Healthcare Policy Study

Prepared for the William D. Ruckelshaus Center
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The following report was prepared by the William D. Ruckelshaus Center, a joint effort of the University of Washington and Washington State University whose mission is to act as a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest. University leadership and the Center's Advisory Board support the preparation of this and other reports produced under the Center's auspices. However, the key themes contained in this report are intended to reflect the opinions of the interviewed parties, and the findings are those of the Center's assessment team. Those themes and findings do not represent the views of the universities or Advisory Board members.

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Report overview

The healthcare sector in Washington includes a variety of sub-sectors, including public health, publically financed and delivered healthcare (Medicaid, General Fund programs, public employee healthcare), private/commercial healthcare delivery, and an increasing global health presence in Seattle. Although stakeholders often have a long history of conflict, as well as shared complaints about lack of genuine decision-making progress, third-party neutral facilitation services are not *systematically* embedded in the healthcare sector. When convening or facilitation does occur, it is often informal and unstructured, often hosted by state health and human service agencies themselves, and lacking neutrality to support interest-based negotiating and trust building.

Established facilitation and mediation organizations demonstrate varying degrees of healthcare projects. Many of these are short-term assignments; for example, single day facilitations to develop consensus on pandemic resource allocation. Others build experience working on organizational development for healthcare entities; for example, facilitating a transitional change in a pharmaceutical company's internal organizational structure, or within a division of the U.S. Health and Human Services Agency. Others conduct 'one-off' facilitation sessions within a state or county that assessed stakeholder concerns prior to national healthcare reform roll-out.

> **Healthcare may be categorized as a complex set of subject areas, including:**
> - Healthcare Policy and Financing (Public and Private)
> - Healthcare Delivery
> - Public Health, Wellness and Prevention
> - Global Health

The Ruckelshaus Center is interested in establishing whether increased and sustainable involvement in healthcare policy projects would be welcomed by its universities and external stakeholder communities. This report is a summary of eighteen months of internal and external interviews that assess the Center's capacity and capability to address potential demand for neutral collaborative problem-solving services. Recommendations are included at the end of this report.

Project Highlights:

- This study included more than 75 informant interviews of sector stakeholders, academic researchers, legislators and practitioners. A sampling of sector stakeholders (including the Governor's Office of Legislative Affairs & Policy, state health and human service agencies, hospital health systems and other providers, associations, advocates and foundations) were interviewed to assess interest and potential demand for Center services. In addition, meetings with faculty and Ph.D. candidates from both Washington State University (Schools of Nursing, Communications, Human Development, Health Sciences and Extension) and the University of Washington (Schools of Public Health, Nursing, Law, Public Policy & Governance, and Medicine) helped to assess the potential 'supply' of qualified health policy subject matter experts and facilitators.
- Interviews with other university-based and affiliated centers, private mediation/facilitation organizations and individuals identified healthcare-related work, opinions about practice development and challenges encountered.

- Results are encouraging. Sector stakeholders have expressed interest in third-party neutral facilitation as a means to potentially break longstanding logjams, improve momentum and quality of decision-making, and to 'own' agreement. A few foundation interviews identified interest in funding opportunities that align with organizational missions, vision and goals. Many long-standing healthcare policy stakeholders envisioned a potential role for the Center based on recent and growing state health transformation activities, which often require significant community and regional-based stakeholder input related to policy design and implementation requirements.

Project opportunities/challenges:

- The Ruckelshaus Center has the opportunity to become a leader in healthcare policy-related consensus building. While other centers across the U.S. have worked sporadically on healthcare related issues, none of those identified have attempted to build a sustainable 'practice'. The centers interviewed (with the exception of Oregon Consensus) had not directly responded to impacts of national healthcare reform, which has created much of the newer consensus-building opportunity in states and local districts.
- If interested, the Center will need to assess its resources and attention required, as well as alternative methods to approach the wide range of health policy issues with respect to subject material complexity, building sector legitimacy and realistic leveraging of staff, university faculty, students and practitioners.
- The Center will need to carefully assess a wide range of potential healthcare projects, as well as involved stakeholders for possible perceptions of conflict. For example, the UW School of Medicine is a major healthcare provider in the state, and has a vested interest in policy discussions that impact their provider reimbursement. The developing WSU School of Medicine will likely have similar future interests. The Center should be sensitive to both UW and WSU connections within the context and limitations of its project criteria.

> **The Center will need to implement a strategic plan if interested in building a sustainable healthcare practice. One full-time equivalent experienced in healthcare policy, with intern and administrative support would provide a reasonable starting point to leverage this report's recommendations.**

In the past several years, the Ruckelshaus Center's positive reputation among legislators, state administrators, local communities and stakeholders has allowed for opportunities to branch out beyond traditional natural resource and environmental projects. The Center's staff and leveraged academic/practitioner teams have successfully facilitated projects involving governance, emergency preparedness and public records issues, among others. The Center has conducted collaboration and civil discourse training, as well as engaged university-leveraged opportunities related to two healthcare projects on nurse staffing and eldercare workforce issues.

Other centers, firms and individuals who have health policy/dispute resolution-preemption experience have leveraged their ties to traditional environmental/natural resource work. In addition, natural connections between healthcare and environmental issues, emergency preparedness, built

environments, community economics and development provide numerous potential avenues to explore beyond traditional healthcare policy and conflicts.

One common link between several informants involved pandemic disease and other health outbreak preparation, including assessment of multi-governmental health department's capacity; development of decision-making criteria; scare resource allocation and triaging policy in the aftermath of an event, and convening community awareness sessions. Other projects included development of food safety protocols and policy, and facilitating higher level stakeholder sessions to work on public awareness campaigns related to public and environmental health.

Healthcare is one of the largest economic sectors in the Northwest, as well as one of the most transformative and dynamic. Recent national and state transformation efforts are already impacting the education, delivery, financing and evaluation of both individual and population health in our state. Newer research and innovation evaluating and impacting an individual's personal biology, wellness and prevention, medical and behavioral intervention, and chronic disease care will continue to evolve, along with respective public policy. 'Big Data' in healthcare may help facilitate improved population health, and bio-ethics and other complex policy debates will likely overshadow current issues, such as data confidentiality.

The remainder of this report attempts to frame certain facets of healthcare, including examples the Ruckelshaus Center might consider when addressing a more active role in healthcare policy and collaborative problem solving.

General study chronology

This report's content and recommendations rely on more than 75 in-person interviews that were completed to assess both potential 'demand' for Center services and 'supply' of university-based health policy subject matter experts (as potential future Center project partners), as well as possible facilitators. A number of early presentations were conducted at the WSU/Pullman and WSU/Spokane campuses. Those materials were subsequently modified to help structure individual interviews with UW faculty, health sector stakeholders, foundations and advocates. Formal presentations were made at the 2014 UW/School of Law's Northwest Dispute Resolution Conference, as well as the 2014 Association for Conflict Resolution Conference in Cincinnati.

In addition, numerous phone and in-person interviews of established independent facilitators, private facilitation/mediation firms and university-based and affiliated centers provided considerable opinions about and experience with healthcare/policy engagements.

Several meetings with Bill Ruckelshaus and a number of the Ruckelshaus Center's Advisory Board members were held. These conversations provided a context of their different perspectives and opinions related to health policy involvement, the Center's best strengths, and contact referrals for additional interviews.

All interviews took place between late 2013 and the first quarter of 2015. As expected, the conversations frequently included topical issues reflecting the month the interview took place. Some issues were consistently referenced throughout the study time period (for example, the significant

Washington Statewide Innovation Model grant process that requires community collaboration in many aspects). Other issues surfaced based on current academic research projects (for example, public health-related). Some issues were brought up by informants who were simply verbalizing a 'wish list' of projects that could gain value from a third party neutral. *The interviewing goal was simply to introduce and frame the type of collaborative problem-solving work the Center provides, and to listen to each informant's need for services that might fit within the Center's Project Criteria.*

Interviews with experienced facilitators and other center's directors and staff included discussion about their operational and business models, and how they have (or why they have not) approached health policy issues, relevant stakeholders and funding sources.

Interviews with UW and WSU faculty, staff and students provided a deeper understanding of their healthcare research and practice goals, their potential interest in collaborating with the Center, and their ideas of examples of projects in their 'space' that might benefit from consensus building processes.

Finally, time was spent throughout the study with Ruckelshaus Center staff to develop a sense of organizational culture, operational standards, inertia, scale and reflective self-critique. The latter portion of this report includes recommendations to address the Center's current capability and capacity to 'stretch' further into healthcare policy issues – the time spent with Center staff helped to develop that sense of scope and potential relative to healthcare policy issues.

Executive Summary

Healthcare consists of a dynamic set of sectors that continue to transform, creating some of the Northwest's most urgent public policy challenges. Healthcare needs, laws and funding structures have changed dramatically over the past several decades, making the system more complex and costly. Efficient, effective and coordinated healthcare delivery requires close collaboration and innovation from all stakeholders, including providers, government, insurers, advocates and the consuming public. Improving the quality of care and lowering costs involve complex policy decisions related to:

- reform and transformation;
- aging and increasingly complex patient populations;
- shortages of certain skilled providers;
- a slow-to-engage consumer base;
- fragmented delivery and oversight systems; and
- non-medical determinants of health (environmental factors, health behaviors, social issues and others).

Many healthcare issues are interconnected with traditional public health challenges including obesity, diabetes, cardiovascular disease, mental health, substance abuse, community wellness and disease prevention, and even global health. Large policy decisions may also be connected to environmental health, community and population health, urban and transportation planning, recreation access and emergency preparedness for pandemic and catastrophic natural disasters.

Efficient, effective and sustainable healthcare delivery will require close collaboration and innovation from all involved parties, including healthcare providers, governments, insurers, advocates and the consuming public. However, unlike other sectors in the Northwest such as natural resources, health policy decision makers have not benefited from the systematic use of collaborative governance and neutral, third party facilitation to improve policy design and healthcare delivery.

American healthcare evolved slowly over much of the past century. More recent transformation has accelerated the pace of innovation and change – concurrent public policy and regulation frequently lags behind this pace of change, complicating stakeholder and authorizer collaboration.

The delivery of care is changing from the historic 'physician-patient' concept to a more complex relationship between patients (as consumers) and physicians (who are often employees of hospital/health systems or large clinics) and a diverse set of other providers. These include community and rural health centers, home care providers, county-based agencies and a range of others that focus on primary and specialty care, residential care, behavioral health and other non-medical determinants of health and health outcomes. In addition, newer or updated provider and payer collaboratives have assumed varying degrees of the financial risk of provided benefits, including traditional health insurers, managed care entities and health plans, 'accountable care' organizations, 'patient-centered medical home' models and others. Consolidations between hospital organizations and acquisitions of physician practices add another complicated layer to the mix. These and other changes have increased both the number and complexity of stakeholders and interest-based issues for payers to consider when developing healthcare policy.

Medicare and Medicaid programs represent the majority of program dollars, and are expanding. States and the federal government are the payers of these two programs, and share varying policy-making and oversight responsibilities to ensure they are viable, sustainable, efficient and economic. Commercial insurance represents a larger role with the implementation of statewide benefits exchanges, which extends coverage to the uninsured.

Traditional challenges, including fragmentation of physical and behavioral care are being addressed using new integrated partnerships and sharing of financial risk between stakeholders. Technological healthcare innovation, designed to more fully engage consumers in prevention, wellness and chronic disease maintenance is in the early stages of regulation and delivery.

Many of these challenges involve a variety of policy decisions to design and implement programs and their underlying regulations and rules. Many formal and informal stakeholder workgroups are created by state and local agencies and other authorities to attempt to provide policy guidance, program design, barrier identification and contracting mechanisms without structured facilitation. Frustrated Study informants spoke of stakeholder meetings that could not seem to produce tangible results on a timely basis. Transformation programs often include relatively short federally mandated timelines that require effective group cooperation and alignment. State and local administrators want to build consensus, as well as political capital to support and sustain effective programs.

