Health Care Transformation Task Force
Partners in Promoting Value

NAACOS
Advancing Value in Health Care

REIMAGINING BENEFICIARY ENGAGEMENT IN ACCOUNTABLE CARE MODELS

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Overview

One of the biggest challenges in advancing accountable care is successfully communicating the benefits of these models to the people they serve. Patients and their caregivers are often unaware of how their care is being coordinated or the other benefits that value-based care models provide. Effectively communicating these benefits is one strategy providers can implement to better engage patients in their care. There are many levels of patient engagement, and this paper reimagines how people should best be engaged in governance, care planning, and care delivery redesign, primarily in accountable care organizations (ACOs).

ACOs are the largest and longest-standing alternative payment model (APM), and are designed to provide high quality, cost-effective, coordinated health care that focuses on keeping people healthy through prevention and effective care management that address both social and clinical risk factors. The Medicare Shared Savings Program (MSSP) – the largest ACO initiative in the United States – now has well over a decade of experience in pursuing these goals. The Centers for Medicare and Medicaid Services (CMS) has also tested several accountable care models through the CMS Innovation Center, including the current ACO Realizing Equity, Access, and Community Health (REACH) Model. ACOs have learned much about policies, incentives, and care delivery strategies that advance patient engagement and pursue effective and efficient person-centered care.

Building on the more than a decade of success, it is critical to reexamine how ACOs are engaging beneficiaries in both care delivery and care redesign. By design, ACOs offer opportunities for providers to better address patients' needs that are not available in the fragmented fee-for-service (FFS) system. ACOs also offer an important opportunity to address current health care delivery inequities, having demonstrated reducing racial and ethnic disparities in care and better serving rural and underserved communities. Yet, patients in ACOs or other APMs often are unaware of their inclusion in models and the benefits they provide. Additionally, the success of ACOs and APMs has overly focused on cost savings and not on improved beneficiary outcomes. Accordingly, the National Association of ACOs (NAACOS) and the Health Care Transformation Task Force (HCTTF) sought to identify opportunities to improve beneficiary engagement in ACOs.

NAACOS and HCTTF convened a cross section of their memberships – including ACO and patient and consumer representatives – for a roundtable discussion on what person-centered care means today and how policies can best support these perspectives. This roundtable produced policy recommendations focusing on what changes should be made to CMS accountable care models to strengthen patient engagement and advance person-centered care.

The participants noted that much of the current MSSP policies around beneficiary engagement are rooted in regulation, and therefore present some unwelcome rigidity in practice. Additionally, these policies were not developed with input from beneficiaries or their advocates (patient or consumer groups, family caregivers, etc.). CMS should consider removing regulatory rigidity by making the recommended policy changes through interpretative guidance to allow for more flexibility in implementation. Additionally, CMS can amplify its communication about ACOs. Participants appreciate the Innovation Center's recent work to tell stories of patients in ACOs and other APMs, but this information is disjointed from CMS' ongoing and regular communication to beneficiaries.

With the goal of incorporating beneficiary engagement across all aspects of an ACO, this paper highlights several recommendations that CMS should implement to better support ACOs in patient engagement.

1. **Beneficiary communications must be tailored to different patient populations.** Current regulations require a one-size-fits-all approach which limits educational and engagement potential to specific audiences. CMS should transition to approaches that empower ACOs to tailor the timing and information communicated to beneficiaries. As with other programs, CMS could set broader parameters for beneficiary communications and timelines and allow ACOs to customize their approaches. For example, beneficiaries are best served when communicated with in their primary language to build trust and foster the full understanding of what is being communicated to them.
2. **ACOs and other APMs can be improved with enhanced beneficiary engagement tools.** ACOs offer freedom from regulatory burden by waiving certain Medicare FFS requirements. Many waivers tested offer a direct benefit to the patient, such as waiving cost-sharing for certain services or allowing a beneficiary to be directly discharged to a skilled nursing facility (SNF) without meeting the minimum nights of a hospital stay. These benefits facilitate improved engagement for patients with the health care they seek. However, waivers are inconsistently applied across the various ACO models. CMS should work to expand and align waivers that provide direct benefits to beneficiaries and support ACOs with understanding parameters for meeting beneficiary-related requirements.
3. **Meaningful input from patients, family caregivers, and communities is critical to the success of accountable care models.** Effective two-way communication promotes person-centeredness and can advance population health goals. CMS should ensure ACOs and other APM participants have adequate guidance to solicit beneficiary input and feedback, establish community partnerships, and incorporate these perspectives into their work. The focus should be on co-creation of care delivery models where the patient voice is considered and acted upon throughout the care continuum.

