



Primary Care's Essential Role in Advancing Health Equity for California

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About the Foundation

[The California Health Care Foundation \(CHCF\)](#)

is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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About the Primary Care Matters Resource Center

Primary care is the foundation of health and health equity.

This report is part of a series on strengthening primary care in California.

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Executive Summary

Primary care is the most fair, efficient, and accessible way for all people — regardless of race, ethnicity, or income — to enter the health care system and obtain the services they need. Yet it is frequently absent from policy conversations about advancing health equity in California.

This report explores the unique role of primary care in the health care system, outlines the large body of evidence demonstrating its essential contribution to advancing health equity, calls for a paradigm shift in our thinking and actions, and recommends a new forum for leadership and accountability. In addition, it provides example recommendations that a variety of actors can take now to strengthen primary care and advance health equity in California.

Primary care is the only component of health care where an increased supply leads to better population health and more equitable outcomes — making it a vital ingredient for an organized, high-functioning health care system. Having a relationship with a trusted primary care provider helps people make good health care decisions and prevents them from getting lost in or ignored by our complex health care system. This makes primary care access a universal need.

However, systems, laws, and policies create unequal primary care access based on socioeconomic status, race/ethnicity, and geography. Here are a few examples of the obstacles highlighted in this report:

- ▶ The United States spends less on primary care (about 5% of total health care spending) than other industrialized democracies.
- ▶ Decades of underinvestment have resulted in a depleted workforce struggling to deliver high-quality primary care in a weakened infrastructure.

What Is Primary Care?

Primary care addresses patients' physical and mental health needs. It is essential to keep us healthy by preventing disease, managing chronic illness, and addressing social realities impacting our health. Delivered by primary care clinicians and teams — including physicians, nurse practitioners, physician assistants, community health workers, and behavioral health staff — primary care is the first point of contact in our health care system for nearly all patient concerns and helps coordinate care for patients across the health care system, including testing and specialist care.

- ▶ California and the US don't have enough primary care physicians, which limits access to primary care for all people. Fewer medical students enter the field, in part because they earn less than they would in other medical fields, making it difficult to pay off medical school debt. Practitioners are also unequally distributed across the state, with higher concentrations in wealthier and predominantly White urban areas. Lower concentrations of primary care physicians practice in rural communities and in lower-income urban and suburban areas, home to many of the state's Black, Latino/x, and other historically underrepresented racial and ethnic groups.
- ▶ Primary care access is further limited among populations with low incomes because Medi-Cal fee-for-service physician reimbursement for primary care is only 76% of Medicare rates. Lower rates plus a heavy administrative burden cause many practices to not accept Medi-Cal patients. This is a health equity issue because more than two of every three Medi-Cal enrollees are people of color,¹ and about 40% of Black and Latino/x Californians and more than 20% of Asian, Native Hawaiian, and Pacific Islander people in the state rely on Medi-Cal for coverage.²

“Only through the radical reimagining of our health care system and the explicit pursuit of anti-racist policy and systems changes can we achieve health equity.”

— Kiran Savage-Sangwan,
Executive Director, California Pan-Ethnic Health Network

Better access to primary care (typically measured by a higher concentration of primary care physicians per capita) is associated with improved life expectancy and lower rates of premature mortality in both international comparisons and across regions within the United States.³ Conversely, communities with fewer primary care physicians per capita experience greater access challenges, fragmented care, and more costly and duplicative health care services. When facing a shortage of primary care providers, patients also experience a higher risk of medical errors and reduced trust in health care providers.

Access to primary care provides important health benefits: more complete immunization, improved dental health, earlier detection and treatment of chronic conditions (such as hypertension, lipid disorders, congestive heart failure, chronic obstructive pulmonary disease, and diabetes), and reduced severity of disease through both effective management for individual conditions and ongoing management of multimorbidity. These benefits are important for all people, but especially for the elderly and economically and socially marginalized groups experiencing the highest burdens of preventable illness, chronic disease (e.g., diabetes), and negative outcomes (e.g., amputation) associated with unmanaged and uncontrolled disease.

What explains primary care’s potential for advancing health equity? Studies have linked primary care’s additional defining elements to improved health equity in the following ways:

- ▶ **Continuity of care.** Greater continuity of care is associated with lower mortality rates,⁴ and fewer disparities in rates of recommended cancer screening services among Black and Latino/x populations⁵ and of several types of evidence-based, high-value services such as vaccinations (including for COVID-19).⁶
- ▶ **Coordination of care.** Patients with better-coordinated care are more satisfied and more likely to follow evidence-based recommendations for treatment and self-care because they are less likely to receive conflicting messages from different providers. More coordinated primary care is associated with reduced racial and ethnic disparities in preventable emergency department visits and improved blood pressure control.⁷
- ▶ **Comprehensiveness.** More comprehensive primary care is associated with reduced disparities in disease severity as a result of earlier detection and prevention across different populations.⁸
- ▶ **Whole-person orientation.** Elements of whole-person care, including clinician knowledge of a person’s overall medical history, preferences, and family and cultural orientation, have been associated with improved patient self-management for chronic conditions such as hypertension, congestive heart failure, depression, diabetes, and asthma⁹; better adherence to physicians’ advice; and improvements in self-reported health status.

California has embraced the charge to strengthen primary care and increase sustained systemwide investments in primary care services and teams. The authors call for a paradigm shift in our thinking and actions to ensure these efforts prioritize equity. This paradigm shift includes (1) recognizing high-quality primary care as a common good, (2) embracing the diversity of primary care settings and investing resources according to need with the intentional goal of reducing health and social inequities, (3) proactively applying principles of equity and justice to all decisions, and (4) building accountability for action.

As a starting point, the authors present examples of recommendations to strengthen primary care and advance health equity within the primary care practice and the greater health care community. Recommendations are sorted into five key arenas for action: (1) community engagement; (2) workforce education and training; (3) clinical practice transformation; (4) payment and spending; and (5) data collection, measurement, and reporting. For

additional context, the authors provide selected examples of current policies in California that support each recommendation and identify options to advance progress. Looking forward, the authors recommend that California establish a primary care equity action forum to build new partnerships and provide ongoing statewide leadership and accountability for this important work.

Example Recommendations to Strengthen Primary Care and Advance Health Equity in California

1. Involve people with lived experiences of discrimination in primary care policymaking and governance bodies to identify impediments to health equity and generate solutions.
2. Expand and scale pipeline programs to recruit, prepare, and mentor students from historically and systematically excluded communities and backgrounds for careers in primary care.
3. Hire and mentor team members from and within the community, to better reflect the community's racial and ethnic composition within the practice. Incorporate the lived experiences of staff into training for care delivery to encourage empathy and bring cultural context to interactions with patients.
4. Support whole-person care through behavioral health and primary care integration across all practice settings, and strengthen training for primary care providers on behavioral health (including substance use disorder treatment) and wellness.
5. Promote equitable access to telehealth by improving broadband access, infrastructure, payment models, provider readiness, and patient engagement, especially for rural and safety-net communities.
6. Strengthen access to and quality of language assistance services, including providing qualified interpreters; translated documents in understandable, plain language in at least all Medi-Cal threshold languages; and a notice of the right to language assistance services to all patients.
7. Provide an option for primary care continuity after hours and on weekends.
8. Ask patients about their needs and in what areas they want help. Use validated screening tools to identify health-related social needs, and, when possible, prescribe services and activities that are tailored to the individual's needs (e.g., financial support, food access, trauma-informed counseling, or a walking group).
9. Increase the overall proportion of health care spending that is directed toward primary care, establishing spending targets for public and private payers.
10. Increase Medi-Cal physician payment levels in order to incentivize service delivery to Californians with low incomes.
11. Implement and encourage participation in equity-focused alternative payment models that enable integration of social services, public health, and community partnerships into clinical practice.
12. Carefully collect accurate, self-identified electronic health record data on race and ethnicity, sexual orientation, gender identity, language proficiency, and disability as an important first step to providing whole-person, equitable care and improving provider-patient concordance for diverse Californians.
13. Incorporate measures on equity and social needs in data collection for clinical, quality improvement, and research purposes. Collect and stratify data on social needs to identify and document health inequities.
14. Use quality improvement approaches to identify and analyze root causes of identified inequities in the clinical setting.

Introduction

California is the most populous and racially diverse state in the nation. It is the fifth-largest economy in the world and leads in developing innovative policy solutions to global and national problems such as climate change, immigration challenges, and health insurance coverage. This report highlights California's unique opportunities to lead in strengthening the primary care foundation of a high-quality, accessible, and affordable health care system that can improve health outcomes for all.

