

Running Head: ACA AND UTAHANS

Engaging Utahans in the Democratic Process and Policy Development: Synergy and Knowledge
Translation
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ABSTRACT

The Patient Protection Affordable Care Act (ACA) is the result of years of struggle to address the knotty problem of health care, and the nation must continue to move forward and build a sustainable healthcare system that will survive the future and provide top quality care. Political actors for decades have been unsure how to organize an effective response. Governor Herbert stated that Utah has a clear vision to pioneer health care innovation and reform, harness the power of collective efforts and market principles, and become the healthiest people in the nation, including solutions for low-income, uninsured and vulnerable populations. This study proposes evaluating two methods, Synergy and Knowledge Translation, to ascertain whether community engagement can effectively enhance the direction of Utah's health policy by assessing following: whether diverse, multidimensional, multidiscipline resources are necessary to enhance policy goal congruence, policy effectiveness, financial resources, and joint governance structures to address the common good and changing demographics in Utah; whether the supply of research and information and collaborative endeavors can forward the salient concerns in a community and refocus goals for the public good in order to shift political impetuses and elitist behaviors; and, whether policy directives arising from community involvement are necessary to improve local health determinants. Both methods could advance the diverse, multidimensional, multidiscipline resources that are necessary to enhance policy goal congruence, policy effectiveness, and financial resources and could help frame the joint governance structures to address the common good and changing demographics in Utah.

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Yet, there is little evidence to suggest that peer review journals, whose functions are to screen research for rigor and originality and to consolidate a foundation for future research are the right vehicles for advancing the use of research (including health equity research) in policy.
(Murphy)

Patient Protection Affordable Care Act

The Patient Protection Affordable Care Act (ACA) is the result of years of struggle in the American political system to address the knotty problem of health care. In his 1949 State of the Union address, President Truman noted, "Our health is far behind the progress of medical science. Proper medical care is so expensive that it is out of the reach of the great majority of our citizens." Today, sixty years later, technology and medical advancements has exponentially advanced creating ethical dilemmas never envisioned by Truman. The seminal question Americans face is whether America can "turn health and healthcare from a problem into an opportunity, making it the leading creator of high-value jobs and foreign exchange earning American society with an efficient health system" that maximizes accuracy, minimizes errors, and reduces inefficiencies to improve care (Health Transformations, 2008). Currently, our health care system operates under a paradigm that treats "sick people as a commodity and doctors as an investor tool shifting the burden of administration costs on the backs of physicians who attempt to 'walk a tightrope between thrift and penuriousness' in a business environment where "scholarly traditions of openness and collaboration give way to secrecy and assertions of private ownership of vital ideas, and the search for knowledge displaced by a search for intellectual property (Physicians' for a National Health Program, 2008). Robert Rubin in a Brookings Institution report stated "healthcare reform, including universal coverage, is a critical social and moral issue, but it is also an economic imperative" for this generation (2007). In essence, we as a nation must continue to move forward and build a sustainable healthcare system that will survive the future and provide top quality care. According to the Committee for Economic Development

(2007), no one had an incentive to seek or provide, quality, or cost-efficient health care in our employer-based health insurance system. The states and the federal administration must now address the difficult task of restructuring our current health care system, and perhaps, even the more difficult task of restructuring the public perceptions regarding what is an efficient, quality health care system. Political systems, both at the federal and state levels, need to evaluate how the ACA's goals will translate into policy and programs and whether a state can shape and transform the knotty issue of affordable healthcare in an acceptable framework for diverse constituents, industry partners, and the looming global fiscal challenges.

According to Robert E. Moffitt (2006), director of the Center for Health Policy Studies, the basis of an insurance exchange must rest in governmental action:

[S]hort of congressional action. . . , the burden to improve health coverage rests with state officials. The best way to enable individuals and families to buy, own, and keep health insurance from job to job . . . is to transform the balkanized and dysfunctional state health insurance market into a single health insurance market. This new market would function well for all sorts of individuals and small businesses, not just workers employed by large companies.”

