Promoting Health Equity through Primary Care Innovation in Medicaid Managed Care

July 20, 2021, 3:00-4:00 pm ET

Part of CHCS’ Strengthening Primary Care through Medicaid Managed Care learning series.

Made possible through support from The Commonwealth Fund.
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
A nonprofit policy center dedicated to improving the health of low-income Americans
This webinar is part of our series **Strengthening Primary Care through Medicaid Managed Care**.

The series, made possible by The Commonwealth Fund, will examine the tools and levers that states can use to advance comprehensive primary care strategies.

For information on future webinars and resources in this series, as well as the resource **Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States**, please visit [www.chcs.org/primary-care-innovation](http://www.chcs.org/primary-care-innovation).
Core Features of Advanced Primary Care and Levers to Drive Uptake and Spread

- Enhance Team-Based Care
- Use Technology to Improve Access
- Integrate Behavioral Health Care
- Identify and Address Social Needs
- Promote Health Equity
- Move to Value-Based Payment in Primary Care
- Monitor Primary Care Spending and Investment
- Promote Accountability for MCOs
Today’s Learning Objectives

- Learn about a new module in the *Advancing Primary Care Innovation in Medicaid Managed Care* toolkit: **Promote Health Equity**
- Understand how state Medicaid programs can use their managed care programs to advance health equity
- Understand how primary care providers can promote health equity and racial justice
Agenda

- Introductions
- Promote Health Equity: Advancing Primary Care Innovation in Medicaid Managed Care
- Leveraging Managed Care to Advance Health Equity: Michigan’s Approach
- Incorporating Racial Justice Into Primary Care: Southern Jamaica Plain Health Center’s Equity Journey
- Moderated Q&A
Welcome & Introductions
Today’s Presenters

Laurie Zephyrin, MD  
Vice President,  
Health System Equity  
The Commonwealth Fund

Shilpa Patel, PhD  
Associate Director, Health Equity  
Center for Health Care Strategies

Kate Massey, MPA  
Senior Deputy Director, Medical Services Administration  
Michigan Department of Health and Human Services

Thomas Kieffer, MPH  
Executive Director  
Southern Jamaica Plain Health Center

Juan Jaime de Zengotita, MD  
Medical Director  
Southern Jamaica Plain Health Center

Diana Crumley, JD, MPA  
Senior Program Officer  
Center for Health Care Strategies
Opening Comments

Laurie Zephyrin, MD
Vice President, Health System Equity
The Commonwealth Fund
Advancing Health Equity

Laurie Zephyrin, M.D., M.P.H., M.B.A.
Vice President, Advancing Health Systems Equity
The Commonwealth Fund

July 20, 2021
Promoting Health Equity through Primary Care Innovation in Medicaid Managed Care Webinar

The Commonwealth Fund
Evidence shows that high-quality primary health care is associated with...

- Improved Health Outcomes
- Decreased Health Disparities
- Reduced Health Care Costs

Sources:
Primary health care with these key attributes can reduce fragmentation
Primary health care is a key piece of the puzzle

- High-Quality, Comprehensive Primary Health Care
- Eliminating Systemic Racism
- Advancing Health Equity
- Ensuring Universal Coverage
- Promoting Health Equity in payment models
ADVANCING HEALTH EQUITY PROGRAM

Antiracism in Health Care Delivery Systems

Using Policy to Bring About Equitable Access

Changing Culture, Beliefs, and Attitudes
Strategies for Delivery System Change

- Promote economic and educational opportunities and affordable health care access for the workforce
- Reduce provider bias
- Actively investing in and engaging with community partners
- Increase knowledge about the impact of racism on health and health care, and have practical, actionable tools
- Improve training of professionals and staff
- Identify & correcting racially-biased health care algorithms
- Communicate values including commitments to equity, racial justice and inclusion
- Disaggregate data on outcomes, experience and quality
- Diversify health care workforce at leadership levels

**Identifying & correcting racially-biased health care algorithms**

**Communicate values including commitments to equity, racial justice and inclusion**

**Disaggregate data on outcomes, experience and quality**

**Diversify health care workforce at leadership levels**

**Improve training of professionals and staff**

**Actively investing in and engaging with community partners**

**Increase knowledge about the impact of racism on health and health care, and have practical, actionable tools**

**Reduce provider bias**
Strategies for Policy Change

- Analyze policies for health equity impact
- Incorporate equity in value-based care arrangements
- Address residential segregation impacts on hospital quality and hospital closures
- Report disaggregated data on outcomes, experience and quality
- Increase affordability and availability of health coverage
- Advance equity through workforce policy, licensure, and certification
- Promote health equity via managed care
- Improve payment parity in Medicaid
WHAT SHOULD CHANGE

