Primary Care Systems & Innovation

MOREHOUSE SCHOOL OF MEDICINE | NCPC National Center for Primary Care

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PRIMARY CARE:
A Key Lever to Advance Health Equity

ABSTRACT

Introduction

This report examines the relationship between health equity and primary care. It identifies concrete, practice- and policy-level actions that primary care stakeholders can pursue to reduce inequities and take steps toward achieving health equity.

Background

In the U.S., life expectancy, a marker of overall health, has remained relatively flat at about 79 years for the general population between 2010 and 2018. Unfortunately, lower life expectancies persist for people of color, indigenous people, rural communities, and individuals facing socioeconomic challenges. The COVID-19 pandemic had a disproportionate impact on these same populations, further exacerbating these longstanding inequities in health and life expectancy.

Healthcare leaders and policymakers increasingly acknowledge health inequities and the importance of focusing on their root causes: systemic racism and discrimination, social and economic drivers, health behaviors, and built environments. For populations experiencing health inequities, high-quality primary care can offer a usual source of care and provide access to needed services like chronic disease management, vaccinations, and preventive services and screenings to improve their health.

Opportunities

More can be done to leverage primary care to advance health equity. At its core, primary care is about building trust and relationships, two key ingredients to mitigating the social and structural drivers of inequities. Primary care practices can connect patients to available sources of health insurance, use telehealth and other digital health interventions to enhance access, provide culturally and linguistically appropriate care, utilize an expanded care team and community assets to address unmet social needs, and engage the community in practice- and system-level decision-making.

To fully leverage this opportunity will require changing both how we pay for primary care and how much is invested in primary care. Related policy levers include maintaining and expanding the primary care safety net, incorporating equity and social needs in data collection, quality assessment and measurement, transforming primary care's fee-for-service payment paradigm, adapting telehealth flexibilities to reduce inequities, and monitoring implementation.

Conclusion

Inequities have deep roots in our broader society, and neither primary care nor the broader healthcare system can provide the only solution to overcoming barriers that prevent healthy outcomes. However, primary care does play a vital role in ensuring population health and equity by providing whole-person care, advocating for polices to accelerate practice transformation, and partnering with sectors outside of clinical medicine like social programs.

- Inequities have deep roots in the broader society
- Primary Care nor Health Systems can be only solutions
- Primary Care is a Key Lever/Health Equity and plays a vital role in:
  - Ensuring population health & equity thru whole-person care
  - Advocating for policies to accelerate practice transformation
  - Partnering with sectors outside of medicine (ex: social programs)

What are the unintended adverse effects on innovation?

