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AGING & HEALTH

The John A. Hartford Foundation And The Growth Of Geriatrics

ABSTRACT Motivated by the increasing number of older people—many with chronic illnesses—and the lack of support for them, the John A. Hartford Foundation (JAHF) made improving the care of older adults one of its two priorities in 1983 and its sole priority in 1994. To accomplish this, the foundation adopted a two-part strategy: first, create a field of professionals capable of caring for an aging population, and second, test models of care for older adults. The JAHF steadfastly pursued that strategy until 2013, when it adopted an approach focused on advancing age-friendly health systems. Geriatrics is now a recognized medical, nursing, and social work specialty, although low reimbursement, the stigma associated with caring for older people, and low prestige discourage students from entering it. Foundation-funded models of care have proven viable, and one of them—palliative care—has been widely adopted. The JAHF focused on an important social need for more than three decades, and this targeted and consistent effort has magnified its impact.

Established in 1929 by the brothers John A. and George L. Hartford, both former CEOs of the A&P grocery chain, the John A. Hartford Foundation (JAHF) largely focused on biomedical research and health care cost and quality in the years before 1983. When the rising number of older people and the lack of support for them[1] led the foundation to name aging and health a funding priority that year, the Veterans Health Administration and the Bureau of Health Professions within the Health Resources and Services Administration were virtually the only entities that financed the training of geriatricians. The National Institute on Aging, established in 1974, primarily funded clinical research. The Gerontological Society of America and the American Geriatrics Society, both of which originated in the 1940s, served researchers and clinicians in aging.

Study Data And Methods

In 2017 the JAHF commissioned an evaluation of the impact of its thirty-plus years of grant making in aging and health. The evaluation, whose results are summarized in this article, considered the question from three perspectives.

The first was a quantitative assessment of the output and impact of each of the JAHF's major programs in health and aging in the period 1983–2015. This assessment was compiled from the findings of multiple program evaluations conducted by other researchers, many of which were published in peer-reviewed journals.

The second was a qualitative assessment of the cumulative impact of the foundation's programs in health and aging, based on structured in-person and telephone interviews conducted in 2017 with forty-five past and current grantees, staff and trustees of the JAHF, and staff members of other foundations, as well as on 163 responses to an email survey that was sent to 1,731 people who had received JAHF funding in the study period.

The third was a combined quantitative-qualitative assessment of the extent to which health care for older adults has improved since the early 1980s and how much the foundation contributed to any improvement. The evaluation's conclusions were derived from a review of published trends data reported by others, such as the National Center for Health Statistics and the Centers for Disease Control and Prevention, and from the views of the experts interviewed.

Each of the three approaches had limitations, among them being that reliable data were not always available and that nearly all interviewees were or are associated with the foundation in some way, which possibly biased their responses. (Many people working in aging have been associated with the JAHF at some point.) Given the degree to which the findings from the approaches converged, however, we believe that the three provide a consistent composite picture of the foundation's impact.

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Study Results

GERIATRICS TRAINING: A BRIEF SUMMARY The JAHF began by developing programs to engage university-based geriatric physicians, and it then expanded its efforts to geriatric nurses and social workers. The idea was to build a corps of faculty members who would conduct research on aging and teach future generations of academic geriatricians. The foundation later turned to ensuring that all physicians, nurses, and social workers who treated adults would be prepared to care for older people.

GERIATRIC MEDICINE The foundation began its aging and health program in 1983 with grants to four leading medical centers. In addition to giving the field immediate credibility, the awards provided geriatrics training to twenty-nine midcareer internal medicine faculty members, many of whom became leaders in the field. The foundation soon realized, however, that making a meaningful dent in the projected need for academic geriatricians would require reaching many more people.

In 1986 the JAHF developed what became one of its signature programs: the establishment of geriatrics "centers of excellence." Based in medical schools with strong geriatrics programs, the centers were expected to attract academic geriatricians from medical disciplines such as internal medicine and family practice, who—working in a collegial setting—would conduct research and teach more geriatricians. At the peak of the program, there were twenty-eight centers. It has been estimated that the centers trained or mentored about 55,000 physicians a year.[2] Virtually all of the centers continue to work in aging now. The Donald W. Reynolds Foundation adapted the model in its multimillion-dollar effort to strengthen medical school geriatrics departments.

