DAY 2 TRACK: HEALTH CARE DELIVERY SYSTEM TRANSFORMATION

CENTERING EQUITY IN PAYMENT AND DELIVERY REFORM

Despite a stated commitment by Medi-Cal and our public health systems to addressing health inequities, very few payment and delivery reform efforts have resulted in measurable reductions. The next chapter of health care delivery and payment reform in California offers both a significant opportunity to address disparities and potential challenges as we continue to push the envelope. Hear from consumers, state policymakers, health systems and providers about strategies and approaches to health system transformation that are centered in equity and responsive to the needs of consumers.
Thank you to our sponsors for their generous support!

**Diamond Leaders**

Anthem BlueCross

blue california

**Silver Leaders**

AmeriHealth Caritas

Kaiser Permanente

**Bronze Leaders**

California Community Foundation
L.A. Care
Health Net
NextGen Policy

**Copper Leaders**

Lucile Packard Foundation for Children’s Health
California Institute for Behavioral Health Solutions

**Equity & Justice Supporter**

Justice in Aging

**Community Partner**

The Children's Partnership
Latino Coalition for a Healthy California
Southeast Asia Resource Action Center
Vision y Compromiso

California Pan-Ethnic Health Network
Housekeeping

- All sessions will be recorded and recordings and slides will be available after the conference.
- You will be on mute. Please use the chat & Q&A features. CPEHN staff will be monitoring the chat and Q&A.
- If you need technology help:
  - Use the Zoom links on the event home page:
    - Day 1: https://zoom.us/j/97211570956?pwd=MzVNRjFtQkdyV1JZcmdkTkVFbWFUUT09
    - Day 2: https://zoom.us/j/97748180307?pwd=emFYiJNZFjOlT2k3VUM1NW92ZjU3UT09
    - Day 3: https://zoom.us/j/96150407381?pwd=dUtmRVpoOEJHTndoWG9PNnlGeERHZz09
  - Call (510) 832-1160 ext. 308
  - Post in the "Ask Organizers Anything" community board.
- At the end of the session, click "like session" under the video screen to complete an evaluation!

#VoicesForChange2021
Centering Equity

• Policies…the need for intentionality and “lens”
• Defining health…clinical v whole person
• System design…FFS v Managed Care
• Contracting…what we are paying for
• How we pay…cost/volume or VBP (and caveats)
• Workforce…identity and bias
We believe that the healthcare system should be worthy of all our family and friends and sustainably affordable.

The reality is California’s diverse population continues to face persistent and unjustifiable health inequities that result in health disparities.

Our pillars are
- Get rooted
- Get and use meaningful data & analytics
- Solicit and integrate diverse perspectives
- Reduce inequities
- Tell the/our story

We’ll partner with
- Those who are closest to the problem with lived experience and expertise
- Intermediate partners who are impacted by the problem or by the solutions
- Subject matter experts

The vision is a healthcare system where everyone has fair and just opportunities to be as healthy as possible, free from bias, racism and discrimination.
Drivers of health equity

Historical realities to contemporary health injustices

### Historical Context
- Slavery
- Colonialism
- Pseudo-Science
- Immigration Exclusion
- Mexican-American War
- Eugenics
- Indian Removal Act
- Whiteness and Wealth
- Internment

### Social Inequities
- Racism
- Heteronormativism
- Chauvinism
- Classism
- Ageism
- Ableism
- Religious Discrimination
- Sexism

### Policy
- Segregation
- Data collection and reporting standards
- Mass incarceration
- Don’t Ask/Don’t Tell
- U.S.-Mexico border wall
- Muslim Immigration Ban

### Structural / Institutional Inequities
- Colorblindness
- Communication channels
- Power distribution
- Community investment
- Hiring / promotion practices
- Healthcare access

### Living Conditions / SDoH
- Education
- Childhood poverty
- Nutrition
- Income
- Housing
- Smoking
- Food access
- Culture
- Diet
- Environmental toxins
- Language
- Physical activity

### Social Factors
- Risk Behaviors
- Health Behaviors
- Disease and Injury

### Systemic (Macro)
- Social, economic, and political context
  - Assigns social position

### Community (Meso)
- Responsive exposure, behaviors, and impact on health and wellbeing
  - Differential consequence

### Individual (Micro)
- Distribution of resources
  - Differential exposure and vulnerability

Sources: CDPH, OHE, WHO, Socioecological Model and BARHI Conceptual Framework
Health equity advances our strategy

Create a personal, high-quality experience:
Principles of health equity integrated throughout member, provider, and community initiatives for measurable impact.