AMA
AMERICAN MEDICAL ASSOCIATION

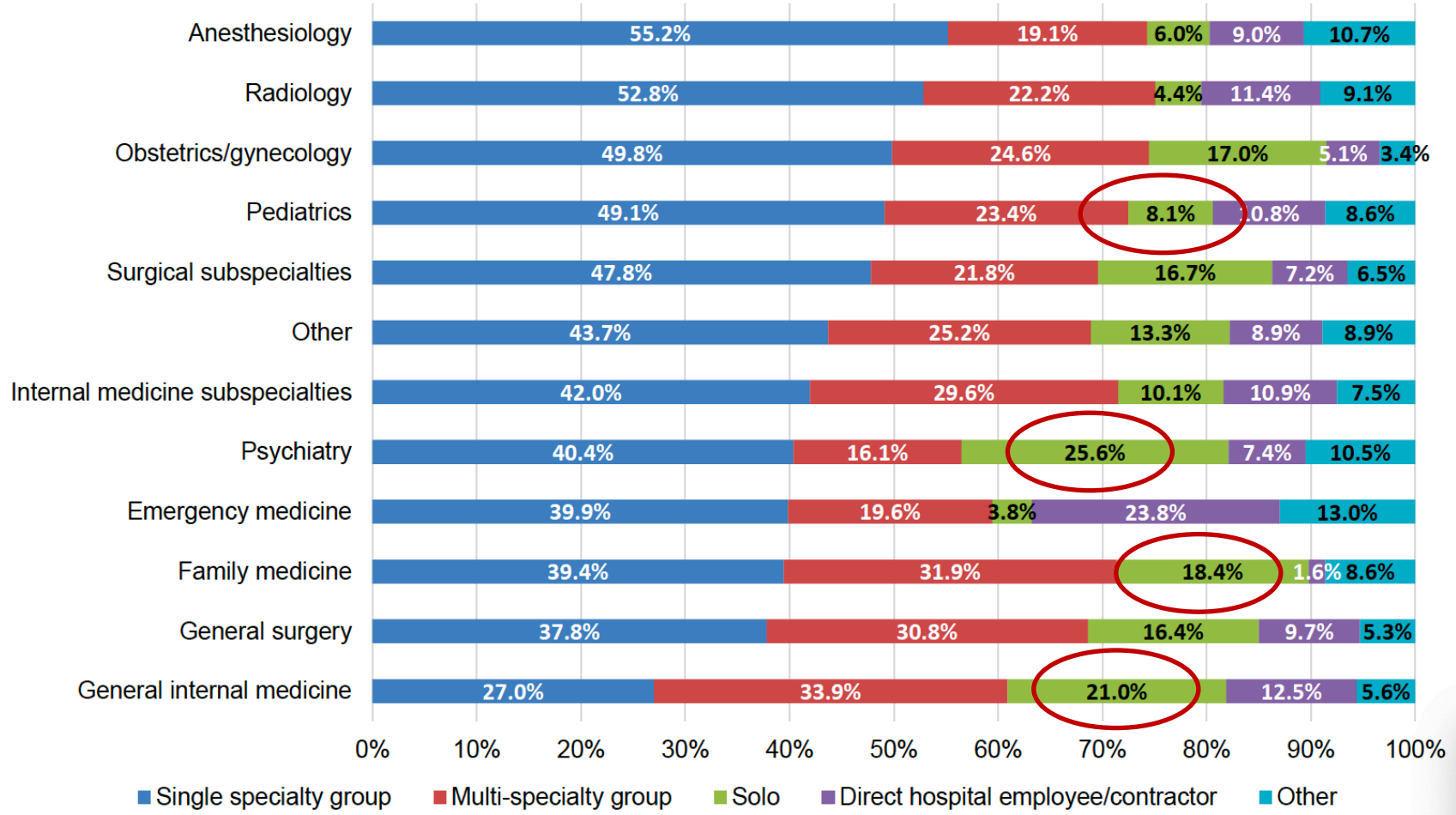
May 2021

Policy Research Perspectives

Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020

By Carol K. Kane, PhD

Exhibit 4: Distribution of physicians by practice type: specialty-level estimates (2020)



