A CONSUMER POLICY PLATFORM *for* HEALTH SYSTEM TRANSFORMATION

CENTER FOR **CONSUMER ENGAGEMENT**
in **health innovation**

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INTRODUCTION

What Should We Hope To Achieve Through Health System Transformation?

Although much work remains to fully realize the coverage vision embodied in the Affordable Care Act (ACA), another aspect of the ACA – how we deliver and pay for health care – is receiving increasing attention. To date, the bulk of this attention has come from providers and public and private payers. But consumer advocates are coming to the table, increasingly recognizing that critical decisions about access, quality and affordability are being made.

With support from The Atlantic Philanthropies, Robert Wood Johnson Foundation, The John A. Hartford Foundation and others, and working closely with other national and state partners, Community Catalyst has committed itself to supporting an effective consumer voice in the debate over "Health System Transformation." The Center for Consumer Engagement in Health Innovation is the new center at Community Catalyst that will be pursuing this work on many fronts. A necessary (though not sufficient) step in this direction is to clarify what we hope to get out of Health System Transformation, what the risks are to consumers in a reorganized system, and consequently, what our agenda for change should look like.

What We Hope to Achieve

The Institute for Healthcare Improvement's "triple aim" – better care/better health/lower cost – provides a good starting point to develop a framework for transforming our health system. But it can be made more specific by answering three questions:

Better care for whom? Primarily, for two intersecting groups:

- people with multiple chronic conditions and disabilities who account for the bulk of our national health care spending and who are often poorly served by a system that is better designed to address discrete episodes of acute illness
- low-income people, racial and ethnic minorities and other marginalized populations

Better health how? Better health will be achieved not only by improving clinical processes to get better health outcomes, but also by redirecting wasted resources in an inefficient medical care system to improve the social and economic conditions that generate a lot of acute and chronic health spending.

Finally, better value how? By addressing those features of the U.S. health care financing and delivery system that inflate our spending relative to other advanced industrial democracies but fail to improve clinical outcomes (see *The Path to a People-Centered Health System*[1] for more discussion of these drivers of low-value care).

What Are the Risks?

1. The push to achieve cost savings will come at the expense of better care and better health. We see this risk in the alarming trend toward higher patient cost-sharing, which can lower health spending but also puts the greatest economic burden on people with chronic conditions and low-income people.

2. Plans and providers will seek to achieve results by avoiding or underserving high-need/high-cost patients. Reengineering care is hard. Relatively speaking, avoiding patients who might drag down quality scores or bust through budget caps is easy.

[1] http://www.communitycatalyst.org/resources/publications/the-path-to-a-people-centered-health-system-next-generation-consumer-health-advocacy

What Policy Agenda Can Help Us Realize Our Positive Goals, While Minimizing the Risks?

The Center for Consumer Engagement in Health Innovation has defined **six policy areas**[2] we believe are critical to address in order to ensure that the promise of better care, better value and better health is realized and the pitfalls avoided.

1. ***Structures for meaningful consumer engagement*** to ensure that people have a voice in policy decisions, the health care organizations that serve them and their own health care. The Center promotes a meaningful role for consumers, family members and advocates in advisory councils and engagement of patients as part of clinical care.

2. ***Payment arrangements that incentivize people-centered health care*** by paying providers for achieving the health outcomes that matter most, ensuring that providers are appropriately compensated for the care of complex patients, and reducing patient barriers to accessing needed care.

3. ***Resources for community and population health*** in order to address the social and economic factors affecting the health of people in their communities. The Center supports the use of community benefit programs to reflect and target community needs and priorities, the improved alignment of community resources, an increased investment in prevention, and robust evaluation of population health outcomes.

4. ***Consumer protection*** through the application of strong safeguards including independent and effective ombudsman programs. The Center also backs protections in the form of consumer-centric quality measures, transparency and consumer choice.

5. ***Person-centered culture of care*** through the adoption of care models and best practices that meet the specific goals, preferences and needs of the population being served, including at the end of life. The Center promotes coordinated care and the integration of physical health, behavioral health and community supports and services. We place particular emphasis on the care of three vulnerable populations:

   - Older adults and people with disabilities who have both Medicare and Medicaid coverage ("dual eligibles")

   - People with substance use disorders and mental health conditions

   - Children and youth with special health care needs

6. ***Health equity for underserved populations*** in all health system transformation efforts. The Center prioritizes expanding the collection and reporting of data on disparities, ensuring that care improvement efforts specifically address health disparities, and promoting a culturally competent workforce, including the use of community health workers.

We recognize that all of this change will not happen overnight. Placing these priorities at the heart of efforts to transform the way we pay for and deliver health care and how we promote health more broadly will require sustained advocacy over many years. We welcome feedback on this agenda from our state and national colleagues and from other stakeholders, and look forward to making the promise of better care, better value and better health a reality. Each of the Center's six policy priorities is explored in more detail in the corresponding sections below.

