Meeting Book - July 15, 2020 Board of Directors Meeting

July 15, 2020 Board of Directors Meeting (Hosted via Zoom)

10:00am	Welcome & Call to Order	Roll-Call	President, Jennifer Kreidler-Moss
10:10am	The Work of Upstream in Washington		Cara Bilodeau, Public Policy Manager
	Upstream USA Presentation		
	Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences		
10:30am	Consent Agenda		President, Jennifer Kreidler-Moss
10:30am	April 2, 2020 Board of Directors Meeting DRAFT Minutes	Motion to Approve Needed	Jim Davis, Secretary
	Quarter 2 Committee Reports		
	Board Financial Report Out		
10:35am	Finance Committee Report		Aaron Wilson, Treasurer
	Quarter 2 Financial Reports	Motion to Approve Needed	
	FY2020-2021 Annual Operating Budget	Motion to Approve Needed	
10:45am	2019-2020 Fiscal Year Audit Report	Motion to Approve Needed	Kyla Delgado, CPA Principal, Health Care CLA (CliftonLarsonAllen LLP)
	FY2019-2020 990 Narrative		
	Convening		
11:15am	Proposed Equity Proclamation (Process Discussion)	Break-Out Sessions	Jennifer Kreidler-Moss, President
	Toward Racial Justice: A Commitment of the Washington Association for Community Health		
11:25am	Breakout Rooms		
	Racial Justice		
	COVID-19 Best Practices		
	Resources		
	Awake to Woke to Work: Building a Race Equity Culture		
	The Moral Determinants of Health		
	COVID-19 and Racial Ethnic Disparities		
	Policy Advocacy & Implementation		
12:00pm	APM4/5, FFSE Equivalency Rulemaking		Ian Randall, Senior Strategy Advisor
	Discussion Points		

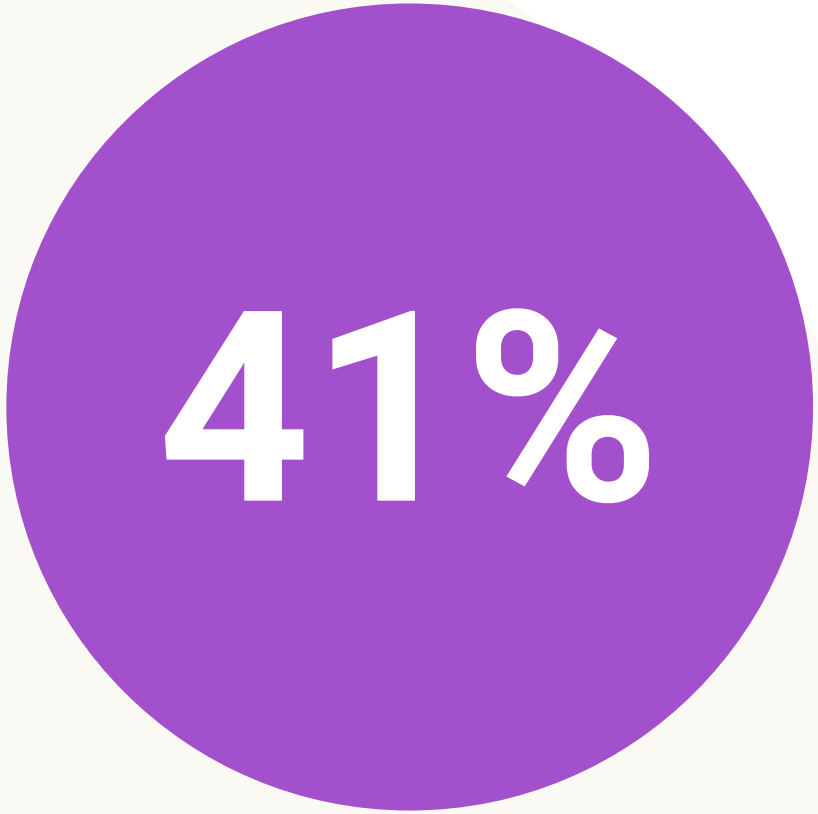
	FQHC External Rule Review DRAFT	
12:15pm	Federal & State Budget Updates	Chris Kaasa, Senior Policy Advisor
	State & Federal Policy Updates	
12:30pm	Airtime/Adjourn	Bob Marsalli, CEO
	Board of Director's Retreat: October 7-8, 2020 in Spokane, WA	Pandemic Permitting

upstream USA

Upstream USA works to expand opportunity by reducing unplanned pregnancy across the U.S. We partner with states to provide training and technical assistance to health centers, increasing equitable access to the full range of contraceptive options. Our transformative approach supports patients to decide when and if they want to become pregnant, a critical step towards improving outcomes for parents and children.

Of All Pregnancies in Washington are unplanned

Source: WA Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS) Data

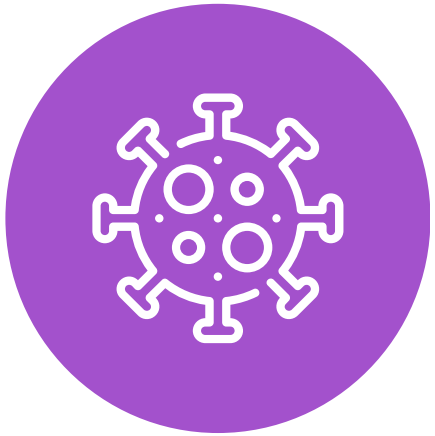


Of women who use contraception inconsistently will have an unplanned pregnancy.

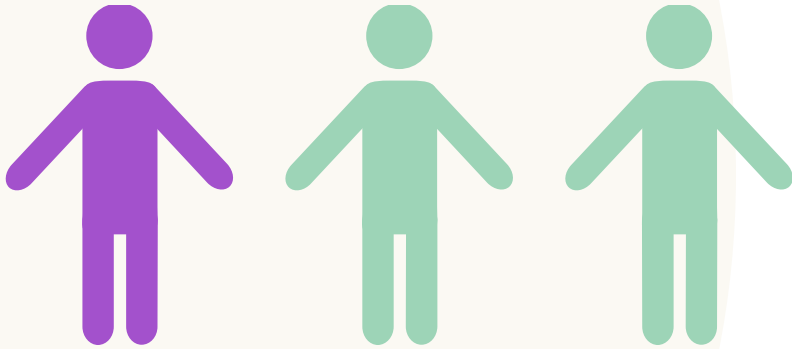
Source: Guttmacher Institute

upstream USA

Inequity in contraceptive access fails patients



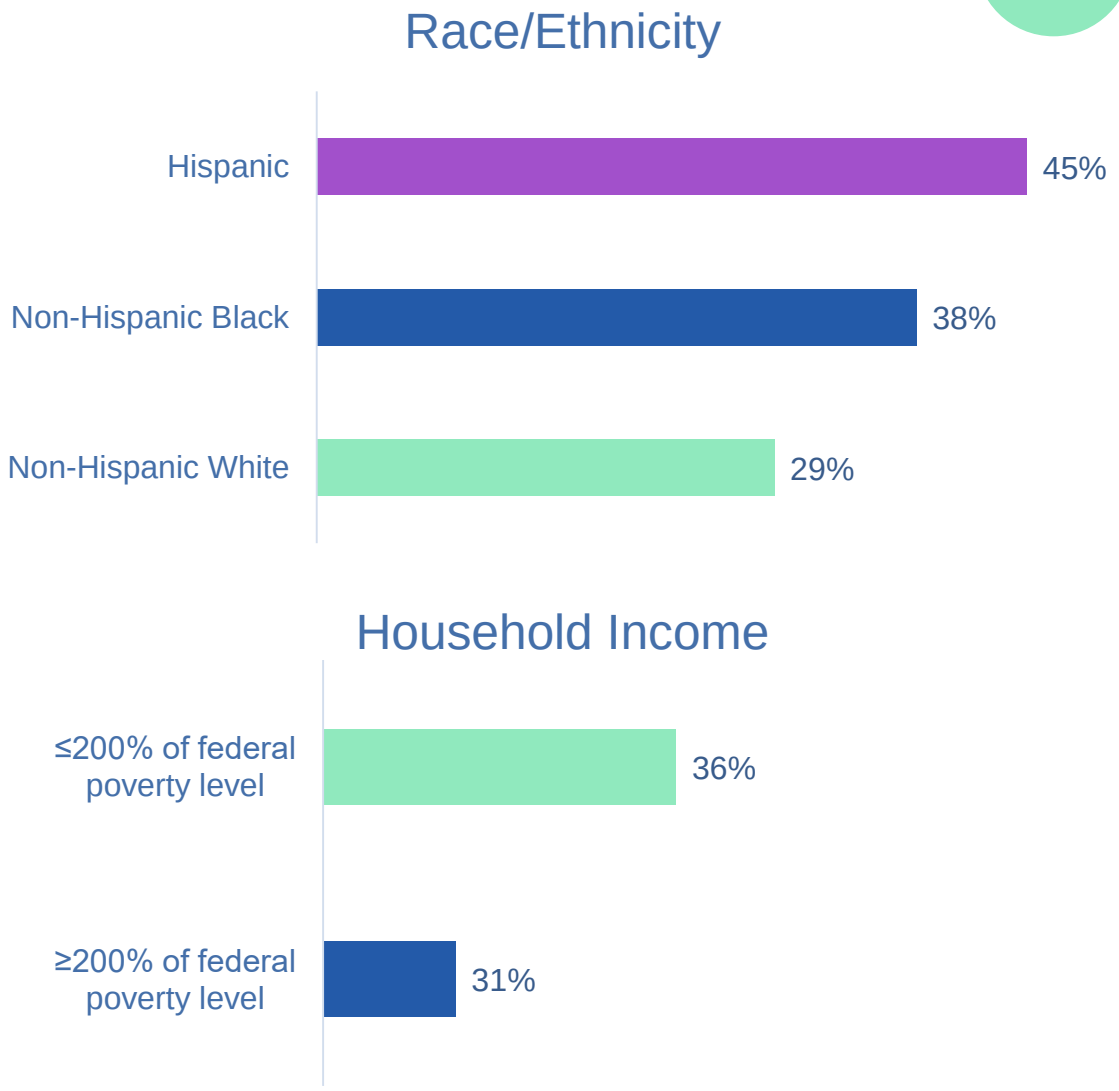
Systemic inequities in healthcare prevent providers from offering the full range of birth control methods to all patients.



One in three women reported that because of the pandemic, they have had to delay or cancel visiting a health care provider for sexual and reproductive care, or have had trouble getting their birth control.

Source: Guttmacher Institute

Disparities are higher for women of color and low income women



Source: Guttmacher Institute

Many patients face barriers when accessing birth control.

Lack of Trained Providers

Unnecessary Appointments

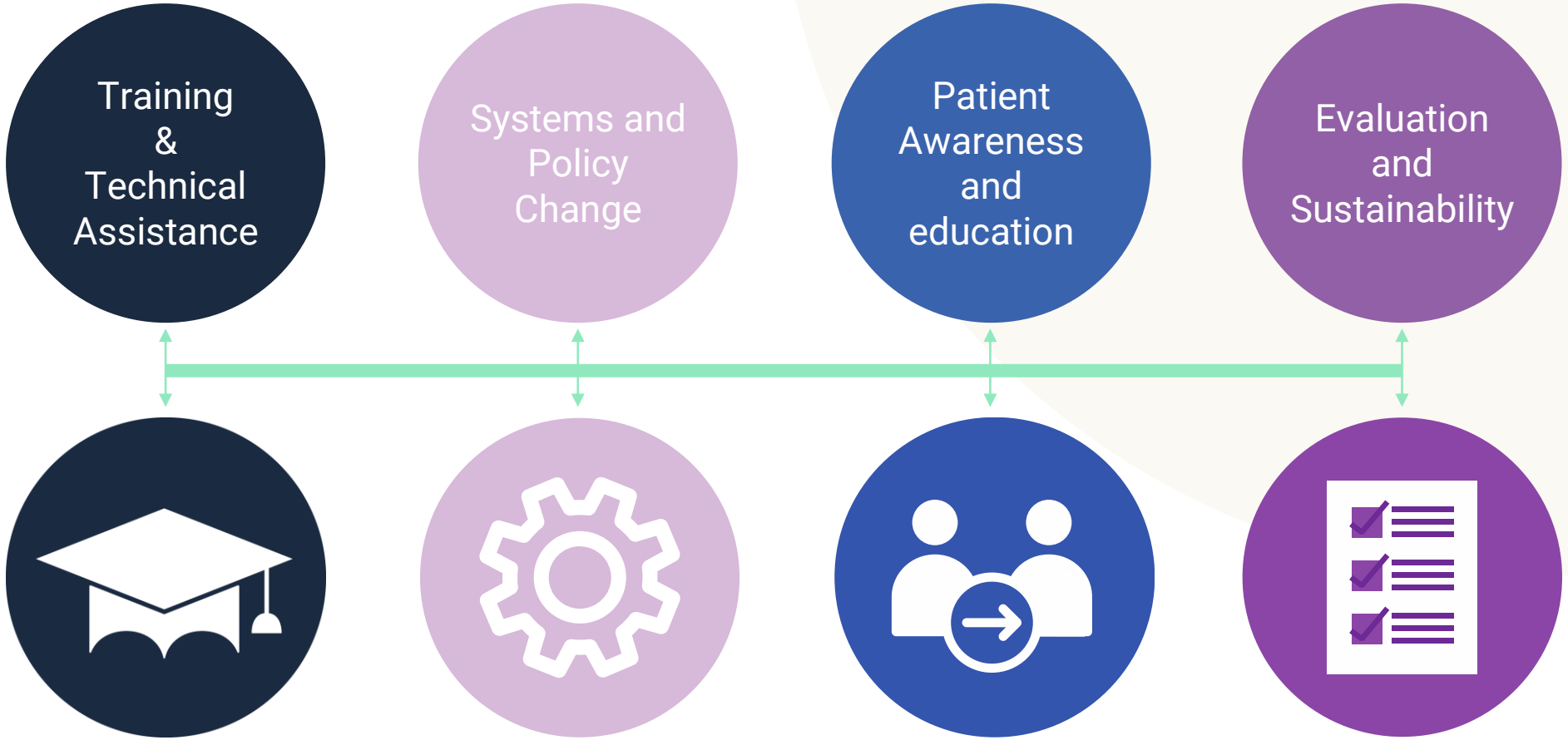
Contraceptive Counseling

Billing & Coding Errors

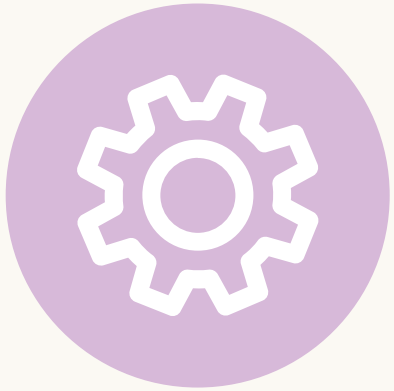
Bias & Coercion

How we work

Our partnership includes:



Systems and Policy Change



- Partnering with DOH and HCA to ensure our technical assistance offerings are in line with Family Planning and Medicaid Programs
- Support funding for family planning services that increases access to patients who need it most and ensure providers are adequately reimbursed for provided care
- Embed measurement and data into state systems to evaluate our state's ability to provide high quality care

Health Center Training

- Virtual & Blended Training Approaches
- Self-Guided Modules
- Zoom or In-person sessions
- Tailored learning package to meet agency needs

Health Center Technical Assistance

- Virtual Needs Assessment
- Virtual Coaching
- Workflow & Telehealth Support
- Support for Stocking, Billing, & Coding

Upstream Monitoring & Evaluation

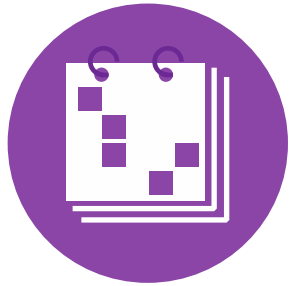
Upstream collects data on contraceptive measures to track the progress of our work with partner agencies, so that we can promptly and continuously adjust our quality improvement activities to meet the needs of our partner health centers. These measures include:

Patient Counseling

% of patients that have received contraceptive counseling and the % of patients screened for pregnancy intention

Contraceptive Method Mix

Monitors trends in contraceptive method provision and use among patient populations



National Contraceptive Care Measures

Producing results that can be examined alongside national trends in contraceptive care.

Real—time Data Monitoring

We've partnered with Azara, a specialized data analytics platform, to provide a seamless and secure EHR integration, and enable real-time data monitoring for both Upstream and our health center partners.

The Azara integration will provide:

- Real-time monitoring data, including ready-made measures calculated from existing data
- Monitoring data at the provider, site, and agency level
- On-demand, turnkey reports for agency leadership accessible directly from data analytics platform
- The ability to compare quality improvement metrics across sites, and against state and country-wide benchmarks

As part of our partnership, Upstream will provide a **complimentary Azara subscription for five years**. This subscription will include access to a number of standard FQHC reporting measures and public health metrics, in addition to Upstream's contraceptive care measures.

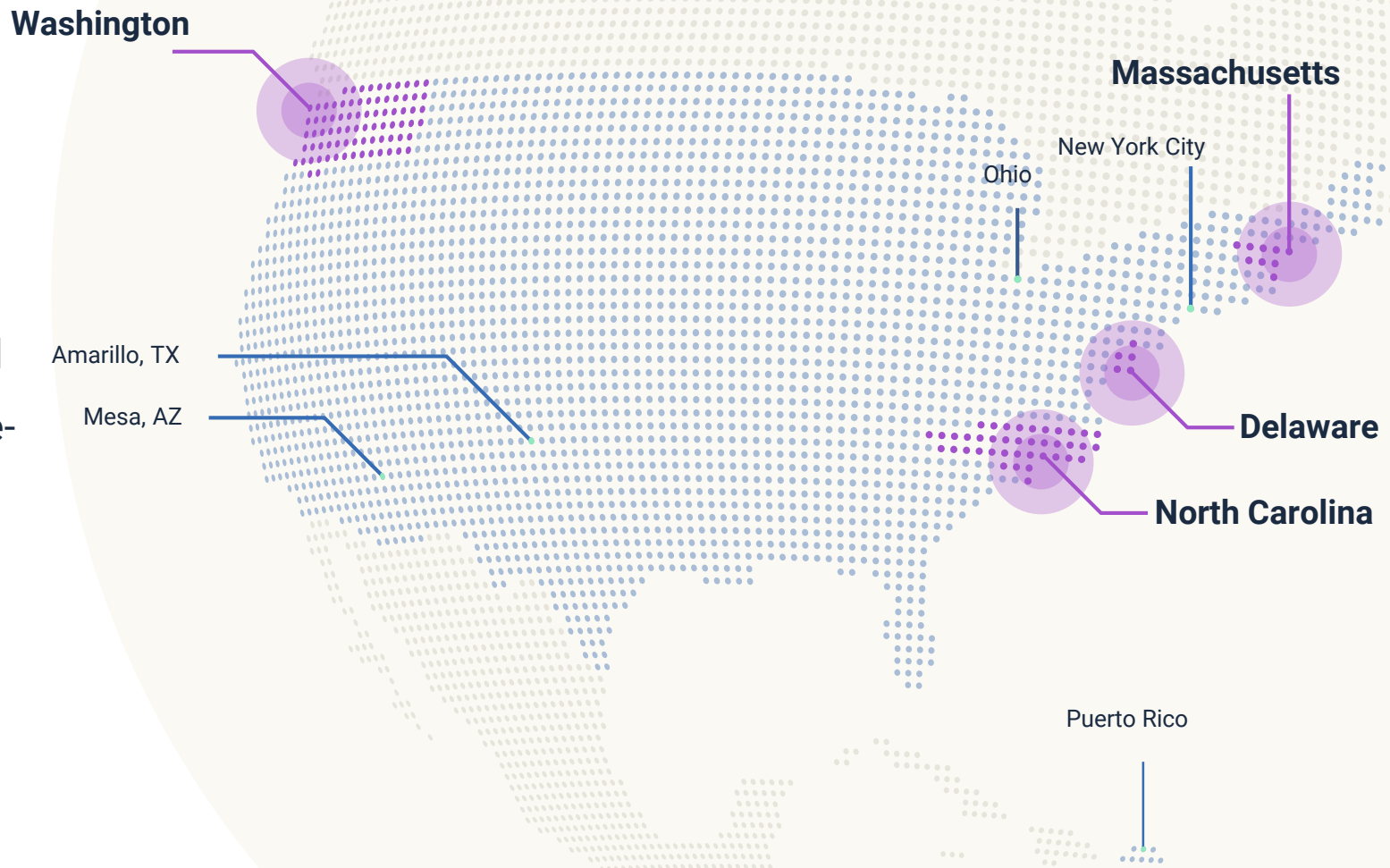
Patient Education and Awareness

- Patient education materials
- Referral network
- Community engagement toolbox for health center partners

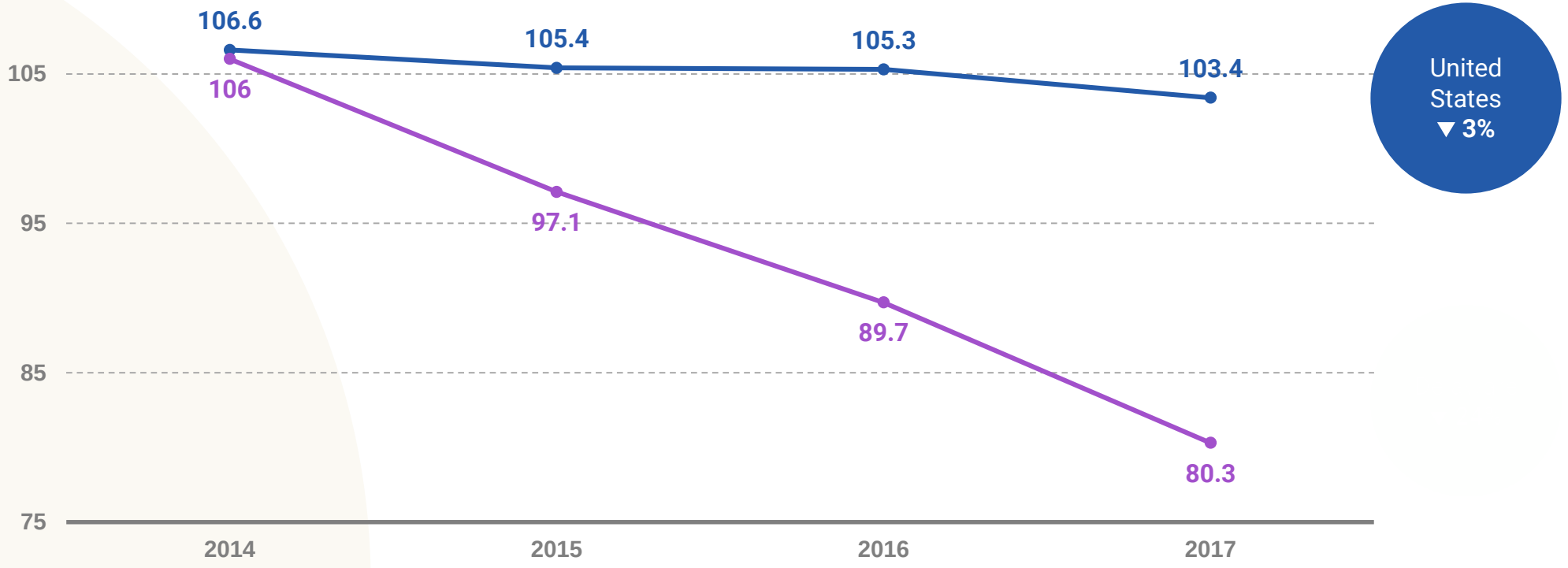
Where we work

Upstream has worked across the United States, and is now engaged in four state-based efforts in **Delaware, Massachusetts, Washington and North Carolina**.

We are on track to reach more than **1 million women** by 2024.

