

Conceptualizing a Value-Based Care Model

Introduction

Value-Based type initiatives offer solutions to the rising inequities in the American Healthcare system. Healthcare inequity is driven by a lack of affordability, a lack of accessibility, and a lack of consistency in the quality of healthcare provision. Value-Based care models seek to reduce costs through price references measures, increase accessibility by targeting high-need populations, and increase consistency of quality in health care services by mandating adherence to certain quality standards or risk losing payment for services rendered. The following logic model is offered to explain the resources, activities, outputs, outcomes and impacts that are related, and expected to occur from the implementation of a value based health plan designed to reduce inequity.

What does Healthcare Inequity Mean?

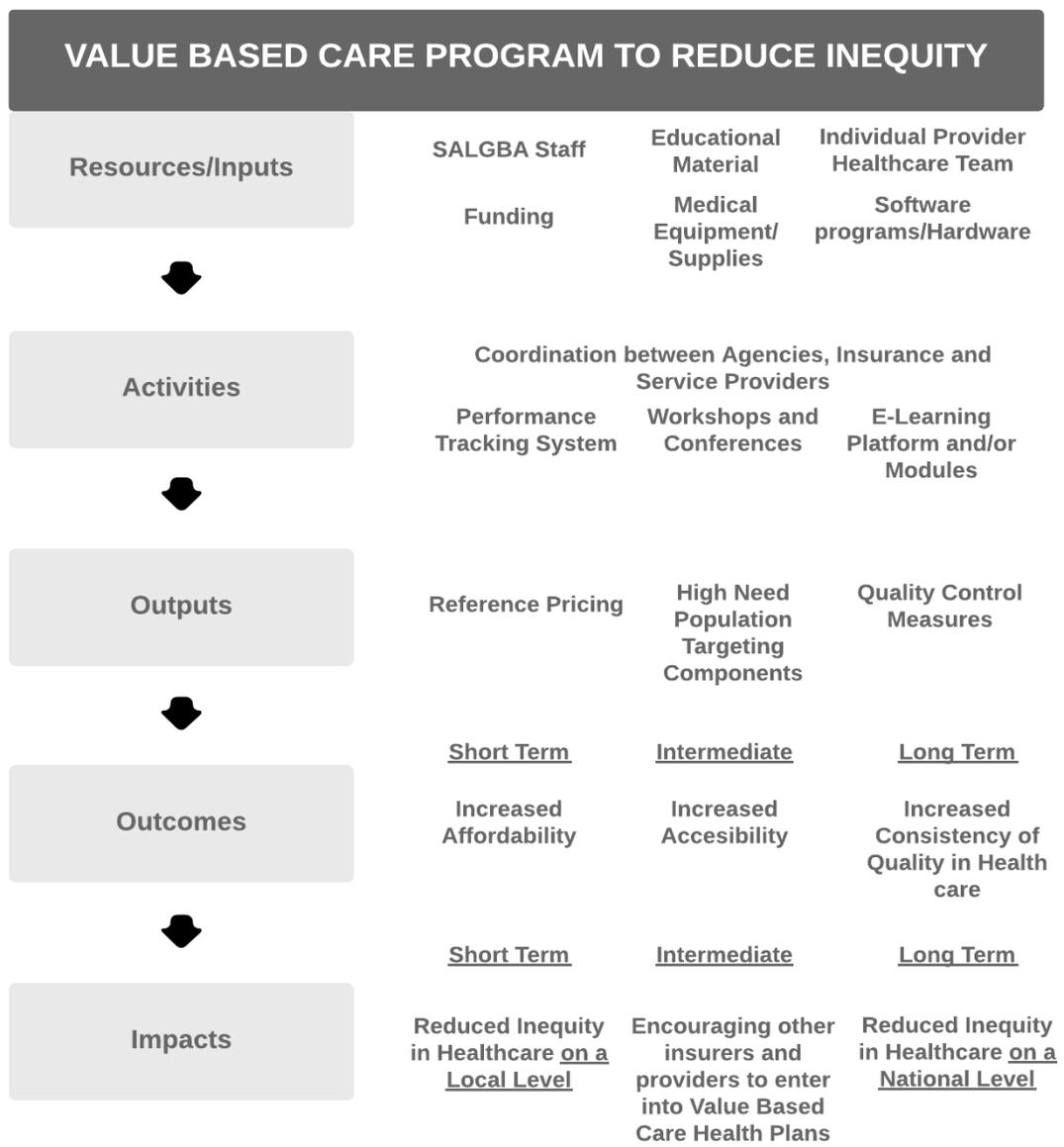
Despite being a relatively wealthy nation, the United States has very visible disparities in the provision of its healthcare (Sridhar, 2005). 8.8 percent of the U.S. population, or 28.5 million, do not have healthcare insurance (Berchick, Hood, & Barnett, 2018), and family coverage for the insurance has risen from 14% to 32% since 2012 (Japinga, Bleser, Feingold, & Saunders, 2017). Rural residents (Ricketts, 2002), minority populations (Arpey, Gaglioti, & Rosenbaum, 2017), and noncitizens (Ku & Waidmann, 2003) have lower levels of accessibility to healthcare providers than their urban, white, and citizen counterparts. These populations, even when insured, also experience lower quality of care (Powell, 2017; Ku & Waidmann, 2003; Schneider, Leape, Weissman, Piana, Gatsonis, and Epstein, 2001), with inconsistencies being further exacerbated by a lack of consensus on the measures, definitions, and evaluations concerning what constitutes

