MULTI-STAKEHOLDER COLLABORATION

A Relational Roadmap Toward Whole Person Health

OPTIMIZING OUTCOMES ACROSS EMPLOYERS, HEALTH PLANS, PROVIDERS, AND PATIENTS/EMPLOYEES

A SHARED VISION OF:

National Alliance of Healthcare Purchaser Coalitions (National Alliance)

Alliance of Community Health Plans (ACHP)

UPMC Center for High-Value Health Care (the Center)

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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Introduction

Over the past several years, many stakeholders have sought to shift health ecosystems toward whole person health, **defined as a focus on a person's total well-being, including their physical, behavioral and social health—not just the presence or absence of disease.** This viewpoint recognizes that health improvement occurs through multiple interconnected biological, behavioral, social and environmental systems (collectively known as an ecosystem), and focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.[1]

The role that key stakeholders—including employers, providers, patients, families and health plan partners—can play to enhance whole person health is more important than ever, especially in the rapidly evolving environment since the 2020 start of the COVID-19 pandemic. The pandemic magnified the flaws and weaknesses in our current health ecosystems and, at the same time, highlighted an opportunity **that multi-stakeholder collaboration can play when we re-orient our ecosystems toward achieving outcomes that address the tenets of whole person health.**

Although all stakeholder groups are committed to moving our system toward goals such as high-value care and whole person health, each stakeholder defines these differently and has historically followed their own approach without understanding the full impact of their methods. This has resulted in mixed outcomes, inefficiencies in care delivery, increased costs, and barriers to optimal patient health.[2] To address this, the National Alliance of Healthcare Purchasers (National Alliance), the Alliance of Community Health Plans (ACHP), and UPMC's Center for High-Value Health Care (the Center) partnered in early 2021 to combine their unique perspectives and develop a path forward by defining mutual objectives and actions, in service of more comprehensive and disruptive progress toward whole person health.

Looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease leads to better care and lower costs.

This work was catalyzed by the National Alliance, recognizing that employers are crucial participants in multi-stakeholder collaborations. Yet there has been limited inclusion of employers, who are responsible for making decisions about the plans they offer and benefits they provide to their workforce and their families—over 180 million individuals, at a cost exceeding $4.5 billion.

Our challenges and successes throughout this initiative led us to a slightly different endpoint than initially conceived. Rather than developing a set of objectives and specific actions for stakeholders to take, we experienced an insight: That **a new kind of multi-stakeholder collaboration is needed and possible—one that can be more effective than traditional approaches.** While more research and experimentation are needed to test the conceptual model, the nature of this collaboration can lead to breakthroughs in whole person health.

This collaboration—driven by an asset-based mindset and rethinking how those assets are brought to bear through the relationships and roles that support

1 nccih.nih.gov/health/whole-person-health-what-you-need-to-know

2 nam.edu/programs/value-science-driven-health-care/multi-payer-alignment-on-value-based-care

optimized health—can disrupt the traditional siloed view of the healthcare system and replace it with a shared vision and associated actions that will result in whole person health advancements.

Rather than producing a national strategic action plan, we offer a guide for local collaborators to:

- Map available assets in their regions.
- Help align incentives within markets.
- Create the conditions for change.
- Create a sustainable mechanism for the ongoing work of changing community systems that enhance health.

Taken together, we hope this process will facilitate the production of **local strategic action plans** that move communities and regions down a collaborative path toward a system built on the value of whole person health. We also outline the opportunity for research and pilot-testing of the model developed through this multi-stakeholder partnership.

How Did We Get Here?

A multi-stakeholder project team was assembled to model and learn how to best bring together patients/employees, employers, providers, and health plans in new ways that bridge gaps and enhance current approaches to operating in the healthcare ecosystem. Through a series of working sessions and meetings, we developed an initial set of guiding principles to be used by all stakeholders to improve patient care, member experience, and employee/consumer health engagement. Members of the project team included the leadership team of the National Alliance, ACHP's associate director of clinical innovation, and the associate chief research and translation officer from UPMC's Center for High-Value Health Care.

The project team also convened an **advisory board** of diverse industry experts to discuss the current direction and focus of a strategic action plan. Input from the advisory board informed project team efforts to refine and focus an early set of guiding principles and draft objectives for the strategic action plan. Two advisory board meetings were conducted and feedback was solicited from individual members.

A **Delphi study**, a process that leads to results from multiple rounds of questionnaires sent to a panel of experts, was also conducted to understand how to best engage patients in their health in a more comprehensive way. Whole person health was defined as "*a focus on a person's wellbeing—their physical, mental/behavioral, and social health—not just the presence/absence of physical disease.*" The study was designed to inform the project team which outcomes are most important to employees who receive health benefits from their employers, as well as to identify leading ways to increase participation in health-related programs.

While the Delphi study allowed direct access to the perspectives of individuals, convenience sampling of participants (i.e., the majority were drawn from employees who work in healthcare and social services) limited the generalizability of the results. While we recommend this type of consensus-building be integrated into any person-centered multi-stakeholder collaboration, there were shortcomings to this particular study, which are provided in a summary of the Delphi Study results (available in the Appendix).

The experience and lessons learned through our discussions of the Delphi study results with the advisory board, and later discussions with the project team, helped us recognize that **the who and the why of multi-stakeholder collaboration must be re-imagined in more relational ways**. To that end, we partnered with subject-matter experts in social impact design and relational strategies to help us develop and propose **a relational roadmap** that is actionable and adaptable and, when implemented, could yield significant research opportunities in communities nationwide.