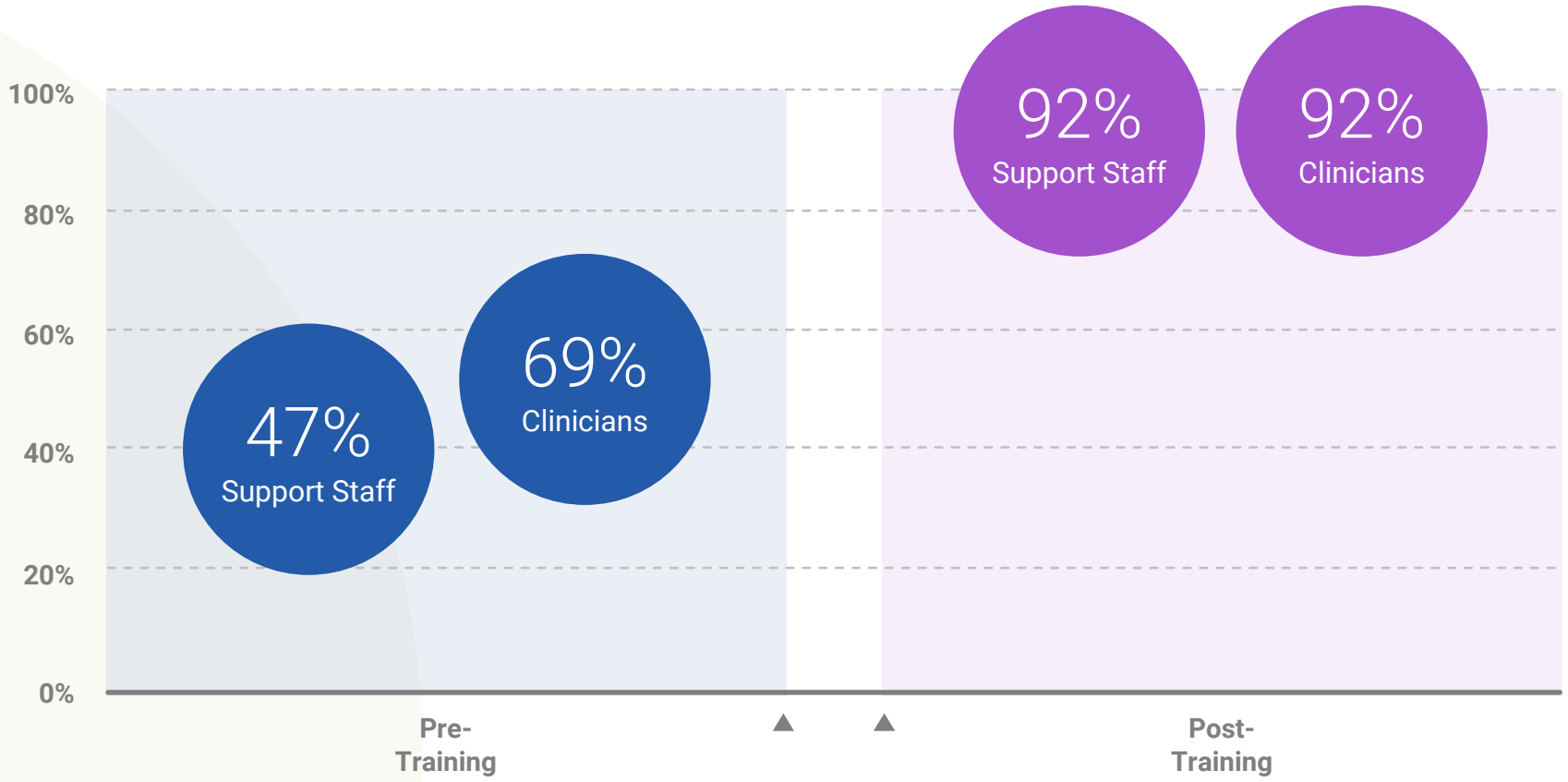


Simulated unintended pregnancy rates dropped 24% among Title X family planning clients aged 20–39 in Delaware compared with 3% nationally.



FamilyScape simulations using state-level Title X data from Delaware and from the U.S. Title X data, 2014-2017. Study limited to women at risk of unintended pregnancy (sexually active and not pregnant or seeking pregnancy). Complete methodology and limitations can be found at Child Trends.

Clinician and support staff knowledge improved after Upstream's training.

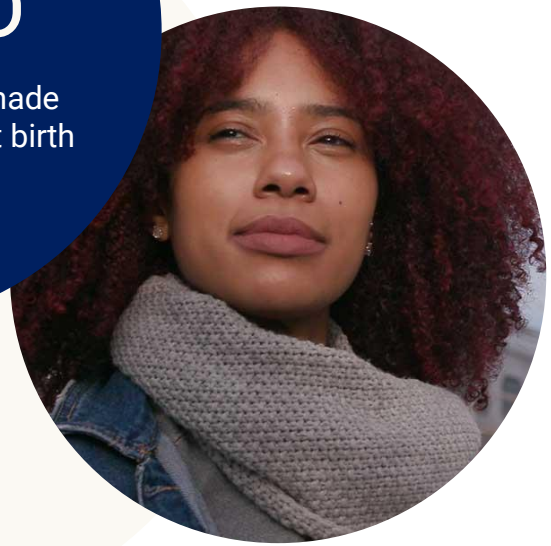


Data represent group-level averages for attendees at over 30 Upstream trainings held in Delaware from mid-2017 to early 2019.
Pre-survey data were collected up to 2 weeks before trainings, and post-survey data were collected immediately following trainings.

Patients surveyed feel empowered to make their own decisions about which birth control method is right for them.

99%

of Delaware patients made their own choices about birth control.



98%

of Delaware patients feel that health center staff listen to them and their preferences.

Survey of 554 patients at Upstream-trained Delaware health centers conducted July-September 2017.

Our partners

Public Health — Seattle & King County

Questions?

cwaliser@upstream.org

blaughery@upstream.org

cbilodeau@upstream.org

Appendix

Only 30%
of community health centers offer same-day access to IUDs.

Source: Guttmacher Institute

Women of Reproductive Age in Washington

1.4M

Women of Reproductive Age in Washington

400,000

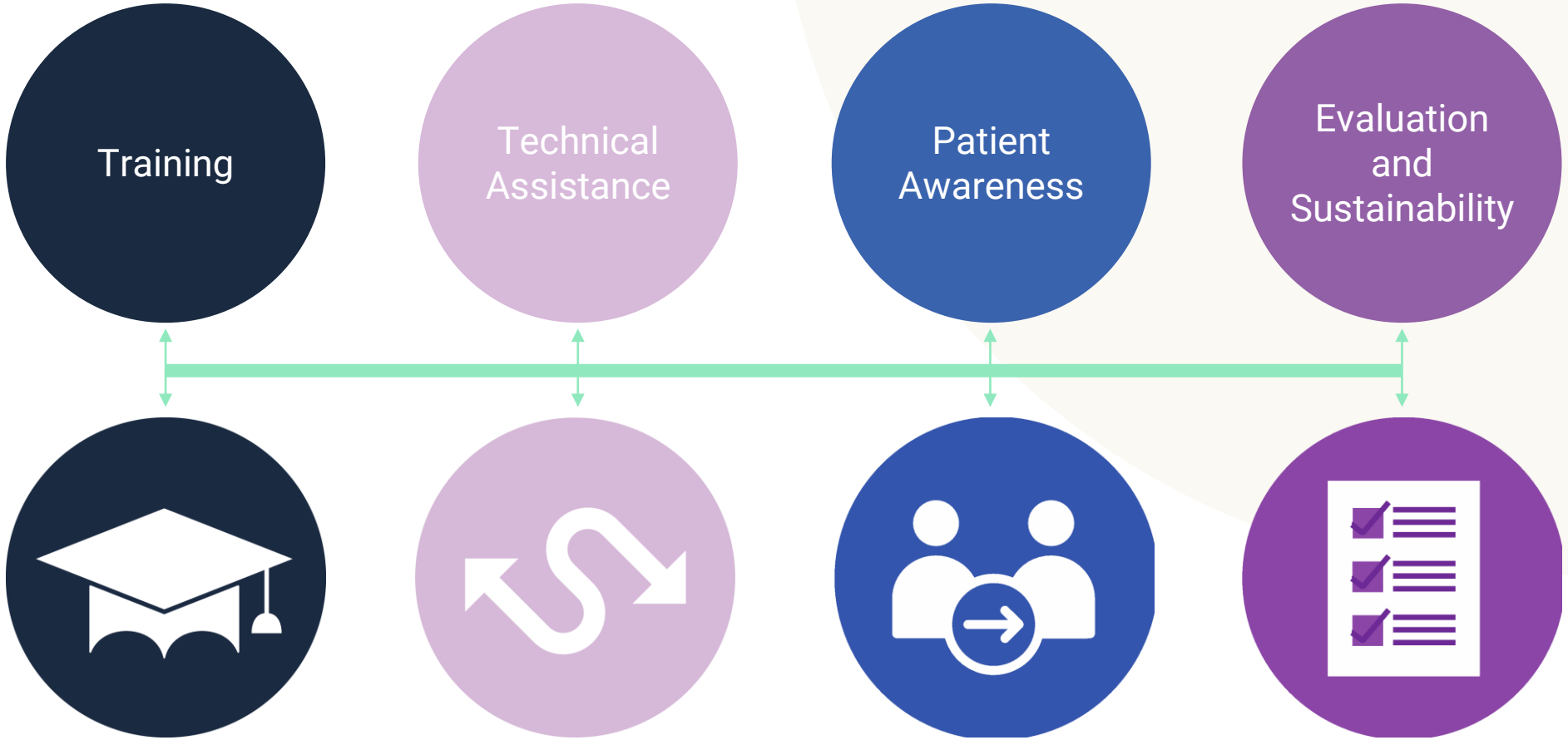
In need of publicly funded services

14 of 39

Counties with one or zero publicly funded sites offering all methods of birth control

How we work

Our partnership includes:



Our approach to partnerships

Upstream works with health care providers engaging the entire team in each health center. We meet every organization where they are, taking time to understand and address their unique challenges.

We prioritize the patient experience

We meet every partner where they are

We work remotely, tailoring interventions to the partner

We give our partners the resources the need

Our interventions are timely and efficient

We create sustainable results

Washington: Our Planned Scope

5

Years of training and technical assistance delivery, starting in 2019

40

Participating agencies, including FQHCs, Tribal and IHS providers, rural health centers, and family planning agencies serving a high percentage of Medicaid patients

300

Agency sites receive training and technical assistance

540k

Women of reproductive age (WRA) reached by health centers served when initiative is complete

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

BOARD OF DIRECTORS MEETING

APRIL 2, 2020 | ZOOM MEETING

PRESENT: BOARD MEMBERS		
1. Dian Cooper, CFH	9. Angela Gonzalez, CHCW	17. Mary Bartolo, SeaMar
2. Jennifer Kreidler-Moss, PCHS	10. Raleigh Watts, CDCHC	18. Jim Davis, TCCH
3. David Olson, CVCH	11. Gaelon Spradley, VVHC	19. Anita Monoian, YNHS
4. Aaron Wilson, CHAS	12. Michael Erikson, NeighborCare	20. Jesus Hernandez, FHC
5. David Flentge, CHC	13. Toni Lodge, NATIVE	21. Teresita Batayola, ICHS
6. Carlos Olivares, YVFWC	14. Lisa Yohalem, HealthPoint	22. Desiree Sweeney, NEWHP
7. Nieves Gomez, CBHA	15. Dana Fox, Mattawa	
8. Jodi Joyce, UCNW	16. Michael Maxwell, NOHN	
BOARD MEMBER PROXY:		
1. Aron Spark, SIHB		

ABSENT BOARD MEMBERS:	
1. Joseph Pakootas, LRCHC	3. Joe Vessey, CHC Sno
2. Sheila Berschauer, MLCHC	4. TJ Cosgrove, HCHN
STAFF/FACILITATOR:	
1. Bob Marsalli, CEO	3. Ian Randall, SSA
2. Deanna Fluke, EA	4. Chris Kaasa, SPA

APRIL 2, 2020 CALL TO ORDER

President Dian Cooper called The Board of Directors Meeting to order at 9:00am on April 2, 2020.

WELCOME & INTRODUCTIONS

An overview of the agenda provided as well as introductions of Board Members.

CONVENING

Minutes of The Board: January 28, 2020

MOTION: *Anita Monoian motioned to approve January 28, 2020 minutes with revisions to remove Raliegh Watts and Michael Erikson from attendance. Seconded by Aaron Wilson. Abstained by Jodi Joyce. All in favor. Motion Carries with recommended revisions.*

Executive Committee: January and February 2020 meeting minutes are available to the Board for reading; no action needed.

Finance Committee Report: Committee Chair, Treasurer, Aaron Wilson, CHAS

December, January and February financial statements presented for approval.

MOTION: *Finance Committee motioned to approve of financials as presented. Seconded by Jim Davis. Motion Carries.*

Delay review and approval of FY2020-2021 Associaiton O&M budget.

MOTION: *Finance Committee motioned to delay review and approval of FY2020-2021 Associaition O&M budget.. Seconded by Jim Davis. Motion Carries.*

Forgiveness of Q1 (April-June), FY2020-2021 Membership Dues recommended by the Executive Committee. Association will continue to monitor financial forecast and if required, additional dues forfiveness will move through the Executive Committee. Associaiton's Director of Finance will model loss of revenue to discuss scenarios with the Finance Committee in May.

MOTION: *Anita Monoian motioned to approve the forgiveness of Q1 membership dues for FY2020-2021. Motion seconded by Michael Erikson. Motion Carries.*

Election of Officers

- President: Jennifer Kreidler-Moss
- Vice President: David Olson (to complete current second year of 1st 2-year term)
- Secretary: Vacant
- Western Representative: Michael Maxwell
- Immediate Past President: Dian Cooper

Jim Davis, TCCH, volunteered as Secretary position during discussion.

MOTION: *Teresita Batayola motioned to approve slate as presented, with Jim Davis volunteering for the Secretary position. Motion seconded by Angela Gonzales.. Motion Carries.*

CAPACITY BUILDING

BPHC/COVID-19 Response, Part 1 attachments provided. Responses will be shared with the Board as received.

Temporary Site Template provided-required to complete and submit within 15 days of an established temporary site

All OSVs canceled through June 2020 Changes will be communicated with the Board as they come in.

Needs/Questions from CEOs

- MA Apprenticeship: No cohorts are being offered at this time, with hopes of restarting in late-Spring with an eye on safety and suppression of the spread. Board recommends to be ready to go when the Governor's orders are lifted.

FQHC Committee/COVID-19 Response, Part 2 FQHCs are engaged with continuing to lea conversation with HCA around APM4 and proposal for APM5- goal is to not have a two-tiered payment structure within CHCs. Current conversations with HCA around 2017-2018 reconciliation payments

Telehealth Billing and Coding Learning Collaborative Webinar developed with CHNW to convene CFOs, billing managers etc. will continue on a temporary basis as needed.

HCA/MCO Revenue Relief Strategies Plans are waiting for direction around HCA to waive requirement of quality measures and 2% withhold be released to CHCs. Asked HCA to consider capitated payment for dental encounters, and spoken with BPHC about quality awards to make it a pay for reporting vs hitting targets around quality metrics. Partnering with Dekker with CHPW. Associaiton has asked HCA to forgive overpayment for 2020 in APM3 and for APM4 clinics to be awarded wedge payment for reporting around quality. On APM3 side, encouters are dropping so risk of overpayment is high. Bob will get back to CHCs with written documents to produce a coordinated effort for all to reference.

CliftonLarsonAllen Business Intelligence Initiative working with CLA to delveop a tool to estimate revenue loss to aggregate and bild up to losses around COVID-19. The advocacy document to provide at CHC and district level to determine the economical impact for all health centers to show critical need and use for advocacy. Board requests the tool to be distributed to their finance staff and the CEOs. CLA is offering TA through the weekend to have a quick turnaround.

POLICY, ADVOCACY & IMPLEMENTATION

Federal/State Policy Updates/Association COVID-19 Policy & Advocacy Strategy, Part 3 In a state that depends on taxes for operational budget, we are in an environment where no one is spending; certain there will be special sessions with an expanded 2021 session. Keeping a close eye on state budget. Federal budget has been

borrowing on an unwarranted scale. Possible 4th response on its way. Next steps with HCA is to request for forgiveness in overpayments. Exploring potential in maintaining cash flow from HCA to CHCs to keep dental operational, reaching for PMPM replacement with Medicaid clients.

Congressional Strategy Financial projections: provide with clear picture of what we are looking at. Distributing tool from CLA, timely completion could be issue with some. Request from senators and congress of idea and estimate of what this is going to cost.

Save Healthcare in Washington Website Some health centers have appeared in newspaper and political blogs. We want to sell the message CHCs have stepped up for the time in need, and now the nation needs to step up for us. Request to add a line in asks for relief at our tribal CHCs as well.

Adjourn

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DENTAL & BEHAVIORAL HEALTH COMMITTEE REPORTS

April 2020 – June 2020

DENTAL COMMITTEE

Committee Work

- Monitored status of Covid-19 and its impacts on dental operations.

Dental Committee Tasks to Be Completed in 2020

- Recruit new dental committee chair.
- Continue monitoring status of Covid-19 and dental budget implications.

Dental Learning Network

- The DLN hosted 3 virtual meetings for dental directors to discuss strategies and protocols for practicing dentistry during the Covid-19 pandemic.

BEHAVIORAL HEALTH COMMITTEE

Committee Work

- Recruiting for new behavioral health committee chair.

Behavioral Health Committee Tasks to Be Completed in 2020

- Recruit new behavioral health committee chair.
- Host the annual behavioral health round table meeting.

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PHARMACY LEARNING NETWORK

April 2020 – June 2020

Learning Network Work

- Participation continues to expand as Learning Network opens meetings to broader position types involved in pharmacy operations.
- Learning Network met in a conference call on April 14, 2020. This meeting was previously planned for an in-person convening in Tacoma. The group plans to meet in a conference call on July 7. Another in-person convening is tentatively scheduled for September in Wenatchee, though this may also be cancelled in favor of a conference call.
- Topics of discussion for April agenda included: 1) COVID-19 response and challenges, including mail and delivery expansion, staffing innovations, and controlled substance regulations on delivery; 2) policy updates including securing PPE and CHC funding, and PBM legislation.
- Members of the Learning Network continue to reach out to peers and Association staff for input on a variety of topics, including pharmacist billing models.

Pending Policy Work

- Continues to monitor discriminatory contracting between PBMs and 340B covered entities. Association staff has worked to educate legislators about discriminatory contracting and continues strategy to create allies in the legislature to defend 340B.
- Licensing and regulation of PBMs by the Office of the Insurance Commissioner.
- Reimbursement for pharmacists' services in Medicare and Medicaid.

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WORKFORCE COMMITTEE REPORT

April 2020 – June 2020

HR METRICS

The Association distributed the CY 2019 HR Metrics Report in May 2020. The Workforce Committee will be discussing the report and next steps for metrics collection during the July 2020 Committee meeting. Individualized reports are available for a fee of $250. If an organization is interested, please contact the Association's Data Analyst, Karie Nicholas here: KNicholas@wacommunityhealth.org.

Workforce Committee Meetings

In May 2020 the Workforce Committee held a shared learning event in lieu of the regularly scheduled Spring face-to-face meeting due to covid-19 restrictions. The event featured a presentation focused on utilization of Naturopathic providers in community health, along with a roundtable discussion on the effects of covid-19 from an HR/Workforce perspective. Association workforce staff continues to hold bi-monthly roundtable discussion for CHC workforce professionals to discuss ongoing issues of covid-19 on CHCs staffing, protocols, patient engagement, etc.

2017-2020 HRSA GRANT DELIVERABLES

Apprenticeship Development

- MA: 81% of CHCs (n=22) will be enrolled as a participating MA apprenticeship employer by April 2019. 25 apprentices will complete the program and become employed as MA-C's at member CHCs by June 2020.

  Update of Completed Cohorts:
  - As of January 2020, this goal has been met.

  Update of New Cohorts:
  - A private MA Apprenticeship with Olympic Medical Physicians began in May 2020 with 12 apprentices. ***this kick-off took place virtually***

  Upcoming Cohorts:
  - Due to covid-19, all other Spring 2020 healthcare apprenticeship cohorts have been postponed to the Fall. Enrollment will open in August 2020.

PROVIDER VACANCY REPORT

Washington CHC vacancies from the NHSC Health Workforce Connector website as of July 2020.

MD/DO	MID LEVEL	CNM	DDS	DH	BH	TOTAL
52	20		6		12	**90**

LOAN REPAYMENT/SCHOLARSHIP PROGRAMS

Federal:

Now Open: National Health Service Corps (NHSC) New Site Application

As an NHSC-approved site, your providers may apply for one of the loan repayment programs and you can take advantage of helpful recruitment tools like the Health Workforce Connector and Virtual Job Fairs. For a complete list of eligible sites and requirements, visit the NHSC website and review the 2020 NHSC Site Reference Guide. **Deadline 7/21/2020.**

State:

- 2020 Provider Application
  - Have closed

- 2020 Site Application
  - Applications are available for sites to request pre-approval status.

TRAINING AND TECHNICAL ASSISTANCE OPPORTUNTIES

Next Workforce Committee Meeting

- July 9th, 2020 10:00AM-11:00AM

Healthcare Staff Resiliency During Covi-19

- Three-part series begins: July 22nd, 2020 12:00PM-1:00PM
- https://www.nwrpca.org/view.aspx?messageId=c229866a36154a78bcf35b6dfa45f62f

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JOINT LEGISLATIVE COMMITTEE REPORT

April-July 2020

STATE ISSUES

- Convened COVID-19 Expanded Joint Legislative Committee meetings to track outbreaks, health center operational and financial challenges, and community needs across the state.
- Served as conduit between health centers and state agency leaders, key legislators, and the Governor's Office concerning the need for personal protective equipment and regulatory flexibility.
- Advocated for Medicaid emergency telehealth administrative and reimbursement changes for the duration of the COVID-19 emergency, including:
    - Cost-based reimbursement for telephone- and audio/visual-based clinical services in order to offset some revenue losses.
    - Reduced regulatory barriers to quickly standing up telehealth programs, including temporary loosening IT security and software standards in order to deliver critical care expeditiously.
- Developed a plan to facilitate, and convened discussions with Health Care Authority and managed care organization leadership to advocate for, emergency funding disbursements to health centers.
- Using the Save Health Care in Washington platform, developed a library of resources for use by health center leadership:
    - Workforce resources, including information on federal and state worker and unemployment protections;
    - Information on telehealth flexibilities and reimbursement updates;
    - Information on care and coverage options for the newly-uninsured;
    - Information on care and coverage options for immigrants and refugees;
- Convened an ad hoc task force of state and federal public health officials to hear health center concerns on agricultural worker health and safety protections in rural Washington.
- Monitored state budget developments, including proposed cuts in light of the COVID-19 recession, and summarized them and likely impact for the health center network. Distributed survey on ground-level impacts of proposed cuts.
- In partnership with the Arcora Foundation, formed the Medicaid Dental Coalition to protect the highly-vulnerable Apple Health adult dental benefit.
- Actively participated in the Healthy Washington Coalition and its Eligibility & Enrollment (E&E) and Low-Income Populations (LIP) subgroups; convened a workgroup of LIP advocates to offer a Medicaid consumer perspective on the development of HCA's dental managed care RFP.

FEDERAL ISSUES

- Participated in NACHC's early warning communications to Congress, participating in calls with House and Senate leadership staff to convince them early that COVID-19 is a major public health and economic threat.
- Advocated with members of Congress and HRSA to secure billions of dollars in emergency cash funding to maintain health center financial integrity.
- Advocated with members of Congress and FEMA to secure major shipments of personal protective equipment to Washington State.
- Collaborated with the offices of Sen. Patty Murray, Sen. Maria Cantwell, and key members of the House of Representatives to ensure that the reauthorization of the Primary Care Cliff programs remains at the top of the congressional agenda and is reauthorized.

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GROUP PURCHASING REPORT

April 2020 – June 2020

PPE SUPPLIES

- We are monitoring the shortage situation and updating our members on the most recent information available regarding supplier rationing and possible sources for more product.
- We negotiated a special deal from Staples for a stand-alone no-touch Temperature Kiosk. Group Purchasing members will receive $54 below the quoted price.
- Found a local source for donated face shields.

2ND ANNUAL GROUP PURCHASING CONFERENCE: CANCELLED

- A Purchasing 101 Webinar was held in its place.
- 28 members attended.

VENDOR NEWS

- THMED / Fidelis: our GP recruiting and staffing partner has been acquired by Doximity.
- They have been renamed Curative but are still providing the same recruitment services for our members as before.
- Our Group Purchasing terms with them have not changed.

GROUP PURCHASING REVENUE [Gross]

- Current Quarter 2020: April 2020 – June 2020 $12,678.79
- Fiscal Year to date: April 2019 – March 2020 $12,678.79

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

OUTREACH & ENROLLMENT, HEALTH EQUITY AND EMERGENCY PREPAREDNESS UPDATES

April 2020 – June 2020

OUTREACH & ENROLLMENT

Due to the effects of COVID-19, WA State Office of Financial Management estimated the uninsured rate has increased to 13%. Washington State Health Care Authority reported an average of 1,224 new enrollees in Apple Health programs daily.

Health centers are requesting more resources and advertising from Washington Health Benefit Exchange and Washington State Health Care Authority to encourage people to apply for coverage, especially targeting the unemployed who may be unaware they have only 60 days to apply for QHPs.

O & E staff are still not going out into the community due to concerns about COVID-19. They are doing outreach mainly over the phone and beginning to do some in-person enrollment appointments with clients when necessary.

Migrant health centers are beginning to do outreach with H-2A workers at farms and farmworker housing due to the vulnerability of this population.

HEALTH EQUITY

May 2020 Combined Community Health Workers Workgroup & Health Equity Workgroup Call: Health centers discussed how clients' social needs were being exacerbated by COVID-19 and what they were doing to connect to resources.

June 2020 webinar "Helping Vulnerable Populations Access Needed Resources": Health centers learned about resources to meet clients' social needs from Washington State Community Action Partnership and Washington 211.

June 2020 webinar "Keep Kids Safe, Healthy & Vaccinated During COVID-19": Health centers learned to apply communication strategies to mitigate concerns and increase well child visits and childhood immunizations.

EMERGENCY PREPAREDNESS

April 2020 webinar "Planning For COVID-19 At FQHCs": Health centers learned lessons from the H1N1 pandemic, how to manage COVID-19 in the health center setting and business continuity planning considerations.

May 2020 Emergency Preparedness Workgroup Call: Health centers discussed how their Emergency Preparedness plans were working in response to COVID-19, identified challenges and shared best practices.

May 2020 webinar "Coordinating With Regional Healthcare Coalitions Before And During Emergencies": Health centers learned about regional emergency support and building relationships with their regional healthcare coalitions.

The Association will begin coordinating with health centers in the upcoming project period to develop site status reporting agreements in the event of a disaster or public health emergency, as per HRSA directives.