Source: Author's analysis of AMA 2020 Physician Practice Benchmark Survey

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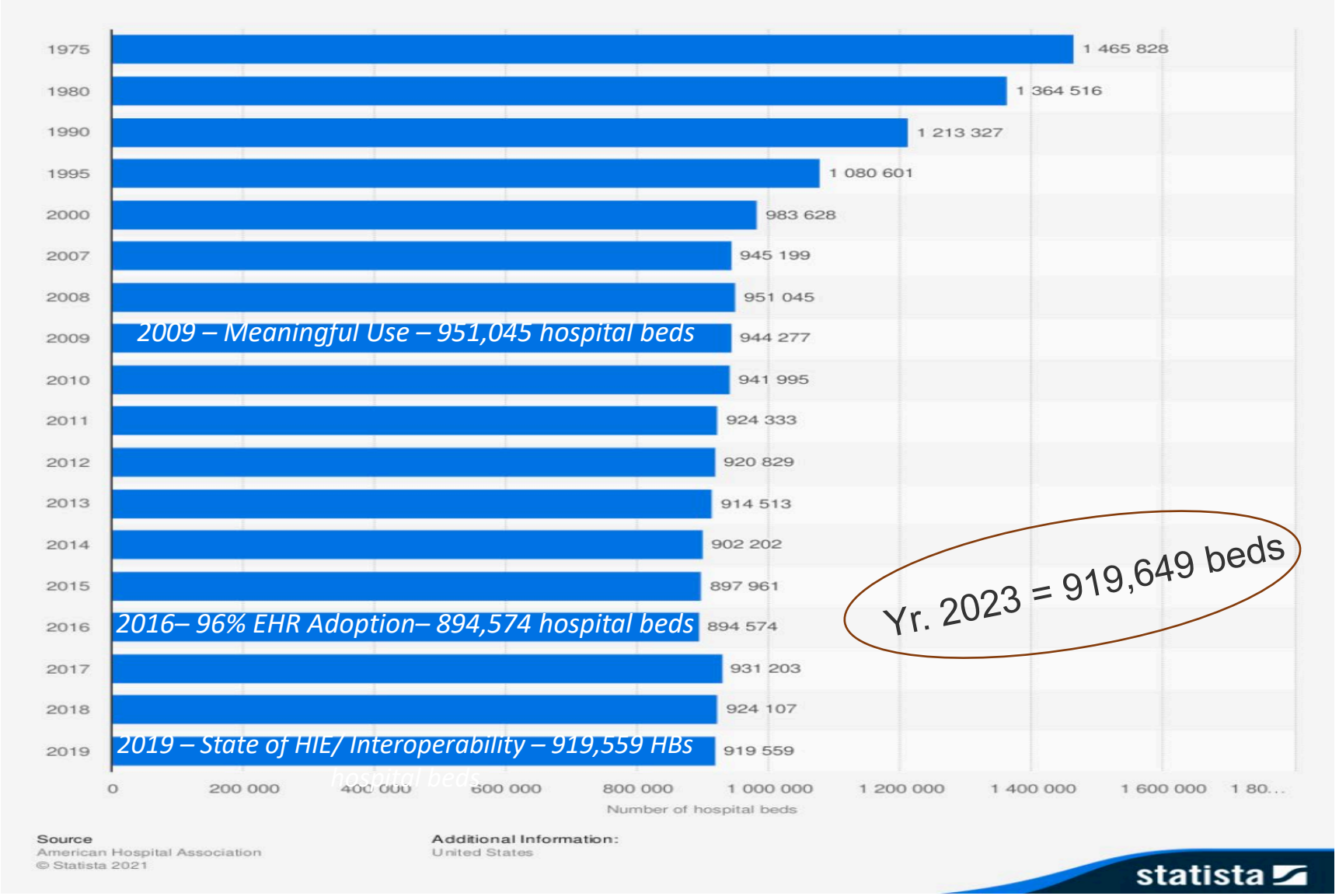
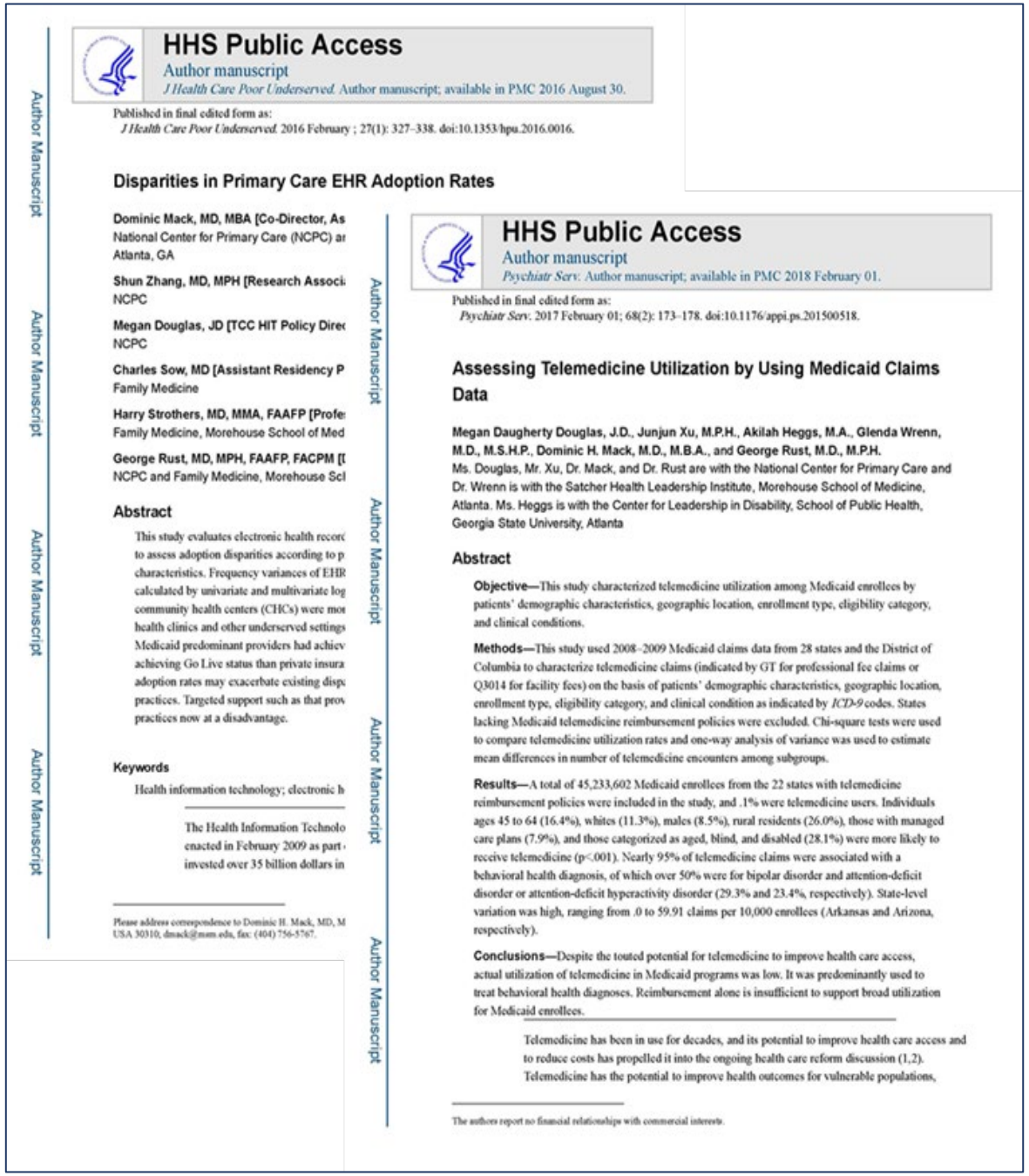
Nearly 70% of U.S. physicians are employed by hospitals or corporate entities