High-quality primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs and who develop sustained, trusting partnerships with patients over time.¹⁰ Primary care clinicians include physicians trained in generalist specialties such as family medicine, pediatrics, general internal medicine, and geriatrics, and nurse practitioners trained in family, gerontological, and pediatric care. Primary care clinicians typically work closely with one or more members of a team that can include nurses, physician assistants, medical assistants, community health workers, behavioral health counselors, social workers, and pharmacists.

High-quality primary care is unique because it is typically the first point of health care access for a person experiencing new symptoms or concerns. High-quality primary care includes preventive services, acute care, and ongoing management of chronic and comorbid physical and behavioral health conditions.¹¹ High-quality primary care also plays an important role in coordinating care for patients across the health system. 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. To optimize health, primary care is 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.

These unique attributes of high-quality primary care make it the most fair, efficient, and accessible way for people, regardless of race, ethnicity, or income, to enter the health care system and obtain health services to meet their needs.¹² As such, high-quality primary care is foundational to a high-functioning health care system and essential to any discussion of health equity.¹³ Yet despite decades of evidence demonstrating the essential role of primary care in improving health equity, primary care is often absent — or not explicitly referenced — in policy conversations about advancing health equity in California.

Recent health and social crises, such as the COVID-19 pandemic and police brutality against people of color, have dramatically changed the national conversation about health equity, underscoring, for example, how systemic and structural racism increases exposure to unhealthy conditions and limits access to health-promoting resources and opportunities.¹⁴ Within California, these events focused attention on deep and long-standing health inequities for people of color; people with low incomes; people with disabilities; and people who identify as lesbian, gay, bisexual, transgender, and queer.¹⁵ Systems, laws, policies, and explicit and implicit biases have created these inequities in the key drivers of health, including housing, food security, and clean water.¹⁶ These same factors have created inequities in the health care delivery system.¹⁷ For example, in 2019, although 39% of Californians identified as Latino/x, only 6% of physicians in California were Latino/x, resulting in a lack of racial and ethnic concordance between physicians and patients.¹⁸ California's Medicaid program

(Medi-Cal) covers one in three Californians, including over 10 million Latino/x; Black; Asian, Native Hawaiian, and Pacific Islander; and American Indian and Alaska Native people¹⁹. Yet Medi-Cal physician fees for primary care are only 76% of Medicare rates.²⁰ Low provider payments and high administrative burden lead many primary care practices to not accept Medi-Cal patients because payment does not cover the practice's cost to provide high-quality care.²¹ This is a social justice issue that limits Medi-Cal patients' access to care and perpetuates health disparities.²²

Despite significant increases in insurance coverage over the past decade, one in five Californians who identify as Latino/x still do not have a particular medical professional, doctor's office, clinic, health center, or other place where they would usually go if sick or in need of advice about their health (often called a usual source of care).²³ This signals continuing challenges with access to primary care among specific population groups and exemplifies the structural inequities that continue to drive disparities in health outcomes. For example, Black Californians have a shorter life expectancy than other racial and ethnic groups in the state; they experience the highest rates of infant and maternal mortality as well as the highest death rates from breast, lung, cervical, and prostate cancer.²⁴

In this report the authors summarize the large body of compelling evidence of primary care's unique role in the health care system and its contribution to advancing health equity. To strengthen primary care in California and optimize equitable care and health outcomes, the authors make the case that incremental actions by actors in silos are insufficient and that a paradigm shift is required in how we consider, fund, and ultimately deliver primary care. They call for a new statewide forum to consider

primary care from multiple vantage points, with equity at the forefront. To catalyze movement from evidence to action in the meantime, however, the authors present example recommendations that a variety of actors can take to strengthen primary care and advance health equity in California.

“Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes.”

Source: Linda McCauley et al., eds., [*Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*](#) (Washington, DC: National Academies Press, 2021), 4.

Defining Health Equity and Why It Matters

Clearly defining health equity is important because what gets defined and measured is more likely to be addressed. In addition, a shared definition allows for collective action for improvement. Multiple definitions of health equity exist. The most recent definitions convey the imperative for broad solutions that address a wide range of factors, including public and private policies, institutional practices, norms, and cultural representations that inherently procure *unequal* freedom, opportunity, value, resources, advantage, restrictions, constraints, or disadvantage according to race and ethnicity,²⁵ rural or urban location, or other group identity. Some definitions finally acknowledge that health inequity is directly shaped by racism, which structures opportunity, assigns value, and unfairly disadvantages some people.²⁶

- ▶ The California Health Care Foundation affirms that “all Californians should have the opportunity to achieve their fullest potential for health. This includes not only access to health care, but also other social factors like housing, food, and jobs that contribute to a person’s well-being.”²⁷
- ▶ Taking an even broader approach, the World Health Organization defines health equity as “the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation).”²⁸
- ▶ Other researchers and practitioners remind us that poverty, discrimination, and other health-damaging consequences must ultimately be addressed in order to eliminate disparities in health outcomes.²⁹

Levels of Racism

Racism can take many forms, and operates on multiple levels in individuals and society.

- ▶ **Internalized racism** refers to “acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth” and exists within individuals.
- ▶ **Interpersonal racism** is “the expression of racism between individuals,” through discrimination, harassment, or slurs.
- ▶ **Institutionalized racism** refers to “discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.”
- ▶ **Structural racism** represents the deep and compounding impact of racial bias across institutions and society, which in turn shapes and mutually reinforces the patterns and experience of other forms of racism.

Source: Camara Phyllis Jones, “Levels of Racism: A Theoretic Framework and a Gardener’s Tale,” *American Journal of Public Health* 90, no.8 (Aug. 2000): 1212–1215

What Is Unique About Primary Care?

For decades, primary care has been defined as having five essential elements, which, when present, collectively differentiate primary care from specialty-oriented care³⁰:

- 1. Accessible first-contact care.** Primary care services are available and easily accessible to patients with new medical needs or ongoing health concerns. This includes shorter waiting times for urgent needs, enhanced hours, around-the-clock telephone or electronic access to a member of the care team who has access to the patient's medical record, and alternative methods of communication such as patient portals. This also includes providers who speak the language of the population they serve.
- 2. Continuous care.** Patients and primary care clinicians have a personal and uninterrupted caring relationship, with ongoing exchange of relevant information about health care and health needs.
- 3. Comprehensive care.** Primary care clinicians, working with the interprofessional primary care team, meet the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic and comorbid care, to include discussing end-of-life care.
- 4. Coordinated care.** Primary care practices coordinate care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and support.
- 5. Accountable whole-person care.** Primary care clinicians and teams are knowledgeable about and oriented toward the whole person, understanding and respecting each patient's unique needs, culture, values, and preferences within the context of their family and community. Accountability refers to caring for the whole person, not just an isolated body system.

“The focus of primary care on recognizing and meeting patients’ needs (including but not limited to ‘diagnoses’) is the reason primary care-oriented services are associated with greater equity in distribution of health in populations. Different populations differ in the kind and extent of their health problems, with more socially deprived populations having a greater number, greater severity and greater variability in their health needs than is the case in more socially advantaged populations. Primary care, the place where needs are best recognized, is the venue by which equity in health services and, hence, equity in those aspects of health responsive to health services, is attained. Person-centered services are the essential hallmark of primary care.”

Source: Barbara Starfield, “Primary Care and Equity in Health: The Importance to Effectiveness and Equity of Responsiveness to Peoples’ Needs,” *Humanity & Society* 33, no. 1–2 (Feb. 2009): 62–63.

The Essential Role of Primary Care in Advancing Health Equity: The Evidence

Decades of patient-level studies as well as system- and population-level studies reveal complex and interrelated factors that support the positive association between primary care and health equity.³¹ In this section, the authors first summarize evidence

of the link between health equity and primary care supply and access, then summarize evidence of the link between health equity and primary care's other defining elements: continuity, comprehensiveness, coordination, and whole-person orientation. Evidence of the counterfactual is also presented — what happens to patient experience and health outcomes in the absence of high-quality primary care. In the text boxes, the authors highlight examples of health care systems that have strengthened primary care with an explicit emphasis on advancing health equity.

