities.

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## 2. SOCIAL DETERMINANTS OF HEALTH VS. MEDICAID PROGRAM OBJECTIVES

Because Medicaid waiver programs are paid for with Medicaid funding, they must generally focus on augmenting health care services, coverage or delivery systems.<sup>160</sup> By contrast, ACHs were designed in significant part to improve population health by addressing factors outside of the health care system – the social determinants of health.<sup>161</sup> That doesn't mean that Medicaid dollars can in no way be used to improve health while also benefiting a recipient in a different sphere of their lives. So, for example, Medicaid funds cannot be used to pay a recipient's rent or board, but Medicaid funding can be used to deliver care and case management services in a supported housing environment.<sup>162</sup> ACH staff, advocates and consumers alike must join together to seek to ensure that waiver-funded projects may be directed at improving population health by addressing its social determinants, to the greatest extent that this is compatible with federal law.

## C. MESSAGING AND TIMING

Advocates and ACH staff alike have related concerns that, up to this point, it has been difficult to explain to the public exactly what ACHs are and do. This has likely resulted from the fact that, until now, most ACHs have had no independent legal status and most have yet to create or bring about the expansion of substantive health improvement projects in their communities. It has thus been challenging for ACH staff to explain to consumers, who will often need to take time out from their jobs and families to become engaged with their ACHs, how and why those consumers and their communities will benefit from becoming involved in ACH activities. This is, however, all beginning to change, as ACHs are being forced to emerge from their extended "design" phase childhood, during which they could put off many major substantive decisions and actions. As RCEs, ACHs will select projects that they will have to monitor and report on to HCA and that will be in a position to receive what may be millions of waiver-derived dollars to fund their operation. To do this, ACHs will have to hire and train the staff, and ensure that they have a legal status, governing oversight bodies and procedures, and other infrastructure

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<sup>160</sup> Medicaid Waivers, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>

<sup>161</sup> "ACHs are Washington's structured approach to incorporating social determinants of health in all aspects of health transformation across public and private payers and delivery settings." Medicaid Transformation Waiver application at 8.

<sup>162</sup> Using Medicaid to Support Services in Supportive Housing: New Opportunities, Homeless Resource Center, SAMSHA, <http://homeless.samhsa.gov/resource/using-medicaid-to-support-services-in-supportive-housing-new-opportunities-54886.aspx>, last viewed March 3, 2016.

needed to support that enhanced level of financial and programmatic activity. Given the projected upcoming approval of the Medicaid Transformation Waiver, ACHs will not only have to make these structural changes similarly quickly to become RCEs, but they will also very soon have to finalize their regional priorities (if they have not done so already) and begin to make choices about projects for which to seek funding. These are precisely the types of decisions that cannot be fairly and effectively made without direction from the low-income consumers who will be most impacted by the activities of ACHs soon to have their programmatic capacity bulked up by the waiver.

Meaningful multi-tiered consumer engagement does not, however, happen overnight or without thoughtful planning and resourcing. ACHs must begin now to develop and implement consumer engagement plans and reach into their communities to identify, educate and recruit consumers to become involved in their activities in a variety of ways. Otherwise, critical changes that most need the input of the ACHs' grassroots consumers will be made without those consumers' participation. And, once these decisions are initially made, it will likely become extremely difficult to walk them back in the near future, if and when grassroots consumers who become involved in ACH activities conclude that (at least some of) these policy and financial choices do not reflect their communities' priorities. ACHs may then find that the consumer engagement programs they implement, only after many of the most important initial decisions about ACH activities are made, end up dying on the vine from lack of consumer interest. "[E]ngaging community members in nonstrategic ways can lead to feelings of "tokenism" and disrespect. Over time, they may disengage from the initiative if they do not see their opinions contributing to the overall goals."<sup>163</sup>

To ensure the effective and just development of ACHs as they make crucial decisions over the next year that are likely to define how they operate and set their agenda for years to come, advocates and consumers must press ACHs to begin broad-scale consumer engagement now (if not sooner). To provide ACHs some suggestions on how to start what might seem like a somewhat daunting process, we have included as Appendix C a document outlining seven consumer engagement practices that ACHs can generally implement relatively quickly, that are likely to have high value to ACHs independent of an ACH's individual demographics and circumstances, and that are not likely to require an outlay of significant financial resources.

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<sup>163</sup> "The Why and the How of Working With Communities Through Collective Impact, Jeff Raderstrong, Tynesia Boyea-Robinson, Community Development, January 15, 2016, at 6, downloadable at [http://www.tandfonline.com/doi/abs/10.1080/15575330.2015.1130072?journalCode=rcod20#.Vt5a\\_fkrJjw](http://www.tandfonline.com/doi/abs/10.1080/15575330.2015.1130072?journalCode=rcod20#.Vt5a_fkrJjw).