The remainder of this resource details the background and challenges, key considerations, and recommendations in how ACO policies should be aligned with patient preferences across the following topics:

- Beneficiary communications and education
- Beneficiary engagement in care delivery redesign
- Beneficiary participation and input in ACO governance

While these perspectives generally apply to all populations being served by ACOs, the specific recommendations presented here focus on policies applicable to Medicare ACOs.

Aligning ACO Program Requirements to Better Engage Patients

Beneficiary Communications and Education

Background and Challenges

Communications are a critical element of beneficiary engagement. Most beneficiaries do not know what an ACO is and often have misconceptions about terms like “accountable care” and “value-based care” which necessitates more fundamental education. Current program rules and definitions impede ACOs’ ability to effectively communicate with and educate Medicare beneficiaries.

In MSSP, CMS currently defines any communications or activities “used to educate, solicit, notify, or contact Medicare beneficiaries” that mention the ACO or the MSSP as “marketing materials and activities,” which has deterred ACOs from developing educational content around the benefits of an ACO to beneficiaries. Up until recently, ACOs were required to submit any marketing materials and activities to CMS for approval prior to use. Despite CMS removing this requirement beginning in 2023, the regulatory definition of “marketing materials and activities” has not changed and many ACOs are cautious about developing content that could fall under the definition.

ACOs are required to use CMS template language when available. However, templates are only available for some materials. Additionally, beneficiaries have reported that the language is confusing and does not resonate with them, including because such templates are not provided in multiple languages. Additionally, template language is not publicly available and must be accessed by individual ACOs through the Knowledge Library in the ACO Management System (ACO-MS). This inhibits important stakeholder groups’ ability to review template language and provide feedback to ensure the documents are easily comprehensible to all beneficiaries.

The complexity of the beneficiary notification requirements in MSSP has resulted in administrative burden, beneficiary confusion, and operational complexity. There are different policies for MSSP ACOs operating under prospective assignment versus preliminary prospective assignment with retrospective reconciliation that cause confusion and additional challenges for those under retrospective assignment. ACOs under prospective assignment receive a set list of prospectively assigned beneficiaries who must be provided the standard notice and follow-up communication. ACOs with retrospective assignment must provide the notice and follow-up to all Medicare FFS beneficiaries prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from a provider in the ACO. This makes it difficult for these ACOs to identify the denominator of beneficiaries they are required to notify.

Lack of appropriate guidance from CMS and contradictory information from ACO coordinators have compounded confusion and burden with implementing these requirements. Unfortunately, these requirements have also caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements. Some patients believe these communications are part of a scam, or that they have been enrolled in a managed care plan without their consent, which can erode trust and inhibit engagement efforts.

Key Considerations

Participants shared that the goal of beneficiary communication and education policies should be to build greater engagement with beneficiaries, and that current requirements do not achieve this goal. To better educate consumers on ACOs and communicate important information about ACO initiatives to beneficiaries, communication materials should leverage storytelling and should be tailored for different segments of the population. However, the existing beneficiary notices are passive and bureaucratic and do not resonate with patients nor encourage trust or engagement. Current requirements are too prescriptive and do not allow ACOs to develop and tailor content to the unique needs of their populations.

The group discussed better aligning MSSP communication policies with Medicare Advantage (MA) marketing and communications policies, which define marketing as a subset of communications and lets plans share non-marketing educational materials more freely with beneficiaries. Additionally, participants noted the discrepancy in information that CMS provides to Medicare beneficiaries on MA versus ACOs. For example, the Medicare and You handbook includes a chapter on Medicare Advantage but only provides a brief description of ACOs.

Participants also envisioned policies that shift away from a standardized notice to communications that focus on educating and engaging beneficiaries on how the model impacts them and what they should expect from the care they receive. Such a future state could mirror health equity plans in other models where ACOs are required to submit a plan to CMS but are not prescriptive in how the plan must be implemented. This would allow greater flexibility for ACOs to tailor communications to their patient populations' needs. ACOs should also proactively seek beneficiary and caregiver feedback on the engagement plan.

Recommendations

Participants identified the need for both short and long-term recommendations for updating the beneficiary communication and education policies to better align with person-centered care goals and bolster patient engagement.