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

JOINT LEGISLATIVE COMMITTEE REPORT

April-July 2020

STATE ISSUES

- Convened COVID-19 Expanded Joint Legislative Committee meetings to track outbreaks, health center operational and financial challenges, and community needs across the state.
- Served as conduit between health centers and state agency leaders, key legislators, and the Governor's Office concerning the need for personal protective equipment and regulatory flexibility.
- Advocated for Medicaid emergency telehealth administrative and reimbursement changes for the duration of the COVID-19 emergency, including:
    - Cost-based reimbursement for telephone- and audio/visual-based clinical services in order to offset some revenue losses.
    - Reduced regulatory barriers to quickly standing up telehealth programs, including temporary loosening IT security and software standards in order to deliver critical care expeditiously.
- Developed a plan to facilitate, and convened discussions with Health Care Authority and managed care organization leadership to advocate for, emergency funding disbursements to health centers.
- Using the Save Health Care in Washington platform, developed a library of resources for use by health center leadership:
    - Workforce resources, including information on federal and state worker and unemployment protections;
    - Information on telehealth flexibilities and reimbursement updates;
    - Information on care and coverage options for the newly-uninsured;
    - Information on care and coverage options for immigrants and refugees;
- Convened an ad hoc task force of state and federal public health officials to hear health center concerns on agricultural worker health and safety protections in rural Washington.
- Monitored state budget developments, including proposed cuts in light of the COVID-19 recession, and summarized them and likely impact for the health center network. Distributed survey on ground-level impacts of proposed cuts.
- In partnership with the Arcora Foundation, formed the Medicaid Dental Coalition to protect the highly-vulnerable Apple Health adult dental benefit.
- Actively participated in the Healthy Washington Coalition and its Eligibility & Enrollment (E&E) and Low-Income Populations (LIP) subgroups; convened a workgroup of LIP advocates to offer a Medicaid consumer perspective on the development of HCA's dental managed care RFP.

FEDERAL ISSUES

- Participated in NACHC's early warning communications to Congress, participating in calls with House and Senate leadership staff to convince them early that COVID-19 is a major public health and economic threat.
- Advocated with members of Congress and HRSA to secure billions of dollars in emergency cash funding to maintain health center financial integrity.
- Advocated with members of Congress and FEMA to secure major shipments of personal protective equipment to Washington State.
- Collaborated with the offices of Sen. Patty Murray, Sen. Maria Cantwell, and key members of the House of Representatives to ensure that the reauthorization of the Primary Care Cliff programs remains at the top of the congressional agenda and is reauthorized.

WASHINGTON ASSOCIATION FOR COMMUNITY HEALTH

FINANCE COMMITTEE MEETING

TUESDAY, MAY 19, 2020 | 3:30 PM

CONFERENCE CALL: **1 (404) 891-0552**
ACCESS CODE: **633-074-689**

THIS FILE CONTAINS

- Meeting Agenda
- Finance Committee mtg minutes – March 24, 2020
- Financial Statements: March 2020, April 2020
- Draft Budget for FY 2021 (Round 2)
- Investment report/update

ASSOCIATION FINANCE COMMITTEE MEETING

TUESDAY, MAY 19, 2020 | 3:30 PM

Conference Call: 1 (404) 891-0552
Access Code: 633-074-689

AGENDA

1. Call to Order by Aaron Wilson
2. Acceptance of meeting minutes from March 24, 2020 (Page 3-4)
3. Financial Statements March & April 2020 (Pages 5-12)
4. Acceptance of draft annual budget for FY 2021 (Page 13)
5. Investment report (Page 14)
6. Confirm next meeting: June 16, 2020 3:30 PM

WASHINGTON ASSOCIATION FOR COMMUNITY HEALTH

FINANCE COMMITTEE MEETING VIA CONFERENCE CALL
MINUTES FOR THE MEETING OF TUESDAY, MARCH 24, 2020

MEMBERS PRESENT:
Aaron Wilson, Treasurer
Anita Monoian
Sheila Berschauer
Joel Emery

MEMBERS ABSENT:
Paul Kaschmitter
TJ Cosgrove

STAFF PRESENT:
Eric Griffith
Bob Marsalli

GUEST PRESENT:

STAFF ABSENT:

CALL TO ORDER

Aaron Wilson called the meeting to order at 3:43 P.M.

APPROVAL OF MINUTES

The Committee reviewed the meeting minutes from February 25, 2020

MOTION: Sheila moved and Anita seconded to accept the Finance Committee meeting minutes from February 25, 2020. No one opposed. No one abstained. Motion passed.

MINUTES

- Aaron asked for the presentation of the February 2020 draft financial statements.
- The February Financial Highlights included the ending cash and equivalents total of $2,872,743 with 378 days of operating cash on hand, 83 days of reserve cash on hand. There was a $37k gain for the month, netting a $486k gain YTD. Revenues were 108% of year-to-date budget, while expenses were 118% of year-to-date budget.
- Aaron suggested expediating the review of financial statements and Eric asked if there were any questions about the statements or the notes on budget variances. The Committee commented that nothing on these statements jumped out as unusual, and Aaron called for a vote to accept.

MOTION: Anita moved and Sheila seconded to accept the February 2020 draft financials. No one opposed. No one abstained. Motion passed.

Moving on to the **draft annual budget**, Aaron suggested, and the Committee agreed that because the coronavirus pandemic, the budget may not reflect possible impacts of the crisis. At the very least, Dues revenue and MA tuition could see steep declines. So the Committee agreed that the budget should be put on hold for at least 30 days while Eric and Bob developed scenarios that seemed likely and adjusted the budget accordingly.

The office lease options were put aside as Bob and Eric had already decided not to attempt a move to a more expensive location, but to renew the lease in the Association's current office space.

UPCOMING EVENTS

The next Association Finance Committee meeting is scheduled for Tuesday, May 19, 2020 at 3:30 PM.

ADJOURNMENT

There being no further business, Aaron adjourned the meeting at 4:00 PM.

MARCH 2020 FINANCIAL STATEMENT HIGHLIGHTS

- Total cash and equivalents was $2,741,340 and $2,904,596 at the end of February and March, respectively.
- Reserves = 169 days, or 5.6 months
- Operating cash (includes restricted funds) = 339 days
- Payables cycle remains within 30 days. A/R has some DOH invoices from Nov & Dec 2019 but we're working with them to get those paid.
- The current ratio, current assets compared to current liabilities, is 3.99:1.0
- For March, 2020:

	MONTH	YTD	% OF BUDGET
Revenue	$ 184K	$ 2,705K	107%
Expenses	$ 158K	$ 2,194K	105%
Gain / (Loss)	$ 25K	$ 511K	
From Reserves	-	-	
Net with Reserves	**$ 25K**	**$ 511K**	

Washington Association for Community Health
Statement of Financial Position

Reporting Book: ACCRUAL
As of Date: 03/31/2020

	Month Ending 03/31/2019	Month Ending 02/29/2020	Month Ending 03/31/2020	
	1 Year Ago	Last Month	Current Month	
Assets				
Current Assets				
Cash and Cash Equivalents				
Heritage Bank Checking	1,549,072	2,262,458	1,938,614	
Morgan Stanley - Reserves	470,420	478,882	481,795	
Edward Jones - Reserves	0	0	484,187	
Total Cash and Cash Equivalents	**2,019,492**	**2,741,340**	**2,904,596**	
Accounts Receivable, Net	**178,097**	**105,711**	**121,459**	
Other Current Assets	**9,825**	**12,324**	**10,656**	
Total Current Assets	**2,207,414**	**2,859,375**	**3,036,711**	
Long-term Assets				
Property & Equipment				
Capital Equipment	24,987	8,029	8,028	
Office Furniture	20,629	14,630	14,630	
Accum. Depr. Capital Equip.	(23,853)	(765)	(860)	
Accum. Depr. Office Furniture	(20,629)	(14,630)	(14,630)	
Total Property & Equipment	**1,134**	**7,264**	**7,168**	
Other Long-term Assets	**6,104**	**6,104**	**6,104**	
Total Long-term Assets	**7,238**	**13,368**	**13,272**	
Total Assets	**2,214,652**	**2,872,743**	**3,049,983**	
Liabilities and Net Assets				
Liabilities				
Short-term Liabilities				
Accounts Payable	**54,277**	**56,148**	**16,546**	
Accrued Liabilities				
Accrued Expenses Payable	0	(24)	0	
Wells Fargo Credit Payable	4,096	577	177	
Pre-Tax, Plan 125 P/R Deductions	75	202	202	
Post-Tax P/R Deductions	31	237	237	
Med Ins P/R Deductions	(773)	(1,106)	(716)	
Accrued Vacation Payable	34,390	34,391	45,303	A.
Accrued PCA Fee Sharing	12,832	12,081	13,154	
Total Accrued Liabilities	**50,651**	**46,358**	**58,357**	
Deferred Revenue				
Deferred Member Dues	0	36,960	0	
Deferred Grant Revenue	88,195	184,444	306,898	
Deferred Tuition Revenue	294,184	335,952	378,783	
Total Deferred Revenue	**382,379**	**557,356**	**685,681**	
Total Short-term Liabilities	**487,307**	**659,862**	**760,584**	
Total Liabilities	**487,307**	**659,862**	**760,584**	
Net Assets	**1,727,345**	**2,212,881**	**2,289,399**	
Total Liabilities and Net Assets	**2,214,652**	**2,872,743**	**3,049,983**	

Washington Association for Community Health
Statement of Activities - Board

Reporting Book: ACCRUAL
As of Date: 03/31/2020

	Month Ending 02/29/2020	Month Ending 03/31/2020	Year To Date 03/31/2020				
	Prior Month	Current Month	Actual YTD	Budget YTD	Budget Diff	Budget % Var	
Revenue							
Grants Revenue							
HRSA Grant	67,987	86,671	1,017,499	919,253	98,246	10.68 %	
DOH Grants	1,216	2,634	25,133	0	25,133	(100.00) %	
Dental Grants	2,926	2,644	61,358	64,703	(3,345)	(5.16) %	
MA-DA Grants	17,248	17,733	241,287	130,000	111,287	85.60 %	C.
DeltaCenterGrant	5,000	(46,215)	8,785	60,000	(51,215)	(85.35) %	B.
Kaiser Grant	3,220	7,188	53,225	0	53,225	(100.00) %	
Total Grants Revenue	**97,597**	**70,655**	**1,407,287**	**1,173,956**	**233,331**	**19.87 %**	
MA/DA Tuition Revenue	43,901	60,732	558,601	635,000	(76,399)	(12.03) %	
Membership Dues	36,960	36,960	403,952	351,100	52,852	15.05 %	
GP Administrative Fees	18,261	12,158	171,574	110,000	61,574	55.97 %	C.
Contributions	858	0	40,133	30,000	10,133	33.77 %	
Interest & Other	141	3,052	123,501	237,203	(113,702)	(47.93) %	
Total Revenue	**197,718**	**183,557**	**2,705,048**	**2,537,259**	**167,789**	**6.61 %**	
Expenditures							
Personnel							
Salary and Wages	83,851	93,893	992,926	882,597	110,329	(12.50) %	
PR Benefits	16,508	16,876	195,973	220,957	(24,984)	11.30 %	
PR Taxes & Fees	6,761	6,709	78,033	67,172	10,862	(16.16) %	
Total Personnel	**107,120**	**117,478**	**1,266,932**	**1,170,726**	**96,207**	**(8.21) %**	
Occupancy	7,553	7,751	96,700	94,000	2,699	(2.87) %	
Professional Fees	10,063	13,431	288,318	269,750	18,569	(6.88) %	E.
Lobbyist	7,000	7,000	84,130	82,000	2,130	(2.59) %	
General and Administrative Expenses							
Conferences, Conventions, and Meetings	4,823	(1,579)	40,181	33,000	7,181	(21.76) %	
Depreciation	95	95	1,995	1,600	394	(24.65) %	
Due and Subscriptions	32	0	10,281	7,000	3,282	(46.87) %	
Equipment Rental	170	171	2,131	3,000	(870)	28.98 %	
Finance Charges	0	0	270	400	(130)	32.42 %	
Insurance	416	415	5,058	4,500	559	(12.40) %	
Meals and Entertainment	260	0	498	4,487	(3,990)	88.91 %	
Miscellaneous Expense	245	1,238	3,250	4,000	(749)	18.73 %	
Office Expenses	4,214	3,590	38,039	38,069	(31)	0.08 %	
Other Fees	0	1,072	85,278	122,062	(36,783)	30.13 %	
Printing and Publications	346	333	3,163	2,800	363	(12.96) %	
Program Events & Expenses	11,308	4,337	152,847	126,200	26,647	(21.11) %	
Postage and Delivery	89	0	977	500	476	(95.24) %	
State and Local Taxes	0	90	19,133	11,050	8,083	(73.15) %	
Telecommunication	1,109	1,137	13,415	14,500	(1,085)	7.48 %	
Travel Expenses	5,824	1,694	81,145	96,597	(15,452)	15.99 %	
Utilities	52	0	467	0	468	(100.00) %	
Total General and Administrative Expenses	28,983	12,593	458,128	469,765	(11,637)	2.47 %	
Total Expenditures	**160,719**	**158,253**	**2,194,208**	**2,086,241**	**107,968**	**(5.17) %**	D.
Total Change In Net Assets	**36,999**	**25,304**	**510,840**	**451,018**	**59,822**	**13.26 %**	

NOTES TO MARCH 2020 FINANCIAL STATEMENTS

A. Association turnover near zero for 2 years, PTO balances building up with staff tenure. Annual adjustment made.
B. Delta Center grant revenue had been accured as "deliverables-based" (per contract) but conversations with them indicate the intent was "cost reimbursed". Adjustment made to adjust revenue to date.
C. Group purchasing and MA Apprenticeship programs both had very good years.
D. Confernces & meetings, and Prog Events & Expenses both over budget, balanced by other expenses under budget.
E. Professional Services: March expenses included MA program contracted instructors and ????. Total year-to-date is $288,318 with breakdown in table below:

PROFESSIONAL SERVICES						
		MTD		YTD	Budget	% of Budget
	CliftonLarsonAllen	$ -	$	26,820		
ACCOUNTING & AUDITING		$ -	$	26,820	$24,500	109%
	Feldsman, Tucker, Leifer, Fidell	$ -	$	41,743		
	Bennett, Bigelow & Leedom	$ -	$	3,644		
LEGAL EXPENSE		$ -	$	45,387	$43,500	104%
	Community Link Consulting – FQHC	$ -	$	15,000		
	Team Soapbox LLC	$ -	$	4,000		
	Productive Flourishing (strategic plan)	$ -	$	25,200		
	Action Business Furniture (install)	$ -	$	164		
	Dragon Drop Dev (Prog Mgmt setup)	$ -	$	1,320		
	Integrated Work - PCA CEO Peer Learnin	$ -	$	340		
	Archbright (compensation consulting)	$ -	$	300		
	Thomas Architecture (office configure)	$ 1,352	$	1,352		
	KM Hewitt Consulting (Social Media)	$ -	$	5,000		
ADMINISTRATIVE		$ 1,352	$	52,676	$60,000	88%
	Adriane Engeland - MA instructor	$ 3,117	$	36,457		
	Tanya Van Buskirk - MA instructor	$ 3,680	$	52,166		
	Connie Berrysmith - lab assistant	$ -	$	5,363		
	Lorelei Herzog - DA instructor	$ -	$	9,100		
	Amy Gowan - MA instructor	$ -	$	3,206		
	Jessica Bustillos - MA instructor	$ 1,283	$	6,199		
	Integrated Work - Management coachin	$ -	$	1,250		
	Inland NW Health (Kasey Jones, MA inst	$ -	$	11,105		
MA Apprenticeship		*$ 8,080*	*$*	*124,844*		
	Suter Consulting	$ -	$	1,000		
	Douglas Young	$ -	$	5,071		
	Mark Koday DDS	$ -	$	1,000		
Dental Learning Network		*$ -*	*$*	*7,071*		
	Abbie Chandler-Doran	$ -	$	5,199		
Workforce		*$ -*	*$*	*5,199*		
	Providence Health - Oregon	$ -	$	1,992		
	C4 Innovations	$ -	$	2,150		
	Malika Lamont - SUD training	$ -	$	8,917		
	Oregon PCA	$ 2,000	$	2,000		
	CHCW	$ 2,000	$	2,000		
	Connect Consulting Services	$ -	$	2,250		
	NEW Health Prog - Ops Assessment	$ -	$	7,012		
TRANSFORMATION		*$ 4,000*	*$*	*26,321*		
	NACHC - Webinars		$	-		
O&E and Health Equity		*$ -*	*$*	*-*		
PROGRAM SPECIFIC		$ 12,080	$	163,436	$141,750	115%
TOTAL PROFESSIONAL SERVICES		$ 13,431	$	288,318	$ 269,750	107%

APRIL 2020 FINANCIAL STATEMENT HIGHLIGHTS

- Total cash and equivalents was $2,904,596 and $3,129,566 at the end of March and April, respectively.
- Reserves = 171 days, or 5.7 months
- Operating cash (includes restricted funds) = 377 days
- Payables cycle remains within 30 days. A/R has some old DOH invoices we are working to resolve.
- The current ratio, current assets compared to current liabilities, is 3.09:1.0
- For April, 2020:

	MONTH	YTD	% OF BUDGET
Revenue	$ 165K	$ 165K	???%
Expenses	$ 181K	$ 181K	???%
Gain / (Loss)	$ (17K)	$ (17K)	
From Reserves	-	-	
Net with Reserves	**$ (17K)**	**$ (17K)**	

Washington Association for Community Health
Statement of Financial Position

Reporting Book: ACCRUAL
As of Date: 04/30/2020

	Month Ending 04/30/2019	Month Ending 03/31/2020	Month Ending 04/30/2020	
	1 Year Ago	Last Month	Current Month	
Assets				
Current Assets				
Cash and Cash Equivalents				
Heritage Bank Checking	1,573,157	1,938,614	2,152,292	
Morgan Stanley - Reserves	470,420	481,795	481,795	
Edward Jones - Reserves	0	484,187	495,479	A.
Total Cash and Cash Equivalents	**2,043,577**	**2,904,596**	**3,129,566**	
Accounts Receivable, Net	**447,726**	**121,459**	**77,086**	
Other Current Assets	**8,320**	**10,656**	**8,988**	
Total Current Assets	**2,499,623**	**3,036,711**	**3,215,640**	
Long-term Assets				
Property & Equipment				
Capital Equipment	24,988	8,028	8,028	
Office Furniture	20,628	14,630	14,630	
Accum. Depr. Capital Equip.	(23,916)	(860)	(956)	
Accum. Depr. Office Furniture	(20,628)	(14,630)	(14,630)	
Total Property & Equipment	**1,072**	**7,168**	**7,072**	
Other Long-term Assets	**6,103**	**6,104**	**6,104**	
Total Long-term Assets	**7,175**	**13,272**	**13,176**	
Total Assets	**2,506,798**	**3,049,983**	**3,228,816**	
Liabilities and Net Assets				
Liabilities				
Short-term Liabilities				
Accounts Payable	**74,386**	**16,546**	**129,268**	
Accrued Liabilities				
Wells Fargo Credit Payable	937	177	57	
Pre-Tax, Plan 125 P/R Deductions	203	202	202	
Post-Tax P/R Deductions	236	237	237	
Med Ins P/R Deductions	(773)	(716)	(732)	
Accrued Vacation Payable	34,390	45,303	45,303	
Government Loans	0	0	226,935	B.
Accrued PCA Fee Sharing	14,174	13,154	6,305	
Total Accrued Liabilities	**49,167**	**58,357**	**278,307**	
Deferred Revenue				
Deferred Member Dues	209,485	0	0	
Deferred Grant Revenue	77,411	358,112	354,894	
Deferred Tuition Revenue	314,881	378,783	276,676	C.
Total Deferred Revenue	**601,777**	**736,895**	**631,570**	
Total Short-term Liabilities	**725,330**	**811,798**	**1,039,145**	
Total Liabilities	**725,330**	**811,798**	**1,039,145**	
Net Assets	**1,781,468**	**2,238,185**	**2,189,671**	
Total Liabilities and Net Assets	**2,506,798**	**3,049,983**	**3,228,816**	

Washington Association for Community Health
Statement of Activities - Board

Reporting Book: ACCRUAL
As of Date: 04/30/2020

	Month Ending 03/31/2020	Month Ending 04/30/2020	Year To Date 04/30/2020				
	Prior Month	Current Month	Actual YTD	Budget YTD	Budget Diff	Budget % Var	
Revenue							
Grants Revenue							
HRSA Grant	86,671	51,349	51,349	0	51,349	(100.00) %	
DOH Grants	2,634	3,503	3,503	0	3,503	(100.00) %	
Dental Grants	2,644	2,334	2,334	0	2,334	(100.00) %	
MA-DA Grants	17,733	13,052	13,052	0	13,052	(100.00) %	
DeltaCenterGrant	(46,215)	31,901	31,901	0	31,901	(100.00) %	
Kaiser Grant	7,188	788	788	0	788	(100.00) %	
Total Grants Revenue	**70,655**	**102,927**	**102,927**	**0**	**102,927**	**(100.00) %**	
MA/DA Tuition Revenue	60,732	48,844	48,844	0	48,844	(100.00) %	
Membership Dues	36,960	0	0	0	0	0.00 %	
GP Administrative Fees	12,158	1,360	1,360	0	1,360	(100.00) %	
Interest & Other	3,052	11,391	11,391	0	11,391	(100.00) %	
Total Revenue	**183,557**	**164,522**	**164,522**	**0**	**164,522**	**(100.00) %**	
Expenditures							
Personnel							
Salary and Wages	93,893	84,485	84,485	0	84,485	(100.00) %	
PR Benefits	16,876	15,954	15,954	0	15,955	(100.00) %	
PR Taxes & Fees	6,709	6,807	6,807	0	6,806	(100.00) %	
Total Personnel	**117,478**	**107,246**	**107,246**	**0**	**107,246**	**(100.00) %**	
Occupancy	7,751	7,801	7,801	0	7,801	(100.00) %	
Professional Fees	13,431	44,074	44,074	0	44,075	(100.00) %	E.
Lobbyist	7,000	7,000	7,000	0	7,000	(100.00) %	
General and Administrative Expenses							
Conferences, Conventions, and Meetings	(1,579)	0	0	0	0	0.00 %	
Depreciation	95	96	96	0	95	(100.00) %	
Equipment Rental	171	170	170	0	171	(100.00) %	
Insurance	415	416	416	0	416	(100.00) %	
Miscellaneous Expense	1,238	0	0	0	0	0.00 %	
Office Expenses	3,590	6,080	6,080	0	6,080	(100.00) %	
Other Fees	1,072	2,664	2,664	0	2,664	(100.00) %	
Printing and Publications	333	7	7	0	6	(100.00) %	
Program Events & Expenses	4,337	1,007	1,007	0	1,008	(100.00) %	D.
Postage and Delivery	0	42	42	0	42	(100.00) %	
State and Local Taxes	90	4,621	4,621	0	4,621	(100.00) %	
Telecommunication	1,137	1,060	1,060	0	1,060	(100.00) %	
Travel Expenses	1,694	(1,053)	(1,053)	0	(1,053)	(100.00) %	D.
Total General and Administrative Expenses	12,593	15,110	15,110	0	15,110	(100.00) %	
Total Expenditures	**158,253**	**181,231**	**181,231**	**0**	**181,232**	**(100.00) %**	
Total Change In Net Assets	**25,304**	**(16,709)**	**(16,709)**	**0**	**(16,709)**	**(100.00) %**	

NOTES TO APRIL 2020 FINANCIAL STATEMENTS

A. New bond fund investment in March with Edward Jones lost $16k in March, gained nearly $12k in April.
B. SBA-PPP loan shows as a liability. Once we determine the forgivable portion, that will become revenue.
C. $100k drop in Deferred Tuition Revenue (cohorts cancelled) will translate to revenue loss over the next 12 months.
D. Program Events and Travel already show a drop due to pandemic. Refunds caused negative travel expense.
E. Professional Services: April expenses included CLA invoices for annual GAS audit and assessment of revenue impact for WA CHCs. Total year-to-date is $44,075 with breakdown in table below:

PROFESSIONAL SERVICES					
	MTD	YTD	Budget	% of Budget
CliftonLarsonAllen	$ 4,200	$ 4,200		
ACCOUNTING & AUDITING	$ 4,200	$ 4,200	$27,250	15%
Feldsman, Tucker, Leifer, Fidell	$ -	$ -		
Bennett, Bigelow & Leedom	$ -	$ -		
LEGAL EXPENSE	$ -	$ -	$43,500	0%
Community Link Consulting – FQHC	$ -	$ -		
Team Soapbox LLC	$ -	$ -		
CliftonLarsonAllen (CHC Cov19 Rev Impact)	$ 31,795	$ 31,795		
Dragon Drop Dev (Prog Mgmt setup)	$ -	$ -		
Integrated Work - PCA CEO Peer Learning	$ -	$ -		
Archbright (compensation consulting)	$ -	$ -		
Thomas Architecture (office configure)	$ -	$ -		
ADMINISTRATIVE	$ 31,795	$ 31,795	$40,000	79%
Adriane Engeland - MA instructor	$ 3,117	$ 3,117		
Tanya Van Buskirk - MA instructor	$ 3,680	$ 3,680		
Jessica Bustillos - MA instructor	$ 1,283	$ 1,283		
Integrated Work - Management coaching	$ -	$ -		
Inland NW Health (Kasey Jones, MA inst)	$ -	$ -		
MA Apprenticeship	*$ 8,080*	*$ 8,080*		
Suter Consulting	$ -	$ -		
Douglas Young	$ -	$ -		
Mark Koday DDS	$ -	$ -		
Dental Learning Network	*$ -*	*$ -*		
Abbie Chandler-Doran	$ -	$ -		
Workforce	*$ -*	*$ -*		
Providence Health - Oregon	$ -	$ -		
C4 Innovations	$ -	$ -		
Malika Lamont - SUD training	$ -	$ -		
Oregon PCA	$ -	$ -		
CHCW	$ -	$ -		
Connect Consulting Services	$ -	$ -		
NEW Health Prog - Ops Assessment	$ -	$ -		
TRANSFORMATION	*$ -*	*$ -*		
NACHC - Webinars		$ -		
O&E and Health Equity	*$ -*	*$ -*		
PROGRAM SPECIFIC	$ 8,080	$ 8,080	$127,320	6%
TOTAL PROFESSIONAL SERVICES	$ 44,075	$ 44,075	$ 238,070	19%