“good” and “bad” insurance coverage (Al-Abri & Al-Balushi, 2014). In understanding these realities of the healthcare system, we have grouped these disparities of health care provision into three issue categories - affordability, accessibility, and consistency of quality of services rendered. Inequity, therefore, serves as an umbrella term for these categories. For the purposes of this paper, we hold that changes in each of these categories cause a change in healthcare inequity overall.

General Elements of Value Based Care Health Plan

“Value-Based Care” (VBC) is a term for a health plan that is designed to reduce costs while improving employee health quality (Japinga et al., 2017). While VBC plans vary from state to state, and provider to provider, to meet unique needs and goals (Japinga et al., 2017), the following are 4 general elements found in most plans: (1) they are agreements between insurance providers (government or private entities) and health care providers (hospitals, medical centers, etc.) on how reimbursement rates will be calculated; (2) they tie reimbursement for healthcare services to the quality level provided by the provider (RevCycleIntelligence, 2018); they reward providers for efficiency and effectiveness (Japinga et al., 2017); (3) they encourage the use evidence-based medicine, engagement with clients, and utilization of health information technology and data analytics (RevCycleIntelligence, 2018); and (4) they mandate the reporting of hospital readmissions, adverse events, population health, and other relevant demographic information (RevCycleIntelligence, 2018). The following model showcases our interpretation of how a VBC program designed to reduce inequity in healthcare provision would work. We base our model after the WK Kellogg Foundation’s (2004) interpretation of the development of a logic model. While it may seem intuitive to explain this model sequentially, from the specific types of resources to the intended outputs of the program to its intended impacts, this paper will instead explain in reverse

order. This is done to provide the reader with the intended impacts of the program first, in order to understand how they connect and build off the antecedent components. We begin by describing out intended impacts of a VBC health plan designed to reduce healthcare inequity, and why we deem them to be indicators of a successful or unsuccessful program.



Expected Impacts

The main impact of this model is the reduction of health care inequity, but this is expected to manifest itself differently across shorter and longer time horizons. It is important to note that this particular logical model incorporates impacts that extend beyond the immediate stakeholders of a VBC plan. It accounts for impacts that happen at a state and national level that may not be immediate causes of individual plans. The physical provision of healthcare is local in nature, but it is influenced by state and national governmental structures and market trends. Thus, the success of local VBC plans could have implications beyond local jurisdictions that will, in turn, return and influence them.