In addition, the federal government and states are pushing for greater stakeholder engagement when designing and implementing new healthcare policy. Complex traditional (competitive and combative) relationships between stakeholders are challenged, as policy makers attempt to improve quality and outcomes, reduce waste and save costs. No systematic venue for advanced third-party collaborative problem solving currently exists.

Washington state has embarked on a significant Medicaid transformation, with federal funding from a large 'State Innovation Model' grant. In addition, Washington has recently submitted a five-year 1115 global demonstration waiver application to the federal Centers for Medicaid and Medicare Studies (CMS) to further fund transformative changes that support the current 'Healthier Washington' initiative. The waiver's following goals will initially impact nearly 25 percent of Washington's population:

- Reduce the avoidable use of intensive services and settings, such as acute care hospitals, nursing facilities, psychiatric hospitals, jails, and traditional long-term services and supports;

- Improve population health, with a focus on the prevention and management of diabetes, cardiovascular disease, oral health, pediatric obesity, smoking, mental illness, and substance use disorders- through care that is coordinated and whole-person centered;

- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian health system are maintained for Washington's tribal members, and

- Ensure that Medicaid per capita cost growth is two percentage points lower than national trend.

Washington healthcare transformation success largely depends on the ability of regions throughout the state to develop local collaborative governance, policy design and integration of coordinated care. According to Study informants, many regions in our state feel unprepared to facilitate the effective consensus building activities needed to design and implement local transformation policy.

Traditional public health challenges are integrating with health delivery and financing issues, as consumers are expected (and incented) to take on a greater responsibility and partnership with providers to more actively prevent disease and maintain chronic conditions. Our aging population and a financially stressed long-term care system will require more policy change and imagination than the current home and community-based service options provide. More than 200 global health organizations exist in the greater Puget Sound area, motivating improved alignment and coordination of missions, goals and resulting policy outcomes. Public policy decisions will increasingly require more holistic planning to attend to these intersecting issues and varied stakeholder groups. Greater use of neutral third-party services may provide a deeper set of tools to enable creative ideas, build group integrative value, align disparate stakeholder interests and produce collaborative results.

This Study included informant interviews of more than 75 professionals in the public, private and non-profit sectors who impact healthcare policy in Washington state and the Northwest. Other informants outside of the Northwest were interviewed, including seasoned public policy facilitators, and both private and university-based/affiliated centers. Represented stakeholders, including authorizers, funders, payers, providers and others expressed interest in a potential role for university-based third-party neutral services – to improve collaborative policy-making processes, consensus building and workgroup momentum. Most recognized the lack of professional facilitation expertise in traditional healthcare policy processes, as well as the federal and state governments' recent movement to encourage stronger input from and consensus building between stakeholders.

Faculty at Washington State University and the University of Washington expressed great interest in potential teaming opportunities with the Center. Faculty are interested in expanding opportunities for their programs and students to engage in meaningful healthcare policy collaboration and help to build sustainable consensus between stakeholders, beyond a traditional academic research role. Some informants expressed the desire to become more involved in a greater role involving the large healthcare transformation activities that are currently in progress in Washington. Others involved in traditional public health research and practice recognized the newer integration between population health and financing goals across fragmented state and local agencies. Collaborative techniques may help to align and streamline interagency goals and redundancies, using larger transformation changes to build consensus and integrative value.

Finally, this Study explored recent and current healthcare public policy challenges, to provide some examples of potential areas that the Center might consider if interested in pursuing a healthcare portfolio. These examples should be considered in the context of a strategic plan and filtered through the Center's Project Criteria, with the goals of building healthcare practice credibility, Center and Advisory Board member support and stakeholder confidence. The Center will likely require external funding sources to support a full-time equivalent and requisite support to launch the effort required to build a successful and sustainable healthcare practice.

Brief U.S. healthcare history

A compressed historical perspective may help to frame the present state of healthcare policy and conflict in Washington (and nationwide). Healthcare delivery historically grew out of a trade-oriented structure. In the **late 19ᵗʰ and early 20ᵗʰ centuries**, doctors practiced healthcare as trusted craftsmen. The average age of our citizens was younger, lifespans were shorter, medical 'technology' was rudimentary, house calls were frequent, and hospitals were in place to serve patients at the request of doctor's orders (largely for surgeries and acute health issues). These, among other factors contributed to a relatively low societal cost of healthcare. Limited science resulted in limited diagnoses, and care was primarily provided for acute symptoms. Mental health issues were stigmatized, often labeled as 'feeble-mindedness', and often resulted in asylum institutionalization.

 The 1960s ushered in the 'Great Society', including the Social Security Act that introduced the Medicare (for aged and disabled) and Medicaid (for indigent, aged and disabled) publically funded programs. Public and private insurance (largely a post-WWII phenomenon that linked employment to health benefits to competitively attract employees) became the primary healthcare payers, and most providers accepted a mix of patients in their practices. Providers were largely paid on a 'fee for service' basis, typically as a percentage of their costs. Medicare (federally funded) paid primarily for <u>acute</u> medical care delivered in hospital inpatient settings and physician offices. Medicaid (state funded with federal match) generally covered low income families with children, as well as <u>long-term care</u> (nursing facility care) for the aged. Over time, both Medicare and Medicaid programs grew to cover more types of eligible populations and a wider array of benefits/provided services.

In the **1970s and early 1980s**, the federal government recognized that fee-for-service payments based on costs were increasing at an unsustainable rate of medical inflation. This resulted in a major policy change that altered the methodology that Medicare (the federal government) paid for hospital inpatient services. This method (fundamentally still in place today) pays the hospital a 'fixed' rate per hospital stay per patient, primarily based on the combination of specific patient diagnoses (and other factors) that are coded into the payment system. If you enter the hospital for kidney stone removal, Medicare will pay that hospital a fixed amount (subject to several 'add-ons'), regardless of your length of stay. This shifted the financial risk to the hospital, as additional hospital day volumes were no longer paid for as a 'daily' or procedure-based rate.

Medicare eventually changed the way that physicians are also reimbursed, in an effort to pay doctors on a more systematic basis. A new era of payment reform took hold, and state Medicaid programs generally followed Medicare's lead. Private insurance was still paid on a fee-for-service basis, subject to negotiated discounts between the insurance carriers and providers (still largely in place today). Private and public pay patients had few out-of-pocket costs- premiums were reasonable, and there was little incentive for patients to question costs or volume of services. However, physicians began to notice that their private pay revenue was subsidizing more and more of their lower Medicare and Medicaid reimbursement, creating concerns about Medicaid and Medicare patient access to care.

Managed care programs were introduced on a larger scale in the **late 1980s and 1990s**, in both the private and public sectors. While publically perceived as an initial failure, the concept reformed and eventually became the impetus for many of our current healthcare transformation policies related to

care coordination, consumer-driven care, quality and outcomes measurement, new payment and risk-sharing methods and cost containment.

Today, Medicare and Medicaid represent over half of all healthcare spending in the United States. Our population has aged, and costs related to chronic disease, long-term care and behavioral health (mental health and chemical dependency) have become exponential spending factors. For example, elderly and disabled Medicaid beneficiaries represent only 24 percent of enrollment, but 64 percent of Medicaid payments nationwide.[1]

Payment methods are changing in both the public and private markets. Risk adjusted payments are becoming more complex, and providers are assuming greater risk for the delivery of care and outcomes (which are complicated to measure when patients have many multiple acute and chronic diagnoses). 'Patients' are quickly becoming 'consumers', and have assumed more financial risk in the form of higher premiums, deductibles, co-payments and co-insurance. We are currently experiencing this transformational shift from 'pay-for-volume' (fee-for-service), to 'pay-for outcomes/value', which is impacting both the infrastructure and methods of care delivery and coordination.

Hospitals and physicians are undergoing a substantial cycle of consolidation. Hospitals continue to acquire physician's practices, in an attempt to competitively create scale and vertically integrate. This conversion of doctors to 'employee' status has created challenging cultural and organizational issues for many health systems. Hospital health systems continue to merge or acquire other health systems (e.g., Providence and Swedish), creating entities that combine very different organizational cultures. Other systems are attempting teaming arrangements, to survive, as well as address geographic disparities and provide greater competitive scale (several occurring between Western and Eastern Washington entities).

> **Healthcare Transformation Shifts:**
> ➔ **Pay for Volume**
> ➔ **Pay for Outcomes**
> ➔ **Pay for Value**
>
> *How to transform without pitting hospitals against doctors against consumers against government against other providers and stakeholders?*
>
> *How to treat each person as a 'whole' and as a responsible partner with dignity and respect?*
> - *Medical*
> - *Behavioral*
> - *Social*
> - *Cultural*

The newer insurance benefit exchanges (for example, the 'Washington Healthplan Finder' state exchange) have begun to open up competition for individual and small group markets, but are still in early stages and face ongoing public policy debate and modifications. Public sector agencies (both state and local) are receiving federal funds to design new ways to coordinate siloed care (between providers; between medical/behavioral health; between different state agencies). Siloed state agencies serving the same populations (providing financing, program oversight and regulatory compliance) often result in delayed processing of consumers into publically funded programs, delayed assessments of consumer medical and behavioral issues, duplication between agencies and redundant administrative burden impacting consumers, state employees and providers.

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[1] 2010 Pew Analysis of Medicaid Statistical Information System reported by the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute.

Managed care organizations have 'reinvented' themselves, taking on numerous forms and operational/governance structures – traditional insurance companies, hospital/health systems-based, regional or coordinated care entities and others. Large employers like Boeing have decided to contract directly and competitively with health systems for their employee's care, excluding 'middle man' insurance companies/managed care organizations.

New provider delivery and payment methods (many rebranded from older concepts) are in vogue, to address the goals of care coordination, integrated and 'person-centered' care, improved quality and cost containment. Accountable Care Organizations, Patient-Centered Medical Homes, bundled rates, global rates and other organizational and financing forms have been a large part of federal and state demonstrations, to try to identify elusive best clinical, delivery and payment practices; narrow the wide disparities among outcomes and costs across the country, and share greater responsibility and risk with providers and consumers.

Pharmaceutical utilization and costs have risen dramatically. Multiple prescription drugs have become routine for many, and represent one of the fastest growing cost components of healthcare today. Generic drugs are not always a significantly cheaper alternative to brand medication.

A litany of other types of providers (e.g., community clinics, mental health agencies, school districts, residential care facilities and other home and community-based providers) remain fragmented in the 'system'. Coordinating care delivery to improve quality and reduce costs are elusive goals, as consolidations and related 'narrow' provider network restrictions could marginalize important providers, who often operate in more efficient and less expensive venues.

In addition, rural areas often view the impact of healthcare transformation differently, as consumers endure long travel times, and certain types of providers may not even exist in large geographies (note prior comments on Medicaid and Medicare consumer access based on relatively low reimbursement). Telehealth and other technologies applied to healthcare delivery and care coordination are becoming more prevalent, and frequently require stakeholder design and implementation recommendations for new policy and legislative solutions. Many expect that technology will lower costs over time, scale care delivery and extend the reach of providers into areas that are access-challenged.

State payer and oversight agencies (for example, Medicaid/Apple Health and the Healthcare Authority in Washington) have publically recognized that they cannot prescribe a statewide 'one size fits all' solution to extensive transformation goals. States like Washington are asking local/regional stakeholders to help refine policy and related implementation ideas that make the most sense for their areas. Facilitation is often a critical component to developing regional and local alternatives, but lack of neutral facilitators is problematic.

This preamble is related to the <u>financing</u> and <u>delivery</u> of healthcare services to Washington citizens. These transformational changes also impact the traditional ***public health*** sector. Public health agencies are increasingly working on larger policy and infrastructure issues, and less on the provision of direct service. Public health staff and academic researchers are aligning their work with the delivery sector's realization that acute, chronic and behavioral healthcare costs cannot be truly impacted without a greater emphasis on systematic preventive education and care, individual responsibility and wellness. Wellness programs are poised to evolve from minor employee-based

incentives (such as gym discounts and smoking cessation incentives) to larger community-based programs with significant policy implications. Many of the newer programs involve a wide variety of community partners, working together with healthcare providers, faith-based organizations, foundations and other funders to generationally impact children and young adults, by communicating with them on their own terms. Smart phones, fitness bands and other rapidly emerging technologies are expected to play a major role in the intersection between personal and public health. Convening and facilitating skills are suggested as a way to help scale community partners, and develop, debate and resolve public policy alternatives to build a common mission and design sustainable solutions – with the results impacting the larger goals of civic health, sustainable economies and quality of life.

