SALGBA 2019 World Cafe:

An Explanatory and Exploratory Report

In the spring of 2019, The Bush School of Government & Public Service partnered with the State and Local Government Benefits Association (SALGBA) to conduct a "World Cafe" event at its 37th annual national conference in Ft. Worth, Texas. The purpose of the World Cafe was to bring together 60 healthcare representatives, from a cross section of private and public sector backgrounds, to discuss both the issues facing the healthcare system in the United States and the possibility of implementing Value-Based Care (VBC) initiatives. VBC implementation has become an important topic in healthcare, as healthcare insurers seek to reduce costs and improve quality of care received. Healthcare representatives that participated in the World Cafe then voted on key issues in healthcare brought up during the World Cafe, ranking them in terms of importance. This report serves to explore five of the highest ranked key issues and is divided into three parts. Parts I and II are exploratory in nature: part I provides context to the reader concerning the current demographics of healthcare in the United States, as well as providing an explanation of SALGBA's unique position to influence healthcare trends. Part II explains the process of the World Cafe at SALGBA's 2019 National Conference, the data collected from the interactions at the event, and the methodology used to analyze the data afterwards. Part III explores the previously mentioned five key issues taken from the World Cafe by reviewing and presenting the findings of literature in these respective areas.

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Part I: U.S Healthcare Demographics and importance of SALGBA

This section presents relevant information needed to understand the current demographics of the U.S. healthcare system and the importance of SALGBA in bringing together healthcare professionals from all over the nation with the goal of improving healthcare service delivery.

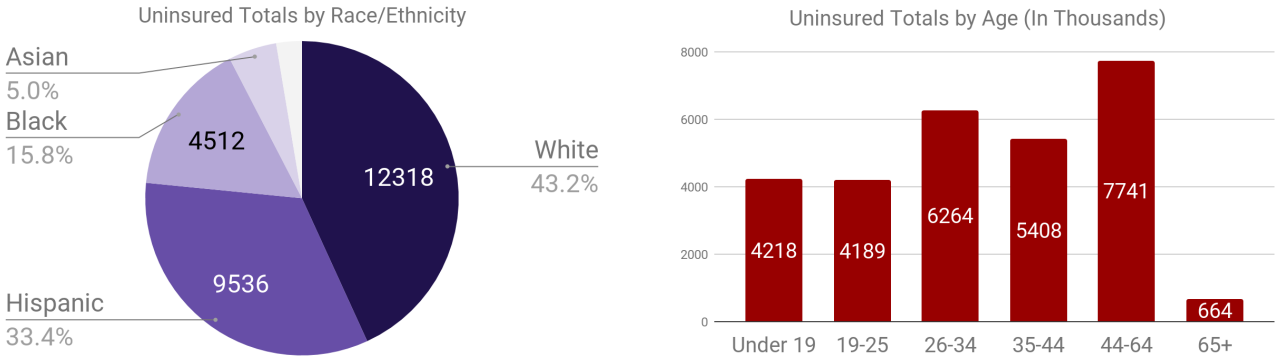
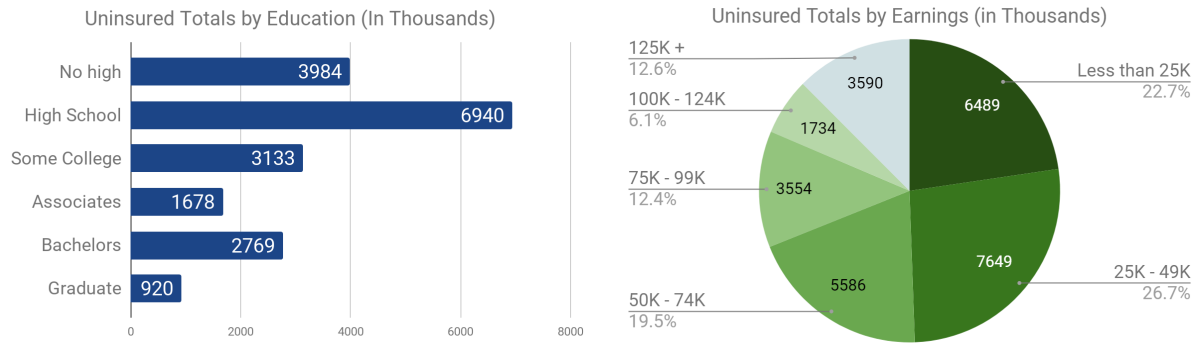


Figure 1 & 2: The above visuals are totals and percentages of race/ethnicity (left) and age (right) demographics of the uninsured population in the U.S. It is important to note that percentages and totals illustrate different aspects of problems of healthcare provision. There may be more white Americans who are uninsured, but by percentage minorities have disproportionate amounts of uninsured within respective populations).