[2] http://www.communitycatalyst.org/initiatives-and-issues/initiatives/center-for-consumer-engagement-in-health-innovation/CCEHI-Policy-Priorities-updated-2.2.16.pdf

PRIORITY ONE – *Structures for meaningful consumer engagement* to ensure that people have a voice in policy decisions, the health care organizations that serve them and their own health care. The Center promotes a meaningful role for consumers, family members and advocates in advisory councils and engagement of patients as part of clinical care.

Engaging Consumers Across Three Levels of the Health Care System

In order to re-align the health care system, to place the consumer at its center, we need to actively and meaningfully engage consumers in every aspect of health system transformation. The refrain "nothing about us, without us," the cornerstone of the disability rights movement, should become the standard in health system redesign.

We were pleased to see that the Institute of Medicine's report, *Vital Signs: Core Metrics for Health and Health Care Progress*[3] identified "engaged people," referring to both individual and community engagement, as one of four key quality domains. "Engaged people," along with "healthy people," "care quality" and "care cost" were recommended as the four domains in a "parsimonious" but comprehensive set of health metrics that could be adopted by public and private health programs and organizations.

At the Center, one of our key policy priorities is to advocate for structures for meaningful consumer engagement. We believe that this engagement must happen at three distinct levels – individual, system and policy. In practice, these translate to the need for engagement in the clinical setting, in health care organizations, and in federal and state policymaking. The table below summarizes the goals of engagement at each of the levels and gives examples of specific policies that can help support these goals.

THREE LEVELS OF CONSUMER ENGAGEMENT

LEVELS	GOALS	POLICY EXAMPLES
Clinical Setting	• Patients as partners • Care matched to needs	• Patient engagement measures • Shared decision-making • Self-management programs
Health Care Organization	• Consumers involved in design, implementation and evaluation of programs	• Consumers on governing councils, advisory committees
Federal, State and Local Government	• Policies are consumer-focused • Consumer voices effectively balance the power of industry stakeholders	• Consumers involved in design, implementation and evaluation of new models, e.g. Medicaid waivers, SIM programs

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[3] http://www.nationalacademies.org/hmd/Reports/2015/Vital-Signs-Core-Metrics.aspx

In the clinical setting, there are a number of tools available to help clinicians and patients work together in the pursuit of better patient engagement in their own care. For example, the Stanford Patient Education Resource Center has developed a Chronic Disease Self Efficacy Scale. There is also a proprietary Patient Activation Measure (PAM 13)[4] and a two-question health confidence measure.[5] We note that the Institute of Medicine's *Vital Signs* report considered health literacy to be the best measure of patient engagement. We support the continued adoption of patient engagement activities, including shared decision-making and evidence-based self-management programs, in light of the body of evidence that shows that patients who are more engaged or activated have better health outcomes.[6] There is also some evidence that shows an association with lower cost. We note examples of practices that have used patient engagement as a focal point for care redesign.[7]

At the health care organization level, we support including consumers in governance of organizations and programs. For example, plans participating in Ohio's dual eligible demonstration project (MyCare Ohio) are required to have a Consumer Advisory Council (CAC) in each region the plan serves. Community Catalyst has supported the work of Ohio Consumer Voice for Integrated Care (OCVIC), a statewide coalition of aging and disability advocates that organizes and educates MyCare Ohio beneficiaries. OCVIC has been heavily involved throughout the MyCare rollout in building a voice for MyCare beneficiaries and advocating for policy changes going forward.

We believe that strong consumer representation like this is critically important in the governance and quality improvement activities of health care organizations, including Accountable Care Organizations and health plans, and that this representation must be supported through training and appropriate levels of funding.

Finally, we believe that consumers must have a seat at policymaking tables. For example, as Massachusetts was developing its dual eligible demonstration, it sought input from diverse consumer perspectives through focus groups and outreach sessions. This process was essential to shaping the design of the state's care delivery model and demonstration proposal to CMS. At the urging of state disability advocates, Massachusetts established an Implementation Council which was charged with monitoring program access and quality, promoting transparency in program implementation, and assessing Americans with Disabilities Act (ADA) compliance. The council's members were identified through an open nomination process. At least half of the slots are required to be filled by MassHealth beneficiaries with disabilities or their family members and the remaining slots were filled by representatives of hospital, provider, collective bargaining and advocacy organizations. The Implementation Council holds monthly meetings that are open to the public and has a workgroup structure to examine specific issues such as long-term services and supports.

In addition to formal structures, we advocate for inclusion of consumers at "ad hoc" gatherings and meetings. For example, in January, 2016, Sylvia Burwell, Secretary of HHS, convened a roundtable in Washington, D.C. to discuss consumer engagement[8] that included consumer advocates, along with representatives of health care providers, health plans, health technology companies, and researchers.

The roundtable was a powerful and validating step toward recognizing the importance of steering our nation's health care onto a more consumer-centered course. We hope to see more such moves at the federal, state and local levels, and additional efforts to advance consumer engagement at all three levels.

