Advancing Health Equity: The Essential Role of Primary Care

2021 Leadership and Faculty Development Program Conference

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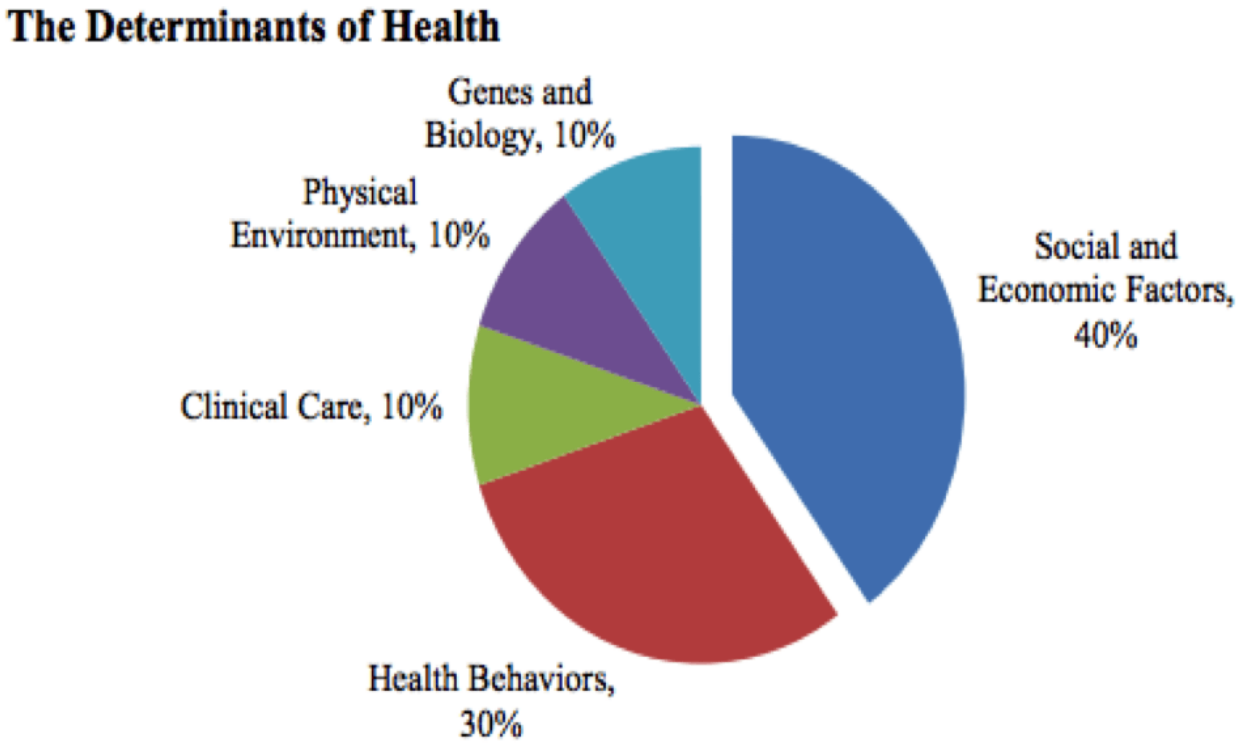
OASH | Office of the Assistant Secretary for Health

Agenda

- Health, health equity, disparities
- Primary care and advanced primary care models
- What's the data?
- Barriers and facilitators
- What's needed?
- Current landscape
- Key takeaways

Health



Cummings Graduate Institute for Behavioral Health Studies

Social Determinants of Health
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Healthy People 2030

Healthy People 2030

Health Equity: *Attaining The Highest Level Of Health For All People*

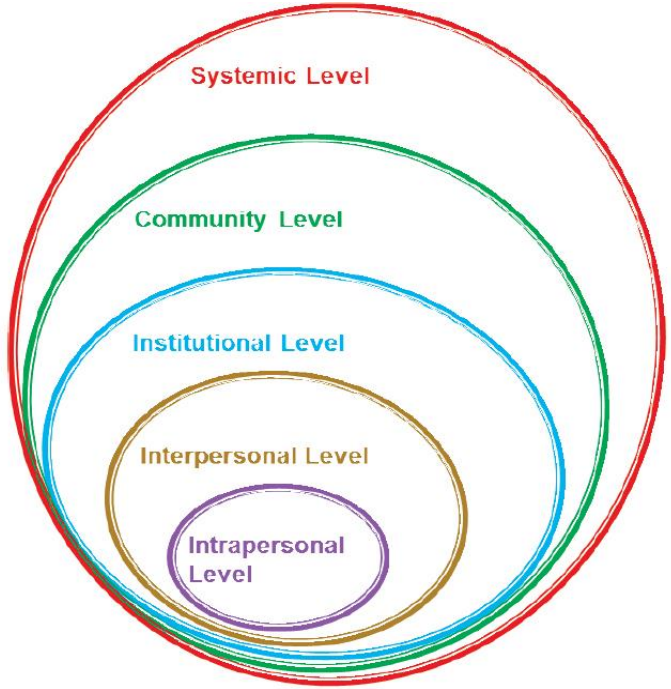
Equality **Equity**

Graphic: NASTAD.org

Health inequities:
Systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes

Root Cause: Structural Inequities

- **Interpersonal, institutional, and systemic biases in policies and practices**



Systemic Level
- Immigration policies
- Incarceration policies
- Predatory banking

Community Level
- Differential resource allocation
- Racially or class segregated schools

Institutional Level
- Hiring and promotion practices
- Under- or over-valuation of contributions

