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Community engagement is a key component of health equity work because it fosters trust and mutual respect, unearths unforeseen or unintended barriers to health, and improves efficacy by ensuring programs respond to the experiences of the people they impact. Lessons learned from COVID-19 outreach and an increased understanding of the importance of community engagement in designing successful health initiatives has led several states to strengthen their community engagement efforts.

Yet, there is little documentation of how to successfully engage program enrollees, translate engagement into policy change, or resolve challenges related to the resource-intensive nature of engagement. This issue brief provides two case studies highlighting work in Virginia and Colorado to meet these challenges. Each state has invested in coordinated community engagement strategies that amplify the voices of those directly impacted by Medicaid and leverage their input to drive improvements. This pioneering work offers practical examples of how to structure community engagement to foster participation and improve program outcomes.

“Community engagement means more than being present in a space. If we want to be intentional about change, we also need to be intentional in valuing lived experience.”

– Virginia Department of Medical Assistance Services staff.

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Terms to Know

Health equity means everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social barrier/factor.

Transformational community engagement is a collaborative process between organizations/institutions and impacted communities to influence decisions and actions through the mutually beneficial and bidirectional exchange of resources, expertise, and information. Engagement is centered on relationships and grounded in reciprocated trust, value, and accountability that is ideally cultivated in partnership with the community. The scope of engagement can vary from a single request for input to ongoing collaboration.

Transactional community engagement asks communities for input on near-final products or narrow questions and is often characterized by single interactions. This frequently results in superficial changes to a policy or program, changes that exacerbate inequities or fail to meet community needs, or no change at all. While transactional engagement requires fewer resources, it also runs the risk of reinforcing a perception that the state is “checking the box” by consumers, results in minimal learning for the state and fatigue among community partners and advocates, and devalues the feedback obtained.

Outreach refers to activities and processes related to raising awareness, disseminating information, or training external partners to connect their constituents or members with a service or program (e.g., Medicaid enrollment services). Outreach is more one-sided, with a goal of conveying clear messages across diverse populations. Effective outreach is a part of strategic communication. Both communication and outreach can be improved when paired with community engagement to align with community needs, priorities, and preferences.

Background

Community engagement goals include, but are not limited to:

- Creating opportunities for exchanges of ideas to understand community needs
- Identifying gaps and barriers in policy design and implementation
- Gathering feedback to improve process, quality, outcomes, and messaging
- Sustaining equitable changes that improve the experiences of those directly impacted

Please refer to the issue brief [Transformational Community Engagement to Advance Health Equity](#) for more information on community engagement design, a framework for assessing community engagement, and strategies and tactics for implementing community engagement.

The case studies in this issue brief describe community engagement efforts by Medicaid programs in Virginia and Colorado. Both states engage members in councils designed to improve processes and outcomes in each state's Medicaid program. The descriptions below were informed by semi-structured interviews with program staff and highlight strategies each state uses to advance health equity in the context of consumer engagement initiatives.

Virginia Department of Medical Assistance Services (DMAS)

Virginia's Department of Medical Assistance Services (DMAS) serves 1.25 million Medicaid enrollees and 140,000 children and pregnant people enrolled in the state's Children's Health Insurance Program. The following section elevates strategies DMAS has instituted or is exploring to strengthen its member engagement initiatives.

Strategy: Invest in Internal Capacity to Support and Carry Out Consumer Engagement Initiatives

Engagement work can be high impact and rewarding and, to be successful, requires sufficient staff and internal resources.

One-third of the member engagement unit of Virginia's Medicaid program consists of part-time, wage-based Community Outreach Coordinators. These two staff members are intentionally hired from the community and job requirements are tailored to accommodate their needs. For example, to create flexibility for individuals working multiple jobs and/or nontraditional working hours the agency works with team members to find a flexible schedule that meets both the needs of those being served and the staff.

