



# High-Value, Patient-Centered Healthcare

Where's the Greatest Return on Investment?



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Support provided by the Robert Wood Johnson Foundation.

This report reflects the discussions and views of participants who attended the Healthcare Value Hub meeting in New Orleans, Nov. 14 -16, 2018.

# CONFERENCE AGENDA

Wednesday, November 14, 2018

*Advocates FOR Humanity* Game Show and Welcome Dinner

Thursday, November 15, 2018

## Welcome and Opening Remarks

David Adler, Robert Wood Johnson Foundation  
Lynn Quincy, Altarum Healthcare Value Hub

## How Consumers Experience the Healthcare System: New State Polling Results

Antoinette Kraus, Pennsylvania Health Access Network  
Richard Seckel, Kentucky Equal Justice Center  
Matthew Slonaker, Utah Health Policy Project  
Jill Zorn, Universal Health Care Foundation of Connecticut

## Targeting Price Variation and High Unit Prices

Vinny DeMarco, Maryland Citizens' Health Initiative  
Sara Flocks, California Labor Federation  
Alyssa Vangeli, Health Care for All Massachusetts  
Chapin White, RAND Corporation

## Targeting High- and Low-Value Care

Beth Bortz, Virginia Center for Health Innovation  
Sinsi Hernández-Cancio, Families USA  
Laura Pennington, Washington State Health Care Authority

## The Business Case for Racial Equity

Sarah de Guia, California Pan-Ethnic Health Network  
Quentin Messer, New Orleans Business Alliance for Economic Development  
Jan Moller, Louisiana Budget Project  
Ani Turner, Altarum

## Addressing Social Determinants of Health: Eliminating Financing Silos

Karen Minyard, Georgia Health Policy Center  
Len Nichols, George Mason Univ., Center for Health Policy Research and Ethics  
Andrew Olson, The Green & Healthy Homes Initiative  
Lynn Quincy, Altarum Healthcare Value Hub

Friday, November 16, 2018

## Addressing Social Determinants of Health: Appropriate Stakeholder Roles

Karen Hacker, Allegheny County Health Department  
Patrick Keenan, Pennsylvania Health Access Network  
Jean McGuire, Northeastern University, Bouvé College of Health Sciences  
Len Nichols, George Mason Univ., Center for Health Policy Research and Ethics

## Patients at the Table: Engaging the Community in Health System Transformation

Jim Carnes, ARISE Citizens' Policy Project  
Sarah Davis, Center for Patient Partnerships  
Jamila Michener, Cornell University  
Jessie Zimmerer, Community Catalyst

## Reflections on What We've Learned and Next Steps

Rachel Rosen DeGolia, Universal Health Care Action Network (UHCAN)  
Tekisha Everette, Health Equity Solutions  
Sheldon Weisgrau, Alliance for a Healthy Kansas  
Chapin White, RAND Corporation  
Anthony Wright, Health Access California

# Conference Sessions

The Hub's *High-Value, Patient-Centered Care: Where's the Greatest Return on Investment?* conference was held Nov. 14-16, 2018, at the Hotel Monteleone in New Orleans. It featured advocate leaders and national experts with an interest in a high-value health system that is equitable, patient-centered, allocates resources wisely and delivers uniformly positive health outcomes.

The conference's unique format blends policy, research and advocacy to provide actionable information and identify strategic partners to help states move forward. This year's agenda was designed to step through the key barriers to high-value, patient-centered care and identify pragmatic approaches that have demonstrated a return on investment. Because most advocates support health and social system investments because it's the right thing to do, the attendees had a healthy debate about the importance of



emphasizing return on investment as a way to achieve buy-in from certain stakeholders. Some expressed support for this strategy, while others felt it could undermine a focus on patient wellbeing.

A high degree of audience interaction and ample time for networking help attendees reflect, engage and act upon the information presented.

