



SW ACH SUMMARY BRIEF



The William D. Ruckelshaus Center's initial assessment of the Southwest Washington Accountable Community of Health's regional potential for collaborative capacity and consensus-building activity

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

The William D. Ruckelshaus Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University hosted and administered by WSU Extension and the University of Washington hosted by the Daniel J. Evans School of Public Policy and Governance. For more information, visit:

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DISCLAIMER

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INITIAL SUMMARY BRIEF

This Brief summarizes a variety of interests, concerns and suggestions heard from 29 leaders representing 24 organizations affiliated with the Southwest Washington Accountable Community of Health (SW ACH). The William D. Ruckelshaus Center (the Center) conducted a series of primarily in-person individual meetings between late May and mid-July of 2017, to assess the potential for collaboration around vision and goals related to the State of Washington Health Care Authority's (HCA) federal Demonstration waiver¹. Those goals include collaboration between organizations; among the SW ACH leadership and staff; and within and between the three-county region representing the SW ACH (Clark, Skamania and Klickitat counties, and the Cowlitz Indian Tribe and Yakima Nation).

SW ACH leadership asked the Center to independently assess the current state of different organization's status and concerns reflecting SW ACH progress across the region. The ACH has evolved to its present state from a two-plus year planning effort involving a Regional Health Alliance and a wide variety of county-based and other community and industry leaders. Governance and participation in these efforts has changed over time. The HCA's 2017 timeline requires the SW ACH to commit in November to a variety of mandatory and optional projects within the Demonstration's explicit domains. The SW ACH and meeting participants expressed a wide variety of optimism and concerns related to: 1) timing, 2) sustainability once the five-year Demonstration ends, 3) rural health issues, 4) ability of organizations that often compete (or have limited history of collaboration) to coordinate and integrate care delivery, and 5) other issues.

In addition to identifying alignments and differences between organizational interests, this Brief includes Center observations and recommendations based on these candid conversations.

These initial meetings were generally limited to provider organizations, payers, public health officials and SW ACH leaders and staff. Many of these people serve on the SW ACH's Board of Trustees and Regional Health Improvement Plan Council (RHIP-C). A list of those who participated is included in the Appendix following this Brief.

The Center also attended several RHIP-C meetings, as well as one Healthy Living Collaborative of Southwest Washington (HLC) quarterly meeting. Future meetings with community leaders related to social determinants of health, public advocates, clinical representatives and others are anticipated, as noted in the Recommendations section of this Brief.

Meeting Process, Timing and Discussion Questions

The Center requested a list of providers, payers (including managed care organizations) and public health representatives involved with the SW ACH (or the predecessor Regional Health Alliance) from ACH leadership, as well as meeting invitations. The Center approached these meetings with the intent of exploring the collaborative potential of providers and payers to work together around five-year Demonstration goals and the short-term choice of and commitment to optional projects.

These meetings took place during a dynamic period, as the HCA provided additional key information to the ACH (for example, required outcome measures and incentive payment methods) throughout the meeting timeframe. In addition, the SW ACH was in the process of hiring key staff, and transitioning its RHIP-C meeting process from introducing significant amounts of HCA Demonstration information to facilitating

¹ For brevity, this Brief assumes the reader's general knowledge of the HCA Demonstration Waiver, domains, projects and requirements. For further information, link to: <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation> and <https://southwestach.org/>

brainstorming sessions. Meeting responses reflected the changing context of this information throughout the six weeks of Center meetings, as answers to questions became more nuanced based on additional external information received. Recommendations in this Brief include awareness of this shift in meeting answers – specifically, less focus on potential consensus around short-term Demonstration compliance, and more attention to long-term community vision agreement, delivery system change and sustainability, as well as the potential gaps between Demonstration trajectory and a larger community vision.

