# Medicaid Learning Lab

**November 3, 2023**
**2:00 pm to 3:30 pm ET**

# Staff Facilitators

**Melody Danko-Holsomback, Vice President of Education, NAACOS**
Melody Danko-Holsomback, MSN, CRNP is the Vice President of Education for NAACOS. She has over 12 years of population health experience and was the CAO and Director of Keystone ACO prior to her current role. She has over 30 years of experience in nursing, including positions in outpatient and inpatient care, as a CRNP healthcare provider and as an IT analysts and performance consultant.
mdholsomback@naacos.com

**Emily Perron, Education Manager**
Emily is the education coordinator at NAACOS where she works directly with the director of operations on tasks related to the day-to-day running of the organization and with the vice president of education on the boot camp and the two annual conferences along with overseeing marketing and registration. Before starting at NAACOS, she previously worked at Police and Firemen's Insurance Association (PFIA) in new business where she handled all incoming new life and disability insurance plans. While at PFIA, she obtained two Life Office Management Association (LOMA) certificates. She received her bachelors of science in elementary education from Liberty University.
eperron@naacos.com

# Welcome!

## AGENDA

**Medicaid Accountable Care Contracting Learning Lab Virtual Series**

**November 3, 2023**
**2:00 pm – 3:30 pm**

**Location: Zoom Meeting **Sent to participants****

| | | Speakers |
|---|---|---|
| 2:00 pm – 2:15 pm | Learning Lab Opening Introduction | Melody Danko-Holsomback, NAACOS |
| 2:15 pm – 3:10 pm | The Transformation of Health and the Healthcare System<br>How Policy Translates Into Practice | Rita Landgraf, Professor of Practice and Distinguished Health and Social Services Administrator in Residence and faculty in Professional and Continued Studies Customized Learning Program and Principal Owner of Landgraf Consulting |
| 3:10 pm – 3:25 pm | Q and A | Attendee participation |
| 3:25 pm - 3:30 pm | Adjourn | Melody Danko-Holsomback |

# Housekeeping Items

- The learning lab is meant to be a classroom type of setting
- We request that participants be on camera whenever possible.  This helps keep you engaged in the meeting material and place faces with names of participants.
- Questions are not only welcomed, but they are also imperative to enhance everyone's learning experience.
- We may call on you at any time for your opinion on the current topic of discussion
- Please mute your microphone when not speaking and unmute when speaking.

# Learning Lab Documents

- Agenda
- Learning Lab Educational Plan
- Learning Lab Note Template
- Monthly Presentations – will be distributed after each meeting
- Meeting recordings and documents found on Learning Lab

  webpage on the NAACOS website

# Presenter

**Rita Landgraf**

Rita Landgraf is Principal Owner of Landgraf Consulting and remains as affiliated faculty with the University of Delaware's College of Health Sciences as Professor of Practice and Distinguished Health and Social Services Administrator in Residence and faculty in Professional and Continued Studies Customized Learning Program. She also provides leadership support to Healthy Communities Delaware. Prior to joining the faculty at UD, she served as Cabinet Secretary of the Delaware Department of Health and Social Services 2009 - 2017, under Governor Jack Markell's administration. Rita currently serves as a member of the Board of Highmark Blue Cross Blue Shield of Delaware; chairing BluePrints Community Advisory Council and is Board Chair of ChristianaCare Home Health, she also is on the Executive Advisory Boards of the National Alliance on Mental Illness (NAMI) Delaware and atTAck Addiction.

# The Transformation of Health and the Healthcare System

## How Policy Translates Into Practice

## The Journey

Rita M. Landgraf

Professor of Practice – College of Health Sciences

Faculty Professional and Continuing Studies

Managerial Operations Partner for Healthy Communities Delaware -- A collaboration among the UD, the Delaware Division of Public Health, and the Delaware Community Foundation

Former Delaware Cabinet Secretary of Health and Social Services

UNIVERSITY OF DELAWARE

# Objectives on Our Interactive Journey

- Explore Efforts in Health Policy – Past, Present and Future
- Explore policy as the driver to advance transformation or perpetuate status quo
- Discuss initiatives for stakeholder engagement to implement and transform health
- Explore the interconnections between health, housing, community development, and social services (SDOH)  aka vital conditions of health
- How is Medicaid (and CMS) advancing equity

UNIVERSITY OF DELAWARE

# What is Health?

## In a Word

# What is the Most Pressing Issue in Health

## In A Word

UNIVERSITY OF DELAWARE

# Health Care, Healthcare and Health

- Health care are the specific things that people do: see a patient or prescribe a medication.

- Healthcare is an industry, the system by which people get the health care they need.

World Health Organization

"state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The opportunity to achieve optimal health

***Think of another word for optimal –***

***Health equity is the assurance of the conditions for optimal health for all people (Jones, 2012).***

UNIVERSITY OF DELAWARE

# HEALTH


Health is socially and politically defined;

- definitions of health ignore important relationships between individuals and social & environmental conditions.

An accumulation of negative social conditions and lack of fundamental resources contribute to health inequities.

UNIVERSITY OF DELAWARE

# Disparity, Determinants & Inequity

## Lack of Opportunity for Optimal Health

**Health Disparity**

….difference in disease prevalence, burden of disease, injury, violence, or opportunities to achieve optimal **health** that are experienced by socially disadvantaged populations – including gender, race or ethnic background, education, income, disability or living in various geographic localities

**Social Determinants of Health**

….economic & social conditions that influence health

and which are largely responsible for health inequities

**Health Inequity**

….difference that is unnecessary, avoidable and result in unjust economic and social practices that create barriers to opportunity

UNIVERSITY OF DELAWARE

# Root Cause Perspective –PAST And What Does Policy Have to Do With My Health?


UNIVERSITY OF DELAWARE

# History of HealthCare Reform

- Healthcare reform has been an evolving political project since 1915 when health insurance was originally proposed as a program at the state level. What has shifted over time are the politics and economics of healthcare. The insurance proposal in the progressive era, between 1915 and 1919, was primarily focused on providing income support for industrial workers during illness.
- This was influenced by programs in Europe with similar benefits provided by mutual societies, unions, and employers. In the 1916, the progressive party broke up and shortly thereafter the US entered World War 1.
- Political forces that played a role in the defeat were the lack of major party sponsorship, a weak US labor movement, and national elites were more focused on the interests of employers, insurers, and physicians.

# US Health Reform Efforts

- 1935 – New Deal – created Social Security but failed in terms of delivering compulsory health insurance ( AMA opposition)

- FDR, who announced in 1939 that
- "a comprehensive health program
- (is) required as an essential link in
- our national defenses against individual
- and social insecurity."


UNIVERSITY OF DELAWARE

# Fair Deal

- 1945 – President Truman  - Fair Deal – proposed health insurance by national, universal comprehensive – failed – thought of as socialized medicine

- Compromises were proposed but  none were successful.
- Instead of a single health insurance system for the entire population, a system of private insurance for those who could afford it and public welfare services for the poor.

# The Great Society Legislation

- 1965 – President Johnson - Medicaid and Medicare adoption ( support from civil rights organizations and unions
- – AMA approved

since care of elderly was costly

-Began reimbursements

physicians – reasonable and prevailing fee

hospitals – cost plus reimbursement

Capped 20 years of Congressional debate

# The goal of healthcare reforms in the 1990s was. . . making health care affordable, comprehensive and accessible.

- The Clinton healthcare plan was a 1993 healthcare reform package proposed by the administration of President Bill Clinton and closely associated with the chair of the task force devising the plan, First Lady of the United States Hillary Clinton.

- A major healthcare speech was delivered by President Clinton to the U.S. Congress in September 1993. The core element of the proposed plan was an enforced mandate for employers to provide health insurance coverage to all of their employees.  Did not advance policy.

