Advancing Health Equity Through Primary Care Policy:
Priorities and Recommendations for California

UCLA Health Department of Family Medicine
Grand Rounds

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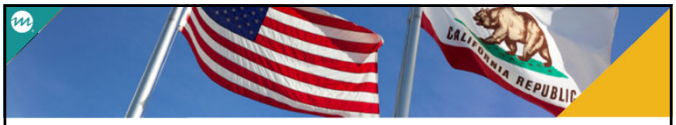

Study objectives

- **To *summarize research* on the association between primary care and health equity**
- **To *put forward specific policy priorities* for strengthening primary care to advance health equity in California**

Funder: California Health Care Foundation.

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Outline

- **Many people involved**
- **Context: Primary care**
- **Summary of evidence linking primary care to health equity**
- **Context: Primary care in California**
- **Policy priorities for California**
- **Discussion**

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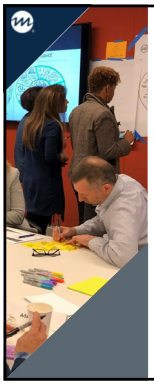

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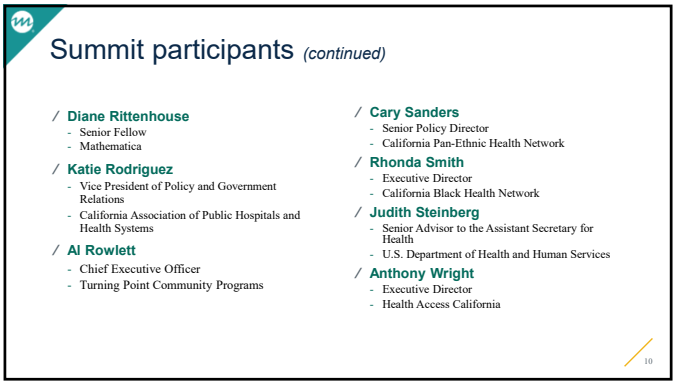
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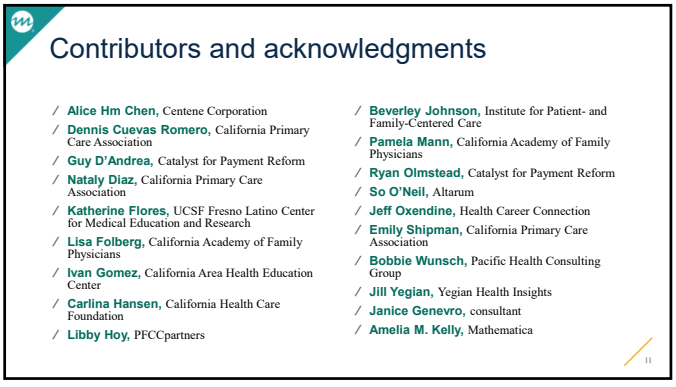
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Context: Primary Care
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High-quality primary care

- **Primary care clinicians**
  - Physicians trained in generalist specialties such as family medicine, general pediatrics, general internal medicine, and geriatrics
  - Nurse practitioners trained in family, gerontological, and pediatric care
- **Primary care team**
  - Nurses, physician assistants, medical assistants, community health workers, behavioral health counselors, social workers, and pharmacists

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Primary care: Study definition

- ***Whole-person*** **orientation**
- ***First point of contact*** **for a person experiencing new symptoms or concerns**
- ***Comprehensive:*** **Includes preventive services, acute care, and ongoing management of chronic and co-morbid physical and behavioral health conditions**
- ***Coordinates*** **care for patients across the health system**
- ***Continuous*** **trusting partnerships with patients**

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High-quality primary care

- **Happens in a *variety of settings* including private practices, community health centers, large health systems, and even in visits to a patient's home**
- **Ideally located in the *neighborhoods* where people live, *providing a more holistic view* of the patient's experience by fostering the primary care team's awareness of the local social, physical, and structural *determinants of health***

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High-quality primary care

- **The unique qualities of high-quality primary care make it the most fair, accessible, and cost-efficient way for people—regardless of race, ethnicity, or income—to enter the health care system and obtain health services to meet their needs.**
- **Primary care is often absent, or not explicitly referenced, in policy conversations about advancing health equity in California.**

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Summary of Evidence Linking Primary Care to Health Equity