## HOW CONSUMERS EXPERIENCE THE HEALTHCARE SYSTEM: NEW STATE POLLING RESULTS

To address the dearth of state level survey data, the Healthcare Value Hub worked with Altarum colleagues to develop the [Consumer Healthcare Experience State Survey \(CHES\)](#) which focuses on how consumers view the healthcare system, including their struggles with healthcare affordability. Matt Slonaker from [Utah Health Policy Project](#) moderated the panel of advocates, noting that the survey “drills down on resident concerns that advocates may not otherwise have access to in their states.”

Panelist Jill Zorn from the [Universal Health Care Foundation of Connecticut](#) presented findings and examples of how the foundation has used their survey results. Zorn mentioned that the [survey data](#) helped contribute to “the buzz about healthcare” in Connecticut, specifically when it comes to drug pricing and healthcare



affordability. Despite being considered a wealthy state, half of adults reported one or more healthcare affordability burdens. The foundation has held press conferences and used patient stories to bolster the survey findings. The data was credited with helping to pass a drug-price transparency bill and generated a lot of interest among legislators and the media.

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**“The poll brings the voice of the people right to the table.”**

**- Jill Zorn, Universal Health Care Foundation of Connecticut**

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Rich Seckel of [Kentucky Equal Justice Center](#) provided an overview of data from the [Kentucky CHES](#) and described the results surfacing “common ground for discussion across party lines.” The center shared the results at several events, including a healthcare boot camp called the Health System Transformation Academy. At this meeting, the hashtag #WeAgree became popular, reflecting the CHES finding of strong, bipartisan support for government solutions to the healthcare affordability problem.

Antoinette Kraus from [Pennsylvania Health Access Network](#) provided an overview of

[Pennsylvania’s state polling results](#) and noted that they also intend to leverage the survey finding that there is strong bipartisan concern about healthcare affordability and support for action. Kraus noted that in Pennsylvania, 1 out of 2 individuals have experienced a healthcare affordability burden and that surprise medical bills are a top concern. The Pennsylvania Health Access Network released survey findings at their annual conference, where the state’s attorney general used the data as part of his presentation.

This session sparked interest in polling data across many states and brought up discussions of the importance of the consumer’s voice. In her presentation, Jill Zorn stated that “the poll brings the voice of the people right to the table” and it can make a huge difference in each state. Matt Slonaker says we are currently “playing around the edges of affordability” but this poll can help us delve deeper into this issue.

## TARGETING PRICE VARIATION AND HIGH HEALTHCARE PRICES

Healthcare affordability is a top consumer concern, and year-over-year increases in prices are a key culprit. The focus of this session was to understand what drives unit price increases and provide advocates with tools they can bring back to their states. Alyssa Vangelli of [Healthcare for All](#) in Massachusetts moderated the panel and provided an overview of how consumers are impacted by high prices. She noted that “we cannot ignore year over year increases” and we “rarely see policies to combat high unit prices that are in a tidy and understandable package.”

Chapin White of RAND started the session by stressing that the complexity of the U.S. healthcare system puts consumers at a disadvantage. He said that a “buyer’s ignorance is seller’s bliss,” noting that consumers’ lack of



health literacy and obscure pricing puts sellers in the driver’s seat with respect to pricing decisions. White noted that Medicare has gone farthest to solve the pricing problem. States could increase the buying power of Medicare even further by allowing nonelderly people to buy into the



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**“We rarely see policies to combat high unit prices that are in a tidy and understandable package.”**

**- Alyssa Vangelli, Healthcare for All**

Medicare program (distinct from the concept of “Medicare for all.”) White also stressed that accessible all-payer claims databases should be used by self-funded employers and unions to increase their leverage with providers and health plans. He also suggested that [fee-for-service payments](#) aren’t necessarily bad. It’s an efficient way to pay for a service provided—as long as the price is reasonable.

Vinny DeMarco of [Maryland Citizens Health Initiative](#) provided attendees with step-by-step information on how his team addressed high prescription drug prices. DeMarco described his organization’s [six-step campaign process](#), explaining how they used the steps to pass legislation in Maryland authorizing the state’s attorney general to address generic drug price gouging. The idea is being considered in other states and represents an important shift in attitudes towards the prices produced by the healthcare marketplace. He also introduced the coalition’s next idea: a [drug price affordability board](#) for the state.