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[4] http://www.insigniahealth.com/products/pam-survey
[5] https://www.howsyourhealth.org/
[6] http://content.healthaffairs.org/content/32/2/207.abstract
[7] http://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/10.1%202011_05_PeaceHealth's_Team%20 Fillingame_Uses_Patient_Activation_Measures_to_Customize_the_Medical_Home.pdf
[8] http://www.hhs.gov/idealab/2016/01/29/putting-engaged-empowered-individuals-center-health-care-system/

Payment Reform: Creating a $trong Foundation for Health System Transformation

As consumer advocates approach the topic of payment reform we should bear in mind the following adages:

> *"Every system is perfectly designed to achieve exactly the results it gets."*
>
> – Don Berwick, founder of the Institute for Healthcare Improvement and former administrator of the Center for Medicare and Medicaid Services (CMS)

> *"Insanity: doing the same thing over and over again and expecting different results"*
>
> – Albert Einstein, Nobel prize-winning physicist, philosopher and humanitarian

> *"You get what you pay for."*
>
> – Anonymous

In other words, if we want different results from our health care system, we have to change the way we pay for health care goods and services.

The development of a pro-consumer agenda on payment reform requires us to look at the issue from three distinct points of view: What is that we are trying to achieve? What is it that we are worried about? What are the available opportunities to move the system forward?

What are we trying to achieve through payment reform?

The goal of consumer advocacy around payment should be to maximize the potential benefits of new payment approaches while minimizing the downside risks. At the same time, consumer groups are not operating in a vacuum. The best way to enter into the debate will be to identify promising opportunities as they unfold in the states, as well as in Washington.

To maximize the benefits of payment reform we should identify and seek to rectify the key weaknesses in the current financing system that relies mainly on fee-for-service (FFS) reimbursement. (Note, this continues to be true notwithstanding the spread of "managed care," since most providers continue to be paid substantially on a fee-for-service basis.)

Those weaknesses are:

- Too much focus on treatment of discreet episodes of acute illness without adequate attention to management of increasingly prevalent chronic conditions and disabilities
- Unequal treatment and outcomes for low-income populations, racial and ethnic minorities and other historically marginalized groups

- Over-reliance on heroic medical interventions[9] (too often in the last stages of life when there is little left to be gained) and underinvestment in interventions to prevent illness, including addressing the social determinants of health

- High levels of spending on health care services relative to other advanced industrial countries without a concomitant improvement in outcomes

What are we concerned about?

Reversing the financial incentives inherent in FFS does not automatically bring about the results we are seeking. Ironically, the very populations who have the most to gain from a shift away from FFS also have a lot to lose if financial incentives are not carefully constructed. That's because it may be easier for provider systems subject to cost and quality targets to meet those goals by avoiding or under-serving high need/high cost patients rather than by reengineering care processes.

What is the opportunity?

The ACA accelerated a movement to payment reform that was already underway prior to passage. Through the creation and funding of the Center for Medicare and Medicaid Innovation, CMS has been testing new models of payment and care delivery. More recently, HHS has adopted a goal of shifting 90 percent of Medicare FFS payments "from volume to value" by the end of 2018.[10] This emphasis on payment reform is turning Medicare into an engine of reform. Other initiatives, including the State Innovation Model grants (SIM) and Medicaid Delivery System Reform Incentive Payment (DSRIP) waivers are increasingly bringing states into the act. Changes in how Medicare pays physicians, adopted as part of the legislation replacing the Medicare Sustainable Growth Rate formula, are likely to add yet more momentum to the shift because under the new formula, physicians' ability to get pay increases will be directly tied to their participation in "Alternative Payment Models" that are accepting financial risk.

Toward a pro-consumer agenda

Relatively speaking, altering the incentives of FFS is the easy part. HHS has identified a continuum of payment reforms[11] starting with enhanced payments for care-coordination at one end of the spectrum, and proceeding to creating fully capitated integrated delivery systems responsible for a defined population of patients.

Making sure that new financial incentives achieve their intended purpose is much more challenging. To realize the benefits of payment reform, we must do three key things:

First, we must tie financial incentives directly to improvements in outcomes with particular focus on improving care for high-need/high-cost populations, reducing health disparities and adjusting payments to recognize the greater needs in low-income communities. The failure to recognize that caring for low-income groups presents challenges not fully captured in clinical risk adjustment methods is more likely to undermine the delivery system for disadvantaged groups than it is to improve it. This problem has been observed in the operation of Medicare's Readmission Reduction Program[12] (and CMS has recently acknowledged[13] that its system of risk-adjustment was underpaying

[9] http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health/dual-agenda-newsletter/the-dual-agenda-november-19-2015/eldercare-voices

[10] http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

[11] https://www.lansummit.org/wp-content/uploads/2015/09/01-00Total.pdf

[12] https://blogs.sph.harvard.edu/ashish-jha/2014/09/29/changing-my-mind-on-ses-risk-adjustment/

[13] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RiskAdj2017ProposedChanges.pdf

Medicare Advantage plans with a high proportion of enrollees eligible for both Medicare and Medicaid).