At present, the role of these staff is to expand the agency's capacity to build relationships with its members and the wider community. Their activities include supporting evaluation of measurable outcomes, strengthening the channels for member feedback, and strategic planning for the sustainability of community engagement workstreams. Recognizing the inextricable link between community engagement efforts, workforce development, and valuing lived experience, the state's goal is to eventually hire these staff as a part of the agency's full-time workforce.

Strategy: Conduct a Landscape Analysis to Document Existing Work and Establish a Cross-Agency Workgroup to Foster Alignment and Address Gaps

Virginia's Medicaid program has historically focused on member outreach within the context of strategic communications to improve education and dissemination of information. At present, the agency is building a community engagement strategy that includes and distinguishes between outreach and engagement initiatives.

The community outreach and member engagement efforts within the agency are not always connected across departments or initiatives. Therefore, mapping existing efforts has been the first step toward implementing a coordinated community engagement strategy. Virginia's Medicaid program is in the initial stages of building an internal group to establish a collective understanding of what member engagement means and looks like across the agency. This process will include identifying the entities engaged in this work at the agency and establishing a common definition of member engagement.

Ultimately, this coalition would be expected to provide feedback on and support the agencywide community engagement goals to encourage alignment of all community engagement activities regardless of which unit is spearheading the effort. The internal community engagement coalition will provide a vehicle to share transferable learnings and elevate synergies within the agency.

Strategy: A Robust Member Advisory Council

Size: 11-person committee.

Composition: Exclusively Medicaid members.

Term Limit: One-year term, with option to serve a total of two terms.

Frequency: Quarterly meetings.

Financial Compensation: None.

In-Kind Compensation: Travel, meals, and accommodations for out-of-town members.

Policies and Procedures: <https://www.dmas.virginia.gov/media/4498/dmas-mac-policies-procedures.pdf>

DMAS' Member Advisory Committee (MAC) has been active for four years. The MAC has evolved over time and its role has been solidified. The current charter emphasizes the MAC's role as an advisory group to the Medicaid Director to provide "insights and recommendations" to affect tangible change for Virginia's Medicaid population.

Strategy: Require Regular and Ongoing Attendance of Executive Leadership at MAC Meetings

Virginia's MAC serves as an advisory group to the state Medicaid director. The director reinforces the influence of the MAC by attending all meetings. This is an intentional and overt signal to members that agency leadership is listening to and addressing their feedback. In addition to formal meetings, agency staff offer several channels for MAC members to provide feedback, for example through email and individual follow-up calls. Issues raised by MAC members that are not immediately resolvable are added to leadership agendas across the agency to include executive leadership. Overall, the Medicaid director has set the tone of the MAC by validating the importance of the issues raised by the MAC in communication with other state leaders and through concrete policy change.

Strategy: Promote Accountability Through Transparent Tracking and Reporting

Agency staff log all issues raised by MAC members. Issues are either resolved in subsequent meetings or, for issues that require more time to address, a status update is provided. The MAC Tracker can be found [here](#). This digital paper trail serves as an accountability mechanism ensuring members have a clear understanding of, if and how their participation yields change.

One example of the MAC's impact on Medicaid processes is DMAS' commitment to limit the number of touchpoints required for a member to resolve an issue or inquiry. When the agency rolled out behavioral health enhancements, members shared their experiences of being transferred to multiple departments when trying to reach staff who could address their questions. This prompted the director to ask for data on the average number of staff a member would interact with before resolving an issue. Based on the initial MAC feedback and the subsequent data analysis, the director established an ongoing practice that members should not have to engage with more staff than absolutely necessary regarding any issue. More than three touch points within the agency have been identified as causing heightened frustration; so, within the agency each staff member tries to do as much of the leg work as possible to avoid members being "bounced around." In practice, when a member reaches out with a question or concern, if they are referred or transferred to additional agency staff, each one is even more committed to ensuring the situation is resolved, following up with any additional staff necessary, or gathering the information necessary for resolving the member's need or question. The standard/goal is for members to have no more than three internal touchpoints unless absolutely necessary. This practice was established by the second MAC meeting after the issue was raised, indicating an ability to quickly change a process in response to member feedback. Ultimately, this process change led to an improvement in response time.