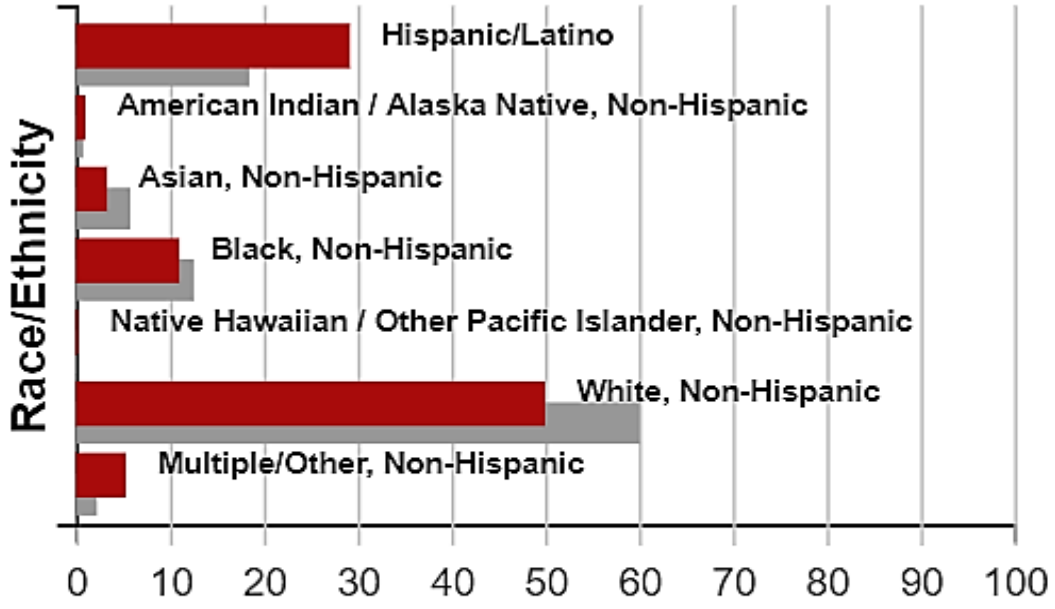
Interpersonal Level
- Overt discrimination
- Implicit bias

Intrapersonal Level
- Internalized racism
- Stereotype threat
- Embodying inequities

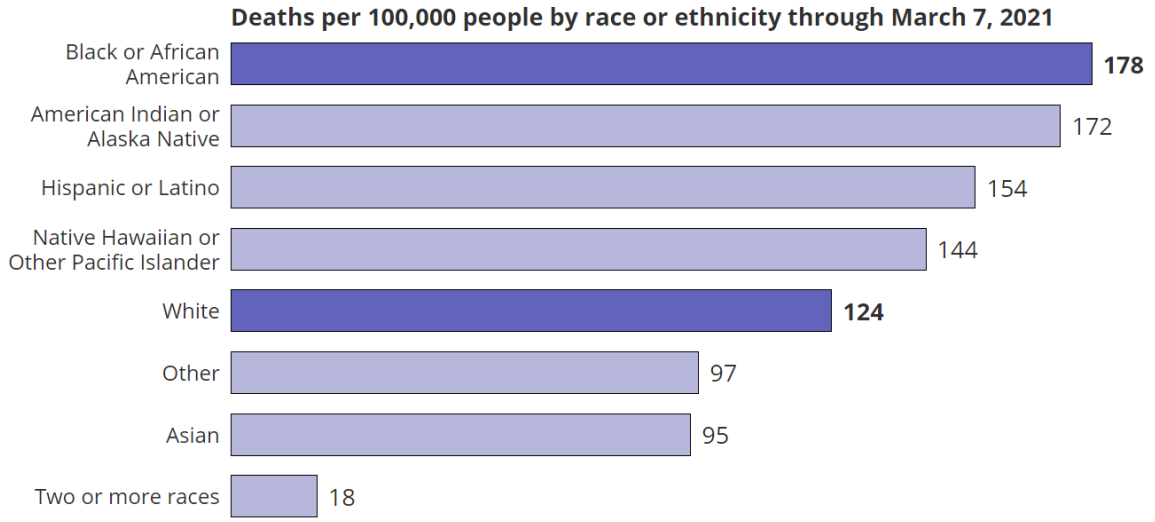
Braveman. Public Health Reports 2014
Braveman, 2006
WHO, 2011
Communities in Action: Pathways to Health Equity, NASEM 2017

The COVID-19 Pandemic Has Exposed And Highlighted Health Inequities In Our Nation