• Use policy and program levers
• Promote systemic change and antiracism in health policy and payment models
• Center community-based solutions

WHAT ACTION & IMPACT

↑ State and Federal legislators enact policies that address systemic inequities
↑ States and communities have resources to implement changes in policy, programs, and practice
↑ Spread and scale of promising/proven equity-centered models of care

• Promote institutional change through new models of care in delivery systems
• Health care delivery systems should achieve measurable progress towards equity
• Disseminate resources on how systemic racism manifests in health care systems

↑ Health system leaders, payers pursue antiracism practices
↑ Spread and scale of promising/proven equity-centered models of care
↑ Health care organizations performance measurement and QI focus explicitly on equity
Contact

Laurie Zephyrin, M.D., M.P.H., M.B.A.
Vice President, Advancing Health System Equity
The Commonwealth Fund

Lz@cmwf.org
@LaurieZephyrin
Promote Health Equity: Advancing Primary Care Innovation in Medicaid Managed Care

Shilpa Patel, PhD
For implementation considerations, state examples, and sample managed care contract language, access the toolkit at: www.chcs.org/primary-care-innovation.
Health Equity and Medicaid

- **Health Equity** = the absence of unfair, avoidable, or remediable differences in health among social groups.

- Medicaid is uniquely situated to advance health equity:
  - Covers roughly 1/3 of Black, Latino, and American Indian and Alaska Native people in the U.S.
  - Covers 10 million people with disabilities
  - Care delivery to low-income individuals
  - History of related initiatives (e.g., member engagement requirements, culturally-sensitive care, addressing social needs)
Primary Care and Health Equity

- Primary care creates a natural opportunity to promote health equity
  - Common and consistent touchpoint to the health care system
  - Opportunity to address a variety of needs, including social needs and behavioral health needs
  - Primary care transformation efforts provide opportunities to integrate explicit health equity goals and standards
  - Evidence shows that health disparities can be mitigated through access to high quality primary care

- Inequities in access to primary care persist for many historically under-resourced communities
Focus of the New Equity Module

Primary Care Innovation
- Health-related social needs
- Behavioral health integration
- Team-based care
- Technology

Health Equity
- Reduce racial and ethnic disparities

Medicaid Managed Care
- Contracts and RFPs
- Accountability
Partner with communities to design more equitable primary care

Define state goals relating to health equity and primary care

Monitor and enhance access to primary care

Promote the collection of race, ethnicity, and language data

Integrate health equity goals into primary care transformation

Target social needs associated with health inequities

Address disparities in behavioral health treatment

Design VBP models to promote comprehensive, equitable care

Hold MCOs accountable for progress toward goals
Leveraging Managed Care to Advance Health Equity: Michigan’s Approach

Kate Massey, State Medicaid Director for Michigan
Michigan, Managed Care and Health Equity
Overview

Michigan has made deliberate changes to our Medicaid managed care contract to address health disparities, leveraging health plans, primary care provider and community-based organizations.

- **Michigan Health Equity Report:** Provides data to indicate where there are opportunities for collaboration.
- **Managed Care Contract:** Uses a portion of the capitation withhold approach to incentivize health plans to address racial disparities and improving regionally-defined performance.
- **Primary Care Partnerships:** Generates value-based purchasing agreements tied to closing health disparities.
Medicaid Health Equity Report

- Performance rates by race/ethnicity
- Tended over time (2012-2018)
- Two calculations:
  - Pairwise comparison (White reference population)
  - Index of Disparity (Each subpopulation rate compared to overall Health Plan rate)
- Year over year, African American subpopulations experience disproportionately lower quality of care than all other comparisons, including the White reference population

Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html
Medicaid Health Equity Report

Post-Partum Care
- African American rate increased from 46% in 2012 to 54% in 2018
- White reference population fluctuated between 2012 and 2018, beginning and ending around 63-64%

Chlamydia Screening
- African American rate increased from 74% to 76%
- Hispanic rate fluctuated, beginning and ending at 65%
- White reference population increased from 56% to 59%
Medicaid Health Equity Report

