Raising the Bar

Healthcare's Transforming Role

Principles into Practice

Provider Role

Supported by the **Robert Wood Johnson Foundation**, ***Raising the Bar*** provides an actionable framework for the entire healthcare sector to embed equity and excellence throughout its work. In this first part of the project the **National Alliance to impact the Social Determinants of Health** (NASDOH) convened extensive discussions with providers, hospitals, payers, and community leaders to develop foundational principles, essential roles, and concrete actions for the sector to help achieve optimal health for all. A second part, led by the National Partnership for Women & Families, is exploring more detailed guidance for maternal health.

Principles into Practice:
Provider Role

Raising the Bar's five principles provide the foundation for transformational action by healthcare payers, providers, and other organizations. *Raising the Bar* describes four essential roles played by healthcare, providing a framework for how the principles can be put into practice.

This section focuses on healthcare's role as a PROVIDER, including the essential role payers and other organizations play in facilitating the provision of healthcare, and outlines concrete actions, each with a commitment that healthcare can make to advance equity and excellence, and a set of tactical strategies.

Following the Roles and Actions, there are a set of vignettes which highlight examples of organizations already advancing efforts in line with those actions outlined in the PROVIDER role. There is also a set of resources for healthcare stakeholders looking for a place to begin or to amplify ongoing work in this role area. An aggregated set of the *Raising the Bar* Resources is available.

PROVIDER ROLE | **Provide Whole-Person Care to Achieve Health Equity**

Achieving equity and excellence is grounded in the ability of individuals to access and receive the full range of affordable care they need, and experience being treated with dignity and respect.

Healthcare's Actions

Action 1 Actively promote and facilitate access to care for all in ways that accomodate diverse life circumstances and needs.

Healthcare's commitment

Ensure that all individuals and families can access the care they need in ways that work best for their lives. Address structural barriers preventing access to healthcare, including financial and physical constraints, and commit to understanding and respecting the preferences, priorities, and constraints of individuals in accessing care.

Why this action is included

Access to care is inextricably linked to equity—if everyone is to have a fair and just opportunity to be as healthy as possible, access to high quality and safe healthcare is essential. However, access is not limited to coverage for healthcare services. It includes ensuring that healthcare services are available and affordable to everyone independent of who they are, where they live, or their insurance status.

Putting this action into practice

- Ensure access by eliminating or mitigating financial constraints and providing affordable care regardless of insurance status or ability to pay. This includes accepting Medicaid and other forms of publicly funded payment, minimizing the role that copays and medical debt play in preventing access to care, and providing coverage and ensuring affordability for essential healthcare services so that needed care is not delayed.
- Facilitate access by understanding the preferences and constraints of individuals, families, and caregivers, and accommodating them, including adjusting hours of operation, easing scheduling, and increasing availability of appointments, and enabling transportation assistance to and from appointments.
- Make accommodations to ensure that all healthcare settings are accessible to people with disabilities.
- Cover and provide care through diverse modes to accommodate diverse life circumstances and needs. For example, cover and provide telehealth options and develop or use innovative care models and payment approaches to ensure rural populations have access to healthcare.
- Ensure access to essential healthcare services to all with unique healthcare needs. For example, LGBTQ+ individuals, individuals with disabilities, people of color, and others may have unique healthcare needs. Coverage, capacity, and diverse providers are key in enabling access to specialized and culturally congruent clinical services and treatments.

Action 2 Establish and sustain a trusting environment where everyone feels they are welcomed and treated with dignity and respect.

Healthcare's Commitment

Treat everyone with dignity and actively work to make all feel respected and heard. Strive to achieve equity in the delivery and outcomes of care, to be antiracist and anti-discriminatory, and to take active steps to remove all systemic barriers to healthcare, optimal health, and well-being. Implement training and protocols that ensure culturally and linguistically congruent care is available for the multiple communities served.

Why this action is included

The elimination of disparities in health outcomes, including disparities based on race, ethnicity, preferred language, gender, sexual identity, age, disability status, religion, employment, income, migrant status, and other factors, is key to an equitable and effective healthcare system. This work begins with addressing the underlying barriers to health and well-being—such as racism and its impact on care delivery, ensuring all have meaningful access to effective and equitable health services, and ensuring that care is delivered in respectful ways.