Strategy: Intentionally Recruit MAC Participants to Reflect Diversity of Member Population

Staff and stakeholders who have direct interaction with members submitting Medicaid-related complaints or feedback about their experience with the agency or managed care plans are encouraged to provide information about joining Virginia's Medicaid MAC to the members they engage with. This approach has yielded member candidates for the MAC. In order to further diversify the pool of applicants and better represent members across the Commonwealth of Virginia, the MAC has developed new recruitment strategies that tap into Medicaid member engagement networks. Leveraging Medicaid demographic data¹ to benchmark representativeness, DMAS is in the process of building a campaign to share MAC application information with external stakeholders. This is one step in progressing towards a larger pool of applicants and a committee that more closely reflects the demographics of the Medicaid member population.

Strategy: Provide Recognition of Participation

Virginia's DMAS does not offer direct compensation for participation on the MAC due to state limitations; however, transportation, hotel stays,² and meals are provided. Member profiles are featured on the Medicaid [website](#) and in newsletters (with members' consent) and members receive certificates at the end of their term. Members have indicated that seeing changes in response to their feedback makes them feel valued.

Colorado Department of Health Care Policy & Financing (HCPF)

The Colorado Department of Health Care Policy and Financing (HCPF) serves 1,609,630 Medicaid enrollees and 49,635 children and pregnant people enrolled in [Child Health Plan Plus](#) (CHP+, Colorado's Children's Health Insurance Program). HCPF's mission is to improve healthcare equity, access, and outcomes for the people it serves while saving Coloradans money on healthcare and driving value for Colorado. Community engagement is seen as key to achieving this mission. This case study highlights community engagement strategies at the agency level and details the practices of two active Medicaid member advisory councils.

Strategy: Collaborate With Members to Reach People With Limited English Language Proficiency

Communicating with members who have limited English language proficiency is an ongoing challenge. Members' lack of trust and comfort in responding to questions about their preferred language poses a significant challenge to meeting members' needs. In response, Colorado's Medicaid program has embraced a transcreation framework,³ which focuses on communication based on culture and preferences for receiving information. For example, HCPF has found that a standard memo on a specific topic (e.g., changes to eligibility) may be less accessible to Spanish-speaking communities than, for example, partnering with trusted community leaders to share information.

According to the U.S. Census, 16.4% of the total population of Colorado lives in a household in which a language other than English is spoken. Of those households, 5.5% or 292,632 individuals reported that they speak English less than "very well." It is also important to note that these are considered low estimates due to fear and distrust among immigrant communities. Colorado's Medicaid program recognizes the need to build internal capacity to serve the large number of enrollees with limited English language proficiency. In response, Colorado is exploring the possibility of hiring in-house, bilingual, bi-cultural staff to support coordination of translation efforts and integration of lived experience across engagement efforts. For Spanish-speaking members, these staff would support ongoing engagement with community-based organizations and community members who speak Spanish, provide consultation on language access equity within the contracting process, serve as the Spanish-speaking media liaison for HCPF, develop relationships with Spanish-language publications, and coordinate the solicitation and implementation of Spanish-language member feedback.

Strategy: Collaborate With and Compensate Community-Based Organizations

Colorado elevates the critical role of sustained, trusted relationships with community-based organizations (CBOs) in the context of member engagement. Through the community ambassador program Colorado will provide funding to participating CBOs and to community ambassadors to help engage with members who speak Spanish and Vietnamese (Colorado's two most commonly spoken languages other than English). Ambassadors will lead conversations, interviews, and focus groups in members' preferred languages both in person and virtually, providing accessible spaces for individuals to share their experiences through local entities they know and trust. CBOs across the state are being recruited to participate with the goals of improving Health First Colorado's communication with members and learning about members' challenges with the program's benefits and services. This model is being refined continually and aims to leverage outreach coordinators to serve as community liaisons, building and maintaining relationships.