The acquisition of private physician practices across the U.S. accelerated after the onset of the pandemic.

US Hospital Beds 1975 – 2019 (American Hospital Association)



Digital health tools have tremendous potential to aid in the elimination of health disparities, but only if they are in the hands of the front-line clinicians serving underserved communities.



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Disparities in Primary Care EHR Adoption Rates

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Abstract

This study evaluates electronic health record
to assess adoption disparities according to p
characteristics. Frequency variances of EHR
calculated by univariate and multivariate log
community health centers (CHCs) were mor
health clinics and other underserved settings
Medicaid predominant providers had achiev
achieving Go Live status than private insura
adoption rates may exacerbate existing disp
practices. Targeted support such as that prov
practices now at a disadvantage.

Keywords

Health information technology; electronic h

The Health Information Technolo
enacted in February 2009 as part
invested over 35 billion dollars in

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Assessing Telemedicine Utilization by Using Medicaid Claims Data

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Abstract

Objective—This study characterized telemedicine utilization among Medicaid enrollees by patients' demographic characteristics, geographic location, enrollment type, eligibility category, and clinical conditions.

Methods—This study used 2008–2009 Medicaid claims data from 28 states and the District of Columbia to characterize telemedicine claims (indicated by GT for professional fee claims or Q3014 for facility fees) on the basis of patients' demographic characteristics, geographic location, enrollment type, eligibility category, and clinical condition as indicated by *ICD-9* codes. States lacking Medicaid telemedicine reimbursement policies were excluded. Chi-square tests were used to compare telemedicine utilization rates and one-way analysis of variance was used to estimate mean differences in number of telemedicine encounters among subgroups.

Results—A total of 45,233,602 Medicaid enrollees from the 22 states with telemedicine reimbursement policies were included in the study, and .1% were telemedicine users. Individuals ages 45 to 64 (16.4%), whites (11.3%), males (8.5%), rural residents (26.0%), those with managed care plans (7.9%), and those categorized as aged, blind, and disabled (28.1%) were more likely to receive telemedicine ($p<.001$). Nearly 95% of telemedicine claims were associated with a behavioral health diagnosis, of which over 50% were for bipolar disorder and attention-deficit disorder or attention-deficit hyperactivity disorder (29.3% and 23.4%, respectively). State-level variation was high, ranging from .0 to 59.91 claims per 10,000 enrollees (Arkansas and Arizona, respectively).

