



Advancing Health Equity through APMs

GUIDANCE FOR EQUITY-CENTERED DESIGN AND IMPLEMENTATION



The following sections provide guidance for designing and implementing the care delivery redesign element: *provision of person-centered, culturally and linguistically appropriate care.*

DESIGN GUIDANCE FOR PROVISION OF PERSON-CENTERED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

ENCOURAGING AND ENABLING PERSON-CENTERED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

Essential and Enhanced Alternative Payment Model (APM) Design Guidance

- Develop a common definition of person-centered, culturally and linguistically appropriate care that is embedded in the APM contract. Incorporate cultural sensitivity and treating people with dignity; address physical, behavioral, oral, and social health.
- Promote the use of a team-based care delivery model to address the holistic health needs of people experiencing disparities. Emphasize the importance of individuals co-creating their care plan, shared decision-making, and self-management.

Examples

- APM stakeholders agree to use the [four core concepts of person-centered care](#) defined by the Institute for Patient- and Family-Centered Care as their shared definition. The provider organization develops training programs for new and existing care teams (e.g., training on [National Culturally and Linguistically Appropriate Services \(CLAS\) Standards](#), trauma-informed care, and collaborative care planning) to meet the agreed upon definition.
- The New York-based [Pathway Home](#) program demonstrates how payers and providers can work together to integrate physical, behavioral, and social health. This community-based program offers care coordination and care management for patients with serious mental illness and other complex health histories, with a focus on holistic, integrated care.
- The provider organization develops a [collaborative care planning](#) model. Implementation of this model is supported, when possible, by frontline staff who are culturally and linguistically concordant with their patients.

INCORPORATING AN EXPANDED HEALTHCARE WORKFORCE

Essential APM Design Guidance

- Develop a common understanding of the services and staffing approaches that promote person-centered, culturally and linguistically appropriate care.
- Provide care using an expanded healthcare workforce, based on the identified needs of the patient population.
 - Collaborate with community-based organizations (CBOs) to hire, train, and manage the expanded healthcare workforce.
 - Integrate the expanded healthcare workforce into workflows/care teams to provide services relevant to the needs and priorities of individuals, families, and communities experiencing health disparities.
- Improve access to healthcare for populations with limited English proficiency or who are Deaf/hard-of-hearing through easy-to-access medical interpretation services. Whenever possible, provide these services in-person rather than telephonically or through video.



Enhanced APM Design Guidance

Essential guidance, plus:

- Partner with individuals and communities who experience inequities to understand community-defined best practices for care, which are reflected in the services and staffing approach.

Examples

- Oregon Health Authority (Medicaid) covers services provided by an expanded healthcare workforce (known as “[traditional health workers](#)”) consisting of birth doulas, personal health navigators, peer support specialists, peer wellness specialists, and community health workers.
- Oregon Health Authority requires provision of high-quality medical interpretation services, paid for as part of a global budget. These requirements include interpretation for languages other than English and for Deaf/hard-of-hearing patients. Oregon measures adoption of this requirement through their [Meaningful Language Access](#) metric.
- Medicaid health plans in Washington, D.C. contract with [Mamatoto Village](#), a community-based program which supports perinatal health workers in providing culturally appropriate prenatal and postpartum services to women of color, who are more likely to experience inequities in maternal health outcomes.
- APM stakeholders (e.g., payers, providers, and CBOs) work with community members to understand [community-defined best practices](#) to address disparities in mental health outcomes. Based on this partnership, stakeholders agree that the APM will include coverage for select new services (e.g., Tribal Traditional Health practices for Native American members).

MEASURING ADOPTION OF PERSON-CENTERED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE PRACTICES

Essential APM Design Guidance

- Develop a concise set of aligned measures, [in partnership](#) with APM stakeholders including individuals and CBOs, for monitoring care delivery redesign, particularly the hiring and utilization of an expanded healthcare workforce and with attention towards minimizing additional provider burden.
- Monitor engagement with the expanded workforce by individuals experiencing health inequities using measures stratified by race, ethnicity, language, and other characteristics.

Enhanced APM Design Guidance

Essential guidance, plus:

- Develop and test the use of a concise set of aligned metrics for person-centered, culturally and linguistically appropriate care, prioritizing patient-reported experience and outcomes measures. Stratify metrics by race, ethnicity, language, and other characteristics to identify disparities.

Examples

- Existing APM reporting requirements are modified to include questions about hiring and retention of the expanded healthcare workforce, utilization of the expanded healthcare workforce (including provision of interpretation services), and implementation of other agreed upon aspects of person-centered, culturally and linguistically appropriate care.
- APM participants test quality metrics related to patient-reported experiences (e.g., [Health Confidence Score](#), [collaboRATE tool](#), [CAHPS ECHO Survey](#)). The payer creates a pay-for-reporting incentive to support data collection for these measures.

STRUCTURING PAYMENT TO SUPPORT PROVISION OF CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

Essential and Enhanced APM Design Guidance

- Incorporate time-limited, upfront payment to support capacity-building activities—including development of data collection and analysis capacity—required to provide person-centered, culturally and linguistically appropriate care to populations experiencing health inequities.
- Adjust prospective, population-based payments to sufficiently account for services provided by the expanded healthcare workforce that are designed to promote health equity but otherwise not accounted for in medical costs.

Examples

- Washington State's [Multi-payer Primary Care Transformation Model](#) includes an upfront care transformation payment which will be provided to practices for up to three years in order to build capacity and support care delivery transformation.
- Prospectively paid primary care/population health APMs are adjusted to support services delivered by an expanded healthcare workforce.

IMPLEMENTATION APPROACHES FOR CARE DELIVERY REDESIGN



Payers and purchasers can create an APM contract that broadly defines the expanded healthcare workforce. This allows provider organizations and **CBOs** the flexibility to work with a meaningful subset from this broad definition, ensuring the expanded workforce is well-suited to address the health disparities experienced by the patient population.

Payers and purchasers can develop guardrails that outline acceptable use of upfront payments to ensure capacity-building and infrastructure development activities focus on advancing health equity.



Provider organizations can implement care delivery redesign by supporting the development of their workforce. For example, organizations might consider mandating annual training for all staff (initially supported by the upfront capacity-building payment) that focuses on culturally and linguistically appropriate care and employing community health workers who are specifically trained in [collaborative care planning](#).



Individuals, families, and communities can work with payers, purchasers, and providers to develop a concise set of metrics to measure progress on care delivery redesign and assess patient experience. **Providers** can work with **individuals, families, and communities** to understand what measures reflect patient values and can employ multiple modalities of data collection to ensure that a diverse set of patients are able to report on their experiences and outcomes. **Payers and purchasers** can consider how to support additional data collection by minimizing administrative burden (e.g., replacing some existing measures with new patient-reported measures, creating time-limited pay-for-reporting programs). **All stakeholders** can develop methods to share this data and use it to inform interventions that promote more equitable experiences and outcomes.

APM stakeholders, especially **provider organizations**, can consider strategies to support the hiring, retention, and diversity of their workforce. This includes creating a workforce that is more representative of the populations they serve (e.g., people of color, people with disabilities, members of the LGBTQIA+ community, immigrants or people with similar cultural backgrounds in communities with large immigrant populations). Workforce diversity can be a goal at all levels of the organization and may be supported through organizational changes such as changing recruitment or interviewing practices, providing sufficient supervision and mentorship, promoting organizational equity (e.g., equal pay across race and gender identity), and creating pathways for career progression. Organizations can also support broader efforts to increase diversity, such as investing in career pipeline programs for people who belong to traditionally marginalized groups. Different strategies may need to be applied for different types of employees.

