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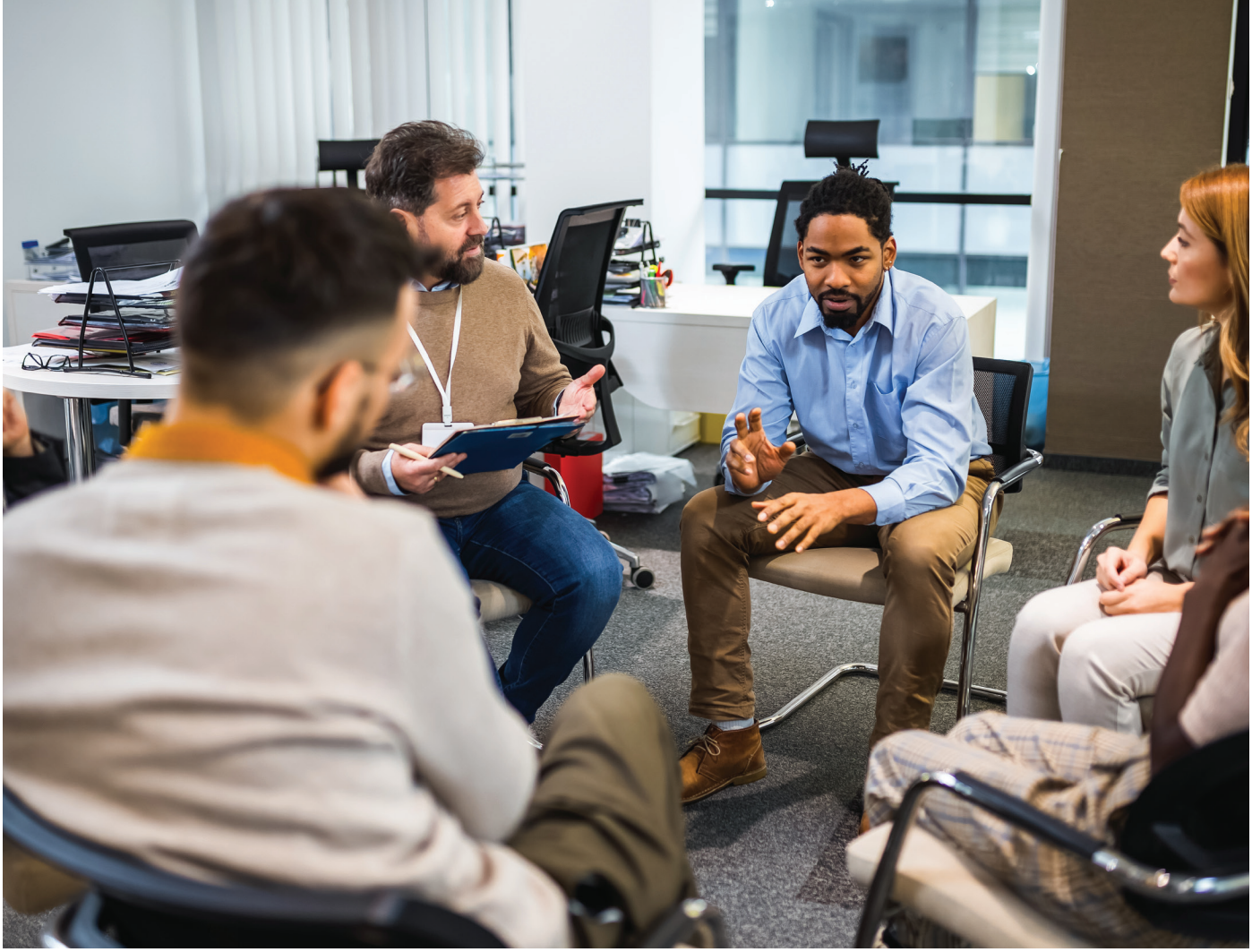
Inclusive Health Attributes and Purchasing Principles

Purchaser Business Group on Health



Introduction

The Inclusive Health Workgroup, a purchaser-led initiative of the Purchaser Business Group on Health (PBGH), has developed inclusive health attributes to define the care and services they expect employees and their families to receive in all health care settings, regardless of personal characteristics or geography. These attributes can be used to guide an organization's broader inclusive health strategy. Additionally, private and public purchasers have collectively agreed to purchasing principles that can be used to guide the procurement of inclusive care and services. Aligning to the PBGH Inclusive Health Vendor Assessment, these resources can articulate purchaser expectations to health plan and vendor partners to ensure employees and their families are receiving the high-quality care and equitable outcomes they deserve.

