MEDICAID ADVISORY COMMITTEE

December 10th

9:00 a.m. – 12:00 p.m.

Department of Transportation Building, Room 240
355 Capital St. NE.
Salem, OR 97301

Public listen - only conference line: 888.398.2342
Committee Member only access code: 5341639
Webinar registration link

Time	Item	Presenter
9:00	Opening Remarks • Approval of minutes – September 2014	Co-Chairs; Committee
9:10	Oregon Health Authority • Update on the Oregon Health Plan (OHP) and Coordinated Care Organizations (CCOs)	Rhonda Busek, OHA
9:25	Creating Empowered Oregon Health Plan Members • Doctor Visit Planning Tool	Leslie Sutton, Oregon Self Advocacy Coalition; Ross Ryan, Consumer
10:00	Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon	Peter Graven, OHSU
10:30	BREAK	
10:40	Children's Health Insurance Program in the Affordable Care Act Coverage Landscape • Premium assistance policy and implementation considerations	Co-chairs; MAC staff
11:45	Public Comment or Testimony	Co-Chairs
11:55	Closing comments	Co-Chairs
12:00	Adjourn	Co-Chairs

Materials

1. Agenda
2. Doctor Visit Planning Tool
3. Report: Impacts of the ACA on Insurance Coverage in Oregon (Sept. 2014)
4. Brief on Program Design and Implementation Considerations for CHIP Premium Assistance in Oregon
5. RWJ Brief: Individual and Family Engagement in Medicaid

Next meeting:
January 28th, 2014
9:00 a.m. – 12:00 p.m.

General Services Building
1225 SE Ferry St.
Mt. Mazama Room
Salem, OR 97301

Doctor Visit Planning Tool

Fill out the top half of this form before you go to the doctor

Why did you come to the doctor today?

_____

_____

_____

Do you have any questions about your medication?

_____

_____

_____

What else would you like to talk to your doctor about today?

_____

_____

_____

Ask your doctor to fill out the bottom half of this form during your appointment

Date: _____ Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____

What steps should I follow to improve my health?

_____

_____

What else should I do for my health?

Schedule:

- ☐ Yearly wellness exam
- ☐ Eye Exam
- ☐ Dental screening
- ☐ Mammogram
- ☐ Colonoscopy
- ☐ Immunization
- ☐ Other: _____

Get a screening for:

- ☐ Alcoholism
- ☐ Mental well-being
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Sexually transmitted infection
- ☐ Other: _____

Lifestyle change:

☐ Exercise more ☐ Eat healthier foods ☐ Stop smoking ☐ Other: _____

Is anyone hurting you? Yes ☐ No ☐

Is anyone stealing from you? Yes ☐ No ☐

Do you like your support workers? Yes ☐ No ☐

Do we need to review what we talked about? Yes ☐ No ☐

Oregon Council on Developmental Disabilities

Oregon Self Advocacy Coalition

Oregon Health & Science University
University Center for Excellence in Developmental Disabilities

September 2014

Impacts of the Affordable Care Act on Health Insurance Coverage In Oregon

OREGON HEALTH & SCIENCE UNIVERSITY
OHSU
Oregon Health Authority
shadac
STATE HEALTH ACCESS DATA ASSISTANCE CENTER
State Health Reform Assistance Network
Charting the Road to Coverage

Executive Summary

Between October 2013 and April 2014 access to health insurance in Oregon expanded in two ways leading to unprecedented changes in insurance coverage in Oregon. First, the state extended Medicaid coverage to many previously ineligible low-income adults. Second, the state created a health insurance marketplace that provided a resource where individuals could learn what they are eligible for, explore financial assistance options available to them, and compare commercial plans.

Researchers from the Oregon Health & Science University (OHSU) and the Oregon Health Authority (OHA), in consultation with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, analyzed the impact of these policies on health insurance coverage, shown in Table 1, with a key objective of estimating the number of uninsured individuals in Oregon after the policy changes.

The major findings of this report are as follows:

- Between June 30, 2013 and June 30, 2014, the **number of uninsured Oregonians fell by approximately 348,000 individuals**, or approximately 63 percent.

- This decline in the number of uninsured was driven in large part by the Medicaid Expansion, which saw **participation in the Oregon Health Plan increase by over 360,000 individuals**, or 59 percent.

- We also observed a **20 percent increase in participation in private non-group health plans**, primarily coming through Cover Oregon, the health insurance exchange.

- Increased access to public and non-group insurance was partially offset by **2 percent declines in enrollment in large and small group plans** (including Associations/Trust plans).

Table 1. Shifts in Oregon Health Insurance Coverage

	Number of people			Percent of population	
	June 30, 2013	June 30, 2014	Percent Change	June 30, 2013	June 30, 2014
Type of insurance					
Private					
Group	1,894,438	1,847,500	-2.5%	48.2%	46.6%
Non-group	180,883	217,563	20.3%	4.6%	5.5%
Total, Private	2,075,321	2,065,063	-0.5%	52.8%	52.1%
Public insurance					
OHP and Other Medicaid Programs	613,782	975,717	59.0%	15.6%	24.6%
Medicare	690,962	718,940	4.0%	17.6%	18.1%
Total, Public	1,304,744	1,694,657	29.9%	33.2%	42.8%
Uninsured					
Uninsured	550,000	201,794	-63.3%	14.0%	5.1%
Total population	3,930,065	3,961,514			

Introduction

A key objective of the Affordable Care Act (ACA) was to increase health insurance, and the legislation included a number of measures to accomplish this goal. For example, carriers are no longer allowed to deny coverage on the basis of pre-existing medical conditions, and most individuals are now required by law to have coverage or be subject to a tax penalty. The ACA also provided the possibility for states to make Medicaid available to more people. Oregon took action to leverage these measures so that, starting January 1, 2014, the maximum number of people could have access to health insurance. In Oregon (as in many other states) access to health insurance was expanded by extending Medicaid coverage to many previously ineligible adults with income less than 138 percent of the federal poverty line; and second, through the establishment of a health insurance marketplace where consumers would be able to purchase private insurance plans and receive income-based financial assistance.

Oregon was one of 27 states to accept federal funding to expand access to the Oregon Health Plan (OHP), the state's Medicaid program. Oregon also received a waiver from the Centers for Medicare and Medicaid Services that allowed for a "Fast-Track" enrollment. OHA pre-screened and recruited Medicaid qualified participants of the Supplemental Nutrition Assistance Program (SNAP) and parents of children enrolled in the OHP. Fast-Track enrollment complemented other outreach efforts and by the second quarter of 2014 OHP enrollment had increased by approximately 360,000 individuals, compared to a year earlier.

Cover Oregon was established as the state's health insurance marketplace. While technical challenges prevented individuals from enrolling online in one sitting, other means, including a manual application process implemented with the Oregon Health Authority, use of agents and community partners, and an extended open enrollment period allowed nearly 80,000 individuals to find coverage through the marketplace; and where they were determined to be eligible, Cover Oregon also directed consumers to OHP. Through April 2014, 80 percent of these consumers received tax credits and cost-sharing subsidies.[1]

While increased Medicaid enrollment and marketplace participation suggest growth in coverage among the previously uninsured, information on the uninsured population typically comes from population surveys such as the Current Population Survey (CPS), the American Community Survey (ACS), or the state-sponsored Oregon Health Insurance Survey (OHIS). However, the earliest of these will not be available until the second half of 2015. To provide a more timely assessment of the impact of the ACA on health insurance coverage (and account for shifts between types of coverage), analysts with the Oregon Health & Science University (OHSU) and the Oregon Health Authority (OHA) collected health insurance enrollment data from commercial and public payers for June 30, 2013 and June 30, 2014. Using a method developed by, and in consultation

with, the State Health Access Data Assistance Center (SHADAC), these data provide snapshots of Oregon's coverage landscape. The two points in time capture the impact of the Medicaid expansion, the extended open enrollment period associated with Cover Oregon, and other ACA and non-ACA factors that may have influenced access to health insurance. This report describes the methods used to calculate the size of the uninsured population and shows the changes in enrollment across types of coverage in Oregon.

Methodology

The methodology used for this analysis is adapted from a method developed by SHADAC to estimate the impact of the ACA on coverage in Minnesota and is similar to a technique that has been used by the State of Minnesota to estimate the distribution of health insurance for more than a decade.[2] This approach accounts for the health insurance coverage status of the state's entire population at two points in time. It uses information from private and public payers on the number of residents enrolled in their health plans, survey data on the uninsured, and population estimates to show gains and losses in coverage. The model has been adapted to accommodate Oregon data sources, which are different from those available in Minnesota.

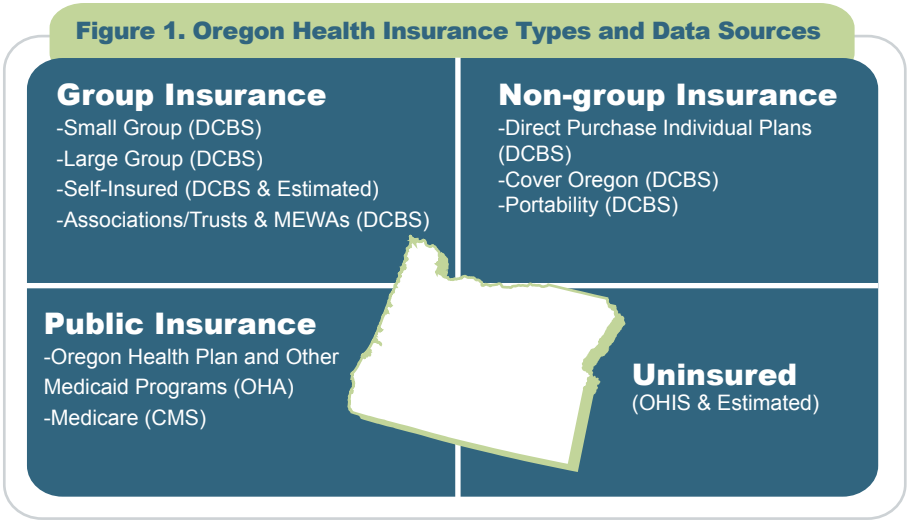
The analysis starts with the total population of the state at each point in time and then accounts for the number of people with each type of health insurance coverage for which data are available. These types of coverage are listed in Figure 1.