## VI. CONCLUSIONS

Washington's Accountable Communities of Health offer the State a singular opportunity to transform the way that it seeks to improve health for its low-income residents. ACHs can offer a model for changing the Evergreen State's public health care system from a predominately top-down planning approach implemented mostly through state-wide programs, to a regionally based system that collaborates with members of the communities it serves to identify their greatest health needs and develop priorities for addressing them. In doing so, ACHs can create a system that leverages the knowledge and experiences of grassroots consumers in a way that will be necessary to insure that the programs they implement succeed in improving their community's health. It also provides a vehicle for beginning to correct structural discrimination in the health care system that has historically excluded marginalized populations, such as racial and ethnic minorities, immigrants, older adults, LGBTQ individuals and persons with disabilities, from the planning and implementation of programs that were intended to improve those populations' health and well-being. To be successful in doing so, ACHs must understand the need for and benefits of embracing this collaborative work model and move quickly to adopt the robust community engagement programs necessary to support it. To assist in doing so, we urge ACHs to adopt the Principles for Community Participation we have outlined and attached as Appendix A to this paper. Through a close collaboration with grassroots consumers, ACHs can make great strides at improving their regions' health and remedying what have appeared to be intractable health disparities. Without such a collaboration, the ACH program seems destined to fall far short of its promise of engaging all sectors of our communities in achieving together better health and well-being throughout and across our State's populations.

## Principles for Community Participation for Accountable Communities of Health - *Consumer Engagement, Transparency, Accessibility and Public Accountability*

### RACIAL/HEALTH EQUITY

Inequities in health outcomes and disparities in access to health care in Washington State often break down along racial and ethnic lines, with health inequities also being experienced by immigrants, older adults, persons with disabilities, and members of the LTBTQ community. The ACH explicitly recognizes that identifying and seeking ways to remedy these inequities and disparities are primary purposes of the ACHs. When the ACH makes decisions about policy and funding priorities and how those priorities are implemented, it makes a principled and concrete commitment to considering how these decisions offer opportunities to remedy these disparities, as well as what impact those decisions will have on health equity.

- The ACH uses a racial equity tool or similar set of priorities and procedures when making significant decisions about its policies and activities and when selecting projects to fund or undertake in support of its policy priorities. Examples of tools of this sort may be found in the City of Seattle’s Racial Equity Toolkit (available online at [http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit\\_FINAL\\_August2012.pdf](http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf)) and the King County Equity Impact Review Tool (available online at <http://www.kingcounty.gov/~media/elected/executive/equity-social-justice/documents/KingCountyEIRTool2010.ashx?la=en>), although the ACH need not adopt either one or use a tool in substantially similar format to abide by this principle. As an example of how such a tool might be structured to make it more amenable for use by an ACH, we have provided an exemplar tool that was adapted from the Seattle Racial Equity Tool. *See Appendix B.*
- The ACH collects and reports on data related to health equity in its region and how the projects funded through or undertaken by the ACH affect health equity, including the ACHs’ programs’ impact on people of color, immigrants, older adults, persons with disabilities, and individuals who are LGBTQ.

## TRANSPARENCY

ACH activities are accessible to the public and transparent to the diverse communities to which the ACH is accountable throughout its region.

- All meetings of the ACH’s governing body, committees, work groups and similar bodies (“ACH bodies”) are open to the public.
- The ACH creates a website on which it posts important information about the ACH’s meetings, operations and activities, including but not necessarily limited to the following: the date, time and location of its bodies’ meetings, the minutes of its bodies’ meetings, application(s) it makes to the State for funding, certification or designation as an ACH or as a Medicaid Transformation Waiver coordinating entity, any responses to these applications that the ACH receives from the State, the criteria the ACH adopts for selecting projects to fund or undertake in support of the ACH’s policy priorities, the ACH’s charter, bylaws, articles of incorporation, conflict of interest policy and other governing documents, and other key documents created by the ACH.
- Members of the public are given a reasonable opportunity to give meaningful written and oral input to ACH bodies at their meetings regarding each substantive issue addressed by the body.
  - Written comments submitted to the ACH a reasonable period of time before the meeting of an ACH body are posted on the ACH’s website, copied by the ACH and distributed to body members a reasonable time before the meeting. The method and any deadlines for the public to submit these comments to the ACH are posted on the ACH’s website.
  - A reasonable time period is provided at ACH body meetings to members of the public to provide comments before discussion of each substantive agenda item is concluded and before each substantive decision is made by the body.
- The agenda and any non-confidential written materials to be considered at ACH body meetings are posted on the ACH’s website and made available in hard copy format upon request at no cost to the public a reasonable period of time before the meeting.
- The ACH agrees to be subject to the Public Records Act and Open Public Meetings Act, as if it were a governmental organization.