COVID-19 Cases by Race/Ethnicity

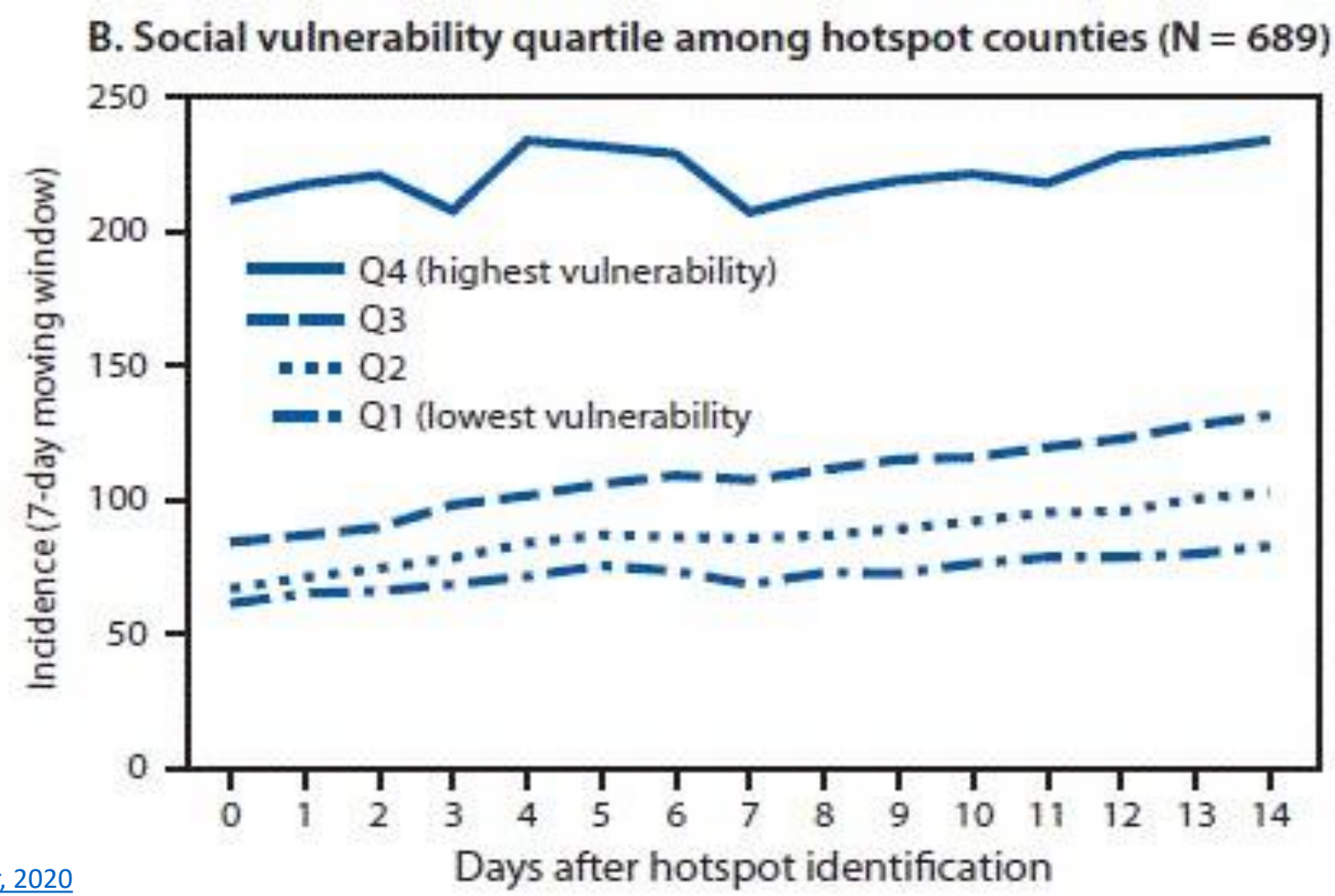


Nationwide, Black people have died at 1.4 times the rate of white people.



COVID Tracking Project

Higher Social Vulnerability Index Predicts COVID 19 Hotspot Areas



Dasgupta, et al. MMWR October, 2020

Primary Care: The Basics

- Founded on ongoing trusting relationship between patient and provider
- Entry point of health care system
- Prevention, screening and wellbeing
- Diagnosis and treatment of acute disease
- Chronic disease: diagnosis, ongoing management
- Referral to specialty care

Photo: Phinney Neighborhood Association

Primary Care Improves Health Outcomes

- 1978 Alma Alta Declaration
  - **First contact**
  - **Longitudinally**
  - **Comprehensiveness**
  - **Coordination**
  - **Person or family centeredness**
  - **Community orientation**

Plus: Cultural competence

Better primary care is associated with more equitable distribution of health[1]

Stronger primary care systems are generally associated with better population health outcomes:[1]

- Lower mortality rate
- Lower rates of premature death and hospitalizations for ambulatory care sensitive conditions
- Higher infant birth weight
- Greater life expectancy
- Higher satisfaction with the healthcare system.

Larger primary care workforce is associated with better health outcomes[2]

- Increased life expectancy; reduced cardiovascular, cancer and respiratory mortality

1. Shi, Scientifica 2012
2. Basu et al. Jama Int Med 2020

Advanced Primary Care

- Whole person, patient centered
  - **Multidisciplinary Team**
- Easy access; bring care to where people are
- Expanded prevention and treatment:
  - **Sexual health and wellbeing, screening, PrEP and PEP**
  - **Vaccine counseling**
  - **HIV, viral hepatitis, STI treatment**
- Integration of services with primary care
  - **Behavioral health**
  - **Oral health**
  - **Social services**
  - **Public health**
- Care management and navigation across the health care and social support systems
- Attention to social determinants of health and the health of communities

Advanced Primary Care Models

- Health Center Program
- Patient Centered Medical Home
- State Advanced Primary Care Initiatives
- Center for Medicare and Medicaid Innovation (CMMI)
  - **Comprehensive Primary Care Plus**
  - **Primary Care First**

Health Center Program: Borne Of The War On Poverty

- Authorized in 1965 in Section 330 of the Public Health Service Act
- Consolidated in 1996 to combine the separate authorities
  - **Community Health Center Program**
  - **Migrant Health Center Program**
  - **Health Care for the Homeless Program**
  - **Public Housing Primary Care Program**

Health Center Program: Fundamentals

Serve High Need Areas

- Must serve a high need community or population (e.g., HPSA, MUA/P)

Patient Directed

- Private non-profit or public agency that is governed by a patient-majority community board

Comprehensive

- Provide comprehensive primary care and enabling services (e.g., education, outreach, and transportation services)

No One is Turned Away

- Services are available to all, with fees adjusted based upon ability to pay

Collaborative

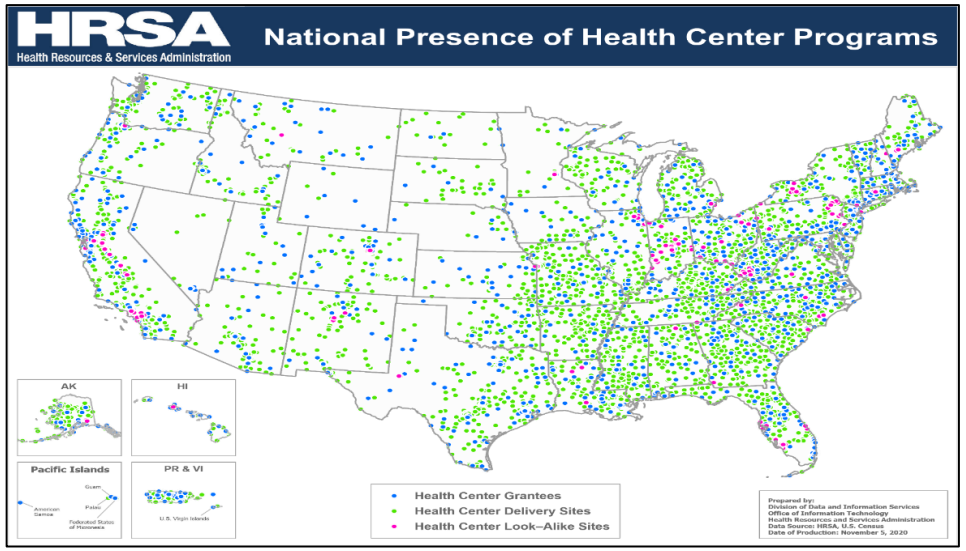
- Collaborate with other community providers to maximize resources and efficiencies in service delivery

Accountable

- Meet performance and accountability requirements regarding administrative, clinical, and financial operations

Health Center Program

- Nearly **1,400** health centers operate over **13,000** service delivery sites that serve nearly **30 million** patients.
- Health centers provide **patient-centered, comprehensive, integrated care** by offering a range of services:
  - **Primary medical, oral, and mental health services**
  - **Substance use disorder and medication-assisted treatment (MAT) services**
  - **Enabling services: case management, health education, and transportation**



Source: Uniform Data System, 2019; HRSA's Electronic Handbooks (EHBs), November 2020