Sara Flocks from the [California Labor Federation](#) gave a presentation on why unions care about healthcare spending. Flocks described a variety of bills that the California Labor Union worked on in collaboration with their partners to reduce unit prices in California. Specifically, Flocks provided information on the [Health Care Price Relief Act](#). The legislation sought to establish an independent state commission with the authority to set provider reimbursement rates in the commercial market. Although this did not pass, Flocks provided the audience with ‘lessons learned’ to encourage other states to push for policy changes to tackle rising prices.



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## TARGETING HIGH- AND LOW-VALUE HEALTHCARE

While utilization trends do not drive year-over-year growth in healthcare spending, the evidence is clear that [many services could be eliminated](#) with no harm to patients—keeping them safer and saving money. At the same time, we need to increase the use of selected [high-value services](#), like tobacco cessation, flu vaccines and certain screenings, to improve outcomes and possibly save money down the road.

This panel discussed strategies to decrease the use of services with low or no value, while increasing the use of high-value preventative services. Sinsi Hernández-Cancio from [Families USA](#) moderated the conversation on appropriate care with a racial equity lens, reminding the audience that, “what is wasteful for one person might be indispensable for another.”

Beth Bortz of the [Virginia Center for Health Innovation](#) (VCHI), a public-private partnership, described her experience leveraging data on low-value care to influence decision making. Using claims data, the VCHI team identified 42 low-value measures that accounted for more than \$700 million spent on unnecessary services in Virginia. The data indicated that 41 percent of Virginians were exposed to at least one unnecessary service. Bortz described how promotion of this data can spur action. One example was a physician who was inspired to learn how often he ordered vitamin D testing (a low-value service). He was surprised to learn he had high levels—owing to the fact that the vitamin D testing was included in a bundle of tests that he ordered for patients all the time! Bortz stressed the value in access to data so clinicians and health systems can change their policies and practices to reduce low-value care.

Laura Pennington of the [Washington State Health Care Authority](#) presented on the



importance of increasing high-value care. The agency uses certified patient-decision making aids to increase shared decision making between providers and patients. Pennington advocated for national certification of patient decision aids, tools that provide comprehensive support and training to providers to support joint decision making with patients. Washington state enacted a policy for ACOs to require shared decision making in their health systems. This resulted in high patient satisfaction and high levels of provider engagement. Pennington described the value of shared decision and patient decision-making aids to reducing variations in care provided to patients.

Hernández-Cancio closed the conversation by emphasizing the importance of addressing appropriate care in the context of persistent health inequities. She reintroduced the term of [“Targeted Universalism.”](#) Targeted universalism alters the usual approach of universal strategies (policies that make no distinctions among citizens’ status, such as universal health care) to achieve universal goals (improved health), and instead suggests we use targeted strategies to reach universal goals. Given that racial and ethnic minority groups are less likely to be provided with an appropriate standard of care, different groups of people may need targeted interventions to reach the level of care they need.

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## THE BUSINESS CASE FOR RACIAL EQUITY

Ani Turner of [Altarum](#) introduced this session by describing the findings of a new study, [The Business Case for Racial Equity](#), which finds the U.S. stands to gain \$8 trillion in GDP by eliminating racial inequities. Bringing it closer to our meeting venue, the analysis also finds that, by 2050, metro New Orleans stands to realize a \$43 billion gain in economic output if they close the racial equity gap.

Turner explained that racial disparities are the result of policy decisions, including housing sales and development, mass incarceration and biases in access to social capital and resources, and therefore will require policy solutions. Turner recommended that advocates focus on policy strategies including investing early in prenatal care and early childhood education, sentencing reform and transitional programs for returning people to society, and systems level change on social determinants of health in their states. She also highlighted that putting economic numbers around disparities is not intended to take the human element out, but to enhance the narrative around addressing inequities.