Finally, Seattle and the greater Puget Sound area has become a powerhouse of **global health**. More than 200 global health organizations call the Puget Sound area home. The Bill and Melinda Gates Foundation is responsible for the existence of many, although a growing number are driven by alternative missions. The need to provide convening services among global health organizations to scale and leverage partnerships is apparent, and addressed in part by groups like the Washington Global Health Alliance.

U.S. healthcare has entered a new chapter of change. Some of the more recent transformational concepts are updated versions of care delivery and integration attempts from past periods. Some of the newer technological experiments are in their infancy, and hope to leverage personal communication devices, genetic typing and 'personalized' medicine. Healthcare providers are being asked by payers to deliver integrated care and manage additional financial risk, with the goal of delivering better care practices, reducing outcome disparities and curbing costs. Consumers are beginning to become incented financially to manage personal responsibility and healthcare utilization, through a more educated use of appropriate settings and care options. Many models are emerging and evolving, which will likely result in a long period of trial and error.

Much of this transformation and experimentation require stakeholders, consumers and communities to find better ways to communicate and align interest based issues and goals. Facilitation and other collaborative processes are tools that can help to pre-empt conflict, build and maintain shared momentum and address policy differences as Washington continues to transform.

Healthcare policy - conflict resolution/pre-emption potential

While the general concept of consensus building is strong in Washington, conflict resolution and pre-emption techniques have not been a generally accepted and standardized practice within healthcare policy circles. Third-party neutral facilitation services are not systemically embedded in the healthcare sector. When facilitation occurs, it is often informal, or may involve a state agency simply convening a work group of stakeholders to provide guidance related to policy design or implementation concerns. There is often no structured process to provide for interest-based negotiating or trust building. Stakeholders may have a long history of shared conflict, as well as shared complaints about lack of genuine decision-making progress. Basic structured collaborative techniques, including situation assessment, group formation, ground rules, criteria development and other consensus building tools are generally lacking.

Infrequently, private sector consultants may be used to convene work groups under their existing service contracts (often tactical program design, evaluation and implementation services) with the state or local governments, but lack third-party neutral credibility. In 'related' cases, public and private consultants may include structured studies/surveys/informant interviews, but these are generally confined to soliciting stakeholder or public input relative to specific program critique.[2] Beyond the historical norms noted, other barriers to public sector use of third-party neutrals include:
- Lack of private sector consultant expertise in both health policy subject matter <u>and</u> structured facilitation expertise.
- Contracting barriers – the public sector is the authorizer of most significant public health policy design, implementation and evaluation work. Although funding for consensus building services could come from a variety of stakeholders, the public sector has historically determined facilitation need. Contracting with the public sector requires lengthy and bureaucratic competitive contracting processes. It's often easier for the public sector to attempt to convene or facilitate workgroups themselves. In rare cases, the public sector has invested internally to grow facilitation expertise.[3]

Healthcare transformation trends include increasing attention and guidance by the federal oversight agencies (for example, CMS, the Centers for Medicare and Medicaid Studies; VA, the Veterans Administration) to encourage (and in some cases require) states to solicit meaningful stakeholder input when considering policy changes to Medicaid and other publically funded programs. State health and human service agencies (Medicaid, Behavioral Health, Developmental Disabilities, Aging, Rehabilitation and others) are under increasing pressure from their federal oversight agencies, governor's offices and legislators to move beyond traditional public hearings ('two minutes at the microphone') and unfacilitated workgroup meetings that often restrict membership.

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[2] A strong example is a Washington State Health Technology Assessment, conducted by the Center for Evidence-Based Policy at the Oregon Health and Science University (OHSU). This study's purpose was to understand stakeholder's perceptions on program/process effectiveness with respect to mandates. In this example, OHSU did provide the Healthcare Authority with an assessment/survey/facilitation process.
http://www.hca.wa.gov/hta/documents/stakeholder_engagement_project_report_final_part_two.pdf
[3] Howard Gadlin is the Director for the Center for Cooperative Resolution in the Office of the Ombudsman within the National Institutes of Health, and was interviewed for this study.

The following quotation examples from federal agencies demonstrate their growing interest in advancing stakeholder input into public policy design and implementation processes:

- (CMS expectations to state agencies related to state development and implementation of managed long-term care supports and services policy):
    - *Adequate Planning: It is essential to allow adequate time in advance of implementing new, expanded or reconfigured MLTSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to MLTSS.*
    - *Stakeholder Engagement: Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross-disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same.[4]*

- (Agency for Healthcare Research and Quality expectations for development of care management programs):
    - *Engaging Stakeholders in a Care Management Program: Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide*
        - *Stakeholder support, beginning with program design and continuing through the evaluation, is critical to a successful Medicaid care management program. Stakeholders should be involved during each stage of the program to build support for it, provide suggestions for its design, and participate in evaluation and continuous quality improvement activities. Stakeholders include senior Medicaid and agency leadership, the Governor's office, the provider community, the patient and advocacy community, the State legislature, and the Centers for Medicare & Medicaid Services (CMS).[5]*

Many health policy authorizers are unaware of the existence of university-based or affiliated third-party neutrals. During interviews, one Washington Apple Health Medicaid official realized the Ruckelshaus Center's potential to fulfill the need to transform their typical stakeholder workgroup methodology into a more structured process. She recognized that situational assessment of stakeholder interests by a neutral party, coupled with professional facilitation methods that seek to find common ground and minimize disparities could help break traditional bottlenecks, allow for stakeholder 'ownership' and potentially lead to an improved base of support for policy direction. In addition, she recognized the relative contracting and administrative ease offered through the use of a Washington inter-agency agreement (or something similar) with a university-based center.

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[4]http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

[5] http://www.ahrq.gov/professionals/systems/long-term care/resources/hcbs/medicaidmgmt/medicaidmgmt2.html

Stakeholder 'demand'

A significant portion of this study's time was spent conversing with diverse stakeholders, including:

- Healthcare providers, including hospital health systems
- Public payers, including Washington's Apple Health (Medicaid) and the Healthcare Authority
- Private payers, including traditional health insurance entities
- Advocates and ombudsmen
- Specialized non-profit agencies, including direct service providers
- Foundations supporting healthcare transformation and public health missions
- State legislators
- Governor's Office senior health policy advisors
- County and regional representatives tasked with health policy multi-party agreement goals
- Provider and other industry associations and alliances
- Other university-based and affiliated alternative conflict resolution Centers and Institutes that have considered or attempted health policy engagements
- Private conflict resolution firms and individual practitioners who have considered or attempted health policy engagements

Stakeholder interview results ranged from curiosity to strong interest in the Center's value proposition for health policy conflict resolution or preemption. Generally, any skepticism noted was questioned, and seemed to be due to the historical lack of this sector's use of third-party neutrals and collaborative problem-solving techniques. Many health policy stakeholders have been enmeshed in traditional negotiation tactics for many decades, creating a conventional culture that often results in inaction, slow action or deadlock. Many informants complained about this culture, while positively recognizing (and volunteering) that the federal government and state are under pressure to expand collaboration and consensus building activity.

Several informants recognized that the 'old way' of negotiating is too cumbersome, slow to gain results, and often hamstrung due to the complex multi-party interests. Several recognized that sometimes marginalized stakeholders, including consumers and advocates are now expected by authorizers to represent an important 'seat' at the table, and to contribute in meaningful ways (for example, the need to redefine 'person-centered planning' within the newer health delivery models will elevate these stakeholder's opinions in policy discussions).

Study time constraints created a limited number of interviewing 'gaps' (for example, union representation). Upcoming interviews with those entities are recommended prior to any substantial Center movement into implementation.

Other than the noted exceptions, very few informants were aware that third-party neutral services could potentially be available to help improve their public policy process. When questioned about this, their answers often indicated their admission of status quo. Several informants liked the concept of using university-based factual data and research, to maintain neutrality between

stakeholder interests and allow for opportunities for stakeholders to modify positions. While many healthcare stakeholders know of Bill Ruckelshaus, and several know of the Center, very few know of the services the Center provides.

The following briefly summarizes some of the informant groups' 'demand' for third-party neutral service value, as well as noted comments of interest. More detailed examples are identified in the 'Healthcare policy and program examples' section.

State of Washington Public Sector: Meetings and follow-up conversations were held with Governor Inslee's Office of Legislative Affairs and Policy, Apple Health (Medicaid) and Healthcare Authority (HCA) officials. A representative from the Office of Legislative Affairs and Policy indicated strong interest in the potential value of services the Ruckelshaus Center might provide. As noted, state health and human service agencies often facilitate policy workgroups themselves. Several interviewees expressed long-term frustration with stakeholder's willingness to attend meetings, without achieving real or timely progress. Others noted that long-standing relationships sometimes create an institutionalized 'fatigue' – everyone believes they know where everyone else stands before the meeting begins, often leading to pre-determined stalemates and bottlenecks. Agency officials are given relatively little time to implement programs, whether answering to the legislature, the federal government, the courts or the Governor. Health transformation often requires maximizing staff time to get through design and implementation phases; time spent on stalemates becomes frustrating for all.

Most of the examples these professionals identified during the interviews involved their greater priorities at the time: large, public policy initiatives that require genuine input, design and implementation recommendations and support from local communities, providers, commercial payers and legislators. Many of these recent examples are on federal timeline requirements (for example, federal grants provided to Washington to advance coordinated care delivery; or to integrate physical and behavioral health through newer contracting methodologies). These types of public policy design projects generally require workgroup formation that includes a wide variety of stakeholders (for example, providers, consumers, advocates, unions, local public sector representatives and others representing differing interests). The timelines are generally tight, depending on the federal and state goals. State authorities are often under pressure to ensure that workgroups meet for a finite period of time, and expect momentum and results. Structured facilitation sounds like an appealing alternative, given past challenges. Stakeholders also hope to avoid unnecessary waste and delay, based on the possibility of advancing program and policy changes that could support their missions and align with their financial goals.

These larger, highly visible project examples overshadow the potential need for convening/facilitating experience relative to less media-sensitive issues. This report's expanded 'Healthcare policy and program examples' section identifies a range of possible projects that might be suitable examples for Center involvement.

Public sector entities interviewed and/or researched: Governor's Office of Legislative Affairs & Policy; Washington Health Benefits Exchange; Washington State Healthcare Authority/Apple Health (Medicaid); Washington State Healthcare Authority/Public Employees Benefits Board; Washington State Department of Health; Washington State Office of the Health Commissioner; county public health agencies; county/regional Accountable Communities of Health representatives

Providers: Hospitals/health systems are not the only representative stakeholders at the taskforce table, but they are one of several powerful stakeholder groups (along with the Washington State Hospital Association) that participate significantly in many policy workgroups. Given the recent acquisition and consolidation cycle, hospital systems have their own internal competing interests, as well as those represented at the workgroup table.

Interviews with providers ranged from facilitation process skepticism (often based on non-structured work group or task force history), to curiosity and guarded interest. One health system executive echoed the frustration of public sector officials with respect to policy stakeholder workgroup's lack of speed and progress, and wondered if a third party neutral might help to restructure a workgroup's time and momentum to everyone's advantage.

Some expressed frustration with barriers to scaling demonstration methodologies believed to be of value on a statewide basis. For example, internal hospital studies measured hospital costs associated with societal issues (and costs to society in the form of charity care); in one case, the costs of the state law requiring that emergency medical technicians bring people to the hospital emergency room, regardless of assessed injury or issue. This hospital demonstrated a significant percentage of 'pickups' involved persons with behavioral problems that cannot be treated in an acute hospital setting, and the associated costs to all through uncompensated care. Suggestions for appropriate diversion protocols- in this example, to divert mental health issues to proper agencies- would require changes to state law. Frustration is based on the inability to get legislative attention when overshadowed by higher priority legislative issues. This hospital executive wondered if a convening/facilitating role for a third party neutral might help stakeholders refine these ideas and build consensus.