Inclusive Health: Defining a Shared Standard

Attributes

Person- and family-centered

Care is tailored to the unique needs and priorities of patients and their families. Patients share preferences and goals of treatment, engage in shared decision-making with their care team and are made to feel their choices are respected and integrated into care plans through provider relationships that are built on trust and compassion.

Accessible

Patients receive appropriate, culturally congruent, affordable and timely care with a care team that is familiar with their needs and is available through multiple modalities (e.g., in-person, virtual, synchronous, and asynchronous). Support is provided for patients residing in care deserts, with accessibility needs, limited English proficiency and varying levels of health literacy.

Whole-person well-being

Care is not limited to an episode in the clinical setting, but includes health restoration, resilience promotion and disease prevention across the lifespan. Care is proactive and includes behavioral health and support for health-related social needs, particularly for patients at high or increasing risk, including patients that have transportation barriers, limited internet access or unstable housing.

Integrated and coordinated

Patients' physical, mental and social needs are communicated across their care teams, with other providers and care settings utilizing a shared electronic medical record (EMR). Care teams have full transparency on a patient's health status and care treatment plan. Patients are guided through transitions between facilities, specialty care and their primary care teams; continuity of care is prioritized. Patients can easily navigate across settings with established referral pathways to high-value providers with whom the care team exchanges information and coordinates care.

High-quality care and services

Patients receive and experience personalized care services and health outcomes that do not vary in quality or access due to personal characteristics, such as geographic location, gender, race, ethnicity, language, gender identity, sexual orientation or socioeconomic status. Care teams proactively monitor the patient's care to identify, eliminate and prevent health disparities. Care is evidence-based, high-value and appropriate, leading to optimal and equitable health outcomes.

Accountable

Patients receive care from providers that are measured and accountable for delivering high-quality, safe and equitable outcomes. Measurement includes physical and mental health outcomes, patient-reported outcomes and experience, and stratification by demographic data to ensure optimal care for all patients.

Inclusive Health Purchasing Principles and Definitions

Principle 1

Respectful care and services built on trusted relationships with exceptional patient experiences that optimizes whole-person health and well-being and support accessibility, language interpretation and translation needs, members with different backgrounds, abilities and health literacy levels.

Patients should experience personalized care tailored to their unique and expressed needs that lead to positive health outcomes. Patients should be able to select care teams based on their self-reported preferences, build trusted relationships and receive compassionate, whole-person care.

To ensure partners are meeting these expectations, public and private purchasers can assess them for inclusive member experiences, including access to care and services, respectful and culturally appropriate care and culturally inclusive standards and training.

Principle 2

Evidence-based, equitable, high-quality and safe care that optimizes health and clinical outcomes, supported by primary care provider continuity, aligned incentives and value-based payment models.

Patients should receive high-quality, safe care that optimizes health, well-being and clinical outcomes. Care teams should have access to transparent information about the safety, quality and experience of care that providers and facilities, provide, and measurement should be used to drive improvement. Care teams should proactively monitor the patients' care to identify, eliminate and prevent poor health outcomes and disparities. Additionally, health plans and providers should leverage value-based payment models that enable providers to deliver timely, affordable, high-quality, patient-centered care. Providers should be held accountable for delivering coordinated, evidence-based services and for reducing avoidable complications that provide the flexibility to deliver appropriate care for each individual.

Private and public purchasers can hold their vendor partners accountable by assessing their vendors' ability to set disparity reduction targets, develop improvement plans and guarantee equitable performance.

Principle 3

Accessible, timely, affordable and coordinated care for all patients, including those experiencing health-related social needs or living in regions with few or no health care providers.

Patients should receive care that is timely, affordable, coordinated, culturally concordant and accessible via multiple modalities (e.g., in-person, virtual, synchronous, asynchronous) regardless of geography or personal characteristics. Care should be seamlessly coordinated across providers and facilities. Coordination should include navigation to high-quality and safe care, including behavioral health care and allow for secure messaging and patient education. Care should include assessments and closed-loop referrals to address patients' health-related social needs, such as food insecurity, transportation, etc.

To ensure members can access and are being referred to services, private and public purchasers can assess their vendors' strategies and abilities to identify health-related social needs and provide referrals to services.

Principle 4

Accountability and transparency for quality of care across all populations and geographies.