## ACCESSIBILITY

To fulfill its commitment to health equity, the ACH makes best efforts to provide persons with disabilities and persons whose preferred language is not English equal access to the ACH's operations, activities, and services.

- Oral language and sign language interpreters are made available for free at ACH body meetings and at public activities conducted by the ACH. Interpreters are made available when requested and when ACH staff are aware that a significant number of individuals likely to be attending an ACH meeting or activity are likely to have a preferred speaking language other than English. Free translations of documents created by the ACH that are otherwise available to the public are provided at no cost when requested.
- Written materials posted on the ACH's website or that are otherwise available to the public are also made available at no cost in large type format and Braille or in other reasonable alternate formats requested to accommodate an individual's disability.
- The ACH provides accommodations and other services needed to offer equal access to its bodies' activities and its services to individuals with disabilities.
- The ACH adopts written policies laying out its commitment to, its methods for, and any substantive limits on its affording persons whose primary language is not English and persons with disabilities equal access to the ACH's operations and services.
- The ACH's website conforms with legal requirements and industry best practices for website accessibility to persons with disabilities.

## COMMUNITY ENGAGEMENT

The voices of diverse members of the community served by the ACH and most in need of its services are included in every level of the ACH's governance, planning, and other activities. Representation of consumers by professional advocates in the ACH's work and decision-making is not substituted for giving seats at the table to low-income consumers themselves in these conversations and decisions.

- The ACH conducts or arranges for a process to recruit, educate and provide a variety of opportunities for consumer participation in every level of the ACH's operations and activities.
- The ACH provides, makes available, or arranges for resources to support low-income consumers' participation in ACH operations and activities and to communicate the importance of the work the consumers are doing to support

the ACH. Resources for purposes such as, but not necessarily limited to transportation and related expenses (e.g., parking, when appropriate), child care, food for meetings/activities of significant length, and a general stipend for lengthy or recurring work should be provided.

- Each ACH budgets in advance for and allocates at least 10% of its annual budget to pay for consumer engagement activities.
- The ACH allocates at least 10% of the voting seats on its governing body to low-income consumers.
- The ACH allocates at least 10% of the seats to low-income consumers on any of its working groups or committees addressing the following: forming the agenda for governing body meetings and/or making decisions in the interim between governing body meetings (e.g., a steering committee), the design, conduct and review of the ACH's regional health assessment, the design of any criteria for selecting priorities or projects for the ACH to fund or undertake in support of those priorities, and the selection of priorities and projects to fund or undertake in support of those priorities.
- The ACH creates and operates a committee, work group or other body charged with addressing consumer engagement in the ACH, along with processes that ensure that the body has access to the information it needs to fulfill its mandate and that meaningful consideration is given to its recommendations and feedback by the ACH and its governing body.
- The ACH creates a written plan outlining the intended activities and methods by which the ACH will conduct community engagement. This plan includes strategies for outreach and engagement to the broad spectrum of health care consumers in the ACH's region most in need of and likely to be served by the ACH including, but not limited to persons of color, immigrants, persons with limited English proficiency, older adults, and persons with disabilities.

## ACCOUNTABLE GOVERNANCE

The ACH adopts a transparent identifiable set of procedures that lay out its conception of its role, how its bodies are constituted, how it makes decisions, and how it identifies and addresses possible conflicts of interest.

- The ACH has a written charter, bylaws, or similar document laying out its structure and how its decisions are made.
- The ACH's governing body's operational procedures provide consumer voices a meaningful role in decision-making that cannot be easily overruled by other

stakeholder participants (e.g., bare majority rule should not be the regular means by which the ACH's governing body makes decisions).

- The ACH has a written conflict of interest policy that is posted on the ACH's website and made freely available at no cost to the general public.
- The ACH has a written statement of purpose, vision statement or statement of values that is posted on the ACH's website and made freely available to the general public at no cost.
- The ACH has procedures in place and operates in a manner so as to ensure its fiscal soundness and accountability to its governing board and the communities in its region.
  - The ACH has the infrastructure and procedures in place needed for it to operate in a financially sound manner in accord with generally accepted business practices.
  - The ACH has procedures in place to ensure that its governing body maintains fiduciary oversight of the ACH's finances.
  - The ACH's governing body actually exercises appropriate fiduciary oversight of the ACH's finances.
  - The ACH posts on its website and makes widely available to the public a financial report listing its budget, its actual income and expenditures broken down by category, and a plain language description thereof, to be compiled and distributed on at least a yearly basis.

