2023
Signature
Series

REPORT:

HALLMARKS OF A PERSON-FIRST HEALTH SYSTEM

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ACKNOWLEDGMENTS

The Alliance for Health Policy recognizes and appreciates the generous support of the sponsors of the 2023 Signature Series. It is more important than ever that we bring the health policy community together for courageous conversations to break through existing challenges.

We also acknowledge and thank Collective Next and Elizabeth Cronen for their facilitation and writing support.

SERIES OVERVIEW

For several decades, people receiving care in the health system have advocated for their experiences in health care to be an important consideration in decision making. Many health care providers, payers, producers and policymakers have also acknowledged that the needs and priorities of the people getting care or trying to stay well should be incorporated into the process. Phrases such as "patient-centered," "consumer-directed", "human-centered," and "whole person care" have emerged throughout the health care lexicon. But, as with many, such phrases, definitions, and operational implications often remain in the eye of the beholder, leading to variable and suboptimal outcomes. Throughout 2023, the Alliance for Health Policy ("the Alliance") convened a cross-section of people experienced in both policy and practice to envision the Hallmarks of a person-centered health system and what that might mean in the context of current and future health policymaking.

> "Nobody should have to feel alone and adrift in the system because even as the Health Secretary, I can't navigate the system by myself."
>
> **– Alex Azar, J.D.,**
> Former U.S. Secretary Health and Human Services

Senior leaders involved in policymaking state that there is often not adequate time or resources in the process for evaluation of whether a policy is allowing for person-centered considerations, and the impact it will have on an individual's experience. With this in mind, the Alliance aimed to develop a resource that provides a framework for those in the policy community to understand and evaluate policy decisions and how they measure up to an ideal of a person-first approach. To do so, the Alliance convened leading experts with deep knowledge of the different facets of the health care ecosystem to examine current barriers, highlight promising opportunities, and curate their ideas and approaches for achieving an ideal model. These structured conversations were held as part of the Alliance's 2023 Signature Series and yielded a set of key Hallmarks characterizing a person-centered health system. These Hallmarks were introduced at the **2023 Signature Series Summit: Envisioning a Person-First Health System** on September 13, 2023. This report provides an overview of the seven Hallmarks of a person-first system and summarizes insights from the multi-sector Signature Series Thought Leader Group (TLG) on person-first care.