Discussion Questions, Themes and Observations

90-minute discussions were held with individual leaders representing their provider, payer, administrative and public health organizations. These discussions focused on a series of questions that fit into the following categories, with general response context:

- a. **Individual and organizational backgrounds.** These discussions demonstrated a wide variety and breadth of experience among leaders and organizations, as well as services provided, relationships with the SW ACH and prior organizations, and past/current relationships with other providers/payers in the region. In addition, an impressive depth of individual experience was shared, as many leaders have backgrounds that cross organizations, sectors and professions, and are capable of evaluating issues and relationships from multiple perspectives.
- b. **‘Visioning’ and ‘Success’.** Two sets of questions were asked in different context: What would Demonstration success look like to you and your organization at the end of Year 5 of the Demonstration? What would overall success look like in Year 6 and beyond? Many participants found it challenging to address the former, and often defaulted to an explanation of short-term barriers.

The latter set of questions seemed to free up many responses, which included success metrics related to population health, holistic integration and coordination of services across prevention, wellness, physical and behavioral delivery of healthcare services, long-term supports and services, and social determinant needs. A common reference to a ‘greater community vision’ was often noted, although no one suggested that there was any consensus around a definition of community vision, related objectives or outcomes².

Other longer-term vision responses centered on financial sustainability and equity. Many participants noted a need for shared sacrifice, asking more providers to offer access and care to Medicaid and uninsured consumers. There were significant commonalities around Demonstration expectations in the short-term, and what the assumed trajectory of the Demonstration and its results in SW Washington could or should mean to help achieve some version of community goals and outcomes.

Most meeting participants viewed the Demonstration as a potential tool that could help move system change in the right direction – if done correctly, and with true collaboration to overcome barriers. Responses varied in this context from cautious optimism to guarded skepticism around specific Demonstration projects.

- c. **Relationship with SW ACH.** Most participants were pleased with current SW ACH leadership and momentum, especially given the large responsibility undertaken. Several who have been involved throughout the past two-plus years of planning and change noted that earlier efforts by

² The SW ACH Board of Trustees has developed three goals: Maximize Demonstration dollars; strive for integration beyond the Medicaid population, and achieve sustainability.

county leaders were important and necessary for that start-up period, and that changes over time (including compression of the Board to its current size) were necessary to get to the current organizational structure that can address current SW ACH and community needs.

Others commented that organizational efforts have not always seemed to accommodate their suggested representation (for example, more rural representation, more public advocates, leaders involved with social determinants and individual clinicians). Most of those involved for a period of time were eager to express optimism, but admitted a sense of ‘planning fatigue’ and readiness to be involved in more tangible movement forward.

Many expressed empathy and understanding with respect to local efforts, timing and pace of progress - but less so with respect to the speed of needed information from the HCA. However, few offered opinions around deadlines and response times from the federal Centers for Medicare and Medicaid Services to the HCA (presumably based on lack of available information or awareness).

Depth of understanding of Demonstration requirements. Most participants ‘graded’ themselves and their organizations conservatively, with respect to detailed depth of Demonstration understanding. However, the meeting responses during the two-month meeting period became progressively more informed, as SW ACH leadership and consultants communicated more information to RHIP-C members in their monthly meetings. In some cases, participants lacked specific, detailed knowledge (for example, around incentive theory or outcomes measures), but admitted they had limited attendance at monthly meetings. Several were enthused about the discussion and indicated interest in re-engaging or ramping up participation in the process.