Lead Screening in Children
- African American rate increased from 75% in 2012 to 78% in 2018
- Hispanic rate increased from 82% to 84%
- White reference population increased from 73% in 2012 to 79% in 2018

Adult Access
- African American rate decreased from 80% to 73%
- Hispanic rate decreased from 82% to 78%
- White reference population decreased from 86% to 82%
Primary Care Partnerships

Example #1: Foundational payments plus incentives for reducing disparities
Providers receive upfront resource funding to establish programs focused on addressing specific health disparities with the opportunity to earn additional incentive payments by demonstrating year-over-year statistically significant reductions in health disparities on targeted measures.

Example #2: Shared Risk
Federally Qualified Health Centers have a withhold on all PCP claims payments with a tiered opportunity to earn based on quality benchmarks. In addition to the quality measures, providers are assigned 1-2 disparity measures with applicable races with existing disparities, in an effort to decrease their current disparity rates.

Example #3: Withhold
Health plan withholds a portion of the PMPM capitation payment. The pediatric provider has the ability to receive the withhold amount if they achieve the agreed upon quality metrics. The PCPs will have the potential to earn an additional incentive payment on two disparity measures.
Incorporating Racial Justice Into Primary Care: Southern Jamaica Plain Health Center’s Equity Journey

Juan Jaime de Zengotita, MD
Thomas Kieffer, MPH
SJPHC Equity Work: Our Journey

Juan Jaime de Zengotita, MD
Southern Jamaica Plain Health Center

Center for Health Care Strategies
July 20, 2021
Goals for Today

• Racial Justice principles and definitions
• The history of our work at SJPHC
• Adaptive Leaders program
• Racial equity and larger structures like ACO
Importance of Shared Definitions

We feel that this work cannot be done without first establishing common definitions.

Many terms are used interchangeably, but have different meanings.
Glossary Terms

Identity:
- Race, Ethnicity,
- Sexual
- Orientation,
- Gender Identity

Outcomes:
- Equity, Equality,
- Disparity,
- Inequity, Justice

Mechanisms:
- Prejudice, Bias,
- Racism,
- Misogyny,
- SDOH, Classism,

Concepts:
- Privilege,
- Oppression,
- Stereotype,
- Intersectionality
Levels of Racism

MICRO LEVEL

INTERNALIZED

INTERPERSONAL

MACRO LEVEL

INSTITUTIONAL

STRUCTURAL
Know Your Community

Asthma Emergency Department Visits

Figure 8.12 Asthma Emergency Department Visits by Age and Race/Ethnicity, 2015

* Statistically significant difference when compared to reference group
§ Rates are based on 20 or fewer cases and should be interpreted with caution.

NOTE: Bars with patterns indicate the reference group within each selected indicator.
DATA SOURCE: Acute hospital case-mix databases, Massachusetts Center for Health Information and Analysis

ED visits per 10,000 residents

0-2 3-5 6-17 18-44 45-64 65+

Asian  | Black  | Latino | White

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40
SJPHC as a Racial Justice Organization
SJP Approach and Concepts

Our Assumptions

1. Racism is a “system of advantage based on race”, David Wellman
2. Racism is structural in our country, it’s in the groundwater
3. Lead with racism explicitly, but never exclusively
4. This can’t just be an academic exercise; it is both head and heart work
5. We won’t solve this if it is merely a diversity project, “don’t mix it up, fix it up!” Rinku Sen
6. White people and people of color each have roles to play
7. Please don’t personalize the critique of systems
8. Now please make it personal
Liberation in the Exam Room: Racial Justice and Equity in Healthcare

As healthcare providers, we want the best for our patients. This includes equitable treatment and health outcomes. Good intentions are important, but how do we ensure that the impact on the patient matches our good intentions?
## Racial Justice Domains