UNIVERSITY OF DELAWARE

# Signing of the ACA – March 23, 2010

- *Because the market alone cannot ensure all Americans access to quality health care, the government must preserve the interests of its citizens by supplementing the market where there are gaps and regulating the market where there is inefficiency or inequality. (Obama,2016)*

# ACCOUNTABLE CARE ORGANIZATIONS

- The term accountable care organization was first used by Elliott Fisher in 2006 during a discussion of the Medicare Payment Advisory Commission. In 2009, the term was included in the federal Patient Protection and Affordable Care Act.[2] It resembles the definition of Health Maintenance Organizations (HMO) that emerged in the 1970s. Like an HMO, an ACO is "an entity that will be 'held accountable' for providing comprehensive health services to a population


UNIVERSITY OF DELAWARE

# Health Policy - Goals

- The Affordable Care Act (ACA) is one of the most monumental pieces of health legislation
- The three main focuses were to (Silvers)
  - Reform the insurance market
  - Expand Medicaid to the working poor
  - Change the way medical decisions are made
- It is unclear whether the act has lowered insurance premiums but there is solid evidence that the ACA has provided coverage for millions of previously uninsured Americans (Patton)

# Challenge and Opportunity

**When the Supreme Court upheld the Affordable Care Act in June 2012, it promoted health equity**

- Increased access to health insurance and quality care.
- Being supported in community-based settings beyond acute care
- Promoting healthy lifestyles.
- Transforming the sick care – fee for service system into comprehensive patient centered, focus on patient outcomes and measurable standards.
- and public health advancements – SDOH/Vital Conditions of Health

UNIVERSITY OF DELAWARE

# Immediate Past  ACA Challenges

- Repeal and Replace Activity -succeeded in repealing the individual mandate.
- ACA marketplace - significant changes. The enrollment period was shortened by six weeks and funding was cut for advertising navigators

UNIVERSITY OF DELAWARE

# Immediate Past

- The Trump administration joined a lawsuit by 20 states that would, if successful, end the requirement that health insurers cover those with pre-existing conditions – could land at the Supreme Court

- The Centers for Medicare & Medicaid Services announced steep funding cuts for sign-up help through state based programs called “navigators.” Financing for the 2019 enrollment season is being cut to $10 million from $36 million.

- The administration also plans to temporarily stop the Obamacare risk adjustment program, which pays insurers billions of dollars to help cover a higher number of sicker patients. It could lead to an increase in premiums.

- Aug 20, 2019 - **Delaware** Receives Federal Approval to Establish **Reinsurance** Program for 2020. ... Coupled with reduced rates already sought on the individual market in **Delaware**, the state expects a significant reduction in premiums for 2020. CMS authorized **Delaware's reinsurance** program through 2024.

UNIVERSITY OF DELAWARE

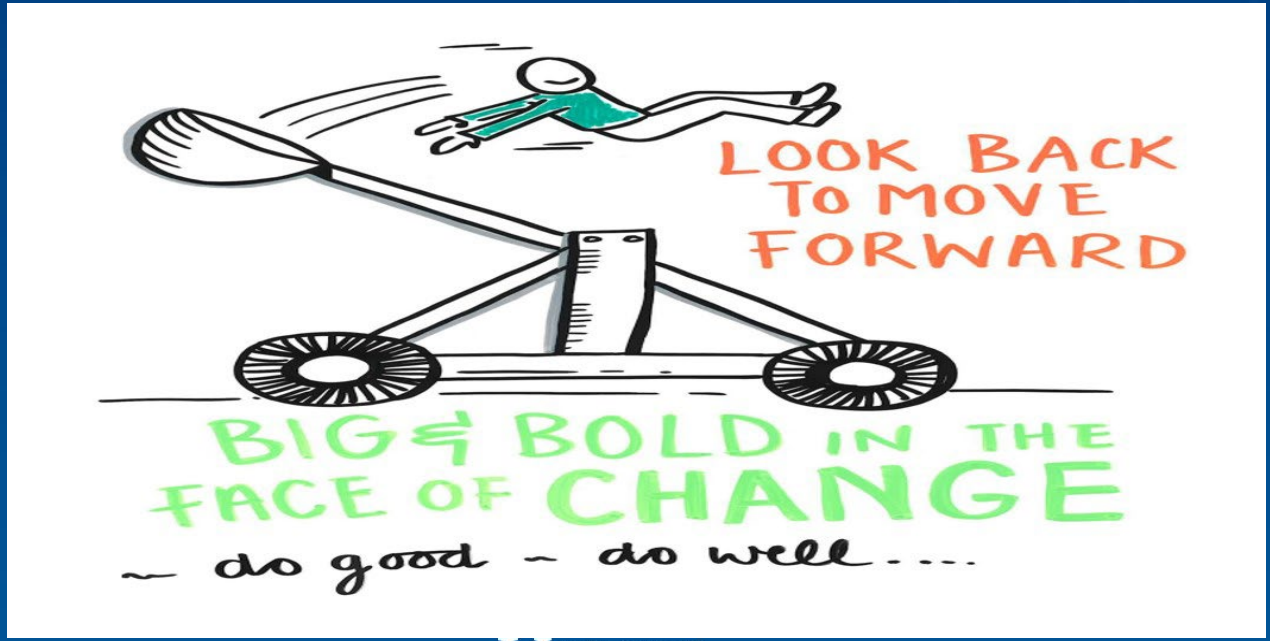
# Recent Past – June 2021

- The Supreme Court issued its much-anticipated opinion in California v. Texas regarding the constitutionality of the Affordable Care Act (ACA), rejecting the third major challenge to the law. The Supreme Court held in a 7–2 opinion that the states and individuals that brought the lawsuit challenging the ACA's individual mandate do not have standing to challenge the law. The Supreme Court did not reach the merits of the challenge, but the decision ends the case.

- The Supreme Court held that the states and individuals that brought the lawsuit do not have standing to challenge the law. In order to have standing, a plaintiff must allege "personal injury" that is "fairly traceable" to the alleged unlawful conduct.6 The Supreme Court held that neither the state nor individual plaintiffs had shown that the injury they will suffer or have suffered is "fairly traceable" to the allegedly unlawful conduct of which they were complaining.

- The individuals pointed to harm in the form of past and future payments. However, with the penalty for failing to comply zeroed out, the Supreme Court noted that the Internal Revenue Service can no longer seek a penalty from those who fail to comply, holding that "because of this, there is no possible government action that is causally connected to the plaintiffs' injury—the costs of purchasing health insurance."

# Root Cause Perspective –PRESENT And What Does Policy Translation Have to Do With My Health?




UNIVERSITY OF DELAWARE

# ACA and President Biden's Health Policy

- The American Rescue Plan Act, President Biden's COVID-19 relief package , temporarily expanded the scope and eligibility of the ACA's tax credits for marketplace health care coverage. As part of the American Families Plan, the human infrastructure component of his Build Back Better Agenda , President Biden extended the ACA tax credits under the American Rescue Plan Act.

- Inflation Reduction Act - Lower prescription drug costs for everyone by letting Medicare negotiate prices, reducing health insurance premiums and deductibles for those who buy coverage on their own, creating a public option and the option for people to enroll in Medicare at age 60, and closing the Medicaid coverage gap, full mental health parity. (AARP and AARP Foundation submitted a brief urging the court to dismiss a lawsuit challenging Medicare's authority to negotiate lower drug prices.)

UNIVERSITY OF DELAWARE

# Pharmaceuticals & Public Policy

- The widespread use and dependency on drugs and drug products in today's society, coupled with an increased utilization and application of pharmaceutical services, has created a need for individuals who can study the social, psychosocial, political, legal, historic and economic factors that impinge upon the use, non-use and abuse of drugs. A number of critical factors shaping the health policies in the United States and around the world emphasize the need for increased research concerning the role of pharmaceuticals and the pharmacy practitioner in new and old systems of health care.

