Medicaid and Public Health Partnership Learning Series

Promoting Value Through Medicaid-Public Health Partnership

CONTENTS

astho™ | NAMD National Association of Medicaid Directors | de Beaumont FOUNDATION

OVERVIEW

This paper is intended to serve as a resource to Medicaid personnel and Medicaid contractors about public health, its role in the healthcare system, and ways that Medicaid and public health can come together to deliver better outcomes for patients, payers, and providers and improve population health.

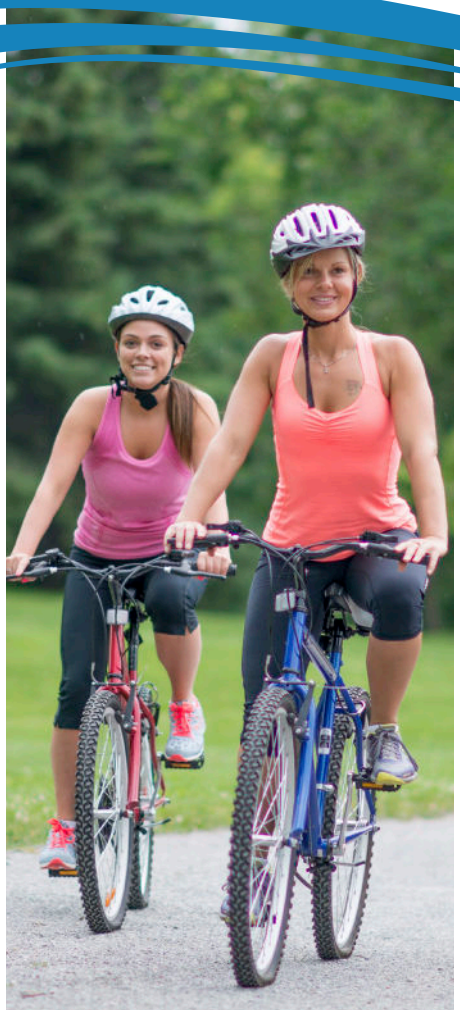
The following steps can support Medicaid and public health in developing effective partnerships:

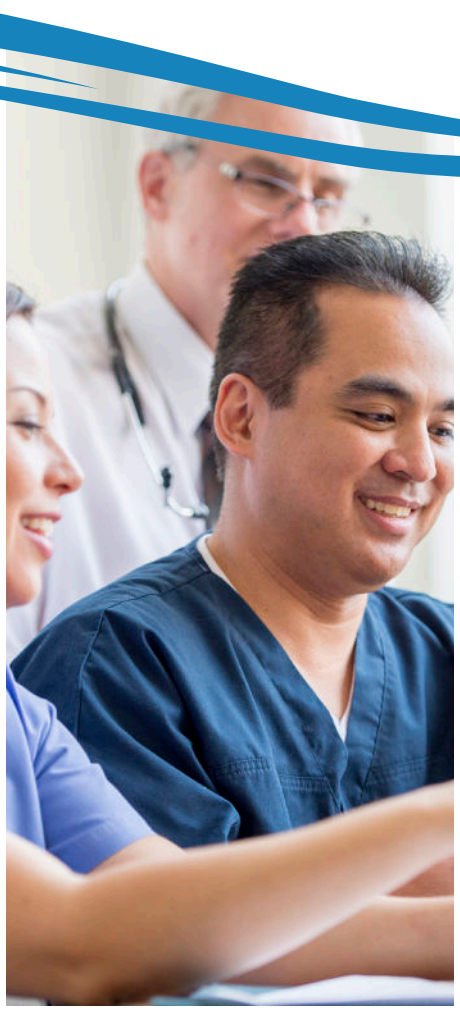
- Learning about each other's structures, as well as their experiences and perspectives regarding budgeting, policy, and implementation.[1]
- Learning about and working toward healthcare transformation while mutually supporting each other's efforts.
- Aligning agency goals through collaborative policy.