In the short term, we focus on the implementation of a single VBC plan and, therefore, expect changes to occur at a local, small scale level; when insurance and service providers agree to a VBC health plan, its implementation will affect the clients who have that particular healthcare insurance and the hospitals or medical centers that agree to accept that insurance. Many of these VBC plans will include mandates that alter reimbursement rates, incentivizing participating service providers to comply or risk losing revenue (Japinga et al., 2017). Thus, the short term impacts of this model would be to see healthcare inequity reduced on a local scale - meaning between individual insurance providers and participating healthcare providers.

Intermediate term goals extend beyond the effects of an individual VBC plan. One of the broad appeals of VBC initiatives is that insurers could effectively *change* the healthcare market by joining other insurer providers in including VBC measures in its reimbursement plans. As more insurers switch to VBC type plans, its mandates, expectations, and practices become further

legitimized and could play increasing critical roles in reshaping health care plans on a state level (Japinga et al., 2017). Thus, the intermediate term goal of the implementation of a VBC model would be to observe other insurance providers, that may be close in proximity, switch over to VBC type plans, increasing collective marketing and negotiating power that would benefit local insurers and clients.

Finally, the long term goal of a VBC plan would be to see a national movement of health care insurers adopted VBC types measures or initiatives in their plans. Much like the intermediate term impacts, this is the logical finality of implementation. Again, we include this impact because if value based care practices become a national norm in the American healthcare systems (increasing legitimacy, marketing power, and negotiating power) local insurers and clients still stand to benefit.

Expected Outcomes: Respective Outputs

We now connect these expected impacts to the expected outcomes and outputs of this logical model. These impacts are driven by the level of affordability, accessibility, and consistency in quality, in the U.S. healthcare system. Our expected outcomes are thus the correction of previously mentioned categorical issues. We organize the following section by (1) the specific outcomes and their respective time horizons, and (2) explaining the outputs that make those outcomes possible.

Short term Outcome: Increased Affordability

We deem increased affordability as a short term outcome because of how quickly it can be attained. While the principal actors in any healthcare plan are the recipients, the providers, and the insurers, costs of the healthcare plan are largely generated via negotiations between providers and insurers alone (Marilyn Bartlett, personal communication, 2019; Paul Campbell, personal communication, 2019; Tina Bowling, personal communication, 2019)¹. Once insurance and service providers agree to a price, the new reimbursement rates would occur the next time a service provider sends the insurance provider a bill.

Respective Output: Reference Pricing

In our model, we list reference pricing as an expected output that would lead to an increased affordability outcome. This is when a healthcare plan (1) sets maximum contributions towards specific services, (2) provides multiple providers for clients to choose from, and (3) provides price data that is easily accessible and comparable. The idea is to allow for clients to “shop” for their healthcare provision by having the ability to “reference” prices quickly, forcing providers to lower prices to remain competitive (Japinga et al., 2017). An example of is how the State of Montana negotiated down its prices, saving roughly \$1 million a month (Allen, 2018). A common trend for hospitals is to have a “chargemaster,” or an itemized list of prices, that are set several times higher than the rates insurers would normally reimburse. This practice is to ensure that when the price is negotiated down by insurers, providers make a profit (Arora, Moriates, & Shah, 2015). Montana used Medicare prices to determine their maximum contributions for

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reimbursements. The implementation of reference pricing in the State of Montana healthcare plan led to a \$17 million reduction of healthcare costs between 2016 and 2017 (Marilyn Bartlett², personal communication, 2019). In our logic model, Medicare prices for medical services would be used to generate the values that would go into our system for reference pricing purposes.

Intermediate Outcome: Increased Accessibility

Increased accessibility was deemed an intermediate goal because of the challenges foreseen in identifying which populations suffer from a lack of accessibility and how to address those challenges if the limiting factors are geography and or limited mobility. Theoretically, this outcome would be achieved via the coordination of like minded local and state agencies, and insurance and service providers. However, having to coordinate joint efforts and information sharing across a network like that is challenging, and would require more time to implement (Japinga et al., 2017).

