

# The Colorado Multi-Payer Collaborative: A Framework for Integration of Whole-Person Care

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## Policy Points

- > The Colorado Multi-Payer Collaborative offered a framework to participating primary care practices seeking to provide more advanced levels of care.
- > The *Framework* also provides guidance for payer organizations migrating toward advanced payment models that pay for value delivered through integrated, comprehensive, whole-person, population-based approaches.

## ABSTRACT

Evidence has been accumulating in support of the successful role primary care plays in health promotion, disease and death prevention, and more equitable distribution of health resources across populations. In Colorado, a group of health plans formed and self-funded the Multi-Payer Collaborative (MPC) in 2012, focused on transforming primary care and reforming health care payment in their state. With support from the Center for Evidence-based Policy, the MPC developed this *Framework for Integration of Whole-Person Care* (adapted from the work of Thomas Bodenheimer and colleagues). The *Framework* provides a roadmap for primary care practices as they seek to provide advanced levels of care, including the integration of behavioral and social health, and it prepares them to receive more advanced models of payment. The *Framework* also provides guidance for payer organizations migrating toward advanced payment models that pay for value delivered through integrated, comprehensive, whole-person, population-based approaches. The *Framework* has implications for supporting care transformation, financing and advanced payment methods, and public policy.

## BACKGROUND

### Primary Care

In 1978, the Institute of Medicine defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”<sup>1</sup> Since then, this definition has been used to position primary care as the foundation of the U.S. health system. It has also fueled models with four cornerstones (as in the work of Barbara Starfield and colleagues): first-contact care, continuity of care, comprehensive care,

and coordinated care.<sup>2</sup> More recently, the National Academies of Science, Engineering, and Medicine defined high-quality primary care as “the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.”<sup>3</sup>

Evidence has been accumulating in support of the successful role primary care plays in health promotion, disease and death prevention, and more equitable distribution of health resources across populations. Health systems built on high-functioning primary care have been shown to decrease racial and socioeconomic health disparities; decrease premature death; decrease death from pulmonary, cardiovascular, and heart diseases; decrease infant mortality; and decrease expenditures overall.<sup>4</sup> Despite these data, in most U.S. states, primary care spending represents between 5% and 7% of overall health care expenditures, compared with an average of 14% in Western European countries.<sup>5</sup>

As a result, the Centers for Medicare & Medicaid Services (CMS) encouraged an increased focus on primary care and primary care payment, through initiatives such as the Comprehensive Primary Care Initiative (CPC), Comprehensive Primary Care Plus (CPC+), State Innovation Model (SIM) grants, and most recently Primary Care First.<sup>6,7</sup> In 2021, the National Academies of Science, Engineering, and Medicine released a new report entitled *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Among other things, the report included payment models, use of interprofessional care teams, accountability, and improving quality as facilitators of high-functioning primary care.<sup>8</sup>

In 2014, Bodenheimer and colleagues published “The 10 Building Blocks of High-Performing Primary Care,” based on the seminal work of Starfield and colleagues,<sup>9</sup> along with studies they conducted of model primary care practices and their experience helping practices transform to higher levels of functioning.<sup>10</sup> These 10 “building blocks” include a foundation of four fundamentals (engaged practice leadership, data-driven improvement, empanment, and team-based care) necessary to achieve the

other six elements (patient-team partnership, population health management, continuity of care, access to care, comprehensiveness of care, and care coordination).<sup>11</sup>

Over the last decade the United States has experienced significant population changes. The country has continued to become more racially, ethnically, and economically diverse, with many ethnic minority groups doubling in population since 2010.<sup>12</sup> The role that social determinants of health (e.g., housing, transportation) and social behaviors (such as alcohol and other drug use) play in achieving health outcomes is increasingly being recognized.<sup>13</sup> Behavioral health and substance use disorder rates, and related deaths, are on the rise. The National Institute of Mental Health estimates that one in every five adults in the U.S. has a mental health disorder, with only half receiving treatment.<sup>14</sup> The Centers for Disease Control and Prevention estimates that one in every six children age two through eight has a mental, behavioral, or developmental disorder, and that one in every six adults had four or more adverse childhood experiences.<sup>15</sup> According to the National Center for Drug Abuse Statistics, if alcohol and tobacco are included, 60% of Americans over the age of 12 currently use or abuse drugs.<sup>16</sup> Deaths from drug overdoses have been rising at least 4% annually, with a current national rate of 21.6 deaths per 100,000 residents.<sup>17</sup> Seven in 10 deaths are linked to opioid overdose.<sup>18</sup> These changes challenge the conventions of a primary care delivery system that focuses on a transaction between one provider and one patient and is financed by a multipayer system in which a health plan pays a specified fee for the transaction.