Providers/provider associations interviewed and/or researched: Providence/Swedish/Northeast Washington Medical Group; Group Health; University of Washington Medicine; Virginia Mason Washington Medical Center; Community Health Systems; Everett Clinic; Community Health Plan of Washington; Polyclinic; MultiCare Health System; Veterans Administration Medical Centers; Washington State Hospital Association; Washington State Medical Association; Washington Healthcare Association; Northwest Physician's Network; Inland Northwest Health Services; Rural Health Clinic Association of Washington; Ryther Health; Critical Access Hospital Network; Yakima Valley Farm Workers Clinic

Foundations: One interviewed health foundation in Eastern Washington expressed interest in the Ruckelshaus Center's potential value. While rural health is one area of focus, this foundation is involved in funding WSU academic research and practice related to traditional public health issues (for example, reducing childhood obesity, improving healthcare access, reducing health disparities in tribal communities) and newer innovative issues (for example, Affordable Care Act implementation, care coordination models, and application of adverse childhood experience science). In addition, this foundation is substantially involved in the recent Accountable Communities of Health (ACH) portion of the Washington State Innovation Model Grant, which includes the significant vision of aligning physical and behavioral healthcare delivery. They attempted to provide convening services to stakeholders in their state ACH regions, but admit to no professional background in this area. They were intrigued with the concept of a university-based third party neutral, and how the Center's facilitation services might benefit the legitimacy of their stakeholder collaboration, as well as help to build durable trust in multi-sector alignment activity (with the goal of building workable delivery of

care contracts between contentious provider groups and multiple stakeholders, including the public sector and business community).

In addition, foundations that focus on healthcare improvement usually work in related public policy areas that could potentially benefit from third-party neutral services. For example, housing and homelessness issues are 'linked' to healthcare, both in research and program funding. Recent health transformation activities (in foundations, as well as other stakeholder groups) include recognition that these linked 'wicked' public policy problems require new approaches, after decades of failed attempts. Newer funded linkages between these issues will likely expand the number of stakeholder teams needing to collaborate - potentially requiring greater convening and facilitation skills as multi-sector and multi-stakeholder interests surface.

Foundations interviewed and/or researched: Empire Health Foundation; Philanthropy Northwest; Foundation for Healthy Generations; Seattle Foundation; Paul G. Allen Family Foundation; Group Health Community Foundation; Inland Northwest Community Foundation

Commercial Payers:
A limited number of interviews were held with commercial payers. The newer Washington Health Benefits Exchange, designed to provide federally subsidized[6] health insurance products to individuals, families and small businesses in Washington is in its second year of operation. Commercial insurance carriers and other entities ('Qualified Health Plans, or QHPs') offer competitive health insurance products through the Exchange. Several of these entities also offer products to serve Medicaid and 'dual eligible' populations (Medicare/Medicaid eligibles) through the state's Medicaid managed care and other waiver programs. Finally, many of these entities continue to provide commercial health insurance through employers, as well as Individual insurance products.

Public policy issues impacting these stakeholders can be significant. For example, consumers with varying income levels from year to year can switch between Medicaid and Exchange eligibility, creating a phenomenon known as 'churning'. This can be costly to all payers, create coverage gaps and inconsistency in physician and other provider care continuity, and add significant administrative costs to QHPs and Apple Health. While Washington and other states have attempted to address this problem through a variety of methods, the Exchange is still relatively new and untested in several aspects; policy is expected to change over time to address emerging issues.

Washington's All Payer Claims Database is one of the fundamental infrastructure changes that allows for state policy development around population metrics, as well as provide consumer visibility related to provider charge and other information, in order to facilitate competitive comparisons. The state encountered several challenges with a major carrier's willingness to participate. Although that matter is now largely settled, a facilitated effort may have saved significant time and funds.

Private health exchanges are becoming an emerging trend, to support new models of benefit design for employers. This 'new' competition may create a need for conveners and facilitators, with respect to education and potential conflict with established systems.

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[6] Federal subsidies vary based on individual/family modified adjusted gross income.

Commercial Payers interviewed and/or researched: Premera/Blue Cross; Regence/Blue Shield; Group Health; Molina Healthcare of Washington; United Healthcare; BridgeSpan; Moda Health; LifeWise; Community Health Plan of Washington; Coordinated Care; Amerigroup; Columbia United Partners; Kaiser Foundation Health Plan of the Northwest; Cigna, Aetna; Aon Hewitt

Consumer Advocates/Unions/Others:
Consumer advocates have historically been relegated to 'second class' status in health policy negotiation. Washington State has been progressive in this regard; coupled with increasing attention and guidance from the federal government, consumer advocates have an increasingly stronger voice and a more significant 'seat at the table'.

The trend in healthcare delivery transformation includes a renewed focus on **person-centered planning** strategies. This includes not only giving consumers a stronger voice and option choices in their own care planning, but redefining the concept itself and how it relates to transformation goals (including care coordination and integration; improving quality and satisfaction; streamlining consumer experience; educating consumers to have an informed 'say' and partnership, and saving costs). The policy design and implementation decisions related to all of transformation's 'moving parts' are subject to stakeholder interpretation and interests – without successful collaboration, consumers and advocates can create significant roadblocks to transformation delivery. For example, several states that have attempted to integrate developmental disability services into Medicaid managed care without collaborative efforts have faced powerful advocacy that has delayed or eliminated integration.

Unions are an important stakeholder in most policy discussions. Representation of licensed, certified and paraprofessional healthcare workers goes beyond traditional collective bargaining issues. Healthcare transformation impacts the way that can healthcare workers conduct their jobs, and integration efforts can have a major impact on 'who does what'. Demographic changes (aging population, population increases in rural areas and a significant retiring tranche of healthcare professionals) will continue to negatively impact access to care[7]. Mitigating factors, including possible changes to scope of practice laws, use of new technology and new supervision requirements will continue to attract union attention, and place unions, providers and payers on opposing sides of many issues. 'New' approaches to collaboration will be required to address the continuing demographic shifts the 'baby boom' generation is experiencing. University-based experts in public health and policy, as well as nursing could provide neutral research on best practices and impacts in other states demonstrating the necessary policy components that could be facilitated.

Migrant farm worker health issues have been researched for many years. The ongoing convergence of public and population health perspectives may require new education, training and care delivery methods that specifically address agricultural labor issues. Agriculture, labor and community involvement may benefit from neutral convening or facilitation services, to address labor shortages, environmental health and justice issues. University-based subject matter expertise in Eastern Washington public/rural health research may provide the necessary credibility to support

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[7] One of the two past Ruckelshaus Center healthcare projects (Eldercare Workforce) addressed these demographic changes in a project conducted with the UW School of Public Health. The two healthcare projects helped the Center develop partnerships with the UW Schools of Public Health and Nursing. Both of the two project managers were included in this study's informant interviews.

convening or facilitating forums. Faculty and students may be able to use research in a neutrally-accepted format to help develop new policy and scale implementation efforts.

Community partnerships are forming exclusive of federal and state-sponsored programs. For example, the Snohomish County Health Leadership Coalition has developed a community alliance with the goal of scaling prevention and wellness programs to all generations on terms they understand and respond to. County and community partners, along with local hospitals (Providence Everett is a sponsoring supporter) and other health providers have developed community partnerships such as United Way, Boys and Girls Clubs, scouts, schools and a variety of faith-based groups to support 'civic health' initiatives. These are designed to actively link community health improvement to economic development and prosperity on a generational level. Such scaling efforts and renewed interest in **population health interventions** may benefit from advanced convening or structured facilitating efforts. Education and communication/messaging subject matter expertise may be one way to link in legitimate university value.

Consumer Advocates/Unions/Others interviewed and/or researched: Washington State Labor Council; Service Employees International Union Healthcare; Washington State Nurses Association; Snohomish County Health Leadership Coalition; Snohomish County Ombudsman; CityClub of Seattle; United Way of King County, United Way of Snohomish County, Washington State Health Advocacy Association; Community Health Network of Washington; Healthcare Leadership Council; Family Voices; National Coalition on Healthcare

WSU and UW – Healthcare policy 'supply'

The two university systems are obviously vast, and represent an extensive set of schools and programs that directly or indirectly impact (or are affected by) healthcare in our state. As expected, university program diversity somewhat mirrors that of healthcare policy issues, covering not only the subsectors noted, but also other significant topics (for example, collective bargaining; competition and antitrust issues; urban planning/built environments and other areas that intersect with health policy). While it may be worthwhile to recognize the importance of these diverse industry issues within the healthcare sector, they were not the focus of this study. It is possible that some of these topics may present a future need for collaborative problem solving techniques, exclusive of traditional bargaining, negotiation and litigation venues.

Such intersections may provide university-based facilitation opportunities to help leverage and scale academic work that is frequently 'siloed', providing greater exposure to and collaboration between health-related initiatives involving wellness and prevention, public education, community health and economic development.

This study's time limits required 'triaging' interviews with university faculty, students and staff. Most of the time spent at **UW** involved interviews in the Schools of **Public Health, Nursing, Law, Public Affairs and Medicine**. Most time at **WSU** included interviews in the **Schools of Nursing, Human Development, Communications and Extension**. The WSU Ph.D. program in Prevention Science is multi-disciplinary, and includes faculty and students from Human Development, Communications, Criminal Justice and Criminology, Psychology, Nursing, Kinesiology and Education. A great number of other identified departments and centers at both universities may offer significant teaming capabilities with the Ruckelshaus Center. Additional interviews are recommended to more fully address potential.

Program faculty and others were generally identified for interviews based on:

- Existing/past relationships with Ruckelshaus Center Advisory Board members and staff;
- School/program searches based on known involvement with state health policy issues;
- Chain-linked referrals from stakeholder interviews;
- Searches for and chain-linking between specific faculty associated with health policy issues, based on published research and practice reputation.

The teaming nature of research and faculty relationships (within and between the two university systems) provided ample opportunities for introductions to others. This may be an obvious positive point for potential Center partnering- it didn't take long to find out who the relevant persons were with respect to different issues, but did require an initial investment of focused time to identify the appropriate 'starting points'.

Practical time constraints limited the number of interviews conducted. If the Center is interested in continuing to broaden its base of healthcare-related contacts, a supplemental list of recommended faculty to interview in included in the interview roster in Appendix A: Informant Roster.

Adequate 'supply' of subject matter experts is not a future barrier. Both universities provide deep experience in a variety of health policy forums. UW's School of Public Health includes a wide variety of teaching, practice centers and research programs, as well as connections to 'affinity groups', including:

- Department of Health Services: Includes a variety of programs, including health informatics, health policy, maternal and child health and social & behavioral science;
    - Community-Oriented Public Health;
    - Health Administration;
    - Biostatistics;
    - Epidemiology;
    - Quality Metrics Research and Training

The UW School of Public Health has a relationship with the Ruckelshaus Center, including faculty, staff and students who have provided both project management and support on past projects. Experienced faculty in the school's many programs are diverse in subject matter expertise, and could provide solid staffing for the Center on healthcare projects, if appropriate incentives are available to attract time commitment. Interviews across both universities identified that junior faculty are generally interested in more practice-orientation, and a desire (if their research aligns) to be more involved in policy-making engagements.

The UW School of Medicine is one of the largest healthcare providers in Washington (including medical practice and hospital services at the UW Medical Center, Harborview, Children's and the VA Puget Sound), and provides an important medical teaching and research component to our state's healthcare sector.

The UW Department of Global Health is a 'bridged' program between the Schools of Medicine and Public Health, and focuses on:
- Health Metrics and Evaluation
- Infectious Diseases
- Workforce Development
- Health Systems Science
- Global Environmental Change
- Global Injury and Violence
- Global Medicines Safety
- Women, Children & Adolescent Health
- Social Justice & Equity

The UW School of Nursing includes programs in:
- Biobehavioral Nursing and Health Systems
- Psychosocial and Community Health
- Family and Child Nursing

The Center has had a project relationship with limited faculty at the School of Nursing. Many nursing faculty also teach at the Schools of Medicine and Public Health. Specific experience (for

example, community nursing) may be quite useful as our state's healthcare transformation includes a significant emphasis on empowering communities, counties and regions. The School of Nursing should be a strong candidate for Center attention, if healthcare projects are solicited[8].