- University of Minnesota
- College of Pharmacy

UNIVERSITY OF DELAWARE

# Advance Primary Care

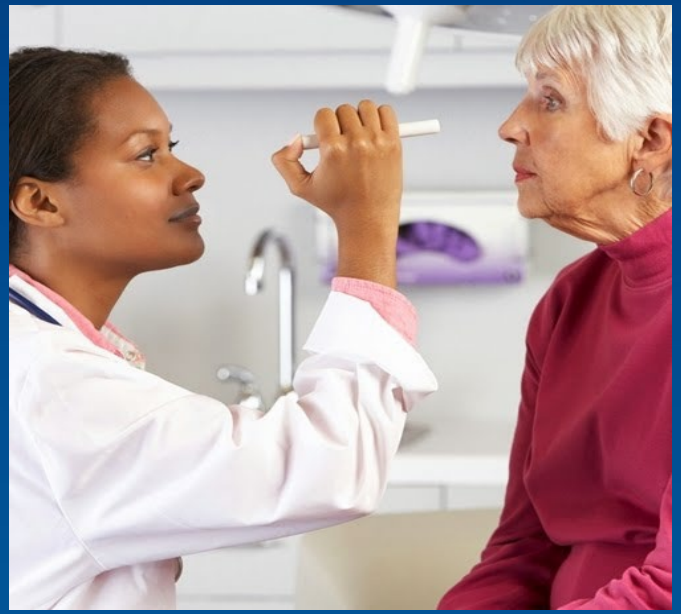
Better coordinated care between primary care practices and other health care providers for those with chronic health conditions

More transparency in how health care dollars are spent

Reimbursements based on how well health care Providers keep patients healthy – not on volume of care

Medicaid lens – ensuring all members have access to primary care – Meeting communities where the are.

.



UNIVERSITY OF DELAWARE

# Cost of medical care in the United States

- Compared to peer nations, United States spends twice as much on healthcare yet we have the lowest life expectancy (*The Commonwealth Fund*)
- As of 2018, average out of pocket spending reached $907 per person (*Health Care Cost and Utilization Report*)
- Median prices for individual services in the United States consistently rate higher than other countries as well (*International comparisons of health care prices from the 2017 iFHP survey*)
    - For example
        - An MRI scan in 2017 cost $1,430 to the price of $450 in the United Kingdom (*International comparisons of health care prices from the 2017 iFHP survey*)
        - The cost of a typical in-hospital vaginal birth costs $11,170 whereas it costs $7,080 in the UK (*International comparisons of health care prices from the 2017 iFHP survey*)

# U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes – The Commonwealth Fund

- The U.S. spends nearly 18 percent of GDP on health care, yet Americans die younger and are less healthy than residents of other high-income countries

1. Health spending per person in the U.S. was nearly two times higher than in the closest country, Germany, and four times higher than in South Korea. In the U.S., that includes spending for people in public programs like Medicaid, the Children's Health Insurance Program, Medicare, and military plans; spending by those with private employer-sponsored coverage or other private insurance; and out-of-pocket health spending.

- Not only does the U.S. have the lowest life expectancy among high-income countries, but it also has the highest rates of avoidable deaths
- All countries in this analysis, except the U.S., guarantee government, or public, health coverage to all their residents. In addition to public coverage, people in several of the countries have the option to also purchase private coverage. In France, nearly the entire population has both private and public insurance.
- Despite high U.S. spending, Americans experience worse health outcomes than their peers around world. For example, life expectancy at birth in the U.S. was 77 years in 2020 — three years lower than the OECD average. Provisional data shows life expectancy in the U.S. dropped even further in 2021.

# What does the United States' healthcare system look like? Some Key Factors:

- As a nation we do not have universal healthcare for all citizens
- There is a mix of government provided and private healthcare
- According to the Census Bureau, 92% of the United States population has health insurance (The United States Census Bureau)
- Of those that have health insurance 68% are on a private plan and 34% are on a government provided plan (The United States Census Bureau)

# What happens to the uninsured?

- There are approximately 30 million (7.7%) Americans that are uninsured [4]
- This can be attributed to the gray area between privatized and government insurance
- When those who are uninsured use health care services they bear a significantly higher cost of care in relation to their income, when compared to insured families and higher incomes (National Academies Press)
- High medical expenses can lead to a lower standard of living and in some cases can cause bankruptcy (National Academies Press)

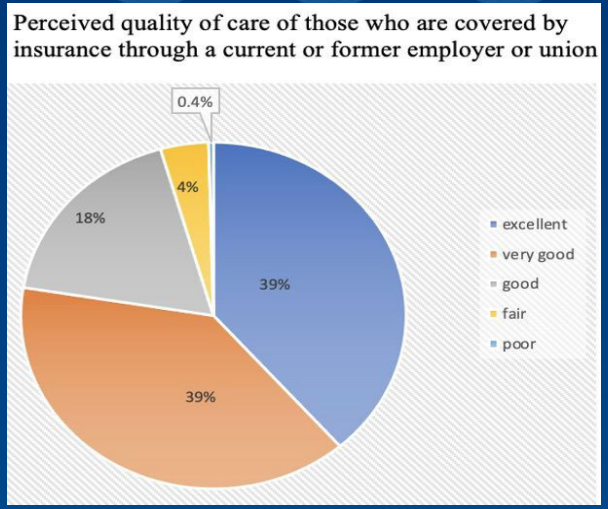
UNIVERSITY OF DELAWARE

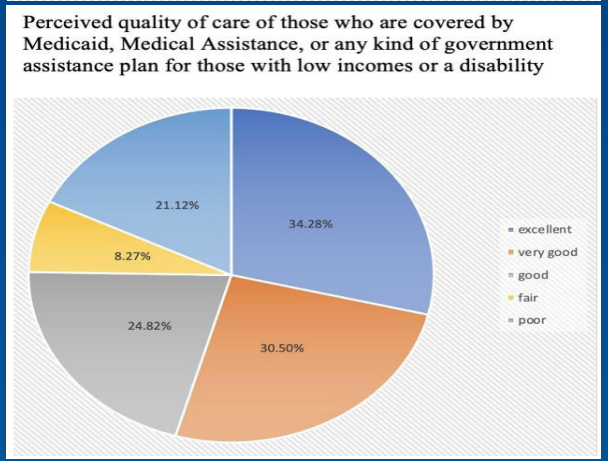
# State Example of Transformation Focus

1. Accelerate Payment Reform Readiness
2. Establish Cost and Quality Benchmarks
3. Strengthen Primary Care
4. Advance Behavioral Health Integration
5. Build Health Care Claims Database
6. Advance and Shift Healthy Communities Work to New Entity
7. Engage Patients and Consumers

# QUALITY OF CARE- Public Perspective

- The Health Information National Trends Survey collects national data about the American public's use of health knowledge and information
- It was found that on average, those who receive government funded insurance rate the quality of their health care lower than those who receive coverage from a private entity
- 21% of respondents who were covered by Medicaid rated their quality of care as poor, compared to the 0.4% of those covered by insurance through an employer