Additional Resources: Colorado Department of Public Health and Environment's [Community Engagement Toolkit](#) and the Colorado Equity Alliance's [Community Partnership Principles Guide](#).

Strategy: Member Experience Advisory Committee

Size: 20-person committee.

Composition: Exclusively Medicaid or Child Health Plan Plus (CHP+) members or parents/caregivers of members.

Term Limit: One-year term, with option to serve a total of two terms.

Frequency: Monthly meetings.

Financial Compensation: \$25 per hour gift card.

In-Kind Compensation: Travel, meals, and accommodation for out-of-town members.

Policies and Procedures: <https://hcpf.colorado.gov/meac>

Colorado's Member Experience Advisory Committee (MEAC) has been in effect since 2015. A space exclusively for Medicaid and CHP+ enrollees helps account for power dynamics and ensures member voices are heard. The MEAC also functions as a pipeline to other agency engagement opportunities, such as workgroups that include providers, community-based organizations, and advocates. Participation in the MEAC prepares members to engage more comfortably with other stakeholders.

Strategy: Financial Compensation

Members participating in Colorado's MEAC have received a \$40 gift card for each three-hour meeting they attended, which will soon increase to \$25 per hour to align with a living wage. Any amount over \$600 annually would require issuing a 1099. The state is exploring ways of exempting stipends from income for eligibility purposes. In the meantime, members are notified that gift cards count as income and they can opt out at any time.

Based on member feedback, the [HCPF website](#) and [YouTube page](#) also host MEAC member bios, headshots, and videos as a non-monetary form of recognition. Members expressed their desire for public visibility, which was identified as valuable in the context of their personal career advancement and other opportunities where members wanted to verify their participation in the MEAC.

Strategy: Commit to Ongoing Public Evaluation

Colorado administers multiple feedback methods to gather qualitative and quantitative data on members' experiences of each meeting and ideas for future meetings. This includes administering a survey at each meeting. Results from the surveys are fed back to members at the top of each meeting to prompt a discussion on what is and is not working and gauge members' comfort when participating in the space. Colorado's MEAC survey questions can be found in the Appendix.

Each MEAC meeting agenda includes a time for self-reflection through a “rose, thorn, unicorn” exercise in which members share their “rose”—one thing they liked, their “thorn”—one thing they did not like or found challenging, and their “unicorn”—something that surprised them.

Colorado also asks each staff presenter to fill out an evaluation noting any tangible changes or plans resulting from MEAC feedback. Staff administering the MEAC regularly follow up to gather information from their colleagues on implementation of these changes.

Strategy: Map Member Experience

MEAC members were engaged in the development of a Colorado Member Journey Map to determine the points of contact most salient for member experience. Member points of interaction with the Medicaid system identified from this process (e.g., applying for benefits, learning what services are covered, finding a doctor, seeing a doctor, working on health goals) determined priority areas for future quality improvement initiatives.

Testing member communications was one outcome from the member journey map. MEAC members engaged in weekly focus groups to test and improve the accessibility and community-readiness of case-related notice letters, website language, and email text. Based on the intensive information gathered from this process, Colorado has cultivated a robust repository of feedback. Colorado now aims to apply the lessons learned to all future communications at the point of development.

Strategy: Maternity Advisory Committee

Size: 20-person committee.

Composition: Current or previous Medicaid members.

Term Limit: One-year term, with option to serve a total of two terms.

Frequency: Monthly meetings.

Financial Compensation: \$25 gift card per meeting.

In-Kind Compensation: Travel, meals, and accommodations for out-of-town members.

Policies and Procedures: <https://hcpf.colorado.gov/maternity-advisory-committee>

Colorado’s Maternity Advisory Committee (MAC) originated from Colorado’s **maternity bundle** initiative focused on cost-sharing to improve outcomes. Advocates participating in this process pushed the agency to gather member feedback to ensure that the policy was meeting community needs and addressing concerns that payment reform would unintentionally entrench disparities by incentivizing lower quality services. In support of this suggestion, the agency requested **legislation** to solidify its authority to convene individuals with lived experience of Medicaid for this purpose, emphasizing representation from people of color.