Disruptive Thinking: Bringing Relationships Back to Health and Healthcare

The vast majority of healthcare collaborations invest energy and resources in the technical and structural work of improving the system (e.g., for example, measuring and reducing hospital readmissions, implementing electronic health records, and testing new payment models), but they fail to devote adequate time and attention to the "relational glue" that holds us together as we navigate a collaborative effort, many times with competing agendas and uncertainty about the future. To date, the focus of most multi-stakeholder collaborations has been on the "what" and the "how,"

In the present ecosystem, stakeholders seek to pursue their interests individually without accounting for unintended consequences, such as higher care costs or the continued dominance of fee-for-service healthcare. As such... a suboptimal system of collective misalignment is created.

—National Academy of Medicine Discussion Proceedings. June 8, 2022

not the "who" and the "why." In this context, it is easier to find high-level principles on which we can all agree and harder to align our efforts around common actions that will lead to person-centered outcomes and more affordable care.

The capabilities and relative strengths of those at the table are important building blocks for re-imagining roles, creating breakthrough ideas, and developing new strategies to make those ideas real. Ideally, each stakeholder contributes to the collaborative experience in ways that optimize their assets, capabilities and comparative value in the relationship, regardless of their "traditional role."

Our experience building and navigating multi-stakeholder collaboration across the lifecycle of this grant, combined with emerging programs and research, reflected these dynamics.

We sought to identify significant disruptions to the healthcare marketplace and arrived at one that is deceptively simple: a new approach to collaboration fueled by deeper interpersonal connections and an asset-based mindset. This relational and strengths-based approach recognizes that the quality of partnerships around the multi-stakeholder table drives the overall outcomes and the sustainability of collaborative efforts.

In this new approach, the group commits its collective assets to achieving an agreed-upon goal, with the work of each stakeholder then identified, examined and reconfigured to produce new outputs related to whole person health. Prioritizing time and energy to develop high-performing partnerships enables local communities to **build on the best work already done by each partner** and achieve value for all partners beyond what could be produced by a partner acting alone or through singular, bidirectional partnerships. This relational approach will not only accelerate collaborative work but will increase and accelerate the overall impact of the work.

What Is Disruptive Thinking?

At its core, disruptive thinking is about thinking differently. Specifically, it's thinking that challenges the traditional way of doing things in an organization (or even an entire market or sector). The reason this is disruptive is that it typically brings about innovations that completely change the way a company or industry behaves.

The results of disruptive thinking can often be something quite radical that actually transforms an experience for a customer or someone else…engaging with the sector. In essence, it's about changing things from the way they've always been and taking them somewhere completely different.

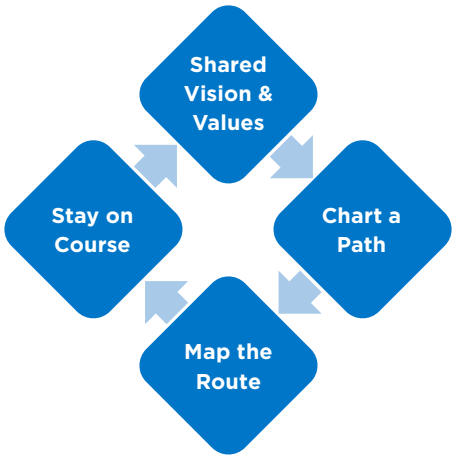
Aberdeen Business School
studyonline.abdn.ac.uk/resources/disruptive-thinking

We are proposing a strengths-based roadmap for a new method of collaboration. We partnered with the social impact design organization X4 Health to develop this roadmap by studying the project team's collaborative experience and drawing from existing programs that utilize these methods.[3] We aim to research and test the implementation of this roadmap in future initiatives.

The roadmap below contains steps that will be familiar to stakeholders with a history of collaboration. We encourage stakeholders to pay close attention to the most innovative and disruptive element of the roadmap, the one that will be new to many stakeholders. It is what supercharges the process as a relational one, in contrast to existing business and other processes, which are largely transactional.

3 Example programs include 3rd Conversation and Community ROCKit, both designed and powered by X4 Health.

Relational and Asset-based Roadmap for Effective Multi-stakeholder Collaboration



Shared Vision and Values

- Explore the "why" and the "why now" of your collaboration; this will inform the "what" and the "how."
- Explore the issue(s) or problem(s) that bring your group together. What problems exist that you hope to solve?
- Create a ***Shared Vision*** for whole person health in your community/region. Use human-focused stories to inform and articulate the goals of the collaboration, the impact you hope to achieve, and why you want to achieve it (e.g., what's at stake). For example, ask collaborators to reflect and share a story about a time when they felt their whole person health was supported. What happened? What systems-level factors were present? Who were the key players? Use these stories to find common ground and craft a shared vision.
- Identify ***common values*** inherent in the shared vision (e.g., we believe people are more than their diagnoses and that factors outside the healthcare system influence health). These will serve as alignment anchors. Common values can serve as guardrails during subsequent phases of this work (charting a path, mapping the route, etc.), especially when misalignment and tensions arise from competing agendas.

Chart a Path

- Select an ***initial priority*** as a starting point, based on the shared vision and common values. Answer these questions:
  - What do our common values and shared vision tell us about what we can first work on together?
  - Where can we make concrete progress while we develop and deepen our working relationships?
  - Where are we all energized to devote our time and effort?
- Use human-focused stories to explore key aspects of the priority and help further define it. For example, if your initial priority is "implementing an advanced primary care model," invite individuals to share a story about a time they experienced excellent primary care. Ask open-ended follow-up questions to uncover as much detail as possible in the stories. What did advanced primary care mean to them in the context of the story; how did it help create whole person health? What systems-level factors enabled the experience? Why was it positive and what was its impact? What does the story tell us about our community?