## Colorado Multi-Payer Collaborative

The Colorado Multi-Payer Collaborative (MPC) was established in 2012 as a self-funded collaborative of payer organizations focused on transforming primary care and reforming health care payment in Colorado. The MPC brought together traditionally competing private and public health care organizations to share resources, coordinate quality efforts, and align payment approaches to achieve increased quality, improved outcomes, and controlled costs in the Colorado health care market. The MPC’s founding membership included Aetna, Anthem Blue Cross Blue Shield of Colorado, Cigna, Colorado Access, Colorado Choice Health Plans, Humana Inc., Rocky Mountain Health Plans, UnitedHealthcare, WellPoint,

Health First Colorado (Medicaid), Teamsters Union Health Plan, a Taft-Hartley Trust, and CMS. Since its founding in 2012, MPC membership has changed over time as the marketplace evolved and mergers occurred, and by the end of 2021 the MPC consisted of five primarily national payer organizations. These payers were represented by dedicated Colorado-based leaders committed to improved primary care and payment in the market. While the number and configuration of participating payers changed over time, MPC members remained focused on their shared commitment to increased quality, improved efficiency, higher value, and continuous improvement. They worked together to diffuse innovative and successful strategies focused on system accountability, improved health outcomes and experiences for patients and providers, and decreased total cost of care.

The MPC was organized with guidance, facilitation, and support from the Center for Evidence-based Policy, based at Oregon Health & Science University in Portland, Oregon. Originally established in response to requirements of the federal CPC initiative, which was designed to strengthen primary care through a core set of comprehensive primary care functions and population-based payments, the MPC built momentum over time and also participated in CPC+ (a successor of CPC), as well as the Colorado SIM initiative. In addition to their aligned participation in these reform initiatives, participating payers advanced their own shared efforts to transform the quality, payment, cost, and outcomes of primary care in the state. The MPC decided not to participate in CMS' most recent model to advance primary care, Primary Care First, although one individual payer is participating in the model.

Central to all the transformation efforts of the MPC was the development of a shared *Framework for Integration of Whole-Person Care* as a transformation and measurement roadmap for primary care practices and payers alike. The Framework, including the process used to develop it, created a common understanding among disparate payer organizations of the core components of advanced primary care, primary care payment, and the transformation needed for both payers and providers to achieve it.

## FRAMEWORK FOR INTEGRATION OF WHOLE-PERSON CARE

### Introduction and Goals

The *Framework for Integration of Whole-Person Care* was adapted from the work of Bodenheimer and colleagues.<sup>19</sup> The *Framework's* goal is to communicate commonalities among MPC member plans in three key areas:

- 1) The journey necessary to achieve more advanced, integrated levels of primary care delivery;
- 2) Key milestones along the journey; and
- 3) Example transformation activities that occur at payer organizations.

By design, the *Framework* does not represent a specific payment model or initiative, nor does it guarantee participation in any payment program by any MPC member plan. Instead, it provides a roadmap for primary care practices as they seek to provide advanced levels of care that account for the challenges of current populations, including the integration of behavioral and social health, and prepares them to receive more advanced models of payment. The *Framework* also provides a roadmap for payer organizations as they migrate toward advanced payment models that pay for value delivered through integrated, comprehensive, whole-person, population-based approaches.

### Process

Over the course of four years, members of the Colorado MPC documented their shared lessons related to the coordination of health care and social supports (including behavioral health). They held two to four work sessions each year for payers, primary and specialty care providers, and other stakeholders to discuss challenges and objectives and to establish common definitions related to the transition toward integrated, whole person primary care in the state. Drawing on "The 10 Building Blocks of High-Performing Primary Care"<sup>20</sup> and feedback from providers and other stakeholders, members of the MPC developed the *Framework for Integration of Whole-Person Care* (Figure 1).

MPC members also worked with the Practice Innovation Program at the University of Colorado Anschutz Medical Campus (CU) to ensure that the identified *Framework*

goals and milestones were available to and consistent with efforts across the state to support the transformation of primary care. The Practice Innovation Program at CU coordinates the Colorado Health Extension System, which convenes and coordinates Practice Transformation Organizations (PTOs) across Colorado. Using regional health connectors, practice facilitators, and clinical health information technology advisors, the PTOs supported by the Practice Innovation Program provide on-site practice support, guide learning networks, and spread transformation best practices.