In the short-term, CMS should:

- Amend the MSSP beneficiary notification requirements to have a fixed deadline, rather than a rolling deadline based on beneficiaries' appointments, and clearly defined population to which the ACO is required to provide the notice. This aligns with the ACO REACH requirement for ACOs to provide all aligned beneficiaries a written notice each performance year, by a date specified by CMS.
- Allow ACOs to edit beneficiary notification templates with input from their affected patient community to include more ACO-specific information, provided that all required core elements are included. For example, ACOs should be allowed to include the clinician's name or name of practice, which is more recognizable to patients than the ACO name.
- Clarify that ACOs are permitted to translate beneficiary notifications into languages that best serve the targeted patient population.
- Modify the definition of "marketing materials and activities" in MSSP to distinguish between education and communication and marketing (aligning with MA rules) and facilitate more ACO-developed education for beneficiaries that are informed by beneficiaries and/or their advocates.
- Educate beneficiaries in a manner that resonates with them about ACOs when they enroll in Medicare, similar to the plan information that beneficiaries receive when they enroll in a Medicare Advantage plan.
- Allow ACOs to send notification information out with other materials rather than as a separate communication to reduce administrative burden and resource use.

In the long-term, CMS should:

- Shift away from requiring ACOs to use a standardized notice and move toward a requirement for ACOs to have a beneficiary-informed education and engagement plan developed in partnership with patients and ACO patient board members, with different levels of engagement tailored to segments of the ACO's population. ACOs could submit the engagement plan (similar to health equity plans in other models) for CMS to track and audit.
- Engage beneficiaries and their advocates to lay the groundwork for educating beneficiaries on available models and enable beneficiaries to seek out providers in those models (e.g., through a directory).
- Include more beneficiary-informed ACO-specific information in the Medicare and You handbook (e.g., a supplement or chapter discussing ACOs).
- Make CMS communication templates optional; CMS should provide language with key elements and allow customization and the addition of ACO-specific information. CMS should also make template language publicly available to promote transparency and solicit feedback from ACOs, patient advocacy groups, and other key stakeholders to ensure that template language truly enhances beneficiary understanding of ACOs.

Beneficiary Engagement in Care Delivery

Background and Challenges

To achieve the right care at the right time and place, care must be easily accessible to patients and delivered in a way that encourages patient engagement. However, many care engagement and delivery tools were not developed in collaboration with patients. Upfront engagement with beneficiaries and caregivers is critical to ensure the tools described below are meaningful.

The process of establishing a primary care relationship is an important step in a patient's care journey. Beneficiaries who select an ACO provider as their primary clinician are better able to establish a continuous trusting relationship. ACOs can leverage voluntary alignment to engage beneficiaries in their care, however, ACOs and Medicare beneficiaries experience several challenges with effectively utilizing voluntary alignment. Additionally, not all beneficiaries are aware of the importance of having a primary care relationship.

Operational challenges with voluntary alignment and how the process is managed by CMS can create confusion for beneficiaries and practices. CMS' factsheet for beneficiaries on how to choose a primary clinician may be misleading, as it indicates beneficiaries are aligning to an individual clinician who they believe is responsible for managing their overall care. Operationally, CMS aligns beneficiaries to a practice location, not a specific clinician. When an individual clinician leaves a particular practice location, the beneficiaries that follow the clinician to a new location will still align to the previous practice location. This results in beneficiaries being attributed to ACOs they are no longer receiving care through, or not being attributed to an ACO provider from which they are receiving primary care services, because voluntary alignment takes precedence over claims-based alignment.

In MSSP, beneficiaries must also use the MyMedicare.gov website to select their primary clinician, but many beneficiaries may not have access to internet or be able to navigate the website to make this selection. Paper-based voluntary alignment is being tested in the ACO REACH Model and increases voluntary alignment. However, the ACO REACH Model has limitations in alignment; home-based primary care providers have no ability to conduct voluntary alignment because it may not be discussed in the patient's home even when that is the site of care. This challenge has been particularly significant for High Needs ACOs in the REACH Model, which serve more homebound patients.

Annual wellness visits (AWVs) are another tool many ACOs use to engage beneficiaries in care and ensure that appropriate screenings and preventive care are provided. Currently, Medicare rules limit AWVs to once every 365 days. This can create scheduling challenges for ACOs working to bring patients in for AWVs earlier in the year to identify potential health concerns before they become more severe and to conduct AWVs in advance of cold and flu season, when clinics have less capacity for wellness services.