The UW School of Law provides concentration tracks in:
- Dispute Resolution
- Health Law

The UW School of Law also hosts the Center for Law and Science in Global Health, and draws on an interdisciplinary faculty team to provide an academic experience in law and policy in domestic and global health law. Specialized Health Law LL.M., dual J.D./M.H.A. and J.D./M.P.H. in health services degrees, and a J.D./M.P.H. in Public Health Genetics are offered. The Dispute Resolution track may be able to provide the Center with interns, project support and possibly future facilitators.

The UW Evans School of Public Policy and Governance offers Public Administration degrees and faculty experience in a variety of healthcare interdisciplinary research and practice efforts, including faculty who work with public health and health benefits issues, in subject areas that correspond to their research interests[9].

Other UW Schools and Centers may have promising potential for teaming opportunities, including:
- College of Built Environments – links to healthcare outcomes
- Center on Human Development & Disability
- Center for Ecogenetics & Environmental Health
- Pacific Northwest Agricultural Safety & Health Center

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WSU's Health Sciences Program includes schools and programs in:
- Health Policy & Administration
- Medical Sciences
- Nursing – includes program in Advanced Population Health
- Speech & Hearing
- Pharmacy
- Nutrition & Exercise Physiology

WSU's School of Nursing faculty and students provide research and practical work on traditional public health issues. As expected, much of this work includes rural health issues. In addition, the new School of Medicine has begun its accreditation process, expecting to graduate its first class of medical students in 2021.

Some of WSU's Department of Human Development faculty are leading the multi-disciplinary Ph.D. program in Prevention Science, as noted. The program emphasizes training in both

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[8] For example, Professor Betty Bekemeier researches public health system development and financing, as well as public health workforce development issues.

[9] For example, Professor Justin Marlowe researches new cost accounting methodologies that address chronic underfunding of local public health districts throughout Washington.

the <u>generation</u> of research-based knowledge and its <u>translation</u> into effective programs and policies that positively impact the well-being of children, youth, adults, families, and their communities. Faculty has expressed interest in teaming with the Ruckelshaus Center on future projects; this may be especially relevant, given major state policy emphasis on scaling wellness and prevention programs as one of the three goals of the Healthier Washington transformation.

WSU's Edward R. Murrow College of Communication hosts the Murrow Center for Media and Health Promotion. Faculty and students conduct applied research that examines how people use media messages in their decisions about health, and how health promotion practitioners can maximize the effectiveness of health messages targeting young people and their families. Their Center's work is intended to help individuals and health professionals use media most effectively to facilitate informed and healthy decisions, a potentially strong component of prevention and wellness programs[10]. Murrow College faculty have also expressed interest in potential teaming opportunities with the Ruckelshaus Center.

The other programs within the Health Sciences program, including Health Policy & Administration may provide the Center with additional subject matter experts. As WSU's medical school program builds, it's likely that other interdisciplinary programs may emerge that may be relevant to the types of projects the Center may be asked to engage.

Faculty at both universities expressed interest (to varying degrees) in working with the Ruckelshaus Center. Their interests include opportunities to participate in policy design and implementation efforts, and to offer opportunities to their students (potential project work, as well as intern opportunities). As noted, senior faculty were excited to be able to offer junior faculty more 'practice-oriented' or applied work, as opposed to pure research studies.

Funding and time commitments are the obvious practical limitations. The Center is used to transferring funds within the universities' systems- hopefully, this will continue to be effective if more healthcare projects are solicited. The time commitment issue seems more challenging. If successful, a long-term strategy might include the development of a Ruckelshaus Center Healthcare Consensus Group, with some formalized inter-disciplinary structure that involves more commitment from specific faculty and/or programs at UW and WSU. In the short to mid-term, more focus and momentum beyond this study will be required to develop deeper relationships with subject matter experts to commit to different project scope.

This study was not successful in identifying new experienced facilitators. The Ruckelshaus Center already has a few healthcare-related faculty/staff who have worked on prior Center projects, but it's unlikely that these people will be able to leverage their facilitation skills to others. The Center might look for opportunities to provide specific internships with the UW's Law School and Evans School graduate students who have studied or worked with collaboration and negotiation techniques, and similar programs at WSU. Building a 'pipeline' is a long and dedicated process – and may require expanding partnerships with both universities.

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[10] For example, Professor Erica Austin researches communication related to politics and health. Professor Stacy Hust researches media effects and strategies to prevent alcohol abuse. Professor Bruce Pinkleton researches health promotion and media literacy related to abuse prevention.

Examples of other Center's healthcare work

A portion of time was spent interviewing experienced individual practitioners, as well as other Centers. Most have operational and business models that vary, depending on historical growth, funding sources and differences in staffing/subcontracting. Several had facilitated healthcare policy or related issues in the past, but had not substantially leveraged those opportunities. All had ranging interests in the potential, but many did not have the dedicated capacity to move proactively into healthcare with deliberate growth goals in mind. Many admitted the complex nature of healthcare policy and the need for subject matter expertise, with the noted exception of the most seasoned individual practitioners; after many decades of experience, they felt comfortable moving through any subject material, without feeling the need to have any specific background in the area. Several of these highly experienced professionals felt that their lack of healthcare expertise (but a solid knowledge of public sector and legislative processes and pressure points) worked to their advantage – this helped them facilitate or mediate from a truly neutral standpoint. None of these individual practitioners has developed a true healthcare 'practice'.

- **Other centers have incrementally added healthcare to their engagement 'portfolios'.**
- **Several would like to dedicate experienced subject matter resources to build out a sustainable healthcare practice.**
- **Current Ruckelshaus Center capacity and capability is currently insufficient to 'grow' a sustainable healthcare practice.**

Most came from a legacy of natural resource/environmental work, but have since branched out into other public policy areas. The following is a brief summary of several representative interviews and related research:

Oregon Consensus (OC): As a Ruckelshaus Center partner, OC's model is well known. OC is the only Center identified in this study that has experience working with healthcare reform and transformation issues specific to state design and implementation.

- OC has provided *facilitation, convening, public engagement and collaborative learning summits on behalf of the Oregon Health Authority related to the rollout of healthcare reform* in the state. They have also provided organizational consultation to the Coordinated Care Organizations (CCOs) that form the 'backbone' of regional coordinated care and oversight. Fifteen CCOs, based on community partnerships are critical to the success of Oregon's model. OC's community/regional work may provide ideas for service value for the Ruckelshaus Center, with respect to the Accountable Communities of Health transformation in Washington.

- OC's Community Health Worker Research and Education Consortium project partners with Portland State University's School for Community Health, and is funded by the Cambia Foundation. In this project, OC and Portland State University have formed a steering team dedicated to understanding the *role and value of the community worker model,* as it relates to health reform goals. OC has helped to prioritize a research agenda, including identification of different community healthcare worker payment methodologies. The Consortium

developed a toolkit that educates stakeholders about the role of the community healthcare worker in healthcare reform efforts.

- OC facilitated a legislatively-mandated workgroup that recommended changes to existing rules administering the *licensing of mental health and substance abuse providers* in Oregon. The group achieved consensus on 90 percent of the recommended rule changes, in order to reduce administrative burden and further the care coordination and cost reduction goals of health reform. This work may help inform potential Ruckelshaus Center value related to Washington's current physical and behavioral health integration efforts.

- OC facilitated a legislatively-mandated Prescription Authority Workgroup, to reach consensus on proposed legislation that would allow psychologists to prescribe medications for certain mental health diagnoses. OC facilitated *scope of practice issues* between medical doctors and psychologists, representing a politically charged conflict in most states. OC experience may help inform eventual scope of service change in Washington, with respect to future eldercare workforce and access issues. In another project, OC facilitated volunteer stakeholder groups that agreed to develop a pilot that identified criterion for a standardized review of scope of practice changes, reporting their final results to the Legislature.

OC has grown their healthcare projects from a grass-roots effort over time – nurturing relationships, building credibility and leveraging opportunities for more than ten years. While their model relies heavily on contracted practitioners, OC staff have been involved in the development of this process.

OC has benefitted greatly from Oregon's ex-Governor John Kitzhaber, who was a huge supporter of consensus building and collaborative problem solving techniques. OC has worked hard to embed this philosophy and the expectation of its use into a variety of sectors, including healthcare. Oregon's progressive stance in this area is somewhat unique. It seems likely that the Ruckelshaus Center's healthcare expansion will require more traditional efforts to build political support among legislators and administrators.

Sacramento State University's Center for Collaborative Policy: Sac State's Center for Collaborative Policy has participated in a number of healthcare-related projects, based on grass-roots project development and professional relationship building. Their Center is a staffed model, but has no dedicated healthcare experts or specific healthcare growth strategy.

- The Center facilitated a two day retreat for the California Mental Health Planning Council, tasked by federal and state mandates with the California Department of Mental Health's program results involving access to care, availability of care, and Departmental accountability. The Council includes consumers, families, providers and advocacy organizations. The retreat was a strategic planning event, designed to set five year goals and action steps. The Center prepared with a traditional situation assessment, and cross-walked prior Council goals to the federal and state mandates.

- The Center is providing help with strategic direction, stakeholder training and process design with respect to a San Francisco community health impact assessment. A community council of more than 30 public and private organizations build consensus on 'built environment'

issues within community planning efforts, realizing that neighborhood design directly impacts healthcare outcomes. A report with final recommendations will be presented to the public, city agency staff, the Planning Commission and the Board of Supervisors on the plans and zoning controls for these neighborhoods.

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Both of these centers offer a diversity of services around different sectors (beyond legacy natural resource/environmental issues). These and other university-based or affiliated centers are interested in providing both collaborative problem solving skills, as well as collaborative public participation efforts, education and training, and strategic planning/visioning/organizational development services through the use of facilitation or convening services. Both of these centers 'grew' healthcare projects the same way- leveraging established contacts in their state's administration though political relationships and professional contacts with state agency officials[11]; starting with reasonably small projects with strong risk assessment in place, building additional and more complex projects over time, and recognizing when outside contractors or technical specialists were needed to augment center staff expertise. Neither center has an established healthcare practice, but this may be a more practical approach for them, given the focus and limited resources needed to deploy on their larger legacy areas.

It's interesting to note that OC's healthcare projects are more plentiful and diverse – perhaps due in part to their contracted practitioner model, which may allow OC to target specific subject matter expertise to specific project need.

Meridian Institute: Meridian has healthcare experience with several state projects, but seems to focus primarily on federal engagements. Their work includes facilitating processes related to pandemic preparedness, healthcare worker shortages and intellectual property rights for medicines. Facilitated stakeholders include the public sector, research scientists, providers, consumer advocates, foundations, insurance companies and the pharmaceutical industry.

- Meridian facilitated a three day dialogue session between twenty representatives from federal agencies and public health departments across the country to achieve consensus on a 21st Century public health model vision. The session was funded by the Robert Wood Johnson Foundation, and co-convened by Trust for America's Health.

- Meridian and Blue Ridge Consulting co-facilitated a series of public engagements and coalition meetings in Seattle for the King County Public Health Department and the King County Healthcare Coalition. These meetings created public dialogue and built consensus on key aspects of emergency preparedness and response to medical disasters. This project evolved out of an earlier Meridian-facilitated process on pandemic flu planning and experience with the H1N1 flu outbreak.

- In partnership with the International City/County Management Association, Meridian contracted with the Centers for Disease Control and Prevention to design, facilitate, and

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[11] In OC's case, the scope of their healthcare work expanded after growing relationships with policy makers at the Oregon Health Authority

document demonstration projects in Washington and Hawaii on issues relating to the planning, management, and control of pandemic flu.

The Keystone Center: Keystone's healthcare project list is similar in content to Meridian's. Many of their noted projects are short-term facilitations.