## Structure

“The 10 Building Blocks of High-Performing Primary Care” by Bodenheimer and colleagues was intended as a simple way for practices to conceptualize quality care. The MPC’s *Framework* used these building blocks as a foundation, but suggested new dimensions to reflect recent population, care, and market changes, adding nuance to the straightforward approach taken by Bodenheimer and colleagues.<sup>21</sup> (See Figure 1.) The *Framework* also adds substantial depth by identifying common payer goals, measures, and metrics to gauge the transition to integrated, whole-person models of primary care.

Based on the experience of MPC member payers and a broad range of stakeholders over four years, the *Framework for Integration of Whole-Person Care* suggests the

addition of four dimensions to the important work of Bodenheimer and colleagues:

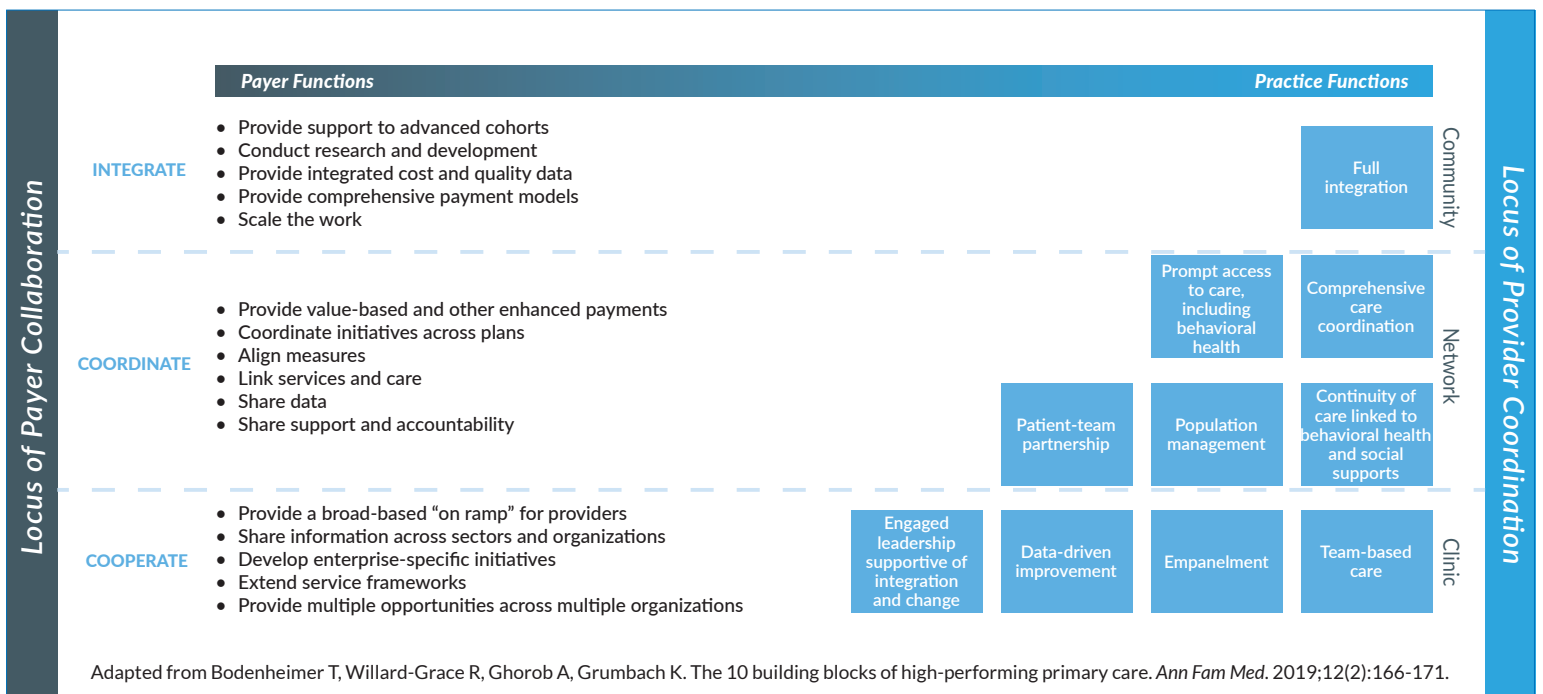
- 1) The integration of behavioral health and social supports in each building block;
- 2) The addition of the “locus of provider coordination”;
- 3) The inclusion of payer functions; and
- 4) The organization of payer functions into “levels of collaboration.”