Highlight: Team-based Primary Care for Veterans — Veterans Affairs PACT

The Veterans Health Administration (VHA) of the Department of Veteran Affairs (VA) began its Patient Aligned Care Teams (PACT) initiative in 2010. Based on the patient-centered medical home model, each PACT care team includes a primary care provider (physician, nurse practitioner, or physician's assistant), a clinical pharmacist, a registered nurse care manager, a licensed practical nurse or medical assistant, and a clerk.³² Each primary care patient within the VHA is assigned to a PACT team designed to provide multidisciplinary health care support that focuses on the individual needs of patients and supports them in taking an active role in their health care.³³ PACT teams also emphasize wellness and disease prevention.³⁴

Meeting the health care needs of California's veterans

Over 1.8 million veterans call California home, the largest number of former service members in any state. California also has the largest number of veterans experiencing homelessness, representing over 30% of the homeless veteran population nationally.³⁵

Many veterans have specific health care needs as a result of military service, and may require treatment for exposure to hazardous substances and ongoing rehabilitation from injuries. Veterans are at disproportionate risk of experiencing mental health and substance use disorders, post-traumatic stress disorder, traumatic brain injury, and suicide.³⁶

VA PACT combines a comprehensive team-based approach with care that is cognizant of and oriented toward the special needs of veterans. PACT care is associated with improved health outcomes, such as improvements in clinical outcomes for patients with diabetes, hypertension, and heart disease, and also with improved patient satisfaction.³⁷ It also is associated with increased receipt of preventive services such as vaccinations, screening for some types of cancer, and being offered medications for tobacco cessation.³⁸ PACT care has been shown in some studies to reduce emergency department visits, hospital visits, and readmissions.³⁹

Highlight: Community-Oriented Primary Care in Costa Rica

Although Costa Rica differs in many important ways from the United States, it offers an example of a health system that prioritizes community-oriented primary care, uses multidisciplinary teams to provide comprehensive primary care to almost all Costa Ricans, and has improved health equity while spending less on health care than the world average.⁴⁰

Costa Rica's model of community-oriented primary health care, which was implemented in the 1990s, is based on five main elements: (1) the integration of public health with primary care; (2) the integration of multidisciplinary teams — including a physician, nurse, pharmacist, medical clerk, and highly trained advanced community health worker — into the community; (3) the empanelment of citizens to care teams based on geographic location; (4) a focus on measurement and quality improvement at all levels; and (5) the integration of digital technology at all levels. Factors that have facilitated health reform in Costa Rica are the national ethos of health as a human right and the principles of universality, equity, and solidarity — the founding principles upon which the health system was based and continues to operate.⁴¹

Costa Rica has improved the quality of health care, health outcomes, and health equity through its primary health care system. For example, deaths from communicable diseases have dropped from 65 per 100,000 people in 1990 to 4.2 per 100,00 in 2010. Maternal and child mortality have also declined. As one approach to improve equity in outcomes,

the first multidisciplinary teams were established in areas with less access to care. In addition, data collected by the multidisciplinary teams are used to focus resources on higher-risk areas. As a result, premature mortality declined overall in Costa Rica between 1980 and 2000, but larger declines were seen in the poorest quintile of the population compared with the richest quintile.⁴²

Adapting Costa Rica's Community-Oriented Primary Care Model to Other Settings

Despite differences between health systems, aspects of the Costa Rican model could be relevant to improving health equity in California.

Examples include:

- ▶ Recognizing community health workers as critical members of the primary care team, and providing training and policy support to expand their role
- ▶ Exploring possibilities for geographic empanelment and/or geographically based care
- ▶ Collecting and using data at the community level to guide the distribution of resources to those areas and populations most at risk

Highlight: Primary Care in Community Health Centers

Community health centers, which include Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, community clinics, free clinics, and rural health centers, provide culturally competent, coordinated, community-directed, comprehensive medical care and supportive services to diverse populations in medically underserved areas, regardless of patients' ability to pay.⁴³ Community health centers emerged in 1965 as part of Lyndon B. Johnson's war on poverty and the civil rights movement and are designed to reduce health disparities by providing high-quality primary care and other services to communities that would otherwise have little or no access to medical care.⁴⁴

Community Health Centers in California

There are over 1300 Community health centers in California. In 2021, these health centers served 7.2 million patients, or one in five Californians, including almost 4 million people whose incomes were more than 100% under the federal poverty level and over 300,000 people experiencing homelessness. More than half of community health center patients in 2021 were Latino/x and about one-third of patients had limited proficiency in English.⁴⁵

To address the needs of the populations they serve, community health centers provide access to integrated clinical and community services, including medical, dental, pharmacy, and behavioral health services, and outreach, education, nutrition, and social services.⁴⁶

FQHCs have been shown to provide better and more cost-effective care, even when serving populations with low incomes, that have historically been marginalized, and that have more complex medical and social needs. FQHCs achieve higher rates of hypertension and diabetes control than the national average. They provide more preventive services (such as immunizations, cancer screening, and education for tobacco cessation) than other primary care providers. FQHCs perform better on primary care quality measures than private practice physicians. They are more likely to provide high-value care (such as providing statins to patients with diabetes) and less likely to provide low-value care (such as providing antibiotics for upper respiratory infections) than private practices. In addition, these outcomes are achieved while spending less per patient than other sources of care. FQHCs save 24% per Medicaid patient compared to other clinics and private physicians' office, and costs for Medicare patients are 10% lower than those for patients in physician office patients, and 30% lower than for patients in outpatient clinics.⁴⁷

Access to stronger primary care systems is associated with improved life expectancy and lower rates of premature mortality in both international comparisons⁴⁸ and across regions within the United States.⁴⁹ A higher density of primary care physicians (number of PCPs per capita) has been repeatedly linked to lower avoidable morbidity and mortality and longer life expectancy in regions within the United States.⁵⁰ This association is stronger in the Black population than the White population.⁵¹ Primary care physician supply is also associated with reductions in racial disparities in referral patterns in addition to an increase in necessary hospital admissions for Black Americans compared to White Americans.⁵² Notably, communities that have been marginalized have some of the lowest PCP densities, and a recent study found that counties with lower PCP density would be expected to disproportionately benefit from an increase in PCPs relative to their population size.⁵³

Access to high-quality primary care helps reduce disparities in receipt of United States Preventive Services Task Force–recommended preventive services (e.g., immunizations and cancer screening).⁵⁴ One study found that “Black patients able to access primary care receive preventive services at rates equal to or greater than White patients. This suggests that efforts to increase delivery of preventive care in Black patients need to focus on access to primary care.”⁵⁵ Access to primary care also leads to earlier detection and treatment of conditions, and reduced severity of disease by effective management both for individual conditions (such as hypertension, lipid disorders, congestive heart failure, chronic obstructive pulmonary disease, and diabetes)⁵⁶ and ongoing management of multimorbidity, which the elderly and groups who are economically marginalized experience at the highest rates.⁵⁷

Enhanced primary care access can extend beyond the primary care clinician and nurse or medical assistant to include the interprofessional team and community health workers (CHWs), who speak the language and know the culture of their local communities. For example, a randomized controlled trial found that primary care patients with low incomes had reduced hospitalizations and better self-reported quality of care when CHWs provided support.⁵⁸ CHWs also help connect individuals with low incomes to Medicaid, which opens the door to primary care.⁵⁹

In addition to access, studies have also linked primary care’s other defining elements — continuity, coordination, comprehensiveness, and whole-person care — to improved health equity⁶⁰:

► **Continuity.** Greater continuity of care is associated with lower mortality rates,⁶¹ fewer disparities in rates of receipt of recommended cancer screening services among Black and Latino/x populations,⁶² and fewer disparities in rates of receipt of several types of evidence-based, high-value services.⁶³ Continuity, which is enhanced by continuous Medicaid coverage for children, is associated with improvements in health and lower spending for hospitalizations that are ambulatory care–sensitive.⁶⁴ Interpersonal continuity with a primary care practitioner is also associated with greater patient trust. Patients, including those who are Black and/or Latino/x with low incomes, are more likely to adhere to recommended preventive services and medications from a trusted primary care practitioner. For example, patients, including those who are Black and/or Latino/x, rate primary care clinicians as the most trusted source of information about vaccines,⁶⁵ and prefer to receive vaccinations (including for COVID-19) from primary care clinicians.⁶⁶

► **Coordination of care** across providers (e.g., primary care and specialist practitioners) and health care settings (inpatient to outpatient) and with community-based services for health-related social needs is a crucial component of addressing patients' specific physical health, mental health, and social needs.⁶⁷ Coordination also reduces the extreme burden of interacting with a fragmented and disorganized health care system for patients with multiple chronic conditions and disabling conditions.⁶⁸ Generally, patients with better-coordinated care are more satisfied⁶⁹ and more likely to follow evidence-based recommendations for treatment and self-care, because they are less likely to receive conflicting messages from different providers.⁷⁰ Specifically, more coordinated primary care is associated with reduced racial and ethnic disparities in many important outcomes — for example, preventable emergency department visits and improved blood pressure control.⁷¹

► **Comprehensiveness.** Given that more comprehensive primary care has been associated with better health outcomes provided at lower costs,⁷² as well as improved health and better self-reported health outcomes,⁷³ it follows that such care would lend itself to more equitable patient outcomes. More comprehensive primary care is associated with greater equity, including reduced disparities in disease severity as a result of earlier detection and prevention across different populations.⁷⁴ Data also suggest that behavioral health integration into primary care — an important component of comprehensiveness — may help reduce mental health disparities for Latinos/x.⁷⁵ A consensus report by national experts based on current literature concluded that the improvement of behavioral health and physical health outcomes and the elimination of disparities for racial and ethnic minority populations can best be addressed by the integration of behavioral health and primary care services.⁷⁶

Embedding care for more common mental health problems like depression and anxiety into primary care helps address many of the barriers in access to mental health care experienced by Black and Latino/x individuals, including stigma around mental health care, mistrust, location, and transportation.