Americans without Healthcare Insurance

A major concern of the U.S. healthcare system is the number and demographics of people who are uninsured. Gender, race, age, income and education all correlate with insurance outcomes: according to a recent U.S. Census study, 8.8 percent of the U.S. population, or 28.5 million people, do not have healthcare insurance (Berchick, Hood, & Barnett, 2018). 14% of males and 11% of females, under the age of 65, were uninsured (Kaiser Family Foundation, 2017). The most insured state in the United States was Massachusetts, with 5% (96,700) of males and 3% (62,000) of females uninsured, respectively (Kaiser Family Foundation, 2017). Texas is the most uninsured state, with 25% (2,037,700) of males and 22% (1,887,900) of females uninsured, respectively (Kaiser Family Foundation, 2017). White, Black, Asian, and Hispanic American populations have uninsured rates of 6.3% (12,313,539), 10.6% (4,456,240), 7.3% (1,369,481) 16.1% (9,284,870), respectively (Berchick et al., 2018). The largest uninsured age group in the United States is between 26 and 34, with 15.7% (4,452,708) uninsured (Berchick et al., 2018). The smallest uninsured age group in the United States is over 65, with 1.2% (612, 960) uninsured (Berchick et al., 2018).



Figures 3 & 4: the totals of respective demographics (bigger graphs can be found in the appendix)

The largest uninsured education group, by percentage, in the U.S. is those without a high school diploma, at a rate of 26.3%, (3,984,450) (Berchick et al., 2018). The smallest uninsured education group in the U.S. is those with a graduate or a professional degree at 4.2% (919,548) (Berchick et al., 2018). For income, 25.7% of those that earn less than 50K are uninsured (14,137,799), while only 4.3% of those with an income of 125K are uninsured (3,589,941) (Berchick et al., 2018). 86% (24,573,000) of uninsured people live within metropolitan areas, while the remaining 14% live outside of metropolitan areas (3,970,000) (Berchick et al., 2018).

Americans with Healthcare Insurance

Even among the insured, there are concerns of affordability and quality. In 2017, 91.2% of Americans had some form of healthcare coverage. 67.2% (217,160,000) were covered by private health insurance while 37.7% (121,830,000) were covered by government health insurance (Berchick et al., 2018). Twenty five percent of Americans under the age of 65 reported difficulty in paying medical bills (an estimated 68,019,000 by Census standards). Of that 25% facing difficulties, 15% (10,202,000) had to take out high interest loans, leading to a significant depletion of disposable income, trends of delayed medical care which becomes costly to reconcile later, and debt (Dickman, Himmelstein, & Woolhandler, 2017).

For those that are insured, access to quality healthcare is also affected by residence and racial demographics. Often, neighborhoods are racially and economically divided, leading to inequity in access to resources such as quality and affordable health services (National Academies of Sciences, Engineering, and Medicine, 2017). Structural inequities lead to “preventable differences in health metrics such as life expectancy, with research indicating that one’s zip code is more important to health than one’s genetic code” (National Academies of Sciences,

Engineering, and Medicine, 2017, p. 101; RWJF, 2009). Additionally, structural inequities impact birth outcomes, such as the difference in birth weight and infant mortality rate, not associated with biological differences amongst African American women; these differences are seen even when researchers account for varying socioeconomic statuses among these women (National Academies of Sciences, Engineering, and Medicine, 2017)

SALGBA

The State and Local Government Benefits Association (SALGBA) is a nonprofit organization that focuses on educating and providing collaborative support to public and private sector employee benefit professionals ("Constitution", 2018). It is in a unique position to influence trends in the U.S. healthcare market given its size and diversity of its membership. SALGBA currently has 1,232 registered members from all over the country, that work for private insurance companies and state and local government entities. SALGBA has four core objectives ("Policy and Procedures", 2018):

(1) Provide valuable opportunities for the exchange of information, ideas, knowledge, and expertise.
(2) Be a collective voice on national employee benefit issues.
(3) Enhance and promote professional education.
(4) Create collaborations with professional, educational and other benefit-related organizations.