Data Sources

The primary source of coverage information for commercial carriers comes from the Oregon Department of Consumer and Business Services (DCBS). Insurers, certain Oregon Public Entities, and licensed Third Party Administrators (TPA) are required to submit information regarding the number of Oregon lives covered by individual or group insurance products on a quarterly basis; information which is then available to the public.[3] Carriers report enrollment by market segment: large group, small group, Associations/ Trusts and Multiple Employer Welfare Arrangements (MEWAs), individual policies (including, after 2014, those purchased through Cover Oregon), and some self-insured medical plans

Overview: SHADAC Method

1. Assemble data by coverage type at two points in time
2. Estimate unknown sources of coverage in time period 1 as residual from total population
3. Estimate growth in this piece from time 1 to time 2
4. Compare gains and losses by type of coverage to estimate change in uninsured population between time 1 and time 2



(specifically, those for which the insurer or TPA provides administrative services).

DCBS is a unique resource, relative to other states, for information regarding commercial insurance coverage. However, there are two important caveats about these data. First, individual carriers are sometimes late to submit. As of this printing, there were only a handful of late reporters and their combined market shares, based on previous quarters' filings, amount to less than one percent of observed enrollment. Nevertheless, our estimates adjust for these missing reporters.[4] Second, all submitted reports are subject to revisions. While these have been typically minor, in 2014 the reporting format was modified (primarily to accommodate marketplace enrollment) and these changes were associated with some confusion and subsequent revisions among reporters in the first-quarter data. The data used for this analysis covers second quarter of 2014 and these issues appear to have been largely worked out, but nonetheless the figures may be revised at a later date.[5]

Information on enrollment in state Medicaid programs comes from OHA. Medicare information comes from the monthly Medicare Advantage State/County Penetration Reports, prepared by the Center for Medicare and Medicaid services (CMS).[6] Individuals who had dual eligibility for both Medicare and Medicaid programs were excluded (but left in the Medicare totals), to avoid double counting.[7] In addition, Medicaid eligibility redetermination may result in revisions to monthly eligibility totals.[8] The 2014 Medicaid enrollment figure is adjusted for the forecasted impact of redetermination, but it may be revised.

The baseline estimated number of uninsured individuals living in Oregon comes from the 2013 Oregon Health Insurance Survey (OHIS), for which approximately 9,000 households completed interviews between January and May of that year. In addition to detailed questions on health insurance coverage, other topics included access to and utilization of health care.

Total Population comes from the U.S. Census Bureau.[9] Oregon's population was estimated to be 3,930,065 as of July 1, 2013, the most recent figure available. The average three-year growth rate (0.8 percent) was used to forecast the state-wide population for July 1, 2014.

Estimating Gaps in Data Availability

Self-insured plans that are not administered by an insurer or third party administrator are not required to report to DCBS.[10] Therefore, only a portion of total enrollment in self-insured plans is observed.[11] To estimate the unobserved portion in 2013, we sum enrollment in all other coverage types—including the uninsured—and subtract this number from the total population. The residual, those without a coverage designation, are assumed to be enrolled in unregulated self-insured plans.[12]

This imputed self-insurance estimate is adjusted for coverage that switched from the un-regulated to regulated self-insurance coverage type over the period. This adjustment assigns 50 percent of the change in observed self-insured to be due to switches from the unobserved category. The 50 percent parameter is estimated by analyzing carrier level data and assuming 3% of any carrier-level growth is due to new enrollment and that growth in excess of that is due to switches of entire employer groups from the unobserved category. The imputed self-insurance number is also adjusted for changes in the number of people with Medicaid and commercial coverage.[13]

Health Insurance Coverage in Oregon

The number of uninsured individuals in 2013 was estimated to be approximately 550,000, or 14 percent of the total population. Using this baseline and the SHADAC method, we estimate that the number of uninsured individuals in Oregon declined to roughly 202,000 in June 2014, or 5.1 percent of the population. This represents a decrease

Figure 2. Percent Change by Type of Insurance 2013:Q2 - 2014Q2

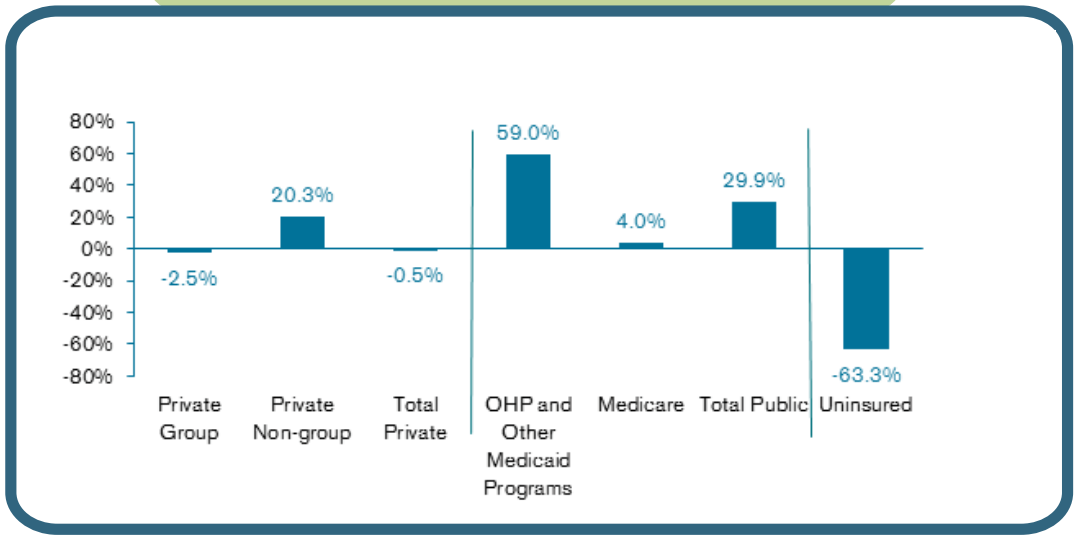


Table 2. Shifts in Oregon Health Insurance Coverage

Type of insurance	Number of people June 30, 2013	Number of people June 30, 2014	Difference	% Change	Percent of population June 30, 2013	Percent of population June 30, 2014
Private						
Group						
Small group	193,323	175,410	-17,913	-9.3%	4.9%	4.4%
Large group	651,666	634,872	-16,794	-2.6%	16.6%	16.0%
Self-insured, DCBS reporters	740,960	790,564	49,604	6.7%	18.9%	20.0%
Self-insured, imputed	162,096	128,518	-33,578	-20.7%	4.1%	3.2%
Associations & Trusts	146,393	118,135	-28,258	-19.3%	3.7%	3.0%
Total, Group	1,894,438	1,847,500	-46,938	-2.5%	48.2%	46.6%
Non-group						
Direct purchase	167,308	140,994	-26,314	-15.7%	4.3%	3.6%
Cover Oregon	0	76,569	76,569	NA	0.0%	1.9%
Portability	13,575	0	-13,575	-100.0%	0.3%	0.0%
Total, Non-group	180,883	217,563	36,680	20.3%	4.6%	5.5%
Total, Private	2,075,321	2,065,063	-10,258	-0.5%	52.8%	52.1%
Public insurance						
OHP and Other Medicaid Programs	613,782	975,717	361,935	59.0%	15.6%	24.6%
Medicare	690,962	718,940	27,978	4.0%	17.6%	18.1%
Total, Public	1,304,744	1,694,657	389,913	29.9%	33.2%	42.8%
Uninsured						
Uninsured	550,000	201,794	-348,206	-63.3%	14.0%	5.1%
Total population	3,930,065	3,961,514	31,449			

of 63 percent in the uninsured rate. This drop in the number of uninsured individuals was due primarily to the increased Medicaid enrollment and in lesser part to increased enrollment in non-group plans. Figure 2 shows changes in enrollment by type of coverage.

Table 2 presents a detailed breakdown of enrollment at the two points in time and calculates the percentage change for each type of insurance over the period.

Private Group Insurance

Small & Large Group

This category is comprised of individuals covered by fully-insured small group (less than 50 employees) and large group plans. Between June 2013 and June 2014, enrollment in small group plans fell by over 9 percent, or roughly 18,000 lives. This is in fact the continuation of a downward trend that begins in the first quarter of 2010, the first quarter for which DCBS data for this market segment is available. Enrollment in large group plans fell by

roughly 17,000 lives, but given the size of their market share (approximately 17 percent of the population, compared to just under 5 percent in small group plans) this translated into a decline of 2.6 percent for this market segment.

Self-Insured

Enrollment in self-insured medical plans is reported to DCBS by both insurers and TPAs providing administrative services on behalf of those plans. Oregon Public Entities (OPEs), such as municipalities, also report their coverage figures. Enrollment in these reported self-insured plans represents the largest source of private coverage in Oregon at roughly 20 percent. Between 2013 and 2014, participation in these reported plans increased by almost 7 percent.

Participation in self-administered self-insured plans for 2013 is imputed as the difference between the total population and the sum of enrollment in observed sources and the number of uninsured individuals. In 2013, this amounts to approximately 162,000 individuals, or 4.1 percent of the total population. To arrive at a total for 2014, this estimate is adjusted downward from the initial estimated number to account for plans that switched to using an insurer or TPA.[14] It is also adjusted for dual coverage in Medicaid and commercial plans, which will make it appear too large.

Associations/Trusts and MEWAs

The smallest segments of private group coverage are the Association/Trusts and MEWA plans. These are plans established by two or more unrelated employers in order to provide health and other benefits to employees who are not subject to collective bargaining agreements. Enrollment in these plans experienced the greatest proportional decline in enrollment, from 146,000 to 118,000 covered lives, a drop of almost 20 percent.

Private Non-group Insurance

Non-group coverage includes individual plans purchased either directly from the carrier or through Cover Oregon. Carriers report enrollment in these plans to DCBS according to their origination. In 2013, nearly 170,000 individuals were covered by direct purchase plans. By 2014, overall enrollment in individual plans, whether purchased inside or outside of the exchange, grew by 20 percent to a combined total of 217,000 lives. As of June 30, 2014, Cover Oregon had generated nearly 77,000 new enrollments.