Serve more people:
Harness the power of timely and actionable data to inform strategic direction to ensure relevant and appropriate services are available.

Be financially responsible:
Reduce excess cost burdens of inequities.

Be a great place to do meaningful work:
Our workforce, reflective of communities we serve, comprises purpose-driven individuals who bring wisdom and insight as their authentic selves. We have the ability and agency to embed equity principles in our work & to hold each other accountable for doing so.

Stand for what’s right:
Passionately deliver on the moral imperative to battle inequities.
Community Health Centers

**California**
1 out of 5 Californians served by community health centers

**Patients**
7.4 million

**Encounters**
24.4 million

**By Race | Ethnicity**
- **HISPANIC/LATINO**
  - 53%
- **LIMITED ENGLISH PROFICIENT**
  - 34%
- **African American**
  - 8%
- **Native American**
  - 6%
- **Asian**
  - 8%
- **White**
  - 5%
- **Unknown**
  - 21%

**860,745**
Agricultural workers

**363,485**
Persons experiencing homelessness
Today vs Tomorrow

Today
• Focus on visits
• Focus on volume
• Trying to get to outcomes but with wrong incentives

Tomorrow
• Focus is on patient experience
• Focus is on patient driven needs
• Easier to achieve outcomes when CHC can look holistically at what patients need to be healthy
Where we are today

Stars have aligned

– HHS/DHCS, CPCA, Health Plans- at the leadership level all agree we need to do this

– Impetus was COVID
  • Had we had an APM, we wouldn’t have lost so much revenue and would have had stable revenue and the necessary flexibilities to deliver care
  • Health centers got the opportunity to do virtual care which is proving to be a great delivery mechanism

– Foundation support- CHCF providing the support to help everyone prioritize the work
What is the driving force for CHC payment reform?

State
- Behavioral health access and integration
- Improve quality (as measured by HEDIS)
- Flexible care delivery
- Larger delivery reform needs CHCs because they are 1/3 of the Medi-Cal system

Plans
- Behavioral health access and integration
- Improve quality
- Flexible care delivery
- CHCs are a strong and reliable partner

CPCA
- Behavioral health access and integration
- Improve quality
- Flexible care delivery
- AND....
  - Stable payment
  - Workforce solutions
  - Stronger positioning for shared savings
  - Wellness and ease for patients
Why now?

• CHCs came of and from the Civil Rights Movement
• CHCs proved to be a tremendous model with amazing people leading the way
• PPS was instrumental in growing the CHC industry in California and delivering access and quality to millions
• But it is not the panacea - it is FFS and its limitations we feel severely
• It’s no longer just about access. It’s about equity and justice.
• The health care system and our communities demand that we lead the charge again and demonstrate how powerful the CHC model is
• This is our opportunity to create the reality we know is right
The model in 2011

Trying to secure all 3 layers

TOTAL COST OF CARE

Base Payment (PPS or APM)

Payment for Delivery System Transformation (PCMH/PCHH)

Incentive tied to Triple Aim PCHH

Incentive

Investment

Flexibility

CALIFORNIA PRIMARY CARE ASSOCIATION
The model in 2023

We have P4P, we have WPC/ECM, and we have telehealth (flexibility)

**Now we just need the APM**

- Pay for Performance/HEDIS
- Whole Person Care/Enhanced Care Management
- Alternative Payment Methodology

