Advancing Health Equity: The Essential Role of Primary Care

2021 Leadership and Faculty Development Program Conference
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Office of Infectious Disease and HIV/AIDS Policy
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

The Determinants of Health

- Genes and Biology, 10%
- Physical Environment, 10%
- Clinical Care, 10%
- Health Behaviors, 30%
- Social and Economic Factors, 40%

Social Determinants of Health

- Education Access and Quality
- Health Care Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context

Cummings Graduate Institute for Behavioral Health Studies

Healthy People 2030
Health Equity: Attaining The Highest Level Of Health For All People

**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

[Braveman, Public Health Reports 2014](#)
[Braveman, 2006](#)
[WHO, 2011](#)
[Communities in Action: Pathways to Health Equity, NASEM 2017](#)

Graphic: NASTAD.org
The COVID-19 Pandemic Has Exposed And Highlighted Health Inequities In Our Nation

COVID-19 Cases by Race/Ethnicity

- Hispanic/Latino
- American Indian / Alaska Native, Non-Hispanic
- Asian, Non-Hispanic
- Black, Non-Hispanic
- Native Hawaiian / Other Pacific Islander, Non-Hispanic
- White, Non-Hispanic
- Multiple/Other, Non-Hispanic

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

Deaths per 100,000 people by race or ethnicity through March 7, 2021
- Black or African American: 178
- American Indian or Alaska Native: 172
- Hispanic or Latino: 154
- Native Hawaiian or Other Pacific Islander: 144
- White: 124
- Other: 97
- Asian: 95
- Two or more races: 18

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
Primary Care Improves Health Outcomes

Better primary care is associated with more equitable distribution of health

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

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

Larger primary care workforce is associated with better health outcomes:

1. Increased life expectancy; reduced cardiovascular, cancer and respiratory mortality

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1. Shi, Scientifica 2012
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

<table>
<thead>
<tr>
<th>Serve High Need Areas</th>
<th>Patient Directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must serve a high need community or population (e.g., HPSA, MUA/P)</td>
<td>• Private non-profit or public agency that is governed by a patient-majority community board</td>
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<tr>
<th>Comprehensive</th>
<th>No One is Turned Away</th>
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<tr>
<td>• Provide comprehensive primary care and enabling services (e.g., education, outreach, and transportation services)</td>
<td>• Services are available to all, with fees adjusted based upon ability to pay</td>
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<th>Collaborative</th>
<th>Accountable</th>
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<tr>
<td>• Collaborate with other community providers to maximize resources and efficiencies in service delivery</td>
<td>• Meet performance and accountability requirements regarding administrative, clinical, and financial operations</td>
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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

HRSA-Funded Health Centers Improve Lives

Nearly 30M people—that’s 1 in 11 in the U.S.—rely on a HRSA-funded health center for care, including:

- 1 in 8 children
- 1 in 5 rural residents
- 1 in 3 living in poverty
- 1 in 5 uninsured
- 398K+ veterans
- 885K+ served at school-based health centers
- 1M+ agricultural workers
- 1.4M+ homeless
# Clinical Quality

## Health Centers Compared to National Averages

<table>
<thead>
<tr>
<th>Clinical Quality Measure</th>
<th>Health Centers (2019)</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling Diabetes (HbA1c ≤ 9)</td>
<td>68%</td>
<td>59%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (&lt; 140/90)</td>
<td>65%</td>
<td>59%</td>
</tr>
<tr>
<td>Prenatal Care in First Trimester</td>
<td>74%</td>
<td>74%</td>
</tr>
</tbody>
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## Health Centers Compared to Healthy People 2020 Goals

<table>
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<tr>
<th>Clinical Quality Measure</th>
<th>Health Centers (2019)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Vascular Disease – Use of Aspirin</td>
<td>81%</td>
<td>52%</td>
</tr>
<tr>
<td>Dental Sealants for Children Between 6-9 Years</td>
<td>57%</td>
<td>28%</td>
</tr>
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</table>
Medication Assisted Treatment (MAT) At Health Centers

Patients Receiving MAT

- 2017: 64,597
- 2018: 94,528
- 2019: 142,919

Providers Eligible to Prescribe MAT

- 2017: 2,973
- 2018: 4,897
- 2019: 7,095

Health Centers Providing MAT to Patients

- 2017: 472
- 2018: 621
- 2019: 803

Uniform Data System 2017-2019
American Rescue Plan Act:
$7,600,000,000 To Health Center Program

- COVID–19 Vaccinations and Related Activities
- Testing, Treatment, and Related Activities to Mitigate COVID–19
- Equipment, Supplies, and Staffing for Mobile COVID–19 Testing and Vaccinations
- Build and Sustain the Health Care Workforce
- Enhance Health Care Services and Infrastructure
- Outreach and Education Related to COVID–19
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
Collecting Data On Social Determinants Of Health

A national standardized patient risk assessment protocol designed to engage patients in assessing and addressing social determinants of health.
Patient Centered Medical Home (PCMH): Pro-Active Multidisciplinary Team-based Care

CARE TEAM
- PCP
- Nurse
- MA
- Behavioralist
- Pharmacist
- Care Coordinator
- Care Manager
- CHW
- Nutritionist

• Primary Care Visits
• Specialty and Hospital Referrals
• Screening, Prevention
• Population Management
• Care Management
• Care Coordination
• Outreach, engagement, navigation
• Community Referrals

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

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

Universal Behavioral Health Screening

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
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
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
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

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%

* 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
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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Questions and Discussion

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