The ACA requires “all children to have health insurance, and employers to offer employee health benefits or contribute to the cost of the new public program. Create a new public plan, and expand Medicaid and State Children’s Health Insurance Program” [SCHIP]. Other factors include the National Health Insurance Exchange, through which small businesses and individuals without access to other public programs or employer-based coverage could enroll in the new public plan or in approved private plans” by way of federal income-related subsidies available to help individuals buy the new public plan or other qualified insurance and premium

subsidies to employers (Kaiser, 2008). Additionally, the employment paradigm by requiring “employers to offer “meaningful” coverage or contribute a percentage of payroll toward the costs of the public plan, with a small business exemption or options for public insurance coverage with comprehensive benefits similar to those available through FEHBP Federal Employees Health Benefits Program (Kaiser, 2008). The federal government in an attempt to help facilitate these exchanges has given states grants to build an Affordable Insurance Exchange, including a \$1,000,000 to the Utah’s Governor’s Office of Economic Development in order to expand the exchange research and better target potential consumers, develop web-based tools, and fund personnel (U.S. Department of Health & Human Services). The ACA requires all children to have health insurance, employers to offer employee health benefits or contribute to the cost of the new public program, a new public plan, and expanded Medicaid and State Children’s Health Insurance Program [SCHIP]. Other factors include the National Health Insurance Exchange, through which small businesses and individuals, without access to other public programs or employer-based coverage, could enroll in the new public plan or in approved private plans “by way of federal income-related subsidies available to help individuals buy the new public plan or other qualified insurance and premium subsidies to employers” (Kaiser, 2008). The ACA solution is to offer Americans healthcare that is equitable, dependable, and efficient for at least minimal services.

The nation is grappling with questions of human rights and traditional American values, which have been based on “traditions of openness and collaboration, [but now] give way to secrecy and assertions of private ownership . . .” and financial enrichment to the few (Physicians’ for a National Health Program, 2008). The ‘predominate goals of health policy initiatives in all developed nations were equity or access and quality of health care’ (Blank & Bureau, 2004,

p.93). If our democratic nation questions the issue whether health care is a human right, as opposed to framing the issue in terms of self-reliance, the ability of policy makers to effectively construct a solution becomes problematic. Whether health care is an entitlement for all and whether the country can bear the burden of supporting such ideology will continue to weave itself into any health care debate along with citizens' concerns regarding the safety and quality of healthcare as the nation moves forward with implementing the Act. "It is difficult to imagine an institution more historically embedded in a nation's politics, economy, and culture than health care" (Dutton, 2007, p.9). In America, deep seeded propaganda entrenches the negative concepts of socialization and mistrust when discussing expanded governmental roles in health care, and a convergence of strategies, such as managed competition or regulated markets, is occurring. Whereas the United States would generally stand outside the normal paradigms of other developed countries due to the tolerance for a large section of its population to go without health insurance, the pattern is changing. Aging populations, increasing impacts from high-risk behaviors, consumer health education via the Internet and advertising, access to technology, and out of control health cost may finally propel the population into evaluating old perceptions and new solutions.

"Every policy is founded on goals and objectives which should be clarified early in the policy making process" (Blank & Bureau, 2004, p.92) A policy must be narrowed down to the specific programmatic goals which will frame the operational guidelines for a particular policy to understand the how the policy will affect the average American. In America, a clarification and delineation of the exact benefits and cost resulting from the policy and the rights within such a governmental policy needs to be carefully defined within the democratic ideals of our nation.

Thus, the fundamental question is how to approach the day-to-day implementation of a health care system and insure that equity, access and quality of health care is available to all the citizenry within the financial constraints of the country and tax system and divest ourselves of the ideological historical legacy. The next question is how the ACA operates within its political and cultural contexts.

Historical Legacy and Free Market Ideology

In the U.S., the mantra of a free market system was touted by proponents as a workable solution, yet was shown “to have little to do with health care changes” during the last century (Dutton, 2007, p. 214). What were major factors were powerful political components, large corporations who have financial interest in health care, employee lobbies, and the insurance third party payer system that distanced the user from the provider. The rallying cry that “providers of services [should] make the fees more transparent” in the 1980 proved even more difficult (Dutton, p. 215). A democratic free market system is predicated upon the foundational prong that both parties have an equally position “bargained for exchange.” In medicine, physicians still hold unequal bargaining power, if one may argue that the exchange is a bargaining one at all when the medical industry comes close to the definition of a monopoly in the evolution of “reasonable and customary” charges that seek to fix prices based upon association agreements and horizontal agreements in a third party payer system (see generally, The Sherman Antitrust Act of 1890). Consequently, the dysfunction market in the U.S. has little to do with a standard business paradigm of a robust “free market” and more to do with the historical factors defining relationships between the patient and the physician in the business relationship.