Respective Output: Targeting High Need Populations

Our model includes the intended output of high need population targeting in order to achieve the increased accessibility outcome. The general concept would be for a healthcare plan to contract with a network of providers, or local and state agencies to physically bring services closer to high need populations. Consider the Accountable Communities for Health initiative of the State of Minnesota healthcare plan as an example of how this could work (Japinga et al., 2017). Through a network of community partnerships, multiple government agencies, and an improved data exchange between these actors, Minnesota has attempted to provide for minority, disability, limited mobility, and rural populations all of whom experience different limitations to healthcare

² Marilyn Bartlett is largely credited for the shift to utilizing “price referencing” techniques in Montana, using Medicare prices of healthcare costs as a reference point to negotiate with healthcare providers.

accessibility (Awsumb, Dobbe, Ly-Xiong, Rodriguez-Hager, Rydrych, & Terrill, 2016). In 2016, approximately 220 partnerships had been formed in Minnesota that linked services (through contracting with local small medical centers close to high need population areas) to provide for 1,600 people that had issues of accessibility (Awsumb et al., 2016).

Long term Outcome: Increased Consistency of Quality

Increased consistency of quality is deemed a long term goal because of the acknowledged and well documented difficulty in finding a consensus on what “quality” performance could mean. A meta-analysis of 29 different studies evaluating healthcare provision performance found a lack of consensus in two areas: metrics to quantify costs, and definitions determining patient satisfaction with services (Al-Abri & Al-Balushi, 2014). Standardized definitions, generalizable data collection methods, and information sharing would be immensely helpful in alleviating these issues but this requires large scale data coordination and sharing which we predict to be time consuming and expensive.

Respective Output: Quality Control Measures and Mandates

Our model includes quality control measures and mandates outputs that could potentially increase the outcome of consistency in quality of care. A VBC plan could have fiscal penalties that are triggered by any errors or malpractice conducted by the healthcare provider. (Japinga et al., 2017). Errors and malpractice are costly, and could damage client quality of life, making them highly observable events in healthcare provision. In theory, these highly observable events could be utilized as triggers that would alter reimbursement rates for providers, or even cancel reimbursements altogether. This could mean that (1) insurance providers will not reimburse for

medical errors, (2) clients are not expected to bear the cost of those medical errors, and or (3) providers must correct those errors even if it means bearing the cost alone and offering compensation. Currently the State of Montana has measures in its healthcare plan that deny reimbursement to providers for medical errors and faculty procedures, which has contributed to both reducing costs and improving quality of care (Allen, 2018); Hospitals maintain stricter protocols to guard against errors or risk losing out on the payout, as a result (Marilyn Bartlett, personal correspondence, 2019).

Indeed, the standards of quality that a VBC would set, coupled with mandated reporting of adverse events, would provide a standardized means of encountering or observing problems but it would be up to individual providers to determine what benchmark to use to determine quality. This could mean surveying patients over time to see if their perception of healthcare has improved, or this could mean the reduction of adverse effects. Providers would need to agree beforehand to what measures they value most, and this could be a rather arduous task to complete.

Activities

The activities in our logic model were designed to provide insurance providers with the knowledge to create a VBC plan that produces the previously mentioned outputs. The following are individual explanations of those activities. The main activity is the coordination between insurance providers, state and local agencies, and healthcare providers. There is no sequential assumptions made in how these activities are conducted. We predict that activities will be occurring simultaneously, further generating knowledge and best practices until insurance providers formulate their VBC type plan. We predict that the membership association, the State

and Local Government Benefits Association, would have a potentially crucial role in providing opportunities for insurance providers to develop and refine their plans.