HALLMARKS OF A PERSON-FIRST HEALTH SYSTEM

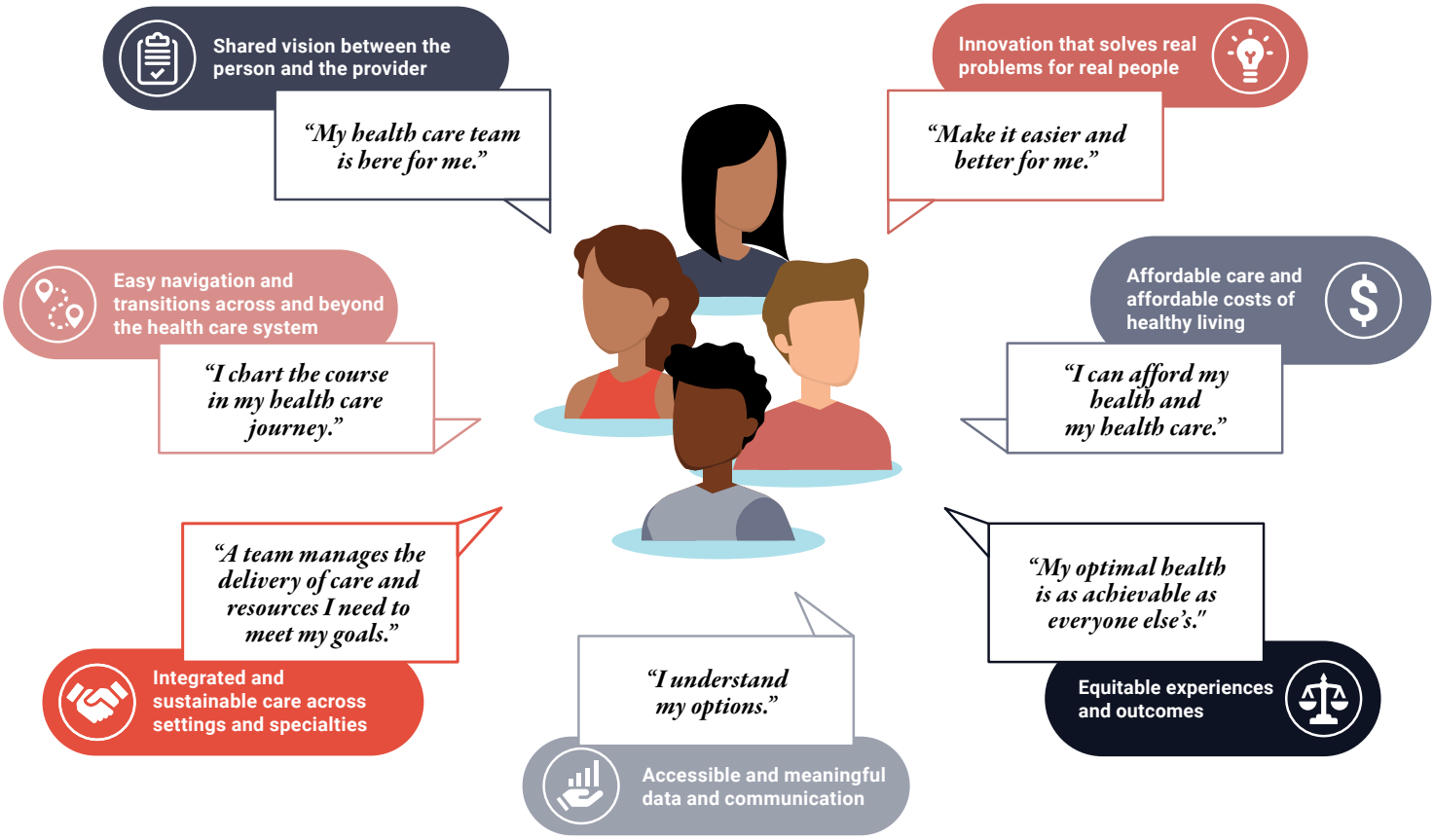
The concept of "patient-centered" care **first arose in psychology in the 1950s** to describe a therapeutic approach. By 2001, the Institute of Medicine had listed **"patient-centered" as one of six aims** for a quality health care system. Interpretations vary, but this style of care is **defined by partnership** between the patient and provider, with the patient's perspectives on their overall well-being driving medical decisions.

Like many in the health care sector, the TLG examined the significance of the term "patient" compared to "person." The Signature Series discussions began with references to "patient-centered" health systems but evolved with participant input. The thought leaders recommended adopting the "person" terminology throughout the program, including in this report, that shifts away from point-in-time care to a whole-person approach that centers the full needs and experiences of patients, caregivers, and care providers. "Person" focuses on the individual, destigmatizes care, and applies equally in care settings and outside of them.

The TLG also concluded that a person-first health system comprises more than this style of care delivery: it is the comprehensive alignment of medical services, social and economic factors, administrative processes, and more to facilitate every person's best health. The group grappled with how to apply a more person-first definition of quality and outcomes in a truly person-centered health system, acknowledging the need to balance population-level evidence with the needs and preferences of the person who is receiving care.

To help make such a massive transformation one that could be understood, the TLG co-created seven specific, meaningful Hallmarks that fit the context of today's system. Each Hallmark includes an associated statement written from the first-person perspective, capturing the thought leaders' best description of an ideal person-first health system.

A person-first health system has:



1) Shared vision between the person and the provider

This Hallmark can be distilled into the statement ***"my health care team is here for me."*** "For me" emphasizes that providers orient their work around the person receiving care in an ideal system.

Health care professionals and the people receiving care collaborate to set health goals, assess effectiveness, and consider care options. With this quality metric, people are not simply expected to comply with treatments but instead are active participants in care planning, adjusting, and evaluating. The power to make decisions is not one-way.

Building trust and understanding between the health care provider and the person receiving care is essential for defining and meeting the person's needs. That relationship is more likely to be possible when the health care workforce is sufficient in size, diverse in lived experience, engaged with their work, and functioning under favorable time, physical and psychological safety, and compensation conditions.

A person's individual health goals may vary from the outcomes measured in standardized quality frameworks and payment models that incorporate those outcomes. For example, an elderly individual with type 2 diabetes may deprioritize reaching a specific weight or maintaining a specific blood sugar level, but instead measure their well-being by their mobility, staying simply at a weight that allows them to walk and stand.

> "Maybe two of the outcomes that were identified in our stakeholder group can connect to clinical guideline-driven metrics. Who were those guidelines developed from and for? Who do they serve? ***They do not serve any whole person***."
>
> **– Mai Pham, M.D., MPH,**
> President and CEO, Institute for Exceptional Care

At the same time, the data that payers, providers, and government officials use in setting policies or achieving outcomes has to be multifaceted to be useful for person-first health care.