In the 1970’s, medical care costs were spiraling out of control. President Nixon and Health, Education, and Welfare secretary Douglas Coleman attributed the crisis to fact that

medical decisions “are made outside any organizational framework” (as cited in Dutton, 2007, p. 167). Consequently, out of this dysfunctional model, Senator Kennedy constructed major reforms in how services were managed, and the Health Maintenance Organization (HMO) was thrust into the forefront of the debate. The perception of patients that doctors’ fees were unreasonable and “usual and customary” fees were untenable opened the door to this seminal solution. The earliest HMOs were large healthcare entities that provided primary care and specialty care and were created specifically to address the perceptions that costs need to be contained and “reasonable” to consumers. Interestingly, out of these organizations and physicians attempting to keep their salaries at par in the new organizational framework, influential ethical conflicts of interest arose relating to physician kickbacks and antitrust actions. Out of this fiscal framework of physician ideology and political pressures, new federal legislation arose limiting the business practices of physicians in complex business self-serving relationships and negotiations in medical practices (see generally, 1 ABA Section of Antitrust Law; Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b); Broccolo, 2000). The art of medicine over the last century has evolved to business of medicine.

Consequently, the discourse surrounding health care over the last century in the United States has been one of social exclusion, elitism, and power structures. Social exclusion can be defined as a condition resulting from the isolation of an individual within his or her culture or society due to an inability to engage rights, resources or services found within that society and which results in affecting the quality of life and equity (Levitas, 2012). This struggle with understanding the “rights” an individual within the United States has been reflected on a global scale.

Marc Block states one can “perceive larger dimensions of the past that would otherwise remain unperceived or worse, misperceived” and to affect demonstrable change, policy must look at these dimensions (as cited in Dutton, 2007, p. 2). To understand a system, one must accept that the complexities of disparate factors and issues. Ideological influences, cultural mores and norms, historical effects, and political systems must be analyzed and weighed as to their proportionate effects upon the desired outcomes. Unfortunately, health policy analysis in the U.S. usually occurs in a venue predicated upon political rhetoric reflecting the dominant political party ideology. Consequently, the clarity of desired outcomes can be distorted or entirely forgotten in the din of rhetoric and bias.

Political actors who have the power to shape and reform policy are unsure how to organize an effective response. One could equate the problem to attempting to repair a dike when the structure is fractured and leaking in thousands of areas. The political backroom knowledge that health care policy reform “is outside an organization framework” (Dutton, p. 167) is problematic, both in its ramifications and simplicity. How can any political body make reforms to an organization that has no framework? If the Health Education Welfare secretary was right, and it would seem so, Utah’s challenge is to bring equity, order, and clarity to the fragmented nature of the American system in a time of unprecedented political dissention and party allegiance?

Utah Perspective

“Education, energy development, job creation, and self-determination are at the heart of what has made America great. And they are the four cornerstones of Utah's strength.”
Governor Herbert

Governor Herbert has stated that “Utah has defined a clear vision for health care: We will pioneer health care innovation and reform, harnessing the power of collective efforts and market principles as we become the healthiest people in the nation. Our efforts include solutions for low-

income, uninsured and vulnerable populations.” Nevertheless, the Governor has stated that “. . . just covering Utahans presently eligible for Medicaid but not yet enrolled will cost the state \$940 million the first decade and \$1.88 billion the next decade. Then the Medicaid expansion tacks on an additional \$240 million the first decade, and \$480 million the next” (Herbert, 2012).

Consequently, the Governor’s philosophical framework for Utah’s vision is predicated on personal responsibility, economic and state autonomy. The Governor’s statement that policy development will be framed from collaborative or collective efforts and market principles reflects elitism and dismisses the potential of collaborative solutions that engage the local community. The challenge for the Governor, if he were to seek solutions through partnerships and participatory work, would be to the key issues based upon complex, disparate factors, managing the enduring tensions and power relationships between the principal interests, framing and implementing a participatory initiative, and managing accountability (Carlisle, 2010).