Health Center Program: National Impact

Bureau of Primary Health Care

Clinical Quality

Health Centers Compared to National Averages

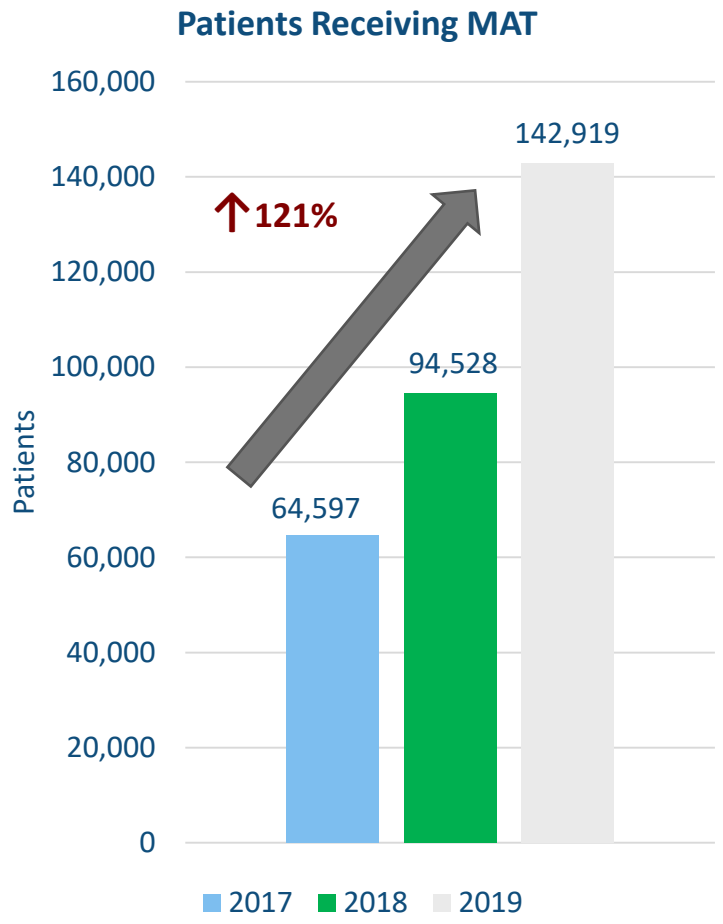
Clinical Quality Measure	Health Centers (2019)	National Average
Controlling Diabetes (HbA1c ≤ 9)	68%	59%
Controlling High Blood Pressure (< 140/90)	65%	59%
Prenatal Care in First Trimester	74%	74%

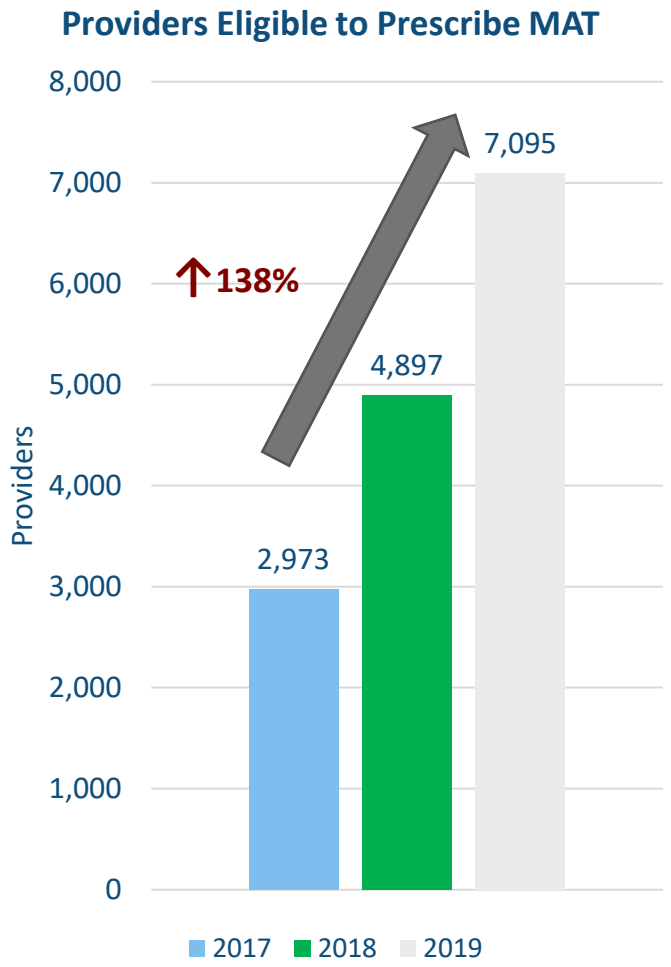
Health Centers Compared to Healthy People 2020 Goals

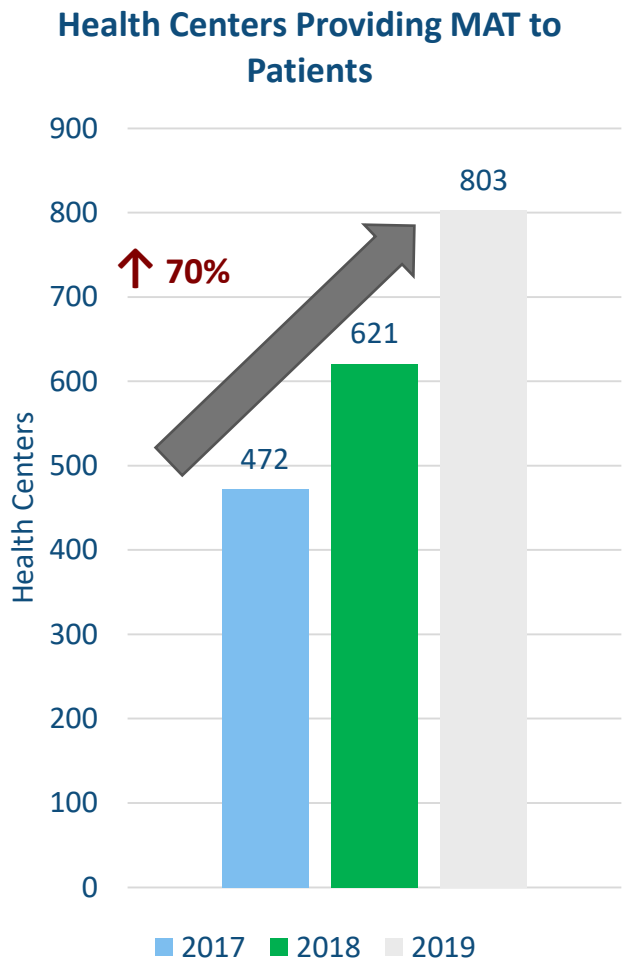
Clinical Quality Measure	Health Centers (2019)	Healthy People 2020
Ischemic Vascular Disease – Use of Aspirin	81%	52%
Dental Sealants for Children Between 6-9 Years	57%	28%