- d. **Interest, concerns and alignment around specific Demonstration projects.** These discussions varied widely, given the range of services that different organizations provide and different populations served. However, most organizations generally aligned with the major Demonstration mandatory project goals (systems and community capacity building, bi-directional integration of physical and behavioral healthcare, and addressing the opioid use crisis). The optional projects (community-based care coordination using the Pathways model, diversion interventions, transitional care, maternal and child health, oral health access and chronic disease prevention/control) elicited a range of interests and perception of alignment, depending on organizational mission and scope of provided services. Many meeting participants raised the basic structural and long-standing Medicaid population need for greater access to and availability of primary care and specialist services, while others suggested this traditional limitation could be partially mitigated by a broader and deeper deployment of existing practitioners.
- e. **Opportunities to use and benefit from collaborative processes moving forward.** Many participants had some degree of past experience with informal collaborative processes, but less so with formal techniques. Several praised SW ACH and their consultants for effective convening, communication and project management skills. While all participants felt that collaborative processes would be beneficial to building trust and capacity moving forward towards negotiation, agreement and consensus, several reiterated concerns about planning fatigue and cautioned against duplication of effort.
- f. **Requests for chain-referrals to other leaders.** The Center typically asks participants to recommend other key people to speak with. This resulted in a chain-referral list of more than a dozen additional people, who may be contacted, depending on upcoming consensus-building direction and focus.

The Center evaluated the discussions for commonalities and differences. While this Brief does not capture all comments and context from all participants, the following is a summary of predominant themes and observations that emerged:

Organizational – SW ACH

- Most participants/organizations have moved past the history and changes leading to the current SW ACH structure, and have a high degree of confidence around the mix of established leadership and newer staff; several noted they always felt ‘heard’ in discussions.
- Many meeting participants are relieved to be moving into a ‘workgroup’ phase towards implementation, feeling fatigued by years of ‘planning’.
- Several participants who do not serve Medicaid populations intend to remain involved, as they believe deeply in the greater potential to impact health prevention, wellness and outcomes at a community-level; others remain involved to leverage new ideas and concepts within their programs.
- Some who had previously disengaged from the process (or have only recently engaged on a peripheral basis) expressed the desire to re-engage, or become more involved.
- Several suggested the need for a broader range of representation within the SW ACH structure, including community leadership from education, criminal justice, housing, employment, transportation and other social determinants, as well as representation from individual clinicians and additional public advocates. One noted that the close relationship between the SW ACH team and the Healthy Living Collaborative will improve community connections and capacity building.

Identity and Experience

- Organizations in the three counties are proud of their historic missions and efforts. Each shared a story about its unique place in its communities, and many shared examples of successful collaborations with others. Each also shared examples of barriers – some relative to work in progress, and others that failed in past attempts. Their stories often reflected the challenges of moving beyond organizational and cultural differences, the natural tendency to default into usual healthcare silos, and differences between leadership personalities. Many of these stories have not yet been shared within the SW ACH structure, including those related to:
 - Care coordination and integration experiences – from both physical and behavioral health perspectives, relative to provider’s and payer’s experience
 - Population health focus and healthcare hot-spotting trends
 - Emergency Department diversion successes
 - Reimbursement and contracting models, including Accountable Care Organizations
 - Rural care delivery and overcoming barriers
 - Oregon Coordinated Care Organization’s (CCO) experience – relevance and difference
 - Other state initiative experience, including Ohio and Colorado
- There is a shared pride and belief among organizations within each county that southwest Washington represents a collaborative place, notwithstanding the historic financial tensions and institutionalized competitiveness embedded in traditional healthcare delivery systems. Participants almost universally referred to their respective areas as ‘my community’ or ‘our community’, emphasizing strong ownership and a sense of responsibility and connectedness. The Healthy Living Collaborative, Healthy Skamania, and fully integrated managed care behavioral health contract

relationships with managed care organizations in Yakima and Walla Walla were referenced as positive role models inside and outside of the region.