Current law allows CMS to waive certain Medicare FFS requirements in accountable care models, enabling providers to operate with fewer restrictions which reduces provider burden and encourages greater patient engagement in care through care delivery innovation. For instance, the telehealth waiver expands access to care for patients by allowing patients to engage in virtual care appointments. This benefits patients who are older or have conditions that make it challenging to travel and allows patients to reduce indirect care costs like transportation and childcare by staying home. However, the availability and implementation of waivers vary by model. MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility stays.

Participants in Innovation Center ACO models have had access to additional waivers including the post discharge home visit waiver, care management home visit waiver, tailored Part B cost sharing support, and others. While Congress established the Beneficiary Incentive Program (BIP) in MSSP to provide cost sharing support for primary care services, it lacks flexibility to tailor the program to the needs of an ACO's population, making it extremely costly and burdensome to implement, and preventing uptake. Tailored Part B cost sharing support waivers tested in Innovation Center models allow ACOs to target specific populations that may otherwise not seek high-value preventive care services due to financial barriers. Cost sharing waivers are also an important means to addressing inequities in care delivery, which go well beyond just economic concerns.

Key Considerations

Participants noted that traditional Medicare beneficiaries currently have no incentive to select a primary care provider and may not understand why it would be beneficial. This was seen as a significant barrier in connecting beneficiaries with a primary care team. Another key barrier identified is beneficiary copays for certain high-value services, including chronic care management (CCM), transitional care management (TCM), and new community health integration (CHI) services. Participants believed that enabling ACOs to waive cost sharing for such services would be an incredibly meaningful tool to incentivize behavior change and would promote more equitable health outcomes.

Patient and consumer advocacy representatives described the current waivers and requirements as the antithesis to person-centeredness, noting that it does not seem like any beneficiaries were engaged in the design of the tools. Accountable care representatives highlighted that ACOs' overall goals are to deliver better care for their patients and support providers in doing so. However, while these waivers are supposed to help achieve that goal, there has been little improvement to available waivers in the permanent program since MSSP was implemented, and challenges with voluntary alignment have rendered it an ineffective tool to eliminate patient churn and increase engagement.

There was consensus among participants that the design of these tools is not person-centered; the requirements make it difficult for beneficiaries to understand what benefits they are eligible for and limit the ability of providers to employ tools and effectively engage patients in care. Waivers need to be implemented in a simplified way that is easy for providers and consumers to understand. Simplification and upfront beneficiary engagement in the design would promote person-centeredness.

Recommendations

Improvements to how voluntary alignment is operationalized would better engage beneficiaries in primary care, increase transparency, and enable providers to understand and manage their attributed populations. To do this, CMS should:

- Improve voluntary alignment such that patients align to an individual clinician versus a practice location. For example, allowing TIN-NPI participation would ensure beneficiaries are aligning to the provider of their choice, rather than to a practice location.
- Provide information to beneficiaries on how to select a primary care provider when they enroll in Medicare and explain why this is beneficial to their care. Provide information on how beneficiaries can access a patient navigator who can help to connect them with a primary care provider.
- Provide ACOs with information on which individual providers their assigned patients are attributed to.
- Provide an exception to allow for home-based primary care providers to discuss voluntary alignment with their patients.

In addition to strengthening patient engagement in care by better facilitating voluntary alignment and the provision of AWVs, CMS should standardize and streamline waivers. CMS has been historically limited in their use of waivers in MSSP, which limits available waivers and effectiveness of waivers as implemented. Waiver implementation should be more streamlined, and ACOs should have maximum flexibility to determine how to implement these benefits for their populations. To increase the positive impacts of tools and waivers on beneficiaries served by these models, CMS should:

- Establish a set of core waivers applied uniformly across all total cost of care models, with additional waiver options available for certain advanced models/tracks.
- Allow ACOs to waive cost-sharing for key high-value services including care management, wellness visits, and health equity-focused services such as CHI and principal illness navigation, which will improve access to care and promote health equity considerations. Over time, ACOs should be required to stratify data on the utilization of these services by demographic factors to ensure equitable engagement.
- Allow ACOs to waive the 365+1-day rule for AWVs and package education about ACOs and voluntary alignment with AWV reminders.
- Create a process to accept public nominations for waivers. A transparent process for adding new waivers would increase ACOs' flexibility to meet the needs of their populations and enable CMS to engage with patients and caregivers in the design and implementation of key tools for innovating care delivery and engaging beneficiaries in their care.