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**“It’s like a band playing a concert without their bassist. That’s what it’s like to be in the business world without key portions of the population.”**

**- Quentin Messer, Jr., New Orleans Business Alliance**

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Jan Moller of the [Louisiana Budget Project](#) spoke about the need to find common ground between the healthcare and anti-poverty advocacy spaces, and the business community, especially in the South. He also shared a recent ballot measure victory in Louisiana to require unanimous juries—the standard in all states besides Louisiana and



Oregon. Moller spoke about how messaging regarding this policy, including honest discussion of its racist history, led to its widespread passage in all but two parishes.

Quentin Messer, Jr., of the [New Orleans Business Alliance](#), finished the panel discussion from an economic development perspective. He stated that capitalism and the flow of money is still the single biggest deciding factor in decision-making. To change the status quo you must get involved in business and the flow of capital. He recommended that advocates find a common language to speak with the business community on these issues because employers do care about their workforce and their reputation in the community. Messer warned that if you continue to under-educate and fail to address the social determinants of health of the workforce then businesses will continue to be disadvantaged. Messer also urged advocates to remind their local businesses that there are changes that can be made that don’t cost anything to implement, including outreach to increase hiring from overlooked communities. The result may include finding untapped entrepreneurial potential. He said it’s like a band playing a concert without their bassist. That’s what it’s like to be in the business world without key portions of the population.



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## ADDRESSING SOCIAL DETERMINANTS OF HEALTH: ELIMINATING FINANCING SILOS

Lynn Quincy, director of the Healthcare Value Hub, opened the discussion by highlighting the importance of investments in social determinants of health (SDoH) and described the goal of the panel: how do we address barriers to financing investments in social determinants of health? These barriers include clinical and social services that are siloed in separate programmatic funding streams (Medicaid, housing, etc.); the business case for increasing social and public health spending may not be clear; and there is often a mismatch between stakeholders who make investments and ones who realize savings and benefits down the road.



Karen Minyard began by describing the work of the [Georgia Health Policy Center](#) (GHPC), which functions as a coordinating center for financing innovations focused on how money in the health system can be deployed towards population health. She noted that more than [80 percent](#) of the nation's health care costs are for care of chronic disease, many of which are preventable. Yet, only [3 percent](#) of the government's health budget is spent on public health and prevention measures.

The GHPC [blueprint](#) on how to think about financing innovations includes the following: how to do it, stewardship, strategy, how much money is needed, what the sources of money are, how money will be governed, and the funding model. Minyard noted that communities often start with discussions around the financial instrument, while GHPC recommends that occur at the end of the process.

GHPC worked with seven sites to increase investments in population health. Notably, all of the sites, working with a variety of partners, turned in the same direction—all took the concept of the [Wellness Trust](#) and made it the umbrella for all other financing innovations. A wellness trust is a funding pool raised to support prevention and wellness interventions that improve population health outcomes.

Andrew Olson, of the [Green & Healthy Homes Initiative](#) (GHHI), provided an overview of GHHI's work on the Le Bonheur Children's Hospital's [CHAMP program](#), which focuses on high-risk pediatric asthma patients in Tennessee. He noted that asthma is a \$50 billion medical burden in the United States. Olson explained that if you marry existing clinical care with social investments to remove causes and triggers of asthma in patients' homes and increase education and support, you can reduce emergency department use by 40 percent. In his example, Amerigroup, Blue Cross and United made payments to Le Bonheur Children's Hospital, which were then used to implement the CHAMP program (for asthma education) and invest in Habitat for Humanity (to implement environmental remediation for asthma patients). Olson described this model as politically palatable, sustainable in the long

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term, fits the existing regulator environment for managed care, and allows for additional flexibility.

Olson went on to discuss priorities for different stakeholders, noting that any approach that expects businesses to act against their own financial interest is not viable. A sustainable and scalable approach is one that makes it financially profitable for all required parties to participate. Before implementing the CHAMP program, GHHI reached the conclusion that they needed to build a program that made investments in health more profitable than the status quo by: monetizing the impact of investments in health, working within the existing regulator structure and building mechanisms to align economics with health. One such hurdle is that hospital CFOs don't want to lose out on potentially profitable patients and would be reluctant to pay for services outside of their purview.

