The development of NAM discussion papers and/or exploratory meetings on the following topics:

- Crosswalk of PFEC standards
- Advancement of improved networking for innovations
- Explicit regulatory supports to promote equity
- Reward system for successful reduction of disparities in outcomes

Executive Community Health Center, Inc. identifies expandable features of successful models based on eight, 000 Medicare beneficiaries, creating collaborative care plans and protocols, processes, and infrastructure that enable peer-to-peer collaboration. (LO)

Camden Coalition enrolls the most vulnerable patients: 93% on 15+ medications, 90% with 4 or more chronic conditions, 30% report depression/anxiety, and 26% homeless upon enrollment. COACH is a model to help people get from where they are to where they want to be by identifying patient priorities, creating collaborative care plans, and motivating patients and connecting with community resources. (RM)

Community Health Center, Inc. recognizes urgent need for increased skill in shared decision making that involves significant patient engagement and trains professionals in multiple disciplines; 91% of trainees practice in primary care and over 80% practice in a community setting. (MF)

Collaborative activities for consideration

- Executive incentives for reducing disparities. Explore the payment structures and incentives of health system and payer executives with respect to the reward system for successful reduction of disparities in outcomes—both within the institution and in the community.
- Regulatory supports to promote equity. Explore how IRS regulations and requirements related to community health needs assessments can be more explicit on identifying health disparities and proposing strategies to reduce them.
- Improved networking for innovations. Assess landscape of proven community engagement models and explore opportunities for better networking so information transfer about successful models is accelerated.
- Advancement of patient and family engaged care. Develop common PFEC action agenda including the creation of national PFEC goals. Develop a crosswalk of PFEC standards and measures and determine ways to digest the framework into messages for various stakeholder groups.
- Compendium of innovations. Explore characteristics of organizations that have set a vision for PFEC and the value proposition for the c-suite.

Core questions:
1. What is the state of the evidence and practice on mobilizing communities to engage underserved and clinically and socially complex populations?
2. What strategies may help communities equip clinicians, patients and families to better manage medical and social complexity effectively?
3. What is the role of leadership in creating and sustaining a community culture of patient, family and community engaged care?

Outcomes intended: Shared stakeholder understanding of the strengths and gaps in evidence on community engagement to reduce health disparities, explore possibilities to develop an index for assessing community values and engagement, and identify ways the NAM might add value.

Representative observations

- Health inequities present a risk to the nation: the gap in life expectancy for the richest 1 percent and poorest 1 percent of men and women is 14.6 and 10.1 years respectively. Community-based solutions rely on multi-sector collaborations ensuring varied approaches. (JW)
- Addressing disparities is a systematic process that requires awareness, prioritization and menu of; evidence-based approaches include: multifactorial/attacking different levers; culturally tailored QI; team-based care; family and community partners; community health workers, and; interactive skills-based training. (MC)
- Creation of learning healthcare community requires active participation of community members and leaders and answering patients’ (not researchers’) questions, improving health and well being of patients and community, and applying principles of CBPR. (CDM)
- Health systems can play various roles in community partnerships to address the building blocks for population health: determinants, community collaboration, quality and equity, access to care for vulnerable populations, and focus on complexity. (IR)
- YMCA has 700+ locations and 75% of US households living within 5 miles of a Y site; Diabetes Prevention Program had $2,650 ROI in 17 cities with 8,000 Medicare beneficiaries showed. Consider impact of hospital competition and compliance and liability issues in partnerships. (ML)
- It is critical that those who work with faith communities acknowledge church resources and potential, and understand their decision making processes; C-TAC’s Interfaith and Diversity Workgroup has a network of over 20 models across the country to address advanced illness. (TP)
- Features of successful models for high cost high need patients include: goal-oriented care; engaging patients and families, and; facilitation of transitions and care coordination. Potential policy improvements include: value-based payment and payment for non-medical services, assist clinicians in adopting best practices, prioritize health information exchange, and support ongoing experimentation. (MA)
- Massachusetts General Hospital is addressing equity in a number of ways including: integration of equity in governance, collecting and stratifying demographic data to identify and address care disparities, and conduct of community health needs assessments for 20 years. (PS)
- Health systems are best equipped to focus on community education, direct care and education; community partnerships are key to addressing broader health needs; barriers to address include fragmentation and competition among hospitals within communities and engaging payers. (JS)
- It is critical that community engagement goals flow through the entire system with leadership driving clarity around goals; barriers to address include articulating the competencies needed for executives addressing equity and engagement and integration with medical education. (JS)
- ImproveCareNow network includes 95 centers, 900 pediatric gastroenterologists and 12,000 children in the US, England, and Qatar. Actor Oriented Structure includes: actors (hospitals, clinics, patients, clinicians, researchers) with shared purpose, capabilities and values; renewable and expandable commons where actors share resources, and; protocols, processes, and infrastructure that enable peer-to-peer collaboration. (LO)
- Community Health Center, Inc. recognizes urgent need for increased skill in shared decision making that involves significant patient engagement and trains professionals in multiple disciplines; 91% of trainees practice in primary care and over 80% practice in a community setting. (MF)
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CARE CULTURE AND DECISION-MAKING COLLABORATIVE
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American Academy of Pediatrics
American Academy of Physician Assistants
American College of Clinical Pharmacy
American College of Nurse-Midwives
American Hospital Association
American Institutes for Research
American Medical Association
American Nurses Association
Association of Academic Health Centers
Association of American Medical Colleges
Asthma and Allergy Foundation of America
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Blue Shield of California Foundation
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C-Change
Cincinnati Children’s Hospital
Coalition to Transform Advanced Care Consumers Union
Consumers United for Evidence-Based Healthcare
C.S. Mott Children’s Hospital
Dana-Farber Cancer Institute
Dartmouth Center for Health Care Delivery Science
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