## Prioritizing Racial Equity in Accountable Communities of Health

By establishing collaborative decision-making on a regional basis, **Accountable Communities of Health (ACHs)** are striving to improve health and health systems and develop shared priorities and strategies. All of this work requires a focus on racial equity in order to ensure that everyone in the region will share in the gains that the ACH creates. Therefore, each ACH should prioritize racial equity, initially as part of the Regional Health Improvement Plans and designated interventions.

When an ACH makes decisions that affect its region, it should involve a diverse group of individuals from the affected communities. Before involving those community members, though, ACH board members should engage with racial equity resources to understand various types of racism (individual, institutional, structural, internalized). Then, utilizing population data, they can identify the communities that should be part of a particular discussion. **Each ACH should seek out county-level or program level data that sorts its communities by race, ethnicity, income, education, and family size.**

Engaging with community members creates numerous benefits, including the opportunity to build relationships and trust, create additional capacities for advocacy, and empower communities and individuals. Together with community members, **each ACH should ask specific questions about policies, programs, and budgets:** Who benefits? Who is burdened? Does the status quo make things worse? How can we mitigate the burdens and maximize the benefits for racially-diverse communities?

Finally, it will important to develop champions on each ACH board who are focused on racial equity work. They will need to engage in finding appropriate data and making connections with local communities.

## SAMPLE RACIAL EQUITY TOOLKIT

This toolkit, which has been adapted from the City of Seattle’s Racial Equity Toolkit,<sup>164</sup> can help Accountable Communities of Health (ACHs) eliminate disparities and inequities in the health care system by reducing negative impacts on both low-income and communities of color. The Sample Racial Equity Toolkit lays out a process and a set of questions to guide an ACH seeking to address racial equity.

The Toolkit should be used when policies, programs, and budgets are developed so racial equity goals and desired outcomes are built into the framework of the project. To be inclusive, the analysis must be developed with and by people with different racial perspectives.

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### STEP 1. SET OUTCOMES FOR THE SPECIFIC PROJECT.

Leadership communicates key community outcomes for racial equity to guide analysis. Outcomes includes the universal goal of the project and specific racial equity outcomes.

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### STEP 2. INVOLVE STAKEHOLDERS + ANALYZE DATA.

Gather information from community and staff on how the issue benefits or burdens the community in terms of racial equity. It is critical that diverse stakeholders participate.

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### STEP 3. DETERMINE BENEFIT AND/OR BURDEN.

Analyze issue for impacts and alignment with racial equity outcomes for various groups.

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### STEP 4. ADVANCE OPPORTUNITY OR MINIMIZE HARM.

Develop strategies to create greater racial equity or minimize unintended consequences.

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### STEP 5. EVALUATE. RAISE RACIAL AWARENESS. BE ACCOUNTABLE.

Track impacts on communities of color over time. Continue to communicate with and involve stakeholders. Document unresolved issues.

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### STEP 6. REPORT BACK.

Share information learned from analysis and unresolved issue with allies and partner organizations.

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<sup>164</sup> See [http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit\\_FINAL\\_August2012.pdf](http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf).

**Title of the Project:**

PROJECT DESCRIPTION:

**Step 1. Set Outcomes for the project.**

**1a. What do you define as the most important racially equitable community outcomes** related to the issue? Leadership communicates key community outcomes for racial equity to guide analysis

UNIVERSAL GOAL (CONDITION OF WELLBEING FOR ALL OF THE ACH'S POPULATION):

RACIAL EQUITY OUTCOMES:

**1b. Are there impacts on:**

- |  |   |
|--|---|
| <input type="checkbox"/> ACH GOVERNANCE        | <input type="checkbox"/> IMMIGRANT AND REFUGEE ACCESS TO SERVICES |
| <input type="checkbox"/> WORKFORCE DEVELOPMENT | <input type="checkbox"/> INCLUSIVE OUTREACH AND PUBLIC ENGAGEMENT |
| <input type="checkbox"/> PROJECT SELECTION     | <input type="checkbox"/> PROJECT MONITORING                       |
| <input type="checkbox"/> OTHER                 |   |

PLEASE DESCRIBE:

**Step 2. Involve stakeholders. Analyze data.**

Gather information with community and staff on how the issue benefits or burdens the community in terms of racial equity. What does data tell you about potential impacts?