Second, we must also capture a portion of current spending on medical care and redirect those resources to address the social determinants of health. Mechanisms for achieving this include hospital community benefits programs, assessment on payers or providers such as the Prevention and Wellness Trust Fund in Massachusetts,[14] or engaging communities in allocating a portion of any shared savings realized by the health care system to meet needs the community itself identifies.

Finally, we cannot ignore excessively high prices. With respect to aggregate system savings, the shift along the spectrum toward capitation will reduce the incentive to boost the overall volume of services, but high unit prices will remain a significant issue that require consumer activism. Two places in particular merit close attention from consumer advocates because the prices paid in the US outstrip payments in other countries. One of these areas is prescription drugs where US consumers pay more than people in other countries for the very same product.[15] Another is hospital outpatient charges. This has become a significant problem as the volume of outpatient services has increased,[16] particularly as hospitals continue to acquire physician practices.

There is a lot of momentum behind payment reform. Because the current arrangements lead to excessive cost relative to outcomes and fail to meet the needs of the most vulnerable populations, consumers should welcome rather than seek to obstruct this shift. At the same time, vigorous consumer advocacy is urgently needed to ensure that the benefits of payment reform are realized and the pitfalls avoided.

Obviously much more detail is needed in order to create an actionable policy agenda. But for now it is important to emphasize that while changing financial incentives are necessary, they alone cannot do the work of positive system transformation. Changes in payment must be accompanied by:

- structural changes to promote team-based care

- meaningful consumer engagement

- better, more person-centered and outcomes-based quality measurement

- robust consumer-protections, including support for complaint resolution and easy-to-navigate appeal rights to guard against under-service, and

- proactive efforts to advance health equity such as expanding data collection and promoting a culturally competent workforce.

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[14] http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness-fund/
[15] http://www.cbsnews.com/news/higher-drug-prices-support-profits-not-research/
[16] http://content.healthaffairs.org/content/33/5/756.abstract

Why Strengthening America's Social Structures Is Essential for Health

Often the factors that have the greatest impact on health don't involve the health care system at all. For example:

- If you did not have a home or a refrigerator to store your insulin, how well would you be able to control your diabetes? Being provided with a safe place to store your medications would be the better solution, compared to waiting until you got so sick from high blood sugars that you needed to be hospitalized.

- If your child's asthma is made worse by air pollution in your neighborhood or the dust in your home, wouldn't addressing the living conditions — by the provision of a home air filter or by public health measures to improve regional air quality — be more effective than increasing the number of your child's medications and trips to the emergency room?

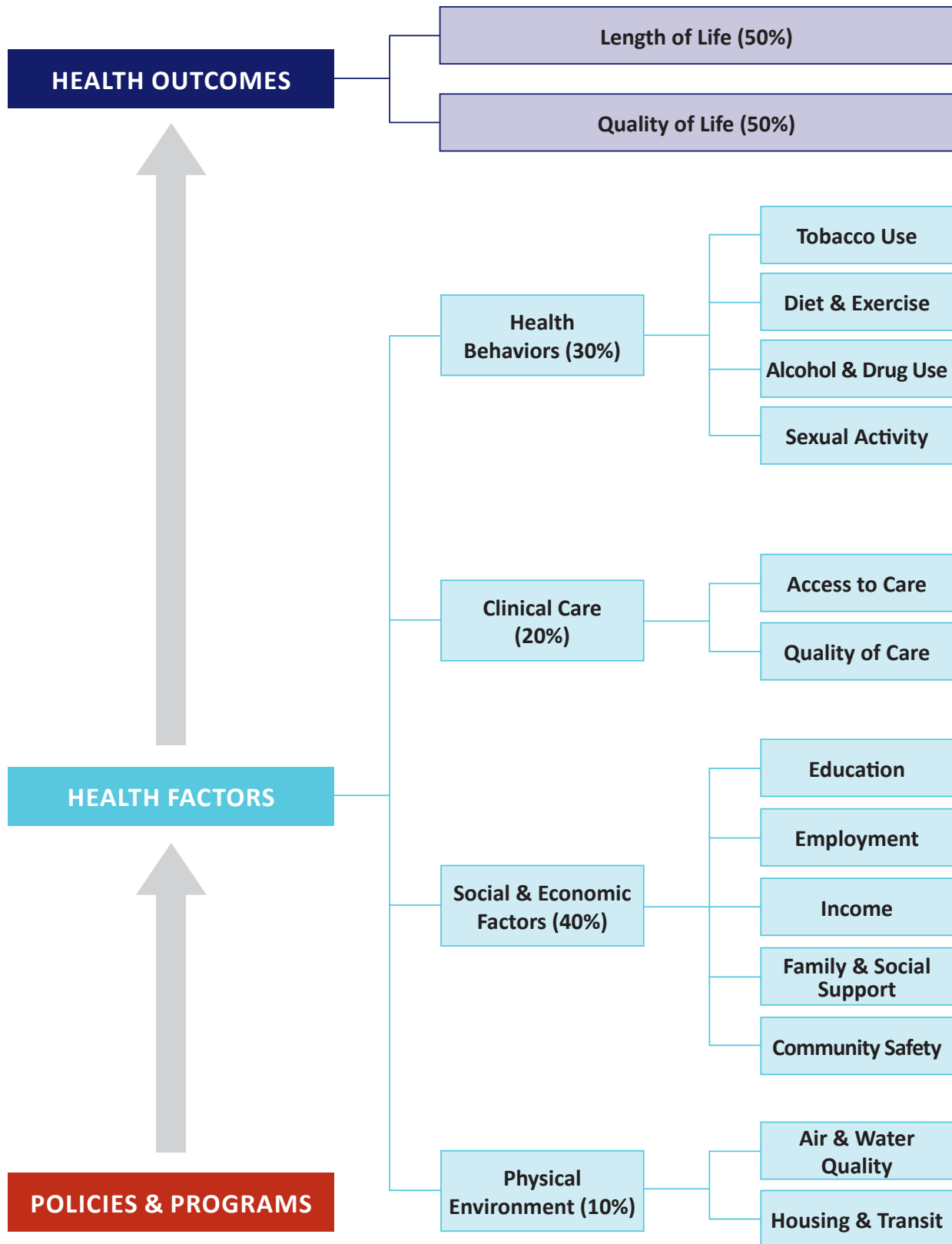- If a family doesn't have enough to eat, wouldn't food be the most important medicine?