- There are also shared beliefs around geographic inequity. Skamania and Klickitat representatives noted rural disparities around historic initiatives, funding and representation issues, as well as lack of attention. In addition, several meeting participants in Clark County noted ‘Vancouver’ vs. the rest of Clark County disparities. Rural representatives also shared success stories around integration and care coordination – experience that could be useful when compared to lessons learned in Clark County. Some participants were hopeful that the SW ACH could provide the space to properly share and leverage these experiences. Others are hopeful that the SW ACH can provide the processes to help organizations break through habitual beliefs, practices and institutionalized barriers to create collaborative group advocacy on behalf of their communities.
- Different perceptions of ‘other’ providers’ and payers’ strengths and weaknesses abound. Many based their opinions on perceived intentions of other organizations, usually based on past relationships (strong and weak), or simply a lack of relationship. Strong examples of positive relationships have not been universally shared, but were considered significant. Negative perceptions were often rooted in a deep sense of inequity – around reimbursement fairness, changes in Medicaid participation, lack of collaboration and investment, and ‘us versus them’ sensitivities. Some organizations have undergone leadership turnover; many others expressed their desire to change (both their outlook and external perception), given the significant state shift in delivery and payment reform. Meeting participants sometimes recognized these shifts in a positive and optimistic way, hoping that the SW ACH processes will create the space for these discussions.

Vision - The Demonstration and larger community vision

- Most participants view the Demonstration as one initiative that could help momentum towards greater health delivery systems change, if organizations are willing to move from siloed positions and historical barriers towards a greater community vision and goals, and make the requisite investments in a collaborative and coordinated manner.
- Several cautioned that a disproportionate focus on meeting specific Demonstration requirements might divert needed attention from the goals of the greater community, and from effecting genuine systems change and impact.
- Although participants offered varied descriptions of a longer-term community vision (often including Triple Aim goals), no one described or recognized an existing consensus-based community vision from collaborative or any other efforts.
- Many found it challenging to describe differences between a short term and longer term vision. This seemed in part due to perceived gaps between the finite Demonstration goals and a greater interest in community vision, goals and outcomes.
- Some approached the discussion systematically, describing a holistic vision that includes wellness and prevention, coordinated care delivery, crisis system improvements, advocacy and education of elected officials and taxpayers around financial sustainability (including demonstration of return on a performance-based system), and full coordination with social determinants of health. Others suggested that any serious vision including cost containment must address social determinants of health, as they represent greater costs compared to traditional care delivery.
- Others gauged success as a staged effort that combines realism and idealism. Some preferred to define their vision as a series of focused barriers to surmount, one at a time, building a series of realistic wins to reach provable integration and coordination goals and participation between organizations.

- Several called out the need for building and improving organizational relationships and moving beyond past contracting hurdles and perceptions as the foundation for any successful vision – either short or long term.
- Some participants noted that Demonstration success metrics don't necessarily focus on projects that will impact population health – suggesting that cost drivers, for example, might be more impacted by scaling programs like early learning and home visits, based on evidenced-based programming for younger children and families to impact toxic stress and adverse childhood experiences.
- Many stressed financial viability and sustainability as a foundational need to move a vision and implementation forward in any direction, but were sometimes unclear on how to fully envision payment reform and value-based payment model success (depending on their own organization's level of experience with risk-based contracting), to change system delivery behavior.
- Many participants stated they hope the Demonstration and incentive payments will be an important, unifying force to help push systems change (and start to change organizational behavior), but that the incentive dollars won't be enough to ensure sustainability without extramural investment and funding. Some wondered about the possibility of 'shared savings' potential for community reinvestment. Others suggested that the managed care organizations be engaged in potential grant-seeking and extramural funding activities.
- One behavioral health provider noted the basic need for engaged and willing primary care providers to be housed as part of a successful bi-directional integration vision, as well as their need to maintain decision-making ability relative to behavioral health and patient outcomes.
- As noted, some expressed the need for all organizations to equitably share the burden of systems change and workforce capacity improvements as fundamental to success.
- One rural organization simplified success as effective coordinated care, based on agencies coordinating together to navigate both delivery and internal cultural differences, including social determinants.
- One payer defined success as a systemic collaborative, with sustainable braided funding to achieve successful community goals.
- One participant identified the need to build community resilience as a key factor in any community vision (this was prior to the SW ACH suggesting setting aside funding for a community resiliency fund).