Portability plans provide coverage to individuals under certain conditions such as switching jobs or retiring.[15] In 2013, enrollment in these plans was just under 14,000 individuals, or 0.3 percent of the population. With the implementation of the insurance exchange and the ACA prohibition on coverage denial for pre-existing conditions, this type of plan ceased to operate in Oregon.

Public Insurance

Oregon Health Plan, Other Medicaid Programs and Medicare

Between 2013 and 2014, enrollment in state coverage increased nearly 60 percent, or roughly 360,000 individuals. This represents, by far, the largest

enrollment increase among each of the market segments, and, as of June 2014, nearly a quarter of the total population is covered by state-administered health insurance. Medicare Fee-for-service (FFS) and Medicare Advantage account for roughly 18 percent of the total population. Enrollment for this segment increased by 4 percent, or approximately 28,000 lives, between 2013 and 2014.

Discussion

The insurance numbers in this report are based on an approach using administrative data sources. These sources are updated more quickly than traditional survey methods. Oregon is one of only a few states that collect comprehensive health insurance enrollment information from its insurers and TPAs. These data sources make it possible to implement this approach with a greater degree of confidence than would otherwise be possible.

The primary limitation of the study methodology relates to the accuracy of two assumptions needed for the calculation. First, the approach implicitly assumes the percentage of people with multiple forms of commercial coverage is consistent over time.[16] Due to the structure of the model, if this percentage increases in 2014, the uninsured rate will be higher than reported. Similarly, if the percentage decreases in 2014 compared to 2013, the uninsured rate will be lower than reported here. Second, the imputed self-insured estimate assumes that 50 percent of the increase in DCBS-reported self-insured enrollment comes from (imputed) unregulated self-insured plans (primarily those that are self-administered). This percentage was based on observed enrollment changes by carrier. Due to the structure of the model, if the percentage is higher than 50 percent, the uninsured rate will be larger than reported. Similarly, if the percentage is lower than 50 percent, the uninsured rate will be smaller than reported.

These estimates show a significant drop in the number of uninsured individuals in Oregon. This change is driven by the substantial increase in enrollment in the Oregon Health Plan as well as the increase in private non-group coverage through Cover Oregon. The modest decline in enrollment in private group plans offset these gains.

While there are no other estimates for Oregon that are limited to the period after open enrollment, Gallup reported that between 2013 and the first half of 2014, the average uninsured rate among all adults (18 and over) in Oregon had fallen by 5.4 percentage points, from 19.4 to 14 percent.[17,18] At the national level, the Urban Institute reported that, over the same time period covered by our analysis, the uninsured rate among non-elderly (18 to 64) adults fell from 18.5 to 13.9 percent, a 4.6 point drop. The drop of 8.9 percentage points from this study in Oregon is reflective of the fact that Oregon led the nation in the percentage increase in enrollment in its Medicaid program.[19]

Acknowledgements

Several people provided valuable assistance with the data and analysis: Elizabeth Klicker at DCBS; Richard Gonzalez at Cambia Health Solutions, and Chris Coon, Steven Broich, Cindy Lacey, Kimberly Yee, Sata Hackenbruck, and Kim Mounts, all with the Oregon Health Authority. Gretchen Morley and Russell Voth, formerly of OHA, also provided valuable feedback.

ENDNOTES

[1]Department of Health and Human Services. "Addendum to the Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period." Accessed August 28, 2014 at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollAddendum.pdf

[2] http://www.shadac.org/MinnesotaCoverageReport

[3] http://www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx

[4] We adjust for missing carriers using the enrollment they reported for the previous quarter.

[5] Data reported here were accessed on September 10, 2014.

[6] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

[7] The 2014 number is preliminary estimate of total coverage, reported enrollment is adjusted to account for the anticipated effect of later verification and redetermination processes.

[8] As determined by the Forecasting Unit of OHA. In Oregon, individuals must reapply for medical assistance on a yearly basis. Redetermination refers to the process by which each month the eligibility of any number of Medicaid enrollees is reevaluated. Some members may have their coverage ended at that time if they are determined to be no longer eligible, for example because of an increase in income. Others who fail to respond in time also have their benefits terminated. Disqualified individuals may reapply and, if found eligible, their benefits are reinstated. Moreover, those who submit information within 90 days of their closure date may have benefits restored back to the day after closure (ultimately resulting in no break in coverage). In this way monthly enrollment totals are subject to revisions after the fact.

[9] U.S. Census Bureau, Population Division. "Table 1. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013 (NST-EST2013-01). December 2013. Accessed June 30, 2014 at http://www.census.gov/popest/data/state/totals/2013/index.html

[10] Specifically, self-insured, self-administered plans are exempt from state regulation under the Employee Retirement Income and Security Act (ERISA).

[11] Types of self-insured plans for which enrollment is reported are public entities, such as municipal governments, and those administered by a third party.

ENDNOTES

[12] In other words, the estimated number of people covered by self-insured plans is the number that are "left over" after accounting for all other categories (including the uninsured). Importantly any errors or imprecision in the other coverage types are captured in this category.

[13] Because dual coverage tends to make the imputed self-insurance number appear large, due to the residual method described above, we subtract from it an amount equal to the increase in people with dual coverage. This amount is estimated by applying the dual coverage rate between commercial and Medicaid (1.8%), calculated from the APAC data in 2013 to the combined enrollment in commercial and Medicaid plans in 2014. The dual coverage is converted into persons by dividing by 2 and subtracting from the imputed self-insurance number.

[14] This adjustment assigns 50% of the increase in the DCBS reported self-insured as losses from the imputed category. The 50% figure was calculated by analyzing carrier-level changes in self-insurance enrollment and assuming growth of 3% would be considered normal and any increases above that amount could be attributed to entire groups switching their self-insurance type.

[15] Not included separately are state- and federally-financed high risk pools. These were administered by a commercial insurer and as a result, enrollment in these plans is included in the DCBS individual category.

[16] Analysis of APAC data suggests that the number of people with multiple sources of commercial coverage (aside from those with Medicaid and commercial plans, who are accounted for) is low, roughly 4 percent among all individuals with any commercial coverage, and consistent over time. SHADAC, reviewing the survey data from the Survey of Income and Program Participation, found the rate to be closer to 2 percent.

[17] Gallup. "Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate." Accessed August 28, 2014 at http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx

[18] The Gallup estimates represent the average uninsured rate over different six month periods, as opposite to point-in-time estimates presented here. Therefore the results are not directly comparable.

[19] As of April, 2014. Department of Health and Human Services. "Medicaid & CHIP: April 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report." Accessed on 9/12/2014 at http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/April-2014-Enrollment-Report.pdf

State Health Reform Assistance Network
Charting the Road to Coverage

SB 1526: Program Design and Implementation Considerations for CHIP Premium Assistance in Oregon

INTRODUCTION

States have the flexibility to offer premium assistance programs using public funds through Medicaid and the Children's Health Insurance Program to subsidize private coverage.[i] Resulting from passage of Senate Bill 1526 (2014), the Oregon Health Authority (OHA) has been charged with examining the feasibility of offering premium assistance in Oregon's Children's Health Insurance Program (CHIP), for children in families with incomes between 200-300% of the federal poverty level (FPL).[ii]

With implementation of the Affordable Care Act (ACA), public and private health coverage options for children and families have changed, with implications for consumer access, benefit coverage, and affordability. The coverage landscape for low-income children includes Medicaid, the Children's Health Insurance Program (CHIP) and subsidized qualified health plans (QHPs) through the Marketplace. The latter potentially offer an alternative coverage source to children in families currently covered in CHIP between 138%-300% FPL. The ACA's individual mandate to obtain coverage may also lead to additional enrollment in employer-sponsored insurance (ESI) by families with children now enrolled in CHIP. This brief provides an overview of key policy and implementation issues in providing premium assistance to CHIP-eligible children.

Highlights

Key policy issues for premium assistance in CHIP for:

Consumers:

- Ensure voluntary participation and choice
- Foster whole family coverage
- Safeguard consumer out-of-pocket costs and affordability

Benefit Coverage and the Health System:

- Guarantee comparable CHIP benefit coverage
- Participation by health plans and overlap in provider networks
- Differences in provider reimbursement in Medicaid and commercial plans
- Impact on quality and accountability

Implementation:

- Requires federal and state authority
- Complexities with program administration
- Program cost-effectiveness and budget neutrality
- Outreach and education

As Oregon contemplates the feasibility of using federal CHIP funds to subsidize commercial insurance for children, there are two main commercial coverage options available[1]: QHPs and ESI. Either approach would shift children from public to private coverage. In enacted, approximately 17,000 children from 200%-300% FPL now enrolled in CHIP, approximately one-third of the state's CHIP population would have the option to enroll in to commercial coverage.

---

[i] See Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, Final Rule. Federal Register/Vol. 78, No. 135 / Monday, July 15, 2013 (codified in title 45 of C.F.R.).

[ii] OHA is required to report its findings and any recommendations for legislation to the Senate Interim Committee on Health Care and Human Services no later than March 2015.

PROGRAM DESIGN CONSIDERATIONS

There are several issues and design parameters to consider regarding premium assistance for the CHIP population between 200%-300% FPL. In general, the structure of premium assistance programs creates a partnership between the government, commercial markets, health systems, and consumers to provide health care for beneficiaries. Several key issues affecting these groups are discussed below.

CONSUMERS

Voluntary Participation and Choice. Any premium assistance program must ensure that families with eligible children would have a choice to participate in premium assistance until they age out at 19, and be able to move back into direct CHIP coverage at any time.

Mixed Family Coverage. Under the ACA, a family may be eligible for different insurance programs—Medicaid, CHIP, Marketplace or ESI—referred to as "mixed" family coverage. Depending on carrier participation and provider network overlap in Medicaid and commercial markets, offering premium assistance to CHIP eligible children may help support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type.

*Cost-sharing and Affordability***.** Oregon families with children enrolled in CHIP do not pay premiums or cost sharing on behalf of their children. To ensure children in premium assistance do not have greater out-of-pocket costs than those with direct CHIP coverage, the state or carrier would have to wrap consumer out-of-pocket costs to the extent that they exceed CHIP levels. The state must also ensure that the total costs of premiums and cost sharing for a child does not exceed 5% of the family's income, per federal regulations.