Washington Association for Community Healtl
Draft Budget
Fiscal Year 2021, including: 04/01/20 - 03/31/21

	MA Prog Budget FY 2021	DLN Grant Budget FY 2021	DentaQuest Budget FY 2021	HRSA Budget FY 2021	Group Purch. Budget FY 2021	Dues & Other Budget FY 2021	Kaiser Grant Budget FY 2021	Overall Budget FY 2021	FY 2020 Last year	% Change
Operating Revenue										
Grant Revenues	91,000	66,792	85,466	919,253	0	0	129,143	**1,291,654**	1,173,956	10%
Contributions	0	0		0	2,000	30,000		**32,000**	30,000	0%
Member Fees	0	0		0	0	199,100		**199,100**	351,100	-43%
Revenue - Other	73,901	0		0	80,000	15,000		**168,901**	347,203	-51%
Tuition Revenue	299,160	0		0	0	0		**299,160**	635,000	-53%
Total Operating Revenue	464,061	66,792	85,466	919,253	82,000	244,100	129,143	**1,990,815**	2,537,259	
Expenditures										
Personnel										
Salary and Wages	147,429	22,400	16,600	571,412	12,097	189,104	39,623	**998,665**	882,597	13%
PR Benefits	55,452	6,720	3,735	119,996	4,046	34,546	9,113	**233,608**	220,957	6%
PR Taxes	11,949	0		45,713	1,087	14,977	3,031	**76,757**	65,116	18%
Total Personnel	214,830	29,120	20,335	737,121	17,230	238,627	51,767	**1,309,031**	1,168,671	
Professional Fees	53,750	6,320	40,000	45,000	0	65,000	28,000	**238,070**	269,750	-12%
Lobbyist	0	0		0	0	85,156		**85,156**	82,000	4%
General and Administrative Expenses										0%
Conferences, Conventions, and Meetings	1,920	1,000		16,700	0	12,500	0	**32,120**	33,000	-3%
Depreciation	0	0		0	0	1,600		**1,600**	1,600	0%
Due and Subscriptions	0	0		0	0	3,500		**3,500**	7,000	-50%
Finance Charges	0	0		0	0	400		**400**	400	0%
Meals and Entertainment	0	0		0	0	2,000		**2,000**	4,500	-56%
Miscellaneous Expense	673	0		0	0	2,000		**2,673**	4,000	-33%
Office Expenses	8,765	0		8,000	0	5,000		**21,765**	18,000	21%
Other Fees	0	0	16,000	0	7,605	0		**23,605**	122,062	-81%
Printing and Publications	60	0		0	0	2,800		**2,860**	2,800	2%
Program Events & Expenses	41,580	11,730		2,079	1,000	4,250	29,429	**90,068**	126,200	-29%
Postage and Delivery	1,200	0		0	0	800		**2,000**	500	300%
State and Local Taxes	6,447				2,231	100		**8,777**	11,050	-21%
Telecommunication	1,260	0		0	0	2,500		**3,760**	7,000	-46%
Travel Expenses	8,132	12,309	2,800	32,353	858	8,000	2,857	**67,308**	96,597	-30%
Allocated Indirect Costs	26,674	6,313	6,331	78,000	1,850	30,888	17,090	**167,146**	131,111	27%
Total General and Administrative Expenses	96,710	31,352	25,131	137,132	13,544	76,338	49,376	**429,582**	565,820	
Total Expenditures	365,290	66,792	85,466	919,253	30,774	465,121	129,143	**2,061,839**	2,086,241	
Change In Net Assets	**98,771**	**0**	**0**	**0**	**51,226**	**(221,021)**	**0**	**(71,024)**	451,018	

- Member Dues, Group Purchasing, & MA Tuition revenues all cut in half
- Assumes continued HRSA funding, but does not include possible L&I or DOH funding beyond Oct 2020.
- MA expenses adjusted for more virtual events, less travel & fewer students
- Besides reduced travel, other expenses were left higher than likely to remain conservative

INVESTMENT/RESERVES REPORT

APRIL 2020

MORGAN STANLEY				
Certificates of Deposit				
Purchase Date	Maturity Date	Bank	Interest Rate	Face Value
6/13/2019	6/12/2020	MS Private Bank CD (NY CD)	2.40%	$ 169,000.00
1/22/2020	1/29/2021	Morgan Stanley Salt Lake City UT CD	1.70%	$ 102,000.00
1/22/2020	1/29/2021	MS Private Bank CD (NY CD)	1.70%	$ 102,000.00
Money Market Account				
		Money Market (Cash)		$ 99,913.73
Account Summary				
		Description		Amount
		Total Face Value		$ 472,913.73
		Diff Due to Market Value Fluctuation		$ 8,880.45
		Balance Per General Ledger		**$ 481,794.18**
EDWARD JONES				
Investment Assets				
Purchase Date	Original Amt	Description	Gain/Loss %	Current Value
3/23/2020	$ 500,000.00	JP Morgan Core Bond Fund	-1%	$ 495,479.42
TOTAL VALUE OF INVESTMENTS / RESERVES				**$ 977,273.60**

Notes: At the date of the statement, there was no 4th CD because many investors are selling equities and buying CDs due to the pandemic, so CDs have been very hard to find. We did find one a couple weeks ago, and the next report will show that.

WASHINGTON ASSOCIATION FOR COMMUNITY HEALTH

FINANCE COMMITTEE MEETING

TUESDAY, JUNE 16, 2020 | 3:30 PM

CONFERENCE CALL: **1 (404) 891-0552**
ACCESS CODE: **633-074-689**

THIS FILE CONTAINS

- Meeting Agenda
- Finance Committee mtg minutes – May 19, 2020
- Financial Statements: May 2020

ASSOCIATION FINANCE COMMITTEE MEETING

TUESDAY, JUNE 16, 2020 | 3:30 PM

Conference Call: 1 (404) 891-0552
Access Code: 633-074-689

AGENDA

1. Call to Order by Aaron Wilson
2. Acceptance of meeting minutes from May 19, 2020 (Page 3-4)
3. Financial Statements May 2020 (Pages 5-8)
4. Confirm next meeting: August, 18, 2020 3:30 PM

WASHINGTON ASSOCIATION FOR COMMUNITY HEALTH

FINANCE COMMITTEE MEETING VIA CONFERENCE CALL
MINUTES FOR THE MEETING OF TUESDAY, MAY 19, 2020

MEMBERS PRESENT:
Aaron Wilson, Treasurer
Anita Monoian
Sheila Berschauer
Joel Emery
Paul Kaschmitter
TJ Cosgrove

MEMBERS ABSENT:

STAFF PRESENT:
Eric Griffith
Bob Marsalli

GUEST PRESENT:

STAFF ABSENT:

CALL TO ORDER

Aaron Wilson called the meeting to order at 3:32 P.M.

APPROVAL OF MINUTES

The Committee reviewed the meeting minutes from March 24, 2020

MOTION: Joel moved and Sheila seconded to accept the Finance Committee meeting minutes from March 24, 2020. No one opposed. Paul abstained, not having been at the meeting. Motion passed.

MINUTES

- Aaron asked for the presentation of the March and April 2020 draft financial statements.
- The March Financial Highlights included the ending cash and equivalents total of $2,904,596 with 339 days of operating cash on hand, 169 days of reserve cash on hand. There was a $17k gain for the month, netting a $511k gain YTD. Revenues were 107% of year-to-date budget, while expenses were 105% of year-to-date budget.
- Eric then walked through the financial statement notes, which included a Delta Grant revenue adjustment in March, and the fact that while there were individual budget line item variances during the fiscal year, the positive and negative variances balanced each other out.
- Eric moved on to April highlights, where total cash and equivalents ended at $3,129,566. Reserves were at 171 days and operating cash was at 377 days. In April, the Association lost $17k overall. There were

no budget variances on statements because the budget had not been approved and entered into the the accounting system.

- Addressing the financial statement notes for April, Eric noted that the new bond investment fund had lost $16k at the beginning of the Covid 19 pandemic, but gained nearly $12k in April. The Association was approved for a Paycheck Protection loan and show it as a liability until the forgivable portion is determined. The Committee asked if the Association expected to pay the loan back in a year or less, or if some portion of it should be a long-term liability. Bob responded that the portion not forgiven would likely be small and paid back in 12 months or less.
- There was a $100k drop in deferred MA tuition revenue, which will impact the next 12 months. Big drops, compared to monthly average expenses, for travel and events due to the pandemic. For professional services, there were invoices from CliftonLarson for the Association's annual audit and one for CLA's evaluation of impact to revenue for WA FQHCs.

MOTION: Sheila moved and Paul seconded to accept the March and April 2020 draft financials. No one opposed. No one abstained. Motion passed.

Next Aaron called for a review of the revised **draft annual budget**. Eric explained that he and Bob had gone through several versions of the budget, including best and worst case scenarios, and this budget was in between the two extremes. He also stated that no possible but not finalized grants revenue was included. The Committee stated that though the budget predicted a $71k loss, the Association leadership should manage costs to avoid this. The Committee asked Bob what made him the most nervous or concerned, and he was most concerned that the MA program was able to recover in the fall.

The Committee agreed, with the exception of one, on recommending forgiving membership dues for a second quarter (July-September) to the full Board. The budget included this assumption.

MOTION: Joel moved and TJ seconded to accept the Fiscal Year 2021 annual budget. No one opposed. No one abstained. Motion passed.

Eric then presented the investment report, which now showed investments with both firms (Morgan Stanley and Edward Jones). He confirmed that this was informational and did not require action.

UPCOMING EVENTS

The next Association Finance Committee meeting is scheduled for Tuesday, June 16, 2020 at 3:30 PM.

ADJOURNMENT

There being no further business, Aaron adjourned the meeting at 4:17 PM.

MAY 2020 FINANCIAL STATEMENT HIGHLIGHTS

- Total cash and equivalents was $3,129,566 and $3,106,634 at the end of April and May, respectively.
- Reserves = 173 days, or 5.75 months
- Operating cash (includes restricted funds) = 377 days
- Payables cycle remains within 30 days. A/R has some DOH invoices from March but we're working with them to get those paid.
- The current ratio, current assets compared to current liabilities, is 3.10:1.0
- For May, 2020:

	MONTH	YTD	% OF BUDGET
Revenue	$ 97K	$ 285K	92%
Expenses	$ 151K	$ 332K	103%
Gain / (Loss)	$ (53K)	$ (48K)	
From Reserves	-	-	
Net with Reserves	**$ (53K)**	**$ (48K)**	

Washington Association for Community Health
Statement of Financial Position

Reporting Book: ACCRUAL
As of Date: 05/31/2020

	Month Ending 05/31/2019	Month Ending 04/30/2020	Month Ending 05/31/2020	
	1 Year Ago	Last Month	Current Month	
Assets				
Current Assets				
Cash and Cash Equivalents				
Heritage Bank Checking	1,695,619	2,152,292	2,129,360	
Morgan Stanley - Reserves	470,420	481,795	481,795	
Edward Jones - Reserves	0	495,479	495,479	
Total Cash and Cash Equivalents	**2,166,039**	**3,129,566**	**3,106,634**	
Accounts Receivable, Net	**305,785**	**76,951**	**66,274**	
Other Current Assets	**32,016**	**8,987**	**7,318**	
Total Current Assets	**2,503,840**	**3,215,504**	**3,180,226**	
Long-term Assets				
Property & Equipment				
Capital Equipment	0	8,028	8,029	
Office Furniture	14,631	14,631	14,630	
Accum. Depr. Capital Equip.	0	(956)	(1,051)	
Accum. Depr. Office Furniture	(14,631)	(14,630)	(14,631)	
Total Property & Equipment	**0**	**7,073**	**6,977**	
Other Long-term Assets	**6,104**	**6,103**	**6,104**	
Total Long-term Assets	**6,104**	**13,176**	**13,081**	
Total Assets	**2,509,944**	**3,228,680**	**3,193,307**	
Liabilities and Net Assets				
Liabilities				
Short-term Liabilities				
Accounts Payable	**42,016**	**129,283**	**45,565**	
Accrued Liabilities				
Wells Fargo Credit Payable	195	57	671	
Pre-Tax, Plan 125 P/R Deductions	203	202	75	
Post-Tax P/R Deductions	236	236	31	
Med Ins P/R Deductions	(750)	(732)	(748)	
Accrued Vacation Payable	34,390	45,304	45,303	
Government Loans	0	226,935	226,935	A.
Accrued PCA Fee Sharing	14,515	6,305	6,551	
Total Accrued Liabilities	**48,789**	**278,307**	**278,818**	
Deferred Revenue				
Deferred Member Dues	285,545	0	0	
Deferred Grant Revenue	67,508	323,089	473,089	B.
Deferred Tuition Revenue	284,044	276,677	227,832	
Total Deferred Revenue	**637,097**	**599,766**	**700,921**	
Total Short-term Liabilities	**727,902**	**1,007,356**	**1,025,304**	
Total Liabilities	**727,902**	**1,007,356**	**1,025,304**	
Net Assets	**1,782,042**	**2,221,324**	**2,168,003**	
Total Liabilities and Net Assets	**2,509,944**	**3,228,680**	**3,193,307**	

Washington Association for Community Health
Statement of Activities - Board

Reporting Book: ACCRUAL
As of Date: 05/31/2020

	Month Ending 04/30/2020	Month Ending 05/31/2020	Year To Date 05/31/2020				
	Prior Month	Current Month	Actual YTD	Budget YTD	Budget Diff	Budget % Var	
Revenue							
Grants Revenue							
HRSA Grant	73,991	29,964	103,955	153,209	(49,254)	(32.14) %	
DOH Grants	3,502	2,397	5,899	0	5,899	(100.00) %	
Dental Grants	2,334	0	2,334	25,376	(23,042)	(90.80) %	
MA-DA Grants	13,053	12,250	25,303	26,000	(698)	(2.68) %	
DeltaCenterGrant	31,901	0	31,900	0	31,901	(100.00) %	
Kaiser Grant	788	0	788	21,524	(20,736)	(96.33) %	
Total Grants Revenue	**125,569**	**44,611**	**170,179**	**226,109**	**(55,930)**	**(24.73) %**	C.
MA/DA Tuition Revenue	48,844	48,844	97,689	49,860	47,829	95.92 %	
GP Administrative Fees	1,359	3,862	5,221	13,333	(8,112)	(60.83) %	
Contributions	0	5	5	5,334	(5,328)	(99.90) %	
Interest & Other	11,392	107	11,500	14,817	(3,318)	(22.39) %	
Total Revenue	**187,164**	**97,429**	**284,594**	**309,453**	**(24,859)**	**(8.03) %**	
Expenditures							
Personnel							
Salary and Wages	84,485	82,979	167,465	166,445	1,021	(0.61) %	
PR Benefits	16,004	15,860	31,864	38,934	(7,071)	18.16 %	
PR Taxes & Fees	6,807	6,691	13,498	12,793	705	(5.51) %	
Total Personnel	**107,296**	**105,530**	**212,827**	**218,172**	**(5,345)**	**2.44 %**	
Occupancy	7,801	7,734	15,535	26,648	(11,113)	41.70 %	
Professional Fees	44,074	19,279	63,353	39,678	23,675	(59.66) %	E.
Lobbyist	7,000	7,000	14,000	14,193	(193)	1.35 %	
General and Administrative Expenses							
Conferences, Conventions, and Meetings	0	150	150	5,353	(5,203)	97.19 %	
Depreciation	96	95	191	267	(76)	28.32 %	
Due and Subscriptions	0	0	0	583	(583)	100.00 %	
Equipment Rental	170	171	341	367	(26)	7.03 %	
Finance Charges	0	0	0	67	(66)	100.00 %	
Insurance	416	416	832	843	(12)	1.40 %	
Meals and Entertainment	0	0	0	333	(334)	100.00 %	
Miscellaneous Expense	0	0	0	446	(445)	100.00 %	
Office Expenses	6,081	2,610	8,690	3,627	5,063	(139.57) %	
Other Fees	2,663	245	2,909	3,934	(1,025)	26.05 %	
Printing and Publications	7	0	7	477	(470)	98.64 %	
Program Events & Expenses	1,007	5,919	6,927	15,011	(8,085)	53.85 %	
Postage and Delivery	42	57	98	334	(235)	70.42 %	
State and Local Taxes	4,622	0	4,622	1,463	3,159	(215.92) %	
Telecommunication	1,160	1,109	2,269	626	1,642	(262.05) %	
Travel Expenses	(1,053)	0	(1,053)	11,218	(12,270)	109.38 %	D.
Utilities	0	436	436	0	435	(100.00) %	
Total General and Administrative Expenses	15,211	11,208	26,419	44,949	(18,531)	41.22 %	
Total Expenditures	**181,382**	**150,751**	**332,134**	**343,640**	**(11,507)**	**3.34 %**	
Total Change In Net Assets	**5,782**	**(53,322)**	**(47,540)**	**(34,187)**	**(13,352)**	**(39.05) %**	

NOTES TO MAY 2020 FINANCIAL STATEMENTS

A. Payroll Protection Program loan liability.
B. Cambia Foundation grant for $150,000 received, increased deferred grants.
C. Grant revenue low due to expenses charged to PPP funding.
D. Travel and other expenses under budget due to pandemic lockdown.
E. Professional Services: May expenses included MA program contracted instructors and CliftonLarsonAllen for audit fees. Total year-to-date is $63,353 with breakdown in table below:

PROFESSIONAL SERVICES					
	MTD	YTD	Budget	% of Budget
CliftonLarsonAllen	$ 5,250	$ 9,450		
ACCOUNTING & AUDITING	$ 5,250	$ 9,450	$27,250	35%
Feldsman, Tucker, Leifer, Fidell	$ -	$ -		
Bennett, Bigelow & Leedom	$ -	$ -		
LEGAL EXPENSE	$ -	$ -	$43,500	0%
Community Link Consulting – FQHC	$ -	$ -		
Team Soapbox LLC	$ 3,500	$ 3,500		
CliftonLarsonAllen (CHC Cov19 Rev Impact)	$ -	$ 31,795		
Dragon Drop Dev (Prog Mgmt setup)	$ -	$ -		
Integrated Work - PCA CEO Peer Learning	$ -	$ -		
Archbright (compensation consulting)	$ -	$ -		
Thomas Architecture (office configure)	$ 1,163	$ 1,163		
ADMINISTRATIVE	$ 4,663	$ 36,458	$40,000	91%
Adriane Engeland - MA instructor	$ 3,117	$ 6,233		
Tanya Van Buskirk - MA instructor	$ 2,817	$ 6,497		
Jessica Bustillos - MA instructor	$ 1,283	$ 2,566		
Integrated Work - Management coaching	$ -	$ -		
Inland NW Health (Kasey Jones, MA inst)	$ -	$ -		
MA Apprenticeship	*$ 7,216*	*$ 15,296*		
Suter Consulting	$ -	$ -		
Douglas Young	$ -	$ -		
Mark Koday DDS	$ -	$ -		
Dental Learning Network	*$ -*	*$ -*		
Abbie Chandler-Doran	$ -	$ -		
Workforce	*$ -*	*$ -*		
Providence Health - Oregon	$ -	$ -		
C4 Innovations	$ -	$ -		
Health Outreach Partners	$ 1,800	$ 1,800		
Oregon PCA	$ -	$ -		
Kenneth Maynard Jones	$ 350	$ 350		
Connect Consulting Services	$ -	$ -		
NEW Health Prog - Ops Assessment	$ -	$ -		
TRANSFORMATION	*$ 2,150*	*$ 2,150*		
NACHC - Webinars		$ -		
O&E and Health Equity	*$ -*	*$ -*		
PROGRAM SPECIFIC	$ 9,366	$ 17,446	$127,320	14%
TOTAL PROFESSIONAL SERVICES	$ 19,279	$ 63,353	$ 238,070	27%

Washington Association for Community Healtl
Draft Budget
Fiscal Year 2021, including: 04/01/20 - 03/31/21

	MA Prog Budget FY 2021	DLN Grant Budget FY 2021	DentaQuest Budget FY 2021	HRSA Budget FY 2021	Group Purch. Budget FY 2021	Dues & Other Budget FY 2021	Kaiser Grant Budget FY 2021	Overall Budget FY 2021	FY 2020 Last year	% Change
Operating Revenue										
Grant Revenues	91,000	66,792	85,466	919,253	0	0	129,143	**1,291,654**	1,173,956	10%
Contributions	0	0		0	2,000	30,000		**32,000**	30,000	0%
Member Fees	0	0		0	0	199,100		**199,100**	351,100	-43%
Revenue - Other	73,901	0		0	80,000	15,000		**168,901**	347,203	-51%
Tuition Revenue	299,160	0		0	0	0		**299,160**	635,000	-53%
Total Operating Revenue	464,061	66,792	85,466	919,253	82,000	244,100	129,143	**1,990,815**	2,537,259	
Expenditures										
Personnel										
Salary and Wages	147,429	22,400	16,600	571,412	12,097	189,104	39,623	**998,665**	882,597	13%
PR Benefits	55,452	6,720	3,735	119,996	4,046	34,546	9,113	**233,608**	220,957	6%
PR Taxes	11,949	0		45,713	1,087	14,977	3,031	**76,757**	65,116	18%
Total Personnel	214,830	29,120	20,335	737,121	17,230	238,627	51,767	**1,309,031**	1,168,671	
Professional Fees	53,750	6,320	40,000	45,000	0	65,000	28,000	**238,070**	269,750	-12%
Lobbyist	0	0		0	0	85,156		**85,156**	82,000	4%
General and Administrative Expenses										0%
Conferences, Conventions, and Meetings	1,920	1,000		16,700	0	12,500	0	**32,120**	33,000	-3%
Depreciation	0	0		0	0	1,600		**1,600**	1,600	0%
Due and Subscriptions	0	0		0	0	3,500		**3,500**	7,000	-50%
Finance Charges	0	0		0	0	400		**400**	400	0%
Meals and Entertainment	0	0		0	0	2,000		**2,000**	4,500	-56%
Miscellaneous Expense	673	0		0	0	2,000		**2,673**	4,000	-33%
Office Expenses	8,765	0		8,000	0	5,000		**21,765**	18,000	21%
Other Fees	0	0	16,000	0	7,605	0		**23,605**	122,062	-81%
Printing and Publications	60	0		0	0	2,800		**2,860**	2,800	2%
Program Events & Expenses	41,580	11,730		2,079	1,000	4,250	29,429	**90,068**	126,200	-29%
Postage and Delivery	1,200	0		0	0	800		**2,000**	500	300%
State and Local Taxes	6,447				2,231	100		**8,777**	11,050	-21%
Telecommunication	1,260	0		0	0	2,500		**3,760**	7,000	-46%
Travel Expenses	8,132	12,309	2,800	32,353	858	8,000	2,857	**67,308**	96,597	-30%
Allocated Indirect Costs	26,674	6,313	6,331	78,000	1,850	30,888	17,090	**167,146**	131,111	27%
Total General and Administrative Expenses	96,710	31,352	25,131	137,132	13,544	76,338	49,376	**429,582**	565,820	
Total Expenditures	365,290	66,792	85,466	919,253	30,774	465,121	129,143	**2,061,839**	2,086,241	
Change In Net Assets	**98,771**	**0**	**0**	**0**	**51,226**	**(221,021)**	**0**	**(71,024)**	451,018	

- Member Dues, Group Purchasing, & MA Tuition revenues all cut in half
- Assumes continued HRSA funding, but does not include possible L&I or DOH funding beyond Oct 2020.
- MA expenses adjusted for more virtual events, less travel & fewer students
- Besides reduced travel, other expenses were left higher than likely to remain conservative

Washington Association for Community Health
FY2019-2020 Program & Expenditure Review

Policy and Advocacy - $349,182

In the last FY, the Association's policy and advocacy team has continued to advocate for the reauthorization of the federal community health center fund and the protection of Washington's healthcare safety net system, pass capital budgets that expand access to dental and behavioral health services for underserved populations, created an "integrated treatment credential" for substance use disorder treatment specialists, added additional dedicated loan repayment revenue for behavioral health professions, and provided consistent and considerable technical assistance to community health centers in understanding and accessing federal and state COVID-19 resources for reimbursement, telehealth implementation, testing, and fiscal relief.

Capacity Building and Convening

- Workforce and Healthcare Apprenticeships - $626,033

  The Association facilitates a bi-monthly workforce meeting with a committee apprised of mainly HR professionals and administrative leadership representing our CHC partners. The purpose of the workforce committee is to provide field updates, solicit strategic guidance, and promote peer learning for current workforce initiatives that directly impact CHC recruitment, retention and development.

  In the fiscal year, the Association trained CHCs on Human Resources metrics (tenure, time to fill, projected vacancies) and the collection process in the period, resulting in a representative sample of these data points in late 2019 to inform strategic priorities and future training development. An aggregated report was released to the committee and board. Other training and peer learning topics included auto-hpsa, best practices for staff onboarding, on-site employer perks, residency programs, implicit bias, loan repayment, and recruiting mental health providers and dental assistants.

  The Association administered two registered apprenticeship programs in Medical Assisting and Dental Assisting through March 2020. From April 1, 2019 – March 31, 2020, there were 14 active Medical Assistant apprenticeship cohorts, 97 apprentices completed the yearlong program in this period, and 186 apprentices were enrolled. In this period, there were 2 active Dental Assisting cohorts. The Medical Assisting apprenticeship program has a completion rate of 86.5% with 319 students graduated or on track to graduate since inception. The MA program has an overall certification exam pass rate of 99%, as of 2019.