- Are there ***existing frameworks,*** plans or other resources we can build on that reflect our shared vision and values (e.g., are there roadmaps or frameworks that will help the community and individual stakeholders build an advanced primary care mindset)?

Map the Route

- Inventory ***individual and organizational capabilities.*** What capabilities do local organizations and individuals bring to the table? For example, self-insured employers can influence the tenets of advanced primary care by adding specific language to health plan contracting processes. Health plans can design coverage and benefit policies that support the implementation of advanced primary care. Below are whiteboard tools to help local stakeholders explore their capacities.
- Map ***assets*** of the community and stakeholders. What assets exist that are related to the initial priority area, and which can we build on? Assets are broadly defined and include people, programs, laws, physical places, and more. For example, a community working on stable housing might provide access to assets like Habitat for Humanity, buildable land, zoning ordinances, developers, and nonprofit housing agencies. Below is a thinking tool to help local stakeholders list their assets.
- Brainstorm ***unique combinations*** of assets and capabilities to help address the priority area, asking the question: ***What can we do with what we already have on hand, in service of the priority area?*** How do the organizational assets and capabilities relate to the gaps identified?
- Map ***actions and strategies*** that emerge. Ensure efficiencies of efforts and be attuned to duplication.
- Create and organize the implementation of a ***strategic action plan*** that reflects the shared vision, values, assets, capabilities and actions.
- Set the ***destination metrics*** for the strategic action plan, ***and periodically check back on the shared vision and values.*** Monitor progress toward the shared vision and values, asking:
  - How will we know when we've arrived? What data will we monitor to know if we're having the impact we desire?
  - What lessons have we learned?
  - Are adjustments to the roadmap needed as a result of these lessons?

Stay on Course

- Establish an ***ongoing collaboration vehicle*** that will function as a forum for continuing to deepen relationships, learn, and coordinate action. For example, create a new regional working group or ask an existing group to manage the ongoing collaboration. It will be important to consider including individuals who understand how to deepen relationships—and will prioritize that—as well as how to inspire action.
- Using the analogy of actors in a play, as a group "go to the balcony"[4] periodically to ***assess the process.*** Take a step back and examine the collaboration, asking:
  - What's working?
  - How are we feeling about what's going well? How can we build on these successes?
  - Where are we struggling? How are we feeling about these challenges? What can we do differently?
  - Are our actions consistent with our common values, who we are or aspire to be, and our shared vision?
- Pick your next destination/priority area of focus, based on your strategic action plan. See the Appendix for a starter list of themes related to whole person health that could become the next destination/priority.

4 Dressler, Larry. (2006). *Consensus through conversation: How to achieve high-commitment decisions*. Berrett-Koehler Publishers.

Remaining Competitive Through Collaboration: Deploying Stakeholder Assets in New Ways

Healthcare today is an ecosystem consisting of an interconnected web of relationships that generally lack coordination. As a result, efforts to achieve a shared vision of health are generalized and do not consider, let alone leverage or coordinate, the unique assets and capabilities of local stakeholders.[5] Each of the stakeholders potentially brings to bear its unique vantage point and assets for improving whole person health. While all these groups are committed to the concept of whole person health, each defines it differently and envisions a different route to achieve it. This was the experience of the project team in conversations with project participants.

An asset-based framework for collaboration instead considers: What can each of us do with the assets and capacities we have, in service of our shared vision? A process of collective asset mapping—inventorying the programs, funding, people, etc. that a community already has—can culminate in a collective stepping back, in which stakeholders work together, examining assets and asking:

→ Given our relative strengths and capabilities, what can we do with these assets, particularly if we were to connect and combine them in new and different ways?

This process can result in a series of actions that advance the community farther and faster toward the vision, because they are built on strengths and assets that already exist. An asset-based approach can break through logjams and solve longstanding problems in fresh ways, enabling faster, more significant progress.

Asset-based thinking can help collaborators work outside traditional stakeholder "role" definitions and build on what is already available in communities, rather than re-creating programs and resources.

While not always a clean definitional line, generally:

- Assets are **resources** that stakeholders have on hand (e.g., funds, buildings, programs, etc.).
- Capabilities are things that stakeholders **can do with their assets** (they often start with verbs: analyze, incentivize, communicate, engage).

The assets and capabilities of employers, health plans, providers, patients, and families differ tremendously across the US based on a variety of factors (size, location, business model, income, etc.). In recognition of this context, we developed a set of tools to provide collaboration leaders with a starting point.

These tools can be used to consider the specific assets and capabilities of local and regional healthcare providers, plans, employers, patients and families, and communities. For example, some employers have employee wellness programs or paid leave policies, while others do not. Some communities have access to food pantries or public transportation, both of which affect whole person health. There are many publicly available resources for asset and capacity mapping.[6]

The asset and capability tools are designed for customization in the context of a strong group process, as outlined in the roadmap.

5 nam.edu/programs/value-science-driven-health-care/multi-payer-alignment-on-value-based-care

6 Example: healthpolicy.ucla.edu/programs/health-data/trainings/documents/tw_cba20.pdf

TOOL #1

A WHITEBOARD VISUAL: ASSET CATEGORIES OF KEY STAKEHOLDERS IN HEALTHCARE

This is a visual example of how asset mapping might be represented.

TOOL #2

A GENERAL LIST OF ASSETS ORGANIZED BY STAKEHOLDER TYPE

Stakeholders may use these categories to develop customized, locally specific asset maps, using the visual example of Tool #1.

