ALTARUM
HEALTHCARE VALUE HUB

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

Appendix G: 10 Policies to Get Started

Creating a healthcare system that is equitable and works seamlessly with public health, social sectors and community members to address the goals and needs of the people it serves will require numerous policy changes at many levels. Nevertheless, we recognize that advocates, funders and others might benefit from a shorter, more manageable list of policies upon which to focus their early efforts.

This appendix lists 10 of our favorite policies, distinguished by one or more of the following attributes:

- Strongly supported by evidence
- Strongly endorsed by interviewees and/or have widespread support in policy circles
- Are local enough to be shaped by community members' goals and needs

Collectively, these policies span our three-part organizing strategy: the need for assessment, the need to create integrated systems and the need to ensure meaningful access to care and services.

10 Policies to Start

1. **Fill in gaps in coverage**, via Medicaid expansion or other evidence-based approaches. (*Federal, state or local health agencies*)
2. **Coordinate the community needs assessment obligations** of nonprofit hospitals, public health departments and FQHCs to support the development of a single, comprehensive county- or city-wide assessment of residents' health and health-related needs. Expand community need reporting requirements to include other nonprofit organizations that influence health, as well. (*IRS and/or state departments of revenue*)
3. Provide technical assistance, funding and research to support states and communities in **identifying a core set of wellbeing measures that reflect community priorities.** (*State and local government agencies*)
4. **Similarly, identify a core set of state-level wellbeing measures** consistent with overall health system transformation goals. **Deploy these wellbeing measures across vendor contracts in different sectors** to create "parallel risk," and seek alignment with private payers in terms of payment and other incentives facing healthcare providers. (*State agencies overseeing health and health-related social sectors*)
5. **Increase funding for Accountable Communities of Health** through state appropriations and/or Section 1115 DSRIP waivers and support with technical assistance. Create wellness trusts to help fund this type of cross-sector collaboration. (*State and local departments of health*)
6. Require (and pay) providers to **use evidence-based, targeted, social needs screening tools** as a condition of participation in government-sponsored health plans. (*State governments, as purchasers*)
7. **Pay for care coordination** activities under FFS and VBP models. (*Federal and state governments, as healthcare purchasers*)
8. Incentivize or create **connected data systems that track people across the health and social sectors**, with the goal of tracking progress in addressing their health and health-related social needs. (*State agencies overseeing health and health-related social sectors and state governments, generally, as healthcare purchasers*)
9. **Remove limits on same-day billing** for medical, behavioral and dental services provided in Federally Qualified Health Centers and other facilities that offer co-located services. Encourage the provision of co-located services. (*Medicaid agencies*)
10. **Mandate consumer representation in health system governance** whenever state or federal funds (or tax exemption) are used to provide services. Establish clear guidelines as to what constitutes sufficient consumer engagement. (*All government agencies related to health*)

Discussion

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. Compared to being uninsured, the benefits, as documented by the Institute of Medicine's *Care without Coverage: Too Little, Too Late* and other studies, include (but are not limited to):[1]

- 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 the 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.[2]

Using a community driven process to assess people's needs and determine priorities is essential to achieving our overall goal. Numerous interviewees cited that community needs assessments conducted by nonprofit hospitals, public health agencies and FQHCs have potential, but that requirements should be strengthened to coordinate efforts and engage a greater diversity of community stakeholders.[3] Amending federal guidance to create a single assessment timeline[4] would facilitate collaboration by making the assessment a priority for each organization/agency at the same time. States can obtain buy-in from additional stakeholders by imposing needs assessment requirements on other nonprofits that influence health, as well. For example, New Hampshire requires nonprofit behavioral health providers, retirement communities and nursing homes to produce needs assessments and community benefit plans, in addition to nonprofit hospitals, public health departments and FQHCs.[5]

Ideally, state or local governments should **go further by requiring the development of comprehensive, city- or county-wide assessments** produced by a coalition of community stakeholders. The Columbia Gorge Regional Community Health Assessment (conducted by a collaborative of hospitals, clinics, public health agencies and community-based organizations operating in the Columbia Gorge Region) is a strong example of a multi-county, multi-stakeholder CHNA produced in response to Oregon's law.[6] 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.

