Planning for Sustainability and Advancing Health Equity during the Public Health Emergency

Overview

The Centers for Medicare & Medicaid Services (CMS) held the 2021 Virtual Accountable Health Communities (AHC) Meeting: "Planning for Sustainability" on February 3 and 4, 2021. This meeting provided a forum for bridge organizations and their partners to discuss strategies to optimize AHC Model implementation and sustain the AHC work beyond the cooperative agreement period. In response to the public health emergency (PHE) and a national call for racial justice, this meeting also highlighted the importance of health equity to advance and sustain the AHC Model activities. Attendees included representatives from the 28 bridge organizations and partners, including community service providers and frontline staff, state Medicaid agencies, CMS Project Officers and leadership, and CMS contractors. This summary includes highlights from each session.

Day 1 Session Summaries

Keynote Address

Speaker:

- Dr. Donald Berwick, M.D., M.P.P., F.R.C.P., K.B.E (President Emeritus and Senior Fellow at the Institute for Healthcare Improvement)

During his keynote address, Dr. Berwick discussed disparities in population health and health care access and noted the important role social determinants of health (SDOH) play in understanding and addressing those gaps.[1] *He shared a Campaign for Moral Determinants of Health, an action plan to address SDOH to achieve equity, which he originally posted on the Journal of the American Medical Association blog (The Moral Determinants of Health, June 2020).*

Key takeaways from his remarks include the following:

- Evidence confirms that social determinants affect the health of populations and individuals. Dr. Berwick presented a variety of studies that show social determinants, such as early childhood experiences, education, workplace, experience of elders, and community resilience, have a great impact on population and individual health. For example, Dr. Berwick discussed how health inequities start at childhood, in which adverse childhood experiences, such as interpersonal violence, low neighborhood opportunity, or food insecurity, increase people's risk for 9 of the 10 leading causes of death in the United States.
- Health risk is significantly higher among predominately Black and Brown communities compared with predominately White communities. Dr. Berwick highlighted several studies that illustrate disparities, including geographic variations in life expectancy based on subway maps for New York City and London, the increased prevalence of infant mortality among Black and Indigenous populations compared with the White population, and higher coronavirus

disease 2019 mortality rates among Black and Brown populations compared with the White population.

- The PHE put racial inequities in U.S. health care and social systems in the spotlight, compelling a campaign to address the "moral determinants of health." Dr. Berwick outlined seven action steps necessary to achieve health equity in the United States. The action steps include advocating for and supporting policies that recognize health care as a human right, reforming the criminal justice system, and ending hunger and homelessness, among others.

Dr. Berwick closed by highlighting the AHC Model's role in shifting communities' focus to addressing disparities in SDOH. Through the AHC Model, bridge organizations and their partners invest in resolving health-related social needs by reallocating resources from a health care system that just acts as a "repair shop" to a population health system that addresses the core sources of health disparities.

Promoting Health Equity through AHC and Beyond

Speakers:

- Rishi Manchanda, M.D., M.P.H. (HealthBegins)
- Sadena Thevarajah, J.D. (HealthBegins)
- Ellie Zuehlke, M.P.H. (Allina Health)
- Dan Behrens, M.H.A. (Allina Health)
- Vivian Anugwom (Allina Health)

> [Social determinants] absolutely affect health and well being far bigger than anything we do in healthcare. If we keep running only the repair shop, we will not be a healthy society.
>
> *–Dr. Berwick*

In this session, HealthBegins discussed the need to address health equity at individual, community, and societal levels. Allina Health, an AHC awardee, described its work moving from awareness to action to reduce racial disparities in AHC Model screening, which is part of its system-level approach to addressing health equity. Attendees also learned about the Greensboro Housing Coalition's multisector collaboration to advance health equity. In light of the ongoing PHE and the national movement to address structural racism, this session underscored the importance of advancing health equity to implement and sustain AHC Model activities using a multilevel approach.