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Summary of findings

- **A large body of literature supports primary care's unique role in promoting equitable care and health outcomes, as well as the potential to do more**
- **Strong evidence exists to support the connection between health equity and:**
  - Access to primary care
  - Continuity of care
  - Coordination of care
  - Comprehensiveness of care

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Access to primary care and health equity

- **Access to stronger primary care systems is associated with improved life expectancy and lower rates of premature mortality**
- **Both international comparisons and across regions within the United States**

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Access to primary care and health equity (II)

- **Higher primary care physician density is associated with better outcomes**
  - Lower avoidable morbidity and mortality and longer life expectancy in regions within the United States. Stronger association in Black than White populations
  - Reduced racial disparities in referral patterns and an increase in necessary hospital admissions for Black Americans, compared to White Americans
- **Access to higher quality primary care is associated with**
  - Better rates of receipt of evidence-based screening and interventions
  - Earlier diagnosis and treatment of conditions (such as hypertension, lipid disorders, congestive heart failure, chronic obstructive pulmonary disease, and diabetes) and ongoing management of multimorbidity, which the elderly and groups who are economically marginalized experience at the highest rates
  - Williams et al. found "Black patients able to access primary care receive preventive services at rates equal to or greater than White patients"

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Continuity and health equity

- **Associated with:**
  - Lower mortality rates
  - Improvements in health and lower spending for ambulatory care sensitive hospitalizations for children
  - Fewer disparities between Black, Hispanic and White populations in:
    - Receipt of recommended cancer screening services
    - Rates of receipt of several types of evidence-based, high-value services
    - Personal trust
    - Patient adherence to recommended preventive services (including vaccines) and medications

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Coordination and health equity

- **Reduces the extreme burden of interacting with a fragmented and disorganized health care system for patients with multiple chronic conditions and disabling conditions**
- **Associated with increased patient satisfaction and following evidence-based recommendations for treatment and self-care**
- **More coordinated primary care is associated with reduced racial and ethnic disparities in, e.g., preventable ED visits and improved blood pressure control**

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Comprehensiveness and health equity

- **Associated with:**
  - Better health outcomes at lower costs
  - Improved health
  - Improved self-management of chronic conditions
  - Improved adherence to physician advice
  - Better self-reported health outcomes
  - Reduced disparities in disease severity as a result of earlier detection and prevention across different populations
  - Behavioral health integration into primary care may help reduce mental health disparities for Latinos; helps address access barriers including stigma, mistrust, location, transportation

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Highlights

- Community Health Centers
- Veteran's Health Administration: Team-based Primary Care for Veterans (VA PACT)
- Costa Rica: Community-oriented primary care

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The counterfactual

- In absence of high-quality primary care, people experience inequitable access to care and more fragmented, more costly, and duplicative service use, partly from poor coordination of care across providers and settings.
- Patients' perceptions of poorer care coordination are associated with higher odds of self-reported medical errors, medication errors, and laboratory errors.
- As availability of primary care physicians declined due to inadequate support and reimbursement, patients experienced a decline in patient-centeredness.

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Context: Primary Care in California

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California: Inequities in health care delivery system

- 39.5% of Californians identified as Latino/x, but only 8% of physicians
- Medi-Cal covers 1/3 Californians
  - Including nearly 10 million Latino/x, Black, Asian and Pacific Islander, and Native American/Indigenous people
- Yet, Medi-Cal fee-for-service physician fees for primary care have historically been low, at only 76% of Medicare rates
  - Low provider payments and high administrative burden lead many primary care practices to not accept Medi-Cal patients because payment does not cover the practices' cost to provide high-quality care
- These are social justice issues

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California: Inequities in health care and health

- E.g., 1/5 Californians who identify as Latino/x still do not have a usual source of care.
- E.g., Black Californians
  - Shorter life expectancy than other racial and ethnic groups
  - Highest rates of infant and maternal mortality
  - Highest death rate from breast, lung, cervical, and prostate cancer

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Californians with a primary care provider

- Seek out and receive more physical health care, including video visits
- Less likely to skip or defer care due to cost
- Report fewer language, distance, and affordability barriers to appropriate care
- Engage in positive health behaviors such as making health a priority, speaking up when visiting the doctor, and getting appropriate screening and preventive care

Source: CHCF/NORC California Health Policy Survey (September 27, 2021 to November 17, 2021).

