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Consumer-Focused Health System Transformation: What are the Policy Priorities?

March 2019

Assess Unmet Needs

Create Integrated Systems

Ensure Meaningful Access
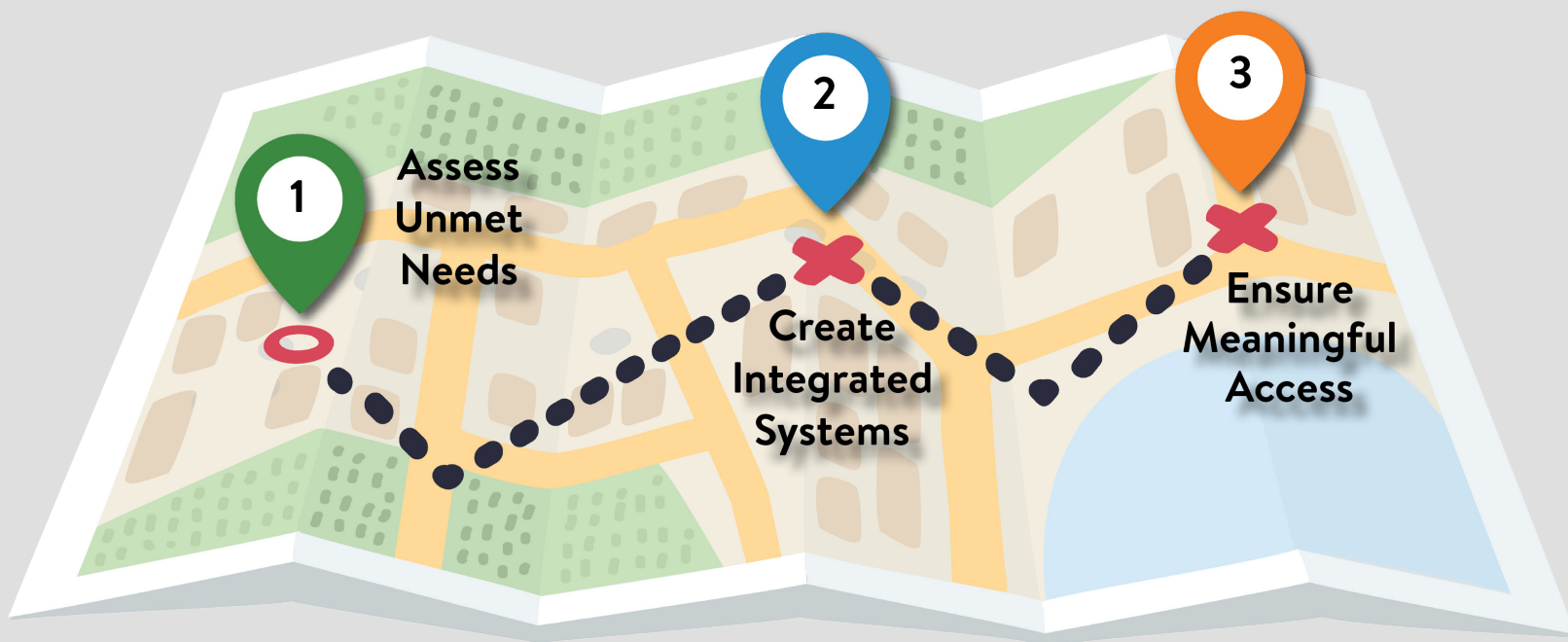
A Policy Roadmap and Toolkit

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Consumer-Focused Health System Transformation: What are the Policy Priorities?

EXECUTIVE SUMMARY

The U.S. healthcare system is transforming in response to many types of pressures. To ensure these changes benefit the people the system is intended to serve, policymakers, funders, advocates and others need actionable information from which to guide improvement efforts. Moreover, given the complexity of the health system, it is imperative that we are systematic and evidence-based in our approach.

> The following policy compendium serves as a roadmap—highlighting a promising set of federal, state and (occasionally) local policies to achieve *our health system transformation goal:*
>
> **Ensuring that the healthcare system works seamlessly with public health, social sectors and community members to address the goals and needs of the people it serves and advance health equity.**

Our work relied heavily on informal interviews with experts from a wide variety of policy fields. The conversations yielded three "interim destinations" on the road to achieving our transformation goal:

- Assess people's physical, behavioral and oral health, as well as social needs, and identify gaps in the community's capacity to address them;

- Create integrated systems to advance population health; and

- Ensure meaningful access to care and services that meet people's goals and needs, especially within underserved communities.

KEY THEMES

Themes that repeatedly surfaced from our discussions with key experts include:

▲ **Strong measurement systems are needed to know where we are headed and whether or not our changes are working.** Our experts stressed that collectively agreed upon measures of success must be established to determine if policies are effective. Similarly, "feedback loops" at many levels are essential to ensuring that people's health-related goals and needs are addressed. Finally, performance measures for providers should be aligned with performance goals for the *overall health system*, in addition to broader measures used to gauge progress towards community goals (across heath, social and public health sectors).

▲ **Meeting people's goals and needs cannot be achieved with a one-size-fits-all approach.** Consumers are diverse and interventions must be targeted in a way that allows *all* people to achieve optimal levels of health and well-being.

▲ **Flexible financing is needed to move healthcare dollars "upstream,"** with the caveat that new dollars must also be invested in social sectors, which are severely under-funded.

▲ **Primary care, dental care, behavioral healthcare and social services should be integrated, and ideally co-located, to improve patient convenience and outcomes.** Successful integration will require aligned incentives, inter-operable data systems that share patient information and empowered care coordinators for patients with complex needs.

▲ **States or the federal government must adopt one of several proven methods to achieve universal coverage** to provide access to these improved, integrated systems of care.

▲ **Policies that elevate the voice of a diversity of consumers (including patients, caregivers and others) are vital to achieving the overarching goal.** Success in this area will take dedicated resources and a clear, shared understanding of best practices in community engagement, including deploying transportation, language assistance and other supports as necessary.

Most importantly, across our literature review and our conversations with experts, we found no barrier that was insurmountable to achieving our health transformation goal. Indeed, the *Policy Roadmap* is replete with proof-of-concept examples of where these policies are already working to make our health system more patient-centered.

ABOUT THIS REPORT

This report introduces an organizing framework and a catalog of federal, state and (occasionally) local policies that work to ensure that the healthcare system works seamlessly with public health, social sectors and community members to:

▲ address the goals and needs of the people it serves and

▲ advance health equity.

The framework identifies three broad strategies necessary to achieve our health system transformation goal.

ORGANIZING FRAMEWORK
Strategies to ensure that the healthcare system works seamlessly with public health, social sectors and community members to address the goals and needs of the people it serves and advance health equity.
① Assess people's physical, behavioral and oral health, as well as social needs, and identify gaps in the community's capacity to address them
② Create integrated systems to advance population health
③ Ensure meaningful access to care and services that meet people's goals and needs, especially within underserved communities

The policy recommendations within each section were developed through literature reviews and informal interviews with experts from the field. To structure the conversations, the following guidelines were put in place:

• A "policy" was defined as an action that a federal, state or local government could take to achieve the overarching goal. This includes legislative and regulatory policymaking and actions that governments can take as healthcare purchasers.

• Recommended policies should address the goals and needs of individuals, rather than community-level goals and needs.

• Policies to address health-related social needs are in-scope and important. This agenda focuses on social determinants of health with "near-term" impacts (like housing) rather than long-term effects (like early education), although both categories must ultimately be addressed.

• Policies that elevate the voice of consumers (including patients, caregivers and others) are equally vital and should be identified, when appropriate.

Governmental policies that were perceived to have the greatest potential (i.e. high endorsement among interviewees and an evidence-base to support them) are featured prominently within each section, however other important approaches are also introduced throughout the text. A two-page summary of policy targets can be found in **Appendix A.**

This roadmap benefits from similar—albeit more targeted—resources produced by the Bi-Partisan Policy Institute, Families USA, Community Catalyst

and others. We gratefully acknowledge their contributions and list them for readers' use in **Appendix C.**

Although federal, state and local polices interact to produce the healthcare, public health and social environments experienced by community residents, we recognize that some readers of this report may work exclusively at one of these policy levels. To improve the report's usefulness for these individuals, **Appendices D** and **E** segment the policy recommendations into their federal and state components.

A comprehensive list of appendices is included below:

- **Appendix A:** Policy Roadmap Summary
- **Appendix B:** Glossary of Terms
- **Appendix C:** Related Resources
- **Appendix D:** Critical Federal Policies
- **Appendix E:** Critical State Policies
- **Appendix F:** Customizing the Policy Roadmap for Your Community: A Checklist
- **Appendix G:** 10 Policies to Start

Authors

Amanda Hunt, policy analyst with the Healthcare Value Hub, is the primary author of this report. Hub Director, Lynn Quincy, provided substantial guidance and review. Several Altarum colleagues also provided feedback—we thank them. Hub Communications Leader, Tad Lee, designed the report.

We consider this roadmap a "living document" and welcome improvements and additions. Please send your comments and suggestions to Hubinfo@altarum.org.

KEY INFORMANTS

We are grateful for the expertise shared with us by many people. The interviewees listed below offered a variety of perspectives, all of which are key to understanding the complex issues, and promising strategies to address them, discussed in this report. These experts challenged us, refined our language and refined our nacent ideas into a coherent narrative. Thanks to all.

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INTRODUCTION

For nearly two decades, advocates, policymakers and others have emphasized making the health system more person-centered. While we have made progress in some areas (for example, increasing the number of people with insurance), it is widely recognized that we still have a long way to go.

An important area for progress is ensuring that the healthcare system works collaboratively with public health, social sectors and community members to address the health-related goals and needs of the people it serves. A key component of this work is ensuring that all people—regardless of race, ethnicity, gender or other demographic characteristics—have equal opportunity to lead healthy lives.

Federal and state governments have both the responsibility (as healthcare payers and regulators) and the power (through their legislative and regulatory authority) to initiate change. It is therefore useful to identify a set of evidence-based governmental policies to guide policymakers', advocates' and funders' priorities moving forward.

This policy roadmap highlights a promising set of federal, state and (occasionally) local policies to ensure that the healthcare system works seamlessly with public health, social sectors and community members to:

▲ address the goals and needs of the people it serves and

▲ advance health equity.
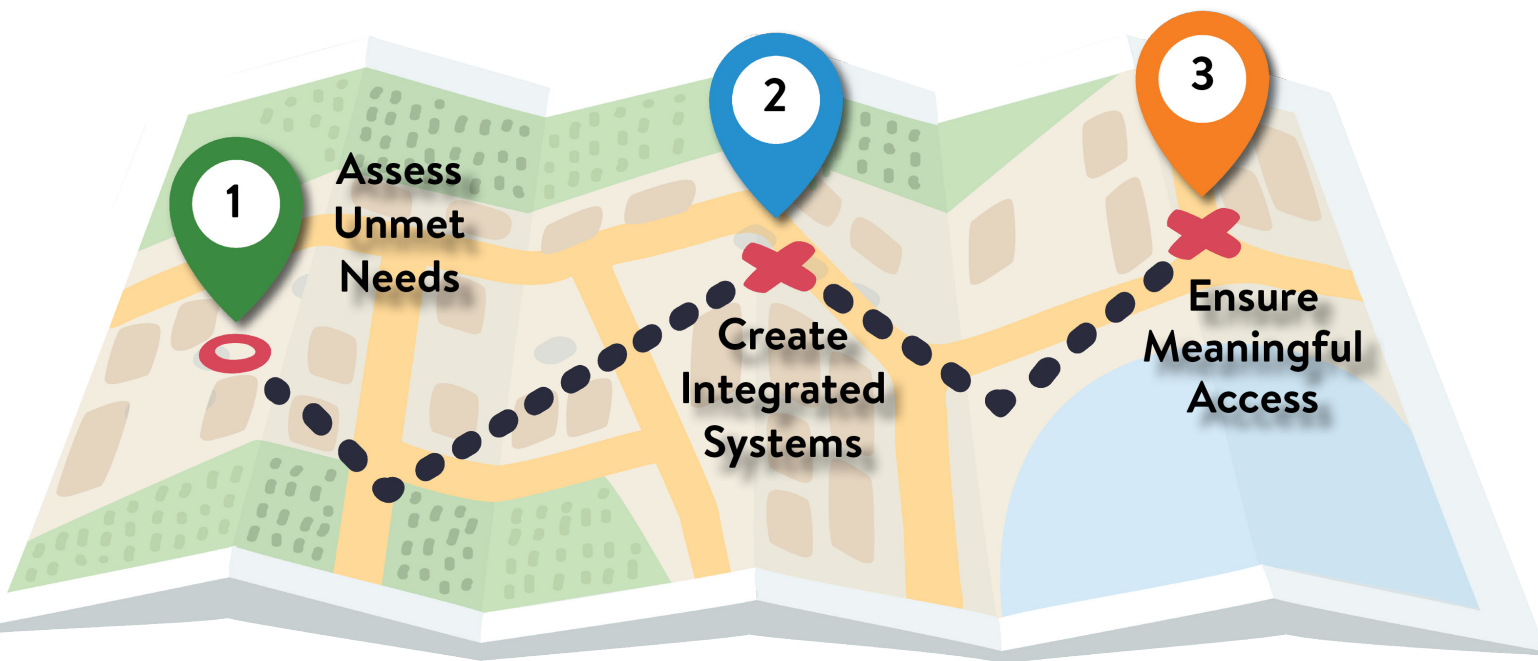
SECTION 1: ASSESS UNMET NEEDS

ASSESS PEOPLES' PHYSICAL, BEHAVIORAL AND ORAL HEALTH, AS WELL AS SOCIAL NEEDS, AND IDENTIFY CAPS IN THE COMMUNITY'S CAPACITY TO ADDRESS THEM

Improving the health and well-being of the people the health system serves first requires a reliable system for assessing people's needs and evaluating the community's capacity to address them. The following table outlines policy targets to ensure that community members' health and health-related social needs are accurately identified, and the availability of community resources to address those needs is well-understood.

TABLE 1 Policy Targets to Assess Peoples' Physical, Behavioral and Oral Health, as well as Social Needs, and Identify Gaps in the Community's Capacity to Address Them

Objectives	Policymaking Body	Policy Targets	
Coordinate and strengthen patient-level data collection	Federal, state & local	1.1	Make medical, behavioral and dental patient-level data systems (like EHRs) inter-operable so patient data can be shared seamlessly while protecting patient privacy. Additionally, these systems should be integrated with data from social services providers to track patients across health and social systems.
		1.2	Require providers to adopt social determinant of health screening tools in accordance with best practices as a condition of participation in Medicare, Medicaid and government employee health plans.
		1.3	Fill in gaps in patient-level data collection (e.g., information on race and primary language) to inform stakeholders' understanding of broader community needs.
Leverage data and community voices to determine unmet needs	Federal & state	1.4	Coordinate the community health needs assessment obligations of nonprofit hospitals, public health departments and FQHCs.
		1.5	Strengthen Community Health Needs Assessment guidance to require meaningful inclusion of all community stakeholders (including low-income and minority residents) and the assessment of social needs.
		1.6	Strengthen guidance and transparency related to the prioritization of community needs in Community Health Improvement Plans.
Identify gaps in infrastructure, workforce, etc.	State & local	1.7	With community involvement, assess local capacity to meet people's needs, with particular emphasis on underserved communities. Use asset mapping to identify existing resources that are not being used to their fullest potential.

DISCUSSION:

COORDINATE AND STRENGTHEN PATIENT-LEVEL DATA COLLECTION

Health-related needs cannot be accurately identified without access to relevant data. Barriers include electronic record keeping systems that cannot easily share information (assuming providers have the resources to adopt these systems at all). Additionally, inconsistent use of social determinant of health screening tools prevent social needs from being systematically detected and subsequently addressed.

1.1 Make Medical, Behavioral and Dental Patient-Level Data Systems Interoperable and Integrate with Data Collected by Social Service Organizations

Data integration at the patient level has long been a challenge for healthcare providers. Too often, lack of interoperability between electronic health record (EHR) systems prevents clinicians from accessing patient data collected by other providers in order to view patients' complete and accurate medical histories. Additionally, EHRs do not typically contain information collected by behavioral health, oral health and social support providers, despite its relevance to patients' health and well-being.

IMPROVING INTEROPERABILITY ACROSS MEDICAL, BEHAVIORAL AND DENTAL SYSTEMS

There are numerous challenges associated with achieving interoperability, in both the public and private sectors. In the public sector, several interviewees identified federal statutes HIPAA and 42 CFR Part 2 as major barriers to sharing medical and substance use disorder information. While all acknowledged that consumer protections are important, many expressed that guidance can be over-interpreted to prevent the flow of information between behavioral health and medical providers.