“The nature and extent of state regulation of health plans varies as the core function of these players shift from pure indemnity on the one hand to comprehensive delivery systems, which integrate the financing and healthcare delivery functions on the other,” and the legislative repercussions of realigning the current employer-sponsored system to a totally private system would entail a major realignment (Broccolo, et. al 2000, p.218). The problematic issue is that “the regulation of private insurance is largely left to the states . . . [and] the results have been a patchwork quilt of state regulation with each state addressing its own unique concerns (Broccolo, p. 230). A broader “public health paradigm” more aligned with public health scholarship would look beyond the cost-benefit analysis and try to uncover and address the population-level factors that contribute to poor health. This paradigm “emphasizes the environmental and social determinants of health and how they affect the well-being of populations,” which leads to policy

interventions designed to address the population-level structures contributing to poor population health (Berman, 2011). Social determinants are responsible for health inequities and are reflective of the health status disparities seen within communities (World Health Organization, 2012). In civil societies, community participation in the design of public policies is essential. “Full democracy . . . requires institutions by which ordinary citizens, as an extension of their intellectual lives, can rehearse and refine arguments about the matters that concern them” (Agre, 2001, p. 295). An approach is contra to established policy approaches that traditionally focus on cost-benefit analyses and political concerns. Utah in the last decade has gained over a million people, and Utah’s demographics are shifting dramatically “experiencing minority population growth more rapidly than the rest of the population” (Perlich, 2011, p. 8). If racial and ethnic categories were thought of in terms of social and cultural characteristics as well as ancestry, the true Utah picture of its community’s composition and health determinant needs over the coming decades would result in identifying the true needs of all Utahans (Perlich).

The principle that personal responsibility as the key to health is deeply engrained in American culture, and political groups and well-funded interests ensure that concept remains a focus in policy debates (Berman, 2011). A reorienting the political norms relating to public health issues must be framed to include additional factors than simply politically focused “personal responsibility, economic and state autonomy.” In this effort, the local community has a crucial role to play (Berman). While the target population is the underinsured, non-insured (socioeconomic class), a reorientation of ethical principals based on premises identifying social determinants, diversity, the proposed analysis will be the linkages, it is the actually exchanges in the political and health care sectors that will stimulate a solution. An effective response would be a collection of actions among identified stakeholders who define the solution mutually

notwithstanding power dynamics and that reflects an advocacy position based upon health indicators and not political or fiscal ideologies. This study proposes evaluating two methods to establish whether community engagement can effectively enhance the direction of Utah's health policy:

- Assess whether diverse, multidimensional, multidiscipline resources are necessary to enhance policy goal congruence, policy effectiveness, financial resources, and joint governance structures to address the common good and changing demographics in Utah.
- Assess whether the supply of research and information, collaborative endeavors that can forward the salient concerns in a community and refocus goals for the public good in order to shift political impetuses and elitist behaviors.
- Assess whether policy directives arising from community involvement are necessary to improve local health determinants.

Engaging a Community in Communication

The processes for health policy development should engage the community and political processes in a framework targeting resources, easing budgetary constraints, and targeting underlying determinants of health (Meier, 2008). Through empowering equitable discourse connecting individuals, local governments, health care entities, health care professionals in collaboration with the federal government and restructure existing channels of communication for individuals and the community, Utah can effectively address underlying determinates of health, thereby enabling a true enactment of Governor's Herbert vision (Meier). "The multi-sectorial partnerships then can become responsible for local improvement in health and the social fabric" (Carlisle, 2010, p. 118). Meaning, by engaging these disparate factions and addressing health disparities, health care could be refocused from a discussion turning on market forces and

economic factors to a discussion focusing on human rights for the collective good mitigating the injurious consequences of development policy implementation that is disconnected from its desired outcomes (Meier).

Currently in Utah, the opportunities for public engagement regarding health care and health care policies are tightly controlled and the opportunity for a robust discussion across the socioeconomic sectors are nonexistent. On important policy development issues, discussions shift to venues in which the salient conversations are framed as political posturing in lieu of engaging constituents to effectively construct a policy solution and with appointed councils. In other words, Utah's dominant political ideology is commanding the framework for discussions and resolutions in lieu of participatory democracy and public participation that promotes equality between partners (Aspen Institute, 2002). The governor, once he publicized that "we" as a state would be looking at the issue of how to launch the Affordable Care Act and integrate the federal law with existing state structures, failed to describe how the implied Utah community would be engaged in this endeavor.