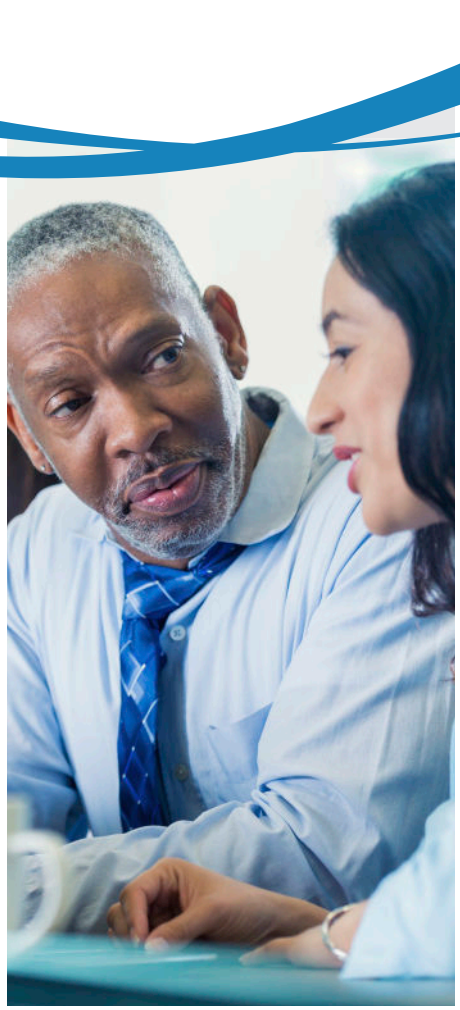
What is Public Health?

Public health refers to "the science and art of preventing disease, prolonging life, and promoting health through organized efforts and informed choices of society, organizations, public and private, communities, and individuals."[2] The work of public health is centered on promoting healthy lifestyles through health education, protecting against environmental hazards, controlling infectious diseases, preparing for and responding to disasters, and promoting healthcare equity, quality, and accessibility. Overall, public health is focused on protecting the health of entire populations, from the community level up to the global level.

Public health also refers to the workforce of health professionals (both governmental and nongovernmental) whose chief focus is preventing health problems from occurring or recurring. Public health professionals develop and implement educational programs, conduct research, administer health services, and make policy recommendations. This is in contrast to clinical professionals, who provide direct patient care through clinical screenings, diagnosis, and treatment after a person has become sick or injured. Although public health professionals work in many organizations, this paper focuses primarily on public health work carried out by those in government agencies, such as state health agencies.







Structure of Public Health in the United States

The governmental public health system in the United States is comprised of several federal agencies, 51 state health agencies, eight territorial health departments, approximately 200 tribal health departments, and more than 2,500 local health departments. Public health programs are funded through a combination of federal, state, and local dollars. Part of the federal funding is awarded through grants for which states and other jurisdictions must compete, and part is awarded through grants determined by population-based formulas derived from disease rates or other incidence formulas.[3] State and local funding varies dramatically due to the variety of organizational arrangements within public health, from full centralization of county and state programs to full decentralization. State public health agencies can either be freestanding agencies or part of an umbrella agency in which they reside alongside other programs, such as Medicaid and Medicare, public assistance, and substance abuse or mental health services.[4]

State health agencies are often programmatically and fiscally responsible for federal initiatives (e.g., CDC's Public Health Emergency Preparedness cooperative agreement, HRSA's Title V Maternal and Child Health funding, the Preventive Health and Health Services Block Grant, and ASPR's Hospital Preparedness Program cooperative agreement). In cases where they are not solely responsible, they usually share it with a nonprofit organization or local governmental agency.[5]

State public health agencies rely on their counterpart Medicaid programs for a significant portion of their financial resources. For example, according to the *ASTHO Profile of State Public Health, Volume Three*, Medicaid accounted for $561 million in funding for the reporting states.[6] Health officials at all levels of government develop prevention and population health initiatives, some of which are funded, either wholly or in part, through Medicaid. A high degree of coordination is necessary to successfully implement these initiatives. For more information on the unique agency features and inherent differences between public health and Medicaid, see the "Unique Agency Features and the Components of Medicaid-Public Health Partnership" issue brief.