Parents with children enrolled in CHIP may be eligible for subsidized QHP coverage through the Marketplace. While Oregon's CHIP does not impose premiums, it is important to examine the ramifications of doing so, if Oregon contemplates using consumer premiums as a mechanism to reduce state costs in a premium assistance program. In states with CHIP programs that have premiums, parents enrolled in QHPs would thus be required to pay premiums for their QHP coverage as well as premiums for children enrolled in CHIP. The could potentially result in an increase in the total percentage of family income required for insurance coverage, and exceed the maximum percentage of income allowed for Marketplace subsidized coverage, otherwise referred to as "premium stacking."

A 2014 study by Wakely Consulting Group [2] identified the most significant impact for CHIP enrollees transitioning to QHPs was a substantial increase in estimated out-of-pocket costs at the point of care (deductibles, copays, and/or coinsurance), which is similar with premium assistance through ESI coverage.[3] Annual cost sharing in QHPs is considerable higher relative to the $0 cost sharing in Oregon's CHIP program. Further, the financial impact to CHIP enrollees transitioning to QHPs is especially pronounced for children with special health care needs who would likely reach the out-of-pocket maximum for cost sharing in a year.[4]

DRAFT

The following table compares the actuarial value[iii], average out-of-pocket costs (copayments, deductibles and coinsurance) and out-of-pocket maximums for children enrolled in CHIP compared to the coverage that would be available through the Marketplace in Oregon (with cost sharing reduction subsidies up to 250% FPL). The figures assume enrollment as an individual in the lowest cost silver plan. Member out-of-pocket costs are capped for coverage under both CHIP and plans offered on the Marketplace, limiting the financial exposure to families.[iv] Member out-of-pockets costs would also have to be capped for ESI offerings.

Table 1. Actuarial Value, Average Cost Sharing and Out-of-Pocket Maximum

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Average Annual Cost Sharing	$0	$411-$480	$0	$891-$960
Out-of-Pocket Maximum	$0	$1,250	$0	$5,000

Note: Wakely estimated the annual cost sharing for each state's CHIP plan using the actuarial value calculated for a standard population reflected in the 2015 Federal Actuarial Value Calculator. Their analysis assumed no difference in provider discounts negotiated by CHIP insurers or QHPs, which may be material. Estimates for the average annual cost sharing for QHPs used the national QHP premium averages for 2014 in states with a Federally-Facilitated Marketplace (FFM).

BENEFIT COVERAGE AND HEALTH SYSTEM

*Benefit Coverage***.** States have flexibility, within federal guidelines, to define the benefits covered by both CHIP and QHPs. Plans under both programs are generally required to provide basic services such as the core services described below. In general, state CHIP programs often provide more comprehensive benefit coverage than found in commercial health plans.[5,6] In Oregon, CHIP beneficiaries have access to full Medicaid benefits under the Oregon Health Plan (OHP) including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services mandated for children in Medicaid.

In the absence of a specific waiver, state premium assistance programs must provide "comparable coverage" to direct CHIP benefits, which often entails providing wraparound coverage to fill in gaps between commercial and CHIP benefits. Oregon's former CHIP premium assistance program, Healthy Kids Connect, phased out in 2013, found this requirement challenging over time as fewer and fewer plans met the benchmark[v] in order to participate in the program, i.e. individuals could only receive premium subsidies for plans that met the benchmark.

[iii] Actuarial value represents the share of health care expenses the plan covers for a typical group of enrollees.
[iv] Oregon's CHIP program does not require copays for its vision and dental services, whereas QHPs generally require 35% coinsurance after a deductible on routine vision exams (except for children age 3-5/6 depending on FPL) as well as on eyeglasses. Compared to CHIP, QHPs do not offer dental checkups as part of their EHBs.
[v] Per federal regulations, the benefit benchmark had to be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

The 2014 Wakely study[vi] also compared CHIP to QHP benefits (assuming enrollment as an individual in the lowest cost silver plan) across core and child-specific domains. Core benefits are those that are typically included in a major medical insurance policy. Child-specific benefits reflect additional services important when considering children's medical needs. See Table 2.

Table 2. Benefit Coverage Categories

Core Benefits	Child-Specific Benefits
1. Physician services	1. Dental – Preventive & Restorative Services
2. Clinic services & other ambulatory health care services	2. Dental Orthodontic
3. Laboratory & radiologic services	3. Vision – Exams
4. Durable medical equipment & other medically-related remedial devices	4. Vision – Corrective Lenses
5. Inpatient services	5. Audiology – Exams
6. Inpatient mental health services	6. Audiology – Hearing Aids
7. Surgical Services	7. ABA Therapy
8. Outpatient Services	8. Autism – General
9. Outpatient Mental Health Services	9. Physical, Occupational , and Speech Therapy
10. Prescription Drugs	10. Podiatry
11. Emergency Medical Transportation	11. Habilitation
	12. Enabling Services
	13. Non-emergency Medical Transportation
	14. Over-the-Counter Medications

Wakely found that benefits available through Oregon's CHIP program were considerably richer than those available through the QHPs in the Marketplace. Table 3 summarizes the coverage limits of core and child-specific benefits in Oregon's QHPs in 2014 compared to more robust coverage in CHIP.[vii]

Table 3. Benefit Coverage and Limits

	Total Benefits	CHIP			QHPs (Based on EHB)		
		Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	71%	29%	0%	29%	29%	43%

*Health Plans, Provider Networks and Reimbursement***.** The state would need to consider what kinds of private coverage it is willing to subsidize with CHIP funds (e.g. individual coverage in and out of the Marketplace, ESI small and large group). Oregon data from 2012 (prior to the ACA's coverage expansions, namely Medicaid and the Marketplace), indicate

[vi] Ibid.

[vii] Please refer to the full Wakely report for methodology, assumptions, and limitations for each comparison, and Appendix B, State-Specific Results for Oregon for more detail on benefit and consumer cost-sharing comparisons.

that 48% of children were covered through ESI, 5% were covered by non-group insurance, 39% were in Medicaid or CHIP, and 7% were uninsured.[7] In Oregon, health plan participation in Medicaid and the commercial markets varies regionally. Of the 21 carriers participating in either the individual or small group markets, eight of them are also partners in a Medicaid CCO.[8] In other words, provider participation and contracts between Medicaid/CHIP and the commercial markets may vary. Lastly, enrollment in Medicaid CCOs could decline if CHIP children enroll in private coverage through premium assistance, potentially affecting the risk pool.

Provider reimbursement would be affected as commercial plans generally reimburse providers at higher levels than in Medicaid or CHIP. Offering premium assistance for QHP or ESI coverage to a segment of Oregon's existing CHIP eligible children could provide enhanced reimbursement to providers relative to CHIP payment rates. This could affect access to care, regionally, and to specialty services due to higher provider participation rates in commercial plans. [9,10] However, if that higher reimbursement leads to higher per member per month (PMPM) charges, that would increase costs to the state.

*Quality and Accountability***.** Quality and accountability are cornerstones of Oregon's health system transformation. The ability for Oregon to monitor quality and access for children's health care is well established in Medicaid. Quality measures are used by OHA to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations they serve. Oregon and CCOs are held accountable through 33 performance measures, 17 of which are incentive metrics; with approximately 1/3 assessing the quality of children's health in OHP. A similar accountability and quality infrastructure is not currently in place, statewide, in the commercial market.

*Commercial Market Trends***.** Recent national analyses on premium assistance programs indicate that commercial market trends are moving in the opposite direction for premium assistance to expand capacity.[11,12] States examined in these analyses were found to experience a general decline in availability of ESI and increase in employee cost sharing, challenging the cost effectiveness requirement of their premium assistance program. Also noted was the increase in high deductible health plans and similar products that are less comparable to Medicaid and CHIP coverage.[13,14]

IMPLEMENTATION CONSIDERATIONS

Timing and Authority. Implementation of a premium assistance program would likely not begin until 2016. OHA would need approval from CMS and the legislature to establish and administer the program. Premium assistance authority, whether achieved through the state plan option and/or a demonstration waiver, would depend on the program's design.[15] In other words, implementation timing for any premium assistance program is determined by its scope and complexity.

Program Administration. The state would need to ensure administrative capability and capacity for eligibility and enrollment determinations, as well as customer support for the population served. There may also be added administrative burden to the state and/or insurance carriers in tracking and monitoring children to ensure they receive comparable benefit coverage and pay no more than 5% cost sharing as a percent of family income.

Financing. Premiums assistance programs must be cost-effective.[viii] Historically, these programs have been funded by federal/state CHIP dollars, employer contributions, and premium contributions by families.[16] Per federal regulations the cost to the state of covering an individual through premium assistance, including administrative costs, must be the same or less than providing "comparable coverage" to the individual in the direct CHIP program.[17] Additionally, if premium assistance is implemented through a demonstration waiver, the program must be "budget neutral," meaning that the federal government's costs must not exceed what they would have been without the premium assistance demonstration.[18]

If premium assistance were to cost the state more than covering an individual in the direct CHIP program, the state may need to identify additional funding sources for the program. In 2013, Oregon's premium assistance program for CHIP eligible children from 200%-300% FPL, Healthy Kids Connect, was funded by approximately 21% state general fund, 6% other funds, and 73% federal CHIP matching funds.[19] The federal match rate for Oregon's CHIP program in 2015 will be 74.84%.

Outreach and Education: Outreach and education is also critical for creating program awareness and providing assistance to the target population, participating carriers, employers, community partners, and other stakeholders. Historically, the Information, Education, and Outreach (IEO) unit (closed as of Jan 2014) aided the premium subsidy programs by providing education, presentations, and trainings at enrollment events, employer job fairs, insurance producer continuing education courses, and by training the state staff. IEO also marketed program information through several mediums, including posters, flyers, brochures, radio and television, to create program awareness. Ultimately, the IEO unit helped eligible beneficiaries enroll and stat in the program and assisted employers in providing subsidized health insurance to their eligible employees and their families.