HealthBegins defined key terms to differentiate three important concepts:

- **Structural determinants of health** refer to the societal-level structural mechanisms that shape social hierarchy and gradients, such as climate, societal norms, macroeconomic, social, and health policies. **Social determinants of health** are underlying community-level social, economic, and physical conditions in which people are born, grow, live, work, and age. **Social needs** are individual-level material resources and psychosocial circumstances required for long-term physical and mental health and well-being.
- Addressing SDOH alone is not sufficient for moving the needle on racial equity; it requires a commitment to improve the distribution of power and resources. Race is a social and political construct, not a biological one; racial equity focuses on racism, not race.

To share a community perspective on health equity, HealthBegins presented the Greensboro Housing Coalition's approach to addressing health equity, which brings together stakeholders across clinical and social sectors—a large health system, a neighborhood housing coalition, a university, and local government—to promote healthy living spaces. The Greensboro Housing Coalition draws on its partners' expertise to determine what it requires to advance equity and align its respective goals to address the health and well-being of the community.

Ellie Zuehlke, Dan Behrens, and **Vivian Anugwom** showed a video highlighting Allina Health's ongoing work to address structural racism and promote community recovery. To detect and reduce disparities in AHC screenings, Allina tracks offers to screen beneficiaries by race and established an organization-wide AHC equity team to ensure data transparency and to raise awareness among clinical delivery site staff of racial and ethnic disparities in AHC screening. The AHC equity team helped Allina Health significantly reduce disparities in screening among African Americans, Hispanics, and Somalis.

Allina's multipronged approach to embedding health equity across its system includes using health and health care disparity data to identify opportunities for addressing health disparities. It also includes increasing communication and transparency with staff and the community about the AHC data to inform its work and discuss the ongoing efforts to address health equity. To maintain accountability across the organization, Allina created a health equity scorecard that enables the organization to track progress on its equity goals.

> We pledge to learn from, listen to, and move forward to help make the systemic changes which will bring about healing, wellness, and justice to our community.
>
> *–Allina Health*

Allina co-develops solutions with beneficiaries, staff, and community members by using its community health needs assessment findings to engage in collaborative goal setting. It also builds capacity among staff by developing trainings on topics such as addressing unconscious bias in patient care. Allina developed tools for leaders to understand the financial value of addressing health disparities for sustainability using the AHC data.

HealthBegins summarized four actionable steps that bridge organizations can implement to advance health equity, including (1) **taking coordinated steps** to improve the health of individuals, communities, and societies; (2) **advancing health equity and racial justice** at all levels; (3) **pursuing an inter-departmental and cross-sector approach** to integrate, align, and redesign services, systems, policies, and structures; and (4) **continuing to ask themselves** how their organization can advance health equity at the population, community, and societal levels.

AHC Model Updates

Speakers:

- Alek Shybut, M.P.H. (CMS Project Officer)
- Natalia Barolín, B.A., B.S.N., R.N. (CMS Project Officer)

During this panel session, CMS shared updates on the AHC Model, including (1) model-wide progress toward screening and navigation milestones and health-related social needs (HRSNs) resolution statuses through November 2020, (2) demographics of beneficiaries who were screened and navigated as of November 2020, (3) CMS priorities for program monitoring for Year 5 of model implementation, and (4) guidance on managing Year 5 of the AHC Model cooperative agreement.

Alek Shybut provided an overview of bridge organizations' model-to-date performance on screening and navigation milestones, noting the effects of the PHE on screening and an increase in beneficiaries who accepted navigation compared with the prior year. He also shared available demographic data of beneficiaries who participated in screening and navigation.

CMS announced that program monitoring in the year ahead will focus on three areas:

1. Monitoring progress towards increased enrollment in the AHC Model;
2. Encouraging ongoing data error corrections and improvements, especially for Medicare and Medicaid IDs, needs left 'In Progress', and navigation case date for Non-CMS Data System users; and
3. Enhancing the Monthly Monitoring Reports, including the recent demographic data as well as upcoming new indicators and metrics.

Natalia Barolín reviewed CMS' approved PHE flexibilities. CMS extended the timeframes for (1) pre-visit screening (from five days to up to two weeks before the visit), (2) post-visit screening (from five days to one year), and (3) navigation follow-up and initiation (from five days to up to two weeks post-screening). In addition, CMS allowed pre- and post-visit screening for all types of clinical visit and eliminated the 10 percent maximum.