Coinciding with its objectives, SALGBA utilizes small instructional groups to create more genuine relationships within the workplace and externally, with other benefit-related organizations. SALGBA annually conducts conferences regionally and nationally in major U.S. cities. At these conferences, SALGBA members host and attend multiple workshops. These workshops are designed to surpass standard education, even at the collegiate level, and enhance workers abilities in areas such as teamwork, communication, and analytical problem solving, among others (SALGBA.org, 2018). After completing these workshops, SALGBA members can earn accreditation as a Certified Government Benefits Administrator (CGBA). SALGBA's success has been grounded in these conferences' ability to make a difference by connecting professionals from around the country by offering opportunities for collaboration, information sharing, and networking.

Part II: The World Cafe

This section explains the process of using a World Cafe workshop at the SALGBA conference to discuss issues in healthcare and implementation of Value Based Care (VBC) initiatives. Information collected from discussions held at the workshop was then analyzed and is presented in this section.

The Concept of a World Cafe Workshop

The World Cafe event at SALGBA's 37th annual conference was led by Paul Campbell, an Adjunct Professor of Health Enterprise Management at the Kellogg School of Management at Northwestern University, the Director of State & Local Solutions at UnitedHealthcare, and a member of SALGBA. The concept of a World Cafe workshop is to create an environment where participants can think freely, expressing their thoughts and opinions without the restrictions of judgment and opposition. In the same way, the World Cafe workshop at the annual SALGBA conference was meant to bring together 60 healthcare representatives, from different private and public sector backgrounds, to discuss openly their thoughts, experiences, concerns, and suggestions when it came to healthcare and the implementation of VBC initiatives (Paul Campbell, personal correspondence, 2019).

Methodology: Data Collection

Participants in the World Cafe workshop were split into groups of five. Mr. Campbell asked three questions concerning the implementation of healthcare. Each question was given 15 minutes of discussion before moving on to the next question. Facilitators navigated through these discussions, writing out key talking points on large easel pads. After 15 minutes, participants would look for another table to join that did not include members of their previous discussion group. The questions asked during these discussions are found below:

(1) Who are the key stakeholders in healthcare, and what can they do to help promote VBC initiatives?
(2) What are the key obstacles that stakeholders face?
(3) What are the greatest incentives for governments to implement VBC initiatives?

At the end of the last discussion, facilitators posted their easel pad paper sheets onto the walls of the room where the World Cafe was held. Participants were then asked to review and rank

the talking points on the easel pads in terms of what they thought was most important. Ranking was done through the use of colored stickers given to the participants at the beginning of the workshop. A blue sticker indicated a topic that was deemed "important", and a red sticker indicated a topic that deemed "very important". Participants placed these stickers (of which there was a finite and equal amount per person) next to key terms, words, or phrases of interest. Once all stickers were placed, Mr. Campbell reviewed the rankings and led a broader final discussion over the most important talking points. The easel pads, with their rankings, were collected by facilitators who were students at the Bush School of Government and Public Service for review for this report. Stickers were tallied in 1-point increments with two columns to distinguish between points for "important" and "very important".

Methodology: Data Analysis

All ranked talking points were translated to Microsoft Excel to begin tabulating which received the most attention. Since different groups were discussing the same question, there were several key talking points that were overlapping, similar, or synonymous across easel pad notes. These similar sounding talking points were only combined if it could be determined that groups were discussing the same issue. For example, when discussing question 2 "what are the key obstacles stakeholders faced", one group discussed a "lack of focus on the topic by healthcare leadership" while another group used the term a lack "buy-in from leadership". Both talking points essentially discussed the same topic. Thus, during the data analysis process, these terms were combined into "leadership buy-in". The use of the "important" and "very important" rankings of the terms was also useful in identifying key points that received the most or considerable attention. Five key points were selected after reviewing the distribution of points in the "important" and "very important" columns. This is illustrated below.