► **Whole-person orientation** is conceptually related to comprehensiveness. Both terms convey providing care for the whole person, across their body systems, needs, and comorbid conditions. Patients from racial and ethnic minority groups and other historically marginalized populations are more likely to have complex comorbid conditions and higher rates of behavioral health and other social needs.⁷⁷ Primary care generalists — when functioning in a way that is consistent with their generalist training — specialize in providing care for the whole person.⁷⁸ Elements of accountable whole-person care, including clinician knowledge of a person's overall medical history, preferences, and family and cultural orientation, have been associated with improved patient self-management for chronic conditions,⁷⁹ better adherence to physicians' advice, and improvements in self-reported health status.

In addition to strong evidence that primary care advances health equity, there is a large body of research that supports the counterfactual. In the absence of high-quality primary care, people experience inequitable access to care, more fragmented care, and more costly and duplicative service use — partly from poor coordination of care across providers and settings.⁸⁰ In a multinational study, patients' perceptions of poorer care coordination was associated with higher odds of self-reported medical errors, medication errors, and laboratory errors. Patients also experienced a decline in patient-centeredness as the availability of primary care physicians declined due to inadequate support and reimbursement.⁸¹ This directly erodes trust between providers and patients and dissolves the

continuous relationships that patients so highly value. Having a generalist physician who knows them well and can care for the majority of their common needs and conditions is a critical aspect of care for everyone,⁸² in particular for individuals in historically marginalized and under-resourced communities. This continuity with a trusted primary care clinician is particularly important for people who have historically distrusted the health care system due to social injustices, receipt of lower-quality care, and challenges navigating the system.⁸³

While the evidence base suggests that primary care has tremendous potential and an important role to play in advancing health equity, it also offers important cautionary lessons.⁸⁴ Policies and incentives have made it easier for many health care systems, including primary care practices, to use one-size-fits-all approaches to care interventions and quality improvement efforts that focus on improving aggregate patient outcomes or clinical performance

measures rather than disaggregating data to identify and then eliminate inequities in access, quality of care, or outcomes. The result is improvement efforts that preferentially benefit majority populations. Additionally, policies have made it easier for health systems to create barriers that make it harder for marginalized populations to access their care — for example, legal issues for migrants and drug users.⁸⁵ Even as health plans and systems commit to improving health equity, they may find it challenging to avoid common pitfalls, such as failing to sufficiently engage patients and community voices, or focusing exclusively on implicit bias trainings and avoiding looking for and explicitly addressing social and structural drivers of health inequities, such as lack of housing or food. The literature suggests that policymakers, payers, and practitioners can help avoid these pitfalls by ensuring that primary care settings are resourced, supported, and held accountable for pursuing clear equity-focused improvement efforts.

Primary Care in the US Is Not Adequately Funded

Although early conceptualizations of health services emphasized the centrality of primary care, it has been inadequately supported in the United States. Early conceptualizations of the health services system in Great Britain in 1920 distinguished three major levels of health service: (1) primary care centers, (2) secondary (specialist) centers that provided consultative care, and (3) hospitals that provided tertiary care. This framework for the organization of health services was designed to respond to levels of need for health care services in the population, and provided the basis for the reorganization of health services in many countries.⁸⁶ In 1966, the Millis Commission report on medical careers that were required to care for a society noted that each person should have a primary care physician.⁸⁷ Later, the International Conference on Primary Health Care in Alma-Ata, USSR, in 1978 and then the Global Conference on Primary Health Care in Astana, Kazakhstan, in 2018 emphasized primary health care as essential to equity and central to an organized health care delivery system that was the main focus of the overall social and economic development of the community.⁸⁸ World leaders envisaged robust community-level responsibility for planning and implementing primary and preventive health care services. Acknowledging the “social roots of illness,” they had a vision for intersectoral, rights-based approaches to improve health care

and, equally important, a host of other social determinants of health, extending far beyond the walls of clinical care. Community health workers were considered a powerful linchpin in advancing this vision of health.⁸⁹ Yet, in the United States, primary care services are shifting from local communities to become more centralized and consolidated under increasingly powerful hospital systems.⁹⁰ In addition, fee-for-service reimbursement rates are heavily influenced by hospitals, specialists, and medical imaging and device manufacturers.⁹¹ Fewer medical students pursue primary care than specialist careers because of lower compensation for primary care, which makes it economically unfeasible for them to cover their burgeoning medical student debt, which was \$250,000 on average in 2022.⁹²

Further compounding inadequate support for primary care, the US spends much less on primary care and more on specialty care, including procedural services, compared to other industrialized democracies.⁹³ Despite primary care accounting for 35% of US health care visits, primary care accounts for only 5.4% of health care expenditures in the United States.⁹⁴ Growth in the number of procedural specialists, combined with financial disincentives to pursue primary care, results in both fewer primary care physicians and a maldistribution of primary care clinicians.⁹⁵ This limits access to primary care, particularly for marginalized populations.

Primary Care and Public Health Integration

In theory, public health and primary care are natural partners and collaborators due to their shared goals of improving population health and preventing disease and disability. Achieving these goals requires understanding individuals in the context of their communities and environment.⁹⁶ Integrating health care and public health services has been an aim of transformation efforts for many years, with better coordination and collaboration seen as important pathways to improving population health.⁹⁷

However, the reality of integration is challenging for many reasons. The most frequently cited reason is that both public health and primary care are chronically underfunded, a situation that many observers feel has worsened, particularly for public health, in recent years. Public health and primary care lack the infrastructure, personnel, and time needed to support the intentional development — and the long-term maintenance — of the good working relationships that are crucial to successful integration. In addition, addressing the social determinants of health is fundamental to both primary care and public health, yet neither has the resources or influence to adequately address the social vulnerabilities suffered by so many.

Over the past century in the United States, public health and primary care have developed distinct cultures and professional identities, with different models of training and professional preparation, and often little opportunity for cross-professional instruction and the sharing of knowledge and approaches. Absent intentional and sustainable efforts to bridge the two cultures during education and training, and in the absence of clearly identified processes for collaborating, it can be daunting for individuals in both fields to find the time and support to engage in productive partnerships, even with the best of intentions.

These were the circumstances prior to the COVID-19 pandemic. The continuing crisis of the pandemic has laid bare significant fault lines in our public health and primary care systems, and in the integration of the two.⁹⁸

Pandemic planning and preparation were inadequate (or ignored), despite repeated warnings and lessons learned from recent epidemics in other places. In addition, efforts to wring inefficiencies out of the public health and health care systems have resulted in limited or no surge capacity in many systems and settings. The United States was initially unable to manufacture, procure, and equitably provide appropriate personal protective equipment and supplies for health care workers, patients, and the population at large. Early testing for the virus was delayed and inadequate, and contact tracing efforts were hindered by the effects of prior cuts to public health infrastructure and personnel, which have also hampered vaccine distribution efforts.

In addition, during the pandemic many primary care practices experienced significant new stress, often struggling to keep their practices alive financially while continuing to do their best to provide high-quality clinical care and address patients' pandemic-related needs.⁹⁹ As one example of the disconnect between primary care and public health, many primary care providers were uniquely well-situated to reach their socially vulnerable patients with actual vaccines and with information and guidance for the vaccine-hesitant. However, they lacked information from and connections with their local public health departments and were not included in vaccination planning at the national, state, or regional level.

The pandemic has also drawn back the curtain, in a dramatic and profound way, on the systemic health inequities that have devastated communities of color. Preexisting disparities in health status left these communities more vulnerable to exposure to the virus, to infection, to more severe illness, and to the long-term consequences of the social and economic disruptions wrought by the pandemic and our responses to it. The pandemic has demonstrated, starkly and unequivocally, that reducing health inequities must be our top priority in envisioning and building integrated public health and primary care systems.

Figure 1. Advancing Health Equity Through High-Quality Primary Care Practices



Source: Mathematica created visual aid, March 2023.