Traditionally, the health care system has not taken on these and many other social and environmental factors that contribute to poor health, but we believe that must change. Social determinants of health — which encompass social, environmental and behavioral influences like access to healthy food and water, safe housing, employment/working conditions, gender and culture — play an important role in promoting health and potentially lowering health care costs, and must be addressed by health system transformation efforts.

The County Health Rankings Model[17] included in our report, *The Path to a People-Centered System: Next Generation Consumer Health Advocacy*,[18] and reproduced below, nicely illustrates the many factors that contribute to health. Furthermore, a substantial body of research, including data compiled in *The American Healthcare Paradox* and "Leveraging the Social Determinants of Health: What Works?"[19] demonstrates that higher ratios of social-to-health care spending are associated with better health outcomes.

[17] http://www.countyhealthrankings.org/our-approach

[18] http://www.communitycatalyst.org/resources/publications/the-path-to-a-people-centered-health-system-next-generation-consumer-health-advocacy

[19] http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

| HEALTH OUTCOMES | Length of Life (50%) |
| | Quality of Life (50%) |

HEALTH FACTORS

Health Behaviors (30%)	Tobacco Use
	Diet & Exercise
	Alcohol & Drug Use
	Sexual Activity

| Clinical Care (20%) | Access to Care |
| | Quality of Care |

Social & Economic Factors (40%)	Education
	Employment
	Income
	Family & Social Support
	Community Safety

| Physical Environment (10%) | Air & Water Quality |
| | Housing & Transit |

POLICIES & PROGRAMS

County Health Rankings model © 2014 UWPHI

The U.S. health care system is the [most costly](#)[20] in the world, but our population's health outcomes [are worse than](#) those of most other Organization for Economic Cooperation and Development (OECD) countries. A driver behind this gap could be the relative "underspending" on social services compared to medical care: in the U.S., for every dollar spent on health care, [only about $0.91 is spent on social services](#).[21] In comparison, for every dollar spent on health care, OECD countries spend $2 on social services. Increasing spending on social services could help improve health, while decreasing health care costs. Across the country, there have been many examples of forward-looking programs that are working to direct resources to address social determinants of health:

- In Massachusetts, the [Medical-Legal Partnership Boston](#),[22] an interdisciplinary team of health care staff, attorneys and paralegals, provides direct legal assistance to low-income patients, ensuring their basic needs for housing and utilities are met. The [impact of their services](#)[23] is significant: by connecting low-income families to utilities, food and housing services, they are able to demonstrate improved health outcomes for the population they serve.

- The Northwest Bronx Community and Clergy Coalition has a grant through the [BUILD Health Challenge to work with Montefiore Hospital](#)[24] to address asthma in their community. The partners are working with tenant organizations in the Bronx to rehabilitate "sick" buildings to prevent and treat asthma that is linked to housing conditions.

- [Maine Equal Justice Partners (MEJP)](#),[25] a legal aid organization, surveyed 1,000 low-income Maine residents to better understand their needs. The results showed that, by far, the greatest need was housing. Using this data, MEJP successfully advocated for increases in access to ongoing housing subsidies and is continuing to advocate, with the support of a newly-created Affordable Housing Working Group, to ensure greater access to affordable housing and therefore, a healthier population.