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**“Any approach that expects businesses to act against their own financial interest is not viable.”**

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Len Nichols, director of George Mason University's [Center for Health Policy Research and Ethics](#), discussed a new financing model in his article written with Lauren Taylor, “[Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities](#).” In this model, Nichols and Taylor set out to solve the “free rider problem,” where stakeholders benefit from the investments of others. Nichols highlighted the need for a trusted broker and a functional local stakeholder coalition to finance investments in SDoH. A trusted broker would assemble the stakeholders who would benefit from



an intervention and get them to submit a secret bid (nonfinancial or financial return on investment). If the sum of the bids exceeds the costs, then the coalition has resources to make the investment and the trusted broker would assign taxes and prices appropriately to each stakeholder. The study describes a twelve-step process for developing an intervention with a variety of partners.

A key question from the audience was whether focusing on the business case for investments in SDoH could be co-opted by stakeholder self-interest in the long term. Panelists asserted that, in the short-run, stakeholders are aware that investments in SDoH benefit the community and that it's too early to determine long-term prospects. Another advocate, Anthony Wright, asked whether a monopoly provider or a dominant insurer are prerequisites for making these investments. Panelists stated that monopoly actors make implementing such interventions easier in some ways, but more difficult in others. Karen Minyard emphasized the need for creating stewardship that is mature enough to negotiate a complicated territory with providers and look at all the money in the system and tweak investments.

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## ADDRESSING SOCIAL DETERMINANTS OF HEALTH: APPROPRIATE STAKEHOLDER ROLES

Len Nichols, director of George Mason University's [Center for Health Policy Research and Ethics](#) introduced the session, which centered on a discussion of how we can align the self-interest of stakeholders with what is best for lowering healthcare costs and improving health. He stated that “good policy is really about channeling self-interest to serve the social interest.”

Panelists gave short presentations before diving into moderator and audience questions.

Karen Hacker, director of the [Allegheny County Health Department](#), provided various definitions of population health and an overview of stakeholder perspectives. For providers, “population” refers to the people they serve, for delivery systems and managed care organizations it is their members and for counties it is the people that live within their jurisdiction. Stakeholders must look at the individual and population level to find the sweet spot for forming partnerships that make investments in social determinants of health. For example, at the individual level we might ask “how do we stop these individuals from smoking?” However, at the population level we would have to ask, “how can we change the social and economic environment so that it discourages smoking?” She suggested that health systems can conduct joint needs assessment with public health entities to identify collaborative opportunities.

Jean McGuire, of [Northeastern University Bouve College of Health Sciences](#), described findings from [Population Health Investments by Health Plans and Large Provider Organizations—Exploring the Business Case](#). Researchers at Northeastern found that the missions of health



plans and health systems, the local market dynamics (whether there is consolidation), payment changes, cost exposure and partner expectations all affect how likely they are to make population health investments. Some concerns include:

- Measuring the impact of a population health intervention is a serious challenge
- There are a limited number of social determinants of health interventions that can achieve a return on investment in the timeline that providers and plans are looking for
- People usually come with more than one SDoH issue and the slicing and dicing creates its own problem when we are trying to address the whole person
- Some models may lead to the devolution of governmental responsibility to plans and other entities

McGuire cautioned we need to ensure that investments in social determinants of health are made with the goal of making positive social change and not just see a return on investment—don't let the “business case” for making investments in social determinants of health be co-opted by for-profit interests.

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Her overarching point: “It’s all about poverty, stupid”—we need to remain focused on the populations these investments are meant to help.

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**“Good policy is really about channeling self-interest to serve the social interest.”**

**- Len Nichols, George Mason University**

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Patrick Keenan, of the [Pennsylvania Health Access Network](#), spoke about his experience with the [Housing as Health](#) campaign. They discovered that people were going to the hospital because they had nowhere else to go. This was especially likely during inclement weather. The campaign developed a model to pay for supportive housing through Medicaid, involved community-based organizations in value-based purchasing agreements and partnered with health providers and managed care organizations (MCOs). To ensure that this program and others are successful partners have to take into account: What health system

or MCO did patients interact with? What programs are those entities supposed to have? Where are the gaps?