(1) A Standard Definition of VBC
(2) Coordination between Entities
(3) Lack of Transparency
(4) Leadership Buy-in
(5) The Need for Evaluable Standards

Key Point	Important	Very Important
A Standard Definition of VBC	6	9
Change Culture of Health Provision	3	1
Coordination Between Entities	9	-
Eliminate Unnecessary Handoffs	3	2
Lack of Resources	4	4
Lack of Transparency	12	11
Leadership Buy-in	10	3
Misinformation/Lack of Info	3	2
Obtaining Relevant Data	3	2
Political Pressure	4	4
Right Technology	3	6
Rural Areas	3	2
The Need for Evaluable Standards	13	6

Table 1. This is a sample of the top ranked terms. It is important to note that while "Coordination between entities" did not receive any points in the "super important" column, it was a major talking point in the final discussion in the World Cafe workshop and thus was selected to be explored in this report.

Part III: Five Key Issues

This section uses the literature surrounding healthcare and discussions from the World Cafe to give an in-depth explanation of the five key issues that were given the most attention at this year's SALGBA conference.

What is Value-based Care?

Participants of the World Cafe mentioned it was initially difficult to talk about value-based care initiatives because there does not seem to be a widely accepted definition of what that is. Participants agreed that value-based care centered around improving health outcomes, and reducing costs, but the methods and strategies used to achieve these two tasks could vary. In this aspect, VBC seems more like a concept rather than a standardized model. A recurring possible key component of VBC, however, was tying reimbursements to quality of care provided. We offer the following definitions and examples in this section to provide a standard idea of VBC.

Value-based care models would have three overarching goals: to provide better care for patients, to improve population health management, and to reduce healthcare costs

(RevCycleIntelligence, 2018) Providers would be reimbursed and rewarded by insurers for their efficiency and effectiveness in these three areas. Providers would be encouraged to use evidence-based medicine, to engage more with clients, and to utilize up-to-date health information technology and data analytics (RevCycleIntelligence, 2018). Providers would be mandated to report hospital readmissions, adverse events, population health, and patient engagement (RevCycleIntelligence, 2018). Value-based care reimbursements would be bundled, a single payment for all services, and encompass metrics that depict improvements in patient health outcomes (RevCycleIntelligence, 2018). In contrast, VBC would be an alternative to the fee-for-service reimbursement model where providers can easily exploit the reimbursement system because services are unbundled and paid for separately. The amount of these unbundled payments are determined by a bill summary of annual fee schedules (RevCycleIntelligence, 2018).

An Example: Bundling Payments

A bundled payment is a single payment to providers for services from the beginning to the end of treatment (RevCycleIntelligence, 2018). Providers are reimbursed for the expected costs: labor fees, facility fees, and procedure costs (RevCycleIntelligence, 2018). For example, if a patient has a hip replacement surgery, Center for Medicare and Medicaid Services would make one payment to the healthcare providers and the hospital, instead of paying each group separately. The bundled payment is based off historical prices. Under this model, if providers are able to reduce the cost of services below the set bundle price, then they pocket the savings. However, if the costs are more than the bundled price, then providers must pay the difference.

What are Evaluable Standards?

The purpose of evaluating, reporting, and comparing healthcare outcomes is to accomplish the Quadruple Aim of healthcare, which states: "1. Improve the patient experience of care; 2. Improve the health of populations; 3. Reduce the per capita cost of healthcare; [and] 4. Reduce clinician and staff burnout" (Tinker, 2018). While there is a multitude of outcome measures to consider, below is a list of the top seven healthcare outcome measures most common in the healthcare arena (Tinker, 2018).

1. **Mortality:** Standardization of care procedures results in reduced disease-specific mortality rates.