**2a. Are there impacts on geographic areas?      Yes      No**

IDENTIFY ALL AFFECTED AREAS IN THE ACCOUNTABLE COMMUNITY OF HEALTH:

**2b. What are the racial demographics of those living in the area or impacted by the issue?**

**2c. What intersections are there between this issue’s impact on communities of color and its impact on other demographic groups that experience health/access disparities (e.g., older adults, immigrants, low-income communities, persons with disabilities, LGBTQ individuals?)**

**2d. How have you involved community members and stakeholders?**

**2e. What do your conversations with stakeholders and data tell you about existing racial inequities that influence people’s lives and should be taken into consideration?**

**2f. What are the root causes or factors creating these racial inequities?**

*Examples: Bias in process; Lack of access or barriers; Lack of racially inclusive engagement*

**Step 3. Determine Benefit and/or Burden.**

Given what you have learned from data and from stakeholder involvement:

**3. How will the policy, initiative, program, or budget issue increase or decrease racial equity?**

What are potential unintended consequences? What benefits may result? Are the impacts aligned with your community outcomes that were defined in Step 1.?

**Step 4. Advance Opportunity or Minimize Harm.**

**4. How will you address the impacts (including unintended consequences) on racial equity?**

What strategies address immediate impacts? What strategies address root causes of inequity listed? How will you partner with stakeholders for long-term positive change? If impacts are not aligned with desired community outcomes, how will you re-align your work?

PROGRAM STRATEGIES:

POLICY STRATEGIES:

PARTNERSHIP STRATEGIES:

## **Step 5. Evaluate. Raise Racial Awareness. Be Accountable.**

**5a. How will you evaluate and be accountable?** How will you evaluate and report impacts on racial equity over time? What is your goal and timeline for eliminating racial inequity? How will you retain stakeholder participation and ensure internal and public accountability? How will you raise awareness about racial inequity related to this issue?

**5b. What is unresolved? What resources/partnerships do you still need to make changes?**

## **Step 6. Report Back.**

**Share analysis and report responses with coalition partners and members involved in Step 1.**

## CREATING EFFECTIVE COMMUNITY OUTCOMES

**OUTCOME:** the result that you seek to achieve through your actions.

**RACIALLY EQUITABLE COMMUNITY OUTCOMES:** the specific result you are seeking to achieve that advances racial equity in the community.

When creating outcomes think about:

- What are the greatest opportunities for creating change in the next year? What strengths does the coalition have that it can build on?
- What challenges, if met, will help move the coalition closer to racial equity goals?

## IDENTIFYING STAKEHOLDERS

**IDENTIFY STAKEHOLDERS:** Find out who are the stakeholders most affected by, concerned with, or having experience relating to the policy, program or initiative. Identify racial demographics of the region or those impacted by issue.

**ONCE YOU HAVE IDENTIFIED YOUR STAKEHOLDERS:** Involve them in the issue. Describe how historically underrepresented community stakeholders can take a leadership role in this policy, program, initiative or budget issue.

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### LISTEN TO THE COMMUNITY – ASK:

- What do we need to know about this issue? How will the policy, program, initiative or budget issue burden or benefit the community? (*concerns, facts, potential impacts*)
- What factors produce or perpetuate racial inequity related to this issue?
- What are ways to minimize any negative impacts (harm to communities of color, increased racial disparities, etc.) that may result? What opportunities exist for increasing racial equity?

### EXAMPLES OF WHAT THIS STEP LOOKS LIKE IN PRACTICE:

- Addressing disparities in health care includes conversations with those who utilize the services as well as staff who work there.
- Before implementing a new policy and program, people from the demographic most impacted are surveyed to learn the best ways to minimize negative impacts.

## GLOSSARY

**ACCOUNTABLE:** Responsive to the needs and concerns of those most impacted by the issues you are working on, particularly to communities of color and those historically underrepresented in the civic process.

**COMMUNITY OUTCOMES:** The specific result you are seeking to achieve that advances racial equity.

**DETERMINANTS OF EQUITY:** The social, economic, geographic, political, and physical environmental conditions in which people are born, grow, live, work, and age that lead to the creation of a fair and just society. Access is necessary regardless of race, class, gender, or language spoken. Inequities are created when barriers exist that prevent individuals and communities from accessing these conditions and reaching their full potential.

**EQUITY:** When every person has full and equal access to opportunities that enable them to attain their full potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

**HEALTH DISPARITIES:** Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

**HEALTH EQUITY:** When every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

**IMMIGRANT AND REFUGEE ACCESS TO SERVICES:** Government services and resources are easily available and understandable to all residents, including non-native English speakers. Full and active participation of immigrant and refugee communities exists in civic, economic and cultural life.