Meaningful efforts to ensure that all feel welcomed in healthcare settings are essential. Healthcare payers, providers, and other stakeholders should use intentional approaches to welcome those who face the greatest challenges accessing care, those with public insurance, and those with specialized healthcare needs, including individuals with disabilities and LGBTQ+ individuals.

Putting this action into practice

- Make information and services available in preferred languages. For example, have materials translated into multiple languages which align to the needs of patients and caregivers, and have timely, high-quality interpreter services available.
- Use multi-specialty care teams that can meet the range of interrelated physical, emotional, and social health needs.

- Create an environment that is physically, aesthetically, and culturally welcoming that shows respect for individuals and their families when they are receiving care.
- Provide coverage for and access to the comprehensive range of clinical, mental, behavioral, dental, and social services that are essential to delivering effective care.
- Ensure care and case management teams and other service providers are diverse and representative of the community served and are equipped to provide appropriate, respectful, and culturally congruent care that builds upon individual's support networks.
- Foster relationships that facilitate the sharing of relevant information between service providers and individuals and their families. This includes communicating and collecting information in ways that are appropriate and reflective of the cultural and demographic background and priorities of individuals and their caregivers and maintaining privacy and securing consent when sharing data.
- Appropriately use disaggregated data on race, ethnicity, and other demographic factors to identify and address disparities, and ensure that care provided and outcomes achieved are equitable and improve the health of communities.

Action 3 Provide holistic, effective, high-quality care responsive to plans co-created with individuals, families, and caregivers.

Healthcare's Commitment

Co-create care plans with patients, beneficiaries, and members, encompassing their overall care and reflecting their physical, social, emotional, mental, behavioral, and oral health, as well as spiritual needs and priorities, across the trajectory of their life. These care plans will be portable and integrate the full range of practitioners—home- and community-based health workers, social workers, licensed behavioral health professionals, and other non-traditional healthcare personnel—and organizations, including social services and public health agencies, which are important to delivering effective and comprehensive care. Deliver care that meets the needs of individuals and their families and caregivers, engaging in effective, respectful, multidirectional communication.

Why this action is included

Effective and holistic care recognizes, understands, and acts on behalf of a person's full range of complex health and health-related needs and priorities. It requires a greater emphasis on promoting wellness, offering primary care and comprehensive preventive services, mental health, and addressing social needs, social risk factors, and adverse social determinants of health. Co-creation is a critical element, acknowledging the importance of learning directly from those served.

Holistic care is important for all, but critical for individuals and communities more likely to experience negative social and structural factors, including systemic racism, sexism, and classism, which result in inadequate access to care, poorer quality and fragmented care, worse experience and dissatisfaction with care, and worse outcomes.

Putting this action into practice

- Enable individuals and their caregivers to make meaningful choices about their care by creating systems for shared decision-making about the effective care they receive, including the kind of care, the setting, and who provides it.
- Utilize care teams with diverse professional types and care providers, drawing from communities in which individuals receiving care live (e.g., community health workers), to develop holistic care plans and deliver effective and culturally congruent care. Care plans and service delivery should integrate physical, mental, and social health services to meet a full range of health needs.

- Develop strong partnerships with the entities and individuals across an individual's care delivery network and social support system to implement holistic care plans.
- Create systems and processes that facilitate coordination and communication between the wide range of practitioners with whom an individual may interact, and enable them to work as a team.
- Collect, use, and share data, as necessary and respecting privacy and patient preferences, on health and social needs to provide responsive and appropriate care to individuals and families as well as improve the health of communities.
- Ground care delivery, coverage, and payment offerings in the best available evidence, while understanding limitations.
- Develop and implement interventions to meet interrelated health and social needs as well as health needs at the community level, evaluate their impact, and share learnings to expand the evidence base on effectiveness and equity.

Provider Role: Vignettes

Open Arms Perinatal Services

Nurturing strong foundations for families is at the core of the services and supports Open Arms Perinatal Services (Open Arms) has been providing to birthing people and parents in the Puget Sound, Washington region since 1997.

Open Arms serves over 400 low-income birthing people and families annually, beginning with pregnancy, through birth, and into early parenting. The community-based nonprofit offers four programs that provide culturally and linguistically responsive support.

The Birth Doula Services program involves several home visits during pregnancy, support during childbirth, and several early postpartum home visits, for referrals to any needed social services. The longer, more intensive Community-Based Outreach Doula program is an evidence-informed home visiting model that provides monthly visits starting in the second trimester, continuous support at the time of birth, and home visits and referrals up to two years after birth. Family Support Services include tailored resource referrals to mental health support, group prenatal care, childbirth education, and baby supplies. Lactation Peer Counselors provide individualized lactation support up to a child's first birthday.