## Four Additional Dimensions

### 1. Integration of Behavioral and Social Supports

The *Framework* calls for behavioral and social supports to be included in the definition of care at each building block. National and international organizations estimate that health care accounts for only 10%-20% of health outcomes.<sup>22,23</sup> It has further been estimated that up to 75% of primary care visits include components related to behavioral health.<sup>24</sup> These estimates are borne out in the experience of MPC member plans, and, as a result, behavioral health and social supports were included in MPC definitions, goals, and measures at each step in the *Framework*, aiming for a final goal of full integration of behavioral health and primary care. *This dimension is included in the definition of each building block and reflected in the transformation goals and milestones* (see Table 1).

**Figure 1: Framework for Integration of Whole-Person Care**



Adapted from Bodenheimer T, Willard-Grace R, Ghorob A, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med.* 2019;12(2):166-171.

## 2. Locus of Provider Coordination

In today's health care market, MPC members suggest that the activities related to some building blocks are more likely or appropriate to be satisfied at the clinic office level (e.g., empanelment, team-based care, engaged leadership), while others may be more efficiently achieved by a network or system of clinics (e.g., population management, continuity of care linked to behavioral and social supports, comprehensive care coordination). Full integration as described by the *Framework* is best achieved at a community level. *This dimension is represented along the right-hand side of the Framework.*

## 3. Payer Functions

Many models of primary care transformation include descriptions of core functions of advanced primary care. Few, however, include a description of what payers can do to support these core functions. Recognizing the symbiotic relationship of transformation between providers and payers, the *Framework* identifies core functions payers may undertake to support the transformation of primary care into advanced, whole-person care models. *This dimension is represented by bullets in the Framework.*

## 4. Levels of Payer Collaboration

The *Framework* organizes core payer functions that support practice transformation into three "levels of collaboration" based on the optimal manner in which payers should interact with one another in fulfilling their core functions.

- Cooperate: Functions that are independent and do not necessitate interaction with other payers (e.g., enterprise-specific models or payment initiatives).
- Coordinate: Functions that require synchronization across payers, and may require the use of an independent facilitator or convener, such as sharing data or aligning measures.
- Integrate: Functions that necessitate shared creation, or collective activity, to craft something that would not be possible by individual payers, such as provision of integrated cost information or comprehensive population payment models. *This dimension is represented along the left-hand side of the Framework.*

## Transformation Goals and Milestones

In addition to the four dimensions described previously, MPC members identified goals and milestones to measure the transition to each of the building blocks, focused on the delivery of whole-person care that includes the integration of behavioral health. This substantive and unprecedented work was designed to serve as a shared expression by payers about the journey necessary to achieve advanced, integrated levels of primary care delivery and to specify a common set of measurable milestones that could be used by practices and payers alike.

Table 1: Transformation Goals and Measures

MPC Integrated Building Block	Goal(s)	Milestones
<b>Engaged leadership supportive of integration and change</b>	<p>Practice leadership demonstrates that integrated care fits into the practice's mission to deliver quality care.</p> <p>Practice has built capacity for continuous quality improvement.</p> <p>Practice establishes transformation agreements with payer organization(s) including payment programs.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Has a documented vision or mission with specific goals linked to quality and value-based care</li> <li>• Establishes value-based payment or other specialized payment agreements with payer(s)</li> <li>• Completes annual budget in which leadership allocates resources for transformation work</li> <li>• Leadership allocates resources for quality improvement work</li> </ul>
<b>Data-driven improvement</b>	<p>Practice uses data to drive change.</p> <p>Practice uses electronic health record clinical quality measures to provide regular panel reports on measures.</p> <p>Practice uses available resources including payer claims data to drive quality improvement processes and sustain outcomes.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Reviews data at least quarterly and conducts regular quality improvement activities</li> <li>• Has identified a model and process for quality improvement using data</li> <li>• Documents and demonstrates that quality improvement processes are focused on all patients and all providers (e.g., not limited to identifying gaps in care and closing them one patient at a time)</li> <li>• Uses available information and tools provided by payers to review cost and utilization data</li> <li>• Has process for providing feedback to providers including cost and utilization data</li> </ul>
<b>Empanelment</b>	<p>Practice has, and maintains, at least 90% of its patient population empaneled.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Has assessed the patient panel and assigned care teams to an increasing percentage of the patient population, beginning with a minimum of 80%</li> <li>• Reviews payer attribution lists on a quarterly basis</li> <li>• Has designed and implemented processes for validating care team assignments</li> <li>• Has developed policies to support empanelment including defining members of care teams, changing primary care providers, assigning new patients, and ensuring continuous coverage</li> </ul>
<b>Team-based care</b>	<p>Practice provides integrated, team-based care. Care teams consistently address physical and behavioral health needs using shared operations, workflows, and formal protocols.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Uses quality, process, and patient satisfaction measures to assess and improve care team relationships and processes</li> <li>• Utilizes written job descriptions including defined roles and responsibilities for all team members</li> <li>• Uses workflow or other process chart to demonstrate coordination of care across team members</li> </ul>