Nearly a decade later, in 1994, the foundation launched—in collaboration with the Atlantic Philanthropies, the Commonwealth Fund, and the Starr Foundation (the National Institute on Aging became a cosponsor in 2004)—another signature program, the Paul Beeson Physician Faculty Scholars in Aging Research Program. This was a three-year fellowship program designed to attract the brightest physicians to careers in geriatrics. A 2011 assessment found that the Beeson Scholars had "made a substantial commitment to the development of aging research."[3] To date, the program has trained 225 scholars.

Even as the centers of excellence and fellowship program engaged university-based geriatricians, it became apparent that there would never be enough geriatricians to care for the aging population in the US.[4] Consequently, the foundation broadened its focus to incorporate geriatrics into the training of all medical and surgical specialists who treated adults. The foundation rounded out its medical geriatrics efforts by attempting to expose medical students to geriatrics. It provided funds for the Association of American Medical Colleges to develop curricula on caring for older people, trained medical residents, and offered geriatrics scholarships to undergraduate medical students.

GERIATRIC NURSING In 1996 the foundation awarded $5 million to New York University to establish the John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing, the first geriatric nursing institute in the US. Formally charged with creating "a national repository of information about gerontological nursing relevant to both policy and practice," its unwritten mandate was far broader: to do great things to advance geriatric nursing.[5]

The institute did this in various ways, including supporting specialty nursing societies and the American Association of Colleges of Nursing to ensure that all nursing students were exposed to the care of older adults. (In a separate initiative, the foundation worked directly with the association to add geriatrics to the core competencies embodied in nursing schools' curricula.) In 2003, 92 percent of bachelor's degree nursing programs incorporated aging content in at least one core course—an increase from 63 percent in 1997.[6]

The foundation next attempted to build a corps of academic teachers and researchers by establishing five centers of geriatric nursing excellence, similar to the physician centers of excellence. Through 2015 the geriatric nursing centers had awarded nearly 300 pre- and postdoctoral fellowships. A 2012 evaluation found that 95 percent of the graduates were currently on the faculties of nursing schools.[7]

GERIATRIC SOCIAL WORK In the late 1990s the foundation launched the Geriatric Social Work Initiative to improve social workers' capacity to care for older adults. The initiative had three objectives: incorporate geriatrics into social work curricula and accreditation standards by funding and collaborating with the Council on Social Work Education, the entity that accredits social work schools; encourage interested junior faculty and doctoral students to pursue careers in geriatric social work education by offering fellowships and scholarships; and enhance field placements by giving interested master's-level social work students practical experience in caring for older people.

Not only did the attention of a major national foundation give geriatric social work credibility, but its scholarships and fellowships also attracted a group of educators and researchers who served as leaders and mentors. Moreover, by supporting the field's accreditation body, the foundation sought to ensure that the care of older adults would remain a part of social work curricula beyond the life of its grants. In our interviews, academicians and practitioners alike used words such as "transformative" to describe the JAHF's impact.

IMPACT ON HEALTH PROFESSIONALS To a great extent, the numbers indicate the impact of the JAHF and others. In the late 1970s fewer than 750 physicians specialized in the care of older people.[8] As of 2010 there were roughly 7,000 certified geriatricians in practice, and most medical schools had geriatrics programs.[9] Virtually all medical and surgical specialties and subspecialties now include aging in their curricula and board certification requirements.[10] The American Board of Internal Medicine, the American Board of Family Medicine, and the American Board of Psychiatry and Neurology recognize geriatrics as a subspecialty.

In the late 1970s fewer than one in five nursing schools required even a single course in the care of older adults.[11] In 2003 more than 90 percent of bachelor's-level nursing programs integrated geriatrics into at least one required course, and all nurses graduating with a bachelor's of science in nursing degree had to know how to care for elderly pa-

tients.[6] Similarly, in the late 1970s fewer than 5 percent of master's-level social work students took any courses in aging.[12] Caring for aging people is now embedded in social work curricula and credentialing.[13]

Beyond the numbers, the foundation's fellowships, scholarships, and support of centers of excellence developed a critical mass of faculty who trained new generations of teachers and practitioners. And through its work with accreditation bodies, the foundation helped ensure that all students in these fields were somewhat exposed to the care of aging adults.