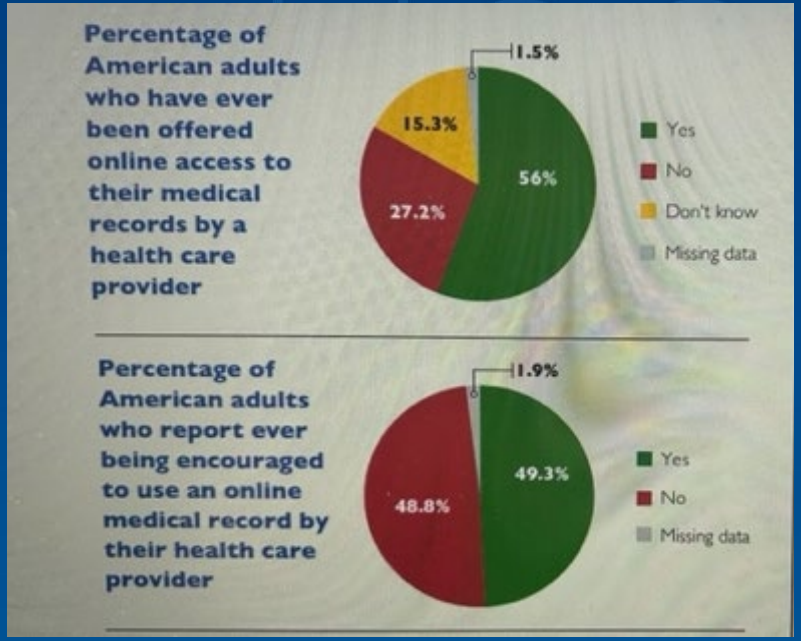



Data from HINTS 5 cycle 2

# Disparities in Patient Portal Communication, Access, and Use

- Even though most health care organizations now offer patient portals, the number of patients reporting portal use remains relatively low. In 2020, approximately 40% of Americans reported accessing their online medical records/patient portals at least once in the past 12 months. Additionally, significant disparities exist in patient portal use, with underserved groups (including racial and ethnic minorities, those with lower socioeconomic status, older individuals, and persons with disabilities) using these tools less often. Limited portal use in these populations may be driven by various factors, such as personal preference or lack of access to technology.




Source: HINTS 5 Cycle 4, 2020

UNIVERSITY OF DELAWARE

# CareMore: Improving Outcomes and Controlling Health Care Spending for High-Needs Patients (2017)-Replicate Best Practice

- Founded more than 20 years ago by a group of physicians, the Cerritos, Calif.–based Medicare Advantage plan and medical provider operates on the premise that a third or more of health care spending on frail and chronically ill patients can be eliminated by restructuring the way their care is delivered.
- CareMore Health specializes in whole-person care for patients with complex and chronic conditions. Our disease management programs are nationally recognized. With a focus on prevention programs to keep you healthy and active.

spending more to anticipate and address the medical challenges its frail and onically ill members will face, CareMore aims to prevent and slow the gression of disease rather than treat its complications.

emore serves 130,000 enrollees in Medicare and Medicaid Managed Care Plans oss 6 states.

UNIVERSITY OF DELAWARE

# CareMore: Improving Outcomes and Controlling Health Care Spending for High-Needs Patients (2017)-Replicate Best Practice

- In 2015, CareMore members had 20 percent fewer hospital admissions, 23 percent fewer bed days, and a 4 percent shorter length-of-stay than beneficiaries covered under fee-for-service Medicare. A comparative analysis of Medicare Advantage plan pricing for beneficiaries in average health indicates CareMore is more efficient in providing standard Medicare benefits than market competitors on average.

- Cuts to Medicare Advantage reimbursement rates threate
model. It has begun to diversify by serving Medicaid bene
partnering with health systems that are moving toward ri

UNIVERSITY OF DELAWARE

# FUTURE OF HEALTHCARE

## POLICY, PAYMENTS and VALUE NEED TO ALIGN ACROSS POPULATIONS

UNIVERSITY OF DELAWARE

# Healthcare as an Economic Driver

The Federal Reserve Bank of Philadelphia is implementing a tool called the Anchor Economy Dashboard: a first-ever national dashboard which captures the importance of anchor institutions across each state or region and the businesses they are connected to. This tool also calculates an anchor institution reliance score for each region, showcasing how dependent that economy is on local medical institutions.

The Federal Reserve Bank is committed to a larger impact for the future of healthcare. As the largest employer of economists in the world, the Federal Reserve Bank was able to act when the pandemic hit to get money into the hands of businesses. These banks also invest in low-income housing, job training and transportation, childcare, and various other contributors to aid the workforce.


UNIVERSITY OF DELAWARE

# Connected Health = Connecting People

1. Enhancing the human experience through ambient technologies
2. Addressing Access challenges
3. Connecting the patient and their families with less effort
4. Improve the Clinician experience and address burnout
5. A more compassionate, human-centered experience

verizon

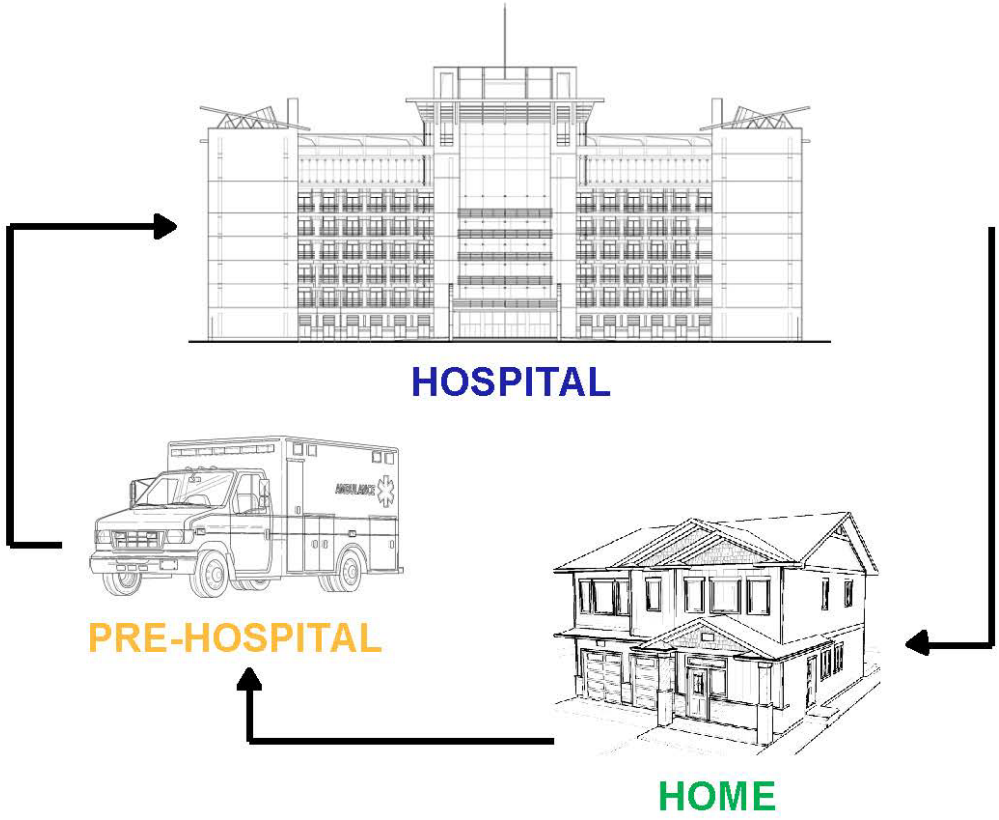
# Connected Health

**Connected hospital of the future** Reimagined networking, in-building connectivity, to support intelligent hospital, real-time applications, and in-room digital experiences.

**Patient experience (digital front door)** Omnichannel CX, and collaboration solutions to deliver real-time, intuitive patient experiences.