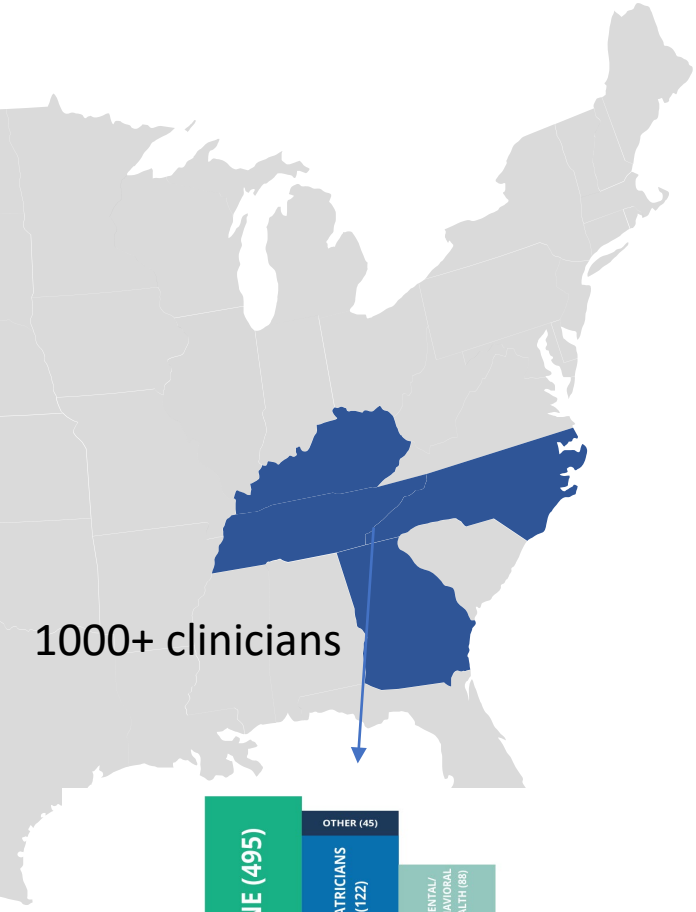
Conclusions—Despite the touted potential for telemedicine to improve health care access, actual utilization of telemedicine in Medicaid programs was low. It was predominantly used to treat behavioral health diagnoses. Reimbursement alone is insufficient to support broad utilization for Medicaid enrollees.

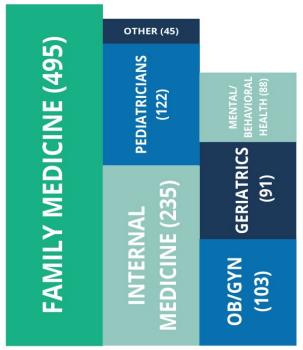
Telemedicine has been in use for decades, and its potential to improve health care access and to reduce costs has propelled it into the ongoing health care reform discussion (1,2). Telemedicine has the potential to improve health outcomes for vulnerable populations,

The authors report no financial relationships with commercial interests.

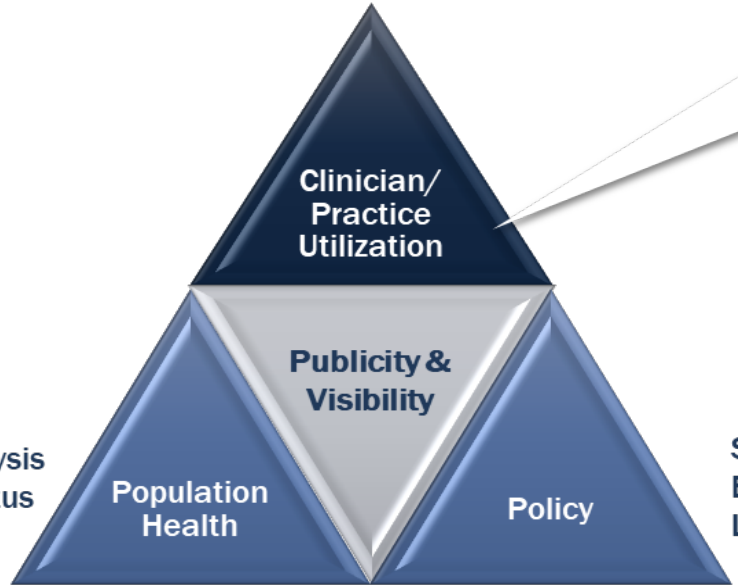
"Advancing Equity Through Primary Care and Digital Health Tools"