Modernly, the venues for political debate and the historical townsquare events are now held in diverse forums and can be accessed with ease by most constituents in a state. "Activists participate through the performance of image events, employing the consequent publicity as a social medium for forming public opinion and holding corporations and states accountable" (DeLuca, Sun, Peeles, 2011). While academics posit that "a decision-relevant culture can be created among researchers, and a research-attuned culture can be created among decision makers" through best practices for knowledge exchange in public venues, the multidisciplinary forums are driving the discussions, framing the issues, and shifting the tone of interventions (Huberman, 1994; Roos and Shapiro, 1999). In other words, the townsquare as a meeting place, which

facilitated a communal venue for a variety of voices to be heard without constraint and with the broadest free speech rights, is no longer germane. Historically, anyone, anywhere, and at any time should be able to participate in the governmental process. Activism, the physical action of wanting knowledge to be heard and acted upon, is now a new technological being, who exhibits associated privileges and powers that are complex, but are easily marginalized and dismissed if governments are not attentive to the power of the new forum. Consequently, governments must be attuned to the new medium and understand the democratic voice that arises from technology.

Cultural shifts, such as the use of social media, webpages, technology, can facilitate the use of research in decision-making and support the effectiveness of intervention (Lavis, Robertson, Woodside, Mcleod, & Abelson, 2003, p. 227) for policy makers.

Dead architectural metaphors, fenced-in pre-approved “free” speech zones, and dusty laws guarantee nothing but moribund public spaces and an apathetic public. Through activist communication acts publics come into being and democracy lives. Focusing on practices moves us beyond “*a priori* conceptual restrictions of citizenship to certain people, places, and topics” (as cited in DeLuca, Sun, & Peeles, 2011).

For policymakers, the objective should be to create opportunities for an inform debate and to make well-measured decisions given the cultural, historical and economic factors in which it operates.

Policy is seen as a process of incremental decision-making (Lindblom, 1959) that involves discussion across multiple perspectives, such as the communal voices expressed in technological venues along with traditional pulpits (Murphy, 2012). Policy and politics are intertwined with ‘solutions’ flowing from problem definitions that are framed and perceived within a political, cultural context (Baachi, 2000). Policy analysis must began to account for

cultural factors, political problems and organizational variables (Dror, 1967) exploring, for instance, how the issue of health inequalities gets accepted on to local and national policy agendas (Exworthy et al., 2002). Often, individuals in America who are marginalized, either through age, unemployment, underemployment, or disadvantaged, are seen as a homogenous group contextualized within the cultural norms and expectations arising from mythical American idealism (Romppainen, Saloniemi, Jahi & Virtanen, 2012). This homogenous treatment of disparate needs results in individuals attempting to react to the shifting policy landscape and resulting in stigmatizing and demoralizing processes (Romppainen, Saloniemi, Jahi & Virtanen). The challenge in Utah's policy development, therefore, should be seeking an integrated value framework that inculcates the ideology of equality while understanding the historical framework and ideology existing in the local community. Rather than seeking to resolve defined problems by identifying the factor that will augment the policy's successful outcomes, the policymaking process is charged with connecting 'what might be wanted' with 'what might be provided,' especially in the current political context of financial crises (Shaw, 2010) at the cost of marginalizing other key factors.

Effective policymaking occurs when decisions have been shaped by local social and political contexts based upon discourses that were sensitive to the "shifting, diverse and contradictory responses to a spectrum of political interest" (as cited in Shaw, 2010, p. 201). Currently the Governor is facing critical decision on how to address the implementation of ACA and including research features of multidimensional determinants is an effective method of policy development. Highly effective, mature, engaged communities can contribute to the process allowing information, resources, and data to flow to agencies and programs that span the organizational field for health and human services in a community (Varda, 2012).