Clarifying federal guidance by describing common scenarios in which the sharing of medical and substance use disorder information is not only permitted but also encouraged may help overcome confusion preventing inter-organizational collaboration. Additionally, the Bipartisan Policy Center and Health IT Now's workgroup on health information technology recommends "designing payment and delivery models, including value-based fee-for-service and alternative payment models, in ways that create a strong business case and clear signals for stakeholders to engage in interoperability and information exchange."[1]

In the private sector, one interviewee noted that interoperability might be perceived in opposition with electronic record vendors' financial best interest. Specifically, developers might fear losing market share as a result of making their products compatible with those of their competitors.[2] The Office of the National Coordinator for Health Information Technology (ONC) can mitigate these concerns by using its interoperability-related authority to encourage data portability.[3,4]

The ONC has documented 32 "policy levers" that states can use to promote health IT and advance interoperability in its *State Health IT Policy Levers Compendium*. These include, but are not limited to, accountable care arrangements, all-payer claims databases, health information exchange (HIE) connection or interoperability mandates, and HIE advisory councils/oversight boards. A detailed map shows which policy levers are being used in various combinations in the majority of states.[5]

Tracking Patients across Health and Social Systems

Clinical data platforms increasingly help clinicians make referrals to social service providers once patient needs have been identified, but few systems follow patients beyond the traditional healthcare setting to (1) monitor whether the recommended services are received and (2) measure improvement. States, as purchasers, could incentivize healthcare providers to adopt and use data systems that track patients' connections to social service organizations to ensure that health-related social needs are addressed (see *Spotlight*). While one interviewee warned of potential pushback from social service providers (who may not have the resources to adopt and maintain multiple record keeping systems), most agreed that "feedback loops" are essential to making progress on individuals' health-related goals.

1.2 Require Providers to Adopt Social Determinant of Health Screening Tools in Accordance with Best Practices

Healthcare providers are trained to identify patients' medical needs, but unmet social needs contributing to poor health outcomes may be more difficult to detect. Social determinant of health screening tools can help providers surface patients' non-medical needs, in order to connect them to social supports. The Federal and state governments can encourage social needs screenings by requiring (and paying) providers to use evidence-based screening tools as a condition of participation in government-sponsored health plans.

While interviewees generally supported the use of social determinant of health screening tools in a clinical setting, some noted areas for improvement. Specifically:

- Providers should be educated on how best to approach these conversations, as patients may perceive the questions to be intrusive or discriminatory if they have not developed a trusted relationship with the asking provider. (See section 3.9 for a discussion of effective anti-oppression and equity training for providers).

- Screening efforts should be coordinated to avoid repeatedly asking questions that patients may consider invasive.

- Requirements to screen for social needs should be accompanied by requirements to address the identified needs to the extent which providers are able. In a fee-for-service system, reimbursing providers for the assessment of social needs without holding them accountable for providing solutions (directly or through appropriate referrals) could become exploitive to patients.

Characteristics of high quality screening tools and best practices can be found in Health Leads' comprehensive *Screening Toolkit*.[7]

SPOTLIGHT: UNIFIED CARE CONTINUUM PLATFORM

The Patient Care Intervention Center's Unified Care Continuum Platform is an exemplar for how medical and social data can be integrated to provide a big picture view of community member's interactions with health and social systems. The platform links data from "disparate medical and social service provider systems to create a comprehensive record" for each person, allowing healthcare and social service providers to track individuals along the care continuum and collaborate to effectively address related health and social needs.[6]

1.3 Fill in Gaps in Patient-Level Data Collection to Inform Stakeholders' Understanding of Broader Community Needs

While many interviewees felt that current data collection efforts are sufficient to make progress on individual and population health goals, interviews repeatedly surfaced three areas for improvement. The following recommendations address gaps in patient-level information that are critical to understanding broader population health trends.

1. Several interviewees cited the absence of data stratified by race as a barrier to understanding the extent of health and social disparities in communities. Some went further, advocating for data stratified by ethnicity, primary language and other cultural aspects to identify disparities within racial groups. An extensive discussion of governmental policies that enable and enhance data disaggregation can be found in Policy Link's *Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health*. Important actions include, but are not limited to, the following:[8]

    a. Congress should fund the U.S. Census Bureau's budget to adequately maintain and improve operations for the 2020 Census and all other surveys.

    b. The U.S. Census Bureau and the Office of Management and Budget should improve the documentation of race and ethnicity in federal data collection.

    c. The Office of Management and Budget and the U.S. Census Bureau should develop protocols for using data disaggregation consistently throughout the collection, analysis and reporting of racial and ethnic subgroup data.

2. Interviewees also highlighted a lack of geographic data (specifically, where consumers reside and where services were received) as a roadblock preventing efforts to allocate greater resources to high-need areas within communities. Relaxing certain safe harbors governing protected health information—particularly the required omission of "all geographic subdivisions smaller than a state, including...city, county, precinct, [and] ZIP code" as specified by HIPAA[9]—would enable healthcare organizations, public health agencies, social support providers and others to allocate scarce resources more wisely. (Information that can be directly traced to individuals, such as a patient's exact home address, should continue to be omitted under the law.)

3. Finally, interviewees voiced concern that government-led data collection efforts often exclude information on privately insured individuals (approximately 67 percent of the covered population),[10] failing to provide an accurate picture of health and health-related needs in mixed coverage communities. Even if information from insurance companies and self-funded employers is available, measures may not be identical to those used by government agencies, preventing reliable comparison.

    Standardizing the data collected across public and private payers is essential to producing meaningful analyses. State departments of insurance could impose reporting requirements on private insurers to align public and private health-related data collection efforts. Additionally, the federal Department of Labor, which regulates self-funded employers, could amend ERISA to require that certain information is made available to state or local government agencies.

SUMMARY: KEY POLICIES TO COORDINATE AND STRENGHTEN PATIENT-LEVEL DATA COLLECTION

Federal

CMS: Clarify guidance with respect to the sharing of medical and substance use disorder information across health and social services systems, while safeguarding patient privacy.

Office of the National Coordinator for Health Information Technology (ONC): Use interoperability-related authority to encourage data portability.

As purchaser: In the design of payment and delivery models, including value-based fee-for-service and alternative payment models, create a strong business case and clear signals for stakeholders to engage in interoperability and information exchange, while safeguarding patient privacy.

As purchaser: Encourage well-targeted social needs screenings by requiring providers to adopt and use evidence-based screening tools as a condition of participation in government-sponsored health plans.

All agencies: Coordinate across agencies to ensure that data collection is stratified by ethnicity, primary language and other cultural aspects to identify disparities within demographic groups.

CMS: Relax certain HIPAA rules governing protected health information—particularly the required omission of "all geographic subdivisions smaller than a state, including...city, county, precinct, ZIP code..." while still maintaining patient privacy.

Department of Labor: Amend ERISA to require self-funded employers to collect and report the same information as governmental insurers (Medicare and Medicaid) to allow for analyses that include all state and/or community residents—both publicly and privately insured.

State

As purchaser: Incentivize healthcare providers to adopt and use data systems that track connections to social service organizations to ensure that patients' health-related social needs are ultimately addressed.

As purchaser: In the design of payment and delivery models, including value-based fee-for-service and alternative payment models, create a strong business case and clear signals for stakeholders to engage in interoperability and information exchange, while safeguarding patient privacy.

As purchaser: Encourage well-targeted social needs screenings by requiring providers to adopt and use evidence-based screening tools as a condition of participation in government-sponsored health plans.

Across agencies: Coordinate across agencies to ensure that data collection is stratified by ethnicity, primary language and other cultural aspects to identify disparities within demographic groups.

Department of Insurance: Require fully-insured private plans to collect and report the same.information as governmental insurers (Medicare and Medicaid) to allow for analyses that include all state and/or community residents—both publicly and privately insured.

DISCUSSION:

LEVERAGE DATA AND COMMUNITY VOICES TO DETERMINE UNMET COMMUNITY NEEDS

1.4 Coordinate and Strengthen Community Health Needs Assessments

Nonprofit hospitals, public health departments, federally qualified health centers (FQHCs) and others (depending on the state) are required to conduct periodic assessments to identify their communities' health-related needs.[11] In many communities, these organizations work in silos, each producing an assessment unique to their organization or agency. Interviewees knowledgeable in this area expressed frustration at the lack of coordination and wasted resources from repetitive, yet incomplete, assessments. They communicated a desire for consolidated reports jointly produced by public health and healthcare stakeholders.

Lack of coordination when conducting needs assessments may be partially due to different schedules for completion. Public health departments are required to conduct assessments every five years, whereas nonprofit hospitals and FQHCs must produce reports every three years. Amending federal guidance to create a single assessment timeline would facilitate collaboration by making the assessment a priority for each organization/agency at the same time.

Alternatively, local governments could require the development of comprehensive, city- or county-wide assessments produced by a coalition of community stakeholders (see *Spotlight*). States can lay the foundation for this work by expanding community health need reporting requirements to include other nonprofit organizations that influence health. For example, New Hampshire requires nonprofit behavioral health providers, retirement communities and nursing homes to produce Community Health Needs Assessments (CHNAs) and community benefit plans, as well.[12]

1.5 Strengthen CHNA Guidance to Meaningfully Include Community Stakeholders and Assess Social Needs

Accurate assessment of community needs requires a diversity of community perspectives. To this end, the Federal government requires nonprofit hospitals to solicit input from public health stakeholders and community members—specifically medically underserved, low-income and/or minority residents—during the CHNA process. Nevertheless, interviewees agreed that existing federal guidance is problematically vague, particularly when it comes to specifying the extent to which public health agencies and community members should be involved. Amending the guidance to establish criteria for "meaningful" participation is vital to ensuring that a diversity of perspectives are adequately represented.

SPOTLIGHT: COLUMBIA GORGE'S COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT

The Columbia Gorge Regional Community Health Assessment is a comprehensive, regional CHNA produced by a collaborative of hospitals, clinics, public health agencies and community-based organizations operating across seven counties in the Columbia Gorge Region.[13] In 2012, 39 organizations participated in the collaborative's first CHNA, which culminated in a list of shared priorities from which to base community health improvement efforts. Columbia Gorge's innovative programs, developed in response to the CHNA, won the region the Robert Wood Johnson Foundation Culture of Health Prize in 2016.[14]

Furthermore, the Internal Revenue Service (IRS), which oversees the CHNA reporting process, should add community-based social support providers to the list of stakeholders that must be engaged. Currently, the IRS encourages but does not require nonprofit hospitals to assess health-related social needs, so involvement from social sector organizations would increase the likelihood that community needs across the wellness spectrum are identified and subsequently addressed.[15]

1.6 Increase Transparency and Accountability in the Prioritization of Community Needs

Another requirement for nonprofit hospitals is to identify the highest-priority community needs and create a plan to address them. Interviewees cited lack of transparency and accountability in the prioritization step as a barrier to a valuable CHNA process.

Specifically, interviewees argued that hospitals have too much flexibility in determining which of the needs identified in CHNAs they plan to address. Currently, hospitals are required to justify decisions to exclude certain needs in community health improvement plans (CHIPs) that accompany

CHNAs, but there is no criteria outlining legitimate grounds for exclusion. The IRS can remedy this problem by issuing guidance identifying a concrete list of situations in which hospitals can, in good faith, exclude community needs from community health improvement plans. Hospitals that do not comply should be fined for failure to satisfy CHNA/CHIP requirements.

Some interviewees felt strongly that community members should ultimately decide which needs are the most important to address. One example of how this could be accomplished is a process called participatory budgeting (see section 2.7). While no interviewees disagreed with this idea, one posed a challenging question: "What if community members' desires are not supported by evidence or do not support population health goals?" For instance, community members might decide that they do not want vaccinations, despite overwhelming evidence that vaccinations reduce the spread of infectious disease. Policymakers, advocates and other stakeholders should carefully consider this and similar questions in their quest for community-driven transformation.

SUMMARY: KEY POLICIES TO LEVERAGE DATA AND COMMUNITY VOICES TO DETERMINE UNMET NEEDS

Federal

IRS/HRSA/Public Health Accreditation Board: Amend federal guidance to create a single community health needs assessment timeline for FQHCs, Public Health and nonprofit hospitals.

IRS: Provide concrete guidance on criteria for "meaningful" community participation in non-profit entities health needs assessments.

IRS: Issue guidance identifying a concrete list of situations in which hospitals can, in good faith, exclude community needs from community health improvement plans.

State

Department of Revenue: Expand state community health need reporting requirements to include other nonprofit organizations that influence health.

Public Health Department: Require/encourage comprehensive, coordinated city- or county-wide health needs assessments.

DISCUSSION:
IDENTIFY GAPS IN WORKFORCE, COMMUNITY INFRASTRUCTURE, ETC.

1.7 Assess Local Capacity to Meet People's Needs

When performed correctly, CHNAs can provide a wealth of information that helps stakeholders assess local capacity. Most notably, they include resource inventories that identify community assets that help meet residents' health-related needs. They can also shed light on gaps in needed services that should be addressed.

ASSET MAPPING

Most interviewees agreed that it is important to identify areas in need of greater investment, but one argued that evaluators too-often adopt a "glass-half-full approach." She expressed the view that there is a tendency to focus on identifying resources that communities need, rather than ones that are not being used to their fullest extent. These underutilized resources, she explained, can be uncovered through an "asset mapping" approach (see textbox). Another interviewee challenged this view, arguing that community-based organizations (CBOs), particularly those in underserved communities, are highly skilled at utilizing available resources. Nevertheless, she agreed that "opportunity" mapping could supercharge the work that they do.

Better information sharing between government agencies would also aid efforts to assess local capacity to meet people's needs. For example, one interviewee highlighted the fact that data collected by urban planners can aid efforts to advocate for better access to services by locating breaks in sidewalks that prevent people from walking to grocery stores and healthcare appointments. Data from urban planners can also be used to layer demographic information on top of food dessert maps to identify populations that should be targeted and engaged in community health improvement efforts (see section 2.7).

Six Stages of Asset Mapping
1. Define community boundaries
2. Identify and involve partners
3. Determine what type of assets to include
4. List the assets of groups
5. List the assets of individuals
6. Organize assets on a map[16]

Federal, state and local governments should facilitate information sharing by developing standard processes for responding to data requests between departments and specifying that programs purchased to store the data must be capable of sharing it in multiple formats to aid in cross-departmental analyses, if these requirements are not already in place.[17,18] Washington State is a national leader in this regard, having created a data warehouse that provides a "comprehensive, cross-agency view of client experiences and service information" (see *Spotlight* on next page).

Some interviewees also stressed the importance of making data (scrubbed clean of personal identifiers) accessible to the public to help advocates, researchers and private sector organizations play a role in transformation efforts, as well. The Allegheny County Department of Human Services has made the information in its data warehouse publicly available, when possible, in recognition of this need.[19]

ASSESSING THE HEALTHCARE WORKFORCE

CHNAs typically provide county-level statistics on the number of primary care physicians, dentists and mental health providers per capita, which can highlight workforce shortages creating barriers to care. One interviewee stated that efforts to assess

workforce capacity (through CHNAs and other means) should include professionals that address psychosocial needs, such as social and Community Health Workers (CHWs).

The Federal government could facilitate these efforts by providing county-level information on the prevalence of these professionals (typically gathered from professional societies and licensing boards) in national databases. This would allow for inclusion in user-friendly resources that are commonly used to inform CHNAs, including the Robert Wood Johnson Foundation's County Health Rankings or the University of Missouri's CARES Engagement Network (affiliated with Community Commons).[21] It is important to note that a lack of credentialing for CHWs poses barriers to tracking their prevalence at the national level (see section 2.6 for a related discussion).

SPOTLIGHT: WASHINGTON'S DATA WAREHOUSE

The Washington Department of Social and Health Services' Research and Data Analysis (RDA) division's data warehouse is an integrated platform that matches client information collected from more than 20 different governmental data systems.[20] The platform allows RDA to regularly assess the state's health and social services—not only by evaluating the impact of specific programs, but also identifying the societal consequences of unmet needs. (For example, analyses demonstrated that insufficient access to treatment for substance use disorders increased avoidable public expenditures and worsened social outcomes.)

Data-sharing agreements ensure that each office maintains ownership over the data it contributes, and allows offices to specify requirements for data security, privacy and the protection of personal information. The agreements also describe how the information can be used, such as for evaluations. Washington is the first state to successfully integrate governmental health and social services data on a large-scale.

SUMMARY: KEY POLICIES TO IDENTIFY GAPS IN WORKFORCE, COMMUNITY INFRASTRUCTURE, ETC.

Federal

All agencies: Facilitate information sharing across departments by developing standard processes for responding to data requests between departments and requiring that systems purchased to store data are capable of sharing it in multiple formats to aid in cross-departmental analyses. Consider making data available to the public and researchers.

HRSA: Ensure that federal data collection efforts that provide county-level information on the prevalence of medical professionals include professionals that address psychosocial needs, such as social and Community Health Workers.