State Health Agency Federal Revenue by Source for FY2011

	TOTAL	CATEGORICAL	GENERAL
USDA	7,100	7,100	
CDC	2,112	2,112	
HRSA	1,285	1,285	
DHS	886	886	
MEDICAID	561		561
EPA	386	386	
MEDICARE	299	299	
FEDERAL INDIRECT	357		357
TOTAL	12,986	12,068	918

***Note: In millions of dollars. Not all states provided values for all federal revenue sources or expenditure categories. Ns range from 29 to 46.**

MAKING THE CASE FOR PARTNERSHIP

Population health is defined as a group's health outcomes, including the distribution of such outcomes within the group, as measured by health status indicators.[7] Population health outcomes are the product of multiple underlying conditions that help determine health (collectively referred to as the social determinants of health), including clinical care, public health, genetics, behaviors, social and economic factors, environmental factors, and disparities in the population. This definition recognizes that it takes many different parts of a community to produce health and well-being, and highlights that population health is a product of collaboration. For more information on public health's role in population health, see the "Public Health and Population Heath 101" learning series document.

Because of their shared focus on population health, Medicaid and public health agencies are natural partners and leaders in efforts to promote collaboration as the health system transforms. As the largest source of healthcare funding for people with low income in the United States, Medicaid is in a special position to bridge public health efforts to the patient level. Furthermore, because the population using Medicaid is the most affected by health disparities, Medicaid has the power to help prevent illness in the people most vulnerable to disease and injury. Preventing illness is the surest way to reduce healthcare expenditures. Together, Medicaid and public health can tackle the determinants of health in ways that improve health outcomes and reduce healthcare costs.

Social and environmental determinants of health:

"Health starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it. Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. It's time we expand the way we think about health to include how to keep it, not just how to get it back."

–Robert Wood Johnson Foundation. "A New Way to Talk About Social Determinants." 2010. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023.

The growing national emphasis on population health and preventive care—for example, through the Affordable Care Act (ACA)—highlights the importance of these collaborations. A 2012 report from the Institute of Medicine recognized that new opportunities are emerging to bring public health and clinical care together in ways that will yield substantial and lasting improvements for individuals, communities, and populations.[8] Initiatives such as the ASTHO-supported Integration Forum emphasize and support this integration.[i] Similarly, the *Practical Playbook*—an initiative of the de Beaumont Foundation, Duke Community and Family Medicine, and CDC—highlights concrete examples of such partnerships.

The biomedical model is shifting to a public heath paradigm,[9] which means the U.S. health system is transitioning from a sick-care model to a model of prevention and health cultivation. Therefore, we need to transform our healthcare system into one which supports population health goals and optimizes health system performance.

[i]The Integration Forum is a partnership of more than 50 organizations and more than 100 individual partners seeking to inform, align, and support the implementation of integrated efforts that improve population health and lower healthcare costs.

Making the Case for Partnership

WHY A HEALTH SYSTEM TRANSFORMATION NOW?[10]
The dramatic rise in healthcare costs has led many stakeholders to embrace innovative ideas.
Health research continues to demonstrate the importance of social and environmental determinants of health and the impact of primary prevention.
An unprecedented wealth of health data is providing new opportunities to understand and address community-level health concerns.
ACA presents new opportunities to change the way health is approached in the United States.

To successfully transform our healthcare system and ensure a functioning partnership, public health and Medicaid should look for opportunities to align their goals. One framework for aligning public health and Medicaid goals is the Triple Aim.

The Triple Aim

The Institute for Healthcare Improvement's Triple Aim framework describes an approach for optimizing health system performance across the healthcare system. The three dimensions of the framework are:

- Improving the patient experience of care, including quality and satisfaction.
- Improving the health of populations.
- Reducing the per capita cost of healthcare.