CMS announced the following guidance for the remainder of the funding period:

- CMS will continue the PHE flexibilities through the remainder of the AHC Model.
- Screening and referral activities will extend to January 21, 2022 (Year 5, Quarter 3), giving bridge organizations through April 30, 2022 to work on navigation cases.
- CMS is streamlining and revising expected documentation for the end of Year 5.

Sustaining AHC Model Activities through Actionable Data and Collaborative Partnerships

Speakers:

- Alissa Beers, M.H.C. (Center for Health Care Strategies)
- Ben Miladin, M.S.W. (United Way of Greater Cleveland)
- Jenn Kons, M.P.A. (United Way of Greater Cleveland)

In this interactive session, United Way of Greater Cleveland (UWGC), an AHC awardee, presented strategies for leveraging the Collaborative Approach to Public Goods Investment (CAPGI) model to advance community partnerships and collaborate with other stakeholders to sustain screening and navigation activities beyond the cooperative agreement. In addition, bridge organizations met in small groups alongside their community and state partners to reflect on their strategic priorities and explore approaches for establishing a shared vision to identify near- and long-term plans for sustaining AHC Model activities.

Ben Miladin and **Jenn Kons** presented UWGC's advisory board's efforts to address the funding disparities between health care and social services in its community through the CAPGI model. The CAPGI model aims to reduce the barriers to upstream investment in social services that stem from competition by creating a cost-sharing investment approach among hospital systems and health plans. This approach minimizes the perception of a "free rider" problem because of frequent changes in health plan enrollment or hospital system use among beneficiaries. UWGC builds trust among its members by serving as the "broker" for the CAPGI model in Cleveland and a neutral repository for confidential information among competitors. The presenters emphasized the importance of characterizing investments in the CAPGI model as sound business investments and not charitable donations. To learn more about the CAPGI model, visit https://capgi.urban.org/.

Key takeaways from the small-group breakout sessions include the following:

Strategies for aligning financial incentives with AHC Model activities

- Use AHC data to demonstrate the effectiveness and financial viability of key AHC Model activities.
- Monetize the value of referral databases such as 2-1-1 service directories.
- Finance social services through insurance plans.

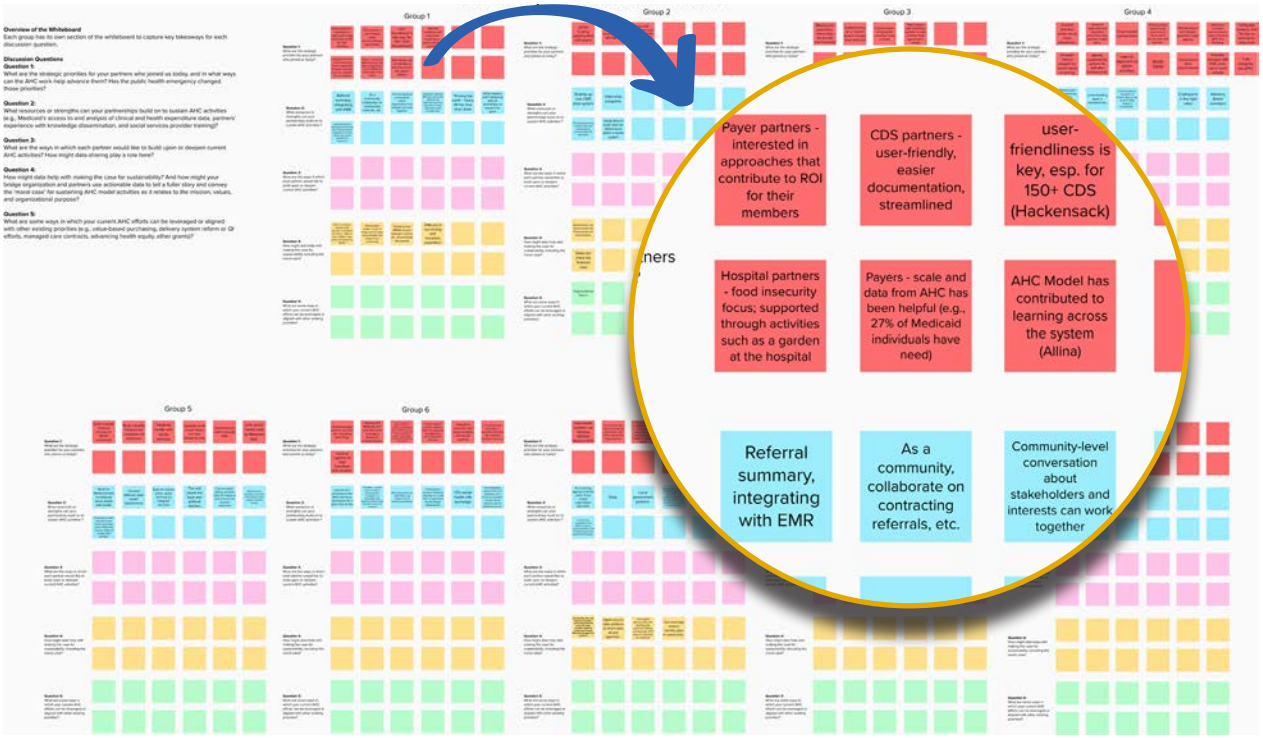
Strategies for shifting the organization's culture to focus on addressing HRSNs