PROVIDERS

Assets

- Presence in community (clinics, offices, etc.)
- Clinical knowledge
- Influence over provider networks and behavior through referrals
- Trusted relationships with patients
- Healthcare teams
- Longitudinal clinical databases in electronic health records
- Healthcare service delivery apparatus: screening, testing, treating, prescribing, telemedicine, etc.
- Connections to state and/or community health information networks
- Linkages to public health departments
- Knowledge of local community
- Patient and family communication channels (portal, phone, email, text)

Capabilities

- Utilize point-of-care technology to inform and guide care
- Measure care quality, safety and efficiency
- Assess drivers, presence/absence of whole person health factors at individual level
- Serve as trusted messengers
- Exercise direct influence on patient care: cost and quality
- Participate in models of advanced care delivery (ACO, PCMH, etc.)

EMPLOYERS

Assets

- Diverse employee populations
- Jobs that provide income
- Large community-based footprint; worksite locations
- Economic influence in communities and states
- Close and frequent contact with employees
- Demographic data (e.g., enrollment, income, race, ethnicity)
- Incentives for whole person health (productivity, cost of care, coverage, etc.)
- Business acumen and infrastructure (finance and accounting, IT, communications, etc.)
- Workplace policies
- Health plan contracts
- Employee wellness programs
- Employee assistance programs

Capabilities

- Pay for healthcare, provide health insurance
- Influence/set whole person health priorities through health-plan contracting
- Facilitate integration of, and collaboration among, disparate service providers
- Establish workplace culture
- Advocate for employees and their families
- Promote culture of innovation
- Communicate with employees and engage community
- Incentivize employee behavior

HEALTH PLANS

Assets

- Information technology infrastructure
- Claims data
- Electronic health record data
- Episode of care definitions and data
- Prior authorization systems
- Clinical experts, including physicians
- Care managers
- Insurance policies, benefit design
- Payment policies
- Actuaries, actuarial analyses
- Business infrastructure and acumen
- Clinical knowledge, expertise in quality and safety
- Legal resources
- Relationships with employers
- Networks of providers
- Disease management programs
- Performance dashboards

Capabilities

- Conduct retrospective review of care and cost management
- Assume and manage risk
- Prioritize evidence-based care
- Set coverage and payment policies
- Scale solutions across diverse populations and communities
- Maintain community presence
- Measure performance (care quality, cost)
- Offer incentives (financial rewards for chronic condition management, prevention, etc.)
- Create tiers of higher-performing provider networks
- Offer financial protection from health events
- Negotiating healthcare prices
- Conduct community outreach
- Markets and communicates
- Invest in primary care foundation

PATIENTS, FAMILIES AND EMPLOYEES*

Assets

- Knowledge of the community
- Connection to employer
- Whole person view of individual health drivers
- Lived experience navigating and getting care in local healthcare systems
- Family and informal caregivers
- Informal and formal networks
- Social media access
- Smartphone capabilities
- Access to information online
- Individual gifts, skills and talents
- Consumer purchasing behavior: motivation for the best care at an affordable price
- Internet networks in the home
- Access to community resources (libraries, pharmacies, etc.)
- Knowledge of personal healthcare providers

Capabilities

- Manage care at home
- Work remotely
- Feel loyalty to provider, plan and employer
- Choose health providers in alignment with coverage policies
- Select, pay for/toward health insurance plan
- Use community resources
- Have social media influence
- Use smartphone features and functions
- Influence friends, neighbors—on provider choice, plan reputation/ loyalty, etc.
- Volunteer and engage fellow community members

*The diversity in assets and capabilities across the population of patients and families in the US cannot be understated. These lists are designed to provide collaboration leaders with a starting point they can apply locally.

COMMUNITIES

Assets

- Transportation networks
- Housing programs
- Mental health programs
- Public libraries
- Broadband
- Faith-based organizations and leaders
- Parks, recreational areas
- Local businesses, employers
- Healthcare systems and providers (hospitals, pharmacies, clinics, public health organizations, doulas, etc.)
- Essential service institutions: schools, police stations, firehouses, grocery stores, post offices, etc.
- Governmental systems (state capitals, city councils, county commissions, etc.)
- Government leaders (mayors, county commissioners, city managers, county staff, etc.)
- Laws, policies, regulations, bonds, taxes, grants
- Community advisory boards
- Community ties, relationships
- Citizen associations
- Nonprofit organizations
- Service directories, resource guides
- Social media groups (Facebook, Nextdoor, etc.)

Capabilities

- Organize broad networks to address issues that require collective action or protections
- Provide context, motivation for deepening social ties across diverse community members
- Raise resources: issue bonds, levy taxes, etc.
- Establish laws, public policies
- Provide common experiences (events, recreation, etc.) that build a sense of community, attract participation/attendance
- Mobilize individual community members in times of need
- Promote collaboration
- Foster and reinforce community-specific norms and culture (e.g., the way we do things here)

Future Considerations

- Emphasize and educate about whole person health at every touch point
- Consider including state and federal government as a separate stakeholder group
- Strengthen the role of trust building
- Perform a periodic SWOT analysis (strengths, weaknesses, opportunities, threats) analysis to continuously understand what's working—and what isn't

A Case Study in Charting the Path and Mapping the Route: Advanced Primary Care

To demonstrate how to use the relational and asset-based road map, a case study is included below. For the sake of brevity, this case study begins with Step 2 of the roadmap, chart the path, and, specifically, the step in which a multi-stakeholder group identifies an initial priority.