Studies have found that collaborative efforts improve health determinants by focusing health policy direction through (1) greater policy goal congruence, (2) greater diversity and policy expertise, (3) a more comprehensive mix of financial resources, and (4) joint governance structures that build capacity for collective action (Percival, 2009). Community engagement by definition must include participation from Utah's minority and underserved populations or Utah will fail to construct an effective solution to the health care crisis notwithstanding addressing the ACA mandates (Lewellen-Williams, Mays, Green, & Henry-Tillman, 2009). Consequently, a method is needed to identify the salient health determinants, cultural and socioeconomic factors, and health disparities concerns from a variety local sources, and arising from this data, key individuals can be identified who can effectively represent those factors (power relations) and posit a method in which the information can be forwarded to the principal decision makers.

Community Engagement Models

"Currently, partnerships in the United States are working in a policy environment that hinders rather than facilitates their efforts"
(Lasker, Weiss & Miller, 2001).

Beaufort B. Longest (1998) proposes a stages heuristic model for complex health policy development and divides the policy making process into a set of stages that lacks causal factors that drive the process (Lee, Estes, & Rodriguez, 2003): the problem, intelligence gathering, analyses, formulization of solutions, dissemination, implementation and evaluation (Hanlon & Carsilie, 2010). Critically, Paul Sabatier advances that for advocacy to work, the process of policy development must work within a framework that recognizes advocacy as a subsystem of government and policies operate as belief systems with values, priorities, and assumptions (Lee, Estes, & Rodriguez). Consequently, policy development operates as a movement in time and incorporates a season of enlightenment where advocates, researchers, and analysts can influence policymaking. While the season of enlightenment is short, Sabatier argues that the effects are cumulative and that has the greatest influence on policy. Government, like Utah, must shift from

an “iron triangle” of policy development (administrative agencies, legislative committees, and interest groups) to a community engagement model that recognized the important role diverse actors can bring to effective governance (Lee, Estes, & Rodriguez).

The role of power in policy development and implementation has not been adequately responded to when the public engages policy makers who have the authority and resources delineate policy solutions, and direct how particular actions are perceived as acceptable options or not. Political elites concerned with “a specific problem or policy area tend to form relatively autonomous subsystems or iron triangles “ (Lee, Estes, & Rodriguez, 2003, p. 152). Sabatier also argues effectively that policy elites have a deep fundamental core that reflects ontological axioms that directly affect basic strategies and policy positions. In Utah, the Latter Day Saint’s values are reflected in political decisions, especially select issues as most legislators share the religious values (Davidson, 2012). The unique religious demographics in the composition of Utah’s government provides a powerful ideological block that can marginalize other ethnic, cultural and religious groups, as Sabatier argues, due to the deep fundamental ontological axioms Utah legislators hold *en mass*. In other words, the unique homogenous composition of policy makers can distort effective governance if not tempered by other methods. Power relations shape the ways that policy problems and solutions are defined, and for researchers who describe policy options in terms that are oppositional to prevailing definitions and norms, critical information is dismissed or discarded. If policy makers are willing to acknowledge that collaboration opens opportunities for effective governance, health policy development over the next decade can effectively ameliorate human suffering, health costs and improve overall public health.

Emerging Models. A review of current studies forward certain factors that should be considered in collaborative models, and two as critical salient factors for successful

projects. One of the critical factors is understanding the audience for whom the collaboration is preparing the information or research, and two, the building of relationships with trust between all the participants. Additionally, key questions should be answered: the composition of the collaboration, what materials or research should be “passed” on, to whom should it be transferred and by whom. Policy development for health concerns need to start with identifying health indication measures, including behavioral, environmental, socioeconomic (Lasker, Weiss & Miller, 2001) and be a stand-alone research initiative (one that can be acted upon by the general audience, provides, decisions makers or policy decision makers), to see improved implementation in health care issues (Lavis, Robertson, Woodside, McLeod, & Abelson, 2003). The research should be in the form of “ideas” and not data as this is the most influential (Lavis, Robertson, Woodside, McLeod, & Abelson). The transferee should have mechanisms in place (trained staff, resources, incentives) to implement the research and interactive engagement and close collaboration between the information sharer and the recipient (Lavis, Robertson, Woodside, McLeod, & Abelson). An active and not passive transfer of knowledge in a process, meaning not a single event should include an assessment process to give feedback including web interactions, blogs and social media sites (Lavis, Robertson, Woodside, McLeod, & Abelson).