Enthusiasm/Concerns – General and Specific Demonstration Projects

- The vast majority of participants listed care integration and care coordination as the projects generating the most enthusiasm. Many view these as part of the 'backbone' of successful system change, along with the need for workforce capacity improvements. These projects also generated a significant number of concerns, including lack of provider capacity and willing providers (in general, and with respect to bi-location), limited federally qualified health centers, uncoordinated care management, a siloed culture within behavioral health, the need to strengthen physical health relationships with behavioral health providers, skepticism related to the Pathways model, potential threats to existing care coordination efforts, and perceived lack of integration definition. Several criticized the physical health orientation and focus of bi-directional integration.
- Others expressed enthusiasm for opioid programs, maternal and child health, oral health, emergency department diversion and transitional care. Concerns about opioid programs included suggestions to balance focus on both prevention and treatment. Some participants were concerned that the SW ACH will be tempted to take on more projects than staffing resources will support, or that an unbalanced focus on smaller projects will result in less community impact.

- Several participants had hoped the SW ACH would provide information-based decision making processes around projects, as well as to prioritize community needs to create linkages to greater community vision. Another suggested that ACH workgroups consider practitioner-specific reimbursement, as opposed to singularly focusing on provider contract reimbursement, referencing a “fourth leg” to the Triple Aim – practitioner satisfaction.
- The general tenor of the conversations around the projects was largely positive. The raised concerns suggested thoughtful deliberation, as well as individual passion for each noted topic.

Collaborative Opportunities

Nearly all participants expressed value in and offered many suggestions for potential collaboration benefits, including:

- Building community consensus around a specific community vision, principles and goals that serve to lead towards implementation of holistic community health.
- Building capacity between providers, as well as between payers, providers and social determinants agencies to create the space to allow candid and transparent conversations without the burden of historic conflict or coalitions, blame or judgement.
- Quantifying collective community resources, using asset-mapping or other techniques.
- Bringing broader and more culturally diverse community representation into the process to create durable consensus around specific community vision; considering Hispanic and Russian representation.
- Bringing physical health practitioners more deeply into the process, to bridge theory and practice, co-create workable solutions, and address uncertainty.
- Bringing behavioral health providers closer to the process, to break down perceptions of silos, achieve greater understanding of organizational alignment and differences, and address concerns of losing control of patient care.
- Leveraging positive existing relationships with and connections to other relevant community leaders, including tribal leadership.
- Expanding diversity around ideas to leverage funding streams, identify braided funding opportunities and other methods to finance resource gaps to achieve specific community vision and goals.
- Aligning diverse perceptions around rural integration experience.
- Bringing providers together with managed care organizations to develop aligned principles and goals, and create effective resource pathways that are financially sustainable.
- Developing proactive processes to mitigate future disagreement.
- Collectively understanding how the incentive dollars are apportioned, to demonstrate best use.
- Identifying ‘low hanging fruit’ – for example, using hot-spotter information to identify super-users, behavioral health risks, emergency department overutilization, chronic disease and case management impact.
- Determining when to engage elected officials in the community visioning process.

The key themes that meeting participants expressed were generally based on the desire and need to build towards greater community health outcomes, and to break through traditional organizational behavior, care fragmentation, barriers and silos that have been historically rewarded and perpetuated by past Medicaid reimbursement methodologies.

Many wondered how to achieve sustainable positive outcomes, if population health, value-based payments and community collaboration aren't aligned and linked. Several noted that, compared to Oregon's CCO model, the lack of direct financing linkages in the ACH model make it difficult to envision financial sustainability, which has led to uncertainty.

The meeting discussions revealed a proud group of leaders representing capable organizations, who are excited about the direction to which the Demonstration might lead, but somewhat overwhelmed by the enormity and complexity of the planning and implementation. Most believe the SW ACH has made considerable improvements and progress, but that the pieces haven't all fallen into place. Many now regard the Demonstration as one initiative on the greater path towards holistic community health – and that this path and its outcomes should be relevant to all of the region's population, regardless of payer source.