Prevention is the underlying driver of health system transformation—it is what will ultimately lower costs, improve patient care, and improve the health of populations. Because prevention is the backbone of public health efforts, Medicaid leaders may want to apply public health's prevention strategies to their own programs. The Medicaid program is likely to benefit from successful prevention strategies because of its disproportionate spending on chronic conditions[11] and the potential for realizing both cost savings and improved health outcomes.

Prevention is Cost-Effective

Preventing disease and injury is one of the most cost-effective ways to improve health. A Trust for America's Health report indicates that spending just $10 per person annually on community-based prevention programs could save the nation more than $16 billion a year within five years, a nearly $6 return for every $1 spent.[12]

Beyond these broad community returns, there is evidence that investments can return savings to the Medicaid program itself. In addition, a George Washington University research report found that every $1 invested in the Massachusetts Medicaid tobacco cessation program produced an average savings to the Medicaid program of $3.12 in cardiovascular-related hospitalization expenditures within three years.[13] The program includes collaboration between Medicaid and public health, as participants can use Quitworks, a telephone counseling service covered by Medicaid and jointly funded by the Massachusetts Department of Public Health. More results from this program can be found in the ROI for the MassHealth Smoking Cessation Benefit Briefing Sheet.

Medicaid and public health leaders can examine how to bend the cost curve, provide coverage for community-based prevention initiatives, and address Medicaid health outcomes and preventable hospitalization challenges. The New York State Medicaid Redesign Team has framed questions that may be helpful for agencies to ask in partnership:[14]

1. **What are we paying for that we shouldn't?**
2. **What aren't we paying for that we should?**
3. **What kinds of prevention could we deliver in public health?**
4. **How do we advance the Triple Aim?**

OPPORTUNITIES FOR PARTNERSHIP

Payment and Delivery Reform Models

The Center for Medicare and Medicaid Innovation has offered opportunities for states and others to implement payment and delivery reform through the State Innovation Models Initiative. Innovative payment models include modified versions of the fee-for-service model that allow states to transition from a volume-based model to a value-based reimbursement model, and are thus aligned to improve health and reduce costs.

In tandem with the burgeoning interest in new payment models, some states are also developing and testing new healthcare delivery approaches, all of which are linked to improved health outcomes. These include:

- Integrating care systems, such as physical and behavioral health, and facilitating smoother hand-offs between providers to better manage chronic conditions for complex patients (e.g., multipayer, dual eligibles, multiple chronic conditions, physical and behavioral comorbidities, etc.). More than 22 states are now using Medicaid Managed Long Term Services and Supports through capitated Medicaid managed care programs as a strategy for expanding home and community-based services. In addition, the Centers for Medicare and Medicaid Services (CMS) launched state demonstrations in 2013 to test capitated and managed-fee-for service models to integrate care and align financing for dual eligible beneficiaries.

- Covering high-yield nonmedical services (e.g., tobacco-cessation group therapy) under home- and community-based and flexible services options. Medicaid and public health can determine the types of nonmedical services that should be covered.[15]

- Increasing utilization of community health aides from outside the traditional licensed medical workforce (e.g., community health workers, patient advocates/health navigators, peer wellness specialists, and doulas). Using these kinds of health workers to increase access to care and reduce health disparities is cost-effective for both Medicaid and public health.[16] Securing Medicaid reimbursement for these types of providers is one approach states may pursue to enhance preventive health services.[17] Examples of these services include community education (e.g., nutrition, chronic disease management, etc.), linkage to health system and social service resources, home visits, and patient advocacy.

- Providing health home services for Medicaid enrollees with chronic conditions under the Health Home state plan option.[18] ACA's Section 2703 authorizes a temporary 90-percent enhanced federal match assistance for health home services specified in the law.

- Developing and implementing Delivery System Reform Incentive Payment (DSRIP) initiatives to fund Medicaid delivery system reforms (e.g., redesigning or expanding care management models, creating integrated delivery systems, improving population and clinical outcomes, and incentivizing providers to meet performance metrics and data reporting requirements).[19] Since 2010, eight states have implemented DSRIP or DSRIP-like programs—a component of Section 1115 demonstrations.[20]

- Many of these efforts are made possible by Medicaid state plan amendments as part of larger Section 1115 waivers, or 1915(c) waivers in the case of many home- and community-based service programs.