Still, few doctors, nurses, and social workers choose to specialize in the care of the elderly. Because of the low reimbursement for geriatrics services, the stigma, and the lack of prestige associated with geriatrics, the foundation has been fighting an uphill battle to make geriatrics an attractive career choice.

CARE MODELS The second part of the JAHF's aging and health strategy was its support of demonstration programs that aimed to provide cost-effective ways of providing care to older patients. Over the years the foundation has funded programs in the areas discussed below.

It should be noted that these programs have a number of characteristics in common: They address serious health concerns; have been tested and evaluated over many years; have been funded consistently by the foundation and, in some cases, by partner foundations; and have been shown to be effective and reduce costs. In addition, with the exception of hospital-based palliative care, the models have not reached as many patients as could benefit from them. This is largely because their approaches—involving team-provided care, extensive use of nursing and social work services, and much time spent with patients—have not been adequately reimbursed (if they are reimbursed at all) by Medicare. It is ironic that Medicare, the landmark federal health insurance program for seniors, is inhibiting the growth of models of care that could improve this population's health.

▶ **COMMUNITY-BASED CARE:** The foundation was an early supporter of Programs of All-Inclusive Care for the Elderly (PACE), which provide health and social services to allow nursing home–eligible people older than age fifty-five to remain in their homes. Now reimbursed by Medicare and Medicaid, PACE covers approximately 40,000 people,[14] a small percentage of those who are potentially eligible.[15] (In 2017 the foundation funded a PACE 2.0 project, which aims to expand the model to 200,000 people in all.)

▶ **TEAM CARE:** The foundation was an early funder of the use of interdisciplinary teams of physicians, nurses, social workers, and others to care for older adults. Although the interdisciplinary training programs it funded had mixed results (they succeeded in changing the attitudes of some participants, but doctors tended not to be receptive to team training),[16] the programs were early examples of what is now accepted as an appropriate method of caring for seniors with complex conditions.

▶ **TRANSITION FROM HOSPITAL TO HOME:** Several JAHF-funded programs, including the Care Transitions Intervention, the Transitional Care Model, and Guided Care, coordinate care for elderly patients who are being discharged from hospitals. Although the programs reported positive results in improving care and lowering costs,[17,18] lack of reimbursement from Medicare and private insurance has hindered the expansion of these models. With the passage of the Affordable Care Act, hospitals can be penalized for early readmissions of Medicare patients, giving hospitals an added incentive to ease the transition from hospital to home.

▶ **HOSPITAL AND HOME CARE:** The foundation funded several experimental ways of treating seriously ill seniors. One of them, Nurses Improving Care for Healthsystem Elders (NICHE), which is used by about 12 percent of hospitals in the US, has become a stepping-stone for hospitals seeking Magnet status.[19] The Hospital at Home program gives patients with specific conditions, such as congestive heart failure and cellulitis, the option of being treated at home instead of in a hospital. A third program, called Acute Care of the Elderly (ACE), sets up age-appropriate hospital rooms. Again, lack of reimbursement has hindered the spread of these programs.

▶ **DEPRESSION TREATMENT:** Since 1988 the foundation has supported an approach to treating depressed older adults that was developed by the psychiatrist Jürgen Unützer. The key to this approach is pairing a primary care practitioner and a staff person serving as a depression care manager with a consulting psychiatrist. In 2002 Unützer and colleagues published an article reporting that the approach, dubbed Project IMPACT (for Improving Mood—Promoting Access to Collaborative Treatment) and since renamed the Collaborative Care Model, was twice as effective as the usual treatment for depression in older adults, and it saved money.[20] Lack of reimbursement has slowed its spread, but in 2016 Unützer worked with the American Psychiatric Association and the Centers for Medicare and Medicaid Services (CMS) to get approval for primary care practitioners to bill Medicare for collaborative care. CMS established new billing codes for collaborative care that became active in January 2017. Several states, such as Washington, have adopted similar codes for Medicaid.