To illustrate these steps of the relational roadmap, imagine that a community has agreed their initial priority for driving toward whole person health will be widespread *advanced primary care*. Primary care, as the front door to the healthcare system, has an outsized influence on whole person health (e.g., prevention, management, coordination, referrals) and many stakeholders recognize the high value of strengthening primary care. If a community came together across stakeholders and examined what actions they could take, individually and collectively, to make advanced primary care adoption widespread, communities might chart a different course than the one we have today.

Assume the multi-stakeholder group has explored what advanced primary care means to the community through **human-focused stories**, and they have **researched existing frameworks**. They have adopted the seven attributes that are core to advanced primary care[7] and then begin to **map assets and capabilities** related to enhanced access for patients.

What Makes Primary Care *ADVANCED* Primary Care? National Alliance Identified SEVEN Key Attributes

1. **Enhanced access for patients**
   Convenient access, same day appointments, walk-ins, virtual access, no financial barriers to primary care
2. **More time with patients**
   Enhanced patient engagement and support, shared decision-making, understanding preferences, social determinants of health
3. **Realigned payment methods**
   Patient-centered experience and outcomes, quality and efficiency metrics, de-emphasize visit volume
4. **Organizational & infrastructure backbone**
   Relevant analytics, reporting and communication, continuous staff training
5. **Disciplined focus on health improvement**
   Risk stratification and population health management, systematic approach to gaps in care
6. **Behavioral Health Integration**
   Screening for BH concerns (e.g., depression, anxiety, substance use disorder), and coordination of care
7. **Referral Management**
   More limited, appropriate and high-quality referral practices, coordination and reintegration of patient care

Source: Developed by the National Alliance of Health Care Purchaser Coalitions. Visit nationalalliancehealth.org to learn more.

7 connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=b846d726-4949-10df-b7c4-fcb7b-5b13641&forceDialog=0

1. The community asks: What are our strengths and assets that could create enhanced access for patients? They use the stakeholder **asset and capability** boards as a starting point, customizing them to local organizations, programs, etc.

2. Stepping back and making sense of the whiteboards, the community then asks: What can we do with the assets and capabilities we already have, especially if we **combine them in new ways**? They move assets around on the whiteboard related to enhanced patient access.

3. Finally, the community asks: Which **strategic actions** can we take, individually and collectively, to achieve this priority of enhanced access for patients in a way that builds on our assets and capacities? How can we work together creatively in ways that leverage and share our strengths?

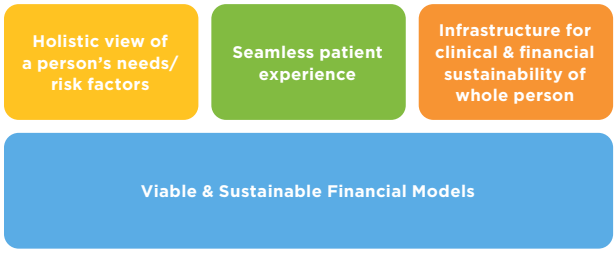
Together, the community might arrive at **actions** such as these:

The community will then develop a comprehensive **strategic action plan** and **establish a mechanism for ongoing collaboration**, measuring progress toward their shared vision and the initial priority.

Appendix

Actions to Drive Whole Person Health and Value in Healthcare

Mutual Objectives for Collaborative Stakeholders



A number of themes arose during our team conversations, both within the Delphi study process and in conversations with the advisory committee, about how to organize and support sustainable collaboration toward whole person health. These themes can guide a journey toward whole person health, so future multi-stakeholder collaborations many find them useful:

In early formulations of this work, we broke these themes down into actions that could potentially disrupt the traditional healthcare market. In the process of researching and outlining these actions, **we arrived at two key insights**:

1. We made well-intended assumptions related to our shared vision and values without fully exploring our collective "why." Doing so might have led to a different set of themes.
2. The actions outlined were siloed by the stakeholder group, which only reinforced the traditional ways of working together. The actions were not informed by asset mapping and were largely not disruptive. **This traditional method—where each stakeholder group uses its own strengths to pursue its own agenda—has produced the system we have today.** Using an asset-based mindset and deepening relationships across stakeholder types might have led to more integrated, collective actions.

The roadmap, offered in place of these actions, more adequately reflects the process of getting to a shared vision and values and will generate action plans that break down silos in support of whole person health.

To inform future local and regional collaborations, we provide the original list of actions organized by theme in the Appendix. Again, these actions were not informed by asset mapping, and we encourage future collaborators to use the relational roadmap outlined.

1. Holistic View of Person's Needs/Risk Factors

Studies show that individual care that is unavailable or unaffordable increases clinical and social risk. Social needs and risks in the community where people live, work and play also have a greater impact on health and health outcomes than the healthcare industry itself. By taking actions that prioritize a holistic view of individuals' health influencers—including understanding social needs/risks—industry stakeholders can drive more meaningful collective action that prioritizes health and outcomes of care by addressing root cause issues. Building trust is essential to founding the sustainable partnerships and engagement necessary for this work, which must be built through relationships and interactions driven by data, compassion and care.

In doing assessments at the population level, a multi-stakeholder team should have representation from those who will be most impacted by the work, including community members. Stakeholders are encouraged to work with state, local and federal governments to understand and address the social risks that diminish health and increase healthcare costs. Some specific roles that each of the stakeholders can take include:

Healthcare Professionals

- Identify what is most important to patients both generally and at specific decision points and

use feedback to enhance patient engagement, treatment plans, etc.

- Identify the personal and environmental strengths/ limitations that impact an individual's health and well-being.
- Engage patients and care teams with a longitudinal view, integrating clinical factors, patient strengths and limitations, and patient goals and values.
- Include caregiver(s) in care planning and treatment decisions, as desired by the patient.