New York's Medicaid Redesign

Under its 1115 waiver, the New York State Medicaid Redesign Team has reinvested in New York's healthcare infrastructure in a number of innovative ways, including: a new multiyear Medicaid Global Spending Cap, which applies to the state share of Medicaid spending controlled by the health department; new powers granted to the health commissioner, which allow him or her to modify the program without legislative approval; and a statewide plan to gradually replace the uncoordinated fee-for-service program with fully-integrated managed care for all Medicaid members. The state has also implemented a delivery system reform incentive payment that seeks to reduce hospital use by 25 percent and enable Medicaid providers to accept risk for populations under alternative payment models (such as capitation and global payments).

–New York Department of Health. "Redesigning New York's Medicaid Program." June 2015. Available at https://www.health.ny.gov/health_care/medicaid/redesign/

Budgeting Metrics

Public health agencies can also help Medicaid develop a fiscal analysis of its prevention programs' healthcare savings by providing data and expertise on what to cover. Demonstrating prevention programs' ROI can help identify population health initiatives that would achieve both economic and health impact, thereby enabling Medicaid programs to target appropriate program investments. This also supports Medicaid agencies in being responsive and accountable to the many entities that provide program oversight, including the legislature.

For example, under the Neonatal Outcomes Improvement Project, CMS funded several states to pilot project interventions through Medicaid Transformation Grants. They produced significant cost savings from averted neonatal intensive-care unit admissions: an estimated $24.8 million in savings for Ohio for the three-year period and $2.4 million in savings for North Carolina.[21] Since then, many state health departments have collaborated with state Medicaid agencies to reduce early elective deliveries in an effort to improve infant and maternal health outcomes and reduce costs. More information about these collaborative efforts can be found in the Reducing Early Elective Deliveries in Medicaid and CHIP brief.

Partners in Data Sharing: Collection, Analysis, and Evaluation

Integrating information technology is key to assessing, monitoring, and improving population health. The uptake of electronic health records (EHR) by private practices, hospitals, and other providers has the potential to allow for clinical data to be analyzed at various granular levels so that best medical practices can be identified and patient outcomes can be systematically analyzed and improved.

Widespread systematic digital recordkeeping has also led to the establishment of:

- Health information exchanges (HIE), which allow doctors, nurses, pharmacists, other healthcare providers, and patients to access and securely share a patient's vital medical information electronically, improving the speed, quality, safety, and cost of patient care.[22] Funding for some state HIE activities is already available through the Medicaid EHR Incentive Program.

- All payers claims databases (APCDs), which are large-scale repositories of healthcare insurance claims and eligibility and provider files, regardless of billing source. According to the Rhode Island Department of Health: "The goal of an APCD is to provide actionable data that supports the study and comparison of healthcare utilization, cost, and trends; to identify opportunities for improvement in healthcare quality; and to inform consumers."[23] An interactive state report map is available from the APCD Council.

Medicaid's EHR Incentive Program and APCDs advance public health's goals of quality improvement and improving the understanding of the healthcare system. Public health's ability to make sound policy recommendations will be enhanced as more state Medicaid agencies participate in APCDs.

Data sharing between the two state agencies can facilitate a mutually beneficial relationship, as each agency can help the other achieve some of its goals. According to the Health Care Financing Administration, HRSA, and CDC, examples of benefits that can be derived from data-sharing include:[24]

- Encouraging the development of integrated information systems at the state level to support the evolving role of state government in assuring appropriate, accessible, cost-effective care for vulnerable populations.

- Improving the technical capacity of states to analyze data from multiple sources to support policy decisionmaking and program monitoring.

- Promoting the development and implementation of common performance measures across multiple programs to improve their effectiveness.

- To better utilize Medicaid encounter data to assist in public health surveillance to ensure appropriate care for the Medicaid population.