▶ **PALLIATIVE CARE:** Supporting the development of palliative care is considered one of the foundation's most significant contributions to the field of aging. When the Robert Wood Johnson Foundation and the Open Society Institute (now the Open Society Foundations) ended their seminal support for the Center for Palliative Care at Mount Sinai Medical Center in New York City in 2006, the JAHF stepped in with funding that allowed the center to continue. Although Medicare reimbursement policies remain an obstacle, Diane Meier, the center's director, successfully made a business case for palliative care to hospital officials nationwide, leading to its widespread adoption. In the US today, 90 percent of hospitals with 300 or more beds, and nearly three-quarters of all hospitals, offer palliative care.[21]

▶ **MEDICATION MANAGEMENT:** In 1989 the foundation awarded $250,000 to Mark Beers, who at the time was a professor at the University of California Los Angeles. This initial grant and subsequent JAHF support led to the development of the Beers Criteria, a screening tool for health systems and others to use in determining which medications are likely to harm older people. The foundation has since supported the expansion of the tool to home health

and social services agencies. Now called the AGS (American Geriatrics Society) Beers Criteria, they are used throughout the country, although many clinicians are unaware of this helpful tool.

LEADERSHIP AND POLICY Although the foundation allocated nearly 90 percent of its grant funds to training and model development, it did not forget about policy and leadership. It supported the National Health Policy Forum's seminars in Washington, D.C., for nearly twenty years, and it funded influential reports by the Institute of Medicine.[4,22,23] With the Atlantic Philanthropies, it provided fellowships for geriatrics leaders to study and be involved in public policy formation. In 2013 the JAHF formed Hartford Change AGEnts, an alumni association comprising former JAHF fellows, scholars, and grantees. It provided a forum for its members and encouraged their involvement in geriatrics policy and practice change.

Cumulative Impact

What was the overall effect of the foundation's investment of nearly a half-billion dollars in improving the care of older adults? The answer can be summarized in four ways.

First, the foundation was instrumental in creating a new field in American health care, essentially from scratch. With regard to the scale of the impact, the centers of excellence for physicians alone met roughly half of the national need for academic geriatricians.

Second, the foundation strove to ensure that all of the nation's practicing physicians, nurses, and social workers who provided care to older adults received at least some geriatrics training during their professional education. The incorporation of geriatrics content into many of the medical and surgical certification exams represents a major achievement.

Third, palliative care, which the foundation supported for many years, has been widely adopted by the US health care system. Other JAHF-funded models of care have been shown to improve care and save money but have had more limited uptake so far.

Fourth, the foundation appears to have helped reduce the stigma of caring for older people, though that stigma has not been eliminated.

One of the reasons for the JAHF's effectiveness has been its steadfast commitment over thirty-plus years to addressing one of the most urgent challenges facing modern society: the aging of the population.

Bringing geriatrics into the mainstream has been and remains an uphill battle. It is somewhat like the ancient Greek myth of Sisyphus, who struggled mightily to roll a boulder uphill, only to have it fall back as it reached the top. The foundation has been disappointed that its efforts were not completely successful in creating the numbers of physicians, nurses, and social workers that are needed to specialize in geriatrics. (Current JAHF programs are taking different approaches by working directly with health systems and their existing workforces.) Perhaps the major barrier that has kept geriatrics on the periphery is the existing financing system: specifically, the fact that there is little or no reimbursement for services provided under traditional Medicare (whose policy is followed by private insurers). As Medicare shifts toward a value-based approach to reimbursement, which many believe will improve outcomes and reduce costs, this approach might help accelerate the adoption of some JAHF-sponsored models of care and might even help increase geriatricians' salaries to align them more closely with those of providers in other specialties.

Finally, there is a bottom-line question: Has the health care of seniors improved? It's nearly impossible to get agreement on the metrics, much less to answer the question. There is some evidence that the health of seniors has improved—life expectancy and disability-free life expectancy after age sixty-five have increased over the past thirty years.[24] Regarding health care, greater attention is now given to illnesses such as heart disease, stroke, and depression that affect older people. On the other hand, death rates from falls have been increasing recently.[25] Among people who were interviewed in the course of the evaluation, there was a widespread perception that the care of older adults has improved over the past thirty years. Even if this is true, it is impossible to know how much of the improvement can be attributed to the JAHF.