Digital Health Tools Study





Clinician Surveys
Focus Groups
Key Informant Interviews



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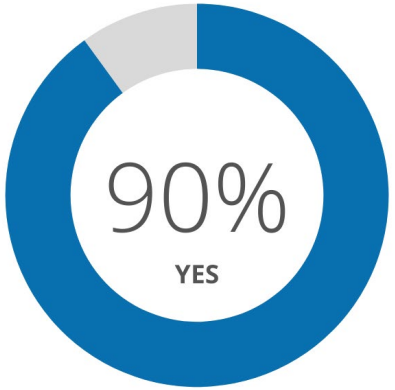
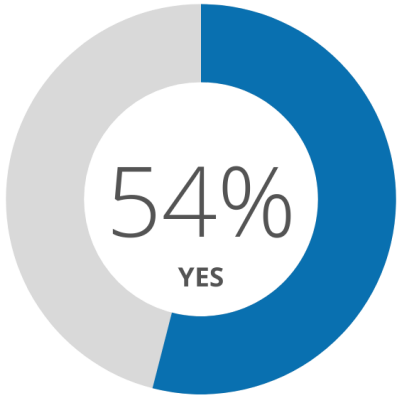
Advancing Equity Through Primary Care and Digital Health Tools

Question: Have you used digital health tools because of the COVID-19 pandemic?

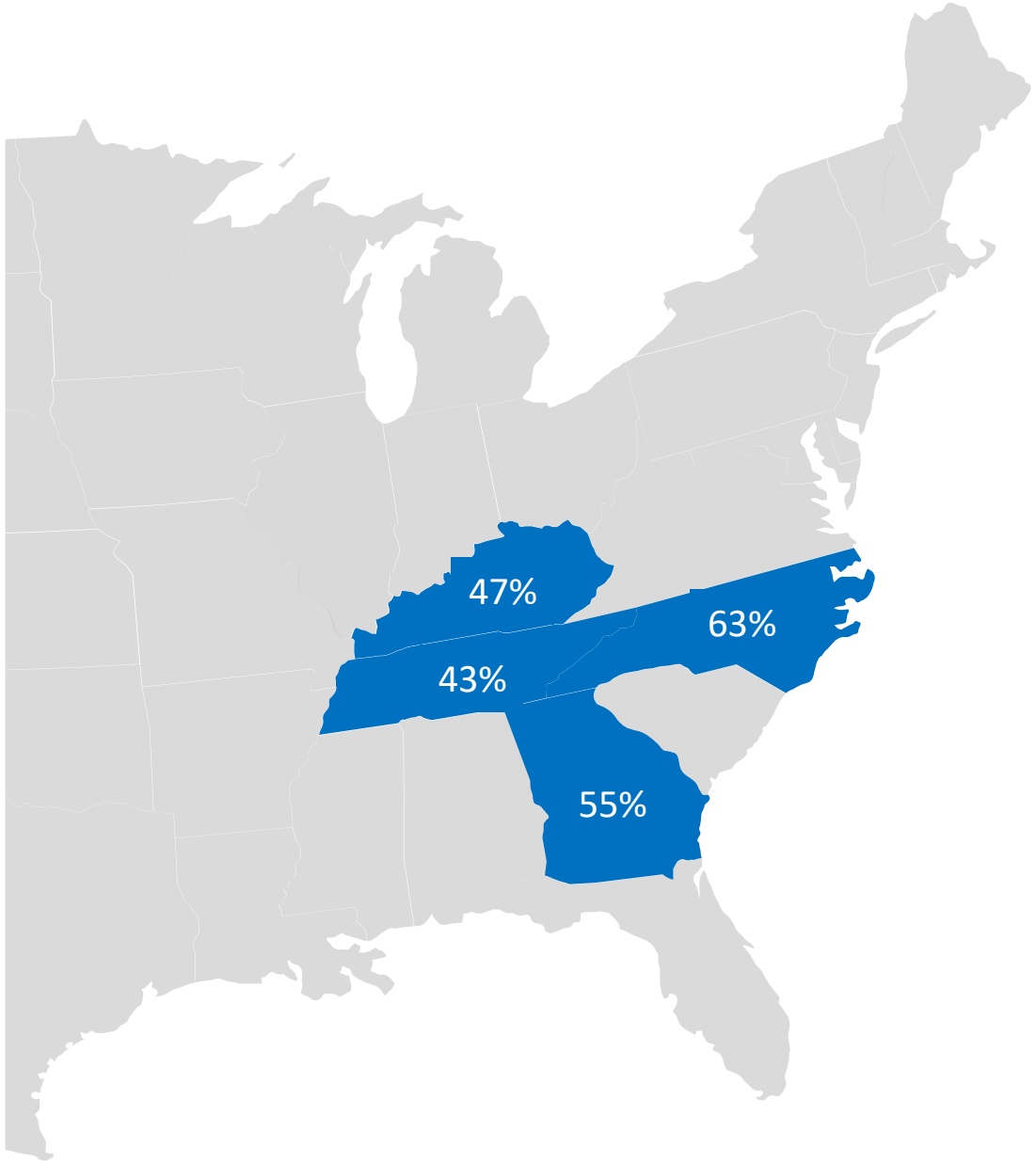


n = 936

Question: If you are providing telehealth services during the COVID-19 pandemic, was this your first use of telehealth in your practice?