<table>
<thead>
<tr>
<th>Knowledge of Self</th>
<th>Knowledge of Community</th>
<th>Knowledge of History</th>
<th>On the Team</th>
<th>In the Exam Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Racial Identity Development stages</td>
<td>• Key inequities in SDOH in your zip code</td>
<td>• Invest in learning the history of racism in the US and its impact on housing, jobs, education, family wealth accumulation, “structural racism”</td>
<td>• Implicit bias acknowledgement and counteraction</td>
<td>• Understand patient identities and experiences</td>
</tr>
<tr>
<td>• Race as a social construct</td>
<td>• History of communities’ relationship with medical system</td>
<td>• History of white supremacy and eugenics in medicine/research</td>
<td>• Sharing of identities within the team</td>
<td>• Build alliance with patients</td>
</tr>
<tr>
<td>• Personal areas of implicit bias</td>
<td>• Know history of racial redlining in community</td>
<td>• How racist medical practices have impacted people of color</td>
<td>• Data across patient panel – look across race/ethnicity data.</td>
<td>• Next slides for specific questions….</td>
</tr>
<tr>
<td>• Social Justice Motivational Interviewing</td>
<td>• Data by race, gender, SES, etc.</td>
<td></td>
<td>• Racial Justice PDSAs and sharing the mistakes and accomplishments.</td>
<td></td>
</tr>
<tr>
<td>• Don’t personalize the critique of systems.</td>
<td></td>
<td></td>
<td>• Explicit conversation about why the people in target groups are not responsible for the education of people in privileged group.</td>
<td></td>
</tr>
</tbody>
</table>
Questions for first visit goal is to make the IMPLICIT, EXPLICIT:

- “I don’t want to assume anything about your identities. How do you identify racially, ethnically, culturally and what are your pronouns? Have any of these identities lead to negative experiences in the health care system you would like to share with me?”
- “Many of my pts experience racism in their health care. Are there any experience you would like to share with me?”
- “Have there been any experiences that caused you to lose trust in the healthcare system?”
- “It is my job to get you. You shouldn’t have to work to get me. If I miss something important or say something that doesn’t feel right please know you can tell me immediately and I will thank you for it.”
Adaptive Leaders for Racial Justice
What is ALRJ?

- “What do we do differently in the exam room?”
- **Evolving scope of training:**
  - Four 3-hour trainings
    - History of racism in medicine and groundwater
    - White Supremacy Culture
    - Racial Justice Framing
    - Racial Justice Communication
  - Lab work
    - 2-hour morning sessions for alumni and recent grads to work projects using capsules, pushback circles, and other techniques from Racial Reconciliation and Healing. Commitments are operating in the room; this is a higher risk space and people who come are ready with projects.
  - One on one coaching
    - two hours per participant in the first pilot, we have not had the funding to continue to offer this to everyone but do offer it informally.
Adaptive Leaders for Racial Justice (ALRJ)
Outcomes on Behaviors and Relationships:

• Practitioners are more likely to name areas of bias
• Practitioners feel more comfortable discussing and utilizing their knowledge of structural racism and how it impacts client health
• Practitioners increased their knowledge of how white supremacy culture operates and can offer “antidotes”
• Practitioners expressed an increased ability to design policies from a CRT lens that include a racial equity impact assessment.
• “The model of how you do all this training is so profound because you can feel very alone out there, especially if you are the only one from your institution doing the work, but at the same time you have a way of pushing, while making it safe.”
Adaptive Leaders for Racial Justice (ALRJ)
Examples of Resulting Projects

• Racial inequity in CHF triage and readmissions (first published in AHA journal!)
• Removal of “race corrections” in GFR and beyond….
• CRT analysis integration into Quality/Patient Safety Collaborative Case Reviews: “racism in a patient safety emergency!”
  • Led to a significant increase in reporting
  • New questions being asked during incident reporting, “would we have done the same thing if the patient’s family member was white?”
• REIA application in email policy, difficult patient protocols and more….
• REIA application to policy during COVID-19: Childcare costs @MGB, tec access, payment structures during COVID, EVS RJ project
Evaluating Variations in the Population