The year 2019-2020 saw expanded partnerships with community colleges to increase college credit opportunity for apprentices, and with a state accountable community of health, bringing guidance and implementation support to the development of a substance use disorder professional apprenticeship program. The Association's healthcare apprenticeship programs have been recognized nation-wide through several partnerships and grant opportunities including the department of labor and industries' raise grant recipient - providing statewide expansion of apprenticeship in non-traditional trades.

- Practice Transformation - $625,484

  The Association facilitates work with federally qualified health centers to provide coaching support and training opportunities for quality improvement (qi) staff and clinical care teams. Accomplishments for the year ended March 31, 2020 included:

  1) facilitating 21 training events to Washington health centers to provide peer-learning, networking, and technical assistance in: substance use disorder care approaches, quality improvement (hypertension, diabetes, childhood immunization combo 10), team based care, blood pressure self-management and train the trainer model, communicable disease outbreaks and pharmacy operations.
  2) working in partnership with the Department of Health to administer and manage a competitive Center for Disease Control and Prevention (CDC) grant opportunity to decrease diabetes and hypertension;
  3) participating in the state's cardiovascular disease and diabetes network leadership team;
  4) peer-linking and resource brokering around hypertension, diabetes, clinical workflows, and other topics requested by the FQHCs;
  5) partnering with the Washington Pharmacy Association to provide online diabetes education for pharmacists;
  6) providing regular 1:1 patient center medical home (PCMH) coaching support to two health centers and ad hoc PCMH support per health center request; and
  7) working with the Washington Council for Behavioral Health in a joint learning collaborative, attending one in person meeting in the period to discuss behavioral health integration approaches, progress on advancing value-based payment and technical assistance strategies.

- Health Equity, Outreach and Enrollment - $94,916

  The Association facilitated health equity, community health worker, and outreach and enrollment workgroup calls that provided updates, followed-up on issues identified by CHCs, and organized in-person meetings on the east and west side of the state to learn and share promising practices. In the last year, the Association worked with state

agencies and was on multiple statewide teams or task forces to support CHC practices that reach Washington's most vulnerable populations. The Association helped facilitate CHC recruitment of migrant and physician testifiers for the national advisory council on migrant health and continues to support CHC participation in the national center for farm worker health's migrant worker id program. Five in-person training events were held with ongoing workgroup discussions throughout the year. The Association began marketing and recruitment, curriculum development, and co-design sessions with health centers to provide a Social Determinants of Health learning collaborative. The Association worked in partnership with the McColl Center for Healthcare Innovation and had to postpone events due to the COVID-19 pandemic.

- Dental Learning Network - $111,459
  The Association works with the Washington Arcora Foundation to coordinate the dental learning network, which provides a framework for peer-to-peer learning, developing leadership skills among CHC Dental Directors, sharing best practices and increasing clinical and quality improvement skills. Achievements for the year ending March 31, 2020 included: implementing 4 full day face-to-face learning sessions, facilitating 4 team meetings to develop the DLN agendas, maintaining and increasing DLN participation. The Association partnered with the WA Health Care Authority, University of WA, and the University of the Pacific to present best practices, new technologies, and current initiatives to DLN members.

Toward Racial Justice: A Commitment of the Washington Association for Community Health

We are anguished by the tragedies of Black lives ended by law enforcement and other violence, and we grieve with Black, Brown, and Indigenous people who for centuries have experienced the cruel injustice and devaluing of their lives that has been woven, by commission and omission, into white, European societies long before our nation's founding.

We admit that racism and white supremacy are real, pervasive, and as such, impediments to the health status of People of Color wherever they live. Violence and racism perpetuate an ongoing public health crisis, now compounded by a pandemic that has disproportionately ravaged People of Color, widening the inequity gap for those who already suffer the most. Justice and respect for People of Color can no longer wait. Racism throughout our society must end, including in policing practices, the legal system, healthcare, educational systems, and in our economy.

Community Health Centers emerged in the 1960's as an outgrowth of the civil rights movement, addressing unjust systems to bring health and healing to individuals, families, and the communities where they live, work, and learn. The Washington Association for Community Health, its staff, and its member community health centers commit to understanding the needs of those affected by racism, to respond in accordance with their needs, and to be leaders in the pursuit of racial and social justice. The Association and its Board stand against racism and will diligently work toward the dismantling of racism, not just in the healthcare sector, but beyond it. Change can and must come – and we will do our part.

AWAKE to WOKE to WORK: Building a Race Equity Culture

EQUITY IN THE CENTER

A project of ProInspire

About Equity in the Center

Equity in the Center works to shift mindsets, practices, and systems within the social sector to increase racial equity. We envision a future where nonprofit and philanthropic organizations advance race equity internally while centering it in their work externally.

Equity in the Center's goals are:

- Nonprofit and philanthropic organizations adopt a Race Equity Culture focused on proactive counteraction of social inequities
- Organizations define, implement, and advance race equity internally while advocating for it in their work externally
- Race equity is centered as a core goal of social impact across the sector

Table of Contents

Executive Summary

Achieving race equity — the condition where one's racial identity has no influence on how one fares in society — is a fundamental element of social change across every issue area in the social sector. Yet the structural racism that endures in U.S. society, deeply rooted in our nation's history and perpetuated through racist policies, practices, attitudes, and cultural messages, prevents us from attaining it. The impact of structural racism is evident not only in societal outcomes, but in the very institutions that seek to positively impact them:

- ***Race Outcomes Gap.*** People of color fare worse than their white counterparts across every age and income level when it comes to societal outcomes. They experience significant disadvantages in education,[1] economic stability,[2] health, life expectancy, and rates of incarceration.[3]
- ***Racial Leadership Gap.*** BoardSource's *Leading with Intent: 2017 National Index of Nonprofit Board Practices* found that people of color comprise 10% of CEOs, 10% of Board Chairs, and 16% of Board members.[4] Compared to 40% of the working population,[5] these figures indicate a large gap between race demographics of the working population and social sector leadership. Building Movement Project's recent report, *Race to Lead: Confronting the Nonprofit Racial Leadership Gap*, highlights that the racial leadership gap is not a pipeline problem, nor is it due to differences in education, skills, or interest; rather, it is a *structural* problem within the sector.[6]

The attainment of race equity requires us to examine all four levels on which racism operates (personal, interpersonal, institutional, and structural), recognize our role in enduring inequities, and commit ourselves to change. As a sector, we must center race equity as a core goal of social impact in order to fulfill our organizational missions.

BUILDING A RACE EQUITY CULTURE

Equity in the Center believes that deep social impact is possible within the context of a ***Race Equity Culture*** — one that is focused on proactive counteraction of race inequities inside and outside of an organization. Building a Race Equity Culture is the foundational work when organizations seek to advance race equity; it creates the *conditions* that help us to adopt anti-racist mindsets and actions as individuals, and to center race equity in our life and in our work. A Race Equity Culture is the antithesis of dominant culture, which promotes assimilation over integration and dismisses opportunities to create a more inclusive, equitable environment. The work of creating a Race Equity Culture requires an *adaptive and transformational approach* that impacts behaviors and mindsets as well as practices, programs, and processes.

The Race Equity Cycle

While each organization will follow its own path towards a Race Equity Culture, our research suggests that *all* organizations go through a cycle of change as they transform from a white dominant culture to a Race Equity Culture. These changes include increased representation; a stronger culture of inclusion; and the application of a race equity lens to how organizations and programs operate. We have coined this process the Race Equity Cycle. This journey of change pushes organizations to become more committed, more knowledgeable, and more skilled in analyzing race, racism, and race equity, and in placing these issues at the forefront of organizational and operational strategy. Because each organization is comprised of different people, systems, and histories, individual organizations will enter the Race Equity Cycle at different stages and will approach their race equity work with varying levels of organizational readiness. And

while the impact will look and feel different at each stage of the Race Equity Cycle, we believe that all three stages mutually reinforce each other.

At the **AWAKE** stage, organizations are focused on *people* and on building a workforce and boards comprised of individuals from different race backgrounds. The primary goal is *representation*, with efforts aimed at increasing the number of people of different race backgrounds.

At the **WOKE** stage, organizations are focused on *culture* and on creating an environment where everyone is comfortable sharing their experiences, and everyone is equipped to talk about race equity and inequities. The primary goal is *inclusion* and internal change in behaviors, policies, and practices.

At the **WORK** stage, organizations are focused on *systems* to improve race equity. The primary goal is *integration of a race equity lens* into all aspects of an organization. This involves internal and external systems change and regularly administering a race equity assessment to evaluate processes, programs, and operations.

The Role of Levers in Building a Race Equity Culture

Our research identified seven levers — strategic elements of an organization that, when leveraged, build momentum towards a Race Equity Culture within each stage and throughout the Race Equity Cycle:

SENIOR LEADERS
Individuals in a formal leadership role

MANAGERS
Individuals who oversee operations of teams

BOARD OF DIRECTORS
Governing body of an organization

COMMUNITY
Populations served by the organization

LEARNING ENVIRONMENT
Investment in staff capacity

DATA
Metrics to drive improvements and focus

ORGANIZATIONAL CULTURE
Shared values, assumptions, and beliefs

HOW TO GET STARTED

There is no singular or 'right' way to engage in race equity work. Even if you don't yet know the precise path your organization will take towards a Race Equity Culture, there are actionable steps to get started:

1. ***Establish a shared vocabulary.*** Ground your organization in shared meaning around race equity, structural racism, and other terms related to this work. The Glossary found in the Appendix is a helpful starting point.
2. ***Identify race equity champions at the board and senior leadership levels.*** Select those who can set race equity priorities, communicate them broadly, drive accountability, and influence the speed and depth at which race equity is embedded in the organization.
3. ***Name race equity work as a strategic imperative for your organization.*** Define and communicate how race equity connects to your mission, vision, organizational values, and strategies.
4. ***Open a continuous dialogue about race equity work.*** Use research and learnings from other organizations to start the conversation with your team or individuals who are invested in your organizational cause.
5. ***Disaggregate data.*** Collect, disaggregate, and report relevant data to get a clear picture of inequities and outcomes gaps both internally and externally.

ENVISIONING A RACE EQUITY CULTURE

When your organization has fully committed to a Race Equity Culture, the associated values become part of its DNA — moving beyond special initiatives, task force groups, and check-the-box approaches into full integration of race equity in every aspect of its operations and programs. Organizations that demonstrate this commitment exhibit characteristics, including the following:

- Leadership ranks hold a critical mass of people of color
- Staff, stakeholders, and leaders are skilled at talking about race, racism, and their implications
- Programs are culturally responsive and explicit about race, racism, and race equity
- Communities are treated as stakeholders, leaders, and assets to the work
- Evaluation efforts incorporate the disaggregation of data
- Expenditures reflect organizational values and a commitment to race equity
- Continuous improvement in race equity work is prioritized

Introduction

In a sector focused on improving social outcomes across a wide range of issues, we need only look within our own organizations to understand why we have not yet achieved the depth of change we seek. Throughout the social sector, there remains a glaring omission of a fundamental element of social impact: **race equity**. While issue-specific dynamics play an important role in driving social impact (e.g., public policy around affordable housing or the elimination of food deserts to create access to nutritious foods), the thread of structural racism runs through almost every issue faced by the U.S. social sector. Race equity must be centered as a core goal of social impact across the sector in order to achieve our true potential and fulfill our organizational missions.

Race is a social construct that has deep societal impact. Our nation's history of racism has been codified through systems such as slavery, education, and housing — all issues that the social sector seeks to address. As such, the social sector has a mandate to eliminate racism at all levels on which it exists and shift its axis towards race equity. While this may sound obvious, most people think about racism as it shows up at the individual and interpersonal level. In fact, few people in the social sector recognize that racism operates on a larger level — often inconspicuously — within both *organizations* and *systems*, and that it underlies every major social issue in the United States. Not only must we recognize that we participate in a racist system that continues to exclude and undervalue people of color, but we must also confront the root causes and manifestations of structural racism. This requires us to eliminate policies, practices, attitudes, and cultural messages that reinforce differential outcomes based on race, and to replace them with ones that promote and sustain race equity.

Race Equity (n): The condition where one's race identity has no influence on how one fares in society.

We believe that successful social sector work is only possible within the context of a Race Equity Culture that is focused on proactive counteraction of race inequities inside and outside of an organization. We start with building a Race Equity Culture because it is the foundational work when organizations seek to advance race equity; it creates the *conditions* that help us to adopt anti-racist mindsets and actions as individuals, and to center race equity in our life and in our work. While the work of true race equity is bigger, deeper, and sometimes more difficult than culture, we believe that by starting here and through sustained dedication and effort, race equity *is* attainable.

This publication is designed to serve as a reference as you build and expand your own and your organization's capacity to advance race equity. In the pages that follow, we outline the need for building a Race Equity Culture in social sector organizations, and introduce resources and strategies to help you move from commitment to action. Through our new tool, the Race Equity Cycle, we identify the three stages and common entry points of building a Race Equity Culture; help organizations find themselves in this work; and name the levers that create momentum in building a Race Equity Culture. Finally, we illustrate how those levers can work by sharing practices from peer organizations and suggesting actions you can take to get started.

Intended Audience

This publication is relevant if you:

- Have some awareness that race equity is essential to driving impactful change within the social sector
- Want to play an active role in advancing race equity in your organization
- Lead, want to lead, or have been asked to lead race equity efforts within your organization
- Want to understand how to build a Race Equity Culture within your organization

Questions you may face as you enter into this work include:

- How do I create change as the only individual formally engaged in race equity work in my organization?
- What tactics can I leverage to build a Race Equity Culture?
- How can I speak on my personal experience with racism and internalized racism in my organization?
- What is my role in leading this work as a person of color?
- What is my role in leading this work as a white person?
- What if I make a mistake?
- How much does race equity work cost, and how do I operationalize it?
- How can I effectively engage senior leaders who may be resistant to directly addressing issues of race and equity?
- How do I assess my organization's state with respect to race equity?
- How do I lobby for the support race equity work requires to be effective?
- How do measurement, data, and learning play a role in driving organizational change around race equity?

We designed this publication with these audiences and questions in mind. Our goal is to meet you where you are in your current efforts to advance race equity — regardless of where you enter this work, or how comfortable you feel with it.

Before reading further, and especially if you are new to race equity work, we suggest you review the Glossary found in the Appendix to familiarize yourself with our terminology and intended meaning for words that are often misunderstood and misappropriated.

Methodology & Research

Equity in the Center created this publication in collaboration with over 120 practitioners, thought leaders, and subject matter experts on diversity, inclusion, and race equity in the social sector. We also engaged in both primary and secondary research to validate our theory and tools, including an extensive literature review (over 25 reports, scholarly articles, other peer materials), in-depth interviews, and a series of focus groups to refine and validate our findings. These activities informed the Race Equity Cycle and helped us identify the key levers for action and impact that we mapped to this tool for organizational change. Our goal was to identify the personal beliefs and behaviors, cultural characteristics, operational tactics, and administrative practices that accelerate measurable progress as organizations move through distinct phases toward race equity. We designed the research agenda to uncover the personal, interpersonal, institutional, and structural components of dominant culture faced by individuals when confronting racism and issues of race equity in their work, as well as successful strategies for dismantling them.

Advisors in this work represent (or have consulted) nonprofit and philanthropic organizations, and were invited to participate based on demonstrated thought leadership and expertise, as well as leadership of diversity, inclusion, and equity initiatives ranging from beginning (less than one year) to established (1-5 years) to mature (5-10 years or more). Diversity of geography, philosophy, practice, and social sub-sector focus were prioritized throughout the process, as was the engagement of advisors with different racial and ethnic backgrounds. Our team assembled a coalition of advisors whose rich experiences yielded best practices and a framework for action that we believe is adaptable in diverse management contexts.

While there is a growing body of work available, cross-sector stakeholders would benefit from further research on race equity in a management context, specifically case studies and examples. Future research would both support nonprofit and philanthropic leaders in defining a clear vision for success in this work and assist in navigating the complex, years-long interpersonal, organizational, and operational transitions that characterize it.

Our Rationale for Emphasizing Race Equity over Diversity

Through our research and engagement with stakeholders, we learned that the term 'diversity' has been so frequently used — and misused — that it no longer communicates a clear definition nor captures our intention for this body of work. 'Diversity' is often focused exclusively (and intentionally, in an organizational context) on representation of 'diverse' individuals as expressed in numbers and percentages. And, while representation is an important element of race equity, it does not take into account how personal and professional inequalities are experienced by people of color. For these reasons, Equity in the Center focuses on race equity explicitly, emphasizing the structures, roles, processes, and practices that negatively impact people of color inside and outside of organizations, and outlining specific tactics to mitigate them as part of a process to drive race equity within an organization's culture.

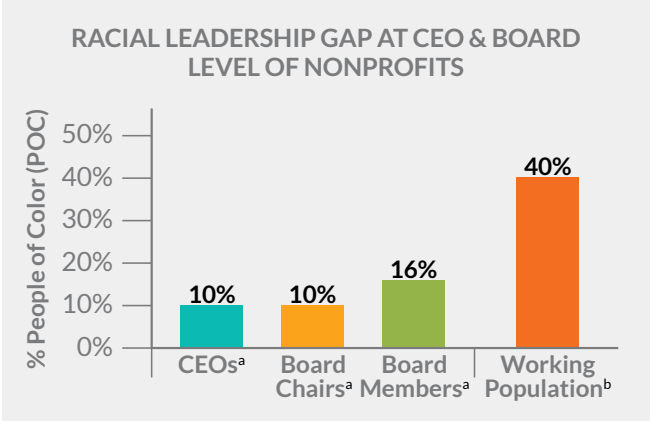
The Need for Race Equity Work

The case for deepening our commitment to race equity is evident when considering racial leadership gaps in the social sector, societal outcomes disparities, and the untapped potential of diverse teams.

RACIAL LEADERSHIP GAP

A racial leadership gap pervades the social sector, caused by a number of factors including cultures, systems, and practices. People of color continue to be underrepresented at the senior, executive, and board levels of leadership — within both social service organizations *and* the foundations that support them. This gap is likely to widen as demographics shift towards a non-white majority[7] in the U.S. while executive and board representation by people of color remains inadequate and out of sync with the general population.[8]

This pattern has not changed, despite consistent efforts to improve diversity in the sector. For many years, nonprofits, philanthropy, and other social sector organizations have focused on expanding the talent pipeline in the sector to increase the number of people of color primed for leadership positions. However, recent research shows that the pipeline is healthy at the front door. Instead, what needs to change are the mindsets, systems, and practices that enable emerging leaders of color to thrive within the sector.

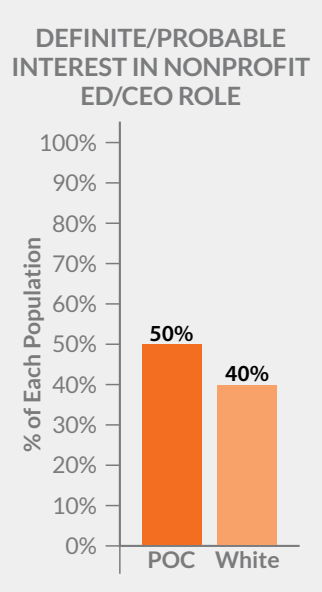


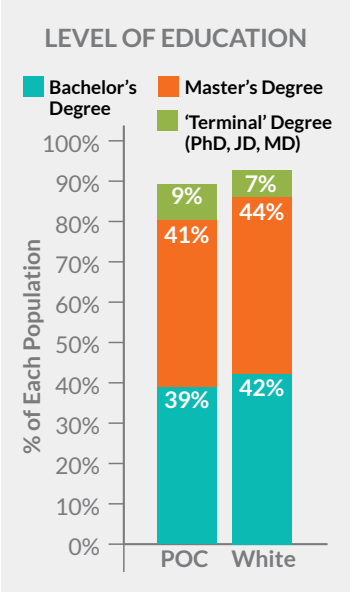
a. Source: BoardSource's *Leading with Intent: 2017 National Index of Nonprofit Board Practices*, https://leadingwithintent.org/?_hstc=98438528.47ca696c84826bfd8626c83b2becf776.1514987143707.1514987143707.1514987143707.1&_hssc=98438528.1.1514987143707&_hsfp=3060434504

b. Source: Pew Center, http://www.pewresearch.org/fact-tank/2017/11/30/5-ways-the-u-s-workforce-has-changed-a-decade-since-the-great-recession-began/

Source: *State of the Work*, D5, 2016. Data reflects respondents to Council on Foundation's annual survey over a five-year period (2010-2014), and is not necessarily reflective of the field overall.

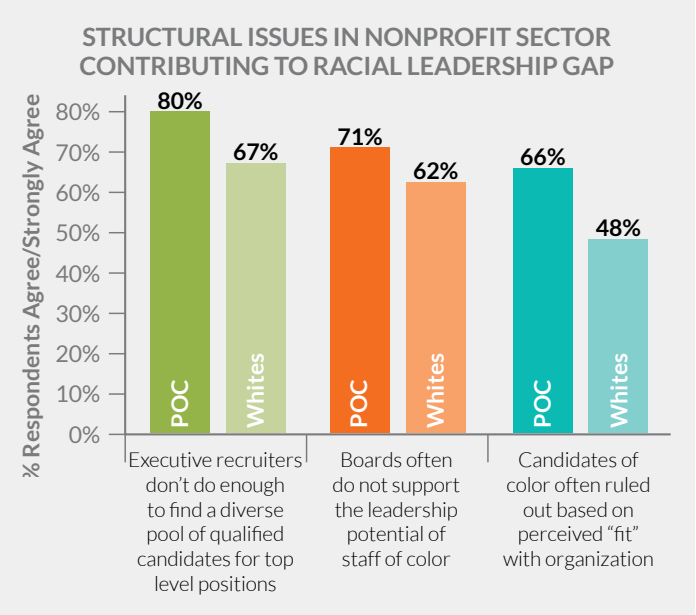
Building Movement Project's report *Race to Lead, Confronting the Nonprofit Racial Leadership Gap* highlights that the racial leadership gap is not due to differences in education, skills, or interest.[9]





Source: Building Movement Project's *Race to Lead, Confronting the Nonprofit Racial Leadership Gap*, http://racetolead.org/race-to-lead/

Rather, the report indicates that the enduring gap stems from a *structural* problem within the nonprofit sector.[10]



Source: Building Movement Project's *Race to Lead, Confronting the Nonprofit Racial Leadership Gap*, http://www.buildingmovement.org/reports/entry/race_to_lead

UNTAPPED POTENTIAL OF DIVERSE TEAMS

Diverse teams lead to better outputs. Scott Page, author of *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools and Societies*, uses mathematical modeling and case studies to show how diversity leads to increased productivity. His research found that diverse groups of problem solvers outperform the groups of the best individuals at solving problems.[11] McKinsey research also proves the results case for diversity: companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians.[12] Diverse nonprofit organizations, and the diversity of perspectives within them, can identify more effective solutions to social problems. Yet with the current state of inequity, we leave untapped potential for social change on the table.

RACE OUTCOMES GAP

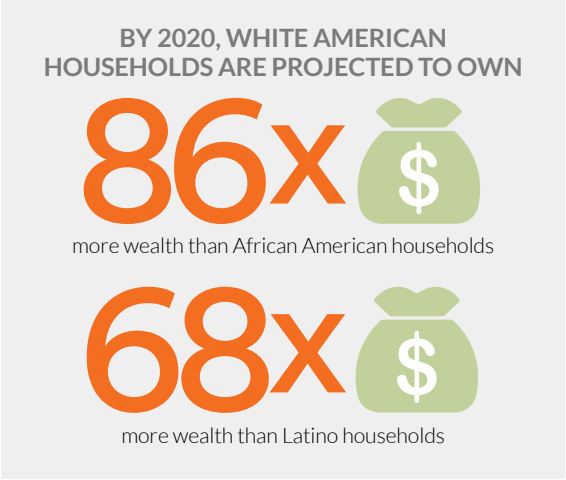
Nearly every indicator across key issue areas in the U.S. social sector shows a race outcomes gap. People of color are far worse off than their white counterparts across every age and income level in education, wealth and economic stability, health, life expectancy, and rates of incarceration. Some startling life circumstances exist for children and adults of color:

Education

- Children of color from immigrant families are nearly seven times less likely to be proficient in math by 8th grade than their U.S. born and primarily white peers, and about four times less likely to be proficient in reading by the fourth grade.[13]
- Starting as early as kindergarten and persisting throughout primary and secondary education, there are significant disparities in school test scores between students of color and their white counterparts.[14]
- Black students entering kindergarten for the first time scored lower than their white counterparts across every category tested, including reading, mathematics, science, cognitive flexibility, and approaches to learning. Black students had lower mean SAT scores for critical reading (428 vs. 527 for white students) and math (428 vs. 536 for white students).[15]

Wealth and Economic Stability

- Black children under the age of six are about three times more likely to live in poverty than their peers.[16]
- By the end of the Great Recession, the net worth of black families was $4,900, compared to $97,000 for /'their white family counterparts.[17]
- If current trends hold, median wealth for African Americans will fall to $0 by 2053, and the median wealth for Latino-Americans will hit $0 nearly two decades later.[18]
- By 2020, white American households are projected to own 86 times more wealth than African American households, and 68 times more wealth than Latino households.[19]



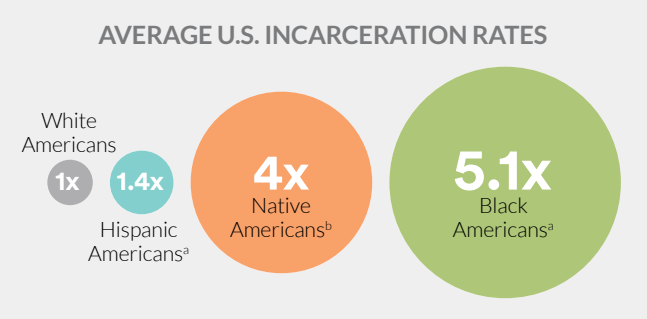
Source: Institute for Policy Studies' *The Road to Zero Wealth*, http://www.ips-dc.org/wp-content/uploads/2017/09/The-Road-to-Zero-Wealth_FINAL.pdf

Incarceration

- Black Americans are incarcerated in state prisons at an average rate of 5.1 times that of white Americans, and in some states that rate is 10 times or more.[20]
- Native Americans are admitted to prison at over four times the rate of white Americans.[21]
- Hispanic Americans are incarcerated at an average rate of 1.4 times that of white Americans, with average rates in some states going up to between three and four times that of whites.[22]

While it is outside the scope of this publication to highlight the numerous examples of disenfranchisement of people of color throughout our nation's history, suffice it to say that the structural racism embedded into every system on which our society is built is a leading cause of these enduring disparities. Other contributing factors include public policy, social and institutional practices, cultural representations, and bias. As a sector focused on the common good, we have a moral imperative to acknowledge the historical context and address the institutional barriers that have created these conditions.