CONCLUSION

There is a range of issues that Oregon policy makers need to address as they consider options that could alter the mix of public and private coverage for low-income children. These include access to services, benefit coverage and comparability, consumer affordability, market dynamics and trends, and federal cost-effectiveness requirements.

---

[1] Urban Institute and Kaiser Commission on Medicaid and the uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).

[2] Wakely Consulting Group. Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans. July 2014.

[viii] See P.L. 111-3 §301 and P.L. 111-148 §10203(b)(1).

[3] McMorrow, S., Kenney, G., Anderson, N. et. al. (2014). Trade-offs between public and private coverage for low-income children have implications for future policy debates. *Health Affairs,* 33(8), 1367-1374.
[4] Wakely Consulting Group. July 2014.
[5] Benefits and Cost Sharing in Separate CHIP Programs. May 2014.
[6] Wakely Consulting Group. July 2014.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).
[8] Overlap Among Carriers Participating in Oregon's Health Insurance Market. 9.26.2014 Materials, 2014 Coordinated Care Model Alignment Workgroup.
[9] Oregon 2012 Physician Workforce Survey. (Unpublished)
[10] McMorrow, S., Kenney, G., Anderson, N. et. al. (2014).
[11] Kaiser Commission on Medicaid and the Uninsured (2013, March). Fact Sheet Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act.
[12] Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., Kenward, K. (2014). Health benefits in 2014: Stability in premiums and coverage for employer-sponsored plans. *Health Affairs, 33(10), 1851-1860.*
[13] Kaiser Commission on Medicaid and the Uninsured (2013, March).
[14] Claxton, G., Rae, M., Panchal, N., et al.. (2014).
[15] Kaiser Commission on Medicaid and the Uninsured (2013, September). Medicaid Expansion through Marketplace Premium Assistance: Fact Sheet.. September 2013.
[16] Premium assistance programs: how are they financed and do states save money. The. Issue paper, October 2005.
[17] Kaiser Commission on Medicaid and the Uninsured (2013, March).
[18] Kaiser Commission on Medicaid and the Uninsured (2013, September).
[19] Office of Private Health Partnerships Governor's Balanced Budget 2013-2015. OHA Presentation to the Human Services Legislative Sub-committee on Ways and Means. February 13, 2013.

DRAFT

Robert Wood Johnson Foundation

NOVEMBER 2014

Individual and Family Engagement in the Medicaid Population: Emerging Best Practices and Recommendations

Prepared by the Institute for Patient- and Family-Centered Care—Mary M. Minniti, Marie R. Abraham, and Beverley H. Johnson

Introduction

Engagement, broadly defined, is an active partnership among individuals, families, health care clinicians, staff, and leaders to improve the health of individuals and communities, and to improve the delivery of health care. Collaborative individual and family engagement is an important strategy for developing a patient- and family-centered system of care.[1] Research shows that engaged individuals and families actively working with their health care teams have better outcomes, often choose less expensive options when participating in shared decision-making, and express greater satisfaction with their health care experiences.[2]

The Institute for Patient- and Family-Centered Care (IPFCC) outlines action-oriented recommendations and strategies to support enhanced individual and family engagement efforts in Medicaid. Specific suggestions for leaders in Medicaid agencies, their staff, and organizations serving these populations include:

1. Advance individual and family engagement best practices as a strategic priority within the Medicaid agency.
2. Expand opportunities for individuals and families to engage with Medicaid staff and managed care entities to influence policies, programs, and practices.
3. Support direct care service providers in acquiring the knowledge and skills to develop effective partnerships with individuals and families.
4. Encourage and support individuals and families in engaging more fully in their health and with their health care team.

While there are no magic formulas or quick fixes for improving health care and care delivery, there is a growing body of knowledge regarding what works to foster engagement of individuals and families, and what does not.

Individuals who were interviewed by IPFCC stated a preference for the label "individuals" rather than "patients," since the term patient is only one of many roles they have. For this reason, the term individual engagement, rather than patient engagement, is used in this brief. In recognition that many who receive Medicaid services are under the age of eighteen, this brief also includes family engagement. Evidence shows that engaging families improves care and leads to better outcomes and satisfaction in both the pediatric and adult populations.[3]

Individual and family engagement occurs at four levels:

- **At the clinical encounter** in direct care, care planning, and health care decision-making.
- **At the practice or organizational level** in quality improvement and system redesign.

ABOUT THE INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

Founded in 1992 as a nonprofit organization, the Institute for Patient- and Family-Centered Care (IPFCC) works to advance the understanding and practice of patient- and family-centered care in all settings where individuals and families receive health care and support. The core concepts of patient- and family-centered care include respect and dignity for all; the sharing of unbiased information in useful and affirming ways; encouraging and supporting participation in care decision making to the level a patient and their family choose; and collaboration in program development, implementation,and evaluation of health care services. IPFCC has worked collaboratively with many national organizations to advance the practice of patient- and family-centered care, and to support the development of mutually beneficial partnerships with patients and families. Patient and family engagement is a key strategy to create a patient- and family-centered health system.

ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years, the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

- **At the community level** in bringing together community resources with health care organizations, individuals, and families.
- **At the policy level** in setting public policy locally, regionally, and nationally.

Engagement is a complex phenomenon and requires the health care programs, as well as the individuals and families served by the programs, be open to creating a trusting relationship based on shared goals. Successful engagement also requires a change in mindset and behaviors for many Medicaid leaders, health care professionals, individuals, and families.

Individual and family engagement strategies seek to create mutually beneficial partnerships that enhance health, well-being, and the management of chronic conditions, and by doing so, improve the cost-effective delivery of patient- and family-centered care. Research shows that patients who lack the skills to manage their health care incur costs 8 to 21 percent higher than those of patients who are highly-engaged in their care, even after adjusting for health status and other factors.[4] Similarly, research studies assessing an individual's level of activation using Insignia Health's Patient Activation Measure™, have shown that 60 percent of Medicaid patients fall into the lower levels of activation.[5]

For engagement in the care experience to be mutual and sustained, interactions need to be authentic and intentional. They also should take into account the preferences, strengths, beliefs, and culture of the patient and his or her family. For engagement at the clinic, community, program, and/or policy level, organizational leaders must believe that the "lived experience"[6] of individuals and families can inform health care transformation and improvement. Providing opportunities for meaningful partnerships with individuals and families requires a commitment by Medicaid leaders and health care professionals. Mechanisms must be in place so that the input and perspectives of Medicaid beneficiaries are sought out, listened to, and acted upon.

Methodology

To develop these recommendations, IPFCC utilized a two-pronged approach that included a targeted literature review and in-depth interviews. The literature review helped determine what characteristics, strategies, and tools are associated with effective individual and family engagement in Medicaid settings. IPFCC conducted interviews with Medicaid beneficiaries and their family members, as well as state agency representatives, clinicians, researchers, and innovative program leaders. Additionally, IPFCC spoke with representatives of managed care plans in states that have adopted Medicaid engagement strategies in order to better understand how different engagement approaches are operationalized. For a full list of interviewees, see Appendix A.

The interviews provided IPFCC insights about successful approaches to individual and family engagement, and how to address challenges. Since these recommendations reflect the viewpoints of Medicaid providers, beneficiaries, and administrators, they are grounded in what is possible and sustainable. In addition, the authors recruited engagement experts to serve as steering committee members and reviewers for this brief. For a full list of advisors, see Appendix B.

Overcoming Roadblocks

Engagement is created through collaborative relationships and requires changes in behavior by health care professionals, as well as patients and families.[7] Given the diversity and unique challenges of the Medicaid population, effective individual and family engagement strategies require a respectful, strength-based approach that is systematically applied with flexibility and persistence, in addition to dedicated resources. Health care system barriers, as well as challenges faced by the individuals receiving care, serve as roadblocks to engagement. Examples of deterrents to the development of successful partnerships include:

- Messages from Medicaid agencies, health plans, and providers are often overly complex and use jargon, thereby creating confusion and stress for many individuals and families.
- Despite best intentions, some health care service organizations and Medicaid agency personnel utilize practice styles and systems that discourage active engagement.
- Many providers are unaware of the impact that health literacy[8], trauma, and other social factors have on an individual and his/her family's ability to reliably and consistently engage in their own health.
- Within most communities and health care organizations, individuals and families aren't prepared to take an active role in health care decision-making and behavior change.
- Evidence-based interventions that are collaborative and strength-based—such as coaching for patient activation, motivational interviewing[9], shared-decision making, self-management support, and peer-to-peer support—are not readily available or effectively integrated into most care settings.

> "Patients, families, and their advocates increasingly understand the wisdom of this partnership. Too often, standing in the way is the health care system itself—whether by intention or not—because of its fragmentation, paternalistic professional culture, abundance of poor process design, and lack of experience on the part of health care leaders and clinicians with practical methods of engaging patients."
>
> —The National Patient Safety Foundation's Lucian Leape Institute, 2014.[10]

Effective engagement initiatives involving Medicaid agencies, providers, and the community exist and can serve as models to address common roadblocks to engagement. This brief describes Oregon's successful engagement initiative, and provides other examples of successful programs in the recommendations section that follows. In addition, visit *http://www.ipfcc.org/advance/topics/medicaid-engagement.html* for additional resources and examples.

Oregon: A Case Study

Individual and family engagement efforts in Oregon highlight the collaborative work of Oregon's legislature, the Oregon Health Authority (OHA), state Medicaid Advisory Committee (MAC), Northwest Health Foundation, CareOregon, community groups, and care providers.

Over time, individuals representing the Medicaid population have become progressively more involved with the OHA's work on policy and program implementation. OHA established task forces to advance patient-centered primary care homes, to explore best practices in patient and family engagement, and, more recently, to promote individual responsibility and health engagement. Increasingly, individuals and families in Oregon have been included as equal members of these influential OHA task forces. MAC undertook a project to explore issues around person- and family-centered care. They invited a broad range of experts, including individuals and families, to inform the committee on how best to engage the Medicaid population. OHA adopted, and is implementing, a series of MAC recommendations including the development and use of a "multidimensional framework for individual and family engagement in Oregon" included in Appendix C.[11]

OHA also worked collaboratively with the Northwest Health Foundation to support the development of the Patient-Centered Primary Care Institute (PCPCI),[12] which brings together technical experts, providers, staff, patient advisors, policymakers, academic centers, and other stakeholders to share valuable practice transformation knowledge and resources. PCPCI provides webinars, on-site coaching, and learning collaborative events for primary care clinics throughout the state to help them achieve patient-centered primary care home recognition.