MPC Integrated Building Block	Goal(s)	Milestones
<p><b>Patient-team partnership</b></p>	<p>Practice has built partnerships with patients.</p> <p>Patients are engaged in shared decision-making that respects their personal goals.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Evaluates patient population to identify and consistently use shared decision aids and self-management support tools</li> <li>• Tracks and evaluates use of shared decision aids and self-management support tools</li> <li>• Has established workflows and protocols for use of shared decision aids and self-management support tools</li> <li>• Has established mechanisms for patients to provide input and feedback, including on transformation activities and progress</li> <li>• Ensures patient feedback is documented, reviewed on a quarterly basis, and used to improve care</li> </ul>
<p><b>Population management</b></p>	<p>Practice stratifies risk and actively manages the patient population using data.</p> <p>Practice uses population-level data to manage care gaps and to develop and implement care management plans (including behavioral health) for targeted high-risk patients and families.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Has and uses a documented risk stratification strategy</li> <li>• Has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families</li> <li>• Has risk stratified 90% of empaneled patients</li> <li>• Has a documented care plan for 90% of high-risk patients and families</li> <li>• Care plan template is embedded in electronic health record</li> <li>• Proactively manages care gaps and documents outcomes</li> </ul>
<p><b>Continuity of care linked to behavioral health and social supports</b></p>	<p>Practice screens for behavioral health and substance use disorders and links patients/families to social supports.</p> <p>Practice screens at least 90% of patients/families for substance use disorder and/or other behavioral health needs.</p> <p>Practice includes behavioral health and community support services as an active part of care management strategies.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Has evaluated and identified behavioral health resources for patients/families</li> <li>• Uses an evidence-based tool to screen for behavioral health issues (including depression, maternal depression, developmental delays, substance use disorders, tobacco use, and other unhealthy behaviors)</li> <li>• Has documented process for connecting patients/families with behavioral health resources following screening, including standing orders and protocols for follow-up</li> <li>• Can document that 75% of patients/families with identified behavioral health needs(s) are connected to resources</li> </ul>

MPC Integrated Building Block	Goal(s)	Milestones
<p><b>Prompt access to care, including behavioral health care</b></p>	<p>Practice provides prompt access to care, including behavioral health care.</p> <p>Practice has established care management agreements with specialists and with medical, behavioral health, and community support resources, and members of the care team can document how to use the agreements.</p> <p>Practice has integrated care and/or has established care management agreements with specialists and community support resources as necessary, and members of the care team know how to use those care management agreements to ensure prompt access to care 24/7.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Makes available a clinical representative with electronic health record access 24 hours/day, 7 days/week</li> <li>• Monitors third next available appointment to ensure timely access to providers/care team</li> <li>• Shares clinical data, in accordance with care management agreements, with behavioral health and community support resources within one week</li> </ul>
<p><b>Comprehensive care coordination</b></p>	<p>Practice provides comprehensive care coordination for primary care and specialty care, including behavioral health.</p> <p>Provision of comprehensive care, with a process for coordination of care, has led to measurable changes in quality and cost of care.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Has demonstrated capacity to provide most of what patient panel needs, and is able to arrange for care they are unable to provide</li> <li>• Is able to identify total cost of care for patient panel, and for the subset of patients with behavioral health conditions</li> <li>• Contacts 75% of patients within 72 hours of hospitalization or emergency department visit, including medication reconciliation</li> <li>• Routinely reviews all available cost data to identify cost drivers for all patients and for patients with behavioral health conditions, and has a quality improvement/operations team that can document, implement, and track improvements based on these cost opportunities to reduce total cost of care</li> </ul>
<p><b>Full integration</b></p>	<p>Practice has successfully integrated patient care to provide current and future concepts of whole-person care.</p> <p>Practice has built a foundation of the prior building blocks that allows flexibility to respond successfully to future visions of integrated patient care.</p>	<p><b>Practice:</b></p> <ul style="list-style-type: none"> <li>• Is nimble and able to adapt to changes</li> <li>• Has a documented plan to systematically measure and track patient outcomes, both physical and behavioral</li> <li>• Routinely develops care plans that include patient actions to manage behavioral health conditions</li> <li>• Systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level</li> <li>• Routinely documents and implements protocols to identify and manage care of high-risk patients, including those with behavioral health conditions</li> </ul>