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Statistically Significant Difference by race</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diastolic Heart Failure</td>
<td>NO</td>
<td>33% of black and latinx patients had diastolic HF v. 28% of white patients.</td>
</tr>
<tr>
<td>Elixhauser Comorbidity Score</td>
<td>NO</td>
<td>ECS was 14 for black patients, 12 for latinx, and 13 for white patients.</td>
</tr>
<tr>
<td>Admitted to Cardiology</td>
<td>Yes</td>
<td>57% of black patients and 56% of latinx were admitted to Cardiology v. 77% of white patients.</td>
</tr>
<tr>
<td>Seen in Cardiology Clinic in past year</td>
<td>Yes</td>
<td>45% of black patients and 52% of latinx were seen in Cardiology clinic v. 60% of white patients.</td>
</tr>
<tr>
<td>Average Length of Stay (ALOS)</td>
<td>No</td>
<td>Median was 5 days for both black and white patients and 4 for latinx patients.</td>
</tr>
<tr>
<td>Subsequent Admissions</td>
<td>Yes</td>
<td>34% of black and 35% of latinx patients were readmitted at least 1x v. 25% of white patients. Black and latinx patients who were readmitted were more likely to have multiple readmissions.</td>
</tr>
<tr>
<td>Age at first admission</td>
<td>Yes</td>
<td>Black patients average age was 64 and latinx was 68 v 71 for white patients.</td>
</tr>
<tr>
<td>Gender</td>
<td>Yes</td>
<td>57% of black and of latinx patients were female v. 40% of white patients.</td>
</tr>
<tr>
<td>Medicaid coverage</td>
<td>Yes</td>
<td>13% of black and 28% of latinx patients had Medicaid compared to 4% of white patients.</td>
</tr>
<tr>
<td>Boston metro resident</td>
<td>Yes</td>
<td>91% of black and 88% of latinx patients are Boston metro v. 65% of white patients.</td>
</tr>
<tr>
<td>Median income</td>
<td>Yes</td>
<td>Median income for black patients by zip code was 50K, 49K for latinx, and . 80K for white patients.</td>
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</table>

Despite no significant differences in disease or co-morbidities...

...Black and white patients show significant differences in access to inpatient setting of care and use of outpatient Cardiology. And while lengths of stay were comparable, readmissions were much higher for black patients.

There are clear racial inequities in the underlying demographics between black and white patients for nearly every attribute reviewed.
Lives Touched

• The CV Triage Project has cascaded from a committee concept, reaching trainees, multiple clinical areas within Department of Medicine, and other clinical areas.

We have not measured patient impact since there is no intervention in place, but word of mouth suggests that this has led to awareness and practice change.
### Story of a Person’s Life Changed

Dr. Joseph Loscalzo, Department Chair, Internal Medicine, Brigham and Women’s Hospital

<table>
<thead>
<tr>
<th>His Challenge</th>
<th>Our Response</th>
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</thead>
<tbody>
<tr>
<td>The data isn't strong enough - try a propensity analysis</td>
<td>Inequity persists, this is real</td>
</tr>
<tr>
<td>Would you call this “structural sexism”?</td>
<td>YES</td>
</tr>
<tr>
<td>Structural racism makes people uncomfortable and can be a conversation stopper</td>
<td>This is the honest description of the data, other institutions are calling it by its name</td>
</tr>
<tr>
<td>How do we message this?</td>
<td>With our response</td>
</tr>
<tr>
<td>Do we publish this?</td>
<td>YES</td>
</tr>
</tbody>
</table>


ACOs and a Racial Justice Approach

• We don’t have experience with this – we’re at the other end of the system, part of a large health care organization (Mass General Brigham) that plans centrally

• Critical Race Theory approach - recognize that our system is infused with structural racism – hospital organizations and modern medical education were built during Jim Crow – how does that impact the present?

• Racial Equity Impact Assessment – a useful and flexible tool

• How do ACOs set up health systems and providers to succeed in addressing racial equity – support effective race data collection; build goals, targets and incentives that reward a racial justice approach
Critical Race Theory

- Racism is embedded in society and we don’t need racists to perpetuate it
- Challenge to dominant ideology (there is belief that neutrality is even possible)
- The commitment to social justice and eradicating racism and all forms of oppression
- Centrality and intersectionality of racism
- Use of interdisciplinary perspective, all tools in the toolbox
- The importance of experiential knowledge and collective learning

- Desiree Adaway, 2018
What are Racial Equity impact assessments? A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities.
Resources

• Liberation in the Exam Room “Five pager”
• SJPHC Glossary- updated
• Race Forward trainings: https://www.raceforward.org/trainings
• SJPHC Training, now virtual https://bit.ly/33Y7CKk
• Critical Race Theory https://adawaygroup.com/critical-race-theory/
• Southern Jamaica Plain Health Center video, Racial Justice Framework https://vimeo.com/268050238/6758d8555f
• Contact us jdezengotita@bwh.harvard.edu; tkieffer@bwh.harvard.edu
Question & Answer
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