Uniform Data System, 2019
HEDIS measures, Medicaid-HMO, 2018, NCQA
Child Health USA 2014, HRSA Maternal and Child Health Bureau
Healthy People 2020

Medication Assisted Treatment (MAT) At Health Centers

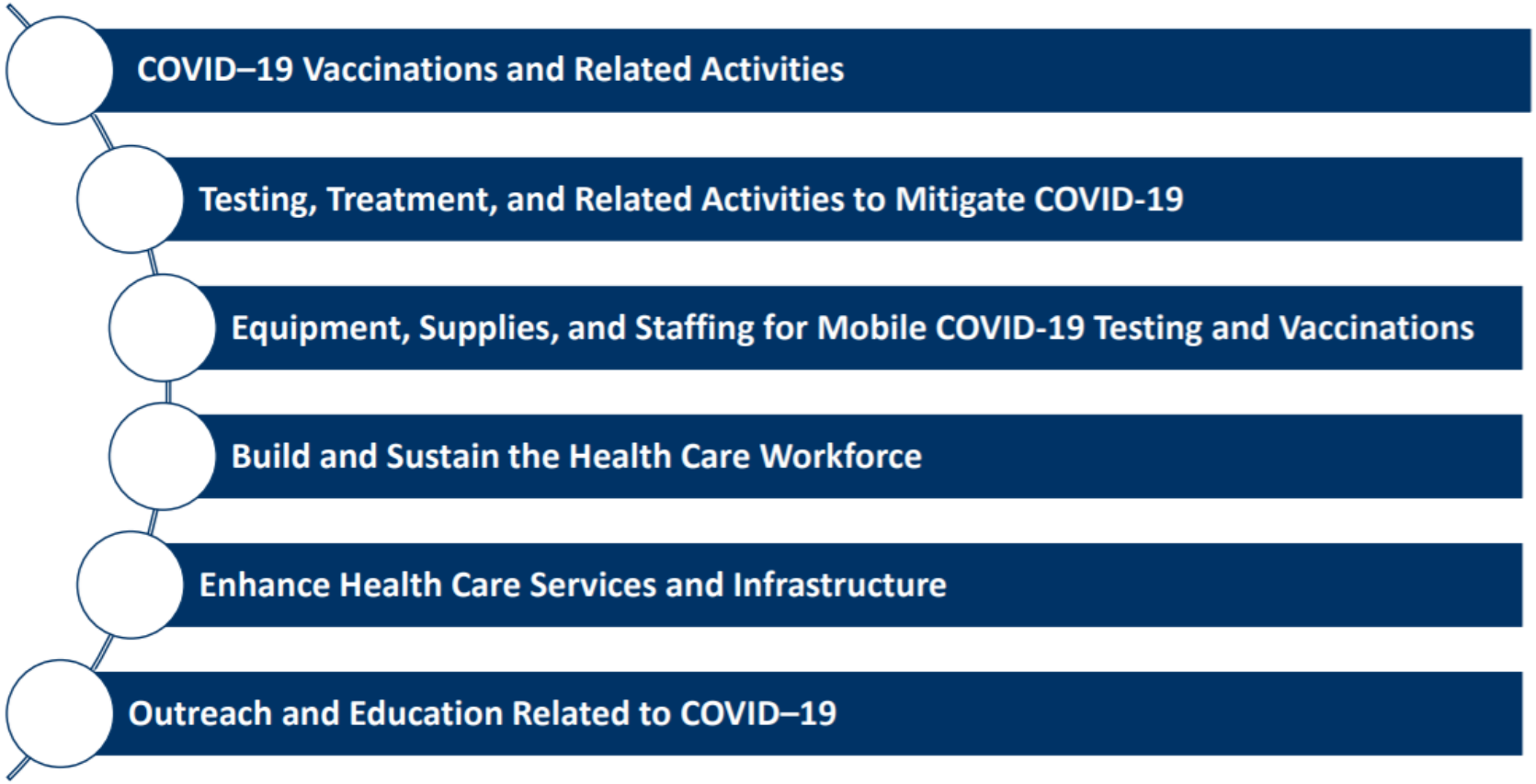






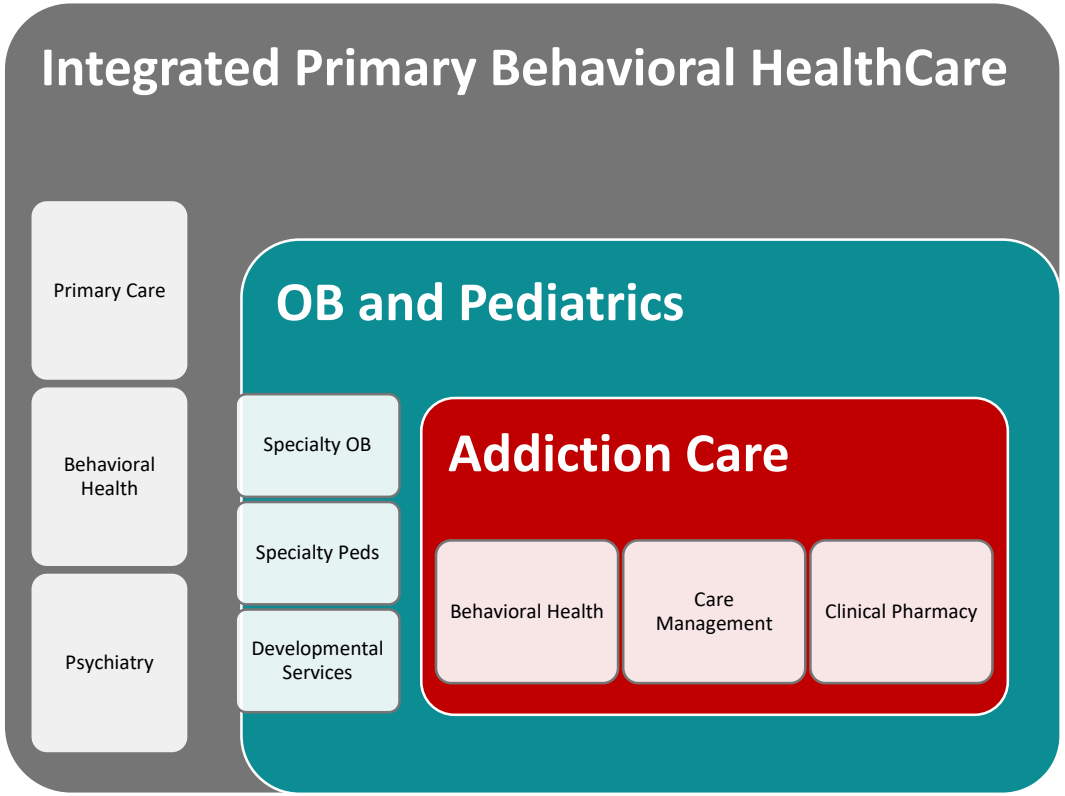
Uniform Data System 2017-2019

American Rescue Plan Act: $7,600,000,000 To Health Center Program



Cherokee Health System: Behaviorally Enhanced Healthcare Home

- Behaviorist, Psychiatrist, CHC on PC team
- Shared patient panel and care plan
- Integrated health record
- Shared support staff, physical space, and clinical flow
- Access and collaboration at point of care
- Team based co-management and care coordination
- Continuum of specialty mental health services



Cherokee HEALTH SYSTEMS

https://www.cherokeehealth.com/

Collecting Data On Social Determinants Of Health

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

A national **standardized** patient risk assessment **protocol** designed to **engage patients** in assessing and addressing social determinants of health

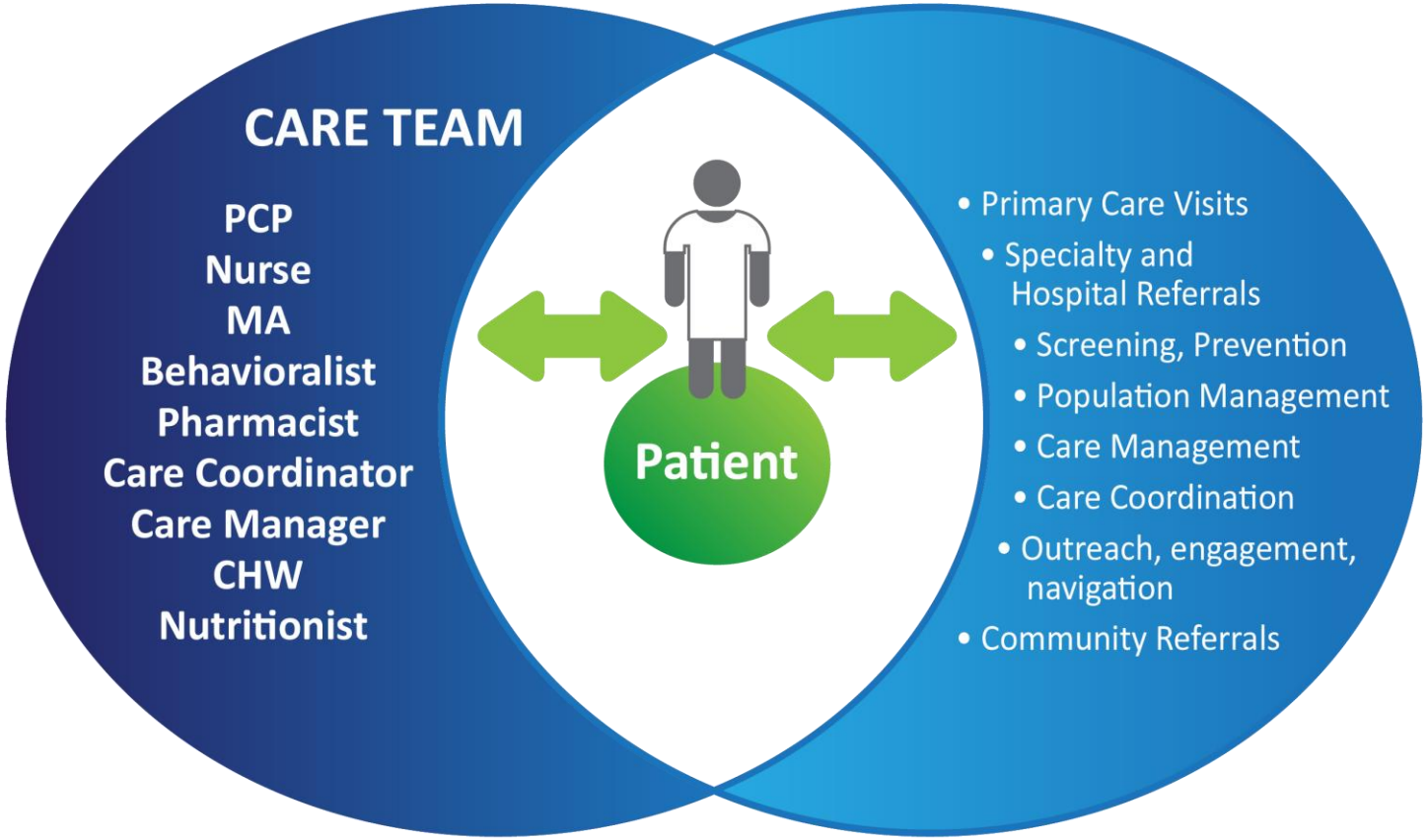
NACHC PRAPARE

NATIONAL ASSOCIATION OF Community Health Centers

AAPCHO ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

OPCA Oregon Primary Care Association

Patient Centered Medical Home (PCMH): Pro-Active Multidisciplinary Team-based Care



Graphic: UMass Medical School

Payment Models

Early models: Care management fees plus fee for service (FFS)

Performance based incentive payment

- **Quality and utilization**

Prospective payments

- **Per member/per month (PMPM) payment for comprehensive primary care services based on patient panel**

Short term Care Transformation Fee

Importance of Risk Adjustment

Research

JAMA Internal Medicine | Original Investigation | HEALTH CARE REFORM

Social Determinants of Health in Managed Care Payment Formulas

Arlene S. Ash, PhD; Eric O. Mick, ScD; Randall P. Ellis, PhD; Catarina I. Kiefe, PhD, MD; Jeroan J. Allison, MD, MS; Melissa A. Clark, PhD

Invited Commentary page 1431

Supplemental content

IMPORTANCE Managed care payment formulas commonly allocate more money for medically complex populations, but ignore most social determinants of health (SDH).