Opportunities for Partnership

Public health is the official repository of vital statistics data on births, deaths, marriages, and other data that can be useful to Medicaid. For example, public health vital event data for deaths form an important quality control component for Medicaid to ensure the integrity of membership rolls. Public health skills in population health data, cost, and quality also present opportunities for Medicaid in terms of streamlining income eligibility, price and quality transparency, and sustainable growth over time.[25]

Maternal and child health (MCH) provides examples of successful data-sharing models, specifically for infant births. Medicaid is the number-one payer for newborn deliveries,[26] and thus has the most clinical data on them. State health agencies have data from MCH programs, such as vital registration, immunization, birth defects registration, and blood lead registries. Linking these MCH data systems can improve MCH program responses and improve outcomes.

Additionally, the federal Maternal and Child Health Bureau's Effective Follow Up Program has supported using HIE in state newborn screening systems. For example, the Indiana State Department of Health has the Newborn Screening Tracking and Education Program (INSTEP)—a web-based application for collecting, managing, and sharing newborn health information. INSTEP enables providers, birthing facilities, and public health agencies to access integrated, population-based, real-time data on newborn screening results.[27]

Medicaid and public health agencies can also work together to develop and select performance metrics, including a unified set of quality measures. This metric set would be useful for demonstrating improved care and savings across a range of settings and could be applicable toward:

- Health system performance (overall quality and efficiency).
- Population health objectives.
- Community health needs assessments.
- Evaluation of population health interventions.
- A standardized definition of "value" in a value-based payment system.
- Clinical quality and efficiency.
- Clinical preventive measures.
- Measures of successful integration to evaluate the impact of the reforms.
- Best practices.

Partners in Community and Consumer Engagement

Public health and Medicaid programs can benefit from each other's positions as trusted conveners of community stakeholders, and work toward mutually agreed upon goals to achieve better outcomes and improve population health. Medicaid can support and participate in regional collaboration between local stakeholders (including local health departments) through community empowerment models in which providers and payers are involved with local planning processes. For example, bodies such as community advisory councils and regional health improvement collaboratives convene providers, payers, purchasers, consumers, and other community members to seek consensus among the stakeholders to establish direction.[28,29] Activities may include developing community health assessments and community health improvement plans, providing measurable outcomes and data sources, and identifying evidence-based interventions.[30]

Public health agencies and Medicaid can also work together to support Medicaid reimbursement for patient navigators to improve health literacy among patients, enabling them to be more engaged in their healthcare and make better-informed decisions. Accountable care organizations, patient-centered medical homes, and other new payment and delivery structures can adopt measures of patient engagement, such as patient activation (the degree to which someone sees himself or herself as a manager of his or her health and care), since engaged patients produce better health outcomes. Additionally, public health and Medicaid programs should ensure that program-related and health-related materials are written at an appropriate level for their audiences. This can enable public health and Medicaid agencies to move toward shared decisionmaking with patients by incorporating the patient's preferences and values into treatment decisions, decreasing their anxiety about the care process, and ultimately improving health outcomes.[31]

States can also begin to explore nontraditional public health and Medicaid partnership opportunities to address the upstream determinants of health of individuals and improve population health. Limited access to transportation, for example, creates health disparities in communities and can limit opportunities for education, employment, and recreational activities for older adults and people with disabilities. Medicaid can collaborate with public health departments to be a voice within government for accessible transportation and more walkable communities. Greater access can significantly improve the health of those Medicaid serves; in turn, Medicaid stands to reap cost-savings from reduced healthcare expenditures. In many cities, public health has already paved the way for partnership with transportation officials and metropolitan planning organizations. Additionally, by exploring a "flexible services" model, Medicaid can pay for nonmedical services or equipment that have not been traditionally covered but have the potential to help patients manage chronic conditions (e.g., an air conditioner for a patient with congestive heart condition), while reducing costs and improving health.