- Workshops and conferences –Workshops and conferences would facilitate the exchange of resources, lessons learned, and best practices. These events are also avenues for reporting on strengths and weaknesses of the value-based care model and developing collaborative informational sessions ranging from educating on how to start a value-based care model to reporting meaningful measures. SALGBA is responsible for providing its members with events to provide education as well as networking opportunities (“Welcome to SALGBA,” n.d.). To fulfill their goals and missions, SALGBA conducts their conferences regionally and nationally in major U.S. cities a few times a year. At these conferences, SALGBA members host and attend multiple workshops. These workshops are designed 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, 2018). One of SALGBA workshops is the World Cafe where attendees are divided up into groups of five and moved from table to table to share ideas and potential solutions strategic challenges. The small groups discuss key stakeholders, obstacles, what works and how to build support for ideas (World Cafe Method, 2018).
- E-learning platform and/or modules – SALGBA would prepare online webinars to remotely train and provide educational and resource information to its members on the value-based care model. Furthermore, SALGBA could consider offering its members an already developed certificate training in value-based care, such as one offered by The Dartmouth Institute for Health Policy & Clinical Practice (“Curriculum,” n.d.).

- Performance tracking system – The development of a reporting forum would be beneficial to track compliance and performance measures of each healthcare provider implementing VBC. This would ensure transparency and ease of generating reports on the successes and failures of the program’s implementation.

Inputs/Resources

Newcomer defines inputs as the human and financial resources required to support a program (Newcomer, Hatry, & Wholey, 2015). This section lists the necessary inputs needed to achieve the activities, outputs, and outcomes of necessary to decrease healthcare inequity in the United States.

- Trained staff – SALGBA staff would be fully trained in the value-based care model to further educate and train their members participating in this healthcare quality model.
- SALGBA membership – SALGBA membership consists of either associate members or jurisdictional members. Associate members are representatives of suppliers and/or vendors (“Membership,” n.d.). Jurisdictional members are representatives of government organizations (“Membership,” n.d.). Jurisdictional members would be trained by SALGBA staff in executing a value-based care model in their respective organizations.
- Healthcare Team – The healthcare team consists of everyone who interacts with patients from their initial intake with a receptionist to the specialized physician performing the surgery. Team members include: Physicians, dentists, dental hygienists, pharmacists, pharmacy technicians, physician assistants, nurses, advanced practice registered nurses,

midwives, dietitians, nutritionists, therapists, chiropractors, phlebotomists, optometrists, radiographers, paramedics, medical laboratory scientists, naturopaths, technicians and front office staff (World Health Organization, 2013).

- Educational material – SALGBA staff would create or use existing educational material regarding the value-based care model to its members, such as posters, flyers, or a policies and procedures manual. This information could be found online from reputable sources providing information and evidence of the benefits of value-based care for the healthcare practice.
- Funding – A funding stream to help cover project-related costs such as staff salaries, staff travel to provide technical assistance, or incentives to members to gain interest in implementing value-based care in their entities. Funding is also needed to cover the costs of the online educational platform and educational materials. In order to implement value-based care there must also be funders of insurance. These funders include both federal and state governments as well as private insurance providers/companies. Funders are also clients themselves, who pay into their insurance either directly or through payroll fees.
- Medical Equipment/Supplies
- Software programs needed to maintain and track data.

Assumptions

While this paper may have already touched on some assumptions its logic model makes implicitly, we provide the following section to discuss them in greater depth. We focus on the most apparent assumptions that would have implications on the perceived success of the implementation of VBC type plans. We divide this section into two sub sections, recipient assumptions and program assumptions.

Recipient Assumptions

Healthcare recipients and health care providers agree on the standard of quality control.

Our model does not include comprehensive evaluative outputs that attempt to understand and bridge the gap between what is considered quality healthcare to a provider and quality healthcare to a recipient. A study of 29 different articles centered around evaluating healthcare quality of service concluded that, while inequities did exist across populations, there was a lack of consensus on what constituted “good” and “bad” coverage. There are two explanations: (1) authors had different definitions of patient satisfaction and (2) quality reported metrics often had to be proxy variables that ranged from financials, to procedures of care, to patient reported experiences (Al-Abri & Al-Balushi, 2014). Quality becomes particularly difficult to assess when insurers provide incentives for “higher performing” providers, because socioeconomic circumstances may serve to explain negative score indicators, such as mortality rates, better than the competence of doctors and practitioners (Dickman, Himmelstein, & Woolhandler, 2017).