State and Local

All agencies: Facilitate information sharing across departments by developing standard processes for responding to inter-departmental data requests and requiring that systems purchased to store data are capable of sharing it in multiple formats to aid in cross-departmental analyses. Consider making data available to the public and researchers.

SECTION 2: CREATE INTEGRATED SYSTEMS
CREATE INTEGRATED SYSTEMS TO ADVANCE POPULATION HEALTH

Systematically addressing people's interrelated health and social needs once they have been identified will require strong, sustainable connections across healthcare, public health and social stakeholders. The following table highlights promising governmental strategies to make needed investments, and provide and align incentives to advance population health.

TABLE 2 **Policy Targets to Create Integrated Systems to Advance Population Health**

Objectives	Policymaking Body	Policy Targets	
Align incentives to support population health goals	Federal, state & local	2.1	Support Accountable Communities of Health models by providing funding, technical assistance and serving as an organizer/convener.
		2.2	When contracting for healthcare and social services, design contracts to support population health and align incentives.
Increase funding and services to address social needs	Federal & state	2.3	Secure new funding to address social needs and improve flexibility to move health spending upstream, for example by eliminating financing silos, using global budgets, establishing wellness trusts, etc.
		2.4	Pursue waivers to pay for housing-related services through state Medicaid programs.
Integrate healthcare and community-based services	Federal & state	2.5	Reimburse for and invest in care coordination across the spectrum of medical and social needs. Incentivize providers to use risk stratification or hotspotting to identify patients in particular need of better coordinated care.
		2.6	Update payment and other policies to support the integration of Community Health Workers into healthcare teams, particularly in underserved areas.
Engage community members in transformation efforts	Federal, state & local	2.7	Support the inclusion of resident voices by incorporating best practice community engagement techniques, such as open meeting laws, multiple avenues for participation, etc.

DISCUSSION: ALIGN INCENTIVES TO SUPPORT POPULATION HEALTH GOALS

2.1 Support Accountable Communities of Health

An Accountable Community for Health (ACH) is a structured alliance of healthcare, public health and other organizations that plans and implements strategies to improve population health and health equity for all residents of a particular geographic area. There is no single approach used by ACHs—rather, successful ACHs embrace their specific community assets and needs and target interventions to goals that are within reach.[22] Wide variation makes it difficult to make generalizations about ACHs' effectiveness,[23] but an extensive review published by the National Academy of Medicine documents their potential to drive us toward population health and wellbeing.[24]

The most effective ACHs will integrate healthcare, public health and social services to create environments that support wellness needs across the health and social spectrum. Additionally, ACHs' governance structure, partners and projects should be tailored according to the unique characteristics and circumstances of the communities they serve. Washington's Accountable Communities of Health Initiative (comprised of 9 regional ACHs)

is a promising example of this approach, however the effort has yet to be formally evaluated. More information will become available in the final stage of the initiative, beginning in 2021.[25] (See *Spotlight*.)

State-level policy options for supporting ACHs include incentivizing non-profit hospitals to participate by allowing them to report meaningful involvement in an ACH as community benefit; increasing funding for ACHs through state appropriations and/or Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers;[28] and providing technical assistance.

Local governments can similarly support ACHs by supplying funding and providing technical assistance, in addition to serving as a convener. While interviewees agreed that "having government at the table" is important to realizing ACHs' goals, a few noted practical considerations that must be addressed. For example, one interviewee emphasized the need for a neutral and trusted convener. In some communities, she stated, local government may not be suited to serve that role.[29] Another interviewee remarked that community organizations can easily feel oppressed in situations where technical assistance is provided

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SPOTLIGHT: NORTH SOUND ACCOUNTABLE COMMUNITY OF HEALTH

North Sound Accountable Community of Health is a multi-sector collaboration in Washington working to "transform the health and healthcare system across the North Sound Region [through] a stronger emphasis on prevention, health promotion and community health, while promoting efficiencies and quality in physical, behavioral and public health systems."[26] Priority areas include integrating clinical and mental healthcare, improving care coordination for Medicaid patients and promoting health equity. As part of its work, North Sound ACH conducts cultural competency and literacy trainings for case managers and other healthcare professionals, has established a Dental Health Aide Therapist workforce pilot with Tribal partners to address access issues and has enhanced EHR use and health information exchange readiness. The collaborative is funded through the state's Medicaid Section 1115 DSRIP Waiver, Designated State Health Programs funding and community benefit grants from local hospitals.[27]

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by the government. Ultimately, the most valuable role for local government will depend on the relationships within a given community.

2.2 Design Contracts to Support Population Health and Align Incentives

DESIGNING CONTRACTS TO SUPPORT POPULATION HEALTH

As healthcare purchasers, states can design managed care and value-based purchasing contracts in ways that advance population health goals. For example, 11 states highlighted in the National Academy for State Health Policy (NASHP)'s recent scan of Medicaid contracts have included a number of provisions related to social determinants, including criminal justice, housing, transportation, employment, education and family/caregiver support. Additionally, approximately half of the states' contracts focused on primary care and behavioral health integration.[30] States can also incorporate requirements to address oral health in managed care contracts (see sections 3.5 and 2.1 for more on oral and behavioral health integration). Oregon, for example, requires their coordinated care organizations (CCOs)[31] to contract with dental providers (in addition to medical and behavioral health professionals), creating a "regulatory framework" to improve coordination between historically siloed areas of care.[32]

See text box for common elements of contractors' obligations, as identified by NASHP.

DESIGNING CONTRACTS TO ALIGN INCENTIVES

Aligning incentives between healthcare providers and community-based organizations, each connected to separate funding streams, is another challenge that states can address by designing contracts in ways that hold service providers financially accountable for meeting similar performance goals (also known as creating "parallel risk"). For example, a state Medicaid agency might coordinate with the state Department of Agriculture to incorporate a Medicaid hemoglobin

Common Elements of Contractors' Obligations in Medicaid Contracts

- Develop relationships with local community organizations to implement social determinant interventions (e.g., housing support services, nutrition classes, exercise equipment)
- Contract with community organizations
- Collaborate on community health needs assessments (CHNAs)
- Develop or access a community resource directory
- Evaluate members' health-related social needs
- Refer individuals to appropriate community services
- Follow-up and assist with access to community services
- Utilize data to address health disparities
- Share information (e.g., health records) with community organizations[33]

A1C measure into the performance metrics for education grants that fund nutrition-focused CBOs. The *Spotlight* on page 21 describes Oregon's efforts to design shared performance measures that create joint accountability between its healthcare and education sectors.

Additionally, AcademyHealth's *Approaches to Cross-Sector Population Health Accountability* offers practical recommendations for cross-sector alignment and sample measures that can unite healthcare providers and CBOs in the pursuit of population health goals.[36]

SPOTLIGHT: OREGON'S HEALTH AND EDUCATION CROSS-SECTOR COLLABORATION[34]

Oregon has undergone considerable efforts to transform both its healthcare delivery and education systems. In the healthcare sector, the state established coordinated care organizations (CCOs) to coordinate care for Medicaid beneficiaries. In the education sector, Early Learning Hubs (Hubs) were established to coordinate early learning services for children and families. Due to the impacts of early experiences on long-term health and education outcomes, both entities adopted an overlapping measure for developmental screening of young children as part of their performance measure set.

In 2014, an oversight body known as the Joint Committee convened a Child and Family Well-being Measures Workgroup, in part, to develop additional measures that would hold the healthcare and education sectors jointly accountable for improving kindergarten readiness. Ultimately, seven measures were recommended and approved by the Joint Committee. While state-level implementation has stalled due a diversity of challenges (including differing organizational structures and resources across Hubs and CCOs, as well as differing capabilities related to data collection and data sharing), Oregon's experience provides valuable lessons for other states. A publication funded by the Robert Wood Johnson Foundation discusses the effort in greater detail and provides a toolkit "to help states 1) assess readiness and 2) develop a shared measurement and joint accountability approach across healthcare and non-healthcare sectors."[35]

SUMMARY: KEY POLICIES TO ALIGN INCENTIVES TO SUPPORT POPULATION HEALTH GOALS

Federal

CMS: Approve Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers to fund Accountable Communities for Health (ACHs).

Across agencies: Adopt cross-sector population health accountability measures to align incentives across vendor contracts ("parallel risk").

State

Department of Revenue: Allow non-profit hospitals to report meaningful participation in an Accountable Communities for Health (ACH) as community benefit.

Department of Health: Increase funding for ACHs through state appropriations and/or Section 1115 DSRIP waivers and support with technical assistance.

Medicaid Agency: Incorporate provisions related to social determinants in Medicaid contracts.

Across agencies: Adopt cross-sector population health accountability measures to align incentives across vendor contracts ("parallel risk").

Local

Department of Public Health: Support ACHs by supplying funding and technical assistance; serve as a convener if a trusted entity in the community

DISCUSSION: INCREASE FUNDING FOR SERVICES TO ADDRESS SOCIAL NEEDS

2.3 Increase Funding for Services to Address Social Needs

SECURE NEW FUNDING

The majority of interviewees strongly agreed that investments in areas like early education and housing are essential to improving population health and reducing disparities. In addition, they overwhelmingly supported financing structures that allow healthcare dollars to be invested "upstream," with the caveat that the funding to address health-related social needs should primarily come from the social sectors.

Blended and braided financing structures (described in the textbox at right) can help conserve Medicaid funds by combining them with money from other agencies to fund programs that address people's health and social needs. States should look for opportunities to expand the use of these models, drawing on lessons learned from successful programs like Minnesota's Hennepin Health (see *Spotlight*).

Another option for providing sustainable funding over time is to establish a wellness trust—an entity governed by community partners that "captures" savings from population health interventions to fund the next round of interventions. Many point to the success of an early model, Massachusetts'

Blended vs. Braided Financing

Blended and braided financing are two methods of combining disparate funding streams to pay for programs that address people's health and social needs. Blended financing combines money from multiple sources into a single pool of funds with minimal administrative oversight (once the funds are combined) and maximum flexibility in how they can be used. Braided financing, on the other hand, keeps funds from the contributing parties separate to ensure the money is used to pay for a more narrowly defined set of eligible services. Both approaches have been successfully employed to finance programs that deliver healthcare and social supports.[37]

Prevention and Wellness Trust Fund (PWTF), that has been used to finance cross-sector collaboration.[39] Independent evaluations of Massachusetts' effort have documented desirable system changes, such as increased capacity and better coordination between clinical and community-based organizations; infrastructure investments; increased reliance on community health workers to engage hard-to-reach populations; and newly created jobs. Health improvements—including lower rates of pediatric asthma, uncontrolled hypertension and falls

SPOTLIGHT: MINNESOTA'S HENNEPIN HEALTH

Hennepin Health is an integrated healthcare delivery network that offers medical, behavioral health and social supports to Medicaid and MinnesotaCare beneficiaries. The network is funded through a braided financing structure—the state Medicaid agency pays a fixed per-member-per-month payment for covered health services, while grants from county agencies support the employment of staff to address social needs.[38] Hennepin Health's integrated approach has decreased avoidable utilization among high-cost, high-need patients and serves as an example of a successful braided financing approach.

among older adults—in addition to savings from decreased use of healthcare services were also observed.[40]

Wellness trusts are still gaining traction and little is currently known about best practices for their design and implementation.[41] State and local governments should therefore look to Massachusetts and others experimenting with this approach (like Brooklyn, New York)[42] as they consider options for financing efforts to better the health of their communities.

Improve Flexibility to Move Health Spending Upstream

As previously stated, interviewees overwhelmingly supported the use of Medicaid funds to address certain social determinants of health. Waivers to pay for supportive housing services, in particular, was a top interviewee recommendation (see section 2.4).

Beyond the moral case for investing in social determinants of health, there are fiscal reasons why states should invest upstream. These include "reductions in Medicaid spending on treatments and services for acute and chronic conditions [and] reduced costs in other sectors resulting from a healthier population" (for example, greater workforce participation).[43] But program rigidity and other barriers can stifle needed investments, even if they create future savings that, in essence, pay for themselves.[44]

A few interviewees emphasized that a desire for increased flexibility should not be remedied by the use of block grants, which would establish fixed amounts of federal funding to cover states' Medicaid expenses each year. States would have maximum flexibility in determining how to use the funds, but healthcare advocates and some policy experts predict that block grants would reduce the federal dollars flowing to states and, ultimately, result in a reduction of services for vulnerable

populations.[45] Eliminating financing silos and implementing global budgets were more palatable options for granting flexibility for stakeholders to address people's health and health-related social needs.

Example 1: Eliminating Financing Silos

Section 1115 Medicaid waivers enable states to extend coverage to additional populations and provide services delivered by non-traditional providers or in non-traditional settings.[46] These include DSRIP waivers that allow states to alter provider payment in attempt to improve coordination between medical, behavioral and social support providers.[47,48]

The nascence of this work makes it difficult to draw conclusions about the effectiveness of states' efforts in attempt to identify the best approach. Nevertheless, case studies like AcademyHealth and Nemours Children's Health System's *Innovative Medicaid Payment Strategies for Upstream Prevention and Population Health* shed light on promising strategies and evidence-based practices, such as use of community care coordination systems and community health workers (discussed in sections 2.5 and 2.6, respectively).[49] Moving forward, state Medicaid agencies should consider these and other lessons learned when designing and testing approaches to invest upstream.

Example 2: Global Budgets

State Medicaid agencies can encourage contracting entities that are paid a set amount per beneficiary—such as managed care organizations and accountable health structures—to invest in prevention and population health efforts that may not be possible under Medicaid fee-for-service arrangements.[50] The Oregon Health Authority, for example, uses global budgets (in addition to other incentives) to encourage CCOs to deliver whole-person care.

In addition to providing services to address people's medical needs, CCOs contract with a diversity of behavioral health, oral health and social support providers. A 2015 survey of beneficiaries documented improvements in healthcare access, quality, use of primary care, care coordination related to social determinants of health and self-reported health outcomes compared to Medicaid fee-for-service.[51,52] These findings indicate that global budgets, as part of a larger strategy, help create an environment that is more conducive to addressing beneficiaries' wellness needs.

Global budgets can also be employed at the organizational level to incentivize providers to prioritize prevention. In Maryland, all payers (Medicare, Medicaid and private insurers) pay hospitals a prospectively-set, fixed amount for the total number of inpatient, outpatient and emergency services provided annually. Hospitals are responsible for expenditures in excess of the amount set by the state's Health Services Cost Review Commission, creating a vested interest in efforts to keep people healthy (thereby reducing avoidable hospital utilization).[53,54] It is important to note that desirable results from Maryland's experiment may be difficult to replicate given the state's unique all-payer system. Findings from Pennsylvania's use of global budgets for rural hospitals (currently in the early stages of implementation) may prove more useful to other states interested in this approach.[55]

2.4 Permit Waivers for Medicaid Programs to Pay for Housing-Related Services

For several interviewees, housing was the dominant health-related social need that Medicaid programs should aim to address.[56] They expressed support for mold removal in households with asthmatic children, rent subsidies for families at risk of homelessness and allowing doctors to weigh in on coding enforcement when health is at risk.

Interviewees recommended that states take greater advantage of waivers and state plan amendments that allow Medicaid programs to experiment with supportive housing.[57] Options that states can pursue (if they have not already) include:[58]

- Section 1115 Research and Demonstration Waivers,
- Section 1915(b) Managed Care Waivers,[59]
- Section 1915(c) Home and Community Based Services Waivers,
- Section 1915(i) Home and Community Based Services State Plan Optional Benefit,
- Section 1915(k) Community First State Plan Optional Benefit,
- 1905(a) Targeted Case Management Services and
- Health Homes State Plan Options.

The National Governor's Association has created a *Housing as Health Care Roadmap* to guide state Medicaid agencies as they pursue strategies to integrate health and housing.[60] Phase 2 provides additional detail on Medicaid authorities that can be leveraged to finance housing supports.[61]

Additionally, the Federal government should reactivate the Money Follows the Person (MFP) demonstration project, which provided federal dollars to help Medicaid beneficiaries transition from nursing facilities back into their communities.[62] Evaluations revealed that the project produced savings for the Medicaid program and that participation improved beneficiaries' quality of life. Forty four states participated in the program until its expiration in 2016.[63] (As of this writing, reauthorization efforts are underway).

While all interviewees agreed that housing supports are vital to improving Medicaid beneficiaries' health outcomes, one stipulated that governments must address shortages of affordable housing units in order for people's needs to be met (see section 2.3 for a discussion of increasing funding to address social needs).

SUMMARY: KEY POLICIES TO INCREASE FUNDING FOR SERVICES TO ADDRESS SOCIAL NEEDS

Federal

CMS: Reactivate the Money Follows the Person (MFP) demonstration project.

State

Across agencies: Explore opportunities to use braiding, blending, global budgets and wellness trusts to break down financing silos that interfere with cross-sector collaboration.

Medicaid Agency: Pursue waivers to pay for housing-related services.