- Encourage buy-in among clinical staff by sharing data that show the value of sustaining and scaling screening and navigation activities.
- Establish accountability for the work of addressing HRSNs throughout the organization (e.g., by defining goals and metrics).

Strategies for leveraging existing partnerships to sustain AHC Model activities

- Partner with accountable care organizations (ACOs) and Medicaid managed care organizations (MCOs) to fund navigation activities.
- Collect and integrate AHC data on social needs and Medicaid data.

Sustaining AHC Model Activities through Actionable Data and Collaborative Partnership Small Group Discussion Whiteboard



Day 2 Session Summaries

Strengthening Diverse Partnerships and Advancing Advisory Board Activities

Facilitators:

- Toni Abrams Weintraub, M.D., M.P.H. (Mathematica)
- Lee-Lee Ellis, Ph.D. (Mathematica)

Panelists:

- Maureen Kirkwood, M.P.H. (Health Net of West Michigan)
- Michele Childs (Beneficiary and Community Advisor to Health Net of West Michigan's advisory board)
- Kathryn Zapach, M.S.W. (Health Quality Innovators)
- Amory James, C.C.C. (Feed More, community service provider)
- Anne King, M.B.A. (Oregon Health and Science University)
- Chris DeMars, M.P.H. (Oregon Health Authority, state Medicaid agency)

The AHC awardees in the Alignment Track are required to convene an advisory board to assess and prioritize stakeholder and community needs, prepare gap analysis, and develop a quality improvement plan. Advisory board members include representatives from state Medicaid agencies, local governments, clinical delivery sites, community service payers and providers, and beneficiaries. During this panel discussion, three AHC awardees—Health Net of West Michigan, Health Quality Innovators, and Oregon Health and Science University—and their respective advisory board members discussed strategies for collaborating to support advisory board activities and community alignment in the AHC Model. The session included a group discussion in which attendees explored opportunities to leverage and strengthen their advisory board partnerships to advance sustainability activities.

Key takeaways from the panel discussion include the following:

- **Maureen Kirkwood** and **Michele Childs** discussed the benefits of empowering community members to contribute their authentic voices and lived experiences to the advisory board work, including opportunities to identify and address disparities in access to resources.
- **Kathryn Zapach** and **Amory James** described how their partnership supports the community during the PHE. Health Quality Innovators (HQI) and Feed More managed to keep pace with increased food needs by continuing to use the hunger hotline to connect beneficiaries with the nearest food pantry and collaborate with clinical delivery sites on the referrals to provide services such as home-delivered meals.
- **Anne King** and **Chris DeMars** described several projects their organizations collaborate on, including creating an HRSN screening metric for Medicaid ACOs, adopting a community information exchange, and providing technical assistance to Medicaid ACOs on identifying and addressing HRSNs.
- Panelists also discussed how the AHC Model and collaboration on their advisory board helps them advance their health equity goals. Although Health Net includes health equity goals in its mission, the community advisors

During the group discussion, bridge organizations and their advisory board partners described key action steps and strategies to strengthen their partnerships.