Organizations that intentionally infuse their strategy with race equity and use it as a key operational driver can weaken structural racism and, through a race-conscious lens, broaden the reach of their work to long-marginalized individuals. The impact of these efforts will reverberate not only within the populations served by social sector organizations, but also within the organizations themselves. FSG and PolicyLink highlight multiple examples of how shared value is created when businesses advance race equity through the services and products they offer, their operations, and how they strengthen the business context and create opportunities for communities of color.[23] Though we are encouraged by the sector's focus on finding solutions to the race outcomes gaps through programs and services, we will not succeed in closing them until we fully buy into the case for race equity, the need to address structural racism, and understand how to achieve a Race Equity Culture within our organizations.



a. Source: The Sentencing Project's *The Color of Justice: Racial and Ethnic Disparity in State Prisons*, https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/#II.%20Overall%20Findings

b. Source: The Sentencing Project's *Race & Justice News: Native Americans in the Justice System*, https://www.sentencingproject.org/news/race-justice-news-native-americans-in-the-justice-system/

Other Industries

From #BlackLivesMatter to #OscarsSoWhite to #UnqualifiedForTech,[24] an increased spotlight shines on race and equity in the U.S. and its institutions. Other sectors are openly sharing their diversity, inclusion, and equity efforts and investing resources to accelerate progress in these areas.

- ***Environmental Sector.*** Since the inception of Green 2.0 in 2014 and the release of its report, Beyond Diversity, A Roadmap to Building an Inclusive Organization, this initiative has added more voices of color to the environmental sector while highlighting environmental issues that are especially important to communities of color.[25] Green 2.0 has successfully influenced leaders at national environmental organizations to share their diversity and inclusion data with Guidestar, the largest source of information on nonprofit organizations.
- ***Public Sector.*** Government Alliance on Race and Equity (GARE) supports a national network of government jurisdictions that are committed to bringing race equity to their local communities. Since its launch in 2014, GARE has worked with 79 local and county government jurisdictions to help them incorporate race equity into their strategic plans, decision making, and communications. They offer sector-specific resources and tools, such as Race Equity Plans: A How To Manual,[26] that provide steps to operationalize race equity inside of government organizations and to bring a race equity lens to their programs.
- ***Private Sector.*** Through the CEO Action for Diversity and Inclusion, Fortune 500 companies are rallying the business community to take measurable action in advancing diversity and inclusion in the workplace.[27] Through this initiative, CEOs from more than 300 national organizations have committed to sharing the actions their companies are taking to encourage peer learning and continued momentum.[28]

Building a Race Equity Culture

Before beginning this work, it's important to start with a clear and shared understanding of a Race Equity Culture and the nature of the work required to create and sustain it. A Race Equity Culture is one that is focused on *proactively counteracting* race inequities inside and outside of an organization. It requires an *adaptive and transformational approach* that impacts behaviors and mindsets as well as practices, programs, and processes. As Ronald Heifetz states in his book, *Adaptive Leadership*, "Adaptive challenges can only be addressed through changes in people's priorities, beliefs, habits, and loyalties. Making progress requires going beyond any authoritative expertise to mobilize discovery, shedding certain entrenched ways, tolerating losses, and generating the new capacity to thrive anew."[29] What's more, there is no checklist or 'one size fits all' approach when it comes to the adaptive challenge of creating a Race Equity Culture; each organization has to chart its own path and define its own success using a combination of tools and tactics mixed with personal and organizational culture changes that make sense for the individual context.

Race Equity Culture (n):
One that is focused on proactively counteracting race inequities inside and outside of an organization

What is Dominant Culture?

The term 'dominant culture' refers to organizational culture that is heavily influenced by the leadership, management, and organizational development as defined by white men and women.[30] Dominant workplace cultures don't embrace racial diversity beyond representation. They promote assimilation over integration, resulting in a missed opportunity to incorporate other cultures and to create a more inclusive, equitable environment. In his blog post "A letter to my POC sisters and brothers," Lupe Poblano speaks to this dynamic: "We are asked to compartmentalize our identity, to check our trauma, and question our own corazón wisdom... and then we are exploited — our hearts and ideas extracted from us while those with the most privilege design the organization and the Board."[31] In contrast, a Race Equity Culture shifts the internal power structure and dilutes the presence of dominant culture within organizations. It gives a larger voice and role to people of color and their lived experiences, both in daily operations and in broader strategic and decision making contexts. The benefits of a Race Equity Culture show up outside of the organization as well, in more culturally responsive programs and services.

THE RACE EQUITY CYCLE

Despite the unique nature of the journey, our research suggests that all organizations go through a cycle of change as they transform from a dominant culture (see above) to a Race Equity Culture. These changes include increased representation; a stronger culture of inclusion; and the application of a race equity lens to how organizations and programs operate. We have coined this process the ***Race Equity Cycle***. This journey of change pushes organizations to become more committed, more knowledgeable, and more skilled in analyzing race, racism, and race equity, and in placing these issues at the forefront of organizational and operational strategy. Because each organization is comprised of different people, systems, and histories, individual organizations will enter the Race Equity Cycle at different stages and will approach their race equity work with varying levels of organizational readiness. And while the impact will look and feel different at each stage of the Race Equity Cycle, we believe that all three stages mutually reinforce each other and help organizations proactively counteract structural racism and race inequities both internally and externally.

At the **AWAKE** stage, organizations are focused on *people* and on building a workforce and boards comprised of individuals from different race backgrounds. The primary goal is *representation*, with efforts aimed at increasing the number of people of different race backgrounds.

At the **WOKE** stage, organizations are focused on *culture* and creating an environment where everyone is comfortable sharing their experiences and everyone is equipped to talk about race equity and inequities. The primary goal is *inclusion* and internal change in behaviors, policies, and practices.

At the **WORK** stage, organizations are focused on *systems* to improve race equity. The primary goal is *integration of a race equity lens* into all aspects of an organization. This involves internal and external systems change and regularly administering a race equity assessment to evaluate processes, programs, and operations.

Although an organization may identify overall with one stage of the Race Equity Cycle, on any given lever it may be at a different stage. For example, an organization can be Woke overall, but may need to activate Managers in the Awake stage.

THE ROLE OF LEVERS IN BUILDING A RACE EQUITY CULTURE

How do organizations move through the Race Equity Cycle to build a Race Equity Culture? Our research identified seven levers[32] — strategic elements of an organization that, when leveraged, build momentum towards a Race Equity Culture within each stage and throughout the Race Equity Cycle. The seven levers represent both specific groups of people engaged with an organization as well as the systems, structures, and processes created — sometimes unconsciously — to help organizations operate: Senior Leaders, Managers, Board of Directors, Community, Learning Environment, Data, and Organizational Culture.

SENIOR LEADERS

Individuals in a formal leadership role

MANAGERS

Individuals who oversee operations of teams

BOARD OF DIRECTORS

Governing body of an organization

COMMUNITY

Populations served by the organization

On the following pages, we outline the characteristics and actions that define each lever. For ease of consideration, we organized them within three categories:

- Personal beliefs and behaviors
- Policies and processes
- Data

We also provide brief examples of how social sector organizations have put these levers into practice to achieve success in building a Race Equity Culture.

It bears repeating that there is no singular or 'right' way to engage in race equity work. Each organization needs to determine the levers to pull, and the actions to take, in order to progress in building its own Race Equity Culture.

LEARNING ENVIRONMENT

Investment in staff capacity

DATA

Metrics to drive improvements and focus

ORGANIZATIONAL CULTURE

Shared values, assumptions, and beliefs

SENIOR LEADERS LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Believe that diverse representation is important, but may feel uncomfortable discussing issues tied to race • Are responsive to encouragement by staff to increase diversity in the organization	• Place responsibility for creating and enforcing DEI policies within HR department	• Have started to gather data about race disparities in the populations they serve
WOKE	• Prioritize an environment where different lived experiences and backgrounds are valued and seen as assets to teams and to the organization • Regularly discuss issues tied to race and recognize that they are on a personal learning journey toward a more inclusive culture	• Take responsibility for a long-term change management strategy to build a Race Equity Culture • Have a critical mass[a] of people of color in leadership positions • Evaluate hiring and advancement requirements that often ignore system inequities and reinforce white dominant culture, such as graduate degrees and internship experience	• Analyze disaggregated data and root causes of race disparities that impact the organization's programs and the populations they serve • Disaggregate internal staffing data to identify areas where race disparities exist, such as compensation and promotion • Review compensation data across the organization (and by staff levels) to identify disparities by race (and gender)
WORK	• Model a responsibility to speak about race, dominant culture, and structural racism both inside and outside the organization	• Show a willingness to review personal and organizational oppression, and have the tools to analyze their contribution to structural racism • Identify organizational power differentials and change them by exploring alternative leadership models, such as shared leadership • Use a vetting process to identify vendors and partners that share their commitment to race equity • Ensure salary disparities do not exist across race, gender, and other identities through analysis of mandated all-staff compensation audits	• Can illustrate, through longitudinal outcomes data, how their efforts are impacting race disparities in the communities they serve • Can track retention and promotion rates by race (and gender) across the organization and by staff level • When salary disparities by race (or other identities) are highlighted through a compensation audit, staff being underpaid in comparison to peers receive immediate retroactive salary corrections

Senior Leaders Lever in Practice

AWAKE

Leadership for Educational Equity: Analyzed disaggregated program data to identify how many people of color participated in external leadership programs about running for elected office.

WOKE

Leadership for Educational Equity: Sets and communicates goals around diversity, equity, and inclusion across all programming. Incorporates goals into staff performance metrics. Adjusts strategy upon quarterly reviews at the department and organizational levels.

Year Up: At the onset of the organization's race equity work, senior leaders were given specific talking points to spark conversation in staff meetings. Prompts included *"What is the role of a sponsor vs. an ally?"* and *"How can we be allies in this work?"*

WORK

Leadership for Educational Equity: After a four-month pilot, executive coaching program for VPs expanded to a year-long investment. VPs receive coaching about diversity/inclusion to help improve their team and organizational leadership.

a. In referencing critical mass as representation of people of color within an organization or at a certain level of leadership, we believe it should be dependent on, and reflective of, the demographics of the communities in which an organization serves or operates.

MANAGERS LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Push past their own low comfort level to discuss race-related issues with staff • Possess an emergent understanding of the race disparities that exist among the populations they serve	• Have familiarity with the organization's diversity policies	• Have diversity goals outlined in their hiring plans that focus on increasing the number of racially diverse staff members
WOKE	• Can recognize and speak about race disparities and/or bias internally and externally • Value diverse teams, providing training and coaching/mentoring support	• Take responsibility for the implementation of change management strategies to build a Race Equity Culture • Have promoted or hired a critical mass[a] of people of color into staff positions	• Hold team members accountable by asking them to identify racial disparities in their programs • Track retention and promotion rates by race (on their team) to identify where they need to offer professional growth and development
WORK	• View race differences as assets to teams and to the organization, enabling people of color to bring their full selves to work and use their lived experiences to fulfill their job responsibilities • Show a willingness to review personal and organizational oppression and have the tools to analyze their contribution to structural racism	• Ensure that people of color have equal access to leadership opportunities and promotions by supporting their professional growth • Have a promotion process that anticipates and mitigates biases about people of color serving in leadership positions • Hire and promote staff members who demonstrate proficiency in how to address racism and race equity with coworkers and in their programs	• Make race equity a performance measure during their team's annual reviews • Have a long-term commitment to policy change based on racial disparities they see both inside and outside of the organization

Managers Lever in Practice

AWAKE

Year Up: Added questions about diversity to performance reviews, holding individuals more accountable for progress.

WOKE

Year Up: Local leadership teams developed site-specific goals to answer the question, *"What will make our team feel more inclusive?"* Each site shared its goals with the national office and continues to track results.

Leadership for Educational Equity: Provided managers training on how to coach, mentor, and manage across differences. They also disaggregate data on performance management (4 years) and promotions (18 months), and clarify management practices to ensure they are more transparent and equitable.

WORK

Annie E. Casey Foundation: Reviews diversity data collected from grantees (across program units) to realign strategies and goals and to ensure positive race equity impact in communities served.

a. In referencing critical mass as representation of people of color within an organization or at a certain level of leadership, we believe it should be dependent on, and reflective of, the demographics of the communities in which an organization serves or operates.

BOARD OF DIRECTORS LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• May not be comfortable discussing issues tied to race at the board level	• Seek individuals from various race backgrounds for board and Executive Director/CEO positions • Show a commitment, at every level of the organization, to diverse representation, and hold the organization accountable for diversity policies and practices	• Have limited understanding about race disparities in the populations served by their organizations
WOKE	• Create and sustain practices (e.g., shared norms, vision, values, policies) to foster an inclusive environment that encourages and values differing viewpoints in decision making process	• Have a critical mass[a] of people of color on the board, including in leadership roles • Evaluate board membership requirements that ignore systemic racial inequities and reinforce dominant culture, such as minimum donation amounts and conventionally prestigious backgrounds • Acknowledge and manage power dynamics that exist on the board, and how decision making may be impacted by biases	• Analyze disaggregated data and root causes of race disparities that impact the organization's programs and the populations they serve
WORK	• Lead internal processes, procedures, and culture to eliminate bias and disparate treatment	• Show a willingness to review personal and organizational oppression, and have the tools to analyze their contribution to structural racism • Commit fully to building a Race Equity Culture and to holding the organization accountable for race equity policies and practices • Adapt their missions to engage and empower communities to work with the organization to achieve shared community advancement and benefit	• Hold the Executive Director/CEO accountable for all measures related to CEO performance on race equity, ensuring that financial resources are allocated to support the work

Board of Directors Lever in Practice

AWAKE

Year Up: Conducted a review of its board member selection process and, based on the outcomes, revamped the composition of the board to include racially diverse alumni from its programs — with the express purpose of providing a unique perspective and skill sets.

WOKE

Year Up: While the board engaged in its own learning about DEI, the organization created a special task force comprised of board members and staff who reviewed board policies and outlined recommendations for change.

WORK

Year Up: Added trainings on diversity and inclusion to the board onboarding process so that every board member had the same base level of DEI knowledge. The board's quarterly learning sessions are focused on different diversity topics, including systemic racism and privilege, that relate to Year Up's work and students served.

a. In referencing critical mass as representation of people of color within an organization or at a certain level of leadership, we believe it should be dependent on, and reflective of, the demographics of the communities in which an organization serves or operates.

COMMUNITY LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Value the community and population served, and believe they are worthy of partnership and investment • Have developed personal relationships with community members	• Encourage staff to volunteer in the community by providing paid time off to do so • Value community members as informal advisors to the organization	• Use data analysis to assess the racial impact of their work on the communities they serve
WOKE	• Know that the community and population the organization serves have been disenfranchised by systemic issues that were most likely not created by the people served by the organization • Believe it is the role of the organization to help fix those inequities and injustices • Regularly seek community input on programs and services they provide or intend to provide	• Have strong feedback loops to encourage and respond to community feedback about race bias, diversity, and inclusion • Have community representation at the board level, either on the board itself or through a community advisory board	• Disaggregate data to adjust programming and educational goals to keep pace with changing needs of the communities they serve
WORK	• Expect staff to work with the community to co-create solutions to problems as a key way to meet the organization's mission • Understand that only through continuous interaction with, and in, the community they serve will race equity be achieved at a systemic level • Is seen and valued as an ally by the community they work with and in	• Invest financial resources to support race equity in their communities • Define criteria and processes for grant awards and partner selection using a race equity lens • Go beyond specific program areas to dedicate organizational time, resources, and influence to address underlying systemic issues that impact their communities • Ally with the community on race-related issues, even when they aren't directly related to the organization's mission	• Measure improvement using baseline data to see if program solutions are having a positive impact

Community Lever in Practice

AWAKE

Annie E. Casey Foundation: Encourages staff to volunteer their time to work on race equity goals in the communities they serve.

Leadership for Educational Equity: Disaggregated member program goals to ensure that investments in members of color are prioritized.

WOKE

Year Up: Held conversations with stakeholders to identify the community's perspective on how well Year Up was doing in terms of its diversity efforts.

Leadership for Educational Equity: Created identity-based resource groups that meet to discuss experiences and identify organizational actions to support them.

WORK

Annie E. Casey Foundation: Defined the work of race equity as mission-critical, along with the organization's need to understand and embrace race equity work internally. Made a clear connection between internal/external equity work and the Foundation's overall outcomes.

Leadership for Educational Equity: Examines disaggregated data about the onboarding experience, performance management, compensation, and retention. Identified disparities trigger deeper work to align policies and strategies.

LEARNING ENVIRONMENT LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Focus on increasing staff knowledge about the individual and interpersonal levels of racism (e.g., individual biases, intercultural communication, and conflict skills)	• Have or are developing a shared language around race identity and issues related to race, racism, and race equity • Have or are building cross-cultural awareness, sensitivity, and empathy, including education about dominant identities that exist in organizational cultures	• Include demographics in evaluation methods to collect race-conscious data on program/training efficacy • Track number of employees who participate in DEI trainings, and amount of conversation around dominant culture and race equity
WOKE	• Expect members of the dominant culture to acknowledge and reduce the emotional labor placed upon people of color within the organization regarding race-related discussions • People of color understand and acknowledge their colleagues' learning journeys around race, racism, and racial equity	• Help senior leadership understand how to be inclusive leaders, with learning approaches that emphasize reflection, iteration, and adaptability • Support teams to improve their skills to work across difference and use constructive conflict to inspire better thinking and solutions	• Employ non-traditional ways to gather feedback on program and trainings, which may include interviews, roundtables, and external reviews • Seek input from people of color to create and iterate learning objectives and measurement strategies • Collect data on effectiveness of DEI trainings and conversations (in addition to participation numbers); conduct reviews from participants to share key insights and learnings with teams or full organization
WORK	• Critically reflect on their progress and intentionally work to sustain race equity	• Increase staff knowledge about race equity and facilitate difficult conversations related to race and racism • Learn how to impact structural racism issues outside the organization and in the communities they serve	• Use data to change culture and processes, and show a willingness to make large-scale changes based on needs surfaced by staff • Allow for multiple entry points and ways of engaging with race equity work by tailoring the use of internal and external race equity/DEI data to individual employee motivations • Formulate development and learning plans for race equity knowledge; track employee learnings and any resistance to growth • Talk freely about key organizational learnings around race equity and their journey

Learning Environment Lever in Practice

AWAKE

Leadership for Educational Equity: Developed a core fundamentals curriculum and implemented it for all teams to better understand race and racism.

WOKE

Year Up: As a part of their 360 review, each senior leader gets feedback on how effective they are at managing diversity on their teams. Based on that feedback, leaders receive coaching on how to be a more inclusive leader/lead inclusive teams. Additionally, white staff are trained as "allies," both to support and model facilitating dialogue on race within teams and learn how to effectively introduce topics that people of color have expressed they are not comfortable raising publicly.

WORK

Leadership for Educational Equity: Trains leadership on how to best support and advocate for people across identities (race, gender, ability, sexual orientation, etc).

DATA LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Believe that successful diversity means increasing the number of racially diverse people on staff • Are not convinced that measuring internal data (such as hiring/retention) based on race/ethnicity matters, but understand value of data analysis to the work of the organization in general	• Focus on the number of employees hired and retained by race/ethnicity • Focus on internal promotion or advancement for people of color	• Track interventions from HR or other parties to mediate conflicts and misunderstandings based on race differences
WOKE	• Support implementation of new, race-conscious ways to measure initiatives, programs, and internal processes • Collect relevant data on internal indicators of diversity/inclusion in hiring and retention • Have a baseline of data indicators that inform the organization of where it can focus efforts	• Measure job applicants by their level of understanding, skill, and attributes related to diversity and race equity • Measure job satisfaction and retention by function, level, and team	• Disaggregate data by demographics such as race in every policy and program measured • Monitor the level of employee engagement and satisfaction from working in an inclusive culture • Create measures and metrics with input from people of color • Track and publish race representation statistics among their workforce, grantees, consultants, and vendors
WORK	• Use data proactively to inform and create their strategies and new initiatives • Understand that internal AND external data analysis is imperative to building a Race Equity Culture, as it builds transparency internally and externally, and allows employees who enter their work with a race equity lens to interact and engage • Use data and measurement in storytelling around their race equity journeys	• Assess alignment between strategy metrics and equity values	• Measure cultural responsiveness of their policies and programs for employees, stakeholders, and communities • Track coordinated diversity activities that align with organizational direction • Measure race equity data by using both quantitative and qualitative data and holding the organization accountable to improve its impact • Use evaluation tools for race equity, including equity assessments, to examine equity work internally and in external partnerships

Data Lever in Practice

AWAKE

Leadership for Educational Equity: Established internal goals of racially diversifying their staff to more closely mirror the diversity in their community.

WOKE

Leadership for Educational Equity: Administers a 90-day onboarding survey to gather feedback on staff experience working in an inclusive environment. They also administer an employee satisfaction survey twice annually that is disaggregated by race and gender.

Annie E. Casey Foundation: For an office improvement project, retained a vendor whose economic inclusion strategy includes the hiring of ex-offenders and other hard-to-place employees.

WORK

Leadership for Educational Equity: Reviewed current strategic goals through a race equity lens to identify areas where they could create more identity-based programming for staff and stakeholders. Measure whether identity-based leadership development efforts produce more racially diverse leaders in the education sector.

ORGANIZATIONAL CULTURE LEVER

	Personal Beliefs & Behaviors	Policies & Processes	Data
AWAKE	• Are aware that a white dominant workplace culture exists, but expect people to adhere to dominant organizational norms in order to succeed • Are learning to address challenges that occur in diverse environments as a result of unconscious biases and microaggressions that create conflict and resentment among staff	• Share the organization's commitment to DEI as part of the onboarding process of new employees	• Emphasize increasing diverse staff representation over addressing retention issues
WOKE	• Are compelled to discuss racially charged events with their staff when they occur, and hold space for their staff to process their feelings without placing undue responsibility on people of color to explain or defend themselves or their communities	• Consider ways to shift organizational norms and team dynamics in order to support racially diverse staff whose lived experiences meaningfully contribute to the organizational mission • Expect participation in race equity work across all levels of the organization	• Have long-term strategic plans and measurable goals for creating an equity culture, and an understanding of the organizational change needed to realize it
WORK	• Communicate proactively around race equity values and initiatives both internally and externally • Foster a positive environment where people feel they can raise race-related concerns about policies and programs without experiencing negative consequences or risking being labeled as a troublemaker	• Engage everyone in organizational race equity work and ensure that individuals understand their role in creating an equitable culture • Thread accountability across all efforts to support and sustain a racially equitable organization	• Assess achievement of social inclusion through employee engagement surveys

Organizational Culture Lever in Practice

AWAKE

Leadership for Educational Equity: Established a DEI Team to set a vision and define positions, language, and curriculum to achieve it.

Year Up: Created a design team comprised of a cross-section of staff that was diverse in terms of race and function. Team met regularly for "deep dives" to improve DEI knowledge.

WOKE

Leadership for Educational Equity: Created identity-based employee resource groups that invited cross-functional staff to discuss their experiences and identify actions the organization can take to support them.

Year Up: Held conversations with senior leadership to create clear definitions for diversity and inclusion prior to writing a diversity statement.

WORK

Annie E. Casey Foundation: Defined the work of race equity, as well as the organizations needed to understand and embrace it internally, as mission-critical. Make a clear and explicit connection between their equity work and the Foundation's overall outcomes.