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Californians ***without*** a primary care provider

- **Face barriers accessing care that they can afford, care that is easy to get to, a doctor who speaks the same language, background or experiences, and a doctor who treats them with dignity and respect**
- **Have negative experiences with health care providers**
  - Having a doctor talk down to them, not listen or not believe what they were saying, assume something about them without asking, suggest they were personally to blame for their health problem, refuse a test or medication that the patient thought they needed

Source: CHCF/NORC California Health Policy Survey (September 27, 2021 to November 17, 2021).

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But…primary care practices are in crisis

- **Chronically underresourced**
  - Overall spending on primary care is low
  - Administrative burdens are high and complex
  - Practices continually asked to accomplish more
  - Fee-for-service focuses on visits and procedures, not education, coordination, etc.
- **Problem brewing for decades**
  - Workforce beleaguered and burned out
  - Health professions students not choosing primary care
  - In need of financial and technical assistance for transformative change
- **COVID-19 pushed primary care to the brink**

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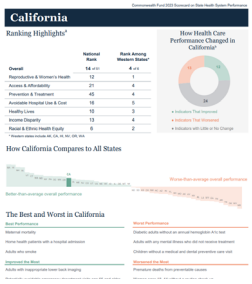
And this is resulting in poor outcomes for Californians

- **The Commonwealth Fund released its 2023 Scorecard on State Health System Performance.**
- **While California's scorecard results were better-than-average overall, with a state ranking of 14 (all measures) and 6 for racial and ethnic health equity, *results for prevention and treatment were dismal.***
- **Most such measures are specific to *primary care settings and teams* (e.g., child medical and dental visits).**



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How California compares

- **California was ranked:**
  - 50 for children without a medical and dental preventive care visit
  - 49 for adults age 18+ with any mental illness who did not receive treatment
  - 48 for adults without an annual HbA1c test*
  - 46 for children with a medical home*
  - 46 for youth 12–17 with a major depressive episode who did not receive MH services
  - 43 for adults with all age- and gender-appropriate cancer screenings*

* California's performance either worsened or did not improve in all of the above categories for which data were available (baseline 2016–2019, reference 2019–2021).

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Momentum to strengthen primary care is growing across the nation

- **Federal government**
  - HHS Primary Care Initiative with issue brief and dashboard
- **National Academies of Sciences, Engineering, and Medicine**
  - New standing committee
- **Health of US Primary Care Scorecard**
  - Milbank Memorial Fund and Robert Graham Center
- **Other states**
  - Virginia, Massachusetts, New York

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Momentum is growing in California

- **Within state government**
  - Department of Health Care Access and Information (HCAI)'s new Office of Health Care Affordability
  - Workforce for a Healthy California for All
  - Medi-Cal's Comprehensive Quality Strategy

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Momentum is growing in California

/ **Beyond state government**
- Primary Care Investment Coordinating Group of California (PICG): Promoting greater investment in primary care and multi-payer alignment
- California Advanced Primary Care Initiative: Multipayer partnership in the commercial market designed to strengthen primary care delivery
- Patients4PrimaryCare (UCSF): Patient and clinician voice/testimony

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Policy Priorities for California

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Primary Care Policy to Advance Health Equity: California Summit 2023

/ **September 2023**

/ **Oakland, CA**

/ ***Given*** **that primary care is essential to advance health equity, the *goal* of the Primary Care Health Equity Summit is to *reach consensus* on primary care policy priorities for California and *catalyze collaborative action* on these policies to advance health equity.**

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Thinking broadly about primary care policy

/ **Seven key arenas**
1. Community engagement
2. Workforce education and training
3. Clinical practice transformation
4. Health system leadership
5. Data, measurement, and reporting
6. Payment and spending
7. Research

/ **Multiple actors**
1. Health care organizations
2. Purchasers, payers
3. Policymakers/regulators
4. Educators
5. Researchers/thought leaders
6. Patient advocacy organizations
7. Community-based nonprofits
8. Public health

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Results

/ ***Three foundational policies*** **required to strengthen primary care and advance health equity**

/ ***Ten priority policy recommendations*** **specific to five primary care topics: community engagement, workforce development, access to care, data standards and sharing, and payment**

/ **A *three-part approach* to increase leadership and accountability to ensure progress**

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Three Foundational policies

1. **Sustainably increase Medi-Cal primary care provider payments to remove all financial disincentives to serving Californians with low incomes.**
2. **Increase the proportion of health care spending directed toward primary care to enable sustained, systemwide investment in primary care services and supports; and establish transparent and enforceable timebound spending targets for public and private payers, to ensure resources are sufficient for the provision of high-quality, equitable primary care for all Californians.**
3. **Create meaningful engagement of people with lived experiences of discrimination in all California state primary care policymaking and governance bodies to identify impediments to health equity and generate solutions. Honor their community wisdom through equitable acknowledgment and compensation for their time.**