**IMPLICIT BIAS:** The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

**INCLUSIVE OUTREACH AND PUBLIC ENGAGEMENT:** Processes inclusive of people of diverse races, cultures, gender identities, sexual orientations and socio-economic status. Access to information, resources and civic processes so community members can effectively engage in the design and delivery of public services.

**INDIVIDUAL RACISM:** Pre-judgment, bias, stereotypes about an individual or group based on race. The impacts of racism on individuals including white people internalizing privilege and people of color internalizing oppression.

**INSTITUTIONAL RACISM:** Organizational programs, policies or procedures that work to the benefit of white people and to the detriment of people of color, usually unintentionally or inadvertently.

**INTERNALIZED RACISM:** When a racial group oppressed by racism supports the supremacy and dominance of the dominating group by maintaining or participating in the set of attitudes, behaviors, social structures, and ideologies that support the dominating group's power.

**RACIAL EQUITY:** When social, economic and political opportunities are not predicted based upon a person's race.

**RACIAL INEQUITY:** When a person's race can predict their social, economic and political opportunities and outcomes.

**RACISM:** A complex system of beliefs and behaviors, grounded in a presumed superiority of the white race. These beliefs and behaviors are conscious and unconscious; personal and institutional; and result in the oppression of people of color and benefit the dominant group, whites. A simpler definition is racial prejudice + power = racism.

**SOCIAL DETERMINANTS OF HEALTH:** The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

**STAKEHOLDERS:** Those impacted by proposed policy, program or budget issue who have potential concerns or issue expertise. Examples might include: specific racial/ethnic groups, other institutions like housing, schools, community-based organizations, unions, etc.

**STRUCTURAL RACISM:** The interplay of policies, practices and programs of multiple institutions which leads to adverse outcomes and conditions for communities of color compared to white communities that occurs within the context of racialized historical and cultural conditions.

## WHAT CAN (AND SHOULD) ACH'S DO NOW TO HELP PROMOTE CONSUMER ENGAGEMENT (THAT WON'T COST THEM A LOT)?

ACHs generally recognize the importance and benefits of engaging grassroots members of their communities to participate in ACH decisions and activities. Most have already taken steps to educate community members about what ACHs do and to get consumers' feedback on what they should be doing. To be honest, though, implementing a robust consumer engagement plan takes time, effort and other resources (including funding). And, ACHs have varying needs and capacities to carry out different kinds of consumer engagement, depending on factors like their local demographics, the funding they can get from sources outside the Health Care Authority, and the institutional resources available to them from their backbone organizations and local partners. At the same time, more than ever, ACHs need to intensively engage grassroots members of their communities to help guide the decisions they are making about changing their structures and selecting waiver-funded projects. This can make consumer engagement planning daunting, as ACHs try to balance their individual needs and for community engagement with the time and resources needed to implement specific engagement strategies, all with an eye to the approaching deadlines for making key decisions about the direction their ACH will be taking for the next few years.

With these considerations in mind, we've put together the following list of **seven consumer engagement practices we recommend ACHs adopt and begin to implement as soon as possible**. These practices will make it possible for ACHs to get the public involved in their work in a meaningful way that:

- a) can be **implemented relatively quickly**;
- b) is likely to have **high value for ACHs regardless of the ACH's individual demographics** and other circumstances; and,
- c) is **not likely to require short-term significant cash expenditures** to achieve, so that they are likely to be feasible even for ACHs with comparatively low outside funding levels.

## 7 High-Value, Low-Cost Consumer Engagement Practices ACHs Can Begin to Implement Right Now

- 1) Designate seats on your governing Board for grassroots consumers.
- 2) (Begin to) Recruit consumer Board members.
- 3) Give the public a chance to give feedback to your Board before each significant decision is made.
- 4) Assign responsibility for overseeing consumer engagement in your ACH to a specific work group or committee.
- 5) Create a written consumer engagement plan for your ACH.
- 6) Budget for consumer engagement.
- 7) Develop a “Road Show” to present at meetings of community organizations.

- 1) **DESIGNATE SEATS ON YOUR GOVERNING BOARD FOR GRASSROOTS CONSUMERS:** For ACHs that have not already incorporated as independent legal entities or that are not run as projects of their backbone organizations, this can likely be done at your next governing body’s meeting.<sup>165</sup> For ACHs that are already forming nonprofit organizations or other independent corporate entities to take over their operations, it will be particularly helpful to include consumers in the initial slate of directors/members/etc. included when you file your articles of incorporation or similar founding documents. Washington nonprofit law does not require you to fix a set number of Directors for a nonprofit corporation when the nonprofit is founded. So, even if your ACH is ready to incorporate as a nonprofit but doesn’t have grassroots consumers ready to take seats on its Board, you can (and should consider) providing in your articles or bylaws for the ability to add seats to your initial slate of Directors without having to amend your organization’s governing documents. As noted before, it is critical that **at least two seats be provided for consumers on your Board**, or you create a serious risk that consumer Board members will feel tokenized, marginalized and discouraged from voicing their perspectives.
- 2) **(BEGIN TO) RECRUIT CONSUMER BOARD MEMBERS:** To have grassroots consumers participate in ACH decision-making about major changes to the ACH’s governing, operational and legal structures and about the waiver-funded projects the ACH selects,