Through legislative mandates, Oregon has developed requirements for meaningful participation of community advisory councils (CACs) with the Medicaid coordinated care organizations (CCOs). CACs are groups of 16 to 20 individuals selected to represent a geographic area and whose role is to work closely with their CCO on services, coverage, and evaluation of Medicaid services. According to state legislation, 51 percent of the membership of each CAC must be comprised of clients or family members receiving Medicaid services. The remaining members generally tend to be community representatives from public health, disability services, or other agencies who work with individuals served by Medicaid.

OHA also created the Transformation Center[13] to capture the learnings gleaned by the CCOs and to widely disseminate best practices in health system transformation, including the engagement of individuals, families, and communities. In May 2014, the OHA Transformation Center hosted the first statewide, in-person gathering for Community Advisory Councils. CACs from around the state gathered to share successes, learn together, and support each other in health system transformations.

CareOregon, a Medicaid managed care organization, established a member advisory council in 2010. The recruited council members first participated in a variety of educational activities that included learning about the role of advisory councils, meeting other advisors from across the country, and participating in a class to understand group dynamics and meeting facilitation. The advisory council subsequently improved internal processes for CareOregon, helped to expand dental coverage, and began to create partnerships in the broader health care community. In collaboration with clinicians and staff, they developed the *Better Together* guide to help CareOregon members prepare for clinic visits. Advisory council members are passionate about outreach on preventative health care, partnership with health care providers, and self-management support. Their conversations with the Oregon legislature influenced the establishment of CACs and the mandate to include Medicaid beneficiaries in the creation and ongoing operations of CCOs.

Other innovative local programs developed across Oregon to better engage individuals in care include:

- The Willamette Valley Community Health Marion-Polk Obstetric Mentoring Service (MOMS) program provides support and care to pregnant women struggling with substance abuse. Services include outreach mentors, weekly contact with a peer mentor, and coordination of care utilizing a team including the mentors and public health nurses. The services of the peer mentor, a mom who participated in the program and experienced success, is key to engaging these women. The peer mentor develops empathetic, authentic relationships with program participants, and helps them build their skills, knowledge, and confidence to have a healthy birth and end the cycle of substance abuse in their families. As one MOMS program participant noted in her interview, "No one had tried to engage me before. I had been homeless for several years. I had looked for help and been turned away. I didn't have

any hope. The outreach worker found me and gently said she noticed I was pregnant and wondered if I would like to know about a program that could help me. I wasn't doing well. Soon, I had a mentor who met with me weekly. She had been where I was. She didn't judge me and knew about resources that could help me have a healthy drug-free baby. That meant a lot to me." Since its inception 332 infants (99.4 percent) of enrolled MOMS participants tested negative for illegal drugs at birth.

- CareOregon created the health resilience specialist role to collaborate with primary care clinics in encouraging individuals to stabilize and improve their health. The health resilience specialist is based in a primary care clinic setting and performs outreach to individuals identified as high utilizers of health services, and who have complex medical and mental health/substance use disorder needs. Functioning as a liaison between the primary care clinic, specialty medical clinics and other community/social services, the specialist sees individuals in their homes and other community settings. The health resilience specialist also builds the knowledge and skills of all clinic staff on topics important to engagement efforts, such as motivational interviewing and trauma-informed care. Preliminary data shows a reduction in inpatient and emergency department visits among high utilizers engaged by health resilience specialists.

Recommendations and Key Action Steps for Medicaid Agencies

Based on this research, IPFCC has practical, action-oriented recommendations for Medicaid agencies seeking to engage individuals and families in improving their health and the health care system. By implementing specific action steps within four broad categories of recommendations, Medicaid leaders will achieve significant and positive change in individual and family engagement.

> "[Engagement] can begin with simple information-sharing, move on to dialogue, and evolve into a partnership. Whatever form it takes, engagement changes the focus, from taking action to improve health and health care for the people, to taking action with the people—a simple yet radical notion."
>
> —Report of the Patient and Family Engagement Work Group 2013, World Innovation Summit for Health.[14]

1. Advance Individual and Family Engagement Best Practices as a Strategic Priority Within the Medicaid Agency.

Medicaid leaders should initially focus on making internal changes that promote effective and sustainable individual and family engagement within the Medicaid agency.

Medicaid agencies should:

- Create a strong and cohesive strategic plan for individual and family engagement within the agency, and a means to achieve this vision through operational activities linked to the strategic plan.
- Appoint an executive sponsor or "champion" within the Medicaid leadership team responsible for overseeing the execution of the strategic plan. The champion will communicate the value of partnerships with internal and external constituencies, remove system barriers, and oversee measurable progress.
- Provide resources and incentives to educate agency staff partnering with individuals and families in their health care in an effort to improve health care for all. Training topics should include best practices in patient activation, cultural competence,[15] trauma-informed care,[16] health literacy, and patient- and family-centered practices including patient-centered communication.
- Establish clear directions for leaders to act as role models for staff, including actively participating in forums with individuals and families serving as Medicaid advisors.

Medicaid advisors in this context are individuals and families who partner with agency staff in improving Medicaid programs and services. These advisors are individuals or family members of individuals who receive, or have received, Medicaid services. Advisors offer agencies input into patient care and organizational processes and advocate on individual and family needs from a broad perspective. As one Medicaid agency leader noted during an interview, "To build these partnerships [with individual and family advisors], we have to demonstrate we will do what we said we'd do. This is hard work and it's important that we listen, demonstrate empathy, and, at times, agree to disagree. In the beginning it takes more time, but we're making better decisions in partnership with our advisors. Significant policy changes around contracting services based on client participation in task forces are being achieved."

2. Expand Opportunities for Individuals and Families to Engage with Medicaid Staff and Managed Care Entities to Influence Policies, Programs, and Practices.

For an engagement initiative to be successful, the Medicaid agency must create and broaden opportunities for individuals

and families to have meaningful dialogue and partnerships on a variety of policies, programs, and practices. To apply lessons from best practices of engagement within health care delivery settings Medicaid leaders should:

- Assign a staff liaison who supports advisors in partnership roles, and creates formal and informal mechanisms for individuals and family members to collaborate with Medicaid staff to improve policies, programs, and practices.[17]
- Offer training and mentorship opportunities that prepare individuals and families to serve as effective advisors with the agency and its related care contractors.
- Reduce financial barriers to engagement in advisory activities by providing individual and family advisors with small stipends to cover transportation or child/respite care costs.
- Develop opportunities for individuals and families to participate in the improvement and ongoing evaluation of the services, processes, and policies of the organization. Consider communication and information technology strategies—such as client portals, websites, automated text, and calling systems—as good beginning areas for collaborative endeavors.
- Create explicit expectations that Medicaid managed care and other contracted entities meaningfully engage individuals and family members as advisors, mirroring the actions taken by the agency.

An advisor who is the parent of a Medicaid beneficiary commented during an interview, "I am hopeful that my participation will result in positive change. My questions have helped staff realize how their messages, although well-meaning, are complex and confusing to parents juggling complex care for their children. Over time, we'll see how the information we've shared will help others in the system."

States can also look to Colorado for emerging best practices regarding engagement. Building on recommendations from a 2012 report, the Colorado Department of Health Care Policy and Finance (DHCPF), which administers the state's Medicaid program, instituted a new focus on the role of effective communication, and is expanding new processes for individual and family involvement. DHCPF identified an executive sponsor, established a person-centered approach project team made up of key staff, and hired an individual- and family-centered care project manager who acts as an engagement liaison and staff resource. To build effective engagement strategies and competence, education and training plans for all DHCPF employees are underway. The project manager is working with Medicaid units that need support to involve clients in benefits design, obtaining clients' input on key initiatives, and preparing clients and others to serve as advisors.

DHCPF changed its organizational structure to accommodate new roles and responsibilities to support this level of engagement. It is also exploring a formal recruitment and "on-boarding" process for advisors. Finally, Colorado Medicaid leaders are actively supporting cultural transformation efforts related to engagement, and they are participating in venues seeking individual and family input.

3. Support Direct Care Service Providers in Acquiring the Knowledge and Skills to Develop Effective Partnerships with Individuals and Families.

Individual and family engagement is achieved across the diverse Medicaid population when direct care service providers demonstrate skills in cultural competency, health literacy, motivational interviewing, trauma-informed care, patient-centered communication,[18] patient activation and coaching skills, and individual and family engagement. To promote engagement activities in direct care environments, Medicaid agencies should:

- Explore partnerships with community organizations, foundations, or others to create technical assistance resources for direct care providers and staff to expand their knowledge and skills.
- Promote the adoption of shared decision-making tools by identifying and reducing barriers to implementation in direct care organizations.
- Disseminate evidence-based best practices for individual and family engagement by hosting webinars and workshops for providers and staff.
- Offer coaching for providers on-site that builds competency in self-management support and the key engagement skills.
- Provide enhanced payment and/or non-monetary incentives, such as recognition of direct care sites that have created opportunities for ongoing engagement of individuals and families.

In developing engagement strategies, Medicaid agencies should consider the approach and experience of "Team Up for Health," a California HealthCare Foundation initiative to advance self-management support in five safety net clinics and one primary care/multispecialty group practice. This project provided the clinics and group practices with technical assistance to further individual and family engagement at three levels—in individual care, in quality improvement at the organizational level, and in expanding use of community resources. Each organization received support to partner with individuals and families through communication and collaborative skills coaching geared toward improving the direct care experience and creating advisory programs. This initiative resulted in tools, developed

by individual and family advisors, to maximize a primary care visit.

In the project's evaluation, clinic leaders, clinicians, and staff emphasized the positive value of partnering with individuals and families. As one "Team Up for Health" participant commented during an interview, "Patient and Family advisors—culturally this was a change to the organization. The value they brought has been huge." Similarly, another participant observed, "We did not expect how much of a difference the patient advisors would make." Since this effort, The Center For Care Innovations and others have provided technical assistance to safety net clinics and group practices, building on the lessons learned about effective engagement at all levels of care.