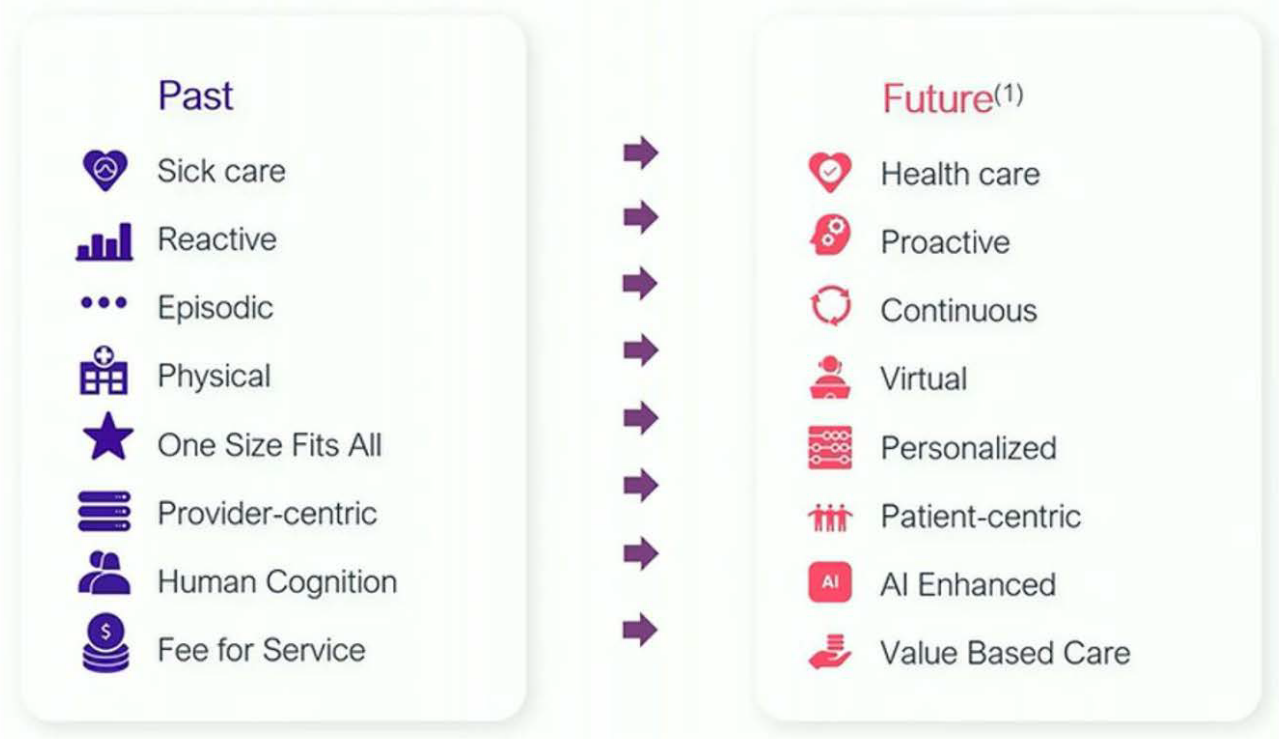
**Secure protected health information** End-to-end security solutions—from risk posture insights to threat detection to mitigation—to safeguard PHI in transit and at rest. Healthcare breaches totaled 599 in 2020, an increase of 55.1%1 from the prior year, and they topped 550 again in 2021.

**Streamlined virtual care** Telehealth, connected devices, and mobility offerings for pre-hospital, inpatient, and at-home remote care and clinical trials.




verizon

# **We are at the dawn** of the transformation of the healthcare sector



# #1

## Workforce Shortages Ranked at the Top

### Among Healthcare CEOs' top concerns in 2021

1 in 5 Doctors and Nurses are going to retire in the next 24 months

2 out of 5 Nurses and Doctors are strongly considering leaving medicine in the next 24 months

20% of HCP's are going to cut back hours.

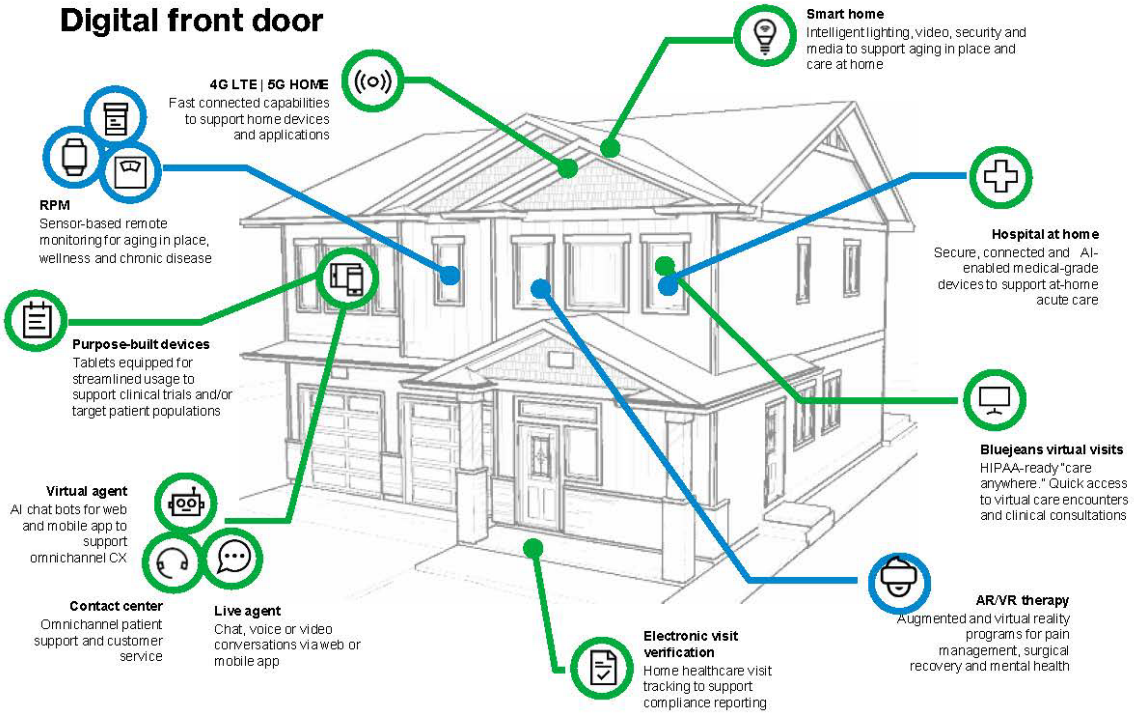
1.2m more nurses needed by 2030

**The fourth pillar of the Quadruple Aim - *improving clinician experience* - becomes important and cannot be ignored in this "Great Resignation."**

verizon

# Patient experience: Up to $265 billion worth of care services for Medicare fee-for-service and Medicare Advantage beneficiaries could shift to the home by 2025*

## Digital front door




### Experience

- 4G LTE | 5G Home
- Smart Home
- Intelligent Solutions
- Virtual Agent (AI Chat bot)
- Live Agent
- Contact Center
- BlueJeans Virtual Visits
- Electronic Visit Verification

### What this enables

#### Connected devices

- Sensor-based remote monitoring devices
- AI-enabled hospital-at-home medical devices and applications
- Purpose-built devices for clinical trials

#### AV/AR Solutions

- Augmented/virtual reality applications for treatment and recovery

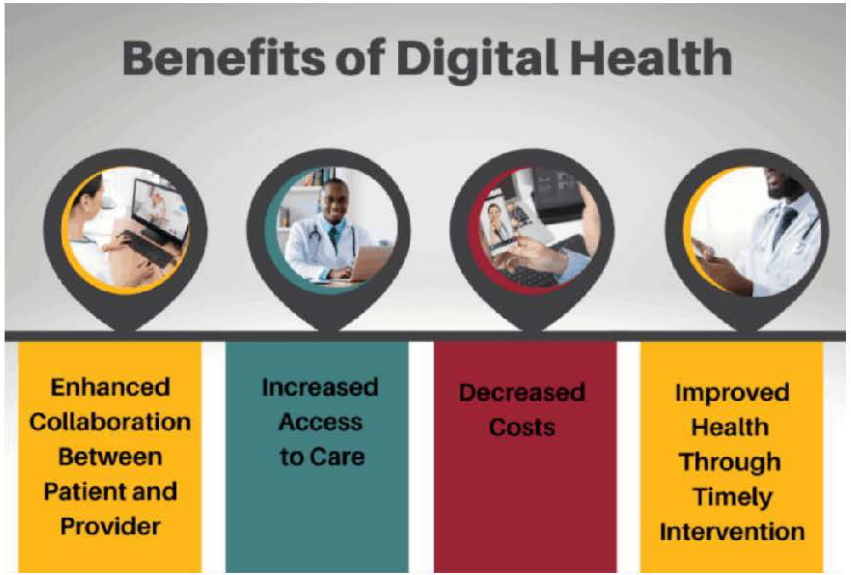
The scenarios depicted describe potential applications of communications and technology platforms offered by Verizon and affiliate companies or partners. Feasibility and performance may vary based on technical requirements and specifications for individual customers or use cases. Verizon products and services are not intended to replace or substitute for the clinical or medical judgement of healthcare providers.