Coordinated community health needs assessments informed by a diversity of perspectives contribute to the development of a community-driven process for determining priorities related to residents' overall well-being. Once established, these **community priorities should inform the creation of performance measures** used to gauge the effectiveness of policies and programs.[7] Widely accepted measures can galvanize action, align disparate stakeholders and influence priorities throughout the system.[8]

Many interviewees felt strongly that outcomes measures should be used to determine whether interventions have been successful.[9] It is important to recognize, however, that structural and process measures have merit in certain situations[10] and should be employed when appropriate. For example, Live Well San Diego—a multi-stakeholder collaboration based in San Diego County, California—uses performance measures that include lowering the percentage of residents experiencing food insecurity and increasing the percentage of county residents healthy enough to live independently.[11]

Similarly, state governments should use a multi-stakeholder process to craft performance measures consistent with their overall health system transformation goals and should **deploy these measures across vendor contracts** to hold healthcare and community-based organizations accountable (a.k.a. creating parallel risk), to the extent that desired outcomes are under the control of the provider. For example, a state Medicaid agency might coordinate with the state Department of Agriculture to incorporate a Medicaid hemoglobin A1C measure into the performance metrics for education grants that fund nutrition-focused CBOs.[12]

Accountable Communities for Health (ACHs) are another vehicle for cross-sector alignment that present an opportunity for wellbeing performance measures to be deployed. Broadly speaking, ACHs are structured alliances of healthcare, public health and other organizations that plan and implement strategies to improve population health and health equity for all residents of a particular geographic area. **Accountable Communities for Health embrace the need to address health risk factors that exist outside the walls of the clinic.**

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.[13] Wide variation makes it difficult to make generalizations about ACHs' effectiveness,[14] but an extensive review published by the National Academy of Medicine documents their potential to drive us toward population health and wellbeing.[15]

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.[16]

States should support ACHs by incentivizing non-profit hospitals to participate by allowing them to report *meaningful* involvement as community benefit; increasing funding through state appropriations and/or Section 1115 DSRIP waivers;[17] and providing technical assistance. Local governments can support ACHs by supplying funding and providing technical assistance, in addition to serving as a convener.

Another option for providing sustainable funding overtime is to establish a wellness trust—an entity governed by community partners that "captures" savings from ACH-supported interventions to fund the next round of interventions. Many point to the success of an early model, Massachusetts' Prevention and Wellness Trust Fund (PWTF), that has been used to finance cross-sector collaboration.[18] 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.[19]

Providers, operating both within and outside ACHs, must **use evidence-based tools to identify patients' unmet health and health-related social needs** in order for them to be addressed. A small but growing body of evidence suggests that providers who are comfortable screening for social needs are more likely to report having helped patients address them.[20] As healthcare purchasers, states should require (and pay) providers to use evidence-based, social needs screening tools as a condition of participation in government-sponsored health plans. Characteristics of a high-quality screening tools and best practices can be found in Health Leads' comprehensive Screening Toolkit.[21] Considerations for implementation are outlined in the Center for Healthcare Strategies, Inc.'s *Implementation Considerations* report.[22]

Care coordination is a widely held "next step" once people's unmet health and social needs have been identified. While research on the impact of care coordination programs has yielded mixed results (due to variation in design and implementation),[23,24,25] 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.[26] Barriers to widespread practice include non-interoperable health records and payment structures that do not reimburse providers for care coordination activities. A logical first step at the Federal and state levels is to *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). Additionally, care coordination should follow protocols that ensure the level of activity is tailored to patients' needs.

Interviewees strongly counseled that mechanisms must be in place to assess whether or not efforts have successfully addressed residents' unmet social and health needs. Key to this assessment are data systems that allow providers to track patients across health and social systems. States, in their role as healthcare purchasers, should incentivize providers to adopt and use data systems (like the Patient Care Intervention

Center's Unified Care Continuum Platform[27]) that **track patients' connections to social service organizations**, in order to (1) monitor whether the recommended services are received and (2) measure improvement.[28]

Co-location of primary care, behavioral health and dental services creates a one-stop-shop for people to receive basic care. The approach received widespread support across our interviewees[29] and in public policy discussions. When designed effectively, the benefits of co-location can include convenience, improved access,[30] streamlined referrals and better communication between healthcare providers.[31] Moreover, locating several services under one roof may decrease stigma-related barriers to access, particularly with regards to behavioral health.[32] The Rural Health Information Hub outlines a number of considerations for effective co-location.[33]

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.[34] 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.[35] Eliminating these policies is vital to integrating medical, dental and behavioral care in order to better meet people's goals and needs.

Creating a healthcare system that works with community members to address their goals and needs **requires consumer representation and effective strategies for engagement.** Documented benefits of public involvement include "enhanced awareness, understanding and competencies among lay participants."[36,37]

Federal, state and local governments can foster consumer engagement by, first, establishing well-specified criteria for efforts that are meaningful. At a minimum, this should include (1) transparency and high quality, accessible information and (2) community member participation. Examples of strong engagement policies 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.). The Collective Impact Forum was specifically identified by our interviewees as a best practice method for meaningfully engaging a diversity of community stakeholders, including community members, in transformation efforts.[38]

In addition, governments can expand engagement opportunities by mandating consumer representation in health system governance whenever state funds (or tax exemption) are used to provide services. For example, the Federal Public Health Service Act requires community health centers to have a consumer majority on their board of directors, while Massachusetts requires hospitals to establish patient and family advisory councils.[39] These laws should be expanded to apply to additional groups of providers and adopted in other states.