> "It's not about patient-reported outcome measures. It is about goal-oriented metrics...shifting to saying, 'Okay, what's a more generic, person-specific way we can measure this?' For example, a metric could be, did you elicit the patient's goals? Did you document it? Did you come up with a plan for how to get there? Do you know what the milestones are on the way to that plan? Where on the milestones are they? Did you get to the goal? Hooray! That's a scale."
>
> **– Mai Pham, M.D., MPH,**
> President and CEO, Institute for Exceptional Care

Reimbursement frameworks that pay for outcomes can support person-centered care if their designs will account for patient-defined goals. **Person-centered outcomes measures** are rooted in the idea that health care delivery should include consideration of the needs, experiences, and goals of the individual, caregiver, and their family. Recent efforts to advance person-centered outcomes measurement, particularly among people with complex health needs, may be useful for informing **value-based care** and payment reform conversations.

2) Easy navigation and transitions across the health care system

In a person-centered system, everyone can say ***"I chart the course in my health care journey."*** When this is a reality, people have the tools and information they need for successful journeys in and out of the health care system to support their comprehensive health.

Every person will have periods of illness, recovery, injury, healing, pain, relief, instability, balance, and more in various combinations over a life course. When health problems first occur, it can be hard for a layperson to know how serious a condition is, what the treatment options are, how to access the right care, and what to do next when conditions change. In a person-first system, care seekers will have information or access to information and services to point them in the right direction, guide them during transitions in care, and weigh care options.

Journey mapping, a tool that has been used in the private sector to illustrate user experience (UX), can help stakeholders understand patient experience over time and from multiple perspectives. Journey maps and similar design-thinking approaches can present new opportunities for addressing challenges that both health systems and policy experts face in engaging patient perspectives and improving a person's health outcomes and experience.

> "I hate using the term non-compliant in health care, because it sounds like it's putting the onus on the patient as if they don't want to be well and they're choosing to not follow their treatment plan. But if we look at these patient journey maps, we see there are all these barriers. It is so hard to follow a treatment plan."
>
> **– Jen Horonjeff, Ph.D., M.S.,**
> Founder and CEO, Savvy Cooperative

Examples of journey mapping include efforts to illustrate **veterans' health care navigation experience, identify barriers for older adults experiencing dementia**, and **capture a lifelong journey overview of a child diagnosed with single ventricle congenital heart disease**.

> "In terms of my vision around patient-centric, or value-based care, or whatever else you want to call it, I could only tell you what my vision of health care is: that everybody in America should feel cared for in the system and feel that they have concierge care. That they've got someone shepherding them through the system, with aligned incentives to theirs. This doesn't have to necessarily be a primary care doctor, but it could be. It could be virtual. It could be AI-based. It could be more intensive for certain people than other people."
>
> **– Alex Azar, J.D.,**
> Former U.S. Secretary Health and Human Services

Tools like journey maps can illuminate the relationships and impact of other key players in the health system that have historically been overlooked, such as caregivers and other health workers including community health workers. The value and unique perspectives each brings to decision-making can enhance person-centered outcomes. Community health workers—local, culturally competent professionals who often provide prevention and navigation services—have been shown to positively impact a person's ability to navigate a health care experience. New coverage approaches have **expanded payment options** for community health workers. A regulation proposed this July would, for the first time, **allow Medicare to pay for services** delivered by community health workers.

3) Care integrated across and beyond the health system

Communication and coordination across care and service providers allow the person getting care to say, ***"A team manages the delivery of care and resources I need to meet my goals."***

Even for relatively limited health care needs, it can feel like a part-time job to line up procedures, imaging, therapies, labs, office visits, and more. In person-first care, health care providers across specialties and related professionals will coordinate "behind the scenes" to deliver services with minimal friction for the person receiving care. In addition to coordinating medical care, a person-first system will connect to nonmedical services like housing, food, and social support when they are relevant to the person's wellbeing.