DISCUSSION: INTEGRATE HEALTHCARE AND COMMUNITY-BASED SERVICES

2.5 Reimburse for, and Invest in, Care Coordination

Care coordination aims to improve patient health outcomes by synchronizing services from disparate providers[64] and reduce healthcare costs by eliminating redundant tests and procedures.[65] Research on the impact of care coordination programs has yielded mixed results (due to variation in design and implementation),[66,67,68] but case studies demonstrating improved outcomes for high-need patients and higher patient satisfaction have made care coordination a central component of efforts to deliver patient-centered care. Indeed, interviewees consistently touted care coordination as a basic building block of a patient-centered system.

Despite overwhelming support, a survey of healthcare organizations found that only 37 percent of respondents "fully" or "mostly" coordinated patient care across the inpatient, post-acute and home settings.[69] Barriers to widespread practice include non-interoperable health records (see section 1.1) and payment structures that do not reimburse providers for care coordination activities. The Federal government, as a major healthcare payer, should reimburse providers for care coordination under fee-for-service and value-based payment models and couple these payments with outcome-based measures to ensure meaningful results (see section 3.11 for a related discussion).

States, as purchasers, can encourage care coordination by reimbursing providers under fee-for-service arrangements or establishing integrated groups of providers that receive capitated payments in the form of global budgets

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(see section 2.3 for a discussion of Oregon's Coordinated Care Organizations). Technical assistance should also be provided to help diverse groups of providers work together to systematically address patients' goals and needs.

Community care coordination systems adopted by providers should have the following components to ensure they are rooted in evidence and driven by patients' goals and needs:

1. "identify and engage patients who are likely to have multiple health and social needs;

2. screen patients for [unmet needs] and determine the appropriate organizations with the resources and knowledge to address [them];

3. connect patients with these community organizations to address their social needs within the community care coordination system;

4. follow up to ensure patients are connected and facilitate completion of the intervention; and

5. track outcomes of patients receiving community-based services."[70]

The Pathways Community HUB model is a small-scale but promising example of one such program (see *Spotlight* on page 27).

RISK STRATIFICATION: A BEST PRACTICE FOR IDENTIFYING PATIENTS IN PARTICULAR NEED OF COORDINATED CARE

Interviewees consistently identified risk stratification as a best practice for identifying complex patients and tailoring care to their level of need. Risk stratification is the process of categorizing patients into tiers depending on the severity of their health-related needs and deploying resources accordingly. Patients with the highest level of need are provided an intensive suite of services, which typically includes care coordination, while the lowest need patients receive more basic care.

Risk Stratification in Action: Denver Health's 21st Century Care Project

Denver Health is an integrated safety net system serving a large portion of Medicaid and uninsured patients in Denver, Colorado. The system's 21st Century Care Project, funded by the Centers for Medicare and Medicaid Innovation, serves as a model for improving outcomes by tailoring care strategies to the level of patients' physical health, behavioral health and social needs.

The 21st Century Care project uses clinical data to categorize patients into four risk tiers, indicating their level of need. Low risk patients receive basic services, while the highest risk patients are matched with intensive resources, such as multi-disciplinary care teams to help with "care-planning, goal-setting and problem-solving" and "referrals for specialty care, substance abuse treatment, housing and other community resources."[76] Evaluations show that risk stratification improved quality, patient satisfaction and reduced the total cost of care.[77]

Risk stratification is similar to the Camden Coalition's renowned hotspotting technique, which uses clinical data to identify "super-utilizers" and deliver targeted interventions to address unmet medical, behavioral and/or social needs that contribute to frequent and avoidable use of the healthcare system.[74] Studies suggest that the Camden Coalition's programs have improved wellness and reduce costly emergency department visits and hospital admissions.[75]

As healthcare payers, the Federal and state governments should incentivize providers to use risk stratification or hotspotting to identify patients in need of coordinated care. Denver Health provides a promising example of a federally funded risk stratification program (see box above).

2.6 Update Payment and Other Policies to Support the Integration of Community Health Workers into Healthcare Teams

Research supports the integration of Community Health Workers (CHWs) into interdisciplinary care teams by documenting their ability to connect people to needed services, improve health outcomes and establish trusted relationships in the communities they serve.[78] Interviewees overwhelmingly supported the use of CHWs, with several expressing their value both within and beyond healthcare teams.

One of the most significant barriers to integration of CHWs into the healthcare system is a lack of stable funding. States can pursue a number of strategies to address this issue, including filing State Plan Amendments to authorize CHWs to be reimbursed for preventive services; using Section 1115 waivers to reimburse CHWs through Medicaid; and creating line-items for CHWs in state budgets (which can be done at the local level, as well).[79] States can also require Medicaid managed care plans to contract with community health workers, in addition to behavioral health and dental providers (see section 2.2). "Including provisions [in Medicaid managed care contracts] to ensure that contracted CHWs [spend] a significant percentage of their time in the community outside of the clinic or hospital setting" is recommended to maintain relationships with members of vulnerable and/or hard-to-reach populations.[80]

Strengthening CHW credentials may add credibility to the profession among skeptics and pave the way for stable funding. Options that some states have pursued, and others should consider, include "implementing CHW certification to establish professional standards [and] defining the CHW scope of practice in the state by specifying the boundaries that separate CHWs from other health professions."[81] It is worth noting, however, that excessive requirements for accreditation may make it difficult for members of underserved communities to enter the profession.[82] As of 2017, no experimental studies had been conducted to assess the impact of certification, but best available evidence suggests that it supports positive CHW performance in the healthcare system.[83]

SPOTLIGHT: PATHWAYS COMMUNITY HUB

The Pathways Community HUB is a nationally certified community care coordination system that utilizes a network of local agencies to identify high-risk individuals; systematically assess their health and health-related needs; and deploy evidence-based interventions to improve outcomes. Community care coordinators (CCCs)[71] employed by local agencies conduct community outreach and home visits to engage high-risk individuals.[72] CCCs then conduct comprehensive assessments of people's physical health, behavioral health, social, economic and other risk factors, each of which is designated as a Pathway in which evidence-based interventions are applied and progress is tracked. A central HUB minimizes duplication of efforts, while outcome-based payments hold agencies accountable for ensuring that risk factors are not only assessed, but ultimately addressed. Early evidence suggests that the program improves health outcomes and reduces costs.[73]

SUMMARY: KEY POLICIES TO INTEGRATE HEALTHCARE AND COMMUNITY-BASED SERVICES

Federal

As purchaser: Pay for care coordination activities under all types of provider payment models; couple these payments with outcome-based measures to ensure meaningful results; incentivize providers to use risk stratification or hotspotting to identify patients in need of coordinated care.

State

As purchaser: Pay for care coordination activities under all types of provider payment models; couple these payments with outcome-based measures to ensure meaningful results; incentivize providers to use risk stratification or hotspotting to identify patients in need of coordinated care.

Medicaid Agency: File State Plan Amendments to authorize community health workers (CHWs) to be reimbursed for preventive services; use Section 1115 waivers to reimburse CHWs through Medicaid; require Medicaid managed care plans to contract with community health workers, in addition to behavioral health and dental providers.

Department of Health: Create line-items for CHWs in state budgets.

Department of Health: Consider CHW certification to establish professional standards and define the CHW scope of practice.

Local

Department of Health: Create line-items for CHWs in local budgets.

DISCUSSION:

ENGAGE COMMUNITY MEMBERS IN TRANSFORMATION EFFORTS

2.7 Incorporate Best Practice Community Engagement Techniques in Health System Transformation and Population Health Improvement Efforts

Consumer involvement in the development and implementation of Federal, state and local transformation efforts is vital to ensuring that healthcare, public health and social systems are responsive to the needs of the people they serve. At all levels, governments should adhere to best practices when it comes to consumer engagement techniques and encourage private sector-led transformation efforts to do the same. Examples at the state and local levels include having strong "open meetings" laws; holding meetings at times that are convenient for community members to attend; assisting with travel, childcare and translation services; and providing multiple avenues for public participation (online, in-person, etc.).

Interviewees proposed other important recommendations, such as:

- **Ensure that information is not only taken *from* communities, but returned *to* communities.** Engagement efforts run the risk of alienating community participants if they do not inform them how the information collected is being used to bring about change. Better yet, community members should be involved in the

improvement effort from the beginning (see discussion of participatory budgeting below), rather than simply partaking in an exchange of information.

- **Include a diversity of community voices to ensure that diverse racial and ethnic populations and other marginalized groups are represented.**[84] Different groups experience healthcare, public health and social systems differently. Engagement efforts targeting "the usual suspects" (e.g. consumers who are enthusiastic, have ample free time, etc.) may fail to surface an "authentic" community perspective.

- **Improve the evidence base for consumer engagement, generally.** Studies are needed to better understand how patient-informed processes can lead to better health outcomes.

The Collective Impact Forum was specifically identified as a best practice method for meaningfully engaging a diversity of community stakeholders, including community members, in transformation efforts.[85]

Governments should also expand opportunities for consumer engagement by mandating consumer representation in health system governance. For example, the Federal Public Health Service Act requires community health centers to have a consumer majority on their board of directors and Massachusetts requires hospitals to establish patient and family advisory councils (discussed in section 3.10).[86] These laws should be expanded to apply to additional groups of providers and adopted in other states.

PROVIDE NEW ENGAGEMENT OPPORTUNITIES THROUGH PARTICIPATORY BUDGETING

Participatory budgeting—a democratic process that empowers community members to determine how to spend public funds—was recommended by some interviewees as a promising tool for improving engagement.[87,88] Evidence suggests that participatory budgeting strengthens relationships between residents, governments and community organizations; broadens political participation (especially from historically marginalized communities); encourages the development of new community leaders; and makes spending more equitable and effective.[89]

State and local government agencies should use participatory budgeting, when appropriate, to allocate public dollars in ways that are meaningful to communities, including in efforts to advance population health. To date, there are few examples of health-focused participatory budgeting initiatives in the U.S. The St. Louis County Department of Public Health in St. Louis, Missouri has led the most robust effort, using participatory budgeting to select projects to be funded as part of SAMSHA's Resiliency in Communities After Stress and Trauma grant awarded to the department in 2016.[90] In Oakland, California, residents voted to use Federal Community Development Block Grant funds to provide "meals, mobile showers and health services for people experiencing homelessness," in addition to funding other community priorities.[91]

Interviewees familiar with participatory budgeting supported the use of the approach. One interviewee added that participatory budgeting could be used to decide how hospitals spend their community benefit dollars, however, this appears to be an untested recommendation.

SUMMARY: KEY POLICIES TO ENGAGE COMMUNITY MEMBERS IN TRANSFORMATION EFFORTS

<u>**Federal**</u>

All agencies: Have strong "open meetings" laws; hold meetings at times that are convenient for community members; assist with travel, childcare and translation services; and provide multiple avenues for public participation (online, in-person, etc.). Deploy principles of the Collective Impact Forum to ensure inclusiveness and impact.

All agencies: Mandate consumer representation in health system governance whenever federal funds (or tax exemption) are used to provide services. Establish clear guidelines as to what constitutes sufficient consumer engagement.

<u>**State**</u>

All agencies: Pass strong "open meetings" laws; hold meetings at times that are convenient for community members; assist with travel, childcare and translation services; and provide multiple avenues for public participation (online, in-person, etc.). Deploy principles of the Collective Impact Forum to ensure inclusiveness and impact.

All agencies: Mandate consumer representation in health system governance whenever state funds (or tax exemption) are used to provide services. Establish clear guidelines as to what constitutes sufficient consumer engagement.

All agencies: Explore use of participatory budgeting to allocate public dollars in a way that is meaningful to communities, including in efforts to advance population health.

SECTION 3: ENSURE MEANINGFUL ACCESS

ENSURE MEANINGFUL ACCESS TO CARE AND SERVICES THAT MEET PEOPLE'S GOALS AND NEEDS, ESPECIALLY WITHIN UNDERSERVED COMMUNITIES

Creating integrated systems to address health and social needs will not result in better health outcomes if people lack access to needed services. For this reason, many interviewees identified a lack of access as a primary issue that policies should address. They argued that policies should not only remedy physical absences of services and providers, but coverage and cultural barriers that prevent people from seeking needed care, as well. The following table identifies important policy targets to expand healthcare access, particularly within underserved communities.[92]

TABLE 3 Policy Targets to Ensure Meaningful Access to Care and Services that Meet People's Goals and Needs, Especially within Underserved Communities

Objectives	Policymaking Body		Policy Targets
Achieve universal, comprehensive coverage	Federal, state & local	3.1	Adopt one of several possible evidence-based universal coverage policies. Ensure covered benefits are comprehensive; premiums and cost-sharing are tailored to family means; and eligibility criteria (if present) are as simple as possible and designed to enhance population health. Similarly, design provider networks to reflect community goals and needs.
Address provider shortages; increase diversity among providers	Federal & state	3.2	Expand scholarships, federal and state loan repayment programs and other incentives for physicians and mid-level providers to practice in underserved areas and recruit those from under-represented (i.e., minority) groups. Similarly, invest in "pipeline" programs to recruit providers likely to practice in underserved areas, as well as those from under-represented groups.
		3.3	Increase reimbursement for primary care (broadly defined).
		3.4	Broaden non-physician providers' "scope of practice" and/or create new categories of medical and dental providers with expanded authority.
Tailor care delivery settings to community needs	Federal & state	3.5	Improve access by co-locating primary care, behavioral health and oral health facilities. Eliminate regulatory barriers preventing payment for same-day services from FQHCs, behavioral health and dental service providers.
		3.6	Support a transition from traditional, hospital-based care to alternative settings that better meet patients' needs by increasing flexibility for critical access hospitals with respect to the services they provide.
		3.7	Expanding use of and reimbursement for telemedicine.
Make clinical care more patient-centered	Federal, state & local	3.8	Require clinicians to use shared decision-making to surface patients' goals, needs and preferences as a condition of participation in Medicare, Medicaid and government employee health plans.
		3.9	Develop standards for and require providers to undergo anti-oppression and equity training as a condition of participation in government-sponsored coverage.
		3.10	Expand the use of patient and family advisory councils to amplify the consumer voice in governance decisions. Provide adequate training and support, when necessary, to ensure that a diversity of community members can participate effectively.
Use measurement and feedback systems to judge performance	Federal, state & local	3.11	Use a multi-stakeholder process to determine how overall success will be measured, develop new measures as needed and ensure meaningful feedback mechanisms to evaluate progress.

DISCUSSION:
ACHIEVE UNIVERSAL, COMPREHENSIVE COVERAGE

It is widely recognized, in the health policy community and among interviewees, that healthcare coverage is a basic prerequisite to ensuring that the health system meets people's goals and needs. This view is supported by overwhelming evidence tying coverage to improved health outcomes and, in some circumstances, greater equity.

The benefits of coverage, as documented by the Institute of Medicine's *Care without Coverage: Too Little, Too Late* and other studies, include (but are not limited to):[93]

- Higher likelihood of receiving preventive and screening services
- Greater likelihood of survival due to an earlier diagnosis and effective treatment of life-threatening conditions
- Better management of chronic diseases
- Fewer disparities in the receipt of preventive, screening and cardiovascular services
- Improved financial security

Similarly, increasing comprehensiveness of covered benefits is associated with additional advantages, such as greater and more appropriate use of services. The evidence is particularly strong with respect to the inclusion of mental health benefits.[94]

High healthcare costs and well-documented market failures have firmly established that universal coverage cannot be achieved through market forces alone. Policy proposals to achieve universal coverage are diverse and range from single payer (Medicare-for-all type approaches) to a combination of coverage approaches that don't leave any "holes."[95,96] Due to the significant body of literature on evidence-based strategies to expand coverage, we do not put forth specific policies in

this agenda. Instead, we recommend that state and federal legislators ensure that coverage policies include the following critical attributes:

1) **Covered benefits must be comprehensive.** Health plans should cover (in an integrated fashion) services to address medical, behavioral and oral healthcare for all individuals. Additionally, health plans should have proven mechanisms for working with non-social support providers, as needed, for their covered population.

2) **Premiums and cost-sharing must be tailored to family means.** Financial barriers far exceed other reasons that people do not obtain coverage or receive care.[97] Unlike other sectors, the healthcare system lacks a standard by which to determine whether healthcare costs are affordable.[98] Research is needed to establish a fair "affordability standard" that not only takes into account income, but individuals' and families' non-healthcare-related living expenses, as well.

3) **Eligibility criteria (if present) must be as simple as possible and designed to enhance population health.**[99] Eligibility criteria must be easy for people to understand and designed in a way that enhances, not inhibits, healthcare access for vulnerable populations. Along these lines, it is important to recognize that equity and health system transformation goals cannot be achieved with restrictions that limit eligibility for certain groups (e.g. undocumented immigrants). These restrictions should be eliminated in recognition that preventing any group of people from accessing healthcare has health and financial implications for the population at-large.