OBJECTIVE To add SDH variables to a diagnosis-based payment formula that allocates funds to managed care plans and accountable care organizations.

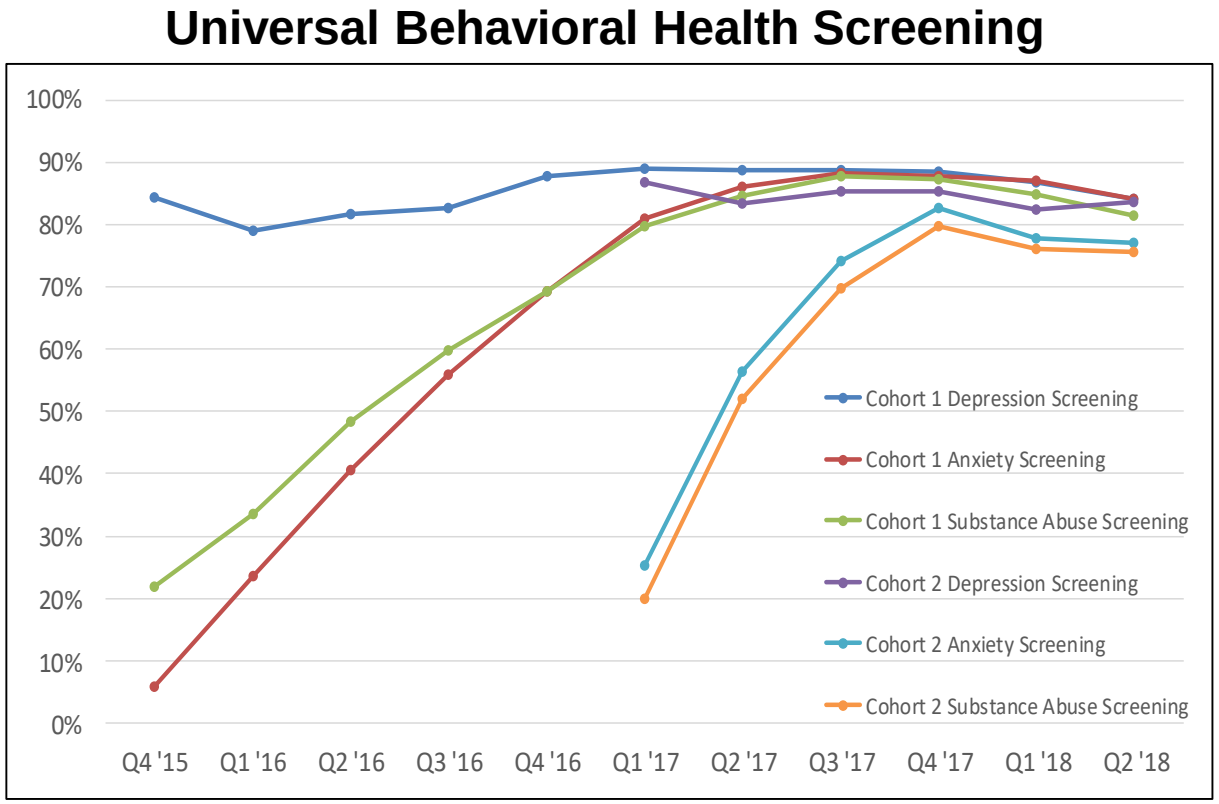
DESIGN, SETTING, AND PARTICIPANTS Using data from MassHealth, the Massachusetts Medicaid and Children's Health Insurance Program, we estimated regression models predicting Medicaid spending using a diagnosis-based and SDH-expanded model, and compared the accuracy of their cost predictions overall and for vulnerable populations. MassHealth members enrolled for at least 6 months in 2013 in fee-for-service (FFS) programs (n = 357 660) or managed care organizations (MCOs) (n = 524 607).

EXPOSURES We built cost prediction models from a fee-for-service program. Predictors in the diagnosis-based model are age, sex, and diagnoses from claims. The SDH model adds

Ash et al. JAMA Int Med 2017

State Advanced Primary Care Initiatives: Care Transformation Collaborative- Rhode Island

- Multi-payer, public-private partnership,
- Expanding PCMH: 128 primary care practices, serving 700,000 RI residents
- Supplemental PMPM and performance based payments
- Community Health Teams
- Integrated Behavioral Health Project – 41 primary care practices
- Association between reduced total cost of care and PCMH, even larger with integrated behavioral health

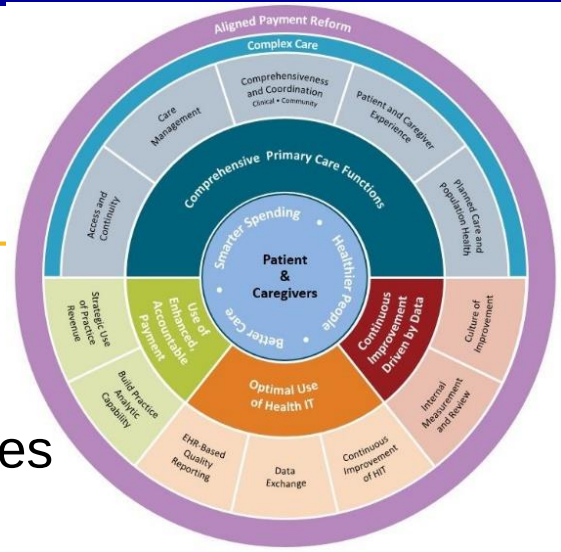


CTC-RI

Advancing Primary Care Innovation in Medicaid Managed Care

- Center for Health Care Strategies initiative, supported by the Commonwealth Fund
- Using state's Medicaid Managed care levers to advance primary care:
  - **Addressing social determinants of health**
  - **Integrating behavioral health and primary care**
  - **Using technology to improve access to care**
  - **Enhancing team-based primary care**
- 10 states: DE, HI, NV, TN, TX, VA, WA, PA, LA, RI,
- Technical assistance, shared learning, peer to peer learning

Center for Medicare & Medicaid Innovation



Comprehensive Primary Care Plus

- 5 year demonstration – year 4
- 3,070 primary care practices
- Multi-payer
- Payment model:
- Track 1 FFS, Care management fee, performance based payment
- Track 2 – Comprehensive Primary Care Payment, reduced FFS, performance based payment
- Care delivery requirements and milestones