RESOURCES

- "**Introduction to Public Health.**" CDC. October 2014. http://www.cdc.gov/publichealth101/documents/introduction-to-public-health.pptx *Introduces public health, the social determinants of health, and the field's history.*

- "**Report to the Congress on Medicaid and CHIP: Medicaid and Population Health.**" Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_and_Population_Health.pdf. *Provides additional information on Medicaid's role in promoting population health.*

- "**Return on Investments in Public Health: Saving Lives and Money.**" Robert Wood Johnson Foundation. December 2013. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf72446. *Provides additional information on the cost-effectiveness of public health services.*

- "**Eye on the Prize: States Looking at Goals, Outcomes for Budget Decisions.**" The Council of State Governments. March 2013. Page 12. http://www.csg.org/pubs/capitolideas/2013_mar_apr/2013_mar_apr_images/CI_MarApr13.pdf. *Provides additional information about performance measures and performance-based budgeting.*

- "**Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models.**" Nemours Foundation. June 2013. http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf. *Provides additional information about Medicaid financing for prevention services, including challenges and policy recommendations.*

- "**Medicaid Reimbursement for Community-Based Prevention.**" The Nemours Foundation. http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/. Based on convening held in October 2013. *Provides additional information on the uptake and implementation of Medicaid-reimbursable, community-based prevention, as well as a list of examples of services by non-licensed providers that could potentially be Medicaid-reimbursable.*

- "**The Practical Playbook.**" The deBeaumont Foundation, Duke Community and Family Medicine, and CDC. 2014. https://www.practicalplaybook.org/. *Provides information on the principles of primary care-public health integration and success stories.*

- "**Report to Congress on Preventive Services and Obesity-related Services Available to Medicaid Enrollees.**" Kathleen Sebelius, Secretary of HHS. 2014. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/rtc-preventive-obesity-related-services2014.pdf. *Provides guidance to states that enables them to design public awareness campaigns to educate Medicaid enrollees on the availability and coverage of preventive and obesity-related services.*

REFERENCES

[1] Nemours Foundation. "Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models." June 2013. Available at: http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf. Accessed 3-31-2015.

[2] Winslow CEA. "The Untilled Fields of Public Health." *Science*. 1920. 51(1306):23-33. Available at http://science.sciencemag.org/content/51/1306/23. Accessed 1-13-2016.

[3] Trust for America's Health, Robert Wood Johnson Foundation. "Investing in America's health: A state-by-state look at public health funding and key health facts." May 2014. Available at: http://healthyamericans.org/assets/files/TFAH2014-InvestInAmericaRpt08.pdf. Accessed 3-31-2015.

[4] Association of State and Territorial Health Officials. *ASTHO Profile of State Public Health*, Volume Three. Arlington, VA: Association of State and Territorial Health Officials. 2014. Available at http://www.astho.org/Profile/Volume-Three/. Accessed 6-11-2015.

[5] *Ibid.*

[6] *Ibid.*

[7] Adapted from Kindig D, Stoddart G. "What is population health?" *American Journal of Public Health*. 2003. 93(3):380-383. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/. Accessed 1-13-2016.

[8] IOM. "Primary Care and Public Health: Exploring Integration to Improve Population Health." Washington, DC: The National Academies Press, 2012. Available at http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx. Accessed 7-24-2014.

[9] Fielding JE, Teutsch S, Breslow L. "A framework for public health in the United States." Public Health Reviews. 2010. 32:174-189. Available at http://www.publichealthreviews.eu/show/f/25. Accessed 4-14-2015.

[10] Wallace P, Michener L, Wellik M. "Primary care and public health: Exploring integration to improve population health." March 28, 2012. Available at http://www.graham-center.org/dam/rgc/documents/publications-reports/presentations/primary-care-public-health.pdf. Accessed 3-31-2015.

[11] Center for Medicaid and CHIP Services. "Targeting Medicaid super-utilizers to decrease costs and improve quality." CMCS Informational Bulletin: July 24, 2013. Available at http://medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf. Accessed 3-31-2015.