Furthermore, streamlining eligibility requirements across Medicaid, SNAP and other safety net programs would decrease administrative complexity that may prevent

some Medicaid-eligible individuals from enrolling in the program. This is a central focus of governmental efforts to create no-wrong-door systems, in which multiple state and community agencies work together to ensure that people are guided to appropriate health-related supports, regardless of the agency they contact for information.[100,101]

4) **Cost-sharing and other benefit design considerations must be as simple as possible and reinforce larger system goals.** Studies show that consumers are impaired by health plan complexity and desire simplicity. For example, they generally prefer cost-sharing in the form of predictable copays as opposed to less predictable co-insurance.[102] While there have been a number of experiments with sophisticated cost-sharing benefit designs (high deductible designs with deductible

exemptions,[103] value-based insurance designs,[104] wellness incentives, etc.[105]), these complex approaches lack evidence of effectiveness.

5) **Provider networks and incentives must be designed to support health equity and a comprehensive approach to meeting patients' goals and needs.** Provider networks should include a diversity of healthcare providers and be tailored to community needs. For example, networks covering communities struggling with mental health and substance use disorders (SUD) should strive to include a greater number of mental health and SUD providers.

6) If single payer is not used, **coverage approaches must achieve alignment across public and private payers with respect to priorities, measures for success, payment and other incentives facing providers.**

SUMMARY: KEY POLICIES TO ACHIEVE UNIVERSAL, COMPREHENSIVE COVERAGE

Federal

Congress: Pass comprehensive, universal health coverage legislation.

CMS: *Alternatively*, modernize the state flexibility offered under 1332 waivers to encourage all evidence-based coverage expansion approaches, while maintaining strict guardrails to ensure residents are not worse off.

AHRQ/NIH: Research to establish an evidence-based, fair "affordability standard" for healthcare.

State

If universal coverage not addressed at the federal level:

Legislature: Expand Medicaid, if not already done.

Department of Health: Use state flexibility offered under 1332 waivers or another approach to further expand comprehensive, affordable coverage; commission research to establish an evidence-based, fair "affordability standard" for healthcare.

Across agencies: Integrate eligibility requirements across Medicaid, SNAP and other safety net programs to support a "no wrong door" approach to enrollment. Minimize the complexity of complying with these requirements.

As purchasers: Keep cost-sharing design as simple as possible and evidence-based; also, require provider networks be tailored to community needs, including pathways to public health and social service providers as needed.

Across agencies: If a single payer approach is not used, strive to achieve alignment across public and private payers with respect to priorities, measures for success, payment approaches and other incentives facing to providers.

DISCUSSION:

ADDRESS PROVIDER SHORTAGES AND INCREASE DIVERSITY AMONG PROVIDERS

As the deliverers of healthcare services, doctors, nurses and other providers are the most important resource in our healthcare system. Their presence or absence in communities has life-altering consequences and their actions, attitudes and beliefs shape the way that people feel about the care they receive. Increasingly, notions of who qualifies as a healthcare provider are expanding beyond the narrow scope of physicians, nurses and dentists. Healthcare stakeholders, including public and private payers, are now recognizing the role of other providers—such as pharmacists, paramedics and nurse midwives—in keeping people healthy. The policy recommendations in the following sections apply to many types of providers in recognition and support of this trend.

3.2 Expand Scholarships and Loan Repayment Programs and Other Incentives to Practice in Underserved Areas and Recruit Providers from Racially and Ethnically Diverse Groups

IMPROVE RECRUITMENT & RETENTION IN UNDERSERVED AREAS

It is well-documented that some communities, such as those in rural areas, struggle to recruit and retain qualified medical professionals, creating significant (and potentially life-threatening) barriers to care. Challenges to recruiting and retaining healthcare providers include too high or too low patient volumes, reduced income from treating populations primarily covered by public insurance and a lower quality of life.[106]

Federal and state loan repayment programs (through the National Health Service Corps) effectively recruit primary care, dental and behavioral health providers in the short term, although retention rates decrease over time.[107] Nevertheless, these programs are vital to

increasing access to primary care, oral health and behavioral health services for high-need populations and should be expanded, along with federal and state scholarships provided to future physicians, physician assistants, nurse practitioners, nurse midwifes and dentists in exchange for service in underserved areas after graduation. Increasing the availability of Graduate Medical Education training in rural settings would further incentivize providers to practice in these communities.[108]

States can grow healthcare workforces locally by investing in pipeline programs and reducing barriers to medical education for students from underserved communities. The University of Kansas School of Medicine, for example, offers admissions preference to applicants raised in rural areas, while other schools have opened campuses in small towns to increase the number of local residents that apply.[109] It is thought that growing healthcare workforces locally will improve retention, as these individuals are more likely to return to their hometowns to practice. Another innovative example of states' efforts to increase the number of providers in underserved areas is Maryland's "Health Enterprise Zones" (see *Spotlight* on page 34).

INCREASE DIVERSITY IN CLINICAL PROFESSIONS

Some evidence suggests that increasing racial and ethnic diversity among healthcare providers can improve access to care in underserved communities with large racially and ethnically diverse populations and increase minority patient satisfaction.[112] State and/or federal policy options for diversifying the healthcare workforce, as identified in Families USA's *Framework for Advancing Health Equity and Value*, include:[113]

- Expanding K-12 pipeline programs to ensure academic readiness and entryways into healthcare professions for more people from underrepresented groups;

- Increasing the amount of loan repayment, loan forgiveness and other financial incentives available for healthcare providers from under-represented groups, such as through the National Health Service Corps and various state initiatives;

- Requiring state health profession licensing boards (physicians, nurses, dentists, etc.) to collect demographic data on recipients of licenses;

- Providing direct financial incentives for healthcare organizations to hire and retain healthcare providers and organizational leaders from underrepresented groups, with a particular focus on hiring those individuals from the health organization's own community; and

- Requiring or incentivizing healthcare systems to have members of under-represented groups serve in senior leadership positions and as board members.

3.3 Increase Reimbursement for Primary Care

Access to primary care plays a major role in determining people's health outcomes, but has long been under-prioritized in our healthcare system.[114] The mindset that primary care is less valuable than specialty is reflected in lower reimbursements for primary care providers compared to specialists.[115] This has contributed to a shortage of primary care providers that, in many communities, translates to an inability for residents to receive basic care.

The Federal and state governments can encourage medical students to specialize in primary care by increasing payments to primary care providers. Because prices paid by private payers are often a multiple of the Medicare rate (for example, 130 percent), government actions may create an environmental shift that encourages private payers to do the same. The Medicare Access and Payment Commission (MedPAC) has proposed a budget-neutral strategy to increase Medicare primary care payments to providers.[116]

A few interviewees also expressed a need for payments (and training) to incentivize primary care physicians to conduct behavioral and oral health screenings and to provide basic dental services when dedicated providers of these services are scarce or otherwise inaccessible. Some states, such as California, have begun experimenting with this approach.[117]

3.4 Broaden "Scope of Practice" Laws and Create New Categories of Non-Physician Providers

Physician shortages and burnout can be mitigated through state "scope of practice"

SPOTLIGHT: MARYLAND'S HEALTH ENTERPRISE ZONES

Maryland's Health Enterprise Zone Initiative was a 4-year, state-funded pilot to "reduce health disparities among diverse racial and ethnic populations and among geographic areas; improve healthcare access and health outcomes in underserved communities; and reduce healthcare costs and hospital admissions."[110] The initiative devoted resources to five economically disadvantaged communities demonstrating poor health outcomes (a.k.a Health Enterprise Zones) and provided tax credits, grants and loan repayment assistance to attract providers. Evaluations showed that the initiative increased the Health Enterprise Zones' capacity to deliver services (by adding and expanding healthcare delivery sites attracting and retaining providers) and provided new/expanded existing primary care, behavioral health, dental, public health and social services.[111]

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laws that authorize other qualified medical professionals, like nurse practitioners and physician assistants, to provide a limited set of services that are traditionally provided by physicians. The rationale is that non-physician providers can skillfully perform routine services, allowing physicians to focus on tasks that require a higher level of clinical expertise. Despite pushback from physician organizations, studies show that non-physician providers can, under the right circumstances, provide an equivalent level of care.[118]

Interviewees overwhelmingly supported this approach. One interviewee stipulated, however, that the services that mid-level providers become empowered to provide must be rooted in an independent, evidence-based determination.

Alternatively, states can use their legislative authority to create entirely new categories of mid-level providers. Examples of medical and dental providers established by governmental bodies to expand access are described in the *Spotlights* below.

SPOTLIGHT: MINNESOTA'S DENTAL THERAPISTS

In 2009, Minnesota became the first state to pass legislation establishing two new categories of mid-level dental providers: dental therapists (DTs) and advanced dental therapists (ADTs).[122] DTs and ADTs work as part of a dental team to deliver educational, clinical and therapeutic services in settings that serve primarily low-income, uninsured and underserved patients, or in Health Professional Shortage Areas for dental care.[123]

Clinics that have employed DTs have reported increased ability to accept new patients—particularly those who are publicly insured, uninsured and/or medically complex (such as elderly people and refugees). Patients (especially those in rural areas) report shorter wait times before getting an appointment and shorter travel distances to receive care.[124] Limited information on the impact of DTs is available after 2014, however, the Minnesota Department of Health's Dental Therapy Toolkit reports largely consistent findings from a survey of DT employers conducted in 2016.[125]

SPOTLIGHT: MISSOURI'S ASSISTANT PHYSICIANS

Missouri passed legislation creating a new type of non-physician provider called an "assistant physician" in 2014. Licensed assistant physicians are medical school graduates who did not complete a residency, but are authorized to practice primary care alongside a physician in one of the state's provider shortage areas.[119,120] **Assistant physicians are different from physician assistants**, who do not attend medical school (and therefore cannot use the title "Dr."), can practice medicine with varying degrees of physician oversight in primary or specialty care and are not restricted to practicing in underserved areas. As the first state to pass such legislation, Missouri's approach has yet to be formally evaluated.[121] Nevertheless, it serves as an innovative example of how states can leverage untapped resources (e.g., medical school graduates who cannot practice independently) to expand access to care.

Additional governmental policies needed to support the expansion of non-physician providers, as identified by Families USA, include:[126]

• "Establishing payment or increasing payment rates for these providers in traditional fee-for-service payment models;

• Requiring Medicaid managed care plans and/or [Qualified Health Plans] to include these providers in their networks;

• Building mid-level providers into the design of Medicaid waivers or other Medicaid value-based payment programs;

• Building mid-level providers into the design of broad CMMI value-based models;

• Designing a CMMI model to specifically test the best models for integrating more mid-level providers into care teams; and

• Increasing the amount of loan repayment, loan forgiveness and other financial incentives available for mid-level providers from underrepresented groups and/or [those] who practice in primary care in health professional shortage areas."

SUMMARY: KEY POLICIES TO ADDRESS PROVIDER SHORTAGES AND INCREASE DIVERSITY AMONG PROVIDERS

Federal

HRSA/NHPC: Increase loan repayment and scholarships to incent primary care, dental and behavioral health providers to serve in underserved areas of the country.

CMS: Increase the availability of Graduate Medical Education opportunities in rural and frontier areas.

State

Department of Health: Increase loan repayment and scholarships to incent primary care, dental and behavioral health providers to serve in underserved areas, including non-physician providers; invest in pipeline programs and reduce barriers to training for students coming from underserved communities.

Department of Health: Broaden non-physician providers' "scope of practice" and/or create new categories of medical and dental providers with expanded authority, consistent with evidence and community needs; require Medicaid managed care plans and/or Qualified Health Plans to include non-physician providers in their networks and consider appropriate payment rates.

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HEALTHCARE VALUE HUB

DISCUSSION:
TAILOR CARE DELIVERY SETTINGS TO COMMUNITY NEED

3.5 Co-locate Primary Care, Behavioral Health and Oral Health Facilities

Co-location of primary care, behavioral health and dental services creates a one-stop-shop for people to receive basic care. The benefits of co-location include convenience, improved access, streamlined referrals and better communication between healthcare providers. Moreover, locating several services under one roof may decrease stigma-related barriers to access, particularly with regards to behavioral health.[127] Interviewees largely supported the co-location of medical, behavioral health and dental services, in addition to social services, but noted that co-location is not the same as integration. According to one interviewee, it is simply the first step towards the ultimate goal.

While co-location may reduce physical barriers to care, Medicaid payment policies in some states undermine the approach. As of December 2018, only 32 states and the District of Columbia allow reimbursement for physical and behavioral health services delivered on the same day at a provider site. In other states, Medicaid may only reimburse providers for one of the services provided, potentially causing beneficiaries to be turned away at the point of care.[128] Some states also limit same-day billing for medical and dental services provided in Federally Qualified Health Centers, facilities which many Medicaid beneficiaries rely on.[129] Eliminating these policies is vital to integrating medical, dental and behavioral care in order to better meet people's goals and needs.

3.6 Increase Flexibility for Critical Access Hospitals to Provide Needed Services

There is a growing understanding that traditional hospital-based care is not always sufficient to meet the goals and needs of the people the health system serves. In rural areas particularly, Critical Access Hospitals (CAHs) increase access to some services, but basic healthcare needs often remain unaddressed. This has led some policy experts to believe that people living in rural communities may be better served through a combination of primary care, emergency services and telehealth for specialty care.

Current regulations governing CAHs prevent them from tailoring their services to community needs. Increasing flexibility to allow for locally-driven approaches to system re-design is a commonly recommended solution among rural stakeholders.[130] In 2017, two federal legislative proposals were set forth that contained flexibility-enhancing provisions, however, neither became law.[131] Federal policymakers should continue to introduce legislation that would allow CAHs to better meet the needs of community residents. CMMI can build support for these proposals by launching a CAH-focused demonstration project to test new models of delivering care.

3.7 Expand Use of and Reimbursement for Telemedicine

The majority of interviewees identified telemedicine as a pivotal strategy to expand access to care in underserved, particularly geographically isolated, communities. However, barriers to widespread implementation—such as infrastructure, licensure and reimbursement challenges—have prevented the use of the strategy to its fullest extent.

Infrastructure. In rural areas, lack of broadband access poses a major barrier to provider participation in telemedicine programs. To address this issue, the Federal Communications Commission (FCC), an independent agency overseen by Congress, should restore cuts to subsidies that reimburse broadband providers for servicing rural areas.[132] Through

expansion of the FCC's Health Care Connect Fund, specifically, the Federal government can further support rural providers in their quest for broadband connectivity.[133]

Licensure. Licensure requirements that prohibit providers from treating patients (even electronically) in states where they are not licensed also undermines the goal of increasing access to care in remote communities. States can, and should, adopt the Interstate Medical Licensure Compact to better enable clinicians to provide telemedicine services across state lines.[134] Other compacts that states can join include the Enhanced Nurses Licensure Compact, the Physical Therapy Compact and the soon-to-be-operational Psychology Interjurisdictional Compact.[135]

Reimbursement. The Federal and state governments have taken several actions to expand telehealth

reimbursement, but barriers remain. Persistent challenges include the lack of parity between payments for telemedicine and in-person visits; the absence of standards specifying how payments should be shared between telemedicine providers and the facilities in which people receive virtual services; changes in private payer reimbursement policies; and limits on the types of services public and private payers will reimburse.[136]

States should begin to address these challenges by broadening the scope of services, settings and providers eligible for reimbursement under their Medicaid programs and comprehensive private payer laws with identical coverage requirements. Additionally, states should require private payers to reimburse equivalent amounts for telemedicine and in-person services. According to Milbank Memorial Fund, 31 states and the District of Columbia had passed some form of private payer law, but only three had passed payment parity laws as of 2017.[137]

SUMMARY: KEY POLICIES TO TAILOR CARE DELIVERY SETTINGS TO COMMUNITY NEEDS

Federal

Federal Communications Commission: Restore subsidies that reimburse broadband providers for servicing rural areas.

Congress: Allow Critical Access Hospitals to offer primary care and telehealth services, as appropriate to meet the needs of community residents.

CMS: Permit demonstration projects to test new Critical Access Hospital based models of delivering care; broaden the scope of telemedicine services, settings and providers eligible for reimbursement under Medicare.

State

Medicaid Agency: Remove limits on same-day billing for medical and dental services provided in Federally Qualitied Health Centers and other facilities that offer co-located services. Encourage the provision of co-located services.

Department of Health: Adopt the Interstate Medical Licensure Compact to better enable clinicians to provide telemedicine services across state lines; Similarly, the Enhanced Nurses Licensure Compact, the Physical Therapy Compact and the soon-to-be-operational Psychology Interjurisdictional Compact.

As purchaser: Broaden the scope of telemedicine services, settings and providers eligible for reimbursement under Medicaid.

Legislature: Pass legislation requiring private payers to reimburse for identical telemedicine services, setting and providers as the state Medicaid program.