- Feed More's hunger hotline and online search tool may be of interest to bridge organizations and other entities interested in creating a statewide effort to address food insecurity.
- Rocky Mountain Health Plans (RMHP) creates formal matches between board members to strengthen the relationships between clinical and community partners. Several of RMHP's clinical delivery sites partner with community-based organizations to establish food banks within the clinics or serve as a distribution site for rent relief funds.

help the organization understand and address needs by identifying inequitable systems within the community. Because HQI primarily screens people of color, specifically African Americans, the bridge organization noted that the AHC data shed light on the need to address health disparities in Richmond beyond the AHC Model.

In response to challenges engaging a champion for utility needs on their advisory boards, a member of the University of Kentucky Research Foundation's advisory board suggested that legal services programs could aid low-income clients seeking utility support. Reading Hospital also has a representative from the Pennsylvania Utility Law Project on its advisory board; the project provides information, assistance, and advice about residential utility and energy matters affecting low-income consumers.

Insights for AHC Sustainability

Speakers:

- Rivka Friedman, B.A. (CMS)
- Ellen-Marie Whelan, N.P., PhD., F.A.A.N. (CMS, Centers for Medicaid and CHIP Services)
- Linda Highfield, Ph.D., M.S. (University of Texas Health Science Center at Houston)
- Dan Culica, M.D., Ph.D., M.A. (Texas Health and Human Services Commission)

During this session, CMS representatives described the value-based payment framework that CMS aims to advance and presented opportunities for state Medicaid agencies to promote value-based care and address SDOH. The University of Texas Health Science Center at Houston and Texas Health and Human Services Commission discussed their joint efforts to advance value-based goals for addressing SDOH.

Rivka Friedman provided an overview of (1) value-based and alternative payment models within the context of value-based care transformation; (2) short- and long-term quality and cost incentives for alternative payment models and how incentives differ across the care continuum; and (3) levers that could help achieve quality and cost goals for inpatient and outpatient care, and in the community. The AHC Model includes a key element of alternative payment models in that health care delivery and social service delivery systems are funded and rewarded for coordinating whole-person care. For more information about alternative payment models, please reference the alternative payment model framework.

Ellen-Marie Whelan described two letters from the Centers for Medicaid and CHIP Services that serve as a primer on existing policies available to states to promote investment in whole-person care. The first letter, published in September 2020, outlines Medicaid

Linda Highfield and **Dan Culica** described how the three Texas-based bridge organizations (University of Texas Health Science Center at Houston, Parkland Center for Clinical Innovations, and CHRISTUS Santa Rosa) collaborate with the state Medicaid agency to identify strategies to sustain AHC activities and address SDOH statewide. These efforts include the following:

Identifying entities that can serve as the "integrator," such as the role that bridge organizations have in the model, in the community as well as understanding the available payment mechanisms to support the infrastructure.

Convening national experts and producing a report that recommends strategies to address one of the milestones on SDOH in the state's Delivery System Reform Incentive Payment Transition Plan.

Establishing the Value-Based Payment and Quality Improvement Advisory Committee to promote quality improvement and value-based payment initiatives for Medicaid and provide recommendations to the state legislature. The committee includes stakeholders across the state, including the bridge organizations in Texas.

Developing milestones and goals related to SDOH with the state Medicaid agency that encourage partnerships between MCOs and community-based organizations.

Analyzing the AHC Model data and Medicaid claims and utilization data to assess the relationship between HRSNs and health outcomes. For example, Parkland Center for Clinical Innovations found a correlation between food needs and diagnoses of hypertension or diabetes among its beneficiaries.

authorities that states can use to promote value-based care. The second letter, published in January 2021, outlines Medicaid authorities that states can use to help address SDOH. Dr. Whelan also shared strategies for AHC bridge organizations to connect with their state Medicaid agencies by (1) sharing successes and lessons learned from the AHC Model, using model data and the Transformed Medicaid Statistical Information System data (i.e., Medicaid data), and (2) leveraging the state Medicaid agency's strategy plan to discuss how the AHC bridge organizations' efforts complement the agency's priorities.