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<sup>165</sup> For ACHs that are operated entirely by a nonprofit organization, there may be provisions of their Articles of Incorporation or Bylaws that set out procedures to be followed for expanding Board membership and/or filling Board vacancies that may prevent new Board seats from being created so quickly.

you will need to start recruiting consumers now. This may seem like a forbidding task. The ACH program, the proposed Medicaid waiver, and other subjects on which your governing board is going to be asked to make decisions in the near future can be hard to understand even for professionals who are well-schooled in our health care system. But, no business expects all of its Board members to be experts in the industry to which the business belongs. And, there are likely grassroots consumers in your community who are already advising different elements of the health care system and advocating for change. For example, many hospitals have patient advisory boards. Numerous BHOs have consumer advisory groups. Each FQHC has a governing board a majority of the members of which are generally low income patients. And, different community groups, like Washington CAN! and Puget Sound Sage provide training to members on health care advocacy. With relatively little effort, you should be able to **perform an inventory of organizations in your area that employ health care consumers as members of advisory or governing bodies or who have formalized trainings for grassroots members to advocate on health care or public benefits issues**. Reaching out to those groups alone may well yield more applicants for the consumer positions you have than there are openings. In the future, it is hoped that ACHs will adopt multi-tiered engagement strategies that will allow consumer leaders to be identified and trained through progressively closer work with their ACHs. But, for the present, at least, it is likely that there are consumer health advocate resources in many communities that will offer educated and engaged grassroots advocates who will ably fill Board positions allocated for consumers.

- 3) **GIVE MEMBERS OF THE PUBLIC THE CHANCE TO PROVIDE ORAL AND WRITTEN FEEDBACK TO YOUR GOVERNING BODY BEFORE EACH SIGNIFICANT DECISION IS MADE:** This can be done in different ways. For example, the Cascade Pacific Action Alliance allows *any person* attending their governing body meetings to participate in the group's discussions. Alternately, a time for public comment can be provided shortly before a vote is held on each issue being considered by the Board and towards the end of Board discussions of substantive issues not resulting in a vote. The important thing is for members of the public to be given a chance to offer feedback on *each significant issue at times at which commenters can benefit from the body's discussion about the factors to be weighed in making the decisions in question and at which the governing body can give the feedback meaningful consideration before they make the decisions*.
- 4) **ASSIGN RESPONSIBILITY FOR OVERSEEING CONSUMER ENGAGEMENT IN YOUR ACH TO A SPECIFIC WORK GROUP OR COMMITTEE:** Consumer engagement is not rocket science, and many powerful consumer engagement practices will not require your ACH to pay for much if any services or materials beyond the staff time and overhead already factored into your budget. Consumer engagement does, however, require a

commitment of time and effort from individuals and organizations interested in helping to promote it within your ACH. With the many responsibilities that ACHs are already required to shoulder, it's easy for consumer engagement to be shunted aside by work in areas that are seen as being more pressing, if no one within your ACH's broader structure is held accountable for making sure that consumer engagement planning and implementation actually takes place. Assigning this area of operations to a group allows for the easier sharing of diverse perspectives on how the work of engaging consumers to collaborate with other ACH partners can be carried out. It also makes it easier to leverage a larger pool of individuals (the community engagement work group's membership) in service of your ACH's consumer engagement planning, rather than relying mostly on a single CE manager. This strategy should also take little to no financial resources to implement<sup>166</sup> and be easy to achieve at the next governing body meeting.

- 5) **CREATE A WRITTEN CONSUMER ENGAGEMENT PLAN FOR YOUR ACH:** Even a relatively simple consumer engagement activity -- like holding a public meeting to introduce the ACH to community members -- requires advance planning and coordinating a number of actions by a group of individuals to complete successfully. And, no one thinks that a single community meeting will deliver the kind of consumer engagement that your ACH needs and that will offer the most benefit to your organization. The best way to ensure that you meet your ACH's consumer engagement goals is to create a written plan that includes the following:
- **GOALS** - Your ACH's aims for consumer engagement; including both higher level and concrete goals will be helpful.
  - **METHODS** - The activities and other methods you plan to use to achieve you ACH's consumer engagement aims.
  - **PARTICIPATING STAFF AND PARTNERS** - Individuals and organizations that will be involved (or whose help will need to be sought) to carry out the listed activities.
  - **RESOURCES** – List the resources you think you'll need to carry out the plan's activities and their (proposed) source; if you don't have (some of) these resources lined up yet, say how you hope to get them.
  - **TIMELINE** – List dates for completing each activity included in the plan.