Open Arms has taken a number of action steps to realize a whole-person care approach to health equity. Recognizing that people have diverse life circumstances and needs, Open Arms fosters access in ways that meet people where they are. This includes offering:

- A broad menu of services at no cost to clients that are enhanced through a broad referral network.
- Services that are culturally and linguistically responsive through staff and doulas that reflect the diversity of clients.

To ensure that all feel welcome and are treated with dignity and respect, Open Arms:

- Provides a community-centered approach that is not hospital-based or directed.
- Culturally and linguistically matches clients with doulas and lactation counselors whenever possible.
- Successfully serves "hard-to-reach" populations, including immigrants, refugees, and houseless or housing insecure birthing people.
- Works with each family to co-create a plan for holistic, effective, high-quality care.

Open Arms providers help clients navigate healthcare and early learning systems by helping to create birth plans, prepare clients for medical visits, and helping them advocate for their needs during pregnancy, birthing, and postpartum. For those participating in the longer Community-Based Outreach Doula program, Open Arms uses the evidence-based curriculum, Promoting First Relationships, to monitor the baby's developmental milestones and will intervene as concerns are identified.

The outcomes are evidence that a community-based holistic approach works. As of 2021, 95 percent of Open Arms participants had full-term pregnancies and healthy birth weight babies compared with 91 and 93 percent in King County. The success rate with chest- or breastfeeding to six months was double that of the rest of King County's population at 82 percent compared with 39 percent.

For additional information about Open Arms Perinatal Services, please visit the Open Arms website and see an overview of programs, approach, and an independent evaluation of the program outcomes.

Kaiser Permanente

Kaiser Permanente is an integrated managed care organization headquartered in Oakland, California, serving about 12.5 million members in eight states across the United States. Kaiser Permanente strives to provide whole-person care to achieve health equity.

Establishing and sustaining a trusting environment where everyone feels welcome and treated with dignity and respect is critical to achieving health equity. Kaiser Permanente actively seeks patient input on what would make them feel welcome from the moment they walk in the door to how to better meet member needs.

As with many other health systems across the country, Kaiser Permanente is working to collect data from members to make programs and policies more effective. In pursuit of transparency and trust, Kaiser Permanente is clear with members about how and why it is collecting the information. Members also have an opportunity to opt out of any data collection.

Kaiser Permanente provides services to millions of people with diverse backgrounds and circumstances across eight different states. Recognizing that a one-size-fits-all approach would not work to meet the needs and preferences of all its members, Kaiser Permanente created multiple channels to gather information including by phone, virtually, or in-person. This allows the member to choose a method that is most comfortable to them. Kaiser Permanente also works to address social risk factors as part of its commitment to providing holistic, effective, high-quality care.

Recognizing that so much of healthcare comes from services outside of the health system, Kaiser Permanente partnered with UniteUs, a coordinated care network. UniteUs provides infrastructure that connects health systems to social services in the community and allows both parties to track outcomes. With this program, Kaiser Permanente can effectively address social risk factors that impact the overall health of a member.

Compass Community Health Center

Compass Community Health is a small health center serving underserved communities in rural Ohio. It is also a trusted, reliable community partner that people turn to for help with anything that affects their overall health. That is why one Compass patient walked barefoot for 20 miles to the health center to escape a domestic violence situation. She knew that the nurse who had worked with her before to address other needs would be there to help her again.

Compass has integrated a wide range of services in an effort to provide whole-person care. Those services include family health, women's health, behavioral health for adults and children. Compass also provides care coordination including transportation, pediatric occupational and speech therapy, outreach and enrollment services, and an on-site pharmacy.

The health center has worked to create a welcoming, trustworthy environment in which the community has confidence that their needs will be heard, respected, and met with compassion rather than judgment. Compass staff demonstrate genuine interest in patient wellness and are committed, above all, to improving the community's health. To build trust and show up as a reliable, understanding resource, the center offers trauma-informed social risk screening and prompt referrals.