Employers

- Identify and share key impact measures that can be monitored and utilized in healthcare planning (e.g., race and ethnicity data, ZIP code, and other demographics).
- Assess the impact of benefits and programs on subsegments of the population.
- Obtain employee/dependent input about the needs and responsiveness of current offerings.
- Assess culture and process to continuously enhance employee/dependent trust.
- Consider partnering with local public health organizations to better understand social needs and risks in the community, possibly using a community health needs assessment (CHNA).
- Establish programs/services through an EAP that supports employees who are also caregivers.

Health Plans

- Integrate social risk and key cultural/linguistic data into performance dashboards.
- Analyze the impact of policies, programs and services on member outcomes, disaggregating data by relevant subgroups.
- Design health plan coverage and benefits in response to input from diverse member communities about what is most important to them.
- Co-design covered programs/services alongside prioritized populations.
- Address health and insurance literacy through outreach, training and advocacy tailored to specific communities

Patients/Employees

- Actively engage in care decision-making by sharing personal goals for care/well-being with advocates and care team.
- Tap available resources (e.g., patient advocate or other support services) to determine available programs and benefits coverage; advocate for changes where gaps exist.
- Engage with available programs and tools when making decisions and managing care of chronic conditions.

2. Seamless Patient Experience

Stakeholders will engage with different employers, providers, health plans, and patients with diverse capabilities and focus. By definition, a one-size-fits-all system, particularly one with overlapping and siloed interventions, will yield a suboptimal personal experience for those you seek to support. Stakeholders need to investigate how technology can improve individualized patient experience, access, and timeliness of care; build a strategy that can phase in continuous improvement; and recognizes and seamlessly supports the unique contributions of the other stakeholders.

Rewards and compensation must similarly be aligned with overall engagement, while recognizing and rewarding strategies that improve provider/patient interactions. With this alignment in place, investments and technology will be designed to make the individual experience seamless and to provide essential infrastructure for highly effective, affordable healthcare. Specific actions each stakeholder can take include:

Healthcare Professionals

- Offer online scheduling with online "office hours" for rapid consults (using telehealth to support where appropriate).

- Capture information about patient communication preferences, key cultural information, goals, and values.
- Create standard procedures for closed-loop communications between care team members, specialty consults, and referral partners (including community-based referral partners for addressing social needs).

Employers

- Integrate and personalize benefits and program support using a bio-psycho-social framework.
- Provide multiple means of accessing care (virtual, in-person, worksite), recognizing diverse circumstances across sub-populations.
- Coordinate programs and services across various service providers (e.g., health plans, specialty providers, EAP, online health-focused apps, etc.).
- Hold service providers accountable for better personalizing care and accommodating differences in patients' needs; provide reports that highlight key areas to address (first care resolution).

Health Plans

- Streamline the prior-approval process to eliminate unnecessary delays and accommodate individual needs; eliminate prior approval, when possible.
- Empower member-facing health plan staff to provide holistic service for the resolution of issues on first contact and facilitation of care-gap closure.
- Provide members with tools that integrate real-time information about coverage, benefits, out-of-pocket costs, and deductibles.
- Empower members to engage more fully in coverage and care decisions through simplified processes, user-friendly tools, education, and navigation services that improve accessibility and ease the use of available programs/services.

Patients/Employees

- Prepare for provider visits by identifying their questions (including *Choosing Wisely* 5 Questions).
- "Opt-in" to sharing information across providers and caregivers through secure and trusted information-sharing tools.
- Engage with resources and advocates across the system (at the plan, employer, and/or provider levels) to support health literacy, address issues, and enhance coordination of care.

3. Infrastructure for Clinical and Financial Sustainability of Whole Person Health

To accelerate the broad adoption of the shared vision and associated actions, it is essential to develop and reinforce the clinical and financial infrastructure needed for returns on whole person health. Often, outcomes are focused on the recovery from illness, the development of medical offsets, and reducing hospital readmissions. However, whole person health involves a broader context, including the functional and emotional status of the patient and their ability to engage in the full context of their life, including work and employment. Clinical outcomes remain critical, but so do the multiple dimensions of well-being (e.g., financial, social, mental, purpose). An individual's short- and long-term livelihood and emotional well-being can be affected by baseline living activities, as well as by their ability to return to full functionality at work. Some specific ways stakeholders can enable the kind of infrastructure that will broaden clinical and financial returns include:

Healthcare Professionals

- Collect and submit performance data on patient-reported outcomes measures (PROMs).
- Operationalize the collection of information on patients' social needs at every encounter and connection with resources to meet identified needs.
- Identify inequities in outcomes among covered populations by disaggregating performance data by relevant racial, ethnic and geographic groups.

Employers

- Integrate a focus on well-being across the spectrum of benefits and health support.
- Analyze and intentionally address outcomes of diverse populations.
- Revise company policies to empower employees and enable them to manage their health needs while at work.

Health Plans

- Collect information on social needs at every member encounter and provide means by which identified needs can be addressed.
- Give providers data, tools and support for connecting members with community resources for health-related social needs.
- Integrate whole person health-related outcomes into policy and process evaluations.
- Share data with providers for a more complete patient profile.
- Give providers performance data by race, ethnicity and geography.
- Identify prevailing barriers to affordability by geography and incorporate ways to address these into product design.

Patients/Employees

- Establish and maintain an ongoing relationship with a primary care physician.
- Engage with advocates and physicians on broader health and well-being expectations.
- Consult primary care regularly when new issues arise.
- Engage with programs and services, as available, to support health and well-being needs.
- Select health plan products with high-performing provider networks and incentives for whole person health.