2. **Safety of care:** Use of evidence-based tools or analytic applications to minimize the incidence of medical mistakes.
3. **Readmissions:** Implementation of healthcare coordination programs as well as analytical platforms to strengthen data accuracy and timeliness in order to better inform healthcare decision-making and performance tracking for the purpose of reducing costly but frequently preventable readmissions.
4. **Patient Experience:** Improvement in healthcare services and quality of care to achieve optimal patient satisfaction.
5. **Effectiveness of Care:** Evaluated by compliance with care guidelines using best practices and completed outcomes such as decreased readmission rates for patients with a specific chronic condition.
6. **Timeliness of Care:** Evaluated by patient access to care; Implementation of process improvement efforts to minimize the barriers in accessing healthcare services and resources.
7. **Efficient Use of Medical Imaging:** Establishment of evidence-based recommendations on the administration of medical imaging orders aimed to reduce excess medical imaging.

What would Coordination of Stakeholders and Related Entities Look Like?

To properly implement value-based care, there must be adequate coordination across stakeholders. Key stakeholders include patients, providers, payers, suppliers, and legislators. Each of these stakeholders has a role in ensuring the effectiveness and efficiency of VBC. For patients, their main role is to achieve a level of patient activation. Ballou- Nelson (n.d.) explains, "Patient activation is defined as a person with skill, knowledge, and confidence to manage his or her health and healthcare in illness and wellness." Ultimately, the main job of patients is to reach a capacity where they have confidence in the care that they are receiving. Patients need to be able to trust that they are receiving the best quality of care in proportion to the cost of the service. Patients should also feel comfortable enough to be an active voice during their treatment process. When their providers are not giving them the best care possible, patients should have the option to ask questions and report unjust practices.

Providers' role is closely related to that of patients. Providers should focus on efficiency and patient satisfaction (NEJM Catalyst, 2017). Efficiency can be achieved when providers utilize

preventative healthcare methods and avoid stacking the charges once a patient's condition has reached chronic status. To quote the Hippocratic Oath, providers should "do no harm." In defining "harm, "it is important not only to do what is best for the patient in treatment, but it is also vital to consider the patients' wellbeing when determining how the patient should be charged for services. VBC is not a crusade to pay providers less for their services; however, it is a movement to ensure patients are not burdened by their illness or condition and the overwhelming expenses that follow.

As providers and payers agree to serve the patient's best interest, suppliers should follow suit. Suppliers, for example prescription drug sellers, have a responsibility to price their products based on patient outcomes. Prescription drugs are expensive, but high costs do not guarantee that they will serve their purpose whether it is to cure a condition or curve certain symptoms. Therefore, their high prices without favorable outcomes do not align with value-based care. Supplies whether it be a drug or an instrument used during surgery should be priced according to its ability to fulfill its intended purpose.

Lastly, it is important to consider the role of state and local legislators, or even if legislators have a role. Some people believe that politics should not be involved in healthcare, yet in recent years, it has become a highly politicized field. For the purposes of VBC and this paper, legislators should promote the health and wellbeing of the people who have elected them into office. Thus, legislators should not only be aware of value-based care, but they should also, potentially provide incentive to insurers/providers that utilize value-based care. This recommendation is explored, in detail, later in the paper. In the end, the implementation of VBC will take the cooperation and coordination of all stakeholders. Without each entity doing its part, the VBC initiative cannot thrive.

What does Leadership Buy in Look Like?

The members of the focus group at the SALGBA national conference made it clear that VBC initiatives cannot be advanced without buy-in from elected officials at the state and federal levels. Legislators are often presented with a plethora of bills and issues to decide during the legislative session, and Congress has its own share of issues at the national level to attend to. Legislative buy-in that advances VBC initiatives consists of three factors: 1) understanding of the terminology surrounding VBC initiatives 2) bringing VBC initiatives to the next stage of the issue

attention cycle 3) a greater willingness to consider legislation that helps accomplish VBC initiatives while recognizing the potential economic gains from doing so.

The terminology surrounding VBC initiatives is not fully streamlined, nor is it comprehensive across all sectors and locales. Members of the SALGBA World Cafe who work at all levels of government and in all sectors expressed frustration with conflicting terminology and its ability to stymie progress in the field. The insight gained from these industry experts is indicative of a need for a coherent and commonly-accepted set of terminologies within the field. Adoption of such terminology does not have to come from legislative mandate but could be provided by each state's entity that governs health services, or the US Department of Health and Human Services (HHS) could provide federal guidelines on this topic.