Compass is adept at providing comprehensive behavioral health services and incorporating social risk screening into behavioral healthcare plans. This is critical given that a significant portion of the local population experience homelessness and are managing substance use disorders. To respond to these needs, Compass acquired a

> **"[Our health center] is big on making sure we're welcoming…when you walk into the health center, there are calm colors and pictures. The front desk staff is welcoming, the nurses are engaging with patients. In a rural community especially, people like to see familiar faces. Word of mouth around here is huge."**
>
> **Clinic & Compliance Manager**, Compass Community Health Care Center, 2021

mobile unit and staffed it with community health workers to better connect with community members experiencing homelessness, screen them for additional social needs, and connect them to both behavioral health and social services. Having diverse care teams communicate and collaborate regularly has generated greater care coordination and increased referrals.

Compass has pioneered ways to scale social determinants of health screening to pediatric populations as well. Compass developed a family-centered workflow for screening pediatric and adolescent patients for social needs, while also identifying sensitive ways to ask pediatric and adolescent patients questions related to safety privately. To meet needs identified via screening, Compass fostered new and expanded community partnerships to provide services for all age groups, created additional in-house services, and worked closely with local businesses to provide material goods and food to families requiring additional assistance.

Community Medical Clinic of Kershaw County

At Community Medical Clinic of Kershaw County (CMCKC) in South Carolina, county residents are the driving force behind its success. CMCKC placed "community" in its name to underscore its mission to empower Kershaw County residents to take charge of their own health and well-being. CMCKC makes this possible by providing a diverse set of quality healthcare services including preventive healthcare to their communities, regardless of insurance status or ability to pay.

Prior to the COVID-19 public health emergency, CMCKC focused its efforts on partnering with other healthcare facilities and schools to meet the health needs of individuals in their communities. While CMCKC's initiatives have shifted in response to changing dynamics and needs in the community, the following examples demonstrate how healthcare organizations can ensure community members have access to effective, responsive, and holistic healthcare.

A majority of CMCKC's patients have more than three chronic conditions and are often from underserved and underinsured communities. As a sign of respect, the organization meets these patients where they are and follows up with them to ensure that patients most likely to be underserved get high quality healthcare. CMCKC collaborated with KershawHealth, an area hospital, to develop patient-centered approaches to coordinating care post-hospital discharge; the resulting Transitional Care Program prioritized patients' "health after healthcare." For example, nurses from CMCKC traveled to KershawHealth to identify patients who had minimal insurance coverage and provided a personal coach to build trust and help coordinate their medical care after hospital discharge. By taking healthcare outside their own facility to where community members needed them, CMCKC took steps to overcome constraints that individuals face in accessing care and ensured that care was available for all in line with individuals' and their families' preferences, priorities, and needs.

CMCKC designs its services based on community input. Community partners, including youth, co-design plans and opportunities for health and well-being advancement in the community. As a result, CMCKC's free, school-based clinics offered holistic health services that have transformed the social, behavioral, mental, and physical health factors in students' and families' lives. This program significantly decreased chronic absenteeism, bolstered positive health outcomes, increased graduation rates, and reduced parental leave from work. By recognizing that measures like high school graduation rate are powerful long-term predictors of health outcomes, and that school absence rates predict graduation rates from K-12, they embraced their role as part of the "school absence reduction team," designing services so that students have to miss as little school as possible.

Community Health Plan of Washington

Community Health Plan of Washington (CHPW) is a non-profit health plan operating in the state of Washington with an explicit mission of delivering whole-person care. The plan serves 280,000+ individuals enrolled in its plans across all counties in Washington state. CHPW was created in 1992 by Washington's community and migrant health centers to provide health insurance to people who were not being served by traditional insurance companies. The health plan works with a network of 21 community health centers that operate over 190 clinics, as well as over 100 hospitals, 3,100 primary care providers, and 23,000 medical and behavioral health specialists.

CHPW has long recognized the importance of advancing health equity due in large part to its origin as a community health center founded health plan. It also recognized that the changes required to achieve this goal aren't easily accomplished within current payment systems or practice patterns, and that additional focus and investment are needed. To this end it launched an equity learning collaborative grant program in 2021 in coordination with the Community Health Network of Washington. The grant program offers community health centers up to $50,000 annually to fund the design and implementation of improvement projects focused on addressing disparities. It also offers them a forum for shared learning as they work individually and collectively to advance their equity initiatives.

In the first year of the program (2021), community health centers focused on developing foundational elements key to advancing equity work. These foundational elements included: 1) embedding root cause analysis into program design, 2) collecting, disaggregating, and interpreting data, as well as applying an equity lens to data analysis, 3) partnering with patients for program planning, implementation, and evaluation and 4) training clinical and administrative staff in equity, diversity, and inclusion.