In communities across California, primary care practices differ substantially in their size, structure, and governance. They also differ substantially in how well they are resourced with necessary money, technical assistance, and workforce. Practices share people and data with numerous other entities, such as specialists, hospitals, social services, and public health departments. Each practice is surrounded by its own unique community of organizations and resources, health plans, purchasers, and other key influencers.

High-quality primary care practices strive to deliver accessible first-contact care that is also continuous, comprehensive, coordinated, and accountable for

the whole person (see Figure 1). It is not enough to simply address acute and preventive care needs; care for people with multiple, complex chronic conditions is at the heart of high-quality primary care.

To advance health equity, primary care needs to be adequately resourced and supported by other entities in its immediate community. Access barriers such as health insurance coverage and benefit design, transportation, and language issues need to be addressed. In turn, primary care practices need to wisely invest the additional resources in people and services with the explicit intention of advancing health equity.

A Radical Reimagining of California Primary Care to Advance Health Equity

Without universal access to high-quality primary care, California will struggle to improve the health of its population and to reduce disparities. But primary care in the United States has been under-resourced for decades, resulting in a depleted workforce struggling to deliver care in a weakened infrastructure. As a result, health indicators across the state have slipped, and troubling disparities persist. Investments in primary care have declined over the past decade, both in California and nationally, putting many primary care practices into crisis. To turn course, California needs a focused effort to strengthen primary care. Ensuring that equity is at the center of this effort will require a paradigm shift in our thinking and our actions.

This section explores the authors' vision for this paradigm shift; the following section and Appendix A provides example recommendations that policymakers and regulators, purchasers and payers, health system leaders, and primary care providers and teams can use to advance primary care and health equity.

A Paradigm Shift to Ensure Efforts to Strengthen Primary Care Prioritize Equity

Recognize high-quality primary care as a common good.

California should adopt the framing of the National Academies of Sciences, Engineering, and Medicine (NASEM) that “high-quality primary care is not a commodity service whose value needs to be demonstrated in a competitive marketplace but

a common good promoted by responsible public policy and supported by private-sector action.”¹⁰⁰ State government/policymakers, purchasers, health plans, and others that command resource-allocation decisions should invest resources (including money, staffing, and technical assistance) to strengthen the primary care infrastructure and adopt payment models and incentives that support high-quality primary care with the ultimate goal of improving population health, reducing disparities, improving worker productivity, and decreasing total cost of care statewide.¹⁰¹

Embrace the diversity of primary care practice settings, and invest resources according to need with the intentional goal of reducing health and social inequities.

California should recognize the diversity of primary care settings in which high-quality primary care can be delivered and provide support according to need. Variations in primary care settings can impact available resources such as staffing, electronic health record capabilities, and even patient services, so the necessary resources (money, staffing, and technical assistance) to strengthen primary care will differ depending on the type of practice and the community context. This commitment is particularly important because populations at the highest risk for health disparities — for example, Black and American Indian and Alaska Native (AIAN) populations — are more likely to live in communities that have weak primary care infrastructure (as measured by PCP density) and face access barriers related to insurance or transportation. State government/policymakers, purchasers, health plans, and others that command resource-allocation decisions should ensure that their quality and performance improvement programs include historically marginalized practices (e.g., small practices, rural health care providers) and support programs that require and reward disparity reduction (not simply aggregate improvement).

Proactively apply principles of equity and justice to all decisions.

Advancing equity in all sectors, including health care, requires attention to economic and political power (as determinants of health¹⁰²) and community and personal empowerment (as a critical process¹⁰³). Ultimately, efforts to reduce disparities will require efforts to address social risk factors such as lack of housing, transportation, education, job opportunities, income, neighborhood safety, access to nutritious foods, opportunities for physical activity, and access to primary care,¹⁰⁴ as well as to confront and uproot structural determinants of health inequities, including structural racism. Embracing equity in health policy requires that policy decisions be informed by those affected by that policy, including groups that are often marginalized from political, social, and economic opportunities, such as those with lived experience of poverty, people with mental illness or substance use disorders, people with

disabilities, and children. Lastly, for primary care to maximize its impact on health equity, patients, families, and caregivers need to be involved in care delivery and quality improvement efforts.

Build accountability for action.

Progress will happen only if we hold our systems, ourselves, and each other accountable. The NASEM report quoted above recommends creating a new federal leadership council and an annual scorecard to ensure progress in the implementation of high-quality primary care across the nation.¹⁰⁵ A similar structure is needed in California to guide the strengthening of and sustain accountability for high-quality primary care as an essential contributor to advancing health equity in the state. The authors view a statewide primary care equity action forum as the vehicle needed in California to propel progress in this work. See the accompanying box for more information.

Convening a Primary Care Equity Action Forum

The National Academies of Sciences, Engineering, and Medicine’s 2021 consensus study report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, is a compelling call to develop and expand collaboration across sectors and silos to establish an overarching vision and leadership for primary care nationally. This is a call to action and innovation in California as well; as a state, we are poised to lead the nation in this work. A new type of entity and a new approach are needed to facilitate the desired paradigm shift, identify specific action steps, and engage existing and previously unrepresented groups to work together to advance health equity through the strengthening of primary care.

The authors view a statewide primary care equity action forum as the vehicle needed in California to propel progress in this work. The forum would address the policy topics of primary care spending, payment models, workforce, innovative delivery models, information technology, and metrics and accountability, among others, to forge a collaborative plan of action. All forum activities would keep health equity — including issues of language, trust, maldistribution of resources, and other barriers to and facilitators of equitable care — at the forefront and as the primary goal. The forum could also provide an ongoing opportunity for primary care and health equity leaders across the state to collectively review and make sense of reports, evidence, and scorecards, and use them as the basis for new policy recommendations.

The Virginia Task Force on Primary Care

The Virginia Task Force on Primary Care, originally developed in response to the COVID-19 pandemic, is one model of a statewide body designed to foster collaboration, action, and accountability to improve primary care. Staffed by the Virginia Center for Health Innovation, the task force brings together primary care clinicians, health plan representatives, patient advocates, employers, and state government to strengthen primary care for all people in the state.

Example Recommendations for California to Strengthen Primary Care and Advance Health Equity

To guide future planning, the authors offer a set of example recommendations for how to advance primary care and health equity within the state. Progress will require action from multiple actors, working individually and in collaboration, including policymakers and regulators, purchasers and payers, health system leaders, and primary care providers and teams. The authors offer their own recommendations, as well as recommendations drawn from other sources.¹⁰⁶ The list is not exhaustive; rather, these examples are offered as a starting point for planning. Refinement and prioritization of a more exhaustive list of recommendations is necessary, but was beyond the scope of this report.

1. Involve people with lived experiences of discrimination in primary care policymaking and governance bodies to identify impediments to health equity and generate solutions.
2. Expand and scale pipeline programs to recruit, prepare, and mentor students from historically and systematically excluded communities and backgrounds for careers in primary care.
3. Hire and mentor team members from and within the community, to better reflect the community's racial and ethnic composition within the practice. Incorporate the lived experiences of staff into training for care delivery to encourage empathy and bring cultural context to interactions with patients.
4. Support whole-person care through behavioral health and primary care integration across all practice settings, and strengthen training for primary care providers on behavioral health (including substance use disorder treatment) and wellness.
5. Promote equitable access to telehealth by improving broadband access, infrastructure, payment models, provider readiness, and patient engagement, especially for rural and safety-net communities.
6. Strengthen access to and quality of language assistance services, including providing qualified interpreters; translated documents in understandable, plain language in at least all Medi-Cal threshold languages; and a notice of the right to language assistance services to all patients.
7. Provide an option for primary care continuity after hours and on weekends.
8. Ask patients about their needs and in what areas they want help. Use validated screening tools to identify social determinants of health-related social needs, and, when possible, prescribe services and activities that are tailored to the individual's needs (e.g., financial support, food access, trauma-informed counseling, or a walking group).
9. Increase the overall proportion of health care spending that is directed toward primary care, establishing spending targets for public and private payers.
10. Increase Medi-Cal physician payment levels in order to incentivize service delivery to Californians with low incomes.

11. Implement and encourage participation in equity-focused alternative payment models that enable integration of social services, public health, and community partnerships into clinical practice.
12. Carefully collect accurate, self-identified electronic health record data on race and ethnicity, sexual orientation, gender identity, language proficiency, and disability as an important first step to providing whole-person, equitable care and improving provider-patient concordance for diverse Californians.
13. Incorporate measures on equity and social needs in data collection for clinical, quality improvement, and research purposes. Collect and stratify data on social needs to identify and document health inequities.
14. Use quality improvement approaches to identify and analyze root causes of identified inequities in the clinical setting.