These discussions reflected a strong consensus for a defined community vision, to co-create an effective 'North Star'. While many participants referenced community vision, objectives and outcomes, no one was able to recall consensus activity or definition around the concept.

Recommendations

Based on the key themes and observations described, the Ruckelshaus Center recommends the following:

- a. Develop a consensus-based community 'North Star' vision that reflects the longer-term needs and health outcomes of the region, as well as of the three individual counties, the Cowlitz Indian Tribe and Yakima Nation. Include a set of agreed-to principles that define common direction and create durable implementation agreements to withstand future barriers and challenges.
 - The SW ACH has already developed a very full organizational structure, including governing oversight, community communication, technical improvement, consulting assistance and workgroups that are addressing short-term Demonstration implementation. Rather than adding a new group to this organization, consider convening existing community, industry and civic representation from the Board of Trustees, RHIP-C, Healthy Living Collaborative, tribal leadership and other groups, and adding representative public advocates, individual clinicians, and rural leaders to augment a representative ad hoc core community visioning team, with a defined lifespan.
 - Use meaningful and tangible collaboration-building processes to move towards consensus, including learning collaboratives, policy dialogs, community town halls or other helpful venues that lead to tangible, long-term, visioning workshops and subsequent agreement towards implementation. Structure a process with clear agreed-to objectives, defined action steps, responsibilities, role-clarity and timelines. Include some form of adaptive design feedback, to address new information and experience, potential federal/state policy changes, as well as process and outcomes measures (relative to achieving community vision and goals).
 - Provide technical assistance to this core community visioning group to identify the gaps between the resulting long-term community vision and the short-term Demonstration strategy, goals and outcomes. This will inform additional resource needs and investments, and help reach consensus around shared commitments, timelines and expected deliverables to achieve implementation of community vision and goals. It could also be used to help define and allocate a community resiliency fund, as well as other extramural funding needs.

- b. Use capacity and consensus-building processes within the SW ACH Demonstration project workgroups to promote candid and open discussions, as well as diversity of opinions and ideas - where each organization can demonstrate past successes, challenges and ideas in an open, positive environment that eliminates blame and judgement. Develop consensus rules of engagement and other group operating principles that help define intent and purpose, as well as build capacity to withstand unknown future barriers and potential conflict.
 - Overlay these processes across potential provider/provider, provider/payer linkages and alignment work within the Integration workgroup; and during potential gap discussions within the Care Coordination workgroup (for example, comparing Pathways and existing care coordination efforts).
- c. Provide and encourage additional rural representation and voice within the SW ACH workgroup structure. Provide appropriate attention to and identification of the different needs within and between Clark, Skamania and Klickitat counties, including rural lessons learned that may be applicable to Clark County. Encourage deeper workgroup participation from out-of-region providers that serve Klickitat and Skamania populations.
 - Convene a facilitated meeting to evaluate mid-adopter status pros and cons with Klickitat leaders, representatives and SW ACH staff.

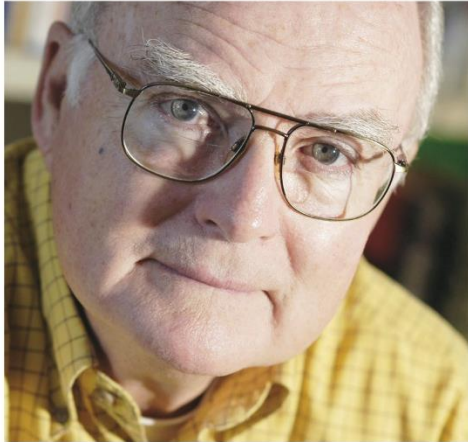
As noted, the Center originally approached these meetings to evaluate the collaborative potential of providers and payers to build capacity to work through short-term Demonstration goals and outcomes mandates, as well as commitments to both mandatory and optional projects. Our recommendations do suggest using collaborative processes and techniques to improve these discussions and underlying relationships, as they are vetted through the existing RHIP-C and workgroup structures and upcoming meetings. However, meeting participant responses demonstrated a shared need for a longer-term, consensus-based community vision, to help drive towards definitive goals and implementation of sustainable community health. Creation of a 'North Star' vision and agreement requires collaboration that includes leadership beyond medical/clinical and traditional healthcare delivery circles. These suggested recommendations broadly describe a sequence of processes that could 'move the needle' beyond the shorter term Demonstration requirements towards greater and holistic community health outcomes.