Once the terminology is clarified, legislators can begin to discuss the issue with constituents and key stakeholders. As this discussion occurs, the issue of value-based care initiatives will progress to the next stage of the issue attention cycle. Downs (1972) describes five stages of the "issue-attention cycle": "the pre-problem stage," "alarmed discovery and euphoric enthusiasm," "realizing the cost of significant progress," "gradual decline of public interest," and "the post-problem stage" (p. 39-40). VBC initiatives are in the first stage of the cycle as not all persons within the legislatures or Congress are discussing this issue, or even aware of its existence. As this issue picks up momentum among persons on public insurance plans, providers, practitioners, and employees at the local, state, and federal levels it will progress to the second stage of the cycle, at which point legislators will start to take a more active interest in the topic. As the issue grows in the second stage and begins to approach the third stage of the cycle, legislators will begin to discuss legislation that can promote and VBC incentives.

As this discussion happens and bills are considered by different state legislatures and Congress, legislators will come to realize the importance of VBC initiatives and their economic impact. Many participants of the World Cafe noted that in their state insurance programs where VBC was successfully implemented there were economic savings that provided additional money to pursue other healthcare incentive programs or this money was moved into a general savings fund, much like Texas' Rainy-Day Fund. The goal of VBC is to save money and pass these savings onto the consumer. As this occurs, and as the issue moves into the third stage of the "issue-attention cycle," consumers will take greater notice of this topic and could use it as a means for determining

who to cast their votes for in upcoming elections. As this happens, legislators will take greater notice of the issue and seek to have greater buy-in on the topic.

What is the Relationship between Transparency and Trust?

When discussing key findings from the World Cafe, one of most identified issues regarding the current state of healthcare provision was a lack of transparency from insurance and healthcare providers. This lack of transparency of the inner workings of healthcare provision has grown the disconnect from the providers and consumers of healthcare. Further adding to this disconnect is the growing lack of trust in the system. Multiple stakeholders at the World Cafe identified this growing lack of trust, giving examples of "an unmeasurable lack of trust that causes people to be scared to go to the doctor when they need to, eventually they end up in the emergency room for something that could have been taken care of earlier and for less money".

Additionally, the growing GDP expense of healthcare, currently at 17.8% (U.S. National Healthcare Expenditures, 2019), adds further concern for the sustainability of the current system. To sustain the current U.S. economic system, healthcare spending would need to return to 10% of the GDP (Jaffe et al., 2006). The benefits of a more transparent healthcare system are numerous: reduced healthcare costs, reduced morbidity and mortality, and reduced suffering and excess death (Jaffe et al., 2006). In addition to this, a newfound trust in the healthcare system will improve the relationship between consumers and providers.

By increasing transparency, the publicly available pricing information would incentivize providers to have competitive prices and in turn lower costs (CRS, 2008). This assumption is primarily based upon the idea that transparency will reduce prices in the way it does in other markets. The long-standing idea of economic theory that markets work most efficiently when consumer prices accurately reflect the actual costs of product creation and delivery (Muri, Alessi, & King, 2013) is the basis for this assumption. While this theory has been proven in a multitude of other markets, there is some doubt it is applicable to the unique nature of the healthcare market (CRS, 2008). To fully take into consideration the unique nature of the healthcare market, transparency initiatives need to target not just the consumer, but service and insurance providers as well (Muri, Alessi, & King, 2013). Additionally, a transparency initiative aiming to reduce healthcare costs must take into account the unique structure of the healthcare market stakeholder interactions, any relevant market conditions, and the ability of targeted entities to use information

gained. If these factors are not accounted for in a transparency initiative occurring at any or all levels, the effort runs the risk of not decreasing prices or even increasing them (Muri, Alessi, & King, 2013).

In addition to market implications, transparency would allow for economic and mortality benefits in the area of "adverse effects" within healthcare. As it relates to healthcare, adverse effects are defined as, "A harmful or abnormal result. An adverse effect may be caused by administration of a medication or by exposure to a chemical and be indicated by an untoward result such as by illness or death" (Shiel, 2018). Thousands of lives and billions of dollars are lost yearly to adverse effects (Jaffe et al., 2006). An increase in transparency would allow for a greater ability to identify the most common areas for adverse effect reduction within healthcare (Jaffe et al., 2006). The subsequent reductions, specifically in unintended deaths and suffering, would additionally increase trust between healthcare recipients and providers.