- Keystone helped Harris County, Texas Public Health and Environmental Services engage community partners in a review of the County's draft plan to allocate scarce medical resources in the case of an influenza pandemic. Keystone facilitated one community partner meeting and eight public meetings that helped the agency refine its prioritized list of the group's resource access. Keystone worked with the U.S. Department of Health and Human Services to address the adult immunization goals outlined in its Healthy People 2020 initiative.

- Keystone worked with federal Region VIII (Department of Health and Human Services) officials to facilitate stakeholders in the field of adult immunization. Stakeholders collaborated during a one-day session on a toolkit design to help providers and public health agencies meet adult vaccination goals.   Keystone partnered with the Alliance for Early Success to develop a Birth through Eight State Health Policy Framework, including a roadmap to improve the health, learning and economic outcomes for vulnerable children. Keystone worked with state and national experts and funders to identify issues that improve healthy development and learning outcomes, and bring together health and early childhood stakeholders. Keystone facilitated a meeting to strategize policy direction, partnering ideas, and funding mechanisms, with a focus on health equity, social capital and social determinants of health.

Resolve: Resolve has developed deep teaming relationships with foundations (Robert Wood Johnson Foundation, the Pew Charitable Trusts, the de Beaumont Foundation), non-profits (American Public Health Association, Trust for America's Health), federal agencies (Food and Drug Administration) and distinctive universities (Johns Hopkins University Schools of Medicine, Public Health and Office of Emergency Management; University of Pittsburgh Medical Center).

As with others, Resolve's projects involve emergency preparedness, public and community health, and 'one-off' facilitations or workshops related to distinct issues. Unlike the others, Resolve seems to have created services and future funding streams through ongoing stakeholder forums in several capacities. Resolve seems to have leveraged earlier projects into trusted forums – good examples of sustainable strategies to build out 'new' practice areas, and brand on-going forums.

- Resolve's Collaborative Food Safety Forum is focused on ongoing implementation the U.S. Food Safety Modernization Act. The forum is attended by a coalition of industry, consumer, academic and federal/state stakeholders. Funding is provided by the Pew Charitable Trusts and the Robert Wood Johnson Foundation.

- Resolve's Public Health Leadership Forum engages public health leaders and stakeholders to discuss challenges and transformational ideas. The group is defining a set of foundational public health services, as well as envisioning what a high functioning governmental public

health department will look like (and be doing differently) in 2020. Funding is provided by the Robert Wood Johnson Foundation.

- Resolve provides logistical support to the National Environmental Health Partnership Council, convening diverse stakeholders to develop and sustain awareness, education, policies and practices related to environmental health.

- Resolve partnered with the George Washington School of Public Health to facilitate an Obesity Drug Outcomes Measure group to identify key issues surrounding the outcomes of pharmaceutical interventions for obesity treatment, and recommend potential solutions to those issues. Stakeholders included clinicians, consumer advocates, industry, researchers and public health organizations.

- Resolve mediated an end-of-life and physician-assisted suicide workgroup of 19 stakeholder groups and other individuals, on behalf of the California State Assembly Select Committee on Palliative Care. The Select Committee asked participants to discuss how to improve the end-of-life process, with a focus on public policy recommendations; and the different values and policy perspectives that underlie attitudes towards physician-assisted suicide. Stakeholders included bio-ethics researchers, clinicians, AARP, Christian Ethics faculty from several universities, the California Healthcare Association, the Hemlock Society, the California Hospice & Palliative Care Association, the California Pro-Life Council, Americans for Death with Dignity, the California Catholic Conference, the California Medical Society and others.

These organizations all rely in part on traditional Requests for Proposal (RFPs) and grant-making processes. Keystone began working with healthcare policy issues about twelve years ago, and identified the need for substantive familiarity and expertise with healthcare strategic and technical issues. RFPs specifically request experienced facilitators with technical expertise. Keystone continues to diversify their staff's credentials, and looks for policy and science backgrounds when hiring. Keystone has found several technical partners, compatible with their mission and values, to fill gaps. Another noted challenge in Keystone's health policy work involves establishing opportunities and proof of concept – the typical concern in dispute resolution circles around quantifying success. Federal government RFPs require proposed evaluation components. Keystone has worked with health economists to attempt to project outcomes, to aid in evaluation. This may be useful guidance for the Ruckelshaus Center, related to ongoing outcomes measurement and evaluation concerns.

Other Washington healthcare conveners

Four healthcare-related conveners were identified in the course of this study:

Washington Health Alliance
The Washington Health Alliance (formerly the Puget Sound Health Alliance) is a nonprofit, nonpartisan organization that shares data on healthcare quality and value in the state to help providers, patients, employers and unions make improved healthcare decisions. The Alliance sets expectations for community performance on evidence-based practices that improve health, while reducing waste and cost.

The Alliance is a key state contractor working on the All Payer Claims Database. The Alliance's Board includes an impressive roster of key public sector leaders, providers, businesses, non-profits, clinicians and unions.

The Alliance is a known convener of healthcare stakeholders, and focuses their work on building the evidence base to support health reform goals.

It would be prudent for the Ruckelshaus Center to meet with the Alliance, to better understand strengths, differences and potential for teaming – perhaps to provide expertise to augment their service capability.

Washington Global Health Alliance
The Washington Global Health Alliance is a relatively young organization originally sponsored by the Gates Foundation. Kristen Tetteh, their Director of Communications is on the Ruckelshaus Center's Advisory Board. The Global Health Alliance's main goals are to leverage member partnerships to 'enhance global equity'. They serve in a convening capacity to connect global health organizations with the public and private sector, hosting an aggressive events schedule.

It might be productive to invite Kristen to have lunch with our staff, and an open dialogue about the Alliance's convening methods, potential teaming, or use of our methodologies to possibly help to expand her organization's service. In addition, she may be able to identify challenges among her membership that might benefit from facilitation, or other Center services.

'State of Reform'
D.J. Wilson convenes several highly regarded 'State of Reform' conferences each year in Western and Eastern Washington, Alaska, Oregon and Idaho. D.J. is well connected with the stakeholder community, the public sector and other relevant healthcare entities. The conference was originally convened by the UW School of Public Health – D.J. took the conference on years ago when UW gave it up. The conferences are well attended, and typically include panel 'tracks'; for example, 'Politics and Policy Updates' (which include legislative panelists), 'The Future of Healthcare in Washington State' (including updates to healthcare transformation efforts), 'Financing and Healthcare Costs' (including payer and provider innovations), 'Operational Challenges' (including provider innovations in care delivery) and 'Innovating Market Activity' (including new business strategies responsive to market changes).

D.J. maintains a separate consulting firm (strategic consulting, public policy and communications) and works primarily for healthcare provider organizations in seven states. He has strong credentials, is well-respected, and maintains a non-partisan approach with respect to his convening conference work. When the Center determines its strategic healthcare plan, it might be helpful to meet again with D.J. to inform him of the Center's goals and vision. Attending his Washington conferences are more than worthwhile; there may be a presentation role, once the Center develops an 'anchor' healthcare project.

Seattle CityClub:
The Ruckelshaus Center already has an established sponsoring relationship with Seattle CityClub. CityClub's convening activities are well-known. Their 'Civic Health Index' does not specifically focus on healthcare issues, but their concept attracts collaboration with healthcare initiatives in the Puget Sound (for example, the Snohomish County Health Leadership Alliance).

The Center might focus on these relationships, as many involve community collaboration. It's unclear if the need for Center services exists, but it might be useful (from at least a public relations perspective) to see if CityClub could provide a venue to introduce Center healthcare interest.

Washington state legislators and committees

The Washington Legislature has a long list of healthcare committees and task forces. The following researched 'short list' identifies some of the key legislators identified as committee leads (in some cases, approached at conferences). It would be logical to assume the Ruckelshaus Center would eventually take requests from legislators with respect to healthcare projects. It would be helpful to approach key legislators to communicate the Center's consensus building efforts – either leveraging contacts through Advisory Board members, Center leadership and/or this study's contacts. Several key healthcare committee legislators identified include:

<u>Democrats:</u>
Senator Karen Keiser (D; 33rd District): Senator Keiser is the assistant ranking member on the Senate Ways and Means Committee, and also sits on the Senate Health Committee (former Chair and ranking member during the Affordable Healthcare Act implementation).

Representative Eileen Cody (D; 34th District): Representative Cody is Chair of the House Healthcare & Wellness Committee. Neuro-rehab nurse at Group Health Cooperative. Founding union member of SEIU/1199NW.

Representative Jim Moeller (D, 49th District): Representative Moeller is House Speaker Pro Tempore, and former co-chair of Senate/House joint taskforce on Public Health Financing. Chemical dependency counselor at Kaiser Permanente.

Senator Jeannie Darnielle (D, 27th District): Senator Darnielle is the ranking minority member of the Human Services, Mental Health & Housing Committee.

Senator David Frockt (D, 46th District): Senator Frockt is the ranking minority member of the Healthcare Committee

Representative Marcus Riccelli (D, 3rd District): Representative Riccelli is the Vice Chair of the Healthcare & Wellness Committee. Adjunct Professor at Eastern Washington University's College of Health Sciences & Public Health.

<u>Republicans:</u>
Senator Linda Parlette (R, 12th District): Senator Parlette sits on the Senate Healthcare Committee, and has sat on many different healthcare joint task forces and committees over the years. Pharmacist in Wenatchee. Senator Parlette is a member of the Ruckelshaus Center's Advisory Board.

Representative Jay Rodne (R, 5th District): Representative Rodne sits on the Healthcare & Wellness Committee. Attorney- in-house general counsel for King County Public Hospital District No. 4

Senator Randi Becker (R, 2nd District): Senator Becker is the Chair of the Healthcare Committee. Surgical center and hospital administrator.

Senator Bruce Dammeier (R, 25th District): Senator Dammeier is Vice-Chair of the Healthcare Committee.

Senator Mark Miloscia (R, 30th District): Senator Miloscia is Vice-Chair of the Human Services, Mental Health & Housing Committee.

Senator Steve O'Ban (R, 28th District): Senator O'Ban is Chair of the Human Services, Mental Health & Housing Committee.

Representative Paul Harris (R, 17th District): Representative Harris is assistant ranking minority member of the Healthcare & Wellness Committee.

Representative Joe Schmick (R, 9th District): Representative Schmick is ranking minority member of the Healthcare & Wellness Committee.

Healthcare policy and program examples that may benefit from consensus building processes

In addition to the previous examples identified in earlier report sections, the following are short representative examples of past policy stakeholder groups and current issues that might benefit from consensus building techniques (these are provided only to demonstrate the variety of potential project issues):

Summit/Forum Example:
2014 Washington Diabetes Epidemic and Action Planning Summit[12]
Authorizers: Legislature and Governor's Office (Healthier Washington Initiative)
Key Stakeholders: Washington Department of Health, DSHS, Healthy Communities Washington and the Healthcare Authority (plus individual groups and clinicians)
Summit Goals: Recommend prevention goals; treatment and management goals; health system goals; estimate costs to public healthcare programs.
Data Analytics: Behavioral Risk Factor Surveillance System data; American Diabetes Association cost data; Office of Financial Management population estimates.
Potential Need for Consensus Building: Group notes indicated significant power imbalances between stakeholders.

Provider Public Payment Methodology Example:
2014 Options for a New Payment Methodology- Federally Qualified Health Centers & Rural Health Centers[13]
Authorizer: Healthcare Authority
Key Stakeholders: HCA, FQHCs, RHCs, others
Goals: Identify and recommend different payment methodologies to reimburse FQHCs and RHCs; how to integrate these critical primary care providers into larger care coordination transformation efforts?
Potential Value of Consensus Building: *'Throughout this process and into the future, all relevant parties will maintain open and honest lines of communication, especially when changes in statute, state plan and/or waiver are under consideration to build a culture of collaboration'.*
Potential Value of University Assets: Public health/policy expertise in Medicaid reimbursement methodologies; utilization data research on safety net primary care providers and impact on reimbursement change to access and quality of care; primary care operational expertise.