Appendix – Initial Meeting Roster

Name		Organization
Sela	Barker	CHPW
Kevin	Barry	Klickitat Public Health
Dawn	Bonder	SW ACH
Sharon	Crowell, MD	Vancouver Clinic
Federico	Cruz-Uribe, MD	Sea-Mar
Dave	Edwards	One Community Health
Vanessa	Gaston	Clark County Community Services
Erin	Hafer	CHPW
Jon	Hersen	Legacy Health
Leslie	Hiebert	Klickitat Valley Health
Kachina	Inman	Healthy Living Collaborative
Robb	Kimmes	Skyline Hospital
Kat	Latet	CHPW
Laurel	Lee	Molina
Inna	Liu	Beacon Health
Alan	Melnick, MD	Clark/Skamania County Public Health
Connie	Mom-Chhing	CHPW
Louise	Nieto	SW ACH
Craig	Pridemore	Columbia River Mental Health
Kirby	Richards	Skamania Public Health
Cindy	Robertson	North Shore Medical
Jared	Sanford	Lifeline Connections
Marla	Sanger	Peace Health
Daniel	Smith	SW ACH
Beth	Spinning	Kaiser
Dawn	Tolotti	Providence
Andy	Tucker	Children's Health Society
Rick	Weaver	Comprehensive Healthcare
Barbe	West	Free Clinic of SW Washington

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"Collaborative problem solving is an enormously powerful approach to resolving conflicts; it holds great promise for better, faster and more sustainable policy decisions. With the combined resources of our premier research institutions, this center establishes an invaluable neutral forum for addressing some of our most complex and pressing challenges."

– WILLIAM D. RUCKELSHAUS

For more information on the William D. Ruckelshaus Center, please visit our web site at:
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About the Ruckelshaus Center

Mission:

The mission of the William D. Ruckelshaus Center is to help parties involved in complex public policy challenges in the State of Washington and the Pacific Northwest tap university expertise to develop collaborative, durable, and effective solutions.

Vision:

The Center envisions a future in which government leaders, policy makers, and citizens routinely employ tools of collaborative decision making to design, conduct, and implement successful public policy processes.

Identity:

We are a joint effort of Washington State University, hosted and administered by the WSU Extension, and the University of Washington, hosted through the Daniel J. Evans School of Public Policy and Governance. Building on the unique strengths of these two institutions, the Center applies university resources and knowledge towards solving challenging public policy issues.

Values:

Collaboration, consensus, neutrality, knowledge, education, inquiry, and civility.

What we do:

The Ruckelshaus Center partners with university faculty, staff, and students to help people work together to develop shared solutions to challenging policy issues. Areas where we work include:

- Community and Economic Development
- Land Use
- Natural Resources
- Transportation
- Agriculture
- Healthcare
- Tribal, Federal, State, and Local Governance

We build problem-solving capacity in the region by helping individuals and organizations better understand, initiate, participate in, and lead collaborative public policy efforts.

Who we serve:

The Center assists public, private, tribal, nonprofit, and other leaders to build consensus, resolve conflicts, and develop innovative, shared solutions for Washington and the Pacific Northwest.

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Thanks to the many leaders who voluntarily shared their time with the Center throughout the course of these meetings.