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Five areas of impact

- **Engage the community to shift and share power**
- **Enhance education and training**
- **Expand access**
- **Improve data standards and sharing**
- **Design payment for equity**

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Ten priority policy recommendations

1. **Provide technical support for primary care practices and community-based organizations to establish partnerships and working relationships** in order to:
   - understand the pressing social needs in the community and how these contribute to health outcomes in their patient panels and the larger local community;
   - learn about existing services (e.g., information and referral services, housing, case management and home and community-based services which help keep older adults and people with disabilities in their own homes programs) that are available to meet those social needs; and
   - integrate services with community-based organizations to ensure that traditionally underserved populations (e.g., those who are experiencing homelessness or incarcerated, with mental illness or substance use disorders) have access to high-quality primary care and social care.

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Ten priority policy recommendations

2. **Provide technical support to practices and communities to make primary care practice-based or community-based patient and family advisory councils (PFACs) standard practice across the state.** PFACs should include people who reflect the diversity of the populations served and those with lived experience of discrimination, and should be designed as a collaborative endeavor among patients, family members, staff, clinicians, and leaders to affirm what is working well in the primary care practice, identify opportunities for improvement, and codesign practice improvement efforts.

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Ten priority policy recommendations

3. **Expand and scale health professions pipeline and pathway programs (including postbaccalaureate programs)** to recruit, prepare, and mentor students from historically and systematically excluded communities and cultural backgrounds for careers in primary care.

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Ten priority policy recommendations

4. **Reduce debt burden for primary care professionals** by offering
   - educational scholarships, subsidies, and loan repayment programs targeted to primary care professionals who train or work in underserved communities;
   - apprenticeships that offer opportunities for people seeking careers in primary care to learn while they earn with on-the-job training; and
   - accelerated education programs that allow primary care professionals to complete their education and training faster and join the workforce sooner.

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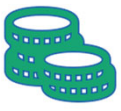
Ten priority policy recommendations

5. **Direct state investments to educational institutions that can demonstrate they are producing health professionals consistent with state goals on diversity and representation in primary care.**



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Ten priority policy recommendations

6. **Support and scale the role that community health workers, promotores, and community health representatives play in primary care delivery** to advance health equity and to increase the connection of primary care providers to the communities they serve. This includes

- prioritizing and incentivizing hiring people with lived experience;
- providing career ladders for community health workers, promotores, and community health representatives;
- establishing sustainable funding mechanisms in primary care settings; and
- facilitating partnerships between primary care providers and community-based organizations.

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Ten priority policy recommendations

7. **Establish or expand community health centers in areas with primary care shortages,** and work with community groups and community leaders to ensure the new health center sites and services are designed to meet community needs. This includes

- identifying a state entity to assess and prioritize areas for new community health center sites relative to need at the state level;
- providing financial support for start-up or expansion of community health centers; and
- streamlining the licensing process for building or expanding community health centers.

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Ten priority policy recommendations

8. **Develop and adopt standards to collect, share, and responsibly use comprehensive data on patients' identities and health and social needs across primary care, public health, community, and social service organizations** with mechanisms to ensure that people with lived experience of discrimination and health care inequities are involved in the oversight of data collection, use, and sharing.

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Ten priority policy recommendations

9. **Implement alternative payment models (APMs) that center equity** by

- accounting for a patient's individual clinical and social risk factors and community-level socioeconomic status;
- rewarding reductions in health inequities, not only overall improvement for the population as a whole; and
- providing financial resources sufficient to enable integration of behavioral health, social services, public health, and community partnerships into clinical practice.

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Ten priority policy recommendations

10. **Evaluate health care benefit design with an equity lens, beginning with a focus on populations with low incomes, which are disproportionately from communities of color,** by

- implementing income-adjusted premium cost sharing;
- reducing out-of-pocket costs for members and employees and their families; and
- proactively educating members and employees on no-cost preventive care services available through their coverage or plan.

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Three-part approach to increase leadership and accountability

- **Task force on primary care and health equity**
- **California state scorecard on primary care and health equity**
- **Office for primary care within state government**

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Thank you!

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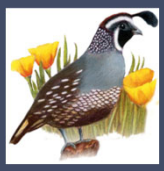

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