To help readers understand the policy context for these recommendations, the authors have provided for each recommendation a few illustrative examples of relevant policies and programs in California, as well as options to further progress. These are presented in Appendix A.

Conclusion

California is the most populous and racially diverse state in the nation. While over 90% of Californians have health insurance, millions do not have access to affordable, high-quality primary care. This report explores the unique role of primary care in the health care system and outlines the large body of evidence demonstrating its essential contribution to advancing health equity. It goes further by calling for a paradigm shift – in both our thinking and our actions -- that includes: (1) recognizing primary care as a common good, (2) embracing the diversity of primary care practice settings and investing resources according to need with the intentional goal of eliminating health and social inequities, (3) proactively applying principles of equity and justice to all decisions, and (4) building accountability for action.

To advance health equity, primary care practices need to be adequately resourced and supported by other entities in their immediate community. A variety of primary care influencers can take equity-focused actions today to strengthen primary care in five key policy arenas outlined in this report, including community engagement; workforce education and training; clinical practice transformation; payment and spending; and data collection, measurement, and reporting. Going forward, California can ensure meaningful statewide progress by establishing a primary care equity action forum that would build new partnerships and provide leadership and accountability for this important work.

Appendix A. Policy Context for Example Recommendations and Options to Advance Progress

In Table A1, the authors have sorted 14 example recommendations into five key arenas for action: (1) community engagement; (2) workforce education and training; (3) clinical practice transformation; (4) payment and spending; and (5) data collection, measurement, and reporting. To help readers understand the policy context for these recommendations, the authors have provided a few illustrative existing policies and programs in California, as well as some examples of potential options for consideration to further advance progress.

Table A1. Policy Context for Example Recommendations and Options to Advance Progress

EXAMPLE RECOMMENDATION	SELECTED EXAMPLES OF RELEVANT POLICIES AND PROGRESS IN CALIFORNIA	OPTIONS TO ADVANCE PROGRESS
Community engagement		
Involve people with lived experiences of discrimination in primary care policymaking and governance bodies to identify impediments to health equity and generate solutions.	<ul style="list-style-type: none"> ▶ In 2022, the California Department of Health Care Services (DHCS) created a Medi-Cal Consumer Advisory Committee in recognition of the need to address structural racism and to provide an active voice for communities and individuals that have been historically marginalized in informing and designing DHCS's programs. Recruitment is underway. 	<ul style="list-style-type: none"> ▶ Identify and implement opportunities to add people with lived experience of discrimination to additional primary care policy-making, advisory, and governance bodies, such as the new Office of Health Care Affordability (OHCA). ▶ Require health care organizations with governing bodies, including health plans, to include patients in governance, not only in advisory capacities. ▶ In its rollout of CCO 2.0, the Oregon Health Authority implemented policies to strengthen Community Advisory Council (CAC) and Community Care Organization (CCO) partnerships by requiring CCOs to have two CAC representatives, one of whom is an Oregon Health Plan consumer, on the CCO board.

Workforce education and training

Expand and scale pipeline programs to recruit, prepare, and mentor students from historically and systematically excluded communities and backgrounds for careers in primary care.

- ▶ The 2022–23 Governor’s Budget included a one-time [\\$1.7 billion investment](#) over three years in care economy workforce development — across agencies — that will create opportunities to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, wages, and health equity outcomes. Programs include a focus on community health workers; training and career advancement for people with barriers to employment, particularly from disadvantaged communities; and vocational pathways for English language learners.
- ▶ The California Department of Health Care Access and Information (HCAI) expanded its pipeline programs in 2022, including the following actions:
 - ▶ It launched the Health Professions Pathways Program, in support of and alignment with the [California Future Health Workforce Commission](#) recommendations 1.1 and 1.2, and awarded \$40.7 million to 20 organizations to develop and implement pipeline programs.
 - ▶ It awarded \$600,000 through its [Health Professions Careers Opportunity Program](#).
 - ▶ It launched the new [Health Workforce Education and Training Council](#). This public body, established in statute, has begun examining ways to build a pipeline to increase health workforce diversity.
- ▶ The 2021–22 Governor’s Budget allocated \$10.5 million in one-time support to pilot the [California Medicine Scholars Program](#), providing resources for a regional pipeline to prepare community college students for careers as primary care physicians in underserved communities.

- ▶ Scale successful programs such as the [University of California Programs in Medical Education \(UC PRIME\)](#), making them the standard instead of a specialty program.
- ▶ Develop and support pathway programs for all degreed health care positions (e.g., nursing, advanced practice nursing, physician assistant) modeled after successful physician pathway programs (such as the California Medical Scholars Program or UC PRIME).
- ▶ Support summer enrichment programs, academic career advising programs, mentoring, research opportunities, and exam preparation, in both high schools and community colleges as well as for those pursuing advanced degrees (such as the [UC Postbaccalaureate Consortium](#)), particularly in underserved communities.
- ▶ Support tuition waivers, room-and-board stipends, and paid internships for economically disadvantaged students.
- ▶ Invest in and increase linkages across programs and educational levels, such as the [Associate Degree for Transfer \(ADT\)](#) and [Community Health Scholars](#).
- ▶ Financially incentivize nursing and medical schools to create formal mentoring programs and other initiatives to diversify their faculties and student bodies.
- ▶ Invest in pathway programs for ancillary health workers to transition into the nursing and medical professions.
- ▶ Provide support for ongoing research and evaluation of pathway programs to inform workforce development strategies.

Hire and mentor team members from and within the community, to better reflect the community’s racial and ethnic composition within the practice. Incorporate the lived experiences of staff into training for care delivery to encourage empathy and bring cultural context to interactions with patients.

- ▶ DHCS added [Community Health Worker \(CHW\) services as a Medi-Cal benefit](#) starting July 1, 2022, after receiving CMS approval for State Plan Amendment (SPA) 22-0001. Providers who work with CHWs and *promotores* (CHW/Ps) and meet the requirements outlined in the recently published Medi-Cal Provider Manual for the CHW benefit will be able to bill Medi-Cal for those services.
- ▶ Governor Gavin Newsom allocated \$1.8 million to HCAI to increase the supply of CHW/Ps in California by creating a CHW/P certification process and support for CHW/P training programs. HCAI is in the process of implementing this funding via a stakeholder-led process.

- ▶ Support health systems and managed care plans in understanding and leveraging the new CHW/P Medi-Cal benefits and how to [engage, support, and use CHW/Ps](#) effectively; and increase knowledge and reduce confusion surrounding how CHW/Ps, doulas, and behavioral health coaches intersect with one another in the context of Medi-Cal and primary care.
- ▶ Expand access to resources to improve community engagement and partnerships between primary care providers and trusted community leaders, including CHW/Ps, faith-based groups, and neighborhood coalitions. Examples of resources include [A Toolkit to Advance Racial Health Equity in Primary Care Improvement](#) and the [Engaging People with Lived Experiences Toolkit](#).
- ▶ Payers could expand reimbursement for peer-based staff, such as patient navigators and CHWs, to include those who share characteristics with groups that experience health inequities. Examples are available from the Center for Health Care Strategies ([toolkit](#)) and the Rural Health Information Hub ([toolkit](#)).

Clinical practice transformation

Support whole-person care through behavioral health and primary care integration across all practice settings, and strengthen training for primary care providers on behavioral health (including substance use disorder treatment) and wellness.

- ▶ CalAIM, California’s Medi-Cal redesign effort, includes several enhancements for [behavioral health integration](#), for example:
 - ▶ A “no wrong door” policy to ensure beneficiaries receive mental health services regardless of the delivery system from which they seek care (county behavioral health, Medi-Cal managed care plan, or the fee-for-service delivery system).
 - ▶ A [Population Health Management Initiative](#) to establish a comprehensive, accountable plan of action for addressing member needs and preferences across the continuum of care, providing care management and coordination across delivery systems, and linking public health and social services.
- ▶ HCAI offers several grant programs to help increase behavioral health training in primary care and social service settings. Examples include the following:
 - ▶ A Community-Based Organization (CBO) Behavioral Health Workforce Grant Program to recruit and retain behavioral health personnel.
 - ▶ A Peer Personnel Training and Placement Program to support individuals with lived experience as a mental/behavioral health services consumer, family member, or caregiver.
 - ▶ Psychiatric Education Capacity Expansion grants to increase the number of psychiatric/mental health nurse practitioners.
 - ▶ A Train New Trainers Primary Care Psychiatry Fellowship to support providers who wish to receive advanced training in primary care psychiatry.
- ▶ California payment and policy changes, as well as clinical and lay leadership, allowed for the rapid and widespread rollout of [medication-assisted treatment \(MAT\)](#) for opioid disorders in primary care settings.