Synergy. The Synergy Model forwards the idea of bringing partners together with similar views or provide the same services, such as advocacy coalitions, to increase the critical mass behind the effort as an effective method the government could implement in health care policy creation (Lasker, Weiss & Miller, 2001). Lasker’s et al. Synergy Model is a method in forwarding the research to decision makers, like Knowledge Translation, but focuses on the composition of the coalition more than the mechanisms of transference. Lasker, Weiss and

Miller claim that the synergy of a community can become a power itself, and thus, become a powerful force to persuade decision makers. While the Synergy Model provides determinates of a partnership synergy, the model does not address the paternalistic adoption of dominant medical paradigm and traditional political point of reference found in most health policy debates (Berman, 2012). Nevertheless, Lasker, Weiss and Miller qualify the efficacy of synergy in cases where financial barriers exist, such as the financial barriers now existing in expanding Medicaid and Medicare.

Knowledge translation (KT). KT forwards a relationship model that is an interactive and engaged process between the research and systems of care (i.e., teams, populations, policymakers, and consumers) and the policy makers (Jacobson, Butterill, & Goering, 2003). Researchers have focused their attention on KT as both a process and a strategy that can lead to utilization of research findings and improved health outcomes (Dobbins, Ciliska, Cockerill, Barnsley, & DiCenso, 2002). KT requires coordination and process improvement amongst a complex system of diverse partners to influence behavior change (Davis et al., 2003). KT structures the relationships as a collaborative process “through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible” (Gray, 1989). Additionally, the collective action will require complex negotiation and coordination among these diverse stakeholders. KT uses interactions between the principals (power status), transferring methods (producer-push and exchanges) and relies upon cultural, intellectual, political, and technological shifts as the salient factors in effectiveness of interventions (Lavis, Robertson, Woodside, McLeod, & Abelson, 2003, p.227). Nevertheless, this type of movement is facing criticism questioning its usefulness as the

KT model is silent on the role of power, authority, and negotiations and the process heavily requires these interactions (Murphy & Fafard, 2012).

Future of Community Engagement and Partnerships

When considering the KT model or Lavin's Synergy model, additional factors should be considered which could transport the model into a true community engagement model for Utah. The framework for KT should enable effective pathways to the decision makers that results in both instrumental and conceptual use but requires creating an entity of complex relationships and lattice organizational structures with dedicated resources and finances. Thus, the governor would have to be deliberative and concerted in constructing an organizational structure incorporating the diverse voices needed for significant reform. Alternately, Lasker's et al. model could work well as the initial step for Utah as existing organizations would be able to be coalesced into a partnership, and these entities represent diverse views that could provide synergy to the existing Utah Health Advisory Council. For example, the Fourth Street clinic has a director that sits on boards, the clinic's and the Utah Health Advisor councils.

Research from countries who have histories operating nationalized health programs demonstrate that they too are grappling with the effective use of community partners to enhance policy goal congruence, policy effectiveness, financial resources, and joint governance structures (see generally, Carlisle, 2010; Lavis, et al., 2002). Their findings would provide great insight into the struggling American system as we go forward into implementing the ACA.

Collaborative endeavors can address the salient concerns in a community and focus on the public good by using models such as the Synergy model initially, and perhaps the KT model as the infrastructure in the U.S. to support the ACA continues to be established.

Both of these models could advance the diverse, multidimensional, multidiscipline

resources that are necessary to enhance policy goal congruence, policy effectiveness, and financial resources and could help frame the joint governance structures to address the common good and changing demographics in Utah. The processes and participants would influence the “stream of information” that often offers real world solutions. These collaborative endeavors can forward the health issues of our community and refocus Utah’s policy goals to effectively address the cultural, socioeconomic and ethnic diversity that Utah will experience over the coming decade. Identifying and understanding local health determinants must be utilized along with financial considerations. Utah citizens’ future healthcare needs must be framed as in terms of community, civic and public responsibility based upon informed factors to address the unique local health determinants, and Utah’s economic considerations must be a prong in the overall analysis of good policy development. Perhaps then Governor Herbert can truly “pioneer health care innovation and reform, harnessing the power of collective efforts and market principles” as Utah becomes the healthiest people in the nation, including solutions for low-income, uninsured and vulnerable populations.

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