Health care will leverage data on quality, patient-reported outcomes and patient experience stratified by the Office of Budget and Management (OMB) 2024 Standards (Revisions to SPD 15), sexual orientation, gender identity and language to ensure quality of care for all demographic and geographic locations. Health plans and providers will be held accountable, either through incentives or risk-based contracts, that drive quality of care for all. Partners will utilize and share comprehensive data to support quality improvement plans, including managing individual member populations. Patients will have access to transparent pricing of medical services and drugs with affordable care options that optimize financial well-being.

Private and public purchasers can assess a vendor's ability to collect and ensure safe governance of demographic data, stratify quality and key performance metrics and report disparities in population health.

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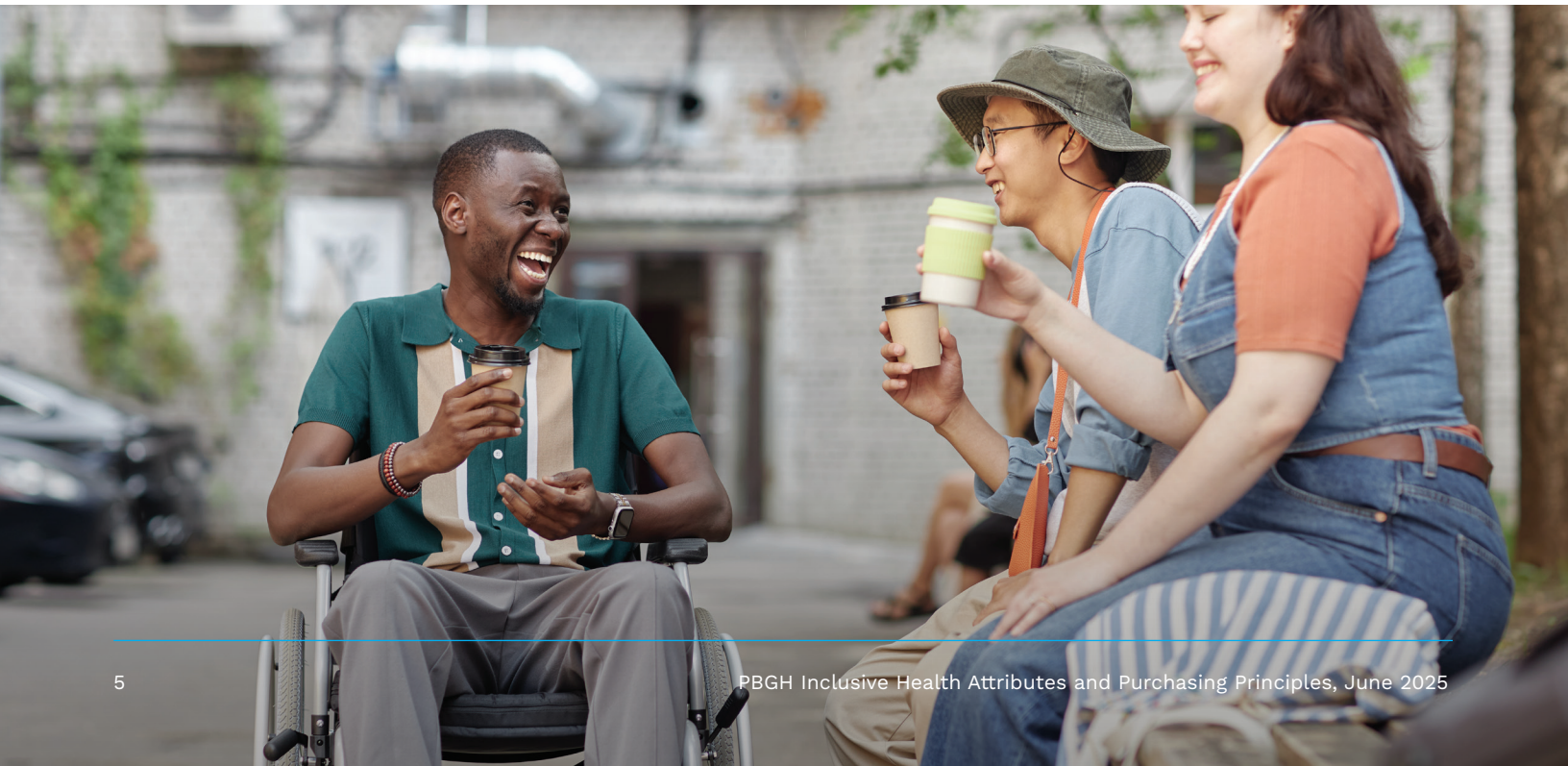

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