There are many more examples of initiatives that can improve the underlying health status of populations, but too often they lack adequate and stable funding. To address this problem, as health advocates, we need to [broaden our partnerships](#)[26] to include organizations that work to secure affordable housing, promote access to healthy food, and address the other social and public health needs of a community. We also need to advance policies that can build support for addressing these issues right into the health care system, such as by:

- Ensuring that **hospital community benefits programs** (a requirement of non-profit hospitals in order to earn their tax-exempt status) [help address the identified needs of their communities, including social supports and housing](#).[27]

- Structuring **new models of integrated health care delivery to include community-based organizations**, who can then share in cost savings generated by achieving better health, as New Jersey has done with its Medicaid Accountable Care Organization model.

- Investing in **organizations that assess patients' needs and connect them to social support services** in the community. One excellent example is [Health Leads](#),[28] which allows health care providers to prescribe basic resources like food and heat just as they do medications,

[20] http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[21] http://ghli.yale.edu/sites/default/files/imce/bmjqs.2010.048363.full_.pdf
[22] http://www.mlpboston.org/
[23] http://www.mlpboston.org/results/mlpb-publications
[24] http://www.montefiore.org/body.cfm?id=1738&action=detail&ref=1236
[25] http://www.mejp.org/
[26] https://www.hcfama.org/coalition/healthy-food-healthy-homes-healthy-children
[27] http://healthaffairs.org/blog/2016/01/08/expanding-the-meaning-of-community-health-improvement-under-tax-exempt-hospital-policy/
[28] https://healthleadsusa.org/

then refers patients to advocates who help fill the prescriptions, working side-by-side with patients to connect them to the additional prescribed resources.

- Encouraging **adequate payments for the housing, transportation, and social support services** that people need to improve their health and ultimately reduce costs.

- Ensuring that **payment models encourage prevention**. One way to do this is to make sure that organizations delivering care are evaluated based on how well they are improving the health of the communities they serve, through the use of quality measures that assess community/population health. This can also be done by designing payment models like the [all-payer model in Maryland](#)[29] that gives a fixed budget to hospitals, so that hospitals benefit if they keep people healthy.

- Directly **supporting prevention and wellness activities**. Massachusetts, as part of its 2012 comprehensive health care cost containment law, levied assessments on plans and providers to create a Prevention and Wellness Trust Fund to support population health interventions.

We have the most costly health care system in the world, but we don't get results commensurate with our level of spending. At the same time, relative to other countries we spend much less on addressing the social and environmental conditions that can lead to poor health. Addressing this imbalance must figure prominently in our Health System Transformation agenda if we are to be successful at improving the value we get for our health care dollars.

PRIORITY FOUR – *Consumer protection* *through the application of strong safeguards including independent and effective ombudsman programs. The Center also backs protections in the form of consumer-centric quality measures, transparency and consumer choice.*

Consumer Protections: More than Appeals and Grievances

Transforming the way we deliver and pay for care holds the promise of better health outcomes and improved quality of life for the tens of millions of Americans who find themselves falling through the cracks of our disorganized and fragmented health care system. Among these populations are frail older adults, people with disabilities, those with multiple chronic conditions, children with special health care needs and people with mental illness or substance use disorders. Spurred by the Affordable Care Act, there are myriad demonstration projects, pilot programs and initiatives underway to achieve better care, better health and better value.

While the promise health system transformation initiatives may offer is considerable, so too are the risks to consumers. For some, the specter of 1990s-style managed care looms large, and any attempt to introduce payment reforms, especially changes that impact the most vulnerable populations, is viewed with great suspicion. The fear – particularly with any initiative that puts providers at risk – is that an inherent incentive is created to ration care or avoid patients who have complex care needs in order to

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[29] https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/

reap greater profits. Others worry the use of limited networks (as a tool for achieving cost savings) will place unreasonable limits on choice or force patients to separate from providers with whom they have ongoing long-term relationships.

These are real concerns. It is incumbent on policymakers designing new initiatives to ensure that consumers enrolled in new programs are protected against plan or provider misconduct, as well as against unjust restrictions on choice. A traditional way of creating these protections is crafting a robust set of grievance and appeals procedures. And, to be sure, these rights are essential. These procedures must be easy to understand and utilize, there must be fair hearing protections, and plans or providers must continue to provide services to consumers throughout the course of an appeals process.

But building consumer protections into health system transformation is so much more, and in some cases requires advocacy around issues not typically seen as being part of the consumer "beat." These include:

Payment: While normally seen as the province of plans and providers, payment rates – that is, getting them right – is fundamentally a consumer protection issue. Put simply, if payment rates are inadequate, the incentive to ration care is heightened. And the consumers most at risk are those with the greatest needs since they also account for the greatest costs. That's why, to cite one example, we are pleased CMS is fine-tuning the risk adjustment system[30] for plans participating in the demonstration projects aimed at improving care for those with both Medicare and Medicaid, often referred to as "dual eligibles." A fair payment structure that takes into account the needs of the beneficiaries being served, especially those with the greatest needs, is truly the most foundational consumer protection.