Promoting Staff Retention and Wellness to Advance Milestones and Sustainability Initiatives

Speakers:

- Anna Spencer, M.P.H. (Center for Health Care Strategies)
- Meryl Schulman, M.P.H. (Center for Health Care Strategies)
- Andrew Katz, M.S.W. (Camden Coalition of Healthcare Partners)
- Marisol Velazquez (Camden Coalition of Healthcare Partners)

During this session, the Center for Health Care Strategies and the Camden Coalition of Healthcare Partners, an AHC awardee, shared opportunities to embed trauma-informed practices to support staff and improve staff wellness and retention. Attendees participated in small group discussions about staff retention challenges and opportunities for workforce development to support sustainability.

Meryl Schulman highlighted the impact of chronic stress on health care workers, including lower quality of care, provider burnout, and higher staff turnover. To support staff and organizations experiencing chronic stress, she shared strategies identified in two national initiatives to integrate trauma-informed approaches into organizational policy and practice. These strategies include offering individual wellness activities (e.g., yoga, meditation, and "mindful minutes" during team huddles), providing education to build awareness, and promoting organizational policies that support work/life balance.

Word Cloud of the Top Barriers to Staff Retention during the 2020 Public Health Emergency

Andrew Katz and **Marisol Velazquez** shared how the Camden Coalition of Healthcare Partners integrates trauma-informed approaches at the organizational and individual levels. For example, Camden Coalition's Diversity, Equity, and Inclusion committee regularly hosts activities such as speaker series, lunch and learns, and table talks for staff to engage one another. Having a consistent structure in place allows the organization to address trauma in a productive way and for staff to continue to work comfortably and be mindful of other cultural backgrounds in their workplace.

Camden Coalition staff actively engage in the organization's annual strategic planning process to share ideas and concerns. Camden Coalition uses several strategies to support the AHC Model staff during the PHE, such as replacing "water cooler" conversations with Google chats and transitioned team huddles from in-person to virtual, in which staff members take turns leading discussions on topics of their choice.

Small group discussions highlighted key strategies attendees plan to take back to their organizations:

- Engage staff in using employee assistance programs to seek resources to support mental health and wellness.
- Highlight the importance of "caring for the caregivers" and supporting supervisors whose caretaker role for their staff might have expanded because of the PHE.
- Create a safe space for sharing and providing an opportunity for fun to improve staff wellness.

Closing Remarks

Speaker:

- Kate Abowd Johnson, Ph.D. (CMS, Acting Deputy Division Director)

Kate Abowd Johnson expressed her gratitude for the opportunity to meet virtually and highlighted core themes that stood out from the sessions: health equity, partnership, and resilience. Dr. Johnson applauded AHC Model awardees' service to their communities' vulnerable populations and noted that identifying and addressing individuals' needs equitably must be intentional.

In addition, she acknowledged the strength of bridge organizations' partnerships, which will be critical to sustaining SDOH work beyond the AHC Model. Dr. Johnson closed by restating the unique duality of the moment: the PHE exposed systemic inequity and accelerated action toward closing the gaps. She commended awardees for their hopefulness and resilience in the face of personal and operational challenges and the disparities exposed by the PHE.

Endnote

[1] Dr. Berwick cited the following works during the keynote, including the Office of the California Surgeon General's Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health, Health Affairs' Racial and Ethnic Inequities in Children's Neighborhoods: Evidence from the New Child Opportunity Index 2.0, an article in the *American Journal of Public Health,* an analysis conducted by the Office of National Statistics, and the book, *The Health Gap: The Challenge of an Unequal World by Michael Marmot.*

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Gallery View of Some AHC Awardees, CMS, CMS Contractors, and Stakeholders Participating in the 2021 Virtual AHC Meeting