Strategy: Intentional Recruitment and Selection

HCPF shared the MAC application widely with community stakeholders resulting in over 100 applications. Interest was higher than anticipated, but it was not clear how members learned about the **application**. HCPF plans to include an additional question about how people learned about the opportunity in future. The application was released in the top six languages spoken in Colorado based on census data. Just one applicant identified English as a second language.

Each application was reviewed by two staff from a team of six, each of whom nominated three to five people from their pool of applicants. The recommended applicants were invited for interviews. Interviews conducted by four staff resulted in a 20-member committee. The Maternity Advisory Committee’s primary criteria for eligibility is having had a child enrolled in Medicaid in the last five years.

Strategy: Recognize Members for Participation

All MAC members are recognized with a \$25 gift card per meeting⁴ and the option to be reimbursed for child care provided by a licensed child care provider. However, obtaining these child care services has proved challenging since the requirement for coverage does not recognize informal social networks such as family or neighbors who are often called upon to provide child care. This is one area of non-monetary compensation that the agency is working to remedy.

Strategy: Hire a Licensed Behavioral Health Provider to Support the Social and Emotional Needs of Participating Members

Building trust among members was and continues to be a primary task of the MAC. A series of absences from several members prompted the agency to reach out to these members. Most members cited their lack of comfort speaking at meetings and the emotional topics that came up during discussions.

Since agency staff working with the MAC were not qualified to support the emotional and behavioral health needs of members, HCPF hired a licensed therapist who is a woman of color specializing in perinatal mood and anxiety disorders among women of color. When relevant, the therapist also serves as a facilitator, presenting certain content to members for consideration and discussion. This clinician provides up to five hours of intensive case management at each meeting. If members are experiencing a crisis, they are referred to the therapist. The main responsibility of the therapist is to connect members to resources and provide therapeutic tools. This is not a substitute for regular therapy, but rather professional support in instances in which the subject matter of meetings is emotionally difficult or retraumatizing. The intervention serves as a link to ongoing Medicaid services, does not include intensive treatment, and is not considered a direct service provider to members.

Strategy: Involve Members in Reporting and Evaluation Efforts

Members of the MAC indicated their desire to make actionable changes. The agency asked the following questions to better understand members' needs:

- What does actionable change look like for you? What would a related product look like?
- How will you know that your participation in this group has made a difference?

During these discussions MAC members indicated an interest in publicly sharing their stories. Follow up meetings were dedicated to discussing how MAC members wanted to share their stories in the near-term versus long-term, resulting in the following strategy:

- 2021: Publication of the **Maternity Report**, which includes short member vignettes to complement outcomes data.
- 2023: Conduct semi-structured interviews of all MAC members and engage in thematic analysis summarized in a standalone qualitative report to accompany the quantitative Maternity Report.
- 2024: Conduct an integrated, mixed methods analysis of maternal and child outcomes and experiences.

Summary

To actively dismantle structural inequities, state agencies must ensure robust platforms to engage community voices and build community power. A Medicaid member advisory council is one such platform; however, the existence of a council alone does not guarantee member engagement that will drive health equity. Resources are needed to build internal capacity to equitably conduct member and community engagement and ensure cross-agency alignment. Successful progress towards equity through community engagement requires a commitment from leadership and staff to ensure engagement is inclusive and accessible to members, reflects the diversity of those being served, and is accountable to these communities. State Medicaid staff looking to improve their member engagement initiatives can tailor the strategies implemented in Colorado and Virginia as they work towards transformational community engagement. Further, the member engagement strategies employed by these Medicaid agencies are applicable to other programs and policies.

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ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We lean on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity.