Lessons For Philanthropy

Because foundations have their own resources and are essentially accountable only to their own governing boards, they are uniquely positioned to take risks on behalf of the greater social good and to stay with a topic or issue for the long haul. In contrast with the government (which is often under pressure to deliver results before the next election) or corporations (which seek to deliver good news in their next quarterly report), foundations can keep working on a problem for as long as it takes to have an impact.[26] It is precisely these advantages that make philanthropy such an invaluable social resource.

Yet few foundations fully use this unique structural advantage. One of the reasons for the JAHF's effectiveness has been its steadfast commitment over thirty-plus years to addressing one of the most urgent challenges facing modern society: the aging of the population. Many of the leaders interviewed for this evaluation commented on—and marveled at—the foundation's sustained focus.

In addition, the foundation also chose a fundamentally important issue to which few others were paying attention at the time (aging); zeroed in on a critical but potentially manageable aspect of the problem (the capacity of the nation's health care system to respond to the needs of an aging population); developed and faithfully implemented a carefully reasoned strategy of mutually reinforcing programs and activities; monitored its own programs and strategies, learned from its experiences, and modified its approach as needed; actively sought funding partners, many of which have been cited above; tolerated failure and adjusted tactics when necessary; and publicly shared the credit for whatever gains its partnerships achieved.

Having developed a large group of geriatric physicians, nurses, and social

workers and tested many models of care, in 2013 the JAHF turned to new ways to improve the care of older adults.[27] Today it is working to establish age-friendly health systems, supporting family caregivers of older adults, and improving the care of people who have serious chronic illnesses, are near the end of their lives, or both. These recently designated priority areas rest on and can be built out from the base created by the foundation's prior three decades of work. ■

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NOTES

1 The number of Americans ages sixty-five and older in 2015 was 47.8 million. That number is predicted to more than double to 98.2 million by 2060. DataGraphic: aging and health. Health Aff (Millwood) 2017; 36(10):1696–7.

2 Reuben DB, Kaplan DB, van der Willik O, O Brien-Suric N. John A. Hartford Foundation centers of excellence program: history, impact, and legacy. J Am Geriatr Soc. 2017;65(7):1396–400.

3 Bragg EJ, Warshaw GA, van der Willik O, Meganathan K, Weber D, Cornwall D, et al. Paul B. Beeson Career Development Awards in aging research and U.S. medical schools aging and geriatric medicine programs. J Am Geriatr Soc. 2011;59(9):1730–1.

4 Reuben DB, Beck JC. Training physicians to care for older Americans: progress, obstacles, and future directions. Washington (DC): National Academies Press; 1994.

5 Watman R, Escobedo M, Langston CA. The Hartford Geriatric Nursing Initiative: developing a focused strategy and strong partnerships to improve nursing care for older adults. Nurs Outlook. 2011;59(4):187.

6 Berman A, Mezey M, Kobayashi M, Fulmer T, Stanley J, Thornlow D, et al. Gerontological nursing content in baccalaureate nursing programs: comparison of findings from 1997 and 2003. J Prof Nurs. 2005;21(5):268–75.

7 Sofaer S, Firminger K. New growth: a decade of cultivating leaders in geriatric nursing [Internet]. New York (NY): Hartford Geriatric Nursing Initiative; [cited 2018 Nov 16]. (Evaluation Brief). Available from: https://www.johnahartford.org/images/uploads/resources/110206_HGNI_EvaluationBrief_Final_(2).pdf

8 Kane RL, Solomon DH, Beck JC, Keeler EB, Kane RA. Geriatrics in the United States: manpower projections and training considerations [Internet]. Santa Monica (CA): RAND Corporation; 1980 May [cited 2018 Nov 20]. Available for download from: https://www.rand.org/pubs/reports/R2543.html

9 Bragg EJ, Warshaw GA, Meganathan K, Brewer DE. The development of academic geriatric medicine in the United States 2005 to 2010: an essential resource for improving the medical care of older adults. J Am Geriatr Soc. 2012;60(8):1540–5.