A Summit panelist described what it might look like when a health system is coordinating well. Executives at a health system observed that a subset of patients only saw specialists and never met with a primary care provider to coordinate preventive services or other health care needs. They set up a program to offer additional services like medication management or overdue vaccines for people going to dermatology appointments. The health system proactively identified the people overdue for needed care using electronic health records, and when the people came in for a dermatology appointment they were offered a chance to go to another room for a "video visit" or telehealth consultation, followed by on-site services as needed. As the panelist described, the health system plans to expand the program:

"We were able to as a system understand what were the barriers that were perhaps presenting or how could we make them informed about various things that might improve their quality of life? Or what are the social determinants that may be playing a role into why they're using the services the way they are? And from a patient's side, it's been very well received because they feel very satisfied that they've been able to get their immunizations on the same day or they're able to go down to the lab or be reminded about a medication refill. So we are now going to expand that into our flu clinics where people will come in and hopefully be offered the same services."

– Amy Duckro, D.O., MPH,
Executive Director,Population Management, Colorado Permanente Medical Group, Kaiser Permanente

4) Accessible and meaningful data and communication

Having the right information to make clinical and financial choices is essential when patients are active participants in their care decisions, as they are in a person-first system. When these qualities are realized, people can say, ***"I understand my options."***

Communicating health data and information both **cultivates and draws upon health literacy**, and the individuals' ability to find, understand, and use information and services to inform health-related decisions. Although understanding medical concepts or interpreting data is not necessary for a person to participate in their own care planning—defining one's own health goals does not require sophisticated medical knowledge—it can help a patient choose from a wide set of options and understand tradeoffs among them. That literacy can build up informally over time, and experience or health education programs can boost understanding.

At any level of health literacy, data and information must be accurate, reliable, and in the right volume and complexity for laypeople. It also must be provided in the language a person and their care team needs and in formats that are accessible to people with disabilities. In addition, panelists emphasized that people are best served when they own all health data about themselves, and it is secure yet shareable.

For example, **improving billing statements to make them more understandable or posting way-finding signs** in a hospital are both innovations that encourage person-centeredness in the health system.

"You need transparency because you can't have a price system without price information, so price and quality information is critical. For competitive markets, you need pricing information. You need portability of patients. The patient has to be able to move where they want to go. That means that you need to have non-captive markets. You need to have EMR systems that are portable and owned by the patient, so the patient's data doesn't have them captive somewhere."

– Alex Azar, J.D.,
Former U.S. Secretary, Health and Human Services

5) Innovation that solves real problems for real people

In a person-first health system, innovation is one response to nearly every care seeker's plea, ***"Make it easier and better for me."*** Bioscience and digital technology dominate typical conversations around medical innovation, and today there are historic opportunities in these fields to address unmet needs for patients and continue the march towards lengthened and improved quality of life for millions. Adopting the technologies that do so in a sustainable way remains an ongoing discussion, as noted in the Signature Series Summit:

"We're going to continue to see new innovation, and it's going to be a spike in cost and then there's going to be a health benefit. If we're constantly focused on the spike in cost, the only reaction is going to be, "Don't use it." We have to face the fact that living longer is a good... living longer has a cost, and we cannot live longer and get more years of life without paying for it. We can pay for it with some cost constraints, we can pay for it efficiently. But if we look at all these things as a bad guy as opposed to a good guy that can help us live longer, at a cost, we're never going to see these diseases eradicated, and we're going to continue to have these fights even though we have great technology that can deal with the conditions."

– Kirsten Axelsen, M.S.,
Consultant, Executive Secretary, Preparedness and Treatment Equity Coalition, Visiting Scholar at American Enterprise Institute

In addition, in the context of person-first care, innovation is not limited to new treatments or tools, and can be any departure from the status quo for an alternative that better serves the person

receiving care. These can be very simple, low-tech changes. At one health system, telehealth technology was applied in a novel way to increase nurse availability for people in the hospital. Dr. Gay Landstrom, Senior Vice President and Chief Nursing Officer at Trinity Health, explained at the Summit that with provider workforces increasingly overstressed and stretched thin, leaders turned to team-based nursing in some situations, pairing a qualified but sometimes junior RN with a certified nursing assistant to deliver care in person, and bringing in a more experienced RN to collaborate via virtual connection. This TogetherTeam model is a solution that retains the patient-care expertise of a nurse who might otherwise retire, increases the capacity of the more junior on-site nurses, and may support longer-term job satisfaction for the on-site nurse and certified nursing assistant. Telehealth regulations and reimbursement rules are the policy levers that can facilitate programs like this one.

6) Affordable care and affordable costs of healthy living

In a person-first health system, people can get the care they need when, where, and how they need it without financial hardship or judgment. The public can say, ***"I can afford my health and my health care."***

Having the resources, including time, to support a healthy life, separate from paying for medical care, also is essential. In a person-first system, people can afford to take time away from paid work to recover from illness or injury or prevent chronic conditions from worsening. Affording good health also means lowering social and financial barriers to physical activity, healthful food, adequate rest, decent housing, and safety from violence. This Hallmark also raises the importance of support from employers and other institutions for time and resources to complete needed health care tasks.