4. Encourage and Support Individuals and Families to Engage More Fully in Their Health and with Their Health Care Team.

To increase individual and family engagement in direct care, Medicaid agencies, in concert with contracted managed care entities, direct care organizations, and involved community organizations, should:

- Collaborate with individual and family advisors to create messages and informational materials that explicitly welcome Medicaid clients as valued members of their own care team, and that encourage them to involve their families in their care.
- Inform individuals, families, and the community about concepts like shared decision-making and self-management, and routinely invite them to actively engage in their care and with their care providers at the level they choose. Offer incentives for their participation in these activities.
- Provide infrastructure and/or training to ensure that individuals and families have access to evidence-based peer support and peer-led self-management programs, such as the Living Well with Chronic Conditions Program in Oregon,[19] which is based on the Stanford Chronic Disease Self-Management Program.
- Invite individuals and families, through a variety of mechanisms, to share their stories of how they successfully partnered with their care team to improve their health and health care, and disseminate these examples broadly to inspire others.

In Minnesota, the Mayo Clinic developed a set of shared-decision making tools that employ user-centered design. Implementation of these tools has helped facilitate important conversations between patients and providers about treatment choices. More importantly, according to Mayo Clinic staff, these tools have helped patients from disadvantaged populations more actively participate in the care decision-making process.[20]

Several *Aligning Forces for Quality* (AF4Q) communities implemented a Patient Partner program, where patients serve as members of their ambulatory care practice's quality improvement leadership team. Patient Partners know firsthand about the challenges patients face in managing chronic diseases, as they have either managed their own chronic condition or have cared for someone with a chronic illness.[21] The perspective of patients familiar with chronic disease management has proven to be an invaluable tool for practices working with Aligning Forces for Quality—South Central Pennsylvania (SCPA). More experienced Patient Partners mentor new Patient Partners, serve on a steering committee, and help develop training materials. "Patient Partners have a great impact on patient engagement," said Christine Amy, SCPA project director. "Providers have become used to quality measures, but struggle with patient engagement. It's a different perspective entirely."

> "…the extent to which patients feel informed about their health, and confident about taking a role in their care decisions predicts their engagement independently of and more strongly than [typical differences among populations]. That suggests that clear information can help level the health care playing field across population groups."
>
> Langer Research Associates, "Empowerment and Engagement Among Low-income Californians: Enhancing Patient-Centered Care," Blue Shield of California Foundation Survey, September 2012.[22]

Conclusion

The question for state Medicaid agencies is not whether to encourage individuals, families, agency staff, and providers to embrace engagement as a means of improving health and health care, but rather *how* best to do so to achieve the greatest improvements in outcomes. Strong leadership within Medicaid programs is necessary to set the expectation that collaboration with those served by Medicaid is valued and benefits everyone. Medicaid leaders can take action to promote, support, and reward programs that create strong partnerships with individuals and families in the care experience, and improve health care. When invited to collaborate, individuals and families are often eager to help make a positive contribution.

A related challenge for Medicaid agencies and other entities implementing engagement strategies is how to measure the outcomes of patient and family engagement initiatives. Systematic measurement can shed light on the factors that encourage and sustain meaningful engagement, but there are few rigorous measures for monitoring the effectiveness of engagement specific to the Medicaid population. Without such measures, Medicaid programs will find it difficult to make timely and

appropriate changes to their engagement programs. For insight into the effectiveness of various strategies, Medicaid programs could utilize the Patient Activation Measure (PAM) for measuring activation levels before and after specific engagement initiatives. A recent report from the National Quality Forum (NQF) provides recommendations for measure development related to individual and family engagement.[23] Forthcoming work on behalf of the Centers for Medicare and Medicaid Services to identify, develop, and support implementation of electronic clinical quality measures, including individual and family engagement measures, will also inform Medicaid leaders on how best to measure and evaluate engagement efforts in the future.[24]

Across the nation, promising practices demonstrate the power of individual and family engagement in their health and in the improvement of Medicaid programs, policies, and services. As leading state Medicaid agencies have discovered, effective relationships with individuals and families are transformative for both the agency and the clients. Developing these engaged relationships in Medicaid is a journey well worth pursuing.

Appendix A: Interviewed Individuals

Francis Afram-Gyening, MBS, MPH, FACHE, *chief executive officer*, Care Alliance Health Center, Cleveland, Oh.

Steven Abramson, *marketing director*, Community Health Alliance of Pasadena, Pasadena, Calif.

Suzanne Brennan, *medicaid director*, Department of Health Care Policy & Financing, Denver, Colo.

Susan Butterworth, PhD, MS, *associate professor*, Oregon Health & Science University, and *principal*, Q-consult, LLC, Portland, Ore.

Crystal Cené, MD, MPH, *assistant professor*, University of North Carolina School of Medicine, Chapel Hill, N.C.

Cliff Coleman, MD MPH, *family practitioner*, Department of Family Medicine, Oregon Health and Science University, Portland, Ore.

Olivia Covey, *client and family centered care & engagement stakeholder liaison*, Department of Health Care Policy & Finance, Denver, Colo.

John R. Corlett, *vice president government relations and community affairs*, The MetroHealth System, Cleveland, Oh.

Tara DaVee, *community advisory council member*, Trillium Coordinated Care Organization, Springfield, Ore.

Chris DeMars, MPH, *director of systems innovation*, Oregon Health Authority Transformation Center, Portland, Ore.

Oliver Droppers, MS, MPH, *director*, Oregon Medicaid Advisory Committee, Oregon Health Authority, Salem, Ore.

Susan Edgman-Levitan, PA, *executive director*, Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital, Boston, Mass.

Rick Ellsmore, *parent*, Arvada, Colo.

Tom Ewing, MD, *chief medical officer*, PacificSource Health Plans, Eugene, Ore.

Joshua K. Graves, MBA, QMHA, *chief administrative officer*, Catholic Community Services, Salem, Ore.

Patrick Gordon, *associate vice president*, Rocky Mountain Health Plans, Denver, Colo.

Gordon J. Harvieux, MD, *pediatrician*, Essentia Health, Duluth, Minn.

Dianne Hasselman, *director of value based purchasing*, Center for Health Care Strategies, Hamilton, N.J.

Lance Hegland, MBA, *patient member state quality council*, Minnesota Department of Human Services, Minneapolis, Minn.

Judith Hibbard, MPH, DrPh, *senior researcher*, Health Policy Research Group, University of Oregon, Portland, Ore.

Libby Hoy, *executive director*, PFCC Partners, Long Beach, Calif.

Alison Hoyt, *community health engagement advocate*, CareOregon, Portland, Ore.

Nancy Judkins, *community health engagement advocate*, CareOregon, Portland, Ore.

Bebe Kleiman, MNM, *executive director*, Doctors Care, Littleton, Colo.

David Labby, MD, *chief medical officer*, Health Share of Oregon, Portland, Ore.

Lisa M. Letourneau, MD, MPH, *executive director*, Maine Quality Counts, Manchester, Maine

Melissa Lu, *certified peer support specialist*, MOMS Plus Program, Medical Foundation of Marion and Polk Counties, Salem, Ore.

Kathryn Lueken, MD, *chief medical officer*, Willamette Valley Community Health, Salem, Ore.

Shera Matthews, *practice director*, Doctors Care, Littleton, Colo.

Judith M. McClenny, *community health engagement advocate*, CareOregon, Portland, Ore.

Floyd McConney, *community health engagement advocate*, CareOregon, Portland, Ore.

Madeline Mettler, *community health engagement advocate*, CareOregon, Portland, Ore.

Doriane C. Miller, MD, *associate professor of medicine and director*, Center for Community Health and Vitality, University of Chicago Medicine, Chicago, Ill.

Victor M. Montori, MD, *director*, Health Care Delivery Research Program, Mayo Clinic Center for the Science of Health Care Delivery, Minneapolis, Minn.

Cheryl L. Nelson, Simon's Mom, Fort Collins, Colo.

Jeannette Nguyen-Johnson, MPH, *policy analyst*, Office for Health Policy and Research, Oregon Health Authority, Salem, Ore.

Annette Parker, *community health engagement advocate*, CareOregon, Portland, Ore.

Lisa Pearlstein, *health resilience specialist*, CareOregon, Portland, Ore.

Tamara Pedrojetti, *centricity and corporate event program coordinator*, CareOregon, Portland, Ore.

Marc Pierson, MD, *consultant and former executive*, PeaceHealth St. Joseph's Hospital, Bellingham, Wash.

Ed. L. Pulanco, *community health engagement advocate*, CareOregon, Portland, Ore.

Sharon Quinlan, RN, MSN, MBA, *administrator*, Department of Primary Care, Essentia Health, Duluth, Minn.

Kevin Rouse, *community health engagement advocate*, CareOregon, Portland, Ore.

Ron Stock, MD, MA, *director of clinical innovation*, Oregon Health Authority Transformation Center, Portland, Ore.

Katherine Van Woert, *co-chair*, Medicaid and Exchange Advisory Board, Shelburne, Vt.

Kate Wells, *director of community health development and coordinated care organization liaison*, PacificSource, Bend, Ore.

Stephen Wilkins, MPH, *founder*, Mind the Gap Academy and Adopt One! Challenge, San Jose, Calif.

Appendix B: Issue Brief Advisors

Issue Brief Steering Committee

Cheri Craft*, M.Ed., *director*, Smart from the Start, Boston, Mass.

Kay Dickerson*, *community health engagement advocate*, CareOregon, Portland, Ore.

Timothy F. McDonald, *principal*, Donaldson Run Consulting, LLC, Arlington, Va.

Josephine St. Clair, *retired social worker*, Portland, Ore.

* Individuals also participated in interviews

Issue Brief Reviewers

Chrissie Blackburn, *parent and principal advisor*, Patient and Family Engagement, University Hospitals Case Medical Center, Cleveland, Oh.

Dana Bright, LSW, MSW, *manager*, Medical Home Initiatives, American Academy of Pediatrics, Elk Grove Village, Ill.