# Conclusion

1. Digital transformation will enable more human-centered experiences that are powered by invisible.

2. Consider the target operating models that will be required to sustain and scale digital transformation over time.

3. By building a clear and specific transformation blueprint, healthcare organizations can deliver on the quadruple aim, supporting patients and clinicians.



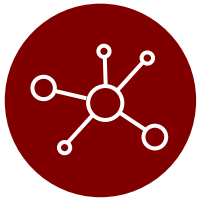
# Persistent Policy Issues

## ACCESS

Make it easier for people to access health care

## ADEQUACY

Balance the supply of health workers with the demand for care



## DISTRIBUTION

Improve distribution of the health workforce

## QUALITY

Improve the quality of the health workforce and the care they provide

# Population Drivers

- Aging of the population was & is still the primary driver of growth for the health workforce: **increased demand**

- U.S. birthrate still at historic lows: **decreased supply**

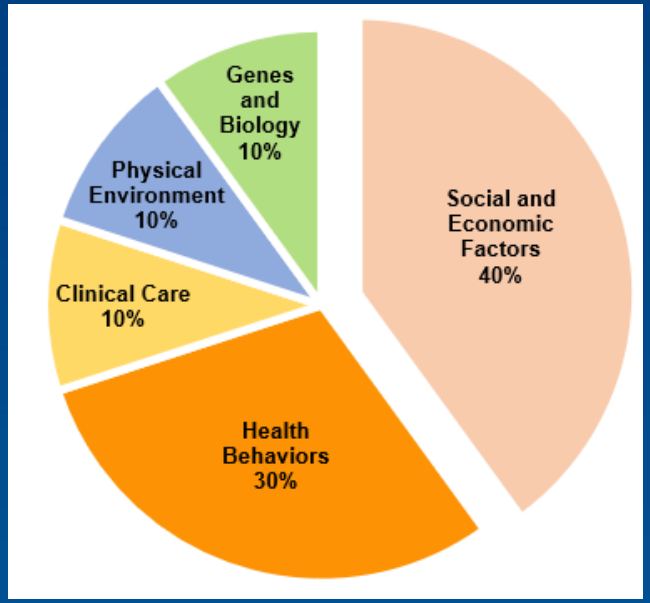
# Predicting COVID's Longer Impacts (cont'd)

- National shortages of active Physicians and Registered Nurses in the US will be exacerbated by the COVID-19 pandemic.
- At the state level, existing mal-distributions will worsen.
- Targeted investments can diffuse near-term impacts:
  - Increase the supply of and encourage re-distribution of Primary Care Physicians/RNs
  - Make expanded Scopes of Practice permanent


health happens here
health happens here

# Determinants of Health

## Consider What Creates Health




**Necessary conditions for health** (according to WHO)

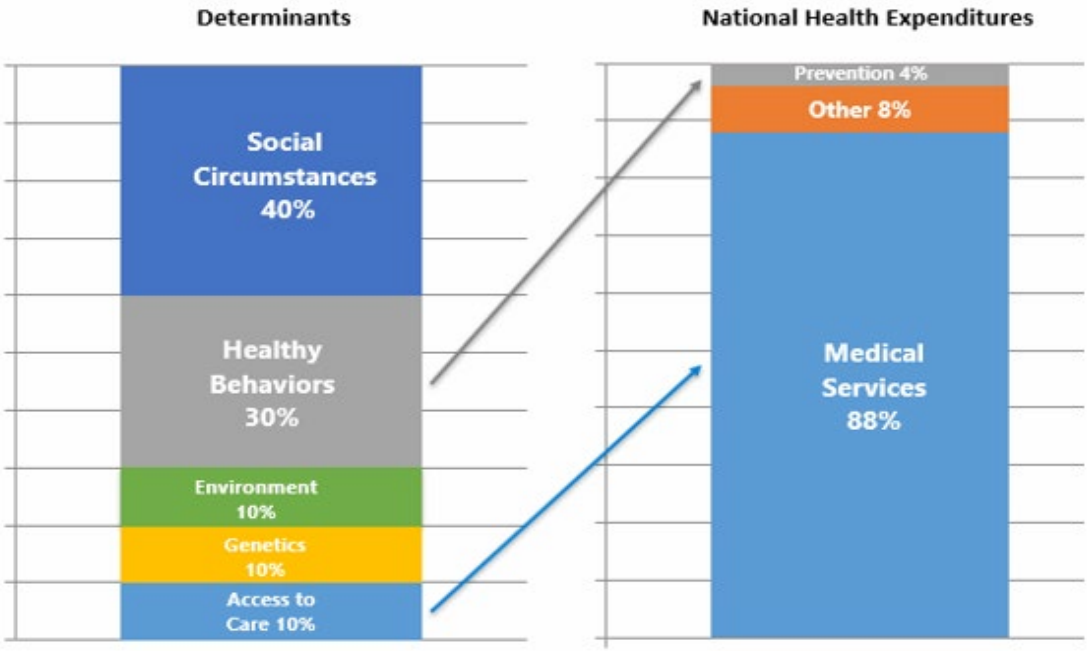
- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Mobility
- Social justice and equity

Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at <http://www.who.int/hpr/archive/docs/ottawa.html>.

UNIVERSITY OF DELAWARE

# Spending Mismatch:
# Health Care vs. Other Key Determinants of Health




UNIVERSITY OF DELAWARE

# Social Position Matters

- Income and education are markers of socioeconomic position.
- Lower socioeconomic position results in:

↑exposure to health threats

↓resources to support or promote health

→poorer health

# Social Conditions in Neighborhoods Can Influence Health

- Perceived neighborhood safety has been associated with levels of physical activity

- Closely knit" neighborhoods are more likely to exchange information and work together to achieve common goals; they also may have more effective social norms that discourage crime and unhealthy or destructive behaviors such as drunkenness, youth alcohol or smoking behavior, littering, and graffiti

# Services in Neighborhoods Can Influence Health

- As the number of alcohol outlets increases, so do levels of crime and violence
- A higher concentration of convenience stores is associated with a higher level of individual smoking
- Access to recreational facilities is associated with greater physical activity among adults, adolescents, and children
- Early childhood development programs have been shown to promote cognitive development and increased readiness to learn

# Advancing Healthy Strong Communities

**by Collective Impact**

- commitment from different sectors to a common agenda for solving a specific social problem, using a form of structured collaboration that is devoted to building a community of problem-solvers focused on challenges associated with sustainability, energy, health care, education, economic opportunity and the environment.

***"The whole is greater than the sum of its parts“***

UNIVERSITY OF DELAWARE

- What is happening in the present and what has history demonstrated?
- What are the key facts?
- As you listen – What words, pieces of data, and conclusions stand out for you?