In 2022, community health centers participating in the program have the option to continue refining the work they started in 2021 or launch new projects focused on one of the following four priority areas:

- **Member Experience/Organizational Equity:** With the goal of Improving diverse members' satisfaction with access to care. This could include internal-facing equity work (i.e., staff training, patient engagement) to drive improvements in member experience.
- **Pregnancy Care:** With the goal of reducing disparities in access and outcomes for pregnant and/or postpartum individuals.
- **Depression and Behavioral Health Management:** With the goal of reducing disparities in diagnosis and treatment of depression or other behavioral health conditions.
- **Chronic Condition Management:** With the goal of reduce disparities in diagnosis and treatment of chronic health conditions.

CHPW recognizes that this is a systemic investment intended to advance and embed equity within the community health centers they partner with. As such, the grant program is explicit in stating that patient-focused projects do not need to focus on CHPW members and should be designed to have the greatest impact on disparities within the organization's full patient population.

Provider Role: Resources

Becoming a Culturally Competent Healthcare Organization
American Hospital Association/Health Research Educational Trust (2013)

- This guide explores the concept of cultural competency and builds the case for the enhancement of cultural competency in healthcare. It offers seven recommendations for improving cultural competence in healthcare organizations. Also included are self-assessment checklists for hospital leaders and a list of relevant cultural competency resources.

Better Care Playbook: Mental Health and Substance Use
Better Care Playbook (n.d.)

- The Better Care Playbook page on Mental Health & Substance Use is a compendium of resources focused on care models that integrate behavioral health into a whole-person approach, as well as policy initiatives to advance these models.

Better Communication, Better Care A Provider Toolkit for Serving Diverse Populations
LA Care Health Plan (2019)

- This toolkit provides recommendations and resources to help providers and care teams offer culturally and linguistically competent care.

Blueprint for Health Plans: Integration of CBOs to Provide Social Services and Supports
The SCAN Foundation (2019)

- This resource provides guidance for integrating community-based organizations in healthcare with a focus on meeting the needs of older adults and dual eligible individuals with complex medical and social needs.

The Building Blocks of High Performing Primary Care
University of California San Francisco Center for Excellence in Primary Care (2012)

- This resource outlines the Building Blocks identified by UCSF through site visits to high-performing primary care practices and clinics in 2010-2011 and provides tools to discuss the Building Blocks within a medical practice.

The Care We Need: Driving Better Health Outcomes for People and Communities
National Quality Forum (2020)

- This report looks back on twenty years since the Crossing the Quality Chasm report and makes recommendations representing the shared priorities of payers, healthcare systems, clinicians, purchasers, patients, consumers, policy, community leaders, and more to improve care quality.

Center of Excellence for Integrated Health Solutions
National Council for Mental Wellbeing (n.d.)

- This resource provides evidence-based resources, tools, and support for organizations working to integrate primary and behavioral care. The Center has a team of experts in organizational readiness, integrated care models, workforce and clinical practice, health and wellness, and financing and sustainability that partner with organizations to create customized approaches to advance integrated care and health outcomes. This program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Coverage and Financing of SDOH Strategies in Medicaid Managed Care
State Health and Value Strategies (2019)

- This resource outlines options for states to finance social needs interventions through Medicaid managed care.

Creating a Culture of Equity
Institute for Medicaid Innovation, Center for Health Care Strategies (n.d.)

- This document outlines how a culture of equity is defined for healthcare organizations and systems and provides resources designed to facilitate the work of creating a culture of equity.

Cultural Competence and Patient Safety
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network (2019)

- This perspective piece explains the links between cultural competence and patient safety and provides guidance for how to improve cultural competence.

The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities
National Birth Equity Collaborative (2021)

- This resource utilizes focus groups and interviews from communities in the U.S. identified as having higher density of Black births to create a framework for training on anti-racist maternity care.

Ensuring Access in Vulnerable Communities - Taskforce Report and Resources
American Hospital Association (n.d.)

- This report and accompanying resources from the American Hospital Association provide 9 strategies for healthcare organizations to pursue to preserve access in vulnerable communities.

Financial Barriers to Healthcare Access
American Medical Assocation Code of Medical Ethics (n.d.)

- This resource outlines physicians' obligations to address financial barriers to healthcare access. It encourages physicians, health facilities, health insurers, professional medical societies, and public policymakers to work together to ensure sufficient access to appropriate healthcare for all people.