Primary Care First

- 5 year demonstration
- Advanced primary care practices
- Multi-payer
- Payment model:
  - PMPM
  - FFS
  - Performance based payment
  - Higher payments for complex patient population
- Model for practices with high complexity patient
  - **Includes linkage to behavioral health and social determinants of health supports**

CPC +
Primary Care First

PCMH and Advanced Model Impact: The Data

Quality, cost, utilization

- 2017 Primary Care Collaborative Review:
  - **Improved quality, cost and utilization outcomes, but not uniformly**

- Year 3 Comprehensive Primary Care Plus:
  - **A few small favorable impacts on some measures of service use, quality of care, and patient experience**
  - **Increased Medicare expenditures**

2017 Primary Care Collaborative Impact report
CPC+ Third Annual Report

PCMH and Advanced Model Impact: The Data

Health Disparities

- 2017 Systematic Review: PCMH interventions showed small improvements in health disparities[1]
- Stakeholders views on PCMH and health disparities: Minimal or indirect influence on health care disparities[2]

This is an important moment to more directly position the PCMH model to address health care disparities. Although the philosophy behind the PCMH model lends itself to addressing health care disparities, this potential has not yet been fully realized by the accreditation process.[2]

1. Olayiwola et al J Health Dispar Res Pract 2017
2. De Marchis et al Pop Health Man 2019

Advancing Primary Care: Barriers and Facilitators

Barriers

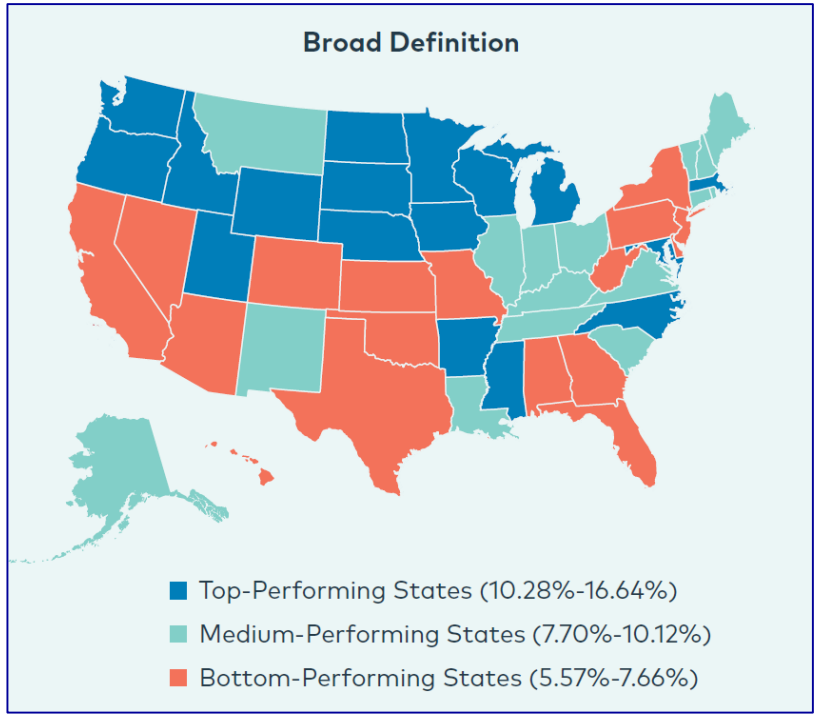
- Lack of access: insurance, distance, workforce, hours of service
- Medical mistrust, stigma, confidentiality concerns
- Bias, lack of cultural and linguistic competency/humility
- Lack of workforce diversity, capacity, knowledge, skills
- Primary care provider ”burnout”
- Payment model, rates, incentives and gaps
- Policies and larger structural factors

Facilitators

- CMS, State Medicaid programs and expansion
- Bureau of Primary Health Care
- Risk adjusted value-based payment models
- Multi-payer: public & private
- Leadership and accountability
- Partnerships and collaborations
- Case management, peer navigators/community health workers
- Technology, data, data sharing
- Community and patient engagement
- Advocacy

Primary Care Spend

Primary Care Spend Percentage 2019



Concern:

- Primary Care spending decreased 2017-2019*
- Primary Care utilization is flat or declining**
- Patients with usual source of care rose slightly 2013-2016 and leveled off after ACA

Promise:

- 10 states measuring primary care spend with aim to increase
  - **Multi-stakeholder advisory groups**
  - **State Innovation model (SIM) grants from CMMI and Medicaid waivers provide support**
- Spending targets set
  - **RI, CT, DE, OR – 10-12%**

PCC Primary Care Spending Dec 2020
Primary Care Collaborative Briefing Paper Dec 2020

* Commercial and Medicare Advantage
** Commercially insured population

What's Needed: Enhancing Primary Care for Health Equity

- Expand the definition of Advanced Primary Care
- Incentivize and monitor for Health Equity
- Enhance data collection and reporting by subpopulation
- Synergize with other Healthcare Transformation:
  - **Accountable Care Organizations, Accountable Entities, Coordinated Care Organizations…..**
  - **Community Based Care teams**
  - **Accountable Communities for Health**
- Increase investment in Primary Care
- Align policies and practices across agencies, sectors
- Involve patients, families, communities

Photo: Business & Finance CEM Toolbox courtesy of richepstein

The Current Landscape Holds Promise

- States expanding Medicaid, ACA strengthening
- American Rescue Plan Act – reduction in child poverty
- Focus on Health Equity and Environmental Justice
  - **Government, professional societies, academia**
  - **Healthy People 2030**
- Primary Care Transformation Initiatives to Advance Health Equity
- Increasing primary care spend
- COVID-19 pandemic: Lessons, innovations and responses
- Implementing High-Quality Primary Care – NASEM, May 2021
- National Strategic Plans- syndemic approach

NASEM May 2021

Key Takeaways

- Stronger primary care improves health outcomes and health equity
- The Health Center Program succeeds in providing healthcare for underserved and vulnerable populations and is advancing its model
- Reducing disparities and improving health equity has *not* been a main focus of advanced primary care model demonstrations
- Primary care transformation is hard
- Primary care can’t do it alone
- Patients and communities must be at the center

The current landscape holds promise to advance primary care and health equity

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- Robert Phillips Jr, American Board of Family Medicine
- Our team in OIDP and OASH

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Questions and Discussion

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