Through our efforts, and the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

For more information, visit www.rwjf.org.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT HEALTH EQUITY SOLUTIONS—This document was prepared by Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel. Health Equity Solutions (HES) promotes policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people regardless of race or income. HES works with State Health and Value Strategies (SHVS) to guide the program's health equity work generally while also providing targeted technical assistance to states. HES is based in Hartford, Connecticut and focuses its work outside of the support it provides to SHVS on achieving health equity in Connecticut.

Appendix A:

Summary of State Strategies and Recommendations Linked to National Academy of Medicine's Conceptual Model to Assess Meaningful Community Engagement

State	Strategy	Domains of Measurable Outcomes (NAM model)*
Agency-Wide Engagement Strategies		
VA	Invest in internal staff capacity and resources to support and carry out consumer engagement initiatives.	Improved health and healthcare programs and policies.
VA	Conduct a landscape analysis to document existing work and build a workgroup to foster alignment and address gaps.	Strengthened partnerships and alliances.
CO	Collaborate with and compensate community-based organizations.	Strengthened partnerships and alliances.
CO	Collaborate with enrollees to reach people with limited English language proficiency.	Expanded knowledge.
Member Council Engagement Strategies		
VA	Hire a licensed behavioral health provider to support the social and emotional needs of members participating in councils.	Thriving communities.
VA	Require regular attendance of executive leadership at member council meetings.	Improved health and healthcare programs and policies.
CO	Involve members in evaluation and reporting efforts.	Expanded knowledge.
CO	Compensate and/or recognize member participation without impacting eligibility.	Strengthened partnerships and alliances.
CO/VA	Intentionally recruit to reflect diversity of member population.	Strengthened partnerships and alliances.
CO/VA	Commit to transparent tracking of and reporting on impact of engagement.	Improved health and healthcare programs and policies.

*For definitions of each domain and related outcome indicators, please refer to: Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. 2022. *Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health*. NAM Perspectives. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202202c>.



Appendix B:

Colorado MEAC Materials

Letter Testing Questions

Standard Questions:

- What do you think about the layout of the letter?
- After reading the letter, how do you feel?
- What do you think is the most important information in the letter?
- Based on what's in this letter, why do you think you got this letter?
- Based on what's in the letter, what do you have to do? What would you actually do (if different)? What happens if you don't do anything?
- Who do you think this letter came from?
- What would you do if you had questions or needed help?
- Are there any words or terms you didn't understand?
- What other questions do you have about the letter?

Questions for Forms:

- Feedback on the layout of the form?
- If you've had to use this form (or one like it) in the past, how did you do that? What method?
- What would make it easier to complete this form?
- What would make it easier to submit this form?
- How effective are the examples provided in the questions?
- Is there anything missing from the examples provided in the questions?
- Are there any words or terms you didn't understand?
- What would you do if you needed help completing this form?

More Specific:

- What would you do if the information in the letter/table was incorrect or didn't match your records?
- What would make it easier to provide the requested information?

Meeting Evaluation Questions

1. On a scale of very dissatisfied to very satisfied rate how satisfied were you with...
 - a. Your own participation in the meeting?
 - b. How much you learned?
 - c. The meeting overall?
 - d. Feeling like your input mattered?
 - e. The amount of time for discussion?
2. On a scale of 1 to 4 with 1 being never and 4 being always, did the facilitators and presenters use plain language (no jargon) and explain things so you could understand?
3. Any other general feedback about the meeting?
4. Any new ideas for future topics?

ENDNOTES

1. This data includes region, age, race, gender, program, and whether the participant is representing themselves or a family member.
2. Hotel accommodations are provided for members who live far from the meeting location or whose access to transportation would otherwise impede their ability to participate.
3. Pedersen, D. (2014). Exploring the concept of transcreation–transcreation as “more than translation”. *Cultus: The Journal of intercultural mediation and communication*, 7, 57-71.
4. Meetings are shorter than MEAC meetings and staff are exploring increasing the amount of the gift cards.