DISCUSSION:
MAKE CLINICAL CARE MORE PATIENT-CENTERED

3.8 Require Clinicians to Use Shared Decision-Making to Surface Patients' Goals, Needs and Preferences

Patient shared decision-making (PSDM) is a process in which clinicians and patients work together to make treatment decisions in a way that balances clinical evidence with patients' goals and needs.[138] When done properly, PSDM can help address communication gaps, increase adherence to treatment regimens and improve patient satisfaction.[139] In 2018, the National Quality Forum began an initiative to make PDSM a standard of care for all patients, regardless of healthcare settings and conditions.[140,141]

As the nations' largest healthcare payers, the Federal and state governments can further this goal by certifying patient decision aids[142] and requiring providers to use them (when appropriate) as a condition of participation in Medicare, Medicaid and government employee health plans. Washington State began certifying patient decision aids in 2016 and has since certified several in the areas of maternity care and labor/delivery; total joint replacement and spine; end of life care.[143]

Interviewees cited logistical challenges to requiring providers to adopt PSDM tools, which will be important to address. These include a lack of payment for the time providers spend educating and communicating with patients and difficulty reliably measuring providers' use of patient decision aids at the point of care. Some also identified a need for a "culture shift" in which providers are trained to view patients as partners.

3.9 Develop Standards for and Require Providers to Undergo Anti-oppression and Equity Training

In their role as healthcare purchasers, states can require provider networks to engage in activities designed to reduce implicit bias and make healthcare more equitable. For example, Oregon requires providers in its coordinated care organizations (CCOs) to undergo cultural competency[144] training and "develop plans to reduce racial and ethnic disparities."[145,146]

Numerous interviewees cited Oregon's CCOs as a model for advancing health equity, but they were less enthusiastic about cultural competency training as a stand-alone approach. Indeed, while there is some evidence to suggest that cultural competency training improves patient satisfaction among racially and ethnically diverse populations, the low quality and methodological rigor of existing studies indicates a need for further examination.[147]

Instead, some interviewees expressed a need for "anti-oppression and equity" training to prepare providers to operate in ways that combat structural racism and oppression. Currently, there are seemingly few examples of anti-oppression and equity training taking place in healthcare settings,[148,149] however, promising programs from other sectors may offer insights regarding best practices moving forward.[150] The Center for Health Progress' *Waiting for Health Equity: A Graphic Novel* is one example of a tool that can be used in trainings for healthcare providers.[151]

3.10 Expand the Use of Patient and Family Advisory Councils to Amplify the Consumer Voice

There is overwhelming consensus that health system transformation requires substantial input from patients and caregivers to make healthcare more patient-centered. At the organizational level, patient and family advisory councils (PFACs) are essential to ensuring that healthcare organizations' goals and activities align with peoples' wants and needs.

States can ensure that consumers get a seat at the decision-making table by requiring hospitals to adopt PFACs and adhere to best practices with regards to their design.[152] In 2008, Massachusetts passed the nation's first Patient and Family Advisory Council law, requiring all acute-care and rehabilitation hospitals to adopt PFACs by 2010.[153] See box on the right for a subset of regulations issued by the state's Department of Public Health.

Massachusetts and other states could go further by requiring hospitals to subsidize transportation and offer childcare, language services and other supports to encourage consumer participation. These offerings are particularly important for engaging members of low-income, underserved communities, who are typically under-represented in these discussions.

Requirements for Massachusetts' Patient and Family Councils

- PFACs must meet at least quarterly.

- Meeting minutes, including accomplishments, must be sent to the hospital's governing body.

- At least 50% of the PFAC members must be current or former patients or family members. It is recommended that each PFAC have a patient or family member as a chair or co-chair.

- PFAC membership should reflect the community served by the hospital.

- Each hospital must write an annual report on the work of the PFAC, which must be available upon request to members of the public and the Department of Public Health.[154]

SUMMARY: KEY POLICIES TO MAKE CLINICAL CARE MORE PATIENT-CENTERED

Federal

As purchaser: Make shared decision-making as the standard of care, providing reimbursement, technical assistance with decision aids and an on-ramp that supports culture shift.

CMS/AHRQ/NIH: Support research on effective "anti-oppression and equity" trainings to prepare providers to operate in ways that combat structural racism and oppression.

State

As purchaser: Make shared decision-making as the standard of care, providing reimbursement, technical assistance with decision aids and an on-ramp that supports culture shift.

Department of Health: Require hospitals to adopt patient and family advisory councils and adhere to best practices with regards to Council design.

DISCUSSION:
USE MEASUREMENT AND FEEDBACK SYSTEMS TO JUDGE PERFORMANCE

3.11 Use a multi-stakeholder process to determine how overall success will be measured, develop new measures as needed and ensure meaningful feedback mechanisms to evaluate progress

A key theme surfaced through expert interviews was the importance of having strong measurement systems to determine whether policies and programs are effective. Interviewees explained that simply screening patients for unmet needs or requiring providers undergo equity training does not ensure that needs are met and equity is achieved. The highly-regarded theory of Collective Impact supports these views—one of the model's core tenets is to, not only establish a shared vision, but also a shared system to measure progress towards communal goals.

Stakeholders, including healthcare consumers, will need to work together to answer questions like "what does success look like?" and "how will we measure it?" It is likely that the measures we use currently will be inadequate for the task. For example, broad measures of population health (including self-reported survey data about disease, disability, health status, service use and access to care) are difficult to attribute to the care people receive versus social factors.[155] On the other hand, we have a wealth of highly specific quality measures, but most are "too narrow to tell us very much about how the health system overall influences the level of health in the population, even assuming that they were consistently reported and available to be analyzed (which they are not)."[156] Another review noted that even these measures contain important gaps, especially in the areas of mental health, financial protection and health system responsiveness research.[157]

An exercise to develop meaningful measures at the national level is described in the Institute of Medicine's *Vital Signs: Core Metrics for Health and Health Care Progress*.[158] The multi-stakeholder working group started by identifying the priority needs of the healthcare system and recommended a core set of measures that could be used to track progress towards addressing those needs. The identified measures extended beyond the traditional healthcare system to include those pertaining to societal factors that influence health, like rates of high school graduation, addiction, health literacy and community support. The exercise surfaced numerous gaps in current measurement efforts, leading working group members to recommend that the Secretary of Health and Human Services leads an effort to implement and improve the identified measures over time. Communities can replicate this process in order to identify and develop measures that reflect the priorities of their residents.

ALIGN PROVIDER PERFORMANCE MEASURES WITH OVERALL SYSTEM MEASURES

Many factors influence the overall wellbeing of community residents. To the extent that wellbeing is influenced by healthcare delivery, measures used to assess provider performance and/or determine provider payment should be aligned with overall health system goals (for example, improving equity). To ensure that providers participating in risk-based payment programs are not unfairly penalized for factors beyond their control, the U.S. Department of Health and Human Services should "prioritize the development and continued refinement of risk adjustment methods to account for social risk factors."[159]

Balance Structural and Process Measures with Outcomes Measures

While outcome-based measures are typically considered "the gold standard" in quality measurement for providers, it is important to recognize that structural and process measures have value, as well. For instance, they can be used to incentivize providers to adopt best practices like patient shared decision making (discussed in section 3.7). Given the nascence of efforts to integrate primary care, behavioral health and oral health, structural and process measures can also incentivize alignment between providers. Examples include measuring the use of health information technology that allows providers to exchange information and screening for oral and behavioral health needs in primary care settings (see section 3.3).[160] The Federal, state and local governments may continue to rely on these measures, as appropriate, but should seek out and seize opportunities to use outcome-based measures when possible.

Interviewees noted that, while the Federal government and some states have experimented with programs that pay traditional healthcare providers based on patient health outcomes,[161] the behavioral health and dental fields are further behind. In particular, efforts to develop outcome-based measures for behavioral health have been hindered by a lack of evidence supporting best-practice treatment for people with substance use disorders.[162]

Evaluate Patient Experience Measures[163]

Patient experience measures are an important contribution to the array of measures supporting our ability to evaluate health system performance. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, developed by the Agency for Healthcare Research and Quality, are currently the most widely distributed tool for collecting information on consumers' healthcare experiences. See Table 4 for the range of organizations and health issues CAHPS surveys cover.

TABLE 4 **Types of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys**

Experience by Type of Organizations
Consumer Experience with Providers
• Clinician & Group (ACOs and MIPS Participants)*
• Hospice*
• Home Health Care*
• Surgical Care
• American Indian
Consumer Experience with Facility Based Care
• Hospital (Adult* & Child)
• In-Center Hemodialysis*
• Nursing Home
• Outpatient & Ambulatory Surgery*
• Emergency Department (Under Development)
Consumer Experience with Health Plans & Related Services
• Health Plan (Commercial & Medicaid)
• Dental Plan
• Home and Community-Based Services*
Experiences by Health Issue
• Cancer Care
• Mental Healthcare

* Survey administered by CMS[165]

In some cases, provider payment is tied to the use of these surveys, incentivizing providers to systematically collect and evaluate patient experience information. Hospitals, for example, must collect and submit Hospital CAHPS (a.k.a HCAHPS) data to receive payments through the Inpatient Prospective Payment System and Hospital Value-Based Purchasing program. Survey results must also be publicly reported, further encouraging hospitals to provide patient-centered care.[164] As healthcare payers, the Federal and state governments should continue to evaluate how and when to tie provider payments to patient experience measures.

All told, a variety of feedback mechanisms is vital to ensure progress towards health system transformation goals.

SUMMARY: KEY POLICIES TO SUPPORT MEASUREMENT AND FEEDBACK SYSTEMS TO JUDGE PERFORMANCE

Federal

HHS: Provide technical assistance, funding, and research to support to states and communities in identifying a core set of measures that reflect community priorities, to be used to assess overall system progress towards goals and establish a diversity of feedback mechanisms.

CMS/AHRQ/NIH: Prioritize the development and continued refinement of risk adjustment methods to account for social risk factors.

State

Across agencies: Use a multi-stakeholder process to identify a core set of measures that reflect community priorities, to be used to assess overall system progress towards goals. Align these overall system measures with performance measures used with vendors.

Across agencies: Identify/establish a diversity of feedback mechanisms to measure progress towards these system performance measures.

CONCLUSION

This policy roadmap provides an extensive, but not exhaustive, discussion of governmental policies needed to achieve our health system transformation goal:

> **Ensuring that the healthcare system works seamlessly with public health, social sectors and community members to address the goals and needs of the people it serves and advance health equity.**

While it is unlikely that these policies will all be implemented simultaneously, it is critical that we work from a comprehensive roadmap to ensure that health system transformation efforts are *systematic* and *evidence-based*.

Critical themes surfaced in this exercise included the following:

▲ Collectively agreed upon performance measures and "feedback loops" at every level of the system are needed to ensure that provider incentives are aligned with overall health system goals, in addition to broader measures used to gauge progress towards community goals (across heath, social and public health sectors).

▲ Flexible financing is needed to move healthcare dollars "upstream," and new dollars must be invested in social sectors, which are severely under-funded.

▲ Successful integration of primary care, dental care, behavioral healthcare and social supports will require aligned incentives, interoperable data systems that share patient data and empowered care coordinators for patients with more complex needs.

▲ Comprehensive, affordable health insurance is critical to accessing care. States or the Federal government must adopt one of several proven methods to achieve universal coverage.

▲ Policies that elevate the voice of a diversity of consumers (including patients, caregivers and others) are vital to achieving the transformation goal.

Most importantly, across our literature review and our conversations with experts, we found no insurmountable barrier to achieving our health system transformation goal. Indeed, the Policy Roadmap is replete with proof-of-concept examples showing where these policies are already working in communities.

Critical next steps identified by our interviewees include learning how to effectively communicate these ideas to non-policy audiences and ensuring that these policy recommendations reach the hands of decision makers at the right time and place.

Altarum's Healthcare Value Hub and other organizations cited throughout this report can serve as partners in these efforts by connecting stakeholders and sharing evidence-based strategies to make the healthcare system more equitable and person-centered. Moreover, our "toolkit" (**Appendices A through G)** provide valuable "quick start" materials for a variety of audiences.

We consider this roadmap a "living document" and welcome improvements and additions. Please send your comments and suggestions to Hubinfo@ altarum.org.

ENDNOTES

1. Bipartisan Policy Center and HealthIT Now, *The Future Role of Government in Health Information Technology and Digital Health*, Washington, D.C. (February 2018). https://bipartisanpolicy.org/wp-content/uploads/2018/02/BPC-Health-Innovation-Information-Technology-and-Digital-Health-1.pdf. See also: https://nam.edu/wp-content/uploads/2018/02/2.2-Alger_NAM-slides_01_30_2018-002.pdf

2. This viewpoint is also described in an article featured in *NEJM Catalyst*. See: Adler-Milstein, Julia, "Moving Past the EHR Interoperability Blame Game," *NEJM Catalyst* (July 18, 2017). https://catalyst.nejm.org/ehr-interoperability-blame-game/

3. Bipartisan Policy Center and *HealthIT Now* (Feb 2018).

4. The U.S. Office of the National Coordinator for Health Information Technology's *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap* describes the department's strategy for expanding interoperability through 2024. https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

5. U.S. Office of the National Coordinator for Health Information Technology, *State Health IT Policy Levers Compendium*, https://dashboard.healthit.gov/apps/state-health-it-policy-levers-compendium.php (accessed on Feb. 15, 2019).

6. Patient Care Intervention Center, *Unified Care Continuum Platform*, https://pcictx.org/products-services/unified-care-continuum-platform (accessed on Feb. 15, 2019).

7. Available at: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

8. Rubin, Victor, *Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health*, Policy Link, Oakland, Calif. (August 2018). http://www.policylink.org/resources-tools/counting-a-diverse-nation

9. U.S Department of Health and Human Services, *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule*, https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#safeharborguidance (accessed on Feb. 14, 2019).

10. Berchick, Edward R., Emily Hood and Jessica C. Barnett, *Health Insurance Coverage in the United States: 2017*, United States Census Bureau, Washington D.C. (September 2018). https://www.census.gov/library/publications/2018/demo/p60-264.html

11. The Hilltop Institute, *Community Benefit State Law Profiles*, Baltimore, M.D. (n.d.). https://hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/

12. Academy for State Health Policy, *Hospital Community Benefits Comparison Table for Six New England States*, (n.d.). https://nashp.org/wp-content/uploads/2018/05/Hospital-community-benefits-chart-final-5_3_2018.pdf

13. The Columbia Gorge Region includes Hood River, Wasco, Sherman, Gilliam, Wheeler counties in Oregon and Skamania and Klickitat counties in Washington.

14. Robert Wood Johnson Foundation, *Columbia Gorge Region, Oregon and Washington: 2016 Culture of Health Prize Winner*, https://www.rwjf.org/en/library/features/culture-of-health-prize/2016-winner-oregon-washington.html (accessed on Feb. 3, 2019). See also: Columbia Gorge Regional Community Health Assessment 2016 See also: *Columbia Gorge Regional Community Health Assessment* 2016 http://cghealthcouncil.org/wp-content/uploads/2017/06/Columbia-Gorge-Community-Health-Assessment-Full-Document-June-2017.pdf and *Columbia Gorge Regional Community Health Improvement Plan 2017* https://cghealthcouncil.org/wp-content/uploads/2018/01/Columbia-Gorge-Community-Health-Improvement-Plan-2017-Final.pdf

15. U.S. Department of the Treasury, Internal Revenue Service, "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return," *Federal Register*, Volume 79, No. 250 (Dec. 31, 2014). https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf

16. UCLA Center for Health Policy Research, *Asset Mapping*, Los Angeles, Calif. (n.d.). https://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba20.pdf

17. U.S. Department of Health and Human Services Office of the Chief Technology Officer, *The State of Data Sharing at the U.S. Department of Health and Human Services*, Washington, D.C. (September 2018). https://www.hhs.gov/sites/default/files/HHS_StateofDataSharing_0915.pdf

18. The Affordable Care Act provided state funding to support the integration of data across state agencies. Information on the status of state efforts to integrate health and human services systems, as of December 2016, can be found here: https://aspe.hhs.gov/system/files/pdf/255411/StateHHSSystems.pdf

19. The Allegheny County Department of Human Services, *Allegheny County Data Warehouse*, Pittsburg, P.A. (July 2018). https://www.alleghenycountyanalytics.us/wp-content/uploads/2018/07/18-ACDHS-20-Data-Warehouse-Doc_v6.pdf

20. Dube, Sara and Darcy White, *Washington State Data Warehouse Fosters Comprehensive, Frequent Program Evaluations*, PEW Charitable Trusts (Dec. 5, 2018). https://www.pewtrusts.org/en/research-and-analysis/articles/2018/12/06/washington-state-data-warehouse-fosters-comprehensive-frequent-program-evaluations

21. See: State Health Reports, County Health Rankings http://www.countyhealthrankings.org/explore-health-rankings/reports/state-reports (accessed on Feb. 15, 2019) and Center for Applied Research and Engagement Systems (CARES) Engagement Network, https://engagementnetwork.org/assessment/ (accessed on Feb. 15, 2019).