How to Get Started

At this point, you may not know where your organization will enter this work, or the precise path your organization will take on its journey towards a Race Equity Culture. Rather than let this uncertainty impede your progress, move forward with the knowledge that it is normal. Even in the absence of a defined path, there are actionable steps your organization can take to launch its race equity work:

1. ***Establish a shared vocabulary.*** Ground your organization in shared meaning around race equity and structural racism. These terms work hand in hand; by achieving race equity, you will be dismantling structural racism. Many organizations maintain a running dictionary of terms from which to draw when needed; the Glossary found in the Appendix is a helpful starting point.
2. ***Identify race equity champions at the board and senior leadership levels.*** While race equity work only succeeds as an organization-wide effort, a critical component is buy-in from board members and senior leaders who can set race equity priorities and communicate them throughout the organization. As these constituent groups make up distinct levers, it's imperative that they independently demonstrate a firm commitment to race equity. Senior leaders must encourage others in the organization to engage in the work, influence the speed and depth at which race equity is embedded in the organization, and continuously drive progress and accountability.
3. ***Name race equity work as a strategic imperative for your organization.***[33] Hold race equity as a north star for your organization. Define and communicate how race equity work helps the organization achieve its mission. The more you connect the reasons for doing this work to your mission, vision, organizational values, and strategies, the more critically important it will feel to everyone in the organization, at every level.
4. ***Open a continuous dialogue about race equity work.*** There are numerous ways to engage in effective conversations on race equity. Host a brown-bag lunch about race equity efforts on your team, or for individuals who are invested in your organizational cause, and secure an external facilitator to ensure discussion is both objectively and effectively managed. Whether it's environmental justice, access to education, or philanthropy and grantmaking, you can find research and examples of organizations that have done race equity work and shared their learnings. Use these stories to start the conversation about race equity within your team, and discuss how the approaches of other organizations might apply to your work.
5. ***Disaggregate data.*** Start looking at your numbers. The only way to get a clear picture of inequities and outcomes gaps both internally and externally is to collect, disaggregate, and report relevant data. Organizations should examine staff engagement, performance, and compensation data by race, at all staff levels. Program data should also be disaggregated and analyzed by race. Hold yourself and your leadership accountable for this work.

What Does it Cost to Build a Race Equity Culture?

Building a Race Equity Culture is an ongoing process that requires a significant investment of time and financial resources. Most organizations we interviewed were three to five years into their journey of building a Race Equity Culture. These organizations attributed their progress to a combination of training, coaching, listening to communities and stakeholders, and planning. In the beginning stages of their race equity work, most organizations invested primarily in consultants to help them articulate their goals and priorities for this work and to support them through coaching and mentoring. Building on the momentum from early wins, the organizations then invested in longer-term strategies to infuse DEI and race equity more deeply into how the organization operates.

Sample investments to build a Race Equity Culture:

	ORGANIZATION A	ORGANIZATION B	ORGANIZATION C
Duration of active commitment to the work	8 years	5 years	4 years
Staff size when work was initiated	200	10	4
Current staff size	750	150	12
Initial annual investment in race equity capacity building	$20,000 - $40,000	$700,000	$15,000
Current annual investment in race equity capacity building	$10,000 - $20,000	Unavailable	$30,000

Envisioning a Race Equity Culture

Building a Race Equity Culture requires intention and effort, and sometimes stirs doubt and discomfort. Holding a vision of the future can sustain you in the challenging times. What does a true Race Equity Culture look like, and what benefits will accrue to your staff, systems, stakeholders, and community served?

When your organization has fully committed itself to a Race Equity Culture, the associated values become part of the organization's DNA. It moves beyond special initiatives, task force groups, and check-the-box approaches into full integration of race equity in every aspect of its operations and programs. Organizations that demonstrate this commitment exhibit the following characteristics:

- Leadership ranks hold a critical mass of people of color, whose perspectives are shifting how the organization fulfills its mission and reinforcing the organization's commitment to race equity.
- Internal change around race equity is embraced. Staff members are supported in managing and integrating the changes, and the organization demonstrates courage to advance external outcomes.
- Staff, stakeholders, and leaders are confident and skilled at talking about race and racism and its implications for the organization and for society.
- Cultural norms and practices exist that promote positive and culturally responsible interpersonal relationships among staff. Individuals are encouraged to share their perspectives and experiences.
- Programs are culturally responsive and explicit about race, racism, and race equity.
- External communications reflect the culture of the communities served.
- Communities are treated not merely as recipients of the organization's services, but rather as stakeholders, leaders, and assets to the work.
- Expenditures on services, vendors, and consultants reflect organizational values and a commitment to race equity.
- Continuous improvement in race equity work is prioritized by requesting feedback from staff and the community.
- Evaluation efforts incorporate the disaggregation of data in order to surface and understand how every program, service, or benefit impacts every beneficiary.

We have bold goals for this work. If enough race equity champions are willing and ready to engage their organizations in the transformational work of building a Race Equity Culture, we will reach the tipping point where this work shifts from an optional exercise or a short-term experiment without results, to a core, critical function of the social sector. By building a Race Equity Culture within organizations and across the social sector, we can begin to dismantle structural racism. Only then will we truly live up to our missions to serve the common good. We're ready for this work; are you?

Appendix A: Call to Action

The work of building a Race Equity Culture demands an intentional approach. People of color and whites alike must interrogate assumptions about how the work of nonprofits, grant makers, and other social sector organizations is and can be done — and by whom. There are specific practices to be followed, at all four levels on which racism operates:

PERSONAL

- ***Decolonize*** your mind. Accept that white supremacy and institutional racism are real and practiced by all races.
- ***Interrogate*** the dominant narrative. Understand implicit bias and your identity and role in enabling and propagating structural racism.
- ***Complete*** your own internal work. Don't put the burden exclusively on people of color or people who you perceive to be more "woke" to explain the system to you. Hold yourself accountable for the work at all four levels on which racism operates.

INTERPERSONAL

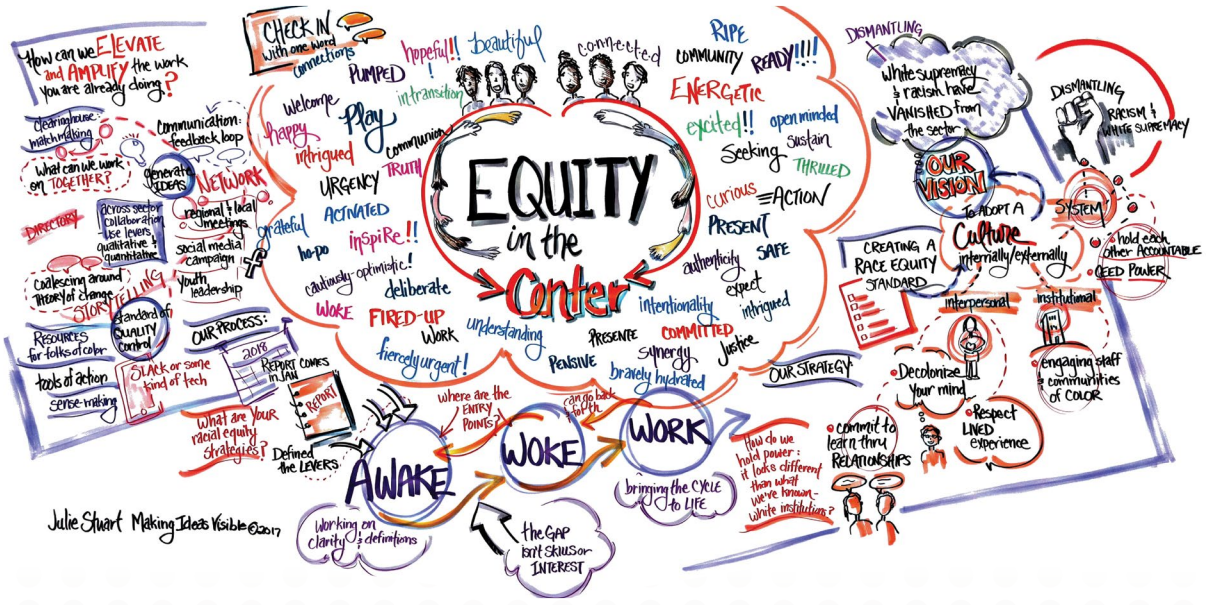
- ***Respect*** the lived experience of people of color operating within white dominant culture, including your own if you're a person of color.
- ***Commit*** to building, being vulnerable to, and learning through, relationships with people of a different race, especially people of color whose voices are often marginalized.
- ***Acknowledge*** the impact of race-based power differentials within organizations.

INSTITUTIONAL

- ***Commit*** to understanding and speaking publicly on principles of race equity, and how they apply in the institutional context.
- ***Disaggregate*** staff engagement, performance, compensation, and promotion/retention data by race at all staff levels. Hold yourself and leadership accountable for this work.
- ***Engage*** staff and communities of color to inform governance, decision making, and execution across organizational processes.

STRUCTURAL

- ***Be accountable,*** at the individual and organizational level, for dismantling personal, interpersonal, institutional, and structural instruments of white supremacy.
- ***Publicly advocate*** for race equity and challenge white dominant cultural norms, including naming microaggressions in interpersonal and institutional contexts.
- ***Cede power*** to people of color within and across teams, organizations, and systems.



Appendix B: Glossary

ANTI-OPPRESSION ORGANIZATION An organization that actively recognizes and mitigates the oppressive effects of white dominant culture and power dynamics, striving to equalize that power imbalance internally and for the communities with which they work.

ASSIMILATE The phenomenon that occurs when people belonging to the nondominant group understand dominant culture norms and take on their characteristics either by choice or by force. Many people of color are asked to "check their identities at the door" in professional settings to make their white peers comfortable. By doing so, many people of color find it easier to get promotions and professional opportunities, as well as to gain access to informal networks typically accessible only to whites.

CRITICAL MASS In reference to representation of people of color within an organization or at a certain level of leadership. This figure is dependent on, and reflective of, the specific demographics of the communities in which an organization serves or operates.

CRITICAL RACE THEORY A theory that explicitly states and recognizes that racism is ingrained in the fabric and system of American society. Even without overt racists present, institutional racism is pervasive in dominant culture. Critical Race Theory examines existing power structures, and identifies these structures as based on white privilege and white supremacy, which perpetuate the marginalization of people of color. Overall, Critical Race Theory examines what the legal and social landscape would look like today if people of color were the decision-makers.

DECOLONIZE (MIND) We exist within societal structures rooted in historical facts, one of which is colonialism: the policy and practice of acquiring control of land (frequently occupied by people of color), occupying it, and codifying power structures to elevate one race and culture above all others. The international practice of colonization informs the dominant culture that characterizes American society today, driving ideologies and subconscious biases rooted in centuries of racism, classism, and white privilege. In order to dismantle white supremacy and the white dominant culture norms it influences, one must actively "decolonize" the mind, recognizing and counteracting the thoughts, preferences, practices, and behaviors that are deeply rooted vestiges of colonization.

DIVERSITY Psychological, physical, and social differences that occur among any and all individuals; including but not limited to race, ethnicity, nationality, religion, socioeconomic status, education, marital status, language, age, gender, sexual orientation, mental or physical ability, and learning styles.[34]

DOMINANT CULTURE Dominant culture in a society refers to the established language, religion, values, rituals, and social customs on which the society was built. It has the most power, is widespread, and influential within a social entity, such as an organization, in which multiple cultures are present. An organization's dominant culture is heavily influenced by the leadership and management standards and preferences of those at the top of the hierarchy. In this paper, dominant culture refers specifically to the American context in which organizational culture is predominantly defined by white men and white women in positional power. See also "White Dominant Culture."

EMPLOYEE RESOURCE GROUP Voluntary, employee-led groups that foster a diverse, inclusive workplace aligned with organizational mission, values, goals, business practices, and objectives. Often, these groups provide support to staff who formally or informally lead race equity work in some capacity within an organization.

EQUITY The guarantee of fair treatment, access, opportunity, and advancement while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups. The principle of equity acknowledges that there are historically underserved and underrepresented populations, and that fairness regarding these unbalanced conditions is needed to assist equality in the provision of effective opportunities to all groups.[35]

INCLUSION The act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate and bring their full, authentic selves to work. An inclusive and welcoming climate embraces differences and offers respect in the words/actions/thoughts of all people.[36]

LEADERSHIP Individuals who influence a group of people to act towards a goal. Individuals may or may not be in positions of authority.[37]

MICROAGGRESSION The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.[38]

RACE EQUITY The condition where one's race identity has no influence on how one fares in society. Race equity is one part of race justice and must be addressed at the root causes and not just the manifestations. This includes the elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race.[39]

RACE EQUITY CULTURE A culture focused on proactive counteraction of social and race inequities inside and outside of an organization.

RACE EQUITY LENS The process of paying disciplined attention to race and ethnicity while analyzing problems, looking for solutions, and defining success. A race equity lens critiques a "color blind" approach, arguing that color blindness perpetuates systems of disadvantage in that it prevents structural racism from being acknowledged. Application of a race equity lens helps to illuminate disparate outcomes, patterns of disadvantage, and root cause.[40]

RACISM A system of advantage and oppression based on race. A way of organizing society based on dominance and subordination based on race. Racism penetrates every aspect of personal, cultural, and institutional life. It includes prejudice against people of color, as well as exclusion, discrimination against, suspicion of, and fear and hate of people of color.[41]

SOCIAL JUSTICE A concept of fair and just relations between the individual and society. This is measured by the explicit and tacit terms for the distribution of power, wealth, education, healthcare, and other opportunities for personal activity and social privileges.[42]

SOCIAL SECTOR The group of organizations that consist of both nonprofit and philanthropic organizations.

STRUCTURAL RACISM The arrangement of institutional, interpersonal, historical, and cultural dynamics in a way that consistently produces advantage for whites and chronic adverse outcomes for people of color. It illuminates that racism exists without the presence of individual actors because it is systemically embedded. When the United States was founded, racist principles were codified in governance structures and policies. As a result, racism is embedded in institutions, structures, and social relations across American society. Today, structural racism is composed of intersecting, overlapping, and codependent racist institutions, policies, practices, ideas, and behaviors that give an unjust amount of resources, rights, and power to white people while denying them to people of color.

WHITE DOMINANT CULTURE Culture defined by white men and white women with social and positional power, enacted both broadly in society and within the context of social entities such as organizations. See also "Dominant Culture" and "White Supremacy Culture."[43]

WHITE PRIVILEGE The power and advantages benefiting perceived white people, derived from the historical oppression and exploitation of other non-white groups.

WHITE SUPREMACY The existence of racial power that denotes a system of structural or societal racism which privileges white people over others, regardless of the presence or the absence of racial hatred. White racial advantages occur at both a collective and an individual level, and both people of color and white people can perpetuate white dominant culture, resulting in the overall disenfranchisement of people of color in many aspects of society.[44]

WHITE SUPREMACY CULTURE Characteristics of white supremacy that manifest in organizational culture, and are used as norms and standards without being proactively named or chosen by the full group. The characteristics are damaging to both people of color and white people in that they elevate the values, preferences, and experiences of one racial group above all others. Organizations that are led by people of color or have a majority of people of color can also demonstrate characteristics of white supremacy culture. Kenneth Jones and Tema Okun identified twelve characteristics of white supremacy culture in organizations: Perfectionism, Sense of Urgency, Defensiveness, Quantity of Quality, Worship of the Written Word, Paternalism, Power Hoarding, Fear of Open Conflict, Individualism, Progress is Bigger/More, Objectivity, and Right to Comfort.[45]

The definitions above are from a number of different sources which are included in the bibliography, as well as from Equity in the Center's research, thinking, and nomenclature.

Appendix C: Endnotes

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Appendix E: Interview Summaries

We interviewed and/or researched three organizations as part of the development of this publication, to learn about their journeys towards race equity: Year Up, Leadership for Educational Equity, and the Annie E. Casey Foundation.

YEAR UP

https://www.yearup.org

Year Up's mission is to close the Opportunity Divide by providing urban young adults with the skills, experience, and support that will empower them to reach their potential through professional careers and higher education.

The organization achieves this mission through a one-year, intensive training program that provides low-income young adults (ages 18-24) with a combination of hands-on skills development, coursework eligible for college credit, corporate internships, and wraparound support.

Year Up's commitment to diversity, equity, and inclusion is visible in its stated organizational values, program recruitment, and organizational culture.

LEADERSHIP FOR EDUCATIONAL EQUITY

https://educationalequity.org

Leadership for Educational Equity (LEE) is a nonpartisan, nonprofit leadership development organization whose mission is to inspire and support a diverse, enduring movement of leaders to engage civically and politically within their communities to end the injustice of educational inequity.

They achieve this mission by offering one-on-one coaching, fellowships, workshops, and resources to a diverse set of leaders to help them become transformative leaders who move educational equity forward.

Leadership for Educational Equity's commitment to diversity, equity, and inclusion is evident in its core values; programmatic priorities; participant recruitment strategies and processes; and equity-based professional development offerings.

ANNIE E CASEY FOUNDATION

http://www.aecf.org

The Annie E. Casey Foundation is devoted to developing a brighter future for millions of children at risk of poor educational, economic, social, and health outcomes. Their work focuses on strengthening families, building stronger communities, and ensuring access to opportunity, because children need all three to succeed. They advance research and solutions to overcome the barriers to success, help communities demonstrate what works, and influence decision makers to invest in strategies based on solid evidence.

One of the key strategies the organization relies on to fulfill its vision is a deep and long-term commitment to equity and inclusion. By employing data-driven, targeted strategies, programs, and resources that have a racial equity lens, AECF can direct its efforts towards those children, families, and communities who need them most.

We relied on their report, Operationalizing Equity (http://www.aecf.org/resources/operationalizing-equity/) to identify examples for this publication.

We would like to thank these organizations for their contributions to this publication, and we applaud each of them for their work towards race equity.

Appendix F: Equity in the Center Partners and Advisors

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The William and Flora Hewlett Foundation

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Mikaela Seligman, AchieveMission

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Our team is deeply grateful to Sean Thomas-Breitfeld and Building Movement Project, whose *Race to Lead: Confronting the Nonprofit Racial Leadership Gap* report played a critical role in shaping our approach to this paper. Both Sean and Carly Hare of CHANGE Philanthropy have played a critical strategic role in our work this past year, both as thought partners and as co-chairs of the Resource Mapping Working Group launched in October 2017.

We are especially indebted to the colleagues who invested hours to review the initial draft of our paper, sharing compelling insights and nuanced feedback based on decades of experience, both leading social sector organizations and implementing best practices around diversity, equity, and inclusion: MacArthur Antigua of Public Allies, Ben Duda of Service Year Alliance, Dana Kawaoka-Chen of Bay Area Justice Funders Network, Isabelle Moses of PICO National Network, Tom Nelson of Share Our Strength, Maggie Potapchuk of MP Associates, and Mikaela Seligman of AchieveMission.

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This report is the result of the invaluable contributions from many individuals across ProInspire, chief among them Ericka Hines, Strategic Advisor to ProInspire for Diversity, Equity, and Inclusion and Principal, Every Level Leadership, who led research and conceptualized the Race Equity Cycle. Kerrien Suarez, Director of Equity in the Center, leads the overall initiative and brought together the many advisors for this work. Martha Searby, Communications Director, invested countless hours in thorough and nuanced editing, while Andrew Plumley, Equity in the Center's Senior Program Manager, and Kate Loving, ProInspire's Marketing and Communications Associate, dedicated hours to filling in gaps with additional data points and insight from a year's worth of research. Finally, ProInspire's Founder and CEO, Monisha Kapila, set the vision that created the conditions for Equity in the Center's successful launch and expansion in the past year.

Finally, an important note: The views and opinions expressed in this paper are the responsibility of Equity in the Center, and do not necessarily reflect the views of our funders or other individuals and organizations acknowledged here.

EQUITY IN THE CENTER

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VIEWPOINT

The Moral Determinants of Health

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Viewpoint and Editorial

The source of what the philosopher Immanuel Kant called "the moral law within" may be mysterious, but its role in the social order is not. In any nation short of dictatorship some form of moral compact, implicit or explicit, should be the basis of a just society. Without a common sense of what is "right," groups fracture and the fragments wander. Science and knowledge can guide action; they do not cause action.

No scientific doubt exists that, mostly, circumstances outside health care nurture or impair health. Except for a few clinical preventive services, most hospitals and physician offices are repair shops, trying to correct the damage of causes collectively denoted "social determinants of health." Marmot[1] has summarized these in 6 categories: conditions of birth and early childhood, education, work, the social circumstances of elders, a collection of elements of community resilience (such as transportation, housing, security, and a sense of community self-efficacy), and, cross-cutting all, what he calls "fairness," which generally amounts to a sufficient redistribution of wealth and income to ensure social and economic security and basic equity. Galea[2] has cataloged social determinants at a somewhat finer grain, calling out, for example, gun violence, loneliness, environmental toxins, and a dozen more causes.

> When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so.

The power of these societal factors is enormous compared with the power of health care to counteract them. One common metaphor for social and health disparities is the "subway map" view of life expectancy, showing the expected life span of people who reside in the neighborhood of a train or subway stop. From midtown Manhattan to the South Bronx in New York City, life expectancy declines by 10 years: 6 months for every minute on the subway. Between the Chicago Loop and west side of the city, the difference in life expectancy is 16 years. At a population level, no existing or conceivable medical intervention comes within an order of magnitude of the effect of place on health. Marmot also estimated if the population were free of heart disease, human life expectancy would increase by 4 years,[1] barely 25% of the effect associated with living in the richer parts of Chicago instead of the poorer ones.

How do humans invest in their own vitality and longevity? The answer seems illogical. In wealthy nations, science points to social causes, but most economic investments are nowhere near those causes. Vast, expensive repair shops (such as medical centers and emergency services) are hard at work, but minimal facilities are available to prevent the damage. In the US at the moment, 40 million people are hungry, almost 600 000 are homeless, 2.3 million are in prisons and jails with minimal health services (70% of whom experience mental illness or substance abuse), 40 million live in poverty, 40% of elders live in loneliness, and public transport in cities is decaying. Today, everywhere, as the murder of George Floyd and the subsequent protests make clear yet again, deep structural racism continues its chronic, destructive work. In recent weeks, people in their streets across the US, many moved perhaps by the "moral law within," have been protesting against vast, cruel, and seemingly endless racial prejudice and inequality.

Decades of research on the true causes of ill health, a long series of pedigreed reports, and voices of public health advocacy have not changed this underinvestment in actual human well-being. Two possible sources of funds seem logically possible: either (a) raise taxes to allow governments to improve social determinants, or (b) shift some substantial fraction of health expenditures from an overbuilt, high-priced, wasteful, and frankly confiscatory system of hospitals and specialty care toward addressing social determinants instead. Either is logically possible, but neither is politically possible, at least not so far.

Neither will happen unless and until an attack on racism and other social determinants of health is motivated by an embrace of the moral determinants of health, including, most crucially, a strong sense of social solidarity in the US. "Solidarity" would mean that individuals in the US legitimately and properly can depend on each other for helping to secure the basic circumstances of healthy lives, no less than they depend legitimately on each other to secure the nation's defense. If that were the moral imperative, government—the primary expression of shared responsibility—would defend and improve health just as energetically as it defends territorial integrity.

Imagine, for a moment, that the moral law within commanded shared endeavor for securing the health of communities. Imagine, further, that the healing professions together saw themselves as bearers of that news and leaders of that change. What would the physicians, nurses, and institutions of US health care insist on and help lead, as an agenda for action? A short list follows, the first-order elements of a morally guided campaign for better health.

- US ratification of the basic human rights treaties and conventions of the international community. The US, alone among western democracies, has not ratified a long list of basic United Nations agreements on human rights, including the International Covenant on

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Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and the Convention on the Rights of Persons with Disabilities.

- Realization in statute of health care as a human right in the US. The number of uninsured individuals in the US is 30 million and increasing. No other wealthy nation on earth tolerates that.
- Restoring US leadership to reverse climate change. The US is nearly alone in its withdrawal from the Paris Agreement.
- Achieving radical reform of the US criminal justice system. The US has by far the highest incarceration rate in the world, and it imprisons people of color at 5 to 7 times the rate of white persons.
- Ending policies of exclusion and achieving compassionate immigration reform. State-sponsored violence, child abuse, and family separation due to US policies remain widespread at the southern border. Congress has failed repeatedly to enact immigration reform.
- Ending hunger and homelessness in the US. These are completely addressable issues.
- Restoring order, dignity, and equity to US democratic institutions and ensuring the right of every single person's vote to count equally. Science is under attack within crucial US agencies, voter suppression tactics continue, and the Electoral College, in which the weight of a citizen's vote varies by a factor of 70 from state to state, is profoundly undemocratic.[3]

To many US physicians and nurses who trained for, are committed to, and are experienced in addressing health problems in individual patients, this campaign list may seem out of character. However, if the moral law within dictated that the shared goal was health, and if logic counseled that science should be the guide to investment and that the endeavor must be communal, not just individual, then the list above would be a clear and rational to-do list to get started on well-being. The agenda includes, but is by no means restricted to, ensuring care for patients with illness and disease, no matter how they acquired their health conditions. But it ranges broadly into the most toxic current social circumstances, including institutional racism, that make people—especially people of color and of lower income—become ill and injured in the first place. It is an agenda for fixing the horrors of the subway map.

No sufficient source of power exists to achieve the investments required other than discovery of the moral law within, with all its "awe and wonder," as Kant wrote. The status quo is simply too strong. The vested interests in the health care system are too deep, proud, and understandably self-righteous; the economic and lobbying forces of the investment community and multinational corporations are too dominant; and the political cards are too stacked against profound change.

The moral force of professional leadership can also be powerful, once grounded and mobilized. A difficult question follows: ought the health professions and their institutions take on this redirection? To use a recent vernacular, what is health care's "lane"?

Honest and compassionate people disagree about health care's proper role in improving social conditions, countering inequity, and fighting against structural racism. Some say it should remain focused on the traditional: caring for illness. Others (this author among them) believe that it is important and appropriate to expand the role of physicians and health care organizations into demanding and supporting societal reform.

The angry, despairing victims of inequity, and their supporters, marching in the streets of the US despair in part because they and their parents and their grandparents and generations before have been waiting far too long. They find no moral law in evidence, no social contract bilaterally intact. They do not believe in promises of change, because for too long people remain hungry and homeless, with the doors of justice so long closed.