- What is new and/or refreshing to you?
- What is surprising to you from the presentations?
- What is challenging your thinking?

- What are the issues that impact the current challenges?
- What patterns did you see across the presentations?
- If we had a chance to create anew what would we do differently?


UNIVERSITY OF DELAWARE

# References


- Edmonds, A. et al (2015). “Making the Case for Linking Community Development and Health.” Building Healthy Places Network.
- Moore, A. (2018). “Partnerships for Health Equity and Opportunity: A Healthcare Playbook for Community Developers.” Building Healthy Places Network.
- Prevention Institute. (2017). What? Why? How? Answers to Frequently Asked Questions About the Adverse Community Experiences and Resilience Framework. Oakland, CA.
- Public Health Leadership Forum and Health Care Transformation Task Force (2018). Partnering to Catalyze Comprehensive Community Wellness: An Actionable Framework for Public Health and Health Care Collaboration. Washington, D.C.
- Nightingale F. Sick nursing and health nursing. In: Billings JS, Hurd HM, eds. *Hospitals, Dispensaries and Nursing: Papers and Discussions in the International Congress of Charities, Correction and Philanthropy*. Section III, Chicago, June 12-17, 1893. Baltimore, MD: The Johns Hopkins Press, 1894.
- Transitional Care Model. accessed August 3, 2010.
- U.S. Department of State, Bureau of International Information Programs. U.S. minorities will be the majority by 2042, Census Bureau says. accessed August 3, 2010.
- **Susan Hassmiller is Senior Advisor for Nursing at the Robert Wood Johnson Foundation in Princeton, New Jersey.**
- UD Stern Future Healthcare Workforce Summit, May 17, 2022
  - Keynote: Healthcare as an Economic Driver, Patrick Harker - President & CEO, Federal Reserve Bank Philadelphia;
  - Keynote: Connected Health, Robin Goldsmith - Health Innovation Principal, Verizon
  - Keynote: Laying the Foundation, Michelle Washko, PhD - Director of the National Center for Health Workforce Analysis


UNIVERSITY OF DELAWARE

Acevedo-Garcia, D. (2000). Residential segregation and the epidemiology of infectious diseases. *Social Science and Medicine*, *51(8),* 1143-1161.

Alexander, D. & Curie, J. (2017). Is it who you are or where you live? Residential segregation and racial gaps in childhood asthma. *Journal of Health Economics, 55,* 186-200.

Bailey, Z. D., Krieger, N., Agenor, M., Graves, J., Linos, N. & Bassett, M. T. (2017) Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 2017 Vol: 389. 1453 – 63. Bravo, M. A., Anthropolos, R., Bell, M. L., & Miranda, M. L. (2016). Racial isolation and exposure to airborne particulate matter and ozone in understudied US populations: Environmental justice applications of downscaled numerical model output. Environ Int. 92-93: 247-55.

Centers for Disease Control and Prevention (CDC) on *Health Equity*: https://www.cdc.gov/chronicdisease/healthequity/index.htm

Dahlgren G, Whitehead M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies

Delaware Health and Social Services, Division of Public Health [DHSS]. (2016). Delaware vital statistics annual report. Retrieved from https://www.dhss.delaware.gov/dhss/dph/hp/files/ar2016_net.pdf

Diehr, A. J. and McDaniel, J. T. (2018). Lack of community-oriented policing practices partially mediates the relationship between racial residential segregation and "black-on-black" homicide rates. *Preventive Medicine, 112*, 179 - 184.

Diez-Roux, A. V. & Mair C. (2010). Neighborhoods and health. *Annals of the New York Academy of Science. 1186(1),* 125-145.

Donnelly, D., Cook, K., Van Ausdale, D., & Foley, L. 2005. White Privilege, Color Blindness, and Services to Battered Women. *Violence Against Women*. 11(1): 6-37.

Grady, S. C. (2006). Racial disparities in low birthweight and the contribution of residential segregation: a multilevel analysis. *Soc Sci Med, 63(12),* 3013-3029.

Hagerman, M. 2018. *White Kids: Growing up with Privilege in a Racially Divided America*. NYU Press.

Hayanga, A. J., Kaiser, H. E., Sinha, R., Berenholtz, S. M., Makary, M., and Chang, D. (2009) Residential segregation and access to surgical care by minority populations in US counties. *Journal of American College of Surgeons, 208(6),* 1017-1022.

Henry J. Kaiser Family Foundation. (2017). Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2017. Retrieved from https://www.kff.org/statedata/?state=de

Ibragimov, U., Beane, S., Admimora, A. A., Friedman, S. R., Samuel, R., and Williams, L. (2018). Relationship of Racial Residential Segregation to Newly Diagnosed Cases of HIV among Black Heterosexuals in US Metropolitan Areas, 2008-2015. *Journal of Urban Health,* 1-12.

Kershaw, K. N., Diez Roux, A. V., Burgard, S. A., Lisabeth, L. D., Mujahid, M. S., and Shulz, A. J. (2011) Metropolitan-level racial residential segregation and black-white disparities in hypertension. *Am J Epidemiol, 174(5),* 537-45.

Kershaw, K. & Albrecht, S. (2015). Racial/ethnic residential segregation and cardiovascular disease risk. *Curr Cardiovasc Risk Rep, 9(3)*, 1-19.

Korver, K. 2019. Privileged. *The Players Tribune*. April 8th, 2019. www.theplayerstribune.com

Kramer M.R. & Hogue, C.R. (2009) Is segregation bad for your health? *Epidemiol Rev 2009; 31:* 178–94.

UNIVERSITY OF DELAWARE

Krivo, L., Byron, R., Calder, C., Peterson, R., Browning, C., Kwan, M. & Lee, J.Y. (2015). Patterns of local segregation: Do they matter for neighborhood crime?. *Social Science Research, 54*, *303-318.*

Landrine, H. & Corral I. (2009). Separate and unequal: Residential segregation and black health disparities. *Ethn Dis. 19(2),* 179-84.

Landrine, H., Corral, I., Lee, J. G. L., Efird, J. T., Hall, M. B., & Bess, J. J. (2017). Residential segregation and racial cancer disparities: A systematic review. *Journal of Racial and Ethnic Health Disparities, 4(6),* 1195-1205.

McIntosh, P. 1989. White Privilege: Unpacking the Invisible Knapsack. *Peace and Freedom*. July/August: 10-12.

Massey, D. S. (2001). Residential segregation and neighborhood conditions in U.S. metropolitan areas. National Academy Press, Washington, D.C. Retrieved from: https://www.asu.edu/courses/aph294/total-readings/massey%20--%20residentialsegregation.pdf

Mehra, R., Boyd, L. M., & Ickovics, J. R. (2017). Racial residential segregation and adverse birth outcomes: A systematic review and meta-analysis. *Social Science and Medicine, 191,* 237-250.

Mohai, P., Lantz, P. M., Morenoff, J., House, J. S., and Mero, R. P. (2008). Racial and socioeconomic disparities in residential proximity to polluting industrial facilities: Evidence from the Americans' changing lives study. *American Public Health Association, 99(3)*, S649-S656.

Moore, L. V., Diez Roux, A. V., Evenson, K. R., McGinn, A. P., and Brines, S. J. (2008). Availability of recreational resources in minority and low socioeconomic status areas. *Am J Prev Med. 34(1):* 16-22.

Moore, L. V., Diez Roux, A. V., Nettleton, J. A., Jacobs, D. R., and Franco, M. (2009). Fast-food, diet quality and neighborhood exposure to fast food: the multi-ethnic study of atherosclerosis. *Am J Empidemiol. 170(1):* 29-36.