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<sup>166</sup> Some ACHs that send staff to each work group meeting or that employ facilitators or other contractors to assist with running work groups might object that creating a new work group or expanding the brief of an existing one to address consumer engagement will certainly require the expenditure funds. We leave it to each ACH to decide how best to staff their work group meetings. However, there are ACH work groups that are chaired or facilitated by ACH partners at no expense to the ACH. This should be possible as well for consumer engagement. We invite ACHs to look how they can best make use of the existing resources that their partners can offer them to achieve important goals like consumer engagement.

Creating a plan with this type of content will help organize your consumer engagement work and provide a means of accountability for reviewing how proposed consumer engagement activities were conducted. Like the practices listed above, putting together a consumer engagement plan should not require the outlay of significant funds to complete. To be clear, though, that doesn't mean that it won't require significant in-kind resources, particularly the work of the individuals who help draft the plan. But, those are exactly the kind of resources in which ACHs are rich – the willingness of members of their allied and partner organizations to research and develop policy proposals for the ACH to implement.

- 6) **BUDGET FOR CONSUMER ENGAGEMENT:** We all know that financial resources are tight for ACHs (and tighter for some than others). A lot of consumer engagement activities can be carried out with funds that are already budgeted (e.g., backbone organization staff's time working on consumer engagement may be able to be paid for as part of your budget allocation for backbone staff compensation). Some consumer engagement activities, however, will likely require some additional expenditures (e.g., translating outward facing ACH materials into non-English languages, providing stipends to consumer Board members, etc.). Actively budgeting for consumer engagement ensures that funds are available for specific activities that can't be neatly shoe-horned into your existing budget categories. It also makes it more likely that consumer engagement funding will be there when you need it. Perhaps most importantly, it will help you plan your consumer engagement activities by giving you a more concrete idea of how much funding you have available for activities that carry a hard price tag
  
- 7) **DEVELOP A "ROAD SHOW" TO PRESENT AT MEETINGS OF COMMUNITY ORGANIZATIONS:** It's great to invite consumers and leaders of community organizations to meetings and presentations that your ACH organizes. But, instead of just asking members of your community to come to you to learn about your ACH and give you feedback, you will likely be most effective at reaching grassroots consumers by going to speak and work with them at places near where they live and work that they already know. Consumers who are already involved with a nearby community organization may feel more comfortable and more easily able to attend a meeting there than they would feel going to an unfamiliar meeting location that is not near where they live at a meeting staffed by people they don't know. You can make this easier by preparing a standard "road show" presentation about your ACH to deliver at meetings of community groups in your region. This presentation can then be adapted to the individual organization and community being addressed and can either be presented entirely by backbone and partner staff or together with leaders of the organization at which the presentation is being given. The presentations themselves may require some funding to deliver (e.g., for

flyers advertising the event, interpreters, and food for the meetings), but that may be able to be shouldered by or shared with the organization at which you are presenting. But, preparing the standard presentation itself should not require any significant expenditures other than the time required to put it together.

## NEXT STEPS

What steps your ACH takes in the medium to long term to promote consumer engagement will depend significantly on your individual ACH's priorities, funding and the characteristics of your region. For example, some ACHs may want to form Community Advisory Councils, which have proved to be a successful means of harnessing consumer input in other health systems. ACHs that include multiple counties may choose to work with local community alliances that are already known to and more accessible to grassroots consumers in their communities than the central ACH administration and that can help serve as conduits of information between the ACH's overarching governance structure and its widely separated and diverse communities.

Other activities are likely to (need to) be pursued by most ACHs. For example, ACHs will generally need to provide orientation and support to consumers who make a commitment to participating in ACH governing boards, work groups or other bodies. And, some ACH meetings and presentations will need to be conducted in a way that is accessible to community members who are not participating in them in a professional capacity (i.e., folks who are not employees of health and social service systems or advocacy groups who are working with ACHs as part of their jobs). This kind of support might include providing parking and/or transportation, serving food (at activities of any significant length), offering child care for parents who wish to participate, and holding meetings outside of normal business hours.

Northwest Health Law Advocates and Washington CAN! are available to consult with you at no charge on consumer engagement in ACHs, including developing public education materials and designing and putting on board orientations and community presentations on ACHs.