What specific actions can individuals and organizations take toward the morally guided campaign sketched above? Physicians, nurses, and other health care professionals can speak out, write opinion pieces, work with community organizations devoted to the issues listed, and, most important of all, vote and ensure that colleagues vote on election days. Organizations can also act: they can contact local criminal justice authorities and develop programs to ensure proper care for incarcerated people and create paths of reentry to work and society for people leaving incarceration. They can identify needs for housing and food security in local communities, set goals for improvement, and manage progress as for any health improvement project. They can pay all staff wages sufficient for healthy living, which is far above legal minimum wages. They can lobby harder for universal health insurance coverage and US participation in human rights conventions than for the usual agendas of better reimbursement and regulatory relief. They can examine and work against implicit and structural racism. They can do whatever it takes to ensure universal voter turnout for the entire health care workforce.

Healers are called to heal. When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so. Improving the social determinants of health will be brought at last to a boil only by the heat of the moral determinants of health.

ARTICLE INFORMATION

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VIEWPOINT

COVID-19 and Racial/Ethnic Disparities

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Editorial page 2478

The novel SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) has led to a global pandemic manifested as coronavirus disease 2019 (COVID-19), with its most severe presentation being acute respiratory distress syndrome leading to severe complications and death. Select underlying medical comorbidities, older age, diabetes, obesity, and male sex have been identified as biological vulnerabilities for more severe COVID-19 outcomes.[1] Geographic locations that reported data by race/ethnicity indicate that African American individuals and, to a lesser extent, Latino individuals bear a disproportionate burden of COVID-19–related outcomes. The pandemic has shone a spotlight on health disparities and created an opportunity to address the causes underlying these inequities.[2]

The most pervasive disparities are observed among African American and Latino individuals, and where data exist, American Indian, Alaska Native, and Pacific Islander populations. Preliminary prevalence and mortality estimates in multiple geographic areas, which are being tracked daily, show a consistent pattern of racial/ethnic differences. In Chicago, Illinois, rates of COVID-19 cases per 100 000 (as of May 6, 2020) are greatest among Latino (1000), African American/black (925), "other" racial groups (865), and white (389) residents. Mortality rates are substantially higher among African American/black individuals (73 per 100 000) compared with Latino (36 per 100 000) and white (22 per 100 000) residents.[3] New York City (as of May 7, 2020) reported greater age-adjusted COVID-19 mortality among Latino persons (187 per 100 000) and African American individuals (184 per 100 000), compared with white (93 per 100 000) residents.[4]

> The pandemic presents a window of opportunity for achieving greater equity in the health care of all vulnerable populations.

These reports signal that prevention efforts, such as shelter-in-place, might have less benefit among African American and Latino populations. Why would racial/ethnic minorities or economically disadvantaged people of any background be more susceptible to becoming infected or developing severe disease and dying? What are possible underlying causes of differential outcomes of a highly infectious respiratory illness in disadvantaged populations?

The underlying causes of health disparities are complex and include social and structural determinants of health, racism and discrimination, economic and educational disadvantages, health care access and quality, individual behavior, and biology. Examining possible precedents, mortality from influenza and pneumonia as causes of death for persons aged 65 years or older are lower among African American and Latino individuals compared with white persons.[5,6] In contrast, historically, pulmonary tuberculosis disproportionately affects persons of lower socioeconomic status, but there is no convincing evidence that rates of tuberculosis reactivation are influenced by socioeconomic status.

Understanding the reasons for the initial reports of excess mortality and economic disruption related to COVID-19 among health disparity populations may allow the scientific, public health, and clinical community to efficiently implement interventions to mitigate these outcomes, particularly if substantial disease emerges in the fall of 2020 or beyond.

The most common explanations for disproportionate burden involve 2 issues. First, racial/ethnic minority populations have a disproportionate burden of underlying comorbidities. This is true for diabetes, cardiovascular disease, asthma, HIV, morbid obesity, liver disease, and kidney disease, but not for chronic lower respiratory disease or COPD. Second, racial/ethnic minorities and poor people in urban settings live in more crowded conditions both by neighborhood and household assessments and are more likely to be employed in public-facing occupations (eg, services and transportation) that would prevent physical distancing. As stated by Yancy,[2] "social distancing is a privilege" and the ability to isolate in a safe home, work remotely with full digital access, and sustain monthly income are components of this privilege. COVID-19–related exposures are also exacerbated by a greater propensity to be homeless and reside in neighborhoods with substandard air quality.[7]

The possibility that genetic or other biological factors may predispose individuals to more severe disease and higher mortality related to COVID-19 is an empirical question that needs to be addressed. These explanations must be considered in the full context of systemic factors such as historical and ongoing discrimination, and chronic stress and its effect on hypothalamic-pituitary-adrenal axis and immunologic functioning. As more data emerge, there will likely be evidence of racial/ethnic health disparities due to differential loss of health insurance, poorer quality of care, inequitable distribution of scarce testing and hospital resources, the digital divide, food insecurity, housing insecurity, and work-related exposures. There is an obligation to address these predictable consequences with evidence-based interventions.

Public policies have the power to enhance health and also exacerbate health disparities. Health interventions that are adapted for local contexts and community

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characteristics are more effective than standard approaches.[8] For example, culturally adapted mental health services are more effective for people of color compared with standard services.[8] Thus, uniform public health recommendations related to physical distancing or sheltering-in-place that fail to consider local contexts and population characteristics may be less effective (often for reasons beyond individual control) among African American, Latino, American Indian, and Alaska Native populations, and economically disadvantaged people in general. Strategies that are culturally appropriate and community competent and that consider the nuances of population, community, family, and individual differences have a vital role in reducing health disparities, promoting health equity, and improving population health. Such approaches require a deep understanding of community, consideration of local data-driven approaches, diverse and equitable partnerships across sectors, messaging that resonates with the target audience(s), and the implementation of policies that support the health of all individuals in the US.

Available data on racial disparities in COVID-19 incidence and mortality are currently limited, but expanding. Collecting and reporting accurate data on demographic and social determinants of health depends on clinical systems reporting to local and state public health departments and to the Centers for Disease Control and Prevention. These data may be incomplete, exclude unconfirmed cases, and obscure racial/ethnic disparities. Moreover, current reports exclude patients who sought COVID-19 testing but whose symptoms did not meet the screening threshold or were otherwise deemed ineligible, and those who did not seek help (eg, due to health care system distrust, lack of insurance, fear of medical costs, or lack of paid sick leave). As such, the current reports may not generalize to the population, underestimating or overestimating proportions of confirmed COVID-19 cases by group.

Representative epidemiological data from ongoing or planned studies using weighted random sampling, standardized racial/ethnic categories, and widespread and accessible testing are needed to advance the science. In addition, given initial indications, potential racial/ethnic differences in post–COVID-19 recovery efforts need to be considered. Health care disparities, generally, and those related to COVID-19 require swift attention and amelioration, as the resultant societal burdens are costly to everyone.

Scientific studies that result in improved understanding of COVID-19 may lead to more targeted and effective community-based and health care system–based interventions. The collection and dissemination of COVID-19 data by race/ethnicity remain critically important to guide policy, health care, prevention, and intervention efforts. This novel disease creates an unfortunate opportunity to conduct ecological experiments focused on the etiology and depth of health disparities in a manner unobserved since this area of science emerged, especially as states begin to relax risk-mitigation policies. Rigorous research in representative samples is needed to identify the roots of inequities beyond the individual level, also examining community, policy, health care system, and society-level determinants (and their intersections).

Studies are needed to understand the influence of state and local mitigation policies on differences in health services utilization and health outcomes, the role of community-level protective factors and interventions in mitigating the adverse consequences of the sector disruptions caused by the outbreak, the influence of COVID-19–related racism and other types of discrimination, and the role of social determinants of health in influencing preventive health behaviors.

Studies are also needed to investigate the short-term and long-term effects of COVID-19 on health and how differential outcomes can be reduced in anticipation of subsequent waves of cases. The National Institute on Minority Health and Health Disparities (NIMHD) at the National Institutes of Health (NIH) is soliciting such studies. In addition, NIMHD will focus on community-engaged interventions to implement point-of-care testing for COVID-19 infection in health disparity and other vulnerable populations by leveraging existing NIH-funded networks, community health centers, and local organizations.

These efforts will help pave the way for therapeutic and vaccine trials that must be inclusive of diverse participants at high risk. These studies are also needed to guide the science of community-engaged intervention development, implementation, and evaluation and lay the foundation for a systemwide goal of decreasing health disparities beyond the detrimental effects of COVID-19. The pandemic presents a window of opportunity for achieving greater equity in the health care of all vulnerable populations.

ARTICLE INFORMATION

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Update on APM3/4/5 and FFSE

- APM3 Sustainability
  - Concern that APM3 (e.g., PPS rate) will be threatened by budget cuts
  - PPS rate, which is identical or close to APM3, is protected by federal law
- APM4/5
  - Ongoing conversations around APM5 (new APM5 contract)
  - HCA proposed new structure has FFSE rule and switch to make HCA paying only enhancements
  - Key changes related to changes to payment methodology and proposed changes to quality measures, among others
  - Looking to move forward with APM5 with ”compromise” (more to come) proposed by FQHC Committee Workgroup
- FFSE rule
  - Proposed rule language released on 7/7
  - Written comments due on 7/27

Proposed Response

- June 20 In-Person FQHC Committee Meeting
  - Awaiting guidance from HCA on whether they want to move forward with APM5
  - Discuss proposed “compromise” that would limit impact of FFSE rule
- Develop and communicate formal opposition to FFSE rule
- Attempt to maintain APM program with APM5
- Seek to clarify:
  - “Safe harbors” in APM5 to shift payment to quality/incentives that are excluded from actual MCO payment calculation
  - Health centers can shift pharmacy out of blended PMPMs

AMENDATORY SECTION (Amending WSR 17-12-016, filed 5/30/17, effective 7/1/17)

WAC 182-548-1400 Federally qualified health centers—Payment methodologies. (1) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the medicaid agency's payment methodology for federally qualified health centers (FQHC) was a prospective payment system (PPS) as authorized by 42 U.S.C. 1396a (bb)(2) and (3).

(2) For services provided beginning January 1, 2009, FQHCs have the choice to be reimbursed under the PPS or to be reimbursed under an alternative payment methodology (APM), as authorized by 42 U.S.C. 1396a (bb)(6). As required by 42 U.S.C. 1396a (bb)(6), payments made under the APM will be at least as much as payments that would have been made under the PPS.

(3) The agency calculates FQHC PPS encounter rates as follows:

(a) Until an FQHC's first audited medicaid cost report is available, the agency pays an average encounter rate of other similar FQHCs within the state, otherwise known as an interim rate.

(b) Upon availability of the FQHC's first audited medicaid cost report, the agency sets FQHC encounter rates at one hundred percent of its total reasonable costs as defined in the cost report. FQHCs receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then increased each January 1st by the percent change in the medicare economic index (MEI).

(4) For FQHCs in existence during calendar years 1999 and 2000, the agency sets encounter rates prospectively using a weighted average of one hundred percent of the FQHC's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The agency adjusts PPS base encounter rates to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 182-548-1500.

(b) PPS base encounter rates are determined using audited cost reports, and each year's rate is weighted by the total reported encounters. The agency does not apply a capped amount to these base encounter rates. The formula used to calculate base encounter rates is as follows:

$$\text{Specific FQHC Base Encounter Rate} = \frac{(\text{Year 1999 Rate} \times \text{Year 1999 Encounters}) + (\text{Year 2000 Rate} \times \text{Year 2000 Encounters})}{(\text{Year 1999 Encounters} + \text{Year 2000 Encounters}) \text{ for each FQHC}}$$

(c) Beginning in calendar year 2002 and any year thereafter, encounter rates are increased by the MEI for primary care services, and adjusted for any increase or decrease in the FQHC's scope of services.

(5) The agency calculates the FQHC's APM encounter rate for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) The APM utilizes the FQHC base encounter rates, as described in subsection (4)(b) of this section.

(b) Base rates are adjusted to reflect any approved changes in scope of service in calendar years 2002 through 2009.

(c) The adjusted base rates are then increased by each annual percentage, from calendar years 2002 through 2009, of the IHS Global Insight index, also called the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

(6) This subsection describes the encounter rates that the agency pays FQHCs for services provided during the period beginning April 7, 2011, and ending June 30, 2011. On January 12, 2012, the federal Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment (SPA) containing the methodology outlined in this section.

(a) During the period that CMS approval of the SPA was pending, the agency continued to pay FQHCs at the encounter rates described in subsection (5) of this section.

(b) Each FQHC has the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM, as described in (c) of this subsection.

(c) The revised APM uses each FQHC's PPS rate for the current calendar year, increased by five percent.

(d) For all payments made for services provided during the period beginning April 7, 2011, and ending June 30, 2011, the agency will recoup from FQHCs any amount in excess of the encounter rate established in this section. This process is specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-002).

(7) This subsection describes the encounter rates that the agency pays FQHCs for services provided on and after July 1, 2011. On January 12, 2012, CMS approved a SPA containing the methodology outlined in this section.

(a) Each FQHC has the choice of receiving either its PPS rate as determined under the method described in subsection (3) of this

section, or a rate determined under a revised APM, as described in (b) of this subsection.

(b) The revised APM is as follows:

(i) For FQHCs that rebased their rate effective January 1, 2010, the revised APM is their allowed cost per visit during the cost report year increased by the cumulative percentage increase in the MEI between the cost report year and January 1, 2011.

(ii) For FQHCs that did not rebase their rate effective January 1, 2010, the revised APM is based on their PPS base rate from 2001 (or subsequent year for FQHCs receiving their initial FQHC designation after 2002) increased by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and by the cumulative percentage increase in the MEI from calendar years 2009 through 2011. The rates were increased by the MEI effective January 1, 2012, and will be increased by the MEI each January 1st thereafter.

(c) For all payments made for services provided during the period beginning July 1, 2011, and ending January 11, 2012, the agency will recoup from FQHCs any amount paid in excess of the encounter rate established in this section. This process is specified in emergency

rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-022).

(d) For FQHCs that choose to be paid under the revised APM, the agency will periodically rebase the encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for FQHCs that are reimbursed under the APM.

(e) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) This subsection describes the payment methodology that the agency uses to pay participating FQHCs for services provided beginning July 1, 2017.

(a) Each FQHC may receive payments under the APM described in subsection (7) of this section, or receive payments under the revised APM described in this subsection.

(b) The revised APM is as follows:

(i) The revised APM establishes a budget-neutral, baseline per member per month (PMPM) rate for each FQHC. The PMPM rate accounts for enhancement payments in accordance with the definition of enhancements in WAC 182-548-1100. For the purposes of this section, "budget-neutral" means the cost of the revised APM to the agency will not

exceed what would have otherwise been spent not including the revised APM on a per member per year basis.

(ii) The agency pays the FQHC a PMPM payment each month for each managed care client assigned to them by an MCO.

(iii) The agency pays the FQHC a PMPM rate in addition to the amounts the MCO pays the FQHC. The agency may prospectively adjust the FQHC's PMPM rate for any of the following reasons:

(A) Quality and access metrics performance.

(B) FQHC encounter rate changes.

(iv) In accordance with 42 U.S.C. 1396a (bb)(5)(A), the agency performs an annual reconciliation.

(A) If the FQHC was underpaid, the agency pays the difference, and the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

(B) If the FQHC was overpaid, the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-548-1400, filed 5/30/17, effective 7/1/17; WSR 15-11-008, § 182-548-1400, filed 5/7/15, effective 6/7/15; WSR 14-14-056, § 182-548-1400, filed 6/26/14, effective 8/1/14. Statutory Authority: RCW 41.05.021. WSR 12-16-060, § 182-548-1400, filed 7/30/12, effective

8/30/12. WSR 11-14-075, recodified as § 182-548-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1400, filed 4/7/10, effective 5/8/10.]

AMENDATORY SECTION (Amending WSR 17-12-016, filed 5/30/17, effective 7/1/17)

WAC 182-548-1450 Federally qualified health centers—General payment information. (1) The agency limits encounters to one per client, per day except in the following circumstances:

(a) The visits occur with different health care professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(2) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(3) Fluoride treatment and sealants must be provided on the same day as an encounter-eligible service. If provided on another day, the rules for non-FQHC services in subsection (4) of this section apply.

(4) Payments for non-FQHC services provided in an FQHC are made on a fee-for-service basis using the agency's published fee schedules. Non-FQHC services are subject to the coverage guidelines and limitations listed in chapters 182-500 through 182-557 WAC.

(5) For clients enrolled with a managed care organization (MCO), covered FQHC services are paid for by that plan.

(6) For clients enrolled with an MCO, the agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

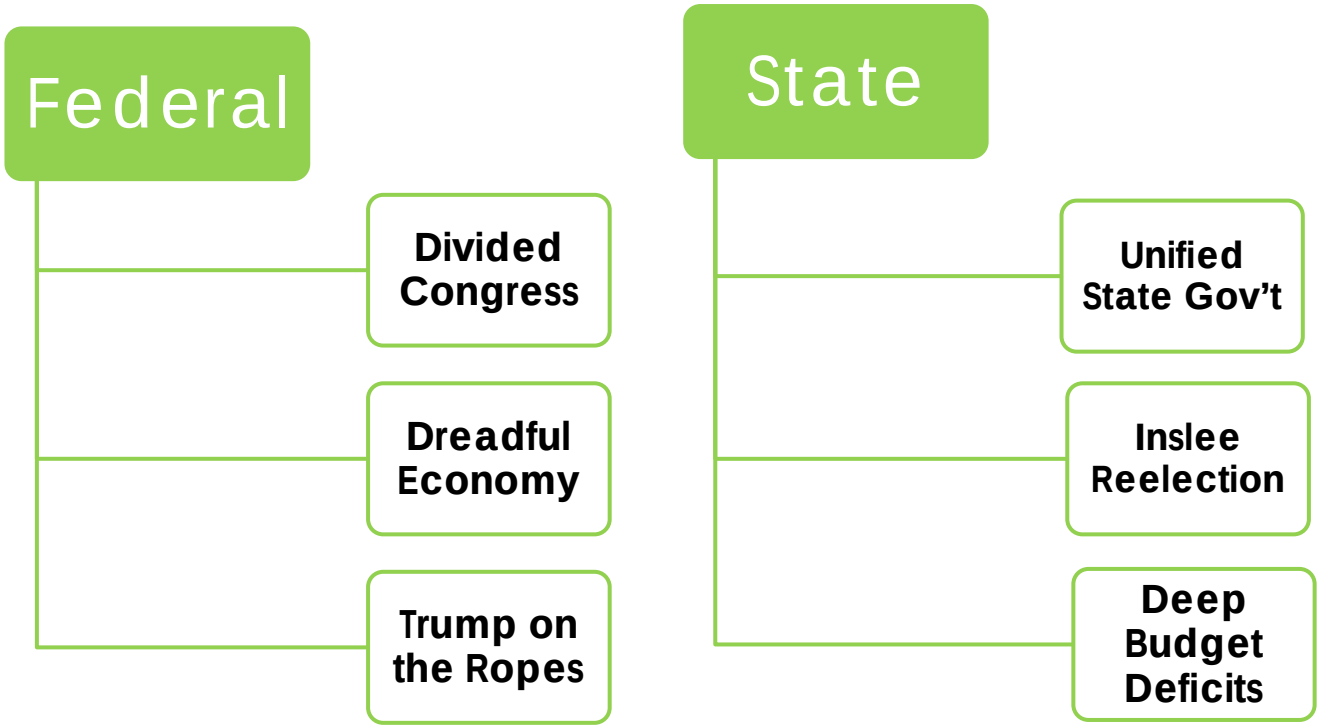
(b) To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments. For each FQHC, the agency ((~~will~~)) compares the amount ((~~actually~~)) paid in enhancement payments to the amount determined by the following formula: (Managed care encounters times encounter rate) less ((~~fee-for-service equivalent of~~)) actual MCO payments for FQHC services. If the FQHC has been overpaid, the agency ((~~will~~)) recoups the appropriate amount. If the FQHC has been underpaid, the agency ((~~will~~)) pays the difference.

(7) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

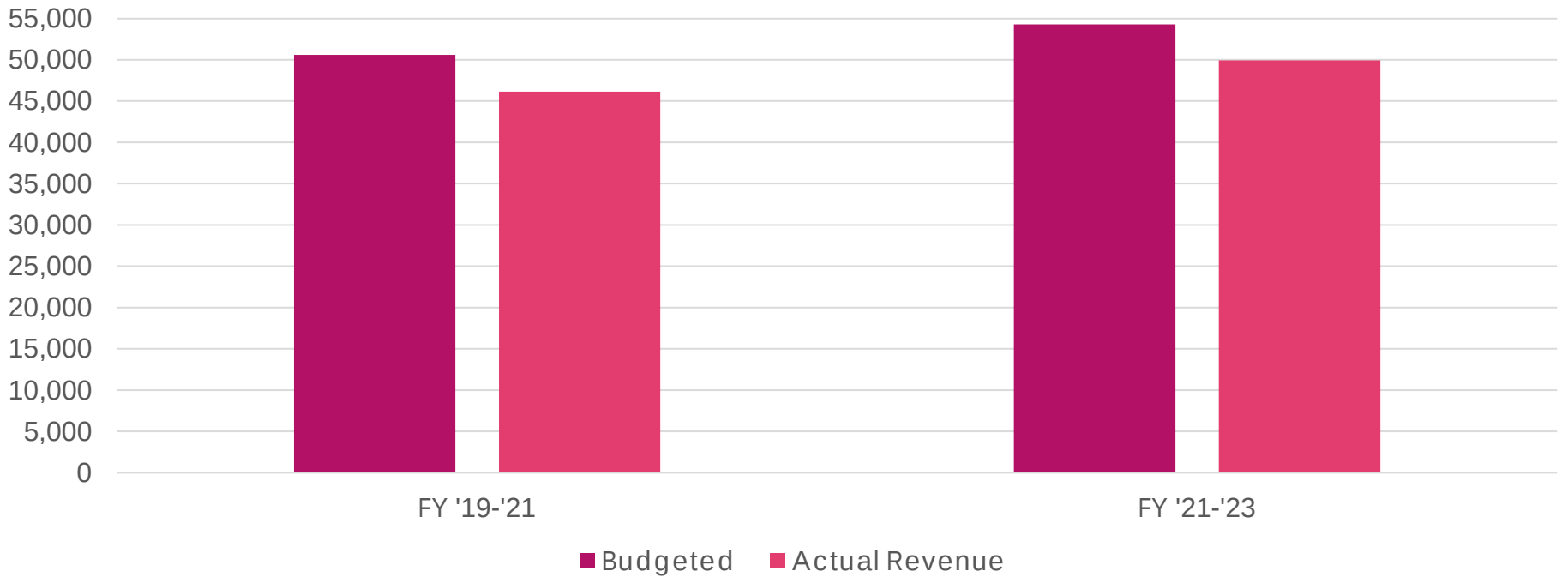
[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-548-1450, filed 5/30/17, effective 7/1/17.]

State and Federal Policy Updates

COVID-19 Political Situation



Washington State Budget Shortfall



Washington State Budget Shortfall

Forecast changes: Near General Fund-State, 2019-2021 biennium, cash basis

$Millions	February 2020 Forecast*	Non-economic Change**	Forecast Change	June 2020 Forecast	Total Change#
General Fund-State	$50,611	$125	($4,607)	$46,129	($4,482)
Education Legacy Trust Account	$1,447	$0	($76)	$1,372	($76)
WA Opportunity Pathways Account	$281	$0	$18	$299	$18
Total Near GF-S	**$52,339**	**$125**	**($4,664)**	**$47,800**	**($4,539)**

*Forecast for the 2019-21 biennium adopted February 19, 2020
**Revenue and budget-driven revenue changes from the 2020 legislative session subsequent to the February forecast.
Detail may not add to total due to rounding

WASHINGTON STATE ECONOMIC AND REVENUE FORECAST COUNCIL

Revenue Review
June 17, 2020

Slide 20

Forecast changes: Near General Fund-State, 2021-23 biennium, cash basis

$Millions	February 2020 Forecast*	Non-economic Change**	Forecast Change	June 2020 Forecast	Total Change#
General Fund-State	$54,291	$213	($4,570)	$49,935	($4,357)
Education Legacy Trust Account	$1,086	$0	$6	$1,092	$6
WA Opportunity Pathways Account	$312	$0	$3	$315	$3
Total Near GF-S	**$55,690**	**$213**	**($4,561)**	**$51,342**	**($4,348)**

*Forecast for the 2021-23 biennium adopted February 19, 2020
**Revenue and budget-driven revenue changes from the 2020 legislative session subsequent to the February forecast.
Detail may not add to total due to rounding

WASHINGTON STATE ECONOMIC AND REVENUE FORECAST COUNCIL

Revenue Review
June 17, 2020

Slide 21

Washington State Budget Shortfall

State Response

- State Hiring Freeze and State Employee Salary Increase Delay
- Agency Budget Cuts Exercise
- Federal Assistance Requests
- Special Budget Session, Likely November 2020
- Revenue Votes - 2021

CHC Preparedness

- Federal Assistance Request – Emergency Funding *and* State Fiscal Relief
- Key Programs Survey
- Medicaid Adult Dental Coalition and Media Work
- Other Coalitions as Needed

Washington State Budget Shortfall

Open Questions

- **What Relief Can the State Expect from the Federal Government?**
  - **Will a different administration take a different line on fiscal stimulus?**
- **What Revenue Options is the Legislature Willing to Consider?**
- **What is the Medium-Term Impact of COVID-19:**
  - **Cycle of consumer-facing business opening and closing?**
  - **Vaccine development?**

Key Program Survey Results

- Placeholder slide – to be filled in later

Key Program Survey Results

- Placeholder slide – to be filled in later

Key Program Survey Results

- **Do these results seem to point toward a set of priorities in a cuts-focused environment?**
- **Are there other programs, services, or dynamics we should be considering?**
- **Should the health center system participate in broader efforts around raising revenue?**
  - **If so, what kind of standards should we adopt for assessing revenue sources?**