4. Viable and Sustainable Financial Models

The overarching issue for any stakeholder seeking to optimize whole person health outcomes is creating a financially viable and sustainable business model that aligns clinical outcomes with financial returns. Rarely do existing models reward this perspective, even though there are many examples where whole person health has outperformed more traditional approaches.

Providers

- Participate in risk-sharing performance-based payment models.
- Enhance transparency by publishing prices of standard elective services.
- Incorporate benefits and trade-offs in the discussion of treatment options and consent processes.
- Share out-of-pocket cost information with patients at the time of referral and point of care.
- Offer service guarantees for wait time, satisfaction, and routine elective procedures.
- Empower patients to be the experts and/or best source of information through self-serve approaches to scheduling; intake of data on demographic, race/ethnicity, social needs, chief complaint, etc.

Employers

- Broaden purchasing requirements to evaluate progress toward whole person health.
- Develop value-based designs that better support patients and reduce barriers.
- Offer value-based choices that include a reduced cost for the employee/patient; include a reduced cost across subpopulations that encompass low-wage workers.
- Understand the financial return on whole person health for the organization; this should include investigating the social needs and risks of subpopulations in various ZIP codes (some

organizations continue to have high healthcare costs, as they are not addressing drivers of health that impact their workforce).

- Restructure rewards and incentives with service providers to reinforce whole person support.
- Engage with stakeholders (provider, plan, patient, government) to reduce healthcare costs.

Health Plans

- Tailor information about how health insurance works to other stakeholders and provide accessible means of engaging with and acting on it.
- Ease provider burden by collaborating with other payers in the market to define and align performance metrics used in value-based care.
- Use patient-reported outcomes or experience measures.
- Structure member and provider rewards and incentives to address both up- and downstream social risk.
- Share total cost-of-care information with providers.
- Provide real-time out-of-pocket member cost information to providers.

Patients/Employees

- Choose coverage that preserves affordability and access.
- Use cost and quality information to choose providers and health plan coverage.
- Understand the downsides to overuse of care, both to individual health and to the overall system.

Whole Person Health Delphi Results Summary

DECEMBER 2021

Background: The National Alliance of Healthcare Purchaser Coalitions, the Alliance of Community Health Plans, and the UPMC Center for High-Value Health Care formed a "healthcare collaborative" partnership through the collaborative project funded by a PCORI Engagement Award entitled *National Alliance, ACHP & UPMC Partner to Optimize Patient Centered Outcomes Across Employers, Plans & Providers*. The partners (a.k.a. project team) developed and conducted a Delphi study in late summer 2021 to identify meaningful whole person health outcomes among a key stakeholder group (i.e., employees) to inform the development of a strategic action plan.

Methods: A Delphi approach is a validated method of consensus development (defined as greater than or equal to 70% agreement) among a panel of individuals regarding a particular topic. Consensus is achieved through a unique framework of iterative, anonymous surveys that eliminate face-to-face meeting barriers, such as geographical impediments, group pressure, and conformity bias. Upon conclusion of each respective survey, the panel's responses are assessed for each item in aggregate using descriptive statistics, and this information is then shared with respondents in the next survey round. This additional information delivers controlled feedback, encourages shared learning, and allows participants to revise their preceding contributions, considering prevailing panel viewpoints.

Limitations: This Delphi study has several limitations to consider. The employee sample was obtained from a small convenience sample, in which the project team engaged members of the advisory board via email to help with recruiting potential individuals into the study. Advisory board members were provided an outreach email with instructions and contact information for those interested in participating in the study. These individuals were put on a list and contacted by the people running the study. Initially, a limited number of people responded, so additional outreach was done to increase the number of participants. Despite efforts to broaden the demographics of the participants, the majority of the sample was drawn from employees who work in healthcare and social services, meaning these panelists may have different viewpoints, priorities, and baseline knowledge about the healthcare system than other groups of individuals/employees. As such, this sample may not be representative of a broader employee population, limiting generalizability. We attempted to account for potential bias within our healthcare and social services sample by including a range of panelists with different job types, such as administrative staff, researchers, management, and skilled laborers. Further, we did not collect information from panelists related to income or other socioeconomic indicators. Such information may have affected our findings, given the potential for varying levels of access to care and familiarity with the healthcare system.

Figure 1: Delphi Panel (N=19)

INDUSTRY
- Health care/social (58%)
- Education (16%)
- Finance/insurance (5%)
- Public admin (5%)
- Other (16%)

GENDER
- Female (79%)
- Male (16%)
- Non-binary (5%)

AGE
- 21–40 (27%)
- 41–60 (37%)
- 61–>71 (37%)

RACE
- White (68%)
- Black (21%)
- More than one race (5%)
- American Indian/Alaska native (5%)

The Delphi study was designed to focus on an employed population so we could better understand how to support whole person health from this stakeholder group's perspective. The primary aim of this Delphi was to understand what employees believe to be the most important factors to support their initial and continued engagement in services and supports to address whole person health. Whole person health was defined as "a focus on a person's well-being—their physical, mental/behavioral, and social health—not just the presence/absence of physical disease." We sometimes used the word "total health" as a plain language alternative to whole person health. This study was designed to identify which outcomes are most important to the employees who receive health benefits from their employers, as well as the top ways to increase participation in healthcare programs.

Results: Figure 1 describes the final Delphi panel. The highlighted pieces of the pie chart in Figures 2 and 3 below reflect the concepts in which consensus was achieved. Tables 1 and 2 display all the comments provided by participants by industry type and race for the top outcomes shown in Figures 2 and 3.