Beneficiary Participation and Input in ACO Governance

Background and Challenges

CMS currently requires MSSP ACOs to include a Medicare beneficiary who is served by the ACO to participate on the ACO's governing body. However, ACOs face several challenges identifying and recruiting beneficiary representatives. Many beneficiaries lack the expertise and background knowledge of health care payment structures and operations necessary for full engagement in board discussions. ACO beneficiaries may also lack the time and resources to participate due to their age and/or health status. While ACO REACH requires that beneficiary representatives have full voting rights on governing bodies, this is not a requirement for MSSP ACOs, further limiting beneficiary influence and participation.

MSSP also includes patient-centeredness criteria that require ACOs to describe how they intend to partner with community stakeholders to improve the health of their beneficiaries, such as by including a stakeholder organization on its governing body. Currently there is a lack of guidance and resources for ACOs looking to establish partnerships with community organizations.

Key Considerations

Participants agreed that having a beneficiary representative on an ACO governing body is necessary but not sufficient to effectively engage and incorporate beneficiary perspectives and feedback throughout the ACO's initiatives and operations. Many topics discussed during board meetings are not relevant to beneficiaries and they can struggle to follow along with the substantial health care jargon. Educational programming both to beneficiary representatives to ensure they are informed and prepared and to ACO boards on how to work with the representative may encourage more fruitful participation and engagement.

Participants noted that many ACOs leverage other forums to solicit beneficiary feedback. For example, patient advisory councils provide opportunities to more effectively and frequently engage with beneficiaries and to dive deeper into relevant topic areas. Participants also discussed ideas around how CMS could support ACO engagement with beneficiaries and community-based organizations (CBOs) such as through community care hub collaborations.

Part of the challenge with the existing requirements is the rigid, one-size-fits-all approach that hinders ACOs' ability to appropriately tailor to their populations. While we encourage CMS to modernize and refine existing policy, we also recognize there must be flexibility in the marketplace. Throughout the discussion, participants identified key areas where additional guidance or supports are needed. These best practices should remain as such, rather than becoming program requirements. CMS should leverage interpretive guidance and ACO education to address certain program aspects that support beneficiary engagement. For example, CMS could partner with other organizations like HCTTF, NAACOS, or the Learning and Action Network to provide education to ACOs to encourage working with patient and family advisory councils, leveraging community health needs assessments, and incorporating other sources of patient input beyond an individual beneficiary board representative.

Recommendations

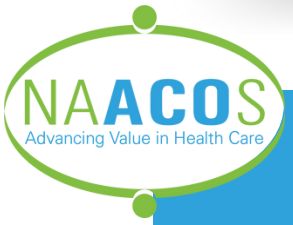
Several ideas discussed by participants are suggested best practices for ACOs, rather than recommended policy changes. Best practices for recruiting and engaging ACO beneficiary representatives can be found in this resource. Participants identified the following recommendations for updating policies on beneficiary participation and input to better align with patient engagement goals. CMS should:

- Modify the MSSP shared governance requirement such that the beneficiary representative must have voting rights.
- Allow caregivers to serve as beneficiary representatives, this may ensure representation of beneficiaries with complex needs and allow caregivers to share their contributions.
- Provide guidance to ACOs on engaging the broader patient community in decision-making and program development. Guidance should include how to reimburse the patient community and community-based organizations for the services they provide.
- Provide guidance to ACOs on appropriate compensation for beneficiary board representatives, including clarification that compensation for beneficiary board representatives does not qualify as "inducements" given the beneficiary must be a patient served by the ACO.

Conclusion

Alternative payment models aim to improve beneficiary outcomes by paying for care differently and giving providers tools to redesign care. To achieve this aim, patients must be at the center of all aspects of the payment model. Unfortunately, in recent years discussion on the success of APMs has overly focused on cost savings. To recenter beneficiaries in the conversation on APMs, NAACOS and HCTTF took this step to identify opportunities to improve patient engagement and person-centered approaches in ACOs, the largest and longest running APM. We believe many of these recommendations can be principally applied to other models tested through the Innovation Center or value-based care arrangements across payers. Additionally, the participants developing these recommendations recognize that these recommendations are an initial first step and more work needs to be done to educate consumers, patients, and their advocates about what alternative payment models and value-based care means to them and why they should engage.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.



The National Association of ACOs (NAACOS) represents more than 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models. NAACOS is a member-led and member-owned nonprofit of more than 470 ACOs in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost.