Getting grounded: Building a Foundation for Health Equity and Racial Justice Work in Healthcare Teams
New England Journal of Medicine Catalyst, Innovations in Care Delivery (2022)

- This article provides concrete recommendations for how to prepare healthcare teams to begin addressing health inequities in their relationships, processes, and outcomes based on a learning and action network that the Institute for Healthcare Improvement (IHI) facilitated from 2017-2019.

Guide to Implementing Social Risk Screening and Referral-Making
Kaiser Permanente Center for Health Research, OCHIN (2022)

- This resource provides practical guidance to help practices implement social risk screening and referrals. The guide uses a 5-step roadmap for implementing or improving social risk screening and related activities within a clinic or practice and provides tools, materials, and resources to support each step.

Healing the Nation: Advancing Mental Health and Addiction Policy
Wellbeing Trust (2019)

- This resource is a framework for federal policymakers with actionable solutions for comprehensive, inclusive mental health and addiction policies. This guide provides actionable solutions for healthcare systems, judicial systems, educational systems, workplace & unemployment systems, and in the community.

Hospitals Index
Lown Institute (2021)

- The Lown Institute Hospitals Index is a ranking system that defines standards for hospital social responsibility by examining performance across health outcomes, value, and equity. The Lown Institute provides a number of listings for hospitals that meet different equity measures such as racial inclusivity, community benefit, cost efficiency, and social responsibility.

Implementation Guide: Patient Centered Interactions
Safety Net Medical Home Initiative: Qualis Health, The Commonwealth Fund, GroupHealth (2013)

- This resource provides guidance on addressing measurement of patient satisfaction and experience and describes other mechanisms to gain and use patient and family feedback. The guide provides a format for the structure and flow of patient visits to optimize positive patient health outcomes, lower costs, and enhance experience.

Implementing High-Quality Primary Care: Rebuilding the Foundation of Healthcare
National Academies of Sciences, Engineering, and Medicine (2021)

- This implementation plan includes five objectives to make high-quality primary care available for everyone in the U.S. The implementation strategy includes an implementation framework, an accountability framework, and a public policy framework.

Integrating Social Care into the Delivery of Healthcare: Moving Upstream to Improve the Nation's Health
National Academy of Medicine (2018)

- This resource uses an 18-month study to develop five healthcare activities to better integrate social care into healthcare. These activities are awareness, adjustment, assistance, alignment, and advocacy. The report details specific tools for change within each activity.

National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare: A Blueprint for Advancing and Sustaining CLAS Policy and Practice
U.S. Department of Health and Human Services Office of Minority Health (2013)

- The Blueprint offers practical information for healthcare organizations to implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Opportunities in Medicaid and CHIP to Address Social Determinants of Health
Centers for Medicare and Medicaid Services (CMS) (2021)

- This letter from CMS to states explains how federal Medicaid and CHIP funds can be used to address social determinants of health and offers CMS support to states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall healthcare costs in the Medicaid and CHIP programs.

Patient Centered Medical Home Assessment
Safety Net Medical Home Initiative: Qualis Health, The Commonwealth Fund, GroupHealth (2014)

- This resource is designed to help healthcare organization sites understand their current level of "medical homeness" and identify opportunities for improvement. This assessment can also help sites track progress toward practice transformation when it is completed at regular intervals.

Patient-Centered Medical Home Recognition program
National Committee for Quality Assurance (n.d.)

- This webpage provides resources on why organizations should implement the Patient-Centered Medical Home (PCMH) model and how to get recognized by NCQA as a PCMH.

Person Centered Engagement at the Organizational Level
Center for Consumer Engagement in Health Innovation, Community Catalyst, Health Care Transformation Task Force (n.d.)

- This resource is a guide for leaders and staff at healthcare organizations to aid in developing meaningful person-centered engagement structures at the organizational level. It is informed by a review of literature on consumer engagement and case studies from healthcare organizations that have made commitments to engaging patients and families at the organizational level.

The SHARE Approach
Agency for Healthcare Research Quality (2014)

- The SHARE Approach is a five-step process for shared decision-making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient. AHRQ provides resources for SHARE Approach workshops and tools for implementation.

Using Data to Reduce Disparities and Improve Quality
Center for Health Care Strategies (2021)

- This brief recommends strategies that healthcare organizations can use to effectively organize and interpret stratified quality data to improve health equity for their patients.

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