22. Mongeon, Marie, Jeffrey Levi, and Janet Heinrich. "Elements of Accountable Communities for Health: A Review of the Literature," *NAM Perspectives*. Discussion Paper, National Academy of Medicine (November 2017). https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/

23. Siegel, Beth, et al., "Multisector Partnerships Need Further Development to Fulfill Aspirations for Transforming Regional Health and Well-Being," *Health Affairs* (January 2018).

24. Mongeon (November 2017).

25. Washington Health Care Authority, *Accountable Communities of Health (ACH)*, https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach (accessed on Feb. 15, 2019).

26. North Sound Accountable Community of Health, *About Our ACH*, http://www.northsoundach.org/about/ (accessed on Feb. 15, 2019).

27. Jones, Shyloe, *Community Level, Multi-Stakeholder Approaches to Improve Healthcare Value*, Research Brief No. 26, Altarum Healthcare Value Hub (May 2018). https://www.healthcarevaluehub.org/files/6615/2657/6508/RB_26_-_Accountable_Health_Structures.pdf

28. In the past, states could also pursue funding through CMMI's State Innovation Model and Accountable Health Communities Model initiatives, but the programs are not currently accepting new applications.

29. Academy Health's Payment Reform for Population Health initiative (supported by RWJF) outlines several considerations for establishing a trusted convener and governance and building a trusted environment. Key considerations and recommendations were gathered from a two-day workshop, convening "five multi-sector teams, comprised of health care sector and non-health care sector partners, and led by regional health improvement collaboratives." See: https://www.academyhealth.org/publications/2017-06/topic-profile-alignment-across-sectors-trusted-convener-and-governance and https://www.academyhealth.org/publications/2017-12/elements-support-payment-reform-population-health-trusted-environment

30. This 2018 NASHP chart identifies the social determinants of health targeted, how states monitored outcomes and how they funded the efforts: Kartika, Tina, *How States Address Social Determinants of Health in Their Medicaid Contracts and Contract Guidance Documents*, National Academy for State Health Policy, Portland, M.E. (August 2018). https://nashp.org/wp-content/uploads/2018/08/social-determinants-chart-8_10_2018-v2.pdf

31. Oregon's coordinated care organizations are a type of accountable care organization (ACO) established to provide comprehensive care for the state's Medicaid population. Coordinated care organizations emphasize primary care and accept of full financial risk for their enrollees in the form of a global budget.

32. National Association for State Health Policy, *Case Study: Oral Health and Oregon's Coordinated Care* (February 2018). https://nashp.org/case-study-oral-

health-and-oregons-coordinated-care-organizations/

33. Kartika (August 2018).

34. Hargunani, Dana, *Shared Measurement and Joint Accountability Across Health Care and Non-Health Care Sectors: State Opportunities to Address Population Health Goals*, State Health and Value Strategies Program at Princeton University, Princeton, N.J. (January 2017). https://www.shvs.org/wp-content/uploads/2017/01/SHVS-Shared-Measurement-and-Joint-Accountability-Across-Health-Care-and-Non-Health-Care-Sectors-January-2017.pdf

35. Ibid.

36. Discern Health for AcademyHealth, *Approaches to Cross-Sector Population Health Accountability* (January 2018). https://www.academyhealth.org/sites/default/files/Approaches_to_CrossSector_Pop_Health_Jan2018_0.pdf

37. Bhatnagar, Sabah and Lynn Quincy, *Tapping into the Benefits of Social Investments: Addressing Financing Silos*, Research Brief No. 29, Altarum Healthcare Value Hub, Washington, D.C. (October 2018). https://www.healthcarevaluehub.org/files/8515/4084/0104/RB_29_-_Financing_Silos.pdf

38. Ibid.

39. Massachusetts' PWTF was established in 2012 and funded through a one-time, $57 million assessment on acute hospitals and payers operating in the state. See: Massachusetts Prevention & Wellness Trust Fund, *Joining Forces: Adding Public Health Value to Healthcare Reform* (January 2017). https://mapublichealth.org/wp-content/uploads/2019/02/PWTF_AnnualReport_2017_interactive_02.17.17-1.pdf

40. Ibid.

41. The City University of New York, *CUNY SPH Researchers Explore Options For Establishing A Wellness Trust In Brooklyn*, News Release (April 24, 2018). http://www1.cuny.edu/mu/forum/2018/04/24/cuny-sph-researchers-explore-options-for-establishing-a-wellness-trust-in-brooklyn/

42. Ibid.

43. Tricia McGinnis, Jennie Bonney and Debbie L. Chang, *Innovative Medicaid Payment Strategies for Upstream Prevention and Population Health*, Academy Health, Washington, D.C. (May 2018). https://www.academyhealth.org/publications/2018-05/innovative-medicaid-payment-strategies-upstream-prevention-

and-population-health-executive-summary

44. Bhatnagar and Quincy (October 2018).

45. Mahan, Dee, *Block Grants: A Bad Idea for Medicaid*, Families USA, Washington, D.C. (n.d.). http://familiesusa.org/sites/default/files/product_documents/MCD_Block_Grant_Factsheet.pdf

46. Crawford, Maia and Rob Houston, S*tate Payment and Financing Models to Promote Health and Social Service Integration*, Center for Health Care Strategies, Hamilton, N.J. (February 2015). https://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf

47. Crumley, Diana, et al., *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*, Center for Health Care Strategies, Hamilton, N.J. (December 2018). https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf

48. To date, the impact of DSRIP waivers on health outcomes is not well-understood. As more information becomes available, conclusions about the demonstration program's success should be made on a case-by-case basis due to differences in waiver design and implementation. See: https://www.healthaffairs.org/do/10.1377/hblog20180920.103967/full/ and https://www.mathematica-mpr.com/our-publications-and-findings/publications/delivery-system-reform-incentive-payments-interim-evaluation-report.

49. McGinnis, Bonney and Chang (May 2018).

50. Clary, Amy, Tina Kartika and Jill Rosenthal, *State Approaches to Addressing Population Health Through Accountable Health Models*, National Academy for State Health Policy, Portland, M.E. (January 2018). https://nashp.org/wp-content/uploads/2018/01/Accountable-Health-Models.pdf

51. Huelskoetter, Thomas, *Evaluating State Innovations to Reduce Health Care Costs*, Center for American Progress, Washington, D.C. (April 2018). https://www.americanprogress.org/issues/healthcare/reports/2018/04/06/448912/evaluating-state-innovations-reduce-health-care-costs/

52. One study published in *Health Affairs* documented reductions in primary care visits from 2011 to 2014. See: McConnell, K. John, et al., "Oregon's Medicaid Reform And Transition To Global Budgets Were Associated With Reductions In Expenditures,"

Health Affairs, Vol. 36, No. 3 (March 2017). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1298?journalCode=hlthaff

53. Future research will be conducted to assess the impact of individual hospital's strategies on expenditures and use. See: https://www.healthaffairs.org/do/10.1377/hblog20180508.819968/full/

54. Findings from RTI International's 2018 evaluation (the most comprehensive and current assessment to-date) suggest that global budgets have meaningfully reduced inpatient admissions, in addition to lowering costs to the Medicare program. Global budgets had a negligible effect on hospital readmissions and, unexpectedly, were associated with higher outpatient emergency department visits. Further research is being conducted to explore these results. See: Haber, Susan, and Heather Beil, "Another Look At The Evidence On Hospital Global Budgets In Maryland: Have They Reduced Expenditures And Use?" *Health Affairs* Blog (May 14, 2018). https://www.healthaffairs.org/do/10.1377/hblog20180508.819968/full/

55. Centers for Medicare & Medicaid Services, *Pennsylvania Rural Health Model*, https://innovation.cms.gov/initiatives/pa-rural-health-model/ (accessed on Jan. 30, 2019).

56. There is a strong body of evidence tying stable, safe and affordable housing to improved health outcomes. Documented benefits include improved physical health, mental health and reduced substance use. See: Taylor, Lauren, "Housing And Health: An Overview Of The Literature," *Health Affairs* Blog (June 7, 2018). https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/ and Paradise, Julia and Donna Cohen Ross, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, Kaiser Family Foundation, San Francisco, Calif. (January 2017). https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-appendix/

57. Medicaid programs have substantial flexibility to provide housing-related services for beneficiaries, but they also have limitations. Examples of allowable housing supports include services to help people transition into communities from institutional settings (like assistance finding housing, filling out applications and paying for one-time moving expenses such as security deposits) and services to maintain housing once it is secured (through education on tenant and landlord rights, dispute resolution to reduce likelihood of eviction, housing recertification, etc.). Importantly, Federal rules prohibit Medicaid programs from paying for beneficiaries' rent.

58. Paradise and Ross (January 2017). See also: Arabo, Flora, et al., *Housing as Health Care: A Road Map for States*, National Governors Association, Washington, D.C. (September 2016). http://ngahousingroadmap.cwsit.org/ and http://ngahousingroadmap.cwsit.org/roadmap-develop-housing-services-strategy-07-develop-waiver-and-state-plan-amendment-options.html

59. According to Kaiser Family Foundation, most states have Section 1915B Managed Care Waivers that allow them to "provide and pay for state plan-covered services, including housing-related services, through managed care programs." See: Paradise and Ross (January 2017).

60. Flora et al. (September 2016).

61. Ibid.

62. See: Schubel, Jessica, *Trump Should Have Proposed "Money Follows the Person" Funding*, Center on Budget and Policy Priorities Blog (Feb. 23, 2018). https://www.cbpp.org/blog/trump-should-have-proposed-money-follows-the-person-funding and Katch, Hannah, *States Are Using Flexibility to Create Successful, Innovative Medicaid Programs*, Center on Budget and Policy Priorities (June 2016). https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs

63. U.S. Department of Health and Human Services, *Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration*, Washington, D.C. (June 2017). https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf

64. Including medical professionals, behavioral health specialists, CBOs and others

65. "What is Care Coordination?" *NEJM Catalyst* (Jan. 1, 2018). https://catalyst.nejm.org/what-is-care-coordination/. See also: Traver, Amy, *The Promise of Care Coordination: Transforming Health Care Delivery*, Families USA, Washington, D.C. (April 2013). https://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf

66. Khullar, Dhruv, and Dave A. Chokshi, "Can Better Care Coordination Lower Health Care Costs?" *JAMA Network Open*, Vol. 1, No. 7 (November 2018). https://

jamanetwork.com/journals/jamanetworkopen/
fullarticle/2712173

67. Lau, Chris, and Amit S. Dhamoon, "The Impact of a Multidisciplinary Care Coordination Protocol On Patient-Centered Outcomes at an Academic Medical Center," *Journal of Clinical Pathways*, Vol. 3, No. 4 (May 2017). https://www.journalofclinicalpathways.com/article/impact-multidisciplinary-care-coordination-protocol-patient-centered-outcomes-academic

68. Peikes, Deborah, Arnold Chen, and Jennifer Schore, "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries," *JAMA*, Vol. 301, No. 6 (February 2009). https://jamanetwork.com/journals/jama/fullarticle/183370

69. *NEJM Catalyst* (Jan. 1, 2018).

70. McGinnis, Bonney and Chang (February 2018). See also: Bonney, Jennie, and Debbie Chang, *Community Care Coordination Systems*, Academy Health, Washington, D.C. (May 2018). https://www.academyhealth.org/publications/2018-05/community-care-coordination-systems

71. Community care coordinators include Community Health workers, nurses, social workers and others.

72. Criteria for high-risk designation may vary according to communities' goals. Example high-risk populations include emergency department super-utilizers or women with high-risk pregnancies.

73. Agency for Healthcare Research and Quality, *Connecting Those at Risk to Care: The Quick Start Guide to Developing Community Care Coordination Pathways*, Washington, D.C. (January 2016). https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf. See also: Agency for Healthcare Research and Quality, *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*, Washington, D.C. (January 2016). https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf and PCHI, Pathways Community HUB Model Overview, https://pchi-hub.com/hubmodeloverview/, (accessed on Feb. 13, 2019).

74. "Nonmedical" services provided have targeted "addiction, housing addiction, housing, transportation, hunger, mental health, and emotional and educational support." For more information, see: Robert Wood Johnson Foundation, "Organizations Provide $8.7 Million to Launch a National Center to Improve Care

for Complex Patients," News Release, (March 8, 2016). https://www.rwjf.org/en/library/articles-and-news/2016/03/organizations-provide-8-7-million-to-launch-national-center.html

75. A randomized controlled trial is currently underway to further explore hotspotting's impact on utilization, health status, psychosocial outcomes and cost. See: Abdul Latif Jameel Poverty Action Lab, *Health Care Hotspotting in the United States*, https://www.povertyactionlab.org/evaluation/health-care-hotspotting-united-states (accessed on Feb. 13, 2019).

76. Doyle, Audrey, *Through Segmentation and Predictive Analytics, Denver Health Brings "21st Century Care" to High-Risk Patients*, Press Ganey, South Bend, I.N. (February 2018). http://www.pressganey.com/docs/default-source/industry-edge/issue-25---february/through-segmentation-and-predictive-analytics-denver-health-brings-39-21st-century-care-39-to-high-risk-patients.pdf?sfvrsn=2

77. Virginia Center for Health Innovation, *21st Century Care*, Henrico, V.A. (May 2016). http://www.vahealthinnovation.org/wp-content/uploads/2016/05/Infographic-21st-Centruy-Care-Tiering-5-20-2016-FINAL-1.pdf

78. Bresciani, Martina, T*rusted Voices: The Role of Community Health Workers in Health System Transformation*, Community Catalyst, Boston, Mass. (n.d.). https://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief-1.pdf?1447103482

79. Ibid.

80. Families USA Health Equity Task Force, *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems*, Washington, D.C. (June 2018). https://familiesusa.org/sites/default/files/product_documents/FamiliesUSA_Policy-Options_Report.pdf

81. Centers for Disease Control and Prevention, *Policy Options for Facilitating the Use of Community Health Workers in Health Delivery Systems*, Atlanta, G.A. (2017). https://www.cdc.gov/dhdsp/pubs/docs/CHW_Policy_Brief_508.pdf

82. Bresciani (n.d.).

83. Centers for Disease Control and Prevention, *What Evidence Supports State Laws to Establish Community Health Worker Scope of Practice and Certification?*

Atlanta, G.A. (2017). https://www.cdc.gov/dhdsp/pubs/docs/CHW-PEAR.pdf

84. Community Catalyst's Center for Consumer Engagement in Health Innovation provides funding to state consumer health advocacy organizations to "elevate consumer voices to advocate for models of delivery reform that are person-centered, consumer led and responsive to the needs of the community," with a particular focus on organizing in low-income communities, communities of color and/or among seniors and people with disabilities. These programs offer important lessons that can inform governmental efforts. See: Center for Consumer Engagement in Health Innovation, *Consumer Voices for Innovation*, https://www.healthinnovation.org/work/building-advocacy-capacity/consumer-voices-for-innovation (accessed on Feb. 12, 2019).

85. Collective Impact Forum, What is Collective Impact, https://www.collectiveimpactforum.org/what-collective-impact (accessed on Feb. 12, 2019).

86. Ditre, Joe, *Consumer-Centric Healthcare: Advocating for System Improvement*, Altarum Healthcare Value Hub, Washington, D.C. (December 2017). https://www.healthcarevaluehub.org/advocate-resources/publications/consumer-centric-healthcare-advocating-health-system-improvements/

87. Participatory Budgeting Project, *What is PB?*, https://www.participatorybudgeting.org/impacts/ (accessed on Feb. 12, 2019).

88. Importantly, the process may include traditionally non-voting community members (i.e. residents under 18 years of age and non-U.S. citizens) in order to gain an accurate understanding of residents' desires.

89. Participatory Budgeting Project (accessed on Feb. 12, 2019).

90. St. Louis Missouri Government Health Department, *Participatory Budgeting Kickoff Events for Re-Cast*, https://www.stlouis-mo.gov/government/departments/health/recast-participatory-budgeting-kickoff-events.cfm (accessed on Feb. 12, 2019). See also: Baumer, Stephanie, *Here's How You Can Help Decide What Community Well-Being Projects $480K Will be Spent On*, https://www.kmov.com/news/here-s-how-you-can-help-decide-what-community-well/article_a60d7be1-dc9b-5fd6-9fae-b6c78613e146.html (accessed on Feb. 14, 2019).

91. Participatory Budgeting Project, Where is PB Happening?, https://www.participatorybudgeting.org/case-studies/ (accessed on Feb. 13, 2019).