Policymakers have many directions to look for opportunities to make this Hallmark a reality, from reimbursement policies for health services to financial assistance for basic needs.

On social determinants of health, some public programs are beginning to weave together financial support for health care along with housing and meals. **Medicaid waivers are one way that states have addressed these health-related social needs**. One Summit panelist raised the importance of all people having health insurance coverage as crucial for universal access to expensive, lifesaving and life-improving drugs.

On costs of care, leaders including former U.S. Secretary of Health and Human Services Alex Azar call for aligning provider incentives with the qualities people want from their care, including transparent price information and opportunities to realize savings themselves, not just return savings to the insurer.

> "When we created health insurance as prepaid health care tied to employers, tax subsidized, and separated the financing from the purchasing decision...you've completely divorced the price and quality mechanism from acting, and at that very moment, you've disempowered the patient as a consumer."
>
> **– Alex Azar, J.D.,**
> Former U.S. Secretary, Health and Human Services

Secretary Azar emphasized that a widespread financial disconnect between people and their health care spending is a barrier to creating this alignment. His vision reorients providers around people as health care consumers, saying at the Summit, "Create the incentives for the players to compete for that patient, to delight that patient, to deliver quality and reduce price...Not the incentive to churn and burn on procedures and diagnostics, but rather the financial incentives to deliver better outcomes. The kind of outcomes the patient wants. Staying out of the hospital, longer-term, better health outcomes, et cetera, lower cost. That's where, that's why changing the payment systems becomes very, very important."

7) Equitable experiences and outcomes

In an equitable health system, the highest standard of care is available to every individual, and the system does not harm a person's health. Everyone is able to say, ***"My optimal health is as achievable as everyone else's."*** In today's system, people in racial and ethnic minority populations **get worse care compared to non-minority populations** even when insurance and income are equal.

Success of the system goes beyond individual clinical outcomes and is reflected in overall well-being across whole populations. Outside-of-care delivery, equity in health also requires reducing the **commercial determinants of health**—strategies and approaches used by the private sector to promote products and choices that are harmful to health and widen disparities.

As policymakers develop solutions to address longstanding and deeply rooted inequities in the health care system, they may consider the historical context that shaped a community's built environment and continues to impact care delivery and health outcomes in the present. For example, public health researchers have found that Black and Hispanic women who live in historically redlined neighborhoods **face increased risk of severe maternal morbidity** compared to other racial and ethnic groups. Discriminatory policies that created an unequal distribution of

neighborhood resources decades ago continue to have a tangible impact on community and individual health today. Recognizing how "race, place, and history" have influenced past environments is key to understanding current challenges.

> "I'm originally from the area in Louisiana called Cancer Alley. It's between Baton Rouge and New Orleans, a 40-mile stretch. Predominantly African-Americans end up with a cancer diagnosis because of our proximity to industrial chemical plants. That itself has probably led to more people in my family, who would take all of our hands on this panel and probably a few more to count the number of persons who've had cancer and who've even died from cancer. My mother, who worked her whole life in the health care industry as a phlebotomist and as a nurse, ended up getting cancer… and it harms us to not consider that historical perspective. And I would urge health care leaders and policymakers to think using the asset base on whether these communities do have so that we can engage with them so that folks can get the health care that they need."
>
> **– Brandon G. Wilson, DrPH, MHA,**
> Senior Director, Center for Community Engagement in Health Innovation

Programs and policies that support a more equitable distribution of resources should leverage preexisting assets and relationships to be effective. A one-size-fits-all approach rarely applies, particularly during moments of a public health crisis, and health systems need to be nimble and responsive to the needs and resources of the communities they serve.

> "We used our relationships, we used our family, and privately-owned pharmacies and we were able to immunize our nursing home population, long-term care population up to two months before other states and we were able to get the second vaccines in people's arms sometimes before other states had gotten the first vaccine in arms. And I'm not saying that because "look how great we are," because we certainly ran into the wall that everybody else did after a while. But it really helped us understand that the more we could communicate, the more we could use the people that really had the knowledge and start to do things in rapid-cycle learning cycles."
>
> **– Clay Marsh, M.D.,**
> Chancellor & Executive Dean, Health Sciences, West Virginia University

Achieving system-level change is no easy feat. Inequities persist through the culmination of millions of individual health care experiences. Realizing a person-first health system is dependent on an individual's ability to be offered and able to access the most effective, evidence-based treatment options. Irrespective of insurance status, implicit bias and other forms of racial discrimination that impact a person's likelihood of being prescribed the standard of care may **continue to perpetuate disparities** in outcomes, screening, and treatment without appropriate intervention. However, new efforts, including projects focused on **overcoming biases in health care through empathy**, may provide a useful framework for improving health equity at the individual and population level.