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Roundtable Participants

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Katie Boyer
agilon health

Casey Korba
Aledade

Karen Johnson
American Academy of Family Physicians

Melanie Phelps
American Heart Association

Brandon Wilson
Community Catalyst

Staci Lofton
Families USA

Jeff Micklos
Health Care Transformation Task Force

Charlotte Burnett
Health Care Transformation Task Force

Liz Adler
Integra Community Care

Jeanne DeCosmo
MedStar Health

Tori Bratcher
Trinity Health

Aisha Pittman
National Association of ACOs

Alyssa Neumann
National Association of ACOs

Sarah Coombs
National Partnership for Women & Families

Alan Balch
National Patient Advocate Foundation

Melissa Medeiros
Premier, Inc

Richard Doane
Premier, Inc

Appendix

Leveraging Other Programs

While improving requirements for Medicare ACOs is critical, there are opportunities to learn and draw from accountable care programs with other payers. Many ACOs have value-based contracts with payers outside of traditional Medicare, which may include requirements to engage beneficiaries or incorporate community input in different ways. ACOs can draw from these various forums to solicit feedback from a more diverse and representative group of beneficiaries and community members.

Patient and Family Advisory Council/Committee (PFAC)

While improving requirements for Medicare ACOs is critical, there are opportunities to learn and draw from accountable care programs with other payers. Many ACOs have value-based contracts with payers outside of traditional Medicare, which may include requirements to engage beneficiaries or incorporate community input in different ways. ACOs can draw from these various forums to solicit feedback from a more diverse and representative group of beneficiaries and community members.

Community Advisory Council

Similar to PFACs, Community Advisory Councils can offer a broader perspective by including diverse voices. These groups are typically comprised of representatives from community-based organizations (CBOs), local nonprofits and faith-based organizations, public health and social services, consumer advocacy groups, or other leaders that understand the community's needs and can provide expertise. ACOs may be able to leverage Community Advisory Councils that have been established by their affiliated hospitals or health systems for feedback, rather than duplicating efforts.

Community Health Needs Assessments (CHNA)

Nonprofit hospitals are required to conduct CHNAs and implement strategies to meet community needs on a regular basis in order to maintain nonprofit status. These CHNAs must include input from individuals who represent the broad interests of the community served by the hospital facility, including those with public health expertise and members of medically underserved, low-income, and minority populations in the community. Hospitals are required to make CHNA reports widely available. Therefore, whether or not an ACO includes a nonprofit hospital in its network, it can utilize information from the CHNA reports of the hospital(s) in its community.

Community Care Hubs

The Accountable Health Communities (AHC) Model provides a framework for connecting diverse stakeholders to align community resources to meet the needs of local beneficiaries. Participants in the Alignment Track acting as bridge organizations (AKA community care hubs, community conveners, etc.) work to foster cross-sector partnerships in the community to identify and address beneficiaries' health related social needs (HRSNs). By connecting health systems, service providers, local health departments, funders, and community members, these organizations can drive alignment around a shared vision for addressing community needs. ACOs can collaborate with local community conveners to drive community connections and broader patient engagement.

Relevant Resources

Several organizations have engaged in work to enhance person-centeredness in accountable care models. The following resources may be relevant to interested parties:

From the Health Care Transformation Task Force:

- Consumer Engagement and Education in Health Care Transformation
- Stories from the Field: Implementing Principles of Person-Centered Care
- Person-Centered Care as a Cornerstone of Value-Based Payment: Five Guiding Principles
- Organizational-Level Consumer Engagement: What It Takes

From the National Association of ACOs:

- ACOs & Patients: Care Focused on Individuals
- Recruiting & Engaging Patient Representatives: Foundations & Best Practices for ACOs
- Survey Results: ACO Patient Engagement Strategies

From the National Partnership for Women & Families:

- Patient & Family Engagement: Improving Health and Advancing Equity
    - Recommendations for Researchers, Health Care Providers and Decisionmakers
- Transforming Health Care to Achieve Equity: Centering Consumer Priorities in Value-Based Payment Reform
- Key Terms & Resource Directory for Equity-Centered Payment Reform

From Community Catalyst:

- Supporting Meaningful Engagement Through Community Advisory Councils

From Families USA:

- A Pro-Consumer Policy Agenda to Achieve Meaningful Health System Transformation
    - The Picture of Health: A Pro-Consumer Blueprint for Health Care Payment and Delivery Reform (webinar)

From the Health Care Payment Learning & Action Network:

- Guidance for Health Care Entities Partnering with Community-Based Organizations