92. "Meaningful access" includes the elimination of services that fail to meet people's needs. Strategies to identify and reduce low-value care are not discussed in this text, however, more information can be found here: Beaudin-Selier, Beth, Lynn Quincy and Rebecca Cooper, *Reducing Low-Value Care: Saving Money and Improving Health*, Altarum Healthcare Value Hub, Washington, D.C. (November 2018). https://www.healthcarevaluehub.org/advocate-resources/publications/reducing-low-value-care-saving-money-and-improving-health/

93. U.S. Institute of Medicine Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, Washington, D.C. (2002). https://www.ncbi.nlm.nih.gov/books/NBK220636/ See also: Sommers, Benjamin D., et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine*, (Aug. 8, 2016). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

94. Ibid.

95. Bindman, Andrew B., Marian R. Mulkey and Richard Kronick, "Beyond the ACA: Paths to Universal Coverage in California," *Health Affairs*, Vol. 37, No. 9 (September 2018). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0504?journalCode=hlthaff

96. Neuman, Tricia, Karen Pollitz and Jennifer Tolbert, *Medicare-for-All and Public Plan Buy-In Proposals: Overview and Key Issues*, Kaiser Family Foundation, Washington, D.C. (Oct. 9, 2018). https://www.kff.org/report-section/medicare-for-all-and-public-plan-buy-in-proposals-overview-and-key-issues-issue-brief/

97. Garfield, Rachel, Kendal Orgera and Anthony Damico, *The Uninsured and the ACA: A Primer*, Kaiser Family Foundation, Washington, D.C. (January 2019). http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act

98. McMonagle, Meghan and Lynn Quincy, *Making Healthcare Affordable: Finding a Common Approach to Measure Progress*, Healthcare Value Hub, Washington, D.C. (January 2017). https://www.healthcarevaluehub.org/advocate-resources/publications/making-

healthcare-affordable-finding-common-approach-measure-progress/

99. This report shows the impact of varying state approaches to eligibility and renewal: Brooks, Tricia, et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey*, Kaiser Family Foundation, Washington, D.C. (March 21, 2018). https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/

100. No Wrong Door, Building and Sustaining a No Wrong Door System, https://nwd.acl.gov/Building_A_NWD_System.html (accessed on Feb. 12, 2019).

101. A publication produced by the U.S. Administration for Community Living outlines key elements of a statewide no-wrong-door approach to providing long-term services and supports for all populations. See: U.S. Administration for Community Living, Key Elements of a NWD System of Access to LTSS for All Populations and Payers, Washington, D.C. (2014). https://nwd.acl.gov/pdf/NWD-National-Elements.pdf

102. Ditre, Joe, *Consumer-Centric Healthcare: Choosing a Health Plan*, Altarum Healthcare Value Hub, Washington, D.C. (December 2017). https://www.healthcarevaluehub.org/advocate-resources/publications/consumer-centric-healthcare-choosing-health-plan/

103. Quincy, Lynn, *Rethinking Consumerism in Healthcare Benefit Design*, Altarum Healthcare Value Hub, Washington, D.C. (April 2016). https://www.healthcarevaluehub.org/advocate-resources/publications/rethinking-consumerism-healthcare-benefit-design/

104. Healthcare Value Hub, *Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality*, Washington, D.C. (July 2016). https://www.healthcarevaluehub.org/files/6114/9910/1842/Hub-Altarum_Easy_Explainer_No._5_-_Value-Based_Insurance_Design.pdf

105. Mitts, Lydia, *Wellness Programs and Incentives: A Review of the Evidence*, Altarum Healthcare Value Hub, Washington, D.C. (July 2018). https://www.healthcarevaluehub.org/advocate-resources/publications/wellness-programs-and-incentives-review-evidence/

106. Hunt, Amanda, *Improving Healthcare Value in Rural America*, Altarum Healthcare Value Hub, Washington, D.C. (October 2017). https://www.healthcarevaluehub.org/advocate-resources/publications/improving-healthcare-value-rural-america/

107. U.S. Department of Health and Human Services, *National Health Service Corps Report to Congress for the Year 2016*, Washington, D.C. (2016). https://www.hrsa.gov/sites/default/files/hrsa/about/organization/bureaus/bhw/reportstocongress/2016-nhsc-rtc.pdf

108. Urban settings, while they may be underserved, are more likely to have Graduate Medical Education training programs as a result of academic medical centers that are located in urban areas.

109. Hunt (October 2017).

110. Maryland Department of Health, Health Enterprise Zones (HEZs), https://health.maryland.gov/healthenterprisezones/Pages/home.aspx (accessed on Feb. 13, 2019)

111. Dwyer, Maura, *Maryland's Health Enterprise Zones Initiative Upstream Strategies to Address Social Determinants of Health*, Maryland Department of Health & Mental Hygiene, Cambridge, M.D. (n.d.). http://www.mdruralhealth.org/wp-content/uploads/2017/10/K-Marylands-Health-Enterprise-Zones.pdf

112. Health Professionals for Diversity Coalition, *Fact Sheet: The Need for Diversity in the Health Care Workforce*, Washington, D.C. (2012). http://www.aapcho.org/wp/wp-content/uploads/2012/11/NeedForDiversityHealthCareWorkforce.pdf

113. Families USA Health Equity Task Force (June 2018).

114. Center for Consumer Engagement in Health Innovation, *Policies to Transform Primary Care: The Gateway to Better Health and Health Care*, Boston, M.A. (December 2018). https://www.healthinnovation.org/resources/publications/Policies-to-Transform-Primary-Care-Report.pdf

115. One interviewee believed that lower payments to primary care providers is symptomatic of a culture that prioritizes procedural medicine over that cognitive medicine (e.g., clinical problem solving). This person asserted that broader payment reform is needed to correct this imbalance.

116. Medicare Payment Advisory Commission, *Physician and Other Health Professional Services*, Washington, D.C. (March 2016). http://medpac.gov/docs/default-

source/reports/chapter-4-physician-and-other-health-professional-services-march-2016-report-.pdf?sfvrsn=0

117. Higgins, Elinor, *States Showcase New Programs that Integrate Oral Health and Primary Care*, National Academy for State Health Policy (Sep. 11, 2018). https://nashp.org/states-showcase-new-programs-that-integrate-oral-health-and-primary-care/

118. Jones, Shyloe, *Provider Scope of Practice: Expanding Non-Physician Providers' Responsibilities Can Benefit Consumers*, Altarum Healthcare Value Hub, Washington, D.C. (November 2017).

119. Lieb, David A., *Missouri Targets Doctor Dearth, Expands First-in-Nation Law*, WSB-TV (May 14, 2017).

120. Missouri Division of Professional Registration, *Missouri Board of Registration for the Healing Arts*, http://pr.mo.gov/healingarts.asp (accessed on Aug. 15, 2017).

121. Preliminary research has raised questions about assistant physicians' ability to provide high quality care. It is recommended that future research study the "quality and safety of the care that assistant physicians provide," in addition to patient perceptions. See: Hoekzema, Grant S., and James J. Stevermer, "Characterization of Licensees During the First Year of Missouri's Assistant Physician Licensure Program," *JAMA* (October 2018). https://jamanetwork.com/journals/jama/article-abstract/2708099

122. Minnesota's effort is conceptually similar to the Alaska's Dental Health Aide Therapists (DHATs), established by the Alaska Native Tribal Health Consortium in 2005. DHATs deliver a "limited scope of preventive and restorative services under the supervision of a dentist." Importantly, they are recruited from the communities in which they later work, facilitating the provision of culturally competent care. There is some evidence to indicate that DHATs and other dental providers established through Alaska's Dental Health Aide Program have increased access and reduced oral health disparities through the provision of evidence-based care. See: "Analysis and Policy Recommendations Concerning Mid-level Dental Providers," *American Academy of Pediatric Dentistry Reference Manual*, Vol. 32, No. 6 (n.d.). http://www.aapd.org/assets/1/7/RS_MidLevel.pdf and Shoffstall-Cone, Sarah, and Mary Williard, *Alaska Dental Health Aide Program, Alaska Native Tribal Health Consortium*, Anchorage, A.K. (n.d.). http://

anthc.org/wp-content/uploads/2016/02/DHAT_AlaskaDentalHealthAideProgram.pdf

123. Minnesota Department of Health, *Early Impacts of Dental Therapists in Minnesota*, St. Paul, M.N. (February 2014). https://mn.gov/boards/assets/2014DentalTherapistReport_tcm21-45970.pdf

124. Ibid.

125. Exception: Only one clinic highlighted in the Dental Therapy Toolkit reported longer wait times for advanced care due to scope of practice limitations for DTs. See: Minnesota Department of Health, *Dental Therapy Toolkit: A Resource for Potential Employers*, St. Paul, M.N. (February 2017). https://www.health.state.mn.us/facilities/ruralhealth/emerging/dt/docs/2017dttool.pdf

126. Families USA Health Equity Task Force (June 2018).

127. Rural Health Information Hub, *Co-locations of Service Model*, https://www.ruralhealthinfo.org/toolkits/services-integration/2/co-location (accessed Feb. 13, 2019).

128. Farber, Amy Simmons, *Same Day Billing Policies Affect Health Consumers*, National Association of Community Health Centers Blog (December 2018). https://blog.nachc.org/same-day-billing-policies-affect-health-centers-and-patients/

129. Hilton, Irene V., *Creating Medical Dental Integration: Helpful Hints and Promising Practices*, National Network for Oral Health Access (June 2014). https://www.nnoha.org/nnoha-content/uploads/2014/06/Creating-Medical-Dental-Integration_2014-06-23.pdf

130. Hoagland, C. William, et al., *Reinventing Rural Health Care: A Case Study of Seven Upper Midwest States*, Bipartisan Policy Center (January 2018). https://bipartisanpolicy.org/wp-content/uploads/2018/01/BPC-Health-Reinventing-Rural-Health-Care-1.pdf

131. The Save Rural Hospitals Act proposed to create a new designation to allow CAHs to exclusively provide emergency and outpatient care, whereas the Rural Emergency Acute Care Hospital Act would allow certain CAHs to become emergency centers, in recognition that some rural communities do not need/cannot afford to provide a broader array of services. See: Hoagland, C. William (January 2018).

132. Reardon, Marguerite, *Why Rural Areas Can't Catch a Break on Speedy Broadband*, CNet, (October 2018).

https://www.cnet.com/news/why-rural-areas-cant-catch-a-break-on-speedy-broadband/

133. Federal Communications Commission, *Rural Health Care Program*, https://www.fcc.gov/general/rural-health-care-program#RHC (accessed on Feb. 14, 2019).

134. The Interstate Medical Licensure Compact is a legal agreement among states that increases access to healthcare in rural and underserved areas by allowing eligible physicians to provide telemedicine services across state lines. To learn more, visit http://www.imlcc.org/.

135. Dizon, Ray, *2018 In Review: State & Federal Telehealth Policy*, National Consortium of Telehealth Resource Centers (December 2018). https://www.telehealthresourcecenter.org/2018-in-review-state-federal-telehealth-policy/

136. Hoagland, C. William (January 2018).

137. Milbank Memorial Fund, *Telehealth Private Payer Laws: Impact and Issues* (August 2017). https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf

138. Patient Advocate Foundation, *The Roadmap To Consumer Clarity in Health Care Decision Making*, Hampton, V.A. (2017).

139. Patient-Centered Outcomes Research Institute, *Shared Decision Making*, https://www.pcori.org/research-results/topics/shared-decision-making (accessed on Feb. 15, 2019).

140. National Quality Forum, *NQF Issues Vital Guidance to Improve Shared Decision Making Between Patients and Healthcare Providers*, https://www.qualityforum.org/Guidance_to_Improve_Shared_Decision_Making.aspx (accessed on Feb. 15, 2019).

141. It is important to note that PDSM is undermined without reliable evidence indicating the best clinical course(s) of action. Therefore, strengthening the both the quality and quantity of comparative effectiveness studies is an important prerequisite to employing this strategy effectively.

142. Patient decision aids, when designed properly, provide actionable information on the risks, benefits and burdens of treatment options, and helps patients identify and communicate their preferences. See Healthcare Value Hub, *The Consumer Benefits of Patient Shared Decision Making*, Research Brief No. 34 (March 2019).

143. For a list of certified decision aids, see: https://www.hca.wa.gov/about-hca/healthier-washington/certified-aids

144. One interviewee felt strongly that cultural competency training is an insufficient term due to the belief that one cannot be truly competent in any culture but their own. This interviewee suggested "cultural responsiveness" to describe the recommended training undergone by providers.

145. Families USA Health Equity Task Force (June 2018).

146. The Oregon Health Authority is also currently developing incentive measures to tie providers' payments to their ability to improve health equity. See: Oregon Health Authority Office of Health Analytics, *Health Equity Measurement Workgroup*, https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx (accessed on Feb. 14, 2019).

147. Govere, Linda and Ephraim Govere, "How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups?," *World Views on Evidence Based Nursing*, Vol. 13 No. 6 (October 2016). https://sigmapubs.onlinelibrary.wiley.com/doi/full/10.1111/wvn.12176

148. Holm, Amanda, et al., "Recognizing Privilege and Bias: An Interactive Exercise to Expand Health Care Provider's Personal Awareness," *Journal of the Association of Americans Medical Colleges*, Vol. 92 No. 3 (March 2017). https://journals.lww.com/academicmedicine/Fulltext/2017/03000/Recognizing_Privilege_and_Bias___An_Interactive.31.aspx

149. Ahmad, Jia and Marc Shi, "The Need for Anti-Racism Training in Medical School Curricula," *Journal of the Association of American Medical Colleges*, Vol. 92 No. 8 (August 2017). https://journals.lww.com/academicmedicine/FullText/2017/08000/The_Need_for_Anti_Racism_Training_in_Medical.19.aspx

150. Shapiro, Ilana, *Training for Racial Equity and Inclusion: A Guide to Selected Programs*, The Aspen Institute, Washington, D.C. (2002). http://www.racialequitytools.org/resourcefiles/shapiro.pdf

151. Center for Health Progress, *Waiting for Health Equity: A Graphic Novel*, https://centerforhealthprogress.

org/blog/publications/waiting-for-health-equity-a-graphic-novel/ (February 2017).

152. Best practices and other resources for designing effective patient and family advisory councils can be found at http://www.ipfcc.org/bestpractices/patient-family-advisory-councils.html. See also: Institute for Patient-and Family-Centered Care, *Strategically Advancing Patient and Family Advisory Councils in New York State Hospitals* (June 2018). http://www.ipfcc.org/bestpractices/NYSHF_2018_PFAC_Online_v3.pdf

153. Massachusetts General Law, Patient and Family Advisory Councils. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section53E

154. Massachusetts Department of Public Health, letter informing hospitals of their obligation to establish a Patient and Family Advisory Council. https://www.mass.gov/files/documents/2016/07/vw/dhcq-0907514.pdf

155. Claxton, Gary, et al., *Measuring the quality of healthcare in the U.S.*, Peterson-Kaiser Health System Tracker (Sept. 10, 2015). https://www.healthsystemtracker.org/brief/measuring-the-quality-of-healthcare-in-the-u-s/#item-start

156. Ibid.

157. Smith, Peter C., Elias Mossialos and Irene Papanicolas, *Performance measurement for Health System Improvement: Experiences, Challenges and Prospects*, World Health Organization, Tallinn, Estonia (June 2008). https://www.who.int/management/district/performance/

158. Blumenthal, David, Elizabeth Malphrus and J. Michael McGinnis, *Core Metrics for Health and Health Care Progress*, Institute of Medicine (2015). https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress

159. Families USA Health Equity Task Force (June 2018).

160. Purington, Kitty and Rachel Yalowich, *Measuring Physical and Behavioral Health Integration: A Look at State Approaches in the Context of Value-Based Purchasing*, National Academy For State Health Policy (January 2017). https://nashp.org/wp-content/uploads/2017/01/Measuring-Integration-Brief.pdf

161. Examples include the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program.

162. Schulman, Meryl, et al., *Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care*, Center for Health Care Strategies, (June 2018). https://www.chcs.org/media/VBP-for-SUD_Final_June-2018.pdf

163. Patient experience measures are different from those of patient satisfaction, although the terms are sometimes used interchangeably. Patient experience surveys aim to determine "whether something that should happen in a healthcare setting (such as clear communication with a provider) actually happened and how often," while patient satisfaction surveys aim to determine whether a person's expectations for an encounter were met. See: Agency for Healthcare Research and Quality, *What is Patient Experience?*, Washington, D.C. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html (accessed on Feb. 18, 2019).

164. Centers for Medicaid & Medicaid Services, *HCAHPS: Patients' Perspectives of Care Survey*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/hospitalqualityinits/hospitalHCAHPS.html (accessed on Feb. 18, 2019).

165. Agency for Healthcare Research and Quality, *CAHPS Survey and Guidance*, https://www.ahrq.gov/cahps/surveys-guidance/index.html (accessed on Feb. 18, 2019).Washington, D.C. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html (accessed on Feb. 18, 2019).