Endnotes

1. Institute of Medicine, "Care without Coverage: Too Little, Too Late," *National Academies Press*, 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*, Vol. 176, No. 10 (2016). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

2. Ibid.

3. For an assessment of CHNA impact, see https://www.ncbi.nlm.nih.gov/pubmed/26440370.

4. 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 5 years, whereas nonprofit hospitals and FQHCs must produce reports every 3 years.

5. 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

6. Oregon's innovative Coordinated Care Organizations are statutorily required to conduct community needs assessments, and produce Community Health Improvement Plans, at least once every five years. See: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-CHIP.aspx

7. Evaluations are scarce with respect to the use of strong, widely agreed upon performance measures, yet the most highly regarded examples of community organized health transformation efforts have used this approach. See: Jones, Shyloe. *Community Level, Multi-Stakeholder Approaches to Improve Healthcare Value*, Healthcare Value Hub, May 2018. https://www.healthcarevaluehub.org/files/6615/2657/6508/RB_26_-_Accountable_Health_Structures.pdf

8. Institute of Medicine, *For the Public's Health: The Role of Measurement in Action and Accountability*, Washington, D.C. (2011). https://www.nap.edu/catalog/13005/for-the-publics-health-the-role-of-measurement-in-action. See also: *Vital Signs: Core Metrics for Health and Health Care Progress, in which* the Institute of Medicine identified a core measure set designed to apply across different levels of the healthcare delivery system: https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress

9. Interviewees noted that, while the Federal government and a few states have experimented with programs that pay providers based on patient health outcomes, the behavioral health and dental fields are further behind. Efforts to develop outcome-based measures for behavioral health, in particular, have been hindered by a lack of evidence supporting best-practice treatment for people with substance use disorders. See: 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

10. Given the nascence of efforts to integrate primary care, behavioral health and oral health, structural and process measures can be used to 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. Process measures can also be used to incentivize providers to adopt best practices, like patient shared decision making.

11. Jones (May 2018).

12. AcademyHealth's *Approaches to Cross-Sector Population Health Accountability* offers practical recommendations and sample measures to align the priorities of healthcare organizations and CBOs: https://www.academyhealth.org/sites/default/files/Approaches_to_CrossSector_Pop_Health_Jan2018_0.pdf

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

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

15. 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/

16. Washington Health Care Authority (accessed on February 15, 2019).

17. 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.

18. 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

19. Ibid.

20. Andermann, Anne, "Screening for social determinants of health in clinical care: moving from the margins to the mainstream," *Public Health Reviews*, No. 39, Vol. 9 (2018). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6014006/

21. The toolkit is available for download at: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

22. Thomas-Henkel, Caitlin and Meryl Schulman, *Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*, Center for Healthcare Strategies (October 2017). https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/

23. 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

24. 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

25. 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

26. "What is Care Coordination?" *NEJM* Catalyst (Jan. 1, 2018). https://catalyst.nejm.org/what-is-care-coordination/

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

28. Healthcare Value Hub report forthcoming.

29. 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.

30. Few recent studies document rigorous evidence of outcomes improvement. One exception: enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals among veterans with serious mental illness. See: Pirraglia, Paul A., et al., "Benefits of a Primary Care Clinic Co-Located and Integrated in a Mental Health Setting for Veterans With Serious Mental Illness," *Preventing Chronic Disease*, Vol. 9, No. 51 (2012). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3340211/

31. Ginsburg, Susanna, *Colocating Health Services: A Way to Improve Coordination of Children's Health Care?*, The Commonwealth Fund, New York, N.Y. (July 2008). https://gucchdtacenter.georgetown.edu/resources/Webinar%20and%20Audio%20Files/Ginsburg_Colocation_Issue_Brief.pdf

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

33. Ibid.

34. 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/

35. 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

36. Conklin, Annalijn, Zoe Morris, and Ellen Nolte, "What is the evidence base for public involvement in healthcare policy?: results of a systematic scoping review," *Health Expectations*, Vol. 18, No. 2 (April 2015). https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12038

37. Assessing the impact of community engagement on health outcomes has proven difficult due wide interpretations of terms like 'community' and 'participation.' See: Rifkin, Sarah F., "Examining the links between community participation and health outcomes: a review of the literature," Health Policy and Planning, Vol. 29, No. 2 (September 2014). https://academic.oup.com/heapol/article/29/suppl_2/ii98/588582

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

39. A list of best practices and other resources for designing effective patient and family advisory councils have been developed by the Institute for Patient- and Family-Centered Care. See: Institute for Patient-and Family-Centered Care, *Patient and Family Advisory Councils*, *http://www.ipfcc.org/bestpractices/patient-family-advisory-councils.html* (accessed on February 15, 2019) and 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