In response to a question from Nichols about aligning healthcare goals with business financial targets, Keenan noted that Allegheny County already has consolidated health plans and an integrated delivery system. He highlighted the importance for advocates to mediate and coordinate between diverging stakeholder interests and to explore and incorporate the roles of state and local agencies in community-based efforts to address SDoH.

Audience questions included how to convince large health systems to change their business processes and assumptions, how to move to a system where stakeholders are less proprietary about needs assessments, assisting under-resourced community organizations, distinguishing between short-term vs. long-term goals, and how to negotiate with health plans and hospitals who want different things despite the existence of good data.

## PATIENTS AT THE TABLE: ENGAGING THE COMMUNITY IN HEALTH SYSTEM TRANSFORMATION

As healthcare recipients and payers (both directly through premiums, deductibles and out-of-pocket costs and indirectly through taxes and diverted wages), consumers are the most important stakeholders in our healthcare system. Yet, all too often, healthcare policies and programs are designed without sufficient consumer input, resulting in a system that does not reflect their goals and needs.

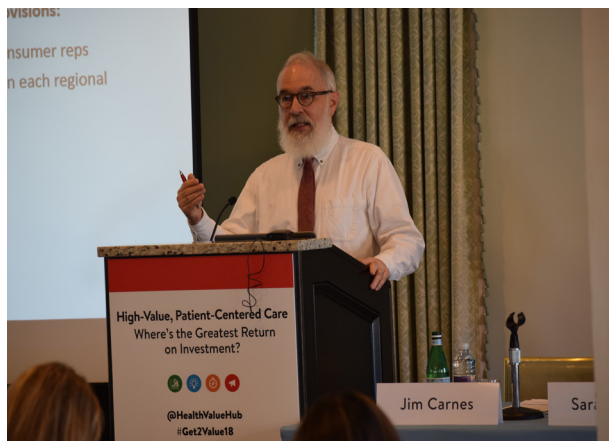
Making the healthcare system work better for consumers will require amplifying the consumer

voice in a variety of ways—civic/grassroots engagement, formal roles designated for consumers, and empowering patients at the point of care.

Jessie Zimmerer opened the discussion with an overview of [Community Catalyst](#)’s recently released guide to grassroots organizing for consumer-driven delivery reform. She highlighted three main takeaways from the report. First, organizing around delivery reform is about moving issues forward. Many advocates



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are used to operating in “defense mode,” but health system transformation and organizing requires a long-term goal. It’s about going from what we don’t want to happen to what we do want to see. Second, consumers with chronic conditions tend to be very effective advocates because they have the most interaction with health system and are familiar with its strengths and weaknesses. Finally, successful transformation requires investing more resources in a smaller group of activated consumers instead of few resources among members of a larger group.

Jim Carnes, of [Alabama Arise Citizens’ Policy Project](#), shared his experience amplifying the consumer voice in Alabama’s ongoing transition from Medicaid fee-for-service to managed care. According to Carnes, Alabama has one of the most stringent Medicaid programs in the country and the consumer voice is “pretty much shut out” at the Medicaid table. In 2012, the governor appointed a 28-member Medicaid transformation commission, with Carnes as the sole consumer representative. To strengthen the quality of his recommendations, he organized a coalition of 17 consumer-focused organizations to set priorities, which he communicated to the commission.

The commission established Regional Care Organizations, based on Oregon’s Coordinated Care Organization model, with a strong, statutorily established role for consumers. However, ambiguity in the legislative language left children covered by Medicaid without formal representation. Additionally, the lack of a “hub” to provide technical assistance and identify best practices, as used in Oregon, failed to supply consumer representatives with needed support. Ultimately, the initiative stalled due to fading support from the legislature.