Conclusion

There are many issues that impact Value-Based Care (VBC) implementation. Among the many, a clear and consistent definition of VBC, evaluable standards, coordination between entities, leadership buy-in, and the relationship between transparency and trust were deemed most important at SALGBA's World Cafe workshop. This workshop provided a space to discuss and analyze these issues with private healthcare representatives as well as with state and local government benefit professionals. Using outside research and narratives collected from the World Cafe, this report explored the issue facing VBC implementation and offered some recommendations for how to overcome these issues.

References

Ballou-Nelson, P. (n.d.). “The role of patient activation in value-based care.” Retrieved from https://www.mgma.com/resources/operations-management/the-role-of-patient-activation-in-value-base-care

Berchick, E. R., Hood, E., & Barnett, J. C. (2018). Health insurance coverage in the United States: 2017. *United States Census Bureau Current Population Reports.*

CMS. (n.d.). U.S. national health expenditure as percent of GDP from 1960 to 2019. In *Statista - The Statistics Portal*. Retrieved April 26, 2019, from https://www.statista.com/statistics/184968/us-health-expenditure-as-percent-of-gdp-since-1960/.

CRS Report for Congress. (2008, April 29). Does price transparency effect market efficiency? Implications of empirical evidence in other markets for the healthcare sector. Retrieved from https://fas.org/sgp/crs/secrecy/RL34101.pdf

Dickman, S., Himmelstein, D., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *Lancet, 389*(10077), 1431-1441.

Downs, A. (1972). Up and down with ecology - the "issue-attention cycle.” *The Public Interest 28*, 38-50. Retrieved from https://www.nationalaffairs.com/public_interest/detail/up-and-down-with-ecologythe-issue-attention-cycle

Jaffe, R., Nash, R. A., Ash, R., Schwartz, N., Corish, R., Born, T., & Lazarus, H. (2006). "Healthcare transparency: opportunity or mirage." ASIMP working group on healthcare transparency. *Journal of Management Development*, *25*(10), 981-995. https://doi.org/10.1108/02621710610708603

Kaiser Family Foundation. (2017). Uninsured rates for nonelderly adults by gender. https://www.kff.org/uninsured/state-indicator/rate-by-gender/?currentTimeframe=0&so

Muir, M. A., Alessi, S. A., & King, J. S. (2013). Clarifying costs: Can increased price transparency reduce healthcare spending. *William Mary Policy Review, 4*(2), 319-366. https://heinonline.org/HOL/Page?collection=journals&handle=hein.journals/wamprev4&id=324&men_tab=srchresults

National Academies of Sciences, Engineering, and Medicine. (2017). *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press. https://doi.org/10.17226/24624.

National Health Expenditure Projections 2018-2027. (2019). Retrieved April 26, 2019, from

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

NEJM Catalyst. (2017). "What is value-based healthcare?" Retrieved from https://catalyst.nejm.org/what-is-value-based-healthcare/

RevCycleIntelligence. (2018, December 17). What is value-based care, what it means for providers? Retrieved January 28, 2019, from https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers.

RWJF (Robert Wood Johnson Foundation). (2009). Beyond health care. Robert Wood Johnson Foundation Commission to Build a Healthier America.

SALGBA membership (2018) *Constitution.* Salgba.org. http://www.salgba.org/doc/who_we_are/ConstitutionRev2011.pdf

SALGBA (2018) *Policy and Procedure Manual.* Salgba.org http://www.salgba.org/doc/who_we_are/SALGBA_PPM_2016.pdf

Shiel, W. (2018). Medical definition of adverse effects. Retrieved from https://www.medicinenet.com/script/main/art.asp?articlekey=12073

Tinker, A. (2018, October 30). The top seven healthcare outcome measures and three Measurement essentials. Retrieved April 21, 2019, from https://www.healthcatalyst.com/insights/top-7-healthcare-outcome-measures