- ▶ Measure and evaluate access and outcomes by race and ethnicity to make disparities visible.
- ▶ Increase cross-training opportunities in primary care and behavioral health education to improve integration and collaboration and reduce stigma.
- ▶ Move away from traditional fee-for-service payments to payments for behavioral health and primary care integration, linking to quality and value instead. Promising models include the following:
 - ▶ [Massachusetts](#) ties ACO payment to health-related social needs screening and many behavioral health quality measures, such as depression remission or response, emergency department (ED) visits for individuals with mental illness, and initiation and engagement of alcohol or other drug abuse or dependence treatment.
 - ▶ [Pennsylvania’s](#) Office of Mental Health and Substance Abuse Services created its own Value-Based Purchasing (VBP) Program.
- ▶ Make Medi-Cal reforms, including the CalAIM framework, more flexible to allow for the addition of [community-defined evidence practices \(CDEPs\)](#) to the suite of outpatient behavioral health services available to people of color and LGBTQ Medi-Cal consumers.
- ▶ Strengthen health information exchanges (HIEs), including supporting county behavioral health participation in regional HIEs.
- ▶ Explore universal consent agreements across all levels and sectors of care.

Promote equitable access to telehealth by improving broadband access, infrastructure, payment models, provider readiness, and patient engagement, especially for rural and safety-net communities.

- ▶ In 2021, DHCS convened the [Telehealth Advisory Workgroup](#) to increase access and equity and reduce disparities in the Medi-Cal program.
- ▶ DHCS has continued and expanded many of the [telehealth policies](#) from the COVID-19 public health emergency.
- ▶ Currently, California is one of a few states to commit to reimbursing a broad array of services at parity when delivered via audio-only visits (i.e., telephone calls).
- ▶ HCAI, through the [California State Office of Rural Health](#), provides technical assistance to rural health organizations, including promotion of telehealth resources.
- ▶ Governor Newsom made a historic investment of over \$6 billion in California’s [broadband infrastructure](#) in 2021. It will take time for the law and changes to take effect.

- ▶ Research the impact of telehealth on access, quality, equity, and cost from both patient, provider, and payer perspectives.
- ▶ Identify and address disparities in access by demographics, geography, and service type.

EXAMPLE RECOMMENDATION	SELECTED EXAMPLES OF RELEVANT POLICIES AND PROGRESS IN CALIFORNIA	OPTIONS TO ADVANCE PROGRESS
<p>Strengthen access to and quality of language assistance services, including providing qualified interpreters; translated documents in understandable, plain language in at least all Medi-Cal threshold languages; and a notice of the right to language assistance services to all patients.</p>	<ul style="list-style-type: none"> ▶ SB 853: The Health Care Language Assistance Act, was the first of its kind in the nation, holding health plans accountable for the provision of language services. Despite substantial progress made because of this law, advocates indicate that there is still a need to strengthen enforcement and accountability. ▶ An evaluation of the state’s Medical Interpreter Pilot Program (MIPP) is underway to help inform expansion strategies for interpreter training programs. 	<ul style="list-style-type: none"> ▶ Expand high-quality medical interpreter training programs to develop sufficient workforce and strengthen access to language services. ▶ Reduce wait times and improve responsiveness of Medi-Cal managed care plan language lines for providers that don’t have on-site capacity for interpretation in a specific language. ▶ Incentivize practices to build their own capabilities for language interpretation, and allow for billing and reimbursement for staff interpretation.
<p>Provide an option for primary care continuity after hours and on weekends.</p>	<ul style="list-style-type: none"> ▶ Many FQHCs, for example, Tiburcio Vasquez Health Center, provide Saturday clinics using regular staff to maintain continuity at the team level. ▶ Some independent practice associations (IPAs), like Allied Pacific, have helped connect small practices to each other in neighborhoods to build the after-hours coverage network and define the collective standards for care. 	<ul style="list-style-type: none"> ▶ Provide incentive payments for after-hours care, or deem after-hours care critical infrastructure and incorporate it in value-based payments.
<p>Ask patients about their needs and in what areas they want help. Use validated screening tools to identify social determinants of health and social needs, and, when possible, prescribe services and activities that are tailored to the individual’s needs (e.g., financial support, food access, trauma-informed counseling, or a walking group).</p>	<ul style="list-style-type: none"> ▶ In 2024, Covered California will add a Social Needs Screening and Intervention (SNS-E) measure to its required stratified measure list for qualified health plans. ▶ The DHCS Population Health Management Initiative will require insurers to identify health-related social needs. 	<ul style="list-style-type: none"> ▶ Purchasers and payers can incentivize or require attainment of Joint Commission accreditation for eligible entities, which requires health care organizations to screen all patients for social needs. ▶ Expand guidance and resources to help primary care practices pursue social needs screening and referral interventions, linking them to quality and equity goals.

Payment and spending

Increase the overall proportion of health care spending that is directed toward primary care, establishing spending targets for public and private payers.

- ▶ California’s major public purchasers, which participate on the [Primary Care Investment Coordinating Group of California \(PICG\)](#), have committed to measuring and reporting primary care spending and to considering setting a target or floor for increased spending. Specifically, contracts adopted by [Covered California](#) (for 2023), DHCS (for 2024), and CalPERS (for HMO in 2024) require contracted plans to do the following:
 - ▶ Report on total primary care spending and percentage of spending within each [Health Care Payment Learning & Action Network Alternative Payment Model \(HCPLAN APM\)](#) category. Additionally, DHCS will require contracted plans to stratify the reporting of primary care spending as a percentage of total spending by age and by race/ethnicity.
 - ▶ Report on the number and percentage of contracted primary care clinicians paid using the HCPLAN APM framework categories and subcategories
 - ▶ Analyze the relationship between the percentage of spending for primary care services with performance of the overall delivery system.
 - ▶ The California Quality Collaborative and the Integrated Healthcare Association have convened a coalition of large commercial health care payers to coordinate on primary care measurement and reporting, payment, investment, and practice transformation with the goal of strengthening primary care and improving practice-level performance. The [memorandum of understanding](#) includes commitment to setting a primary care investment target.
 - ▶ California’s [Office of Health Care Affordability \(OHCA\)](#), housed in the Department of Health Care Access and Information, is charged with measuring and reporting on primary care spending as a share of total health care expenditures and with setting a benchmark for primary care spending. While OHCA has not released a timeline for data collection on primary care spending, it is anticipated that data will be included in the first annual report, to be released in mid-2027 — implying data collection not later than 2026 for calendar year 2025.
 - ▶ The Pacific Business Group on Health created the [Health Value Index](#), a set of key performance indicators that reflects the priorities of its large-employer and public-purchaser members in communicating with contracted health plans. The focused measure set includes primary care spending as a percentage of the total cost of care.
 - ▶ Other examples of California initiatives focusing on primary care can be found on the California Health Care Foundation website under Primary Care Matters, [Current Efforts](#).
- ▶ The new Office of Health Care Affordability (OHCA) should consider enforcement mechanisms to support primary care spending thresholds, once established.
 - ▶ The OHCA should consider whether Medi-Cal should have a discrete target for primary care investment that reflects the needs of Medi-Cal members and serving providers, reflects the structure of the Medi-Cal benefit package, and addresses historic under-investments in Medicaid payments to providers.
 - ▶ Consider opportunities to employ global budget and total costs of care (TCOC) payment models to help increase the proportion of health care spending directed to primary care.