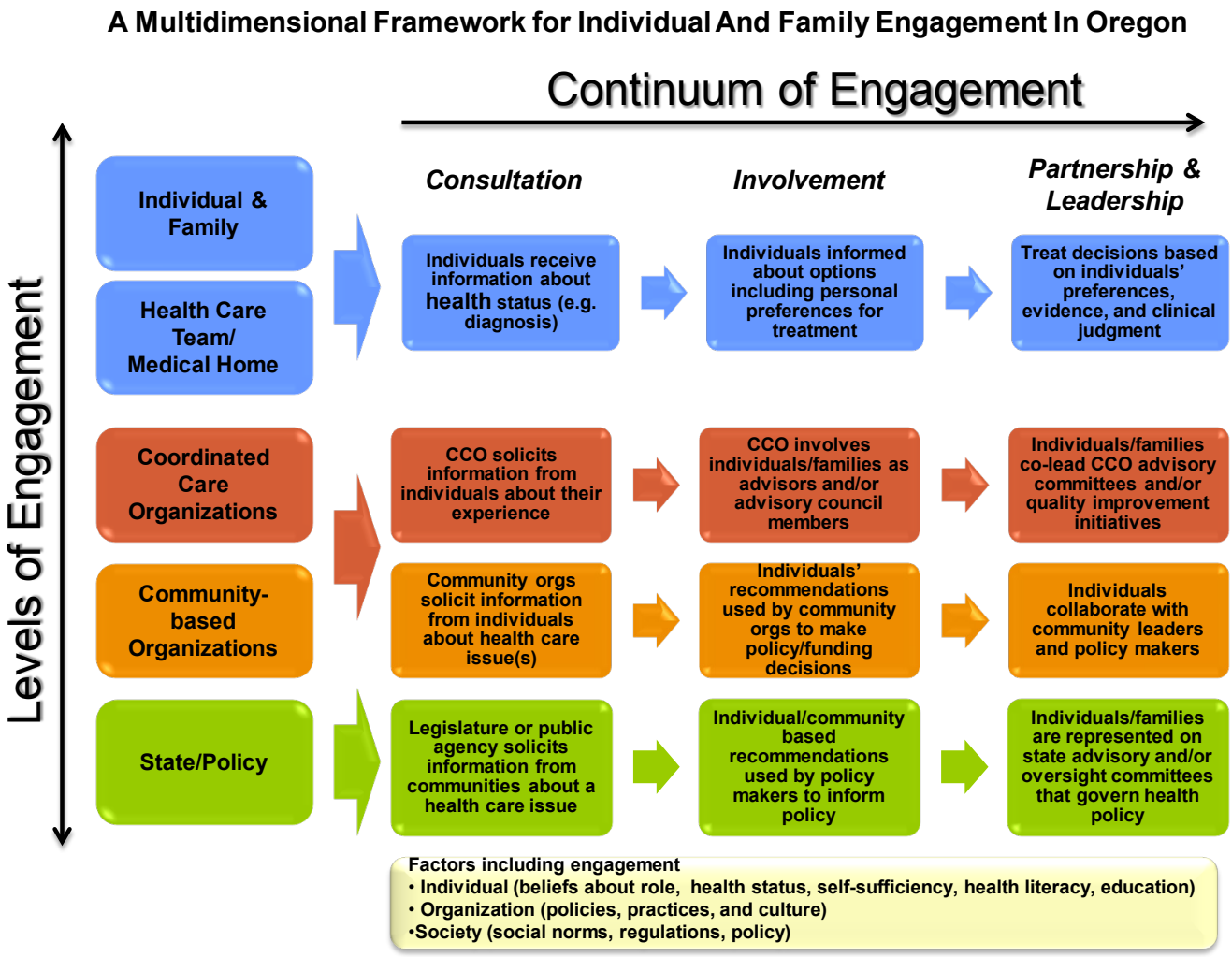
Michelle Esquivel, MPH, *director*, Division of Children with Special Needs, and *director*, National Center for Medical Home Implementation, American Academy of Pediatrics, Elk Grove Village, Ill.

Ralph Fillingame, MD, *family practitioner*, University of Oregon Student Health Clinic, and *consultant*, Patient-Centered Primary Care Home, Eugene, Ore.

Jennifer Sweeney, *director*, Consumer Engagement and Community Outreach, National Partnership for Women & Families, Washington, D.C.

Lou Terranova, *senior health policy analyst*, American Academy of Pediatrics, Elk Grove Village, Ill.

Appendix C: Multidimensional Framework for Individual and Family Engagement in Oregon



Adapted from Carman K L et al. Health Aff 2013;32:223-231

Endnotes

1. Carman KL, Dardess P, Maurer M, et al. "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies." *Health Affairs*, 32(2): 223-231, February 2013, *http://content.healthaffairs.org/content/32/2/223.full* (accessed October 2014).

2. Hibbard JH and Greene J. "What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs." *Health Affairs*, 32(2): 207-214, February 2013, *http://content.healthaffairs.org/content/32/2/207.full* (accessed October 2014).

3. Wolff JL and Roter DL. "Hidden in Plain Sight: Medical Visit Companions as a Resource for Vulnerable Older Adults." *Archives of Internal Medicine*, 168(13): 1409-1415, 2008.; Botelho RJ, Lue BH and Fiscella K. "Family Involvement in Routine Health Care: A Survey of Patients' Behaviors and Preferences." *The Journal of Family Practice*, 42(6):572-576, 1996.; Sayers SL, White T, Zubritsky C, et al. "Family Involvement in the Care of Healthy Medical Outpatients." *The Journal of Family Practice*, 23(3):317-324, 2006.; Wolff JL and Roter DL. "Family Presence in Routine Medical Visits: A Meta-Analytical Revie." *Social Science and Medicine*, 72(6); 823-31, 2011.

4. "Patient Engagement." *Health Affairs*, February 2013, *www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86* (accessed October 2014).

5. Insignia Health holds exclusive rights to PAM per a technology transfer from University of Oregon, for more information and graphics visit, *www.insigniahealth.com/solutions/patient-activation-measure (accessed October 2014)*

6. In this context, the term "lived experience" is used to describe a person with first-hand knowledge of the care experience within the context of their unique values, beliefs, perceptions, and their cultural experiences.

7. Edgman-Levitan S, Brady C and Howitt P. *Partnering with Patients, Families, and Communities for Health: A Global Imperative*. Doha, Qatar: World Innovation Summit for Health's Patient and Family Engagement Working Group, 2013.

8. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, communicate and understand basic health information and services needed to make health care decisions."; Somers SA and Mahadevan R. *Health Literacy Implications of the Affordable Care Act*. Hamilton, N.J.: Center for Health Care Strategies, Inc., 2010.

9. Motivational interviewing (MI) engages individuals to explore their change readiness and engages them in selecting behaviors they will adopt or eliminate to address their health goals. MI is evidence-based, relatively brief, specifiable, applicable across a wide variety of problem areas, complementary to other active treatment methods, and learnable by a broad range of professionals.; Miller WR and Rose GS. "Toward a Theory of Motivational Interviewing." *American Psychologist*, 64(6): 527–537, 2009.

10. Safety is Personal: Partnering with Patients and Families for the Safest Care. Boston: National Patient Safety Foundation's Lucian Leape Institute, 2014.

11. *Person- and Family-Centered Care Engagement Medicaid Advisory Committee Full Report and Recommendations*. Salem, OR: Oregon Health Authority, 2013.

12. *About the Institute*. Portland, OR: Patient-Centered Primary Care Institute, 2014, *www.pcpci.org/about-institute (*accessed May 2014).

13. *About the Transformation Center*. Portland, OR: Oregon Health Authority Transformation Center, 2013, *http://transformationcenter.org/transformation-center/* (accessed May 2014).

14. Edgman-Levitan, Brady and Howitt. A.

15. In health care, cultural competence describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs.

    Betancourt JR, Green AR and Carrillo JR. *Cultural Competence In Health Care: Emerging Frameworks And Practical Approaches*. New York: The Commonwealth Fund, 2002.

16. Trauma-informed care is an approach to care that is cognizant of the impact trauma has on an individual's ability to fully engage with others. Its goals are to develop a trusting relationship that is non-judgmental, empathetic, and supports the individual to make

choices based on his or her values, preferences, and readiness. While research indicates that mental health practitioners have greater understanding of the role of trauma in care, research indicates most other health care providers do not possess this knowledge.

Bloom SF. "Creating Sanctuary: Healing from Systematic Abuses of Power." *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations,* 21(2): 67-91, 2000.

Bloom, S and Farragher, B. *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care.* New York: Oxford University Press, 2013.

17. Minniti M and Abraham M. *Essential Allies—Patient, Resident, and Family Advisors: A Guide for Staff Liaisons*. Bethesda, MD: Institute for Patient- and Family-Centered Care, 2013.

18. Patient-centered communication aims to reduce language barriers and ensure safe, clear, and effective health care interactions, especially for vulnerable populations. Wynia M and Matiasek J. *Promising Practices For Patient-Centered Communication With Vulnerable Populations: Examples From Eight Hospitals* New York: The Commonwealth Fund, 2006.

19. *What is Living Well?* Portland, OR: Oregon Health Authority, 2014, *http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/le_workshop_info.aspx* (accessed October 2014).

20. Victor Montori, MD, *director*, Health Care Delivery Research Program, Mayo Clinic Center for the Science of Health Care Delivery, Minneapolis, Minn. Interviewed by telephone, 14 February 2014.

21. *http://forces4quality.org/node/7382* (accessed October 2014)

22. Empowerment and Engagement Among Low-Income Californians: *Enhancing Patient-Centered Care, 2012 Blue Shield of California Foundation Survey. San Francisco: Blue Shield of California Foundation, 2014, http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/empowerment%20and%20engagement_final.pdf* (accessed October 2014).

23. "*Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Person-Centered Care and Outcomes*," August 15, 2014. National Quality Forum. http://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Person-Centered_Care_and_Outcomes.aspx.

24. "*Call for Measures." Centers for Medicare & Medicaid Services, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallForMeasures.html* (accessed October 2014).