[12] Trust for America's Health. "Prevention for a healthier America: Investments in disease prevention yield significant savings, stronger communities." February 2009. Available at http://healthyamericans.org/reports/prevention08/Prevention08.pdf. Accessed 3-31-2015.

References

[13] Richard P, West K, Ku L. "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts." January 2012. Available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0029665. Accessed 9-18-2015.

[14] Shah N, Helgerson J. "Building partnerships and financing prevention in Medicaid and CHIP: Medicaid – Public Health Collaborations in New York." June 13, 2013. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/ppmc4-partnerships.pdf. Accessed 3-31-2015.

[15] Nemours Foundation. "Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models." June 2013. Available at http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf. Accessed 3-31-2015.

[16] Perry H, Zulliger R. "How effective are community health workers? An Overview of Current Evidence with Recommendations for Strengthening Community Health Worker Programs to Accelerate Progress in Achieving the Health-Related Millennium Development Goals." September 2012. Available at http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/review%20of%20chw%20effectiveness%20for%20mdgs-sept2012.pdf. Accessed 3-31-2015.

[17] Rosenthal EL, Brownstein JN, Rush CH, et al. "Community health workers: Part of the solution." July 2010. Available at http://content.healthaffairs.org/content/29/7/1338.full. Accessed 6-8-2015.

[18] Kaiser Family Foundation. "Medicaid's New 'Health Home' Option." January 2011. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8136.pdf. Accessed 9-18-2015.

[19] Kaiser Family Foundation. "An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers." September 2014. Available at http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers. Accessed 9-18-2015.

[20] National Academy for State Health Policy. "State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools." March 2015. Available at https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf. Accessed 9-18-2015.

[21] Centers for Medicare and Medicaid Services. "Reducing Early Elective Deliveries in Medicaid and CHIP." Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf. Accessed 9-18-2015.

[22] The National Learning Consortium, HIT.gov. "What is HIE?" May 12, 2014. Available at http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie. Accessed 3-31-2015.

[23] Rhode Island Department of Health. "All-Payer Claims Data Base Program." Available at http://www.health.ri.gov/programs/detail.php?pgm_id=117. Accessed 3-31-2015.

References

[24] Health Care Financing Administration, Health Resources and Services Administration, CDC. "Facilitating Collaborations for Data Sharing between State Medicaid and Health Agencies." April 2012. Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD102298.pdf. Accessed 12-27-2015.

[25] Association of State and Territorial Health Officials. "Primary Care and Public Health: Linking Public Health and Advanced Primary Care to Improve Outcomes." Presented at ASTHO's Delivery and Payment Reform Technical Assistance Call #1. Jan. 9, 2015. Available at http://www.astho.org/Programs/Health-Systems-Transformation/TA-Call-Series-Advanced-Primary-Care-Slides/. Accessed 3-31-2015.

[26] Center for Medicaid and CHIP Services. "Strategies for Using Vital Records to Measure Quality of Care in Medicaid and CHIP Programs." 2014. *Technical Assistance Brief*, Issue 4. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Using-Vital-Records.pdf. Accessed 1-4-2016.

[27] Association of State and Territorial Health Officials. "State Options for Enhancing Health Information Exchange for MCH Systems." Available at http://www.astho.org/Maternal-and-Child-Health/Collaborations/MCH-and-Health-Information-Exchange-Issue-Brief. Accessed 12-27-2015.

[28] The Network for Regional Health Improvement Collaborative. "Regional Health Improvement Collaboratives (RHICs): Conveners, Collaborators and Catalysts for change." Available at http://www.nrhi.org/about-collaboratives/. Accessed 3-31-2015.

[29] Health Share of Oregon. "Community Advisory Council." Available at http://www.healthshareoregon.org/about-us/community-advisory-council.html. Accessed 3-31-2015.

[30] *Ibid.*

[31] Lee, EO, Emanuel EJ. " Shared decision making to improve care and reduce costs." *The New England Journal of Medicine*. 2013. 368:6-8. Available at http://www.nejm.org/doi/full/10.1056/NEJMp1209500. Accessed 3-20-16.