10 Hurria A, High KP, Mody L, McFarland Horne F, Escobedo M, Halter J, et al. Aging, the medical subspecialties, and career development: where we were, where we are going. J Am Geriatr Soc. 2017; 65(4):680–7.

11 John A. Hartford Foundation. 2006 annual report [Internet]. New York (NY): The Foundation; [cited 2018 Nov 20]. Available from: https://www.johnahartford.org/images/uploads/reports/JAHF_2006_Annual_Report.pdf

12 John A. Hartford Foundation. 2003 annual report [Internet]. New York (NY): The Foundation; [cited 2018 Nov 20]. Available from: https://www.johnahartford.org/images/uploads/reports/JAHF_2003_Annual_Report.pdf

13 Sanders S, Dorfman LT, Ingram JG. An evaluation of the GeroRich program for infusing social work curriculum with aging content. Gerontol Geriatr Educ. 2008; 28(4):22–38.

14 National PACE Association. Find a PACE program in your neighborhood [Internet]. Alexandria (VA): National PACE Association; c 2018 [cited 2018 Nov 20]. Available from: https://www.npaonline.org/pace-you/find-pace-program-your-neighborhood

15 Centers for Disease Control and Prevention. Nursing home care [Internet]. Atlanta (GA): CDC; [last updated 2017 May 3; cited 2018 Nov 20]. Available from: https://www.cdc.gov/nchs/fastats/nursing-home-care.htm

16 Reuben DB, Levy-Storms L, Yee MN, Lee M, Cole K, Waite M, et al. Disciplinary split: a threat to geriatrics interdisciplinary team training. J Am Geriatr Soc. 2004; 52(6):1000–6.

17 Gardner R, Li Q, Baier RR, Butterfield K, Coleman EA, Gravenstein S. Is implementation of the care transitions intervention associated with cost avoidance after hospital discharge? J Gen Intern Med. 2014;29(6): 878–84.

18 Naylor MD, Sochalski JA. Scaling up: bringing the Transitional Care Model into the mainstream [Internet]. New York (NY); Commonwealth Fund; 2010 Nov [cited 2018 Nov 20]. (Issue Brief). Available from: https://static1.squarespace.com/static/59f0c113fe54ef2f67873a25/t/59fb8f82e2c483961b11b483/1509658500194/TCM_Forefront.pdf

19 Magnet Recognition, awarded by the American Nurses Credentialing Center, is the highest distinction a health care organization can receive for nursing excellence and high-quality patient care.

20 Unützer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, et al. Improving Mood—Promoting Access to Collaborative Treatment. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002;288(22): 2836–45.

21 Dumanovsky T, Augustin R, Rogers M, Lettang K, Meier DE, Morrison RS. The growth of palliative care in U.S. hospitals: a status report. J Palliat Med. 2016; 19(1):8–15.

22 Institute of Medicine. Aging and medical education. Washington (DC): National Academies Press; 1978 Sep.

23 Institute of Medicine. Retooling for an aging America: building the health care workforce. Washington (DC): National Academies Press; 2008.

24 National Center for Health Statistics. Health, United States, 2015, with special feature on racial and ethnic health disparities [Internet]. Hyattsville (MD): NCHS; 2016. Table 15, Life expectancy at birth, at age 65, and at age 75, by sex, race, and Hispanic origin: United States, selected years 1900–2014; [cited 2018 Nov 21]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK367642/table/trendtables.t15//

25 Burns E, Kakara R. Deaths from falls among persons aged ≥65 years—United States, 2007–2016. MMWR Morb Mortal Wkly Rep. 2018;67(18):509–14.

26 Isaacs SL, Jellinek PS. Foundations 101: how to start and run a great foundation. North Charleston (SC): CreateSpace; 2016. p. 5–6.

27 Fulmer T, Berman A. Age-friendly health systems: how do we get there? Health Affairs Blog [blog on the Internet]. 2016 Nov 3 [cited 2018 Nov 21]. Available from: https://www.healthaffairs.org/do/10.1377/hblog20161103.057335/full/