Healthcare Access Example:
2008-2010 Healthcare Authority Centennial Accord Plan[14]
Authorizer: Healthcare Authority
Key Stakeholders: HCA, American Indian Tribes, Providers

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[12] http://www.hca.wa.gov/documents_legislative/Diabetes_Epidemic_and_Action_Report.pdf

[13] http://www.hca.wa.gov/documents_legislative/Options_for_New_Payment_Methodology.pdf

[14] http://www.hca.wa.gov/tribal/Documents/centennial_accord.pdf

Goals: Improve healthcare access and decrease health outcomes disparities in tribal populations. Biennial report with recommendations may be modified based on collaborative opportunities developed with Washington tribes.

Potential Value of Consensus Building: *'The HCA's goal is to ensure communication and collaboration to identify partnership opportunities that help provide access to quality, affordable healthcare'.*

Potential Value of University Assets: Measurement of access indicators; tribal performance and outcomes measures.

Program Improvement/Streamlining Between Agencies Example
2007 Disease Management Report[15]
Authorizer: Healthcare Authority

Key Stakeholders: HCA, DSHS, 11 health plans, 7 large healthcare clinics, Department of Health Collaborative, Department of Corrections

Goals: Identify disparate chronic disease management programs between state agencies and recommend streamlining and integration methods.

Potential Value of Consensus Building: Nothing specific identified based on documentation – assume differing interests based on diverse stakeholder group and natural tensions between state agencies.

Potential Value of University Assets: Clinical and operational expertise; national research on effective disease management program integration.

Community Listening Forum/Work Group Example (internal facilitation)
2015 Alzheimer's Disease Plan Development[16]
Authorizer: DSHS

Key Stakeholders: DSHS, Governor's Office, Alzheimer's Association, provider associations, advocates, long-term supports and service agencies

Goals: Develop consensus-driven comprehensive plan to identify needed policies on early detection and diagnosis, need for coordinated services and supports, capacity to meet the population needs, and strategies to address service gaps.

Potential Value of Consensus Building: No conflict specifically identified based on documentation – noted high degree of stakeholder concern on expected costs - will likely create conflict between providers and payers. Use of traditional listening forums in first stage may lead to need for subsequent structured process between stakeholders.

Potential Value of University Assets: Clinical research; national research on a frontier issue impacting many state health and human service programs.

Large On-Going Policy Implementation Example (multi-faceted)
Healthier Washington (WA State Healthcare Innovation Plan)[17]
Authorizer: Federal Center for Medicare and Medicaid Innovation - $65 million innovation grant.

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[15] http://www.hca.wa.gov/Documents/disease_mngt_5841.pdf

[16] https://www.dshs.wa.gov/altsa/stakeholders/developing-state-plan-address-alzheimers-disease

[17] http://www.hca.wa.gov/documents_legislative/State_Health_Care_Innovation_Plan_Annual_Status_Report.pdf

Key Stakeholders: 11 state agencies[18], tribal-local-county governments statewide, the Health Benefits Exchange, for-profit and non-profit healthcare organizations, individual providers, insurance plans and commercial payers, university experts, consumers and businesses.
Goals: Transform Washington's healthcare system to build healthier communities through prevention and early disease detection; integrate care and social supports for those with physical and behavioral health needs; reward providers for quality, not quantity.
Potential Value of Consensus Building: Accountable Communities of Health require structured facilitation techniques between counties/regions and with providers (only two out of ten regions have been piloted); stakeholder facilitation related to mental health versus chemical dependency provider network conflicts, as well as eventual contract terms to integrate physical and behavioral (mental health and chemical dependency) care delivery. Facilitate workgroups charged with developing statewide health performance measures. (Note: HCA has contracted with the Washington Health Alliance (WHA) to convene and help HCA facilitate several workgroups related to development of the All Payer Claims Database, as well as work on the Performance Measures Reporting Committee- the WHA is a convener, and not a traditional facilitator). Facilitate tribal negotiations with Healthier Washington integration. From the January 2015 HCA Status Report:

> *As the state moves forward with Healthier Washington implementation, the principles of <u>transparent engagement, continuous learning, and collaboration</u> will continue through established workgroups and communication outlets, such as the Healthier Washington website and project webinars. The Healthier Washington initiative will prioritize resources for communications and outreach needed across all initiatives to ensure success at the state and community levels. <u>By their very nature, the interdependent elements of the initiative require community, health system and marketplace engagement</u>. Healthier Washington's letters of support demonstrate Washington's broad state-wide private and public sector commitment to engagement and action.*

Potential Value of University Assets: Physical/behavioral health integration research; clinical best practices research; public policy and network adequacy research; access standards research; communication/messaging research and practice; scope of practice legal and practice research and quantitative impact; rural health research.

Court-Defined Example:
2013 Inpatient Psychiatric 'Boarding' in Acute Care Hospitals
Authorizer: Legislature/Washington Supreme Court
Key Stakeholders: DSHS, Washington State Hospital Association, outpatient mental health providers
Problem: The State Supreme Court upheld an earlier ruling against DSHS after persons with mental health issues were consistently detained in hospital emergency departments, due to the lack of inpatient psychiatric involuntary treatment beds in the state. The Legislature has subsequently appropriated funding to build additional beds, after protracted sessions. In this example, a less-compressed timeline might have afforded the opportunity for consensus building among stakeholders, to offer the Legislature sustainable alternatives, or at least viable bridging options until the physical and behavioral health integration reform movement in our state is implemented.
Potential Value of University Assets: Behavioral health research; access indicators; clinical evidence.

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[18] Healthcare Authority; DSHS; Dept. of Health; Dept. of Corrections; Labor & Industries; Office of the Insurance Commissioner; Office of Financial Management – these seven of the eleven agencies share administrative responsibility.

Convening Examples (prior history of stakeholder policy conflict) - from 2013 Governor's Aging Summit:

Healthy Aging and Long Term Supports & Services
Potential Funders/Stakeholders: Foundations, Washington Healthcare Association, Washington Association of Area Agencies on Aging, Community Living Connections, AARP Washington, Paul G. Allen Family Foundation, Service Employees International Union, AFSCME, UFCW, Seattle Foundation, Ellison Foundation, National Institute of Aging
Other Potential Stakeholders: Access Washington, Alzheimer's Association, NW Justice Project, Washington State Senior Citizens Lobby, National Council on Aging
Aging Summit Selected 'Top Ideas':

- Establish a task force or commission to promote culturally competent activist approach, with a learning community aspect to aging; reform regulations around treatment providers and reimbursement (potential funding via Patient-Centered Outcomes Research Insititute).
- Begin process to develop a WA state Alzheimer's Plan – early detection and treatment
- Grow and sustain a 'Falls Prevention Program' – partner with nursing facilities and other residential providers
- Develop statewide system with measureable goals (report card) around POLST (Physician orders for life-sustaining treatment paradigm), hospice utilization, ICU deaths and desired place of death percentages
- Create a statewide public social insurance system to help families save for long-term care needs
- Expand Aging and Disability Resource Centers to provide options counseling and navigation supports for families and pre-Medicaid populations
- Expand family caregiver support programs, promote cultural and linguistic workforce competency and address workforce turnover
- Develop statewide quality/workforce metrics for home and community-based services

Potential Value of Facilitation Services: Aging Summit ideas generally reflect historical policy decisions that were never collaboratively vetted or facilitated. Traditional stakeholder interests (and lack of funding) often restricted movement on these issues. Healthcare transformation opens up a new 'channel' for some of these issues. Others may still be 'pre-emerging', but still worthy of planning efforts with potential funders/stakeholders. Convening or facilitating would likely require traditional situational assessments to build awareness and identify interest-based issues and stakeholder positions.
Potential Value of University Assets: Public health research on prevention, public health/policy work on public program reimbursement methodology, home and community-based program waiver experience, cultural competency/Hispanic and other minority population access to care and outreach, communication/messaging research, clinical research, healthcare economics research, end-of-life research, human development research/prevention science research, healthcare analytics, bio-ethics and law.
Possible convening/facilitating venues: Deliberative focus groups, deliberative polls, community issues forums, traditional stakeholder workgroups, stakeholder study circles, conferences

Policy Interpretation Example:
'Regence Takes Fight Over Autism Therapy to State's Top Court'[19]
Potential Issue Authorizers/Stakeholders: Washington State Office of the Insurance Commissioner; DSHS
Other Key Stakeholders: Consumer and patient advocates, insurance carriers, developmental disability providers and agencies
Problem: The federal Mental Health Parity Act forbids health insurance entities from adding coverage restrictions on autism spectrum disorder and certain mental illnesses that are not imposed on surgical and medical benefits - some insurers claim complexity and subjectivity of interpreting this standard. Plaintiff families in this litigation claim coverage of Applied Behavioral Analysis therapy, to teach skills and behaviors to autistic children at a young age (requiring individualized treatment from a behavior analyst). Washington did not have a law to cover this type of therapy. Regence/Blue Shield was the sole insurer in Washington denying coverage (the cases subsequently settled, and Washington's Insurance Commissioner instructed insurance companies to change their plan provisions to comply with the Act).
Larger Issue: CMS has just recently introduced the proposed Rule that governs the Mental Health Parity and Equity Addictions Act. States will be required to implement this Rule, when finalized, which is meant to continue to 'de-stigmatize' mental health and chemical dependency issues in the U.S. 'Parity' analysis is complicated, and impacts Medicaid managed care, qualified health plans in the Exchange, state children's health insurance programs (CHIP), commercial coverage, definition of essential health benefits, financial obligation and other difficult care and coverage determinations. States will likely need to standardize terms and definitions across programs, which will be a time-intensive effort. Both the larger 'root' issues (e.g., parity definition) and the 'branch' issues that will address implementation (e.g., exclusions; how to integrate into coordinated care/accountable care organizations/behavioral health organizations) may cause substantial conflict.
Potential Value of University Assets: Intellectual/developmental disabilities research (program experience, clinical experience); healthcare economics; healthcare law; insurance law.

The Washington State Institute for Public Policy Institute (WSIPP) provides trusted policy research and benefit/cost analyses to the state legislature on a variety of sector issues, including healthcare. WSIPP publishes status updates on their legislative research assignments, which may help inform the Center on 'leading' issues that might benefit from consensus building work. Based on this study's interviews, WSIPP is willing to meet with the Center to discuss collaboration.

These examples are meant to demonstrate the diversity of issues, scope and probable expertise to deal with recent or current healthcare public policy issues. This obviously does not suggest that the Center attempt to approach such 'large-scale' projects without careful strategic planning, additional relationship-building with university assets, and more focused follow-up with important stakeholders to build credibility, interest and funding potential.

The Ruckelshaus Center maintains a list of six 'primary' and eight 'secondary' **Project Criteria[20]** to assess the appropriateness of Center involvement prior to accepting an engagement. Conversations are held with stakeholders, government officials, citizens and others to gauge the issue's 'ripeness' and 'fit' with the Center's criteria.

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[19] From June 12, 2014 Puget Sound Business Journal article by Atia Musazay
[20] Note: http://ruckelshauscenter.wsu.edu/provide/ for more Project Criteria detail.

The Center's six primary Project Criteria may create a 'self-leveling' effect, when considering these noted healthcare examples. Most of these prior examples represent complex issues that elicit very diverse (and frequently conflicting) interests among different stakeholders. These examples were purposely meant to conform to the Center's *'vision/mission consistency'* criterion, with respect to bringing collaborative and consensus building techniques to difficult policy issues. All of the examples conform to the Center's *'importance to public policy issues'* criterion.

The Center's *'acceptable involvement'* criterion is difficult to answer in general terms- it's possible that there may be some limited projects where the UW Medicine provider role might cast a 'long shadow' over any UW-affiliated involvement in a neutral capacity. It seems that a project involving facilitated development of state-program's rate reimbursement methodology (for example, changes involving Medicaid hospital reimbursement) might be an obvious 'test case' for neutrality perception. This could be tested both internally (within the University) and externally with stakeholders in an appropriate manner, to see if a precedent for future projects actually exists.