EXAMPLE RECOMMENDATION	SELECTED EXAMPLES OF RELEVANT POLICIES AND PROGRESS IN CALIFORNIA	OPTIONS TO ADVANCE PROGRESS
Increase Medi-Cal physician payment levels in order to incentivize service delivery to Californians with low incomes.	<ul style="list-style-type: none"> ▶ In 2016, voters passed Proposition 56. The majority of these funds were released for provider and supplemental payments to physicians. However, these funds are declining. ▶ As a condition of enhanced federal funding for the Providing Access and Transforming Health (PATH) Initiative, CMS has required California to increase and (at least) sustain Medi-Cal fee-for-service provider base payment rates and Medi-Cal managed care payment rates in primary care, behavioral health, and obstetrics care by closing the gap between Medicaid and Medicare rates by at least 2 percentage points, should the state’s average Medicaid-to-Medicare provider rate ratio be below 80% in any of these categories, effective January 1, 2024. Similar Medicare-Medicaid primary care payment parity policies are already in effect in Arizona, Oregon, and Massachusetts. 	<ul style="list-style-type: none"> ▶ All payers should review their payment rates and consider whether current rates are sufficient to support high-quality primary care for diverse populations, including populations with a high burden of social needs that impact health.
Implement and encourage participation in equity-focused alternative payment models that enable integration of social services, public health, and community partnerships into clinical practice.	<ul style="list-style-type: none"> ▶ CalAIM will enable Medi-Cal managed care plans to couple clinical care with a range of new nonmedical services. These services, which will be reimbursed by Medi-Cal, include housing supports, medical respite, personal care, medically tailored meals, and peer supports. CalAIM will also require plans to coordinate access to services provided by counties and community-based organizations. ▶ Some California FQHCs and other primary care providers have leveraged alternative payment models to enable the integration of social services and community partnerships with primary care. For example, AltaMed Health Services created an IPA to take on risk for primary care patients and better coordinate primary care, specialty care, and hospital use for its patients. ▶ In 2024, DHCS will launch an alternative payment model program for FQHCs. This FQHC APM program will translate the current encounter-based reimbursement system into a prospective, capitated, per-member per-month payment and remove current restrictions on billable provider types and sites of service. These changes will enable participating FQHCs to more fully and sustainably integrate behavioral health, social services, and community partnerships. 	<ul style="list-style-type: none"> ▶ Identify and adopt best strategies used in other states or national programs to reduce and eliminate disparities in health and health care by aligning payment reform and quality improvement efforts. For example, Advancing Health Equity: Leading Care, Payment, and Systems Transformation is a national program supported by the Robert Wood Johnson Foundation; it consists of teams composed of government leaders, insurers, and care providers from 12 states (seven in the first cohort in 2018, with an additional five teams joining in 2023). ▶ Large health systems could invest their reserves in community health, for example: <ul style="list-style-type: none"> ▶ UCSF launched a Community Investment Program supporting housing and minority-owned small businesses to augment its Anchor Institution Initiative. ▶ Kaiser Permanente has made it an explicit goal “to foster health and equity ... by addressing the root causes of health, such as economic opportunity, affordable housing, health and wellness in schools, and a healthy environment,” increasing its investment in community health programs. ▶ Consider opportunities to employ global budgets to enable integrated models of health and social care. Examples include the following: <ul style="list-style-type: none"> ▶ The Pennsylvania Rural Health Model, which provides rural hospitals with an annual global budget based on patient volume, revenue, and services instead of payment for each service provided, and enables support for food access, transportation, or health literacy. ▶ The Community Health Access and Rural Transformation (CHART) Model, also designed specifically for rural communities. ▶ Provide incentives and support for participation in APMs, especially for independent primary care practices that serve Medi-Cal enrollees. ▶ See additional national recommendations from the Health Care Payment Learning & Action Network (HCPLAN).

Data collection, measurement, and reporting

Carefully collect accurate, self-identified electronic health record data on race and ethnicity, sexual orientation, gender identity, language proficiency, and disability as an important first step to providing whole-person, equitable care and improving provider-patient concordance for diverse Californians.

- ▶ The California Health and Human Services Agency has developed a statewide [data exchange framework](#) that will require health care entities to share health information including demographic data, race/ethnicity, ancestry, language, sexual orientation, gender identity, and disability data by 2024.
- ▶ Covered California’s [equity and disparity reduction plan](#) contractually requires qualified health plans to collect demographic data, specifically race and ethnicity, and language preference. In 2023, Covered California implemented [financial penalties](#) tied to disparities reduction.
- ▶ The California Association of Public Hospitals and Health Systems (CAPH) saw large increases in hospital system ability to collect and report REaL (race, ethnicity, and language), sexual orientation, and gender identity data through financial incentives in the [Public Hospital Redesign and Incentives in Medi-Cal \(PRIME\) program](#). Some systems were even able to leap from zero collection to almost 100% REaL data percentages in five years.

- ▶ Increase training and incentives for health programs and providers to collect REaL (race, ethnicity, and language) and SOGI (sexual orientation and gender identity) data.
- ▶ Update race/ethnicity data fields to more specifically represent California’s population; for example, separate and create additional categories within Asian, Native Hawaiian, and Pacific Islander groupings.
- ▶ Standardize the data collected across payers and providers.
- ▶ Purchasers and plans can tie performance guarantees to equity measures. For example, [JPMorgan and Kaiser Permanente](#) plan to roll out performance guarantees tied to health equity on certain quality measures for JPMorgan employees beginning in 2023.

Incorporate measures on equity and social needs in data collection for clinical, quality improvement, and research purposes. Collect and stratify data on social needs to identify and document health inequities.

- ▶ DHCS has expanded provision of community supports to help address identified social needs using [Community Supports](#). Through its Comprehensive Quality Strategy and Population Health Management (PHM) Initiative, DHCS is working toward requiring Medi-Cal managed care plans to have a PHM strategy that includes the collection of social determinants of health data and to increase data collection for social needs and inclusion of social needs data in the risk stratification process.
- ▶ The National Committee for Quality Assurance (NCQA) and Covered California are requiring select measures, deemed to be highly correlated with equity, to be reported stratified by race and ethnicity starting in 2022. The measures are colorectal cancer screening, controlling high blood pressure, diabetes HbA1c control, and childhood immunization status (combo 10).

- ▶ Support California providers to improve data collection, stratification, and analysis. Assistance and support should be made available statewide and through existing regional and local networks and HIEs to ensure that primary care data collection efforts are part of broader infrastructure development efforts to strengthen clinical, public health, and social sector data sharing.
- ▶ The National Quality Forum (NQF) convened a multistakeholder group, the [Measure Applications Partnership \(MAP\)](#), to provide consensus-based recommendations for the selection and removal of measures from federal quality and performance programs. NCQA is expanding the race and ethnicity stratification to eight HEDIS measures in measurement year 2023, bringing the total number of stratified measures to 13. Other large-scale health or accreditation programs could emulate this work by requiring that select measures be reported stratified by race and ethnicity or other demographic variables.

EXAMPLE RECOMMENDATION	SELECTED EXAMPLES OF RELEVANT POLICIES AND PROGRESS IN CALIFORNIA	OPTIONS TO ADVANCE PROGRESS
<p>Use quality improvement approaches to identify and analyze root causes of identified inequities in the clinical setting.</p>	<ul style="list-style-type: none"> ▶ A growing number of medical schools and health professional training programs are teaching “structural competency,” which builds on existing cultural competency and cultural humility training efforts to situate an understanding of social determinants of health in a structural context. By helping the next generation of clinicians understand how unjust social structures lead to harm and inequities, this approach can help inform and improve quality improvement approaches that attempt to address root causes of health inequities and poor outcomes. ▶ Equity and Quality at Independent Practices in LA County (EQuIP LA) is a two-year quality improvement collaborative for small, independent primary care practices and IPAs serving Medi-Cal enrollees of color in Los Angeles County. The program is a joint project of Purchaser Business Group on Health’s California Quality Collaborative, the California Health Care Foundation, Community Partners, Health Net, and L.A. Care Health Plan. ▶ Additional resources on this topic include the following: <ul style="list-style-type: none"> ▶ A Toolkit to Advance Racial Health Equity in Primary Care Improvement, which includes tips and recommendations for implementing upstream, equity-focused quality improvement approaches. ▶ The California Improvement Network curates a collection of tools, insights, and strategies to center equity into clinical quality improvement efforts in primary care. ▶ In Spring 2023, the American Medical Association will publish freely accessible, online continuing education modules to help clinicians and caregivers develop core competencies and skills in upstream quality improvement as well as structural competency. 	<ul style="list-style-type: none"> ▶ California plans, providers, and policymakers can accelerate efforts to translate existing resources into action by supporting regional and local networks of clinical providers to embed equity in primary care–based quality improvement efforts. ▶ California plans, providers, and policymakers can implement the standards and recommendations from national organizations. For example: <ul style="list-style-type: none"> ▶ NCQA has developed Health Equity Accreditation and Health Equity Accreditation Plus programs. NCQA also adopted new disparities reduction and health equity requirements, including standards for completion of REaL data in HEDIS, into other recognition and certification programs, including the Patient-Centered Medical Home (PCMH) Recognition program and Population Health Program Accreditation. ▶ In 2022, the Joint Commission published new requirements to reduce health care disparities. ▶ California policymakers, training organizations, and funders can expand training and technical assistance opportunities to help quality improvement leaders in primary care and health plans develop structural competency to strengthen quality improvement efforts.

Notes: ACO is accountable care organization. *CalAIM* is California Advancing and Innovating Medi-Cal. *CalPERS* is California Public Employees’ Retirement System. *CMS* is Centers for Medicare & Medicaid Services. *FQHC* is Federally Qualified Health Center. *HEDIS* is Healthcare Effectiveness Data and Information Set. *HMO* is health maintenance organization. *LGBTQ* is lesbian, gay, bisexual, transgender, and questioning and/or queer.

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