Quality Measurement: Measuring what matters most to consumers is the way to get the most "bang for the buck" and serves to mitigate potentially negative effects of health system transformation. Among the measures that matter most is care consistent with patient's goals, values and preferences. We also think the measures outlined in the Institute of Medicine's *Vital Signs* report[31] capture many key domains of health.

Meaningful Consumer Engagement: Ensuring a meaningful role[32] for consumers, family members and advocates on advisory councils, for example, serves as a further means of protecting consumers. These types of bodies can serve as an early-warning system for problems arising in new systems of care, and provide the essential consumer-management feedback loop needed for ongoing service improvement.

Transparency: New payment and delivery systems require new levels of transparency with regard to design, implementation and reporting of outcomes. Reporting must be consumer-oriented so that results are understandable and data is offered in ways that reveal progress, or lack thereof, on achieving health equity. Additionally, beneficiaries must be fully informed and engaged on their choices, for example, to be part of an Accountable Care Organization or a Patient-Centered Medical Home.

It's not an accident that these consumer protection priorities largely track the Center's policy agenda. As our health system shifts away from fee-for-service and toward more risk-based payment arrangements for providers, our central task is to ensure that this transformation occurs in a way which benefits consumers, particularly those who are most vulnerable.

[30] http://www.communitycatalyst.org/resources/publications/document/CY16-MMP-Medicare-Payment-Update.pdf
[31] http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf
[32] http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement

> **PRIORITY FIVE** – *Person-centered culture of care* through the adoption of care models and best practices that meet the specific goals, preferences and needs of the population being served, including at the end of life. The Center promotes coordinated care and the integration of physical health, behavioral health and community supports and services. We place particular emphasis on the care of three vulnerable populations:
> - *Older adults and people with disabilities who have both Medicare and Medicaid coverage ("dual eligibles")*
> - *People with substance use disorders and mental health conditions*
> - *Children and youth with special health care needs*

What Does it Take to Create a Person-Centered Culture of Care?

The health system can be a challenge for anyone to navigate, particularly for those with frailties, multiple chronic conditions or complex disabilities. On average, Medicare beneficiaries with multiple chronic conditions have 13 or more physician visits,[33] are more likely to visit the emergency room, and fill 49 prescriptions[34] per year. Keeping track of doctors' visits, medication changes, and provider recommendations is no simple task, making it easy for something to fall through the cracks. Health care providers must work as a team, with the patient at the center, in order to achieve safer and more effective care that is in line with patients' goals, values and preferences.

A simple concept, yet in practice it can be challenging to implement. For example, findings from a new survey[35] conducted in collaboration with the Association for Community-Affiliated Plans revealed that many health plans serving Medicare/Medicaid beneficiaries under the Financial Alignment Initiative[36] found it challenging to engage Primary Care Providers in the care team and found operational issues in the system, such as lack of implementing an effective IT system to enable communication among care team members, as a barrier to coordinating care for their members. These findings were reinforced by a recent survey[37] of beneficiaries enrolled in MyCare Ohio, the state's dual eligible demonstration project. The survey uncover-ed many holes in the demonstration plans' care coordination models, including that many consumers aren't part of their own care planning process or the care team didn't include people they want.

To make care better and safer for patients, person-centered care has to be at the heart of what we do.

In order to improve care and reduce costs,[38] health care providers, plans and policymakers must work toward the integration of physical and behavioral health services with community supports and services. The experience of health care organizations serving some of the most complex populations

[33] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf
[34] http://www.dartmouthatlas.org/downloads/reports/Prescription_Drug_Atlas_101513.pdf
[35] http://www.communitycatalyst.org/resources/publications/document/Key-Findings-from-Survey-of-ACAP-Plans-on-Duals-Demonstrations.pdf
[36] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html
[37] http://www.uhcanohio.org/content/bringing-consumers%E2%80%99-experiences-advocacy-first-look-member-experiences-mycare-ohio
[38] http://www.mercer.us/content/dam/mercer/attachments/north-america/us/Revised_Mercer_H_B_Integrated_Care_Management_in_the_Medicare_Supplement.pdf

(patients who are dually eligible for Medicare and Medicaid), has helped identify core components for this kind of person-centered care:

- Timely, Comprehensive Health Risk Assessments

   Assessments should include functional status information, cultural and linguistic preferences and information about caregiver roles in order to create an individualized plan of care.

- Incorporation of a Patient Preferences into the Plan of Care

   A care plan must be developed in accordance with the patient's values, goals and preferences, and with the patient at the center of the conversation. Care shaped by patient's goals and preferences is important at every point in the care continuum but is particularly critical in palliative and end-of-life care.

- Seamless Care Transitions

   Transitions should be safe, seamless, and person-centered across care settings. When preparing for discharge from the hospital, for example, the patient must be central to the planning process. Instructions must be clear and understandable to the patient and family caregiver (where applicable). The discharge plan must be communicated to other members of the patient's care team, and appropriate post-discharge care should be arranged for the patient.