Alabama is now starting over under the direction of a new governor, with fewer consumer representatives and no statutory requirement that consumer representatives be involved in Medicaid governance. To help consumer representatives stay engaged, Alabama Arise is working to develop a network of “community contacts” who are well informed and have experience with Medicaid to bring forth ideas from the community and provide advice. Despite past challenges, Carnes and others remain dedicated to increasing consumer engagement in Alabama’s Medicaid transformation.

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**“Many advocates are used to operating in ‘defense mode,’ but health system transformation and organizing requires a long-term goal.”**

**- Jessie Zimmerer, Community Catalyst**

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Sarah Davis of the [Center for Patient Partnerships](#) at the University of Wisconsin discussed the importance of soliciting a variety of perspectives to understand the patient experience. There is a tendency, she said, to engage the “usual suspects” (e.g., consumers who are enthusiastic, have ample

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free time, etc.). She stressed that consumer representation must engage a diversity of consumers if it's to be meaningful.

Technology can help bring people to the table who may be left out due to their circumstances, including those who are disabled or otherwise unable to serve on a panel in person. Davis used the example of a project called [Health Experiences USA](#), which provides a collection of short videos featuring many different types of consumers that is made available online and can be used in discussions with providers, policymakers and others. Project participants are also creating a brief “catalyst film” that combines many voices and key messages, which can be used to start a conversation.

[Jamila Michener](#) from [Cornell University](#) concluded the discussion by reminding us of how policy affects levels of political participation and engagement. In the Medicaid program, especially, the way people are treated by administrators or bureaucrats and frequent changes in enrollment/benefit criteria influence how people perceive their place in the system.



Strategies for engaging consumers must evolve as policymakers and political environments change, said Michener. Context across time, in addition to geography, is important. Local institutions can play a key role in engagement efforts because they have the trust and can open people up to being involved. Advocacy organizations should consider how they can partner with local stakeholders like Community Health Centers to further their engagement goals.

## REFLECTIONS ON WHAT WE'VE LEARNED

The conference concluded with a reactor panel in which speakers and audience members shared key takeaways, gaps in the discussion and strategies moving forward.

Anthony Wright of [Health Access California](#) grappled with issues related to power. He asked, “How do we marry broad based public support for change with having individual consumers having a voice in improving specific health system problems? Then, how do we use that to build power for bigger systematic changes that need to happen? Additionally, how do we deal with power imbalance? How do we shift power



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in our healthcare system to hold certain parties accountable?”

Tekisha Dwan Everette from [Health Equity Solutions](#)’ remarks centered on increasing the voices of communities of color and the underserved in health system transformation. She reiterated that it is vital that these groups be represented but wondered how the advocacy community could effectively communicate about complex policy topics – like all-payer claims databases and medical loss ratios – that consumers often don’t understand.

Chapin White from [RAND Corporation](#) pointed out that he heard little discussion of the 2020 election. He challenged attendees to create a plan for working on these issues in a time of intense disagreement between political parties.

Sheldon Weisgrau from [Alliance for a Healthy Kansas](#) also remarked about the “red/blue divide,” expressing a need to develop messaging that enables advocates to discuss pertinent issues in a way that resonates with both conservative and liberal lawmakers.



Audience members engaged in a robust discussion about finding opportunities to make progress on the issues discussed. The opioid crisis, rural hospital closures and high drug prices were cited as entry points to engage with legislators about more controversial issues like universal coverage and behavioral health. On the topic of mobilizing consumers, attendees agreed that advocates must not only identify what messages work in certain communities, but also who is the best person or group to deliver that message.



Launched in March 2015, the Healthcare Value Hub provides free, timely information about the policies and practices needed to achieve health systems that are equitable, affordable, and focused on the goals and needs of the people the system is meant to serve.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating and disseminating evidence, as well as connecting advocates, researchers and policymakers to build communities and create action for a patient-centered, high-value healthcare system.

Getting help is just a simple phone call or email away. You can also sign up for our monthly *Research Roundup*, attend our monthly webinars and follow us @HealthValueHub.

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