## EMPLOYING THE FRAMEWORK

Along with guidance for providers and payers engaging in advanced payment models, there are additional opportunities to deploy the *Framework* to advance efforts. These opportunities lie in three areas: care transformation, financing and advanced payment methods, and public policy.

### Care Transformation

- Health care providers and health care systems could use the *Framework* as a roadmap of key activities necessary for achieving population health goals and adopting new financing mechanisms.
- The 2014 Robert Wood Johnson Foundation Commission to Build a Healthier America called for health system reform strategies that broaden health care outside of the medical system. Providers and systems could use the *Framework* to create systems of care capable of delivering comprehensive approaches to health based on resources that are shared across traditionally siloed funders.
- Integrated data efforts could be established and the resulting information used to stimulate collective, population-driven improvement efforts based on the core functions outlined in the *Framework*. Integrated data efforts should align both quality measures and reporting systems to facilitate use by practices and reduce the associated administrative burden.

### Advanced Payment Methods

- Public and private payers could use the *Framework* to communicate common expectations for transformed care and to stimulate innovation. Further, the *Framework* could be used to communicate how primary care transformation and investments can be facilitated and measured.
- Payer organizations could use the *Framework* to develop payment methods that prioritize coordination and integration across health care, social supports, and behavioral services.

## Multipayer Structures and Public Policy

- Because achieving increased health status is best done in a team environment, payers and public policy bodies could use the *Framework* to develop cross-sector efforts or financing strategies that distribute accountability for improving health, behavioral health, and social supports across multiple sectors or organizations.
- State or federal policymakers interested in facilitating multipayer primary care transformation could use the *Framework* as a scaffold for building multipayer structures (similar to the Colorado MPC) to assist in or guide the coordination of transformation activities. Indeed, the MPC's work informed CPC+ design elements.
- Policymakers could use the *Framework* as a measure of accountability and progress for efforts to improve population health (e.g., primary care reform, accountable care organizations, accountable communities of health efforts).
- The Health Care Payment Learning & Action Network (HCP LAN) could use the *Framework* to deepen its work and provide a detailed roadmap for promoting the transition of care and payment. The HCP LAN was established in 2015, bringing together leaders and public and private health care payers to provide thought leadership, strategic direction, and ongoing support to accelerate the care system's adoption of alternative payment models. In 2019 the HCP LAN developed goals for the percentage of U.S. health care payments tied to value and quality. In 2020, through its Healthcare Resiliency Collaborative, the group developed a shared commitment statement and suggested initial actions for payers, providers, and other stakeholders in three areas of resiliency:<sup>26</sup>
  - Addressing root causes that contribute to poor health outcomes, particularly promoting equity in care;
  - Adjusting population-based payment models for the range of needs of providers while ensuring quality; and
  - Advancing whole-person care through the integration of primary care, behavioral health, specialty care, and other services.

## ACKNOWLEDGMENTS

The authors acknowledge and applaud the work of the members of the Colorado MPC for the development of the *Framework*. In particular, the following individuals provided substantial input and direction:

- Dorien Rawlinson, Vice President, Mountain States Region Network Management, UnitedHealth Group
- Chris Riley, Provider Collaboration Director–Payment Innovation EPHC, Anthem BCBS
- Mark Laitos, MD, Medical Executive, Rocky Mountain States, CIGNA (retired)
- Kim Brown, Clinical Informatics, Rocky Mountain Health Plans

## NOTES

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**Beth Church** is a program manager at the Center for Evidence-based Policy. Ms. Church joined the center in 2009, and her work focuses primarily on engaging health care stakeholders in collaborative efforts and providing direct technical assistance to states. In this role, Ms. Church provides stakeholder outreach and support, meeting and communications coordination, technical assistance, and project management. She has worked on multipayer primary care transformation and payment reform efforts in many states, including through the center's support of the Colorado Multi-Payer Collaborative. Her academic background is in political science and applied linguistics.

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## About the Milbank Memorial Fund

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