The *'sponsorship'* criterion may be self-evident when considering examples where the public sector is the authorizer (and likely participates in the funding). Many of these <u>types</u> of projects (but not necessarily the need for facilitation) are mandated, or at least guided by higher federal policy goals. In these cases, the Center would have to rely on their reputation to provide services, and would assume the trust of sponsor leadership. Mandated timelines and larger policy design and implementation vision requires results – but not necessarily quality results that are collaboratively 'owned' by the stakeholders. It's not clear that this would adequately address the *'sufficiency'* portion of the criterion, but the internal language implies the sufficiency test is 'likely', not absolute. Other potential projects that do not involve a mandated path would presumably be tested no differently than any other project the Ruckelshaus Center would consider.

Six Primary Project Criteria:
- Consistent with Center's Mission/Vision
- Center's role is acceptable to those involved
- Project involves important public policy issues or community needs
- Sponsorship and support sufficient to result in meaningful results
- Project is cost effective
- Project adds university value

The *'cost effectiveness'* criterion may be easier to gauge when comparing healthcare projects to natural resource projects. The cost impacts of large healthcare policy issues can be immense. The costs of facilitation (or other consensus building services) are likely to be relatively miniscule. Smaller projects may be difficult to predict, but the opportunity benefits and costs of many healthcare issues are often estimable based on general calculations; for example, avoided emergency department visits; reduced inpatient admissions; mitigated duplication of program benefits. The Washington State Institute for Public Policy's benefit/cost analyses[21] related to healthcare issues may provide a helpful review of useful metrics to help assess this criterion on specific healthcare projects.

The *'university value'* criterion is addressed in each of the preceding examples. This study's results will hopefully continue to inspire strong confidence in our two sponsoring universities' range of

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[21] http://www.wsipp.wa.gov/BenefitCost

comprehensive subject matter experts. The remaining practical challenges include providing the incentives to engage faculty/student time on projects, as well as identifying or growing a future 'bench' of facilitators who have healthcare credibility.

The eight 'secondary' project criteria requires:

- That each project **involves multiple parties** from the public/private sectors and/or tribal nations. The noted healthcare examples certainly include these types of stakeholders.
- That the Center provide **useful and appropriate resources to obtain results** in a reasonable period of time (in the context of the issue). Potential healthcare engagements may vary from short-term policy agreement to long-term collaborative processes.
- The potential to **build institutional or community capacity, using collaborative approaches** to resolve or avoid conflict. As noted in many of the examples, healthcare transformation challenges and goals are fundamentally tied to capacity-building and integrative collaboration.
- The Center **learn from or assist a diverse set of stakeholders, citizens, communities** and others.
- The project allows for **learning of valuable policy principles and knowledge** that help the Center be of future value to others.
- The project **enriches the universities' missions and goals**, and provides **learning opportunities for students**. Building out a healthcare practice area will require dedicated intern support. Subject matter opportunities with faculty extend to their students.
- The project **encourages intra-university and inter-university collaboration**. Some of the project examples noted involve teaming within and between UW and WSU. Relationship building and presentations related to the conduct of this study have already crossed silos.
- The project **contributes to multiple components of the Center's mission**. Many potential healthcare projects have the capability of addressing the Center's mission of furthering a collaborative public policy process, the two universities' research and teaching missions, and many of WSU Extension's Community and Economic Development goals.

Finally, state authorizers (including the HCA and DSHS) may have strong beliefs about which policy design and/or implementation issues are more appropriate and 'ripe' for collaborative process – and those beliefs could change over the course of some of these project's life cycles. The following recommendations section include some tactical ways to approach this, to build Center healthcare momentum while maintaining Project Criteria integrity.

Ruckelshaus Center capacity and capability – recommendations and potential work steps

The question of the need for Center staff expertise in healthcare policy is an important consideration. Healthcare is obviously a complicated and complex sector; familiarity with the regulatory environment, policy successes and 'traps', experience with stakeholders and knowledge of reform goals/strategies/tactics are important to maintain credibility, especially in venues beyond convening. Perhaps that doesn't necessarily mean that every facilitator needs to have decades of deep experience, but someone entering 'blind' into a highly regulated policy issue may not understand the nuance underlying different stakeholder's interests or strategic positioning. The Center may be faced with two decisions: To accept a more basic level of healthcare projects that clearly do not require deep expertise; or, to gradually move into more complicated projects, perhaps using a co-facilitation team of one staff practitioner and one faculty subject matter expert (who lacks facilitation experience). Either alternative requires relative risk management. The following framing questions and suggested steps may help the Center form its strategy, leveraging this study's results:

A. How does the potential expansion of healthcare project work and development of a sustainable healthcare 'practice' align with the Center's growth goals?

> Recommendation: Develop a strategic plan that references both direct healthcare projects, as well as potential opportunities to develop indirect 'intersections' between healthcare and related policy and subject matter issues relevant to the Center's mission, goals and growth (for example, rural economic development; built environments; environmental health; community health; nutrition; housing; transportation).

B. How would the Center choose to actively or reactively pursue healthcare projects, assuming funding is already available and the authorizers are ready to ask the Center to participate? – How much time and effort is the Center willing to commit to incrementally adding healthcare projects, versus proceeding with a more deliberate strategic approach?

> Recommendation: Consider a deliberate strategic approach. Building a healthcare practice requires full Center support, and is not likely to succeed if planned as an incremental 'addition' to existing services. New sets of industry and governmental relationships will need to be developed over time. Building credibility will require support from all Center staff, with the bulk of the burden on dedicated personnel.

C. Are Advisory Board members willing to provide direct support to the Center's plan (staged approach or otherwise)? Do any Board members have a specific passion for this subject area?[22] Can additional Board members be recruited with strong healthcare ties?

D. Current staff practitioners are very busy. Do they have a genuine interest in expanding beyond their current subject areas (and presumably their current work load) to take on something of this significance? Will they be willing to co-facilitate with subject matter experts who lack consensus building experience? Would they be willing to dedicate time to help build and implement a convening model to address relevant healthcare issues? Does the Center have the funding to invest in a dedicated professional who can lead this effort, with adequate support? How can new staff practically leverage existing staff to ensure

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[22] Bob Drewell has demonstrated significant enthusiasm in the course of this study; others might step up to the challenge of working to get key authorizer/stakeholder meetings in place; provide strategic planning guidance, and assist with building organizational relationships.

appropriate support? (For example, developing qualified practitioners; leveraging existing donor connections and support; obtaining focused intern and administrative support).

E. Does leadership believe and support the idea that moving into additional healthcare work is important to the Center's mission, goals and growth? Is there belief that additional healthcare qualifications could springboard into other tangential areas that may be aligned with the Center's mission, values and goals (other social policy issues, community health and vibrancy, economic development – WSU Extension goals)?

F. Would there be a point when the Center might consider applying for grants? Proposals to RFPs? What are the risks, beyond the administrative burden?

G. What are the internal and external 'forces' that might drive or restrain Center involvement and successful growth in healthcare policy work?

> Recommendation: Develop a traditional stakeholder/issues 'map' and power grid that identifies and prioritizes supporters and potential challengers. Use to 'test' the proposed strategic plan. Use to further this Study's preliminary relationship building to gain political and funding support within the context of the strategic plan.

If the Center commits to moving forward with the development of an expanded healthcare practice, a thoughtful strategic outline (and subsequent plan) will provide a blueprint to document the vision, efforts, near-term and 'stretch' goals, and provide a format to guide and document progress, challenges, course corrections and resource requirements.

Once a strategic outline is developed, the Center might consider how to bridge the period between this Study's conclusion and the planned implementation of building a healthcare practice. This could include developing a series of messaging emails sent to key Study informants and Advisory Board members to explain Study status, Center interest in moving forward and expected timing.

A subsequent strategic plan should inform tactical timing. Tactical recommendations might include:

1) Meeting with Bob Crittenden and Jason McGill (Governor's healthcare policy advisors); MaryAnne Lindeblad (Medicaid Director)/Dorothy Teter (Healthcare Authority) to 'test' Center services against current state transformation examples and state priorities. Meeting goals could include:
    - Updating authorizers on the Center's study;
    - Soliciting updates on current/expected practical project examples from the authorizer's perspective;
    - Obtaining 'pre'-commitment to help the Center confirm a project;
    - Testing for project funding through interagency agreement (or similar).

2) Developing several ideas for convening/facilitating frameworks responsive to the project examples from #1 – communicate with authorizers to refine expectations and goals.

3) Communicating project examples from above meetings to existing WSU and UW study contacts, to test preliminary interest, solicit commitment and/or need to chain link to other faculty.

4) Developing collateral material with 'demand' proposition and 'supply' alternatives. (Different versions for funders, authorizers and stakeholders).

5) Gaining introductions to foundations (beyond study contacts); using leadership's, Advisory Board member's and Chairman's Circle connections to propose project need; demonstrating aligned mission/vision benefits and 'ask' for funding commitment.

6) Hosting an introduction/reception to introduce the Center's work and interest in expanding healthcare policy consensus building to stakeholders. Building a 'panel' of authorizers/potential funders/facilitators to demonstrate vision and examples (could team with CityClub or other venues). Follow up key individual meetings with interested stakeholders. Chain link from study contacts.

7) Hiring an experienced intern dedicated to supporting the healthcare strategic plan rollout.

8) Soliciting university deans, department chairs and faculty to build a presentation/forum at each university to introduce the Center's interest in healthcare policy on a larger scale (use to expand faculty/program network).

9) Meeting with key legislators to communicate Center benefits, potential project examples and diversity of healthcare stakeholder contacts. Ask for commitment for project consideration (e.g., consider Center benefits when authorizing task forces; technical assistance groups; convening or facilitating requirements).

10) Meeting with other conveners to propose Center qualifications and benefits, as well as potential teaming opportunities to enhance/augment existing convener efforts, and to demonstrate (early) a lack of competitive 'threat'.

11) Building thought leadership and presentation materials that can be leveraged to a national platform, to expand Center healthcare policy reputation and 'lessons learned'/best practice material (UNCG or other collaborations/associations).

Epilogue

Healthcare is a vast and diverse sector that impacts our Northwest quality of life and economic well-being. Healthcare policy intersects with social service issues, and shares relationships with environmental, built environments/urban planning, rural community and other key areas that are critical to the preservation of our state's populations and communities. In addition, many healthcare policy issues converge with WSU's Extension programs and goals, including those within Communities, Economic Development, Youth & Families, and Health & Wellness.

The use of collaborative problem solving techniques in healthcare public policy venues in Washington has been limited and fragmented. This study's work indicates that policy makers and stakeholders are interested in the potential value that the Ruckelshaus Center might bring to help prevent or solve policy disputes, improve the collaborative stakeholder process, and possibly create a 'new' structure (from healthcare's perspective) that adds integrative value, momentum and potential sustainability beyond the status quo process.

There are certainly types of healthcare policy issues that may not be appropriate for the Center's involvement. As an obvious example, legacy issues that can only be solved in budget battles may not be good candidates for successful facilitation. The on-going transformation of healthcare will provide a long 'runway' of change (for example, Washington's current five-year 1115 global demonstration waiver application), with many promising new issues that could be negotiated or facilitated. These burgeoning and changing issues, involving familiar and new stakeholders faced with unfamiliar challenges requiring policy innovation may offer the best opportunities for the Center's involvement.

While the Center's existing Project Criteria provides useful guidelines that would likely cover many of these 'new' engagement questions, it's possible that additional screening criteria specific to a 'new practice area' may emerge as potential projects are considered. For example (depending on Center commitment), internal investment to supplement funding sources to launch convening activities that help broadcast the Center's healthcare potential may encourage re-evaluation of the existing 'cost effectiveness' criteria. Expected return on investment could be factored into such outlays; hopefully availability and leveraging of university resources would mitigate investment outflows.

The Ruckelshaus Center has a variety of healthcare practice options to consider, ranging from 'most passive' to 'more active'. Deliberate movement into a new practice area will require different levels of commitment and resources, depending on approach. This study has begun to expand the 'core' of healthcare stakeholder and university relationships, beyond those the Center had developed from past projects. Additional attention to healthcare will certainly require investment in time to build out these relationships, with the goal of developing a sustainable healthcare presence in the Northwest.

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