Figure 2: If you had to limit the number of outcomes to the 3 most important to total-person health, which ones would you choose?

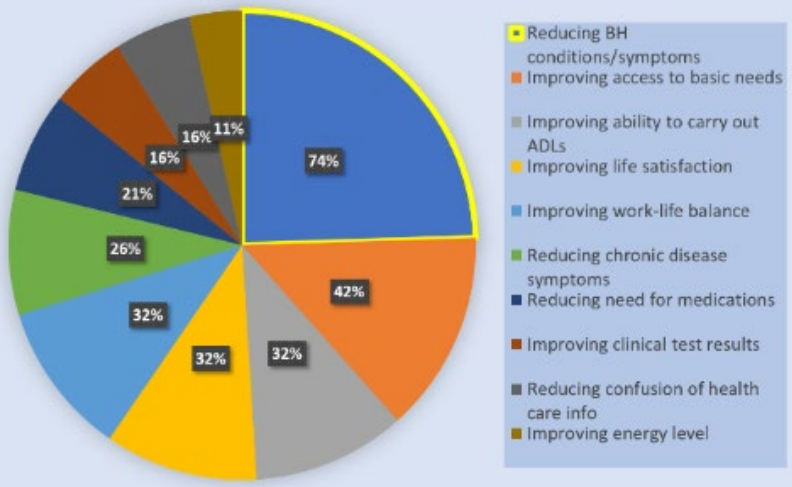
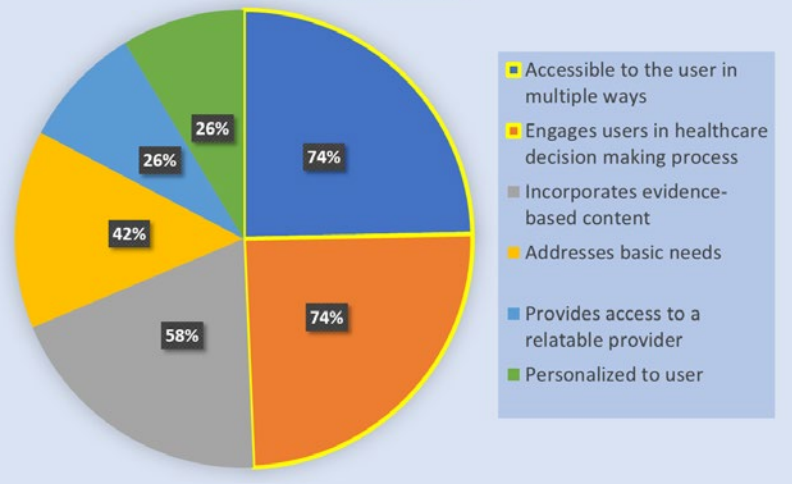


Figure 3: If you had to limit the list of ways in which a person can access or participate in programs, services, and supports that address total health to the 3 most important factors, which ones would you choose?



Future Directions/Next Steps:

- While we are unable to modify the current whole person health Delphi study to include broader stakeholder groups, these results can be used to inform future Delphi studies. This follow-up study might consider including other stakeholders (e.g., employers, providers/wellness advocates, and health system leaders), and broader geographic, industry, income, job type, race/ethnicity, and gender diversity.
- The project team will seek further consultation and input from a subgroup of advisory board members as well as guidance from the PCORI program officer regarding the next steps for expanding efforts to incorporate broader stakeholder feedback.

About the Project's Strategic Partners:

- **Alliance of Community Health Plans:** ACHP is the only national organization promoting the unique, payer-provider aligned model in healthcare. ACHP's nonprofit, community-based member health companies collaborate with provider partners to deliver high-quality coverage and care to tens of millions of Americans in 36 states and Washington, DC.
- **National Alliance of Healthcare Purchaser Coalitions:** The National Alliance is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its members represent private and public sector, nonprofit and Taft-Hartley organizations, and more than 45 million Americans, spending over $300 billion annually on healthcare.
- **UPMC Center for High-Value Health Care:** The UPMC Center for High-Value Health Care (Center) is a nonprofit research organization, housed within the Insurance Services Division of UPMC, which is one of the nation's largest integrated health care delivery and finance systems. The Center translates the work of this unique payer-provider laboratory into evidence-based practice and policy change for improving healthcare quality and efficiency.

RESOURCES

The three organizations that partnered on this project have been previously funded by PCORI to explore partnerships across stakeholder groups to deliver better, more affordable healthcare. These individual projects laid an important foundation for thinking differently about how to drive greater value by working across silos.

- Accelerating the Adoption of Evidence-Based Care: Payer Provider Partnerships (2018) - Report of ACHP's PCORI-funded project demonstrating that when high-performing health plans collaborate closely with health systems and communities, the use of evidence-based care increases.
- Learning Health System Transformation: A Strategic Roadmap for Guiding Stakeholder Driven Health System Research (2021) - Findings from a conference held by the UPMC Center for High-Value Health Care on accelerating stakeholder driven PCOR/CER in a learning health system environment.

National Alliance Resources Resulting from PCORI Collaborations:

- Making Comparative Effectiveness Research a Stronger, More Relevant Tool for Employers
- Rethinking Health and Wellbeing Strategies
- Achieving Value in Cancer Care: Striving for Patient-Centered Care
- Understanding Health Equity in the workplace
- Understanding Health Equity (for employees)
- The New Science of Obesity: Rethinking our Approach
- Supporting Employees with Cardiovascular Disease through Aspirin Therapy

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