CONCLUSION

The idea of a person-centered health system can be seen as an abstract, lofty goal. While many challenges remain, multidisciplinary efforts have made significant inroads to advancing person-first care. Working from these Hallmarks, policymakers and the policy community can incorporate consideration of the experience and values of people using the health system into policy creation and analysis. Together, we can move toward policies that create a health system that treats patients as people and puts their needs first.

ADDITIONAL RESOURCES

"A Blueprint for Developing Patient-Centered Core Impact Sets (PC-CIS): An Introduction." National Health Council. July 8, 2022.

"Cascade of Meaningful Measures." Centers for Medicare & Medicaid Services. March 2023.

"CMS Physician Payment Rule Advances Health Equity." Centers for Medicare & Medicaid Services. July 13, 2023.

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"Patient Journey Map: Substance Use Disorder Treatment and Recovery Experiences." Addiction Policy Forum. October 16, 2022.

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"Person-Centered Outcome Measures: Measuring What Matters Most." National Committee for Quality Assurance. 2023.

"Person-Centered Outcome Measures: Promoting better, more efficient and more effective

health care for people with chronic and complex needs." National Committee for Quality Assurance. 2023.

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"Transforming Measurement for Better Care Lessons Learned from Patient-Centered Measurement Pilots." American Institutes for Research. 2020.

"VA Patient Experience Journey Map." United States Department of Veterans Affairs. 2020.

"What Is Patient-Centered Care?." NEJM Catalyst. January 1, 2017.

APPENDIX

Methodology

These Hallmarks emerged from structured, future-focused conversations about the ideal person-first health system and how policy can achieve it. Like all Alliance events, these Signature Series discussions relied upon diverse viewpoints and perspectives, leveraging an extensive network of experts and leaders to gather the best and brightest minds from across communities and the health care industry. Together, they critically examined the issues to identify what's at stake, as well as areas of challenge and opportunity.

Theory of Change Signature Series Model

We will inspire a structured conversation about the ideal person-first health system and how policy can help achieve it by:

Listening to and identifying thought leaders within the policy community invested in the "person-first" approach

+

Hosting and facilitating dynamic and multi-perspective conversations elevating patient perspectives and experiences in tandem with policy and industry expertise.

+

Identifying and disseminating consensus attributes of what makes a health system "person-first" and key case studies to support.

Participants

The thought-leader group was composed of more than three dozen people invested in the person-first approach. Participants came from diverse professional backgrounds, including hospitals, insurers, pharmaceuticals, government, patient advocacy, and industry associations. Later, the Hallmarks identified by the thought leaders were explored by more than two dozen panelists across six presentations at the Envisioning a Person-First Health System Summit.

Facilitators

We worked with Collective Next, a firm of trained facilitators and expert designers, to create a disciplined and engaging set of convenings that mined the collective expertise of thought leaders. The team utilized a combination of qualitative research and human-centered, collaboration based methodology to engage participants and generate insights.

Process

The thought-leader group first met to brainstorm key themes associated with person-first health systems, then reconvened to synthesize the themes into Hallmarks.

The first discussions addressed person-first outcomes, experiences, and innovation. Participants shared examples of what good looks like from their own perspectives and experiences. They also turned towards the future to envision the next 10 years, and how the health care ecosystem might work differently. Themes included outcomes, equity, affordability, the role of caregivers, communication, continuity of care, and access.

The second gathering of thought leaders focused on creating an actionable framework for policymakers and the health policy community. They reviewed the key themes from the earlier discussion, and considered how they relate to the Hallmarks—or characteristics—of an ideal system. Small groups worked together to define aspects of a person-first system, articulate how they apply to real situations, and identify areas of opportunity to use the Hallmarks.

Discussions continued in the Signature Series Summit and policymaker briefing. The Summit featured a series of discussion panels with industry visionaries, administration executives, and numerous experts to further explore the attributes of an ideal health system and innovative solutions to achieving a person-first health care system. Common themes across six panels stressed the importance of supported, satisfied providers along with the expectation that progress will be incremental and require investment to produce change.

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