Nuru-Jeter, A. M. & LaVeist, T. A. (2011). Racial segregation, income inequality, and mortality in the U.S. metropolitan areas. *J Urban Health, 88(2),* 270-282.

Paradies, Y. (2016). Racism and health. 10.1016/B978-0-12-801238-3.98834-2.

Popescu, I., Duffy, E., Mendlesohn, J., & Escarce, J. J. (2018). Racial residential segregation, socioeconomic disparities, and the White-Black survival gap. *PLoS One, 13(2).*

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2008). A snapshot of Delaware's children. Retrieved from http://www.commissiononhealth.org/PDF/RWJ039_StateSnaps_Delaware.pdf

Salow, A., Pool, L., Grobman, W. Kershaw, K. (2018). Associations of neighborhood-level racial residential segregation with adverse pregnancy outcomes. *American Journal of Obstetrics & Gynecology, 218(3),* 351.e1-351.e7.

United Health Foundation. (2018). America's health rankings annual report. Retrieved from https://www.americashealth rankings.org/learn/reports/2018-annual-report

White, K., Haas, J. S., and Williams, D. R. (2012). Elucidating the role of place in health care disparities: the example of racial/ethnic residential segregation. *Health Serv Res, 47(3 Pt 2),* 1278-1299.

Whitehead M. (1992). The concepts and principles of equity in health. International Journal of Health Services; 76(3), 429-445

Wildemann, C. & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *Lancet. America: Equity and Equality in Health 4,(389),* 1464-1474.

Williams, D. R. & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Rep. 116(5):* 404-416.

Williams, D. R. and Mohammed, S. A. (2013). Racism and health I: pathways and scientific evidence. *American Behavioral Scientist. 57(8):* 1152-1173.

Williams, D. R. & Williams-Morris, R. (2000). Racism and mental health: the African American experience. *Ethn Health. 5(3-4):* 243-268.



UNIVERSITY OF DELAWARE

Health Care and Cost Utilization Report. (n.d.). https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports. How U.S. Health Insurance Works. (n.d.). Vaden Health Services. https://vaden.stanford.edu/insurance/health-insurance-overview/how-us-health-insurance-works Eligibility. (n.d.). Medicaid. https://www.medicaid.gov/medicaid/eligibility/index.html. International comparisons of health care prices from the 2017 iFHP survey. Health Care Cost Institute. (n.d.). https://healthcostinstitute.org/hcci-research/international-comparisons-of-health-care-prices-2017-ifhpsurvey?highlight=WyJpZmhwIiwyMDE3LCIyMDE3J3M iLCJyZXBvcnQiLCJyZXBvcnQncyIsIjIwMTcgcmVwb3J0Il0. National Academies Press. (2003). Spending on Health Care for Uninsured Americans: How Much, and Who Pays? Hidden Costs, Values Lost: Uninsurance in America. https://www.ncbi.nlm.nih.gov/books/NBK221653/. National Cancer Institute. (n.d.). https://hints.cancer.gov/data/download-data.aspx. Patton, M. (2020, November 11). Obamacare 10 Years Later: Success Or Failure? Forbes. https://www.forbes.com/sites/mikepatton/2020/11/11/obamacare-10-years-later-success-or-failure/?sh=1e803c748447. Silvers, J. B. (2013). The Affordable Care Act: Objectives and Likely Results in an Imperfect World. The Annals of Family Medicine, 11(5), 402–405. https://doi.org/10.1370/afm.1567. The United States Census Bureau. (2020, September 15). Health insurance coverage in the United States: 2019. https://www.census.gov/library/publications/2020/demo/p60-271.html. U.S. health care from a global perspective, 2019: Higher spending, worse outcomes? (n.d.). https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

# Questions?

# Upcoming Events

NAACOS Winter Boot Camps

- February 8-9, 2024
- Marriott Orlando Airport Lakeside, Orlando, FL
- 2 Concurrent Boot Camps
  - Clinical Operations in Care Transformation Boot Camp
  - Data and Analytics for Care Excellence Boot Camp

Registration Now Open!

# Learning Lab

AWV Learning Lab series (six sessions)

- Next Meeting November 16, 2023
- Every third Thursday from 2:00 - 3:00 PM Eastern
- Sign-Up Here!

# Thank you!

# Contact Information

- **Melody Danko-Holsomback**, VP of Education, NAACOS, mdholsomback@naacos.com
- **Emily Perron,** Education Manager, NAACOS, eperron@naacos.com
- **Rachel Lesch, R.N., M.B.A.,** Vice President of Population Health and Performance Excellence, LeschR@centracare.com

# Appendix

# Learning Lab Objectives

- Learn about Medicaid contracting throughout the states
- Learn about care models to support your contract populations and networks
- Learn about various care settings to address population needs
- Learn workflow options for value-based care related to primary care, SDOH, BH and high needs people
- Learn how to improve quality in the Medicaid population
- Learn how to enhance patient engagement in the Medicaid population

# Education Project Plan Document

**Project Overview:**

The Medicaid Learning Lab will provide NAACOS ACO members the time and platform to explore and learn about topics related to Medicaid value-based contracting and patient care models that include a focus of issues compounded by the socio-economic factors of the Medicaid population. The learning lab meetings will occur virtually each month for 90-minute sessions and will last for a minimum of 12 months and continue until objectives are completed. Additional in-person sessions may also occur at biannual conferences, if warranted.

**Standards:**

- Participants are asked to be engaged active participants in monthly meetings
- Participants are asked to share best practices and lessons learn from experiences with like populations, care model or topic of discussion
- Participants are expected to actively participate in surveys and document review to better enhance your learning experience and help staff understand your learning needs.
- Please be on camera and ready to participate in each meeting you attend.
- No question, thought, or example is a bad one.  Learning is found in all examples weather a success or failure in the past.

# Education Project Plan Document

**Requirements/Task(s):**

- Attend a minimum of 75% of the meetings to receive CEUs
- Actively participate in topic discussions where appropriate
- Develop a draft plan of what your Medicaid ACO looks likes including participants, Geographics and Medicaid population you are serving or would look like if planning a new contract. Then outline a 2-year strategic plan on how you will include at least 2 to 3 new initiatives based on information gathered during participation in the NAACOS Medicaid Learning Lab. (Turn completed plan in to NAACOS for Completion Certificate)

**Record your notes/research here:**

Use this section to note which initiative you may want to include in your strategic plan

# Education Project Plan Document

**Outline the steps/plan for your project:**

- Use monthly meeting note templates to document your notes and options for your final strategic plan
- Start your project outline from the beginning of the learning lab to prevent an additional large time commitment at the end of the learning lab series to complete your strategic plan.
- Meet with others from your ACO throughout the project to get their input, suggestions, and support for possible implementation of learnings.
- Complete your strategic plan after the final meeting, you will have one month to complete and submit to NAACOS Education staff to receive your NAACOS Medicaid Learning Lab completion certificate. (This will be separate from CEUs for participation in live meetings)
- Your final plan will be reviewed by the NAACOS team and Education Committee for presentation and possible award at a future NAACOS event.
- The strategic plan completion is not a requirement to participate in the learning lab monthly session or to receive CEUs but will provide tangible materials from your participation that have potential for future ACO improvement efforts.
- To Receive the Event CEUs, you must be present and actively participate in a minimum of 75% of the monthly meetings.
- This event is only open to NAACOS members.

# Group Discussion

Note Template Questions:

1. What problem does the topic address?
2. What population of patients could benefit from this?
3. What didn't I know or haven't thought about trying in my ACO?
4. Could any of this presentation work in your ACO or CIN?
5. If yes, how?  If no, why not?

**Take 10 to 15 minutes and create a paragraph describing what your next steps would be to investigate the use of presented material in one or more ACO processes.**