n = 632



FOCUS GROUPS

"We're doing a lot of phone visits…because of…where we live, bandwidth and internet connectivity, there's been some painful appointments both via video and on phone. But when it works, it works very well. Patients are very receptive to it. It eliminates a barrier to access services, especially a transportation barrier, which is very heavy in our community. So I think patients are really loving that.

[I]t's very frustrating to not be able to access records within my own system. And I don't feel like anyone listens when I bring that up or maybe they do and it's just not possible. I don't know.

Health Equity Implications

1

COVID-19 policy changes improved access to telehealth for disproportionately impacted

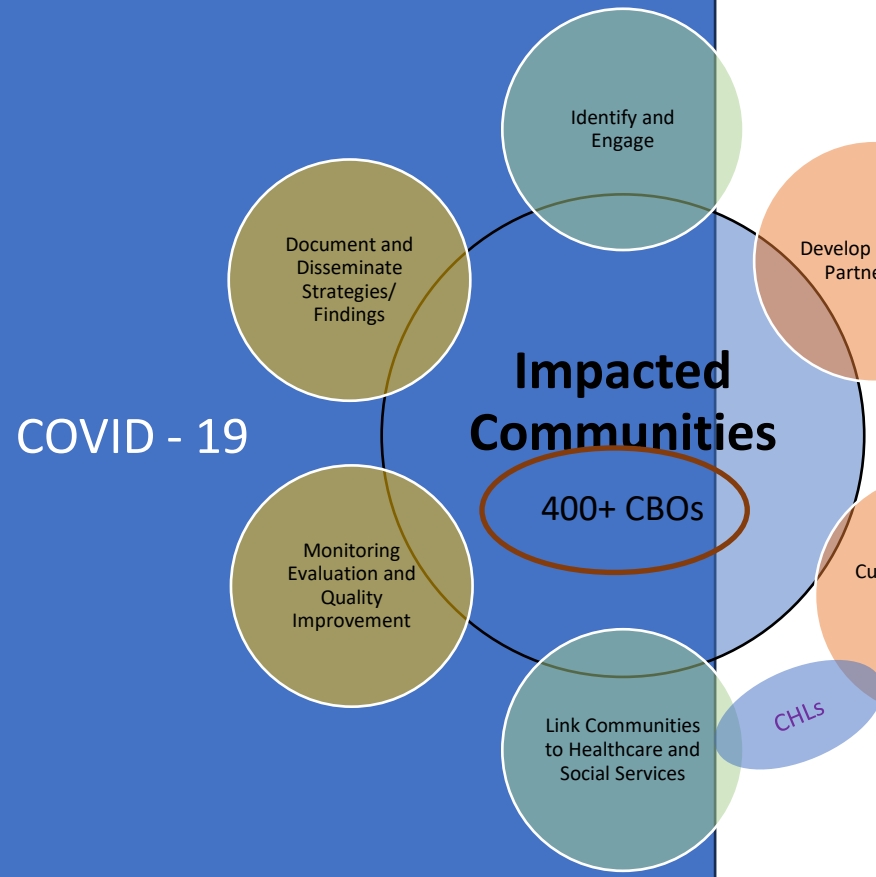
2

Value-based payment models rely on use of DHTs, but evidence of disparity reduction is limited

3

The digital divide continues among *consumers and clinicians* in rural and underserved communities

Dissemination Platform Transitional Framework



Post COVID Environment

- Post COVID Conditions
- Pandemic/Disaster Planning
- Chronic Disease & Prevention
- Behavioral Health Challenges
- Artificial Intelligence Impact
- Scientific Studies – Health Equity
- Funding Resources
- Leadership Opportunities for Commuinities

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Article

Disaster Preparedness and Equitable Care during Pandemics

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