- Culturally Competent Care Teams

   The care team should include diverse providers that understand the needs and preferences of the person being served. Aside from clinical providers, team members could include long-term service and supports providers, peer recovery counselors and/or community health workers.[39]

We believe that these are just some of the key elements of achieving a person-centered culture of care, especially for three vulnerable populations: dual Medicare/Medicaid beneficiaries, people with substance use disorders and children and youth with special health care needs. Other considerations include building a strong payment structure that supports these elements, meaningful consumer engagement in the design, implementation, and evaluation of programs, and patient engagement in clinical decision making and care.

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[39] http://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief-1.pdf

Advancing Health Equity in a New Era of Health System Transformation

Promoting health equity[40] is an organizational priority at Community Catalyst and one of the fundamental pillars of the Center's policy agenda. While we believe a health equity lens must be a part of all of our work, bringing that focus to health system transformation deserves special attention because of both the opportunity and the risk. On the one hand, changing how we finance and deliver care creates a golden opportunity to tackle disparities in health care and health. On the other hand, if those efforts don't focus on addressing health equity, health disparities are likely to persist or widen as system reform unfolds.[41]

When we use the term "health equity," we're speaking of a society in which *everyone* has a fair opportunity to achieve their full health potential. Advocates need to be particularly sensitive to potential harms to people with greater – or different – health care needs as some new policies may have differential impacts on different populations. For instance, some policies may lower costs for some while raising them for others, or they may have a negative health impact on some but not on others. In our work to promote health equity, Community Catalyst is exploring the following areas:

Risk-Adjustment

As providers are increasingly placed at risk for the cost of care, risk-adjustment becomes critical to ensure that there is not an incentive to avoid or under-treat sicker or harder to treat populations. While the need to adjust payment based on clinical factors is widely accepted, we have begun looking into risk-adjustment based on population health measures such as socioeconomic status[42] (SES) that also address non-clinical factors that impact cost and health outcomes. People in lower socioeconomic brackets tend to face greater challenges maintaining their health and are more likely to require expensive interventions or have adverse outcomes. Without SES risk-adjustment, providers who serve lower SES patients have a significant amount of unaccounted risk and fewer resources to provide care because of unfairly designed incentive payments. Conversely, providers giving an identical level of care to higher SES patients will show better results and receive an unfair advantage in payments.

Health Data Collection

Health data collection policies that do not stratify data by race, ethnicity, primary language, and gender identity and sexual orientation lack the detail and information providers, patients, advocates and the public need to understand and address health disparities. Inadequate health data can mask unique patient and population needs and undermine effective interventions. Consumer advocates, such as the Data Equity Legislative Coalition in Oregon,[43] are building support for strategies that improve data collection policies, and Community Catalyst is working to collect and share those strategies with advocates and policymakers across the country

[40] http://www.communitycatalyst.org/initiatives-and-issues/issues/health-equity
[41] http://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf
[42] http://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf
[43] http://www.communitycatalyst.org/blog/the-numbers-dont-lie-advancing-health-equity-in-oregon-through-better-data-collection

Community-Based Providers

As the health system evolves to serve individuals with a variety of physical, behavioral, social and economic needs, we need to ensure that the health care workforce is also evolving to ensure that individuals receive appropriate, culturally competent care. We believe that expanding the role of Community Health Workers[44] within multidisciplinary care teams and as part of population health interventions can facilitate the effective provision of services and make quality health more accessible and equitable.

Cultural Competence and Implicit Bias

Community Catalyst is examining proactive approaches at the policy, delivery system and individual levels for improving cultural competence and reducing implicit bias in health care delivery.[45] Community Catalyst has been promoting networks with culturally and linguistically competent providers[46] and urging emerging alternative payment models to ensure that individuals are guaranteed a choice of providers who speak and understand their culture and language. In recent years, substantial attention has been paid to the possibility that implicit bias among health professionals[47] contributes to health disparities. Community Catalyst is exploring the role implicit bias plays in perpetuating health disparities in treatment outcomes and opportunities to incorporate quality metrics that can assess implicit bias in health care and create incentives and support systems to reward providers who undergo implicit bias trainings.

Population Health

We identified poor population health as a principle driver of poor value in our health care system.[48] In an effort to address this driver, population health is prioritized in our HST agenda, and we are working to promote programs and policies that aim to redirect resources to address major population health determinants beyond the delivery of medical care, such as education, the built environment and housing.

As we move forward in this new era of health care reform, these health equity priorities are meant to guide consumers and their advocates towards a path that will transform how we pay for and deliver care to the most vulnerable populations.

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44 http://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief.pdf
45 http://www.ncbi.nlm.nih.gov/pubmed/23576243
46 http://www.communitycatalyst.org/resources/tools/resources/Network-Adequacy-Checklist-Final-5-20-15.pdf
47 http://kirwaninstitute.osu.edu/wp-content/uploads/2015/05/2015-kirwan-implicit-bias.pdf
48 http://www.communitycatalyst.org/resources/publications/document/Next-Generation-HST-Report.pdf