Healthcare recipients are informed about the services they receive.

Healthcare recipients vary in their level of knowledge about the services they receive. Healthcare literacy which is defined as the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate healthcare decisions” (Healthcare Literacy, n.d.) describes a healthcare recipients level of understanding regarding the service they receive. An individual's healthcare literacy is dependent upon factors such as the communication skills of lay persons and professionals, lay and professional knowledge of health topics, culture, demands of healthcare and public health systems, and demands of the situation (Quick Guide to Health Literacy, n.d.). According to the National Assessment of Adult Literacy, only 12% of adults have proficient healthcare literacy (National

Center for Educational Statistics, 2006). Lower literacy rates rates has been linked to higher rates of hospitalization and less frequent use of preventative services which are associated with higher healthcare costs and healthcare inequality (Quick Guide to Health Literacy, n.d.).

Potential clients don't care about who is the insurance provider

Recent surveys have concluded that more than half of Americans (52%) think that it is the responsibility of the federal government to provide healthcare (PBS NewsHour, 2017). Additionally, 62% of Americans think it is the responsibility of the federal government to ensure all Americans have healthcare provided to them in some facet. (PBS Newshour, 2017). The division of the provision of healthcare services by the federal government falls down party lines as 8/10 democrats and 3/10 republicans think health coverage is a federal responsibility (Zaldivar & Kellman, 2017). Independents are split almost evenly with 54% believing healthcare coverage is a federal responsibility and 44% believing it is not (Zaldivar & Kellman, 2017).

Program Assumptions

Insurance providers have more bargaining power than healthcare providers.

When negotiating pricing and coverage between insurance providers and healthcare providers, we assume insurance providers have the bargaining advantage. Between the two actors, bilateral bargaining occurs over transaction prices yet insurance providers have more control due to the increase of concentration of insurance providers leading to higher market power (Trish & Herring, 2015). Additionally, the effects of provider market power may depend on the amount of insurance market power, and vice versa. The extent to which insurers can use their bargaining power to dictate pricing depends on the amount of competition within the local market. These

prices may already be at or near the point at which economic profits are zero in relatively to the competitive markets (Trish & Herring, 2015). Furthermore, the bargaining power of service providers can be dependent upon the market conditions of local insurance providers (Trish & Herring, 2015).

Medicare Prices are fair.

In terms of reference pricing, we assume that Medicare is the authority on what is considered fair. This may or may not be true. Medicare payment pricing influences both payments by private sector insurance providers that adopt Medicare's pricing levels as well as those who do not (Feldman, Dowd, & Coulam, 2015). Medicare's administrative pricing system cannot replicate the "fair" pricing that is the outcome of a functioning competitive market. The lack of optimal pricing from Medicare can be attributed to factors such as Medicare's resistance to supply and demand, poor information circulation, and the disparity of bargaining power within the market (Feldman et al., 2015). Nonetheless, when Medicare pricing is perceived as fair the pricing of public and private insurance provision must account for: the effect of insurance as the reduced costs for out of pocket payments leads to an increase use of healthcare services as well as flawed competitive market for providers (Feldman et al., 2015).

Conclusion

In this paper we theorize that healthcare inequity is driven by a lack of affordability, a lack of accessibility, and inconsistencies in the quality of care and services rendered. In acknowledging the general elements of Value-Based Care health plans, we provided a logic model of a VBC health plan designed to reduce healthcare inequity. Explanations on the impacts, outcomes, outputs, activities, and resources of this model were offered. Finally, we concluded the paper by addressing

the assumptions our model makes of clients and the program itself. There is a need for a more in depth look at these assumptions, as they could potentially turn into pitfalls that would deter the ability to evaluate the success of a VBC health plan. We aim to structure the next paper, evaluation studies, with these assumptions in mind to find meaningful ways of overcoming possible negative implications.

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