**TOTAL COST OF CARE**

- Base payment and flexibility
- Investment
- Incentive

**Savings finances incentives and ongoing PCHH**

**Non-Primary Care Costs of Care for Patient Population**

**Total Cost of Care Savings**
Today vs Tomorrow

<table>
<thead>
<tr>
<th>Today: Volume-based PPS</th>
<th>PPS-Equivalent Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Volume-based payment</td>
<td>• Monthly payment per member</td>
</tr>
<tr>
<td>• Face-to-face visits</td>
<td>• Some visits converted to new modes of care (phone, email, group visits)</td>
</tr>
<tr>
<td>• Billable providers</td>
<td>• Care teams (including non-billable providers)</td>
</tr>
</tbody>
</table>

Payer driven value

Consumer driven value

Visits paid

PPS

Total PMPY Revenue

APM

PMPM for FQHC services
Health Equity in the Times of COVID
Asian Health Services

• Founded in 1974 by students focused on language and cultural barriers to health care in Oakland Chinatown
• Federally qualified community health center with two pillars of service and advocacy
• Provides primary care, dental, behavioral health care to nearly 50,000 patients
• Cultural competency: 14 Asian languages, bicultural staff from communities we serve: Cantonese, Mandarin, Vietnamese, Korean, Cambodian, Mien, Hmong, Lao, Mongolian, Tagalog, Burmese, Karen, Karenni, and Thai
“Our measure of success is not only in how many patients we see, but also in how many are empowered to assert their right to health care.” -Sherry Hirota, CEO
Dual Pandemic – COVID and Racism

The Perfect Storm

Anti-Asian Attacks

Public Charge chilling effects

Chinatown restaurants closed; economic loss

AAPIs went underground

Invisible and suffering in silence
# National Asian American COVID-19 Research & Policy Team – Disparities in Case Fatality

<table>
<thead>
<tr>
<th>State/County</th>
<th>Case Fatality (Asian)</th>
<th>Case Fatality (Overall)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>8.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>13.8%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Washington</td>
<td>8.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Nevada</td>
<td>9.4%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Illinois</td>
<td>7.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Santa Clara County, CA</td>
<td>8.6%</td>
<td>5.2%</td>
</tr>
<tr>
<td>San Francisco County, CA</td>
<td>5.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Los Angeles County, CA</td>
<td>12.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Chicago, IL</td>
<td>10.5%</td>
<td>4.7%</td>
</tr>
<tr>
<td>New York City</td>
<td>17.7%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>
AHS COVID Community Survey June 2020

Asian Ethnicity of Participants (Total=1,301)

- Chinese: 1,154 (89%)
- Vietnamese: 109 (8%)
- Cambodian: 20 (2%)
- Filipino: 6 (0.5%)
- Other Asian: 12 (1%)

English proficiency:
- Not Fluent: 56%
- Fluent: 44%

Immigrant Status:
- US-born: 20%
- Foreign-born: 80%
<table>
<thead>
<tr>
<th>Question</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many have gotten tested for COVID? (n=1,304)</td>
<td>40</td>
<td>3%</td>
</tr>
<tr>
<td>How many could not find a place for COVID Testing? (n=816)</td>
<td>396</td>
<td>49%</td>
</tr>
<tr>
<td>How many have experienced discrimination/ violence due to race? (n=1,302)</td>
<td>72</td>
<td>6%</td>
</tr>
<tr>
<td>How many have lost their regular job (n=689)</td>
<td>246</td>
<td>36%</td>
</tr>
<tr>
<td>How many have had a reduction in hours, or a reduction in income (n=689)</td>
<td>173</td>
<td>25%</td>
</tr>
</tbody>
</table>
COVID Comprehensive Response for Asian Americans & Pacific Islanders

**Outreach & Education**
- Information on where and why to test
- Multiple languages
- Using ethnic media, WeChat, where communities get info
- Target high-risk groups

**Increased Testing**
- Language access
- Trusted partners brings people out
- Neighborhood/community-based

**Contact Tracing**
- Culturally and linguistically appropriate
- Bilingual/bicultural contact tracers
- Calling from CBOs, not government

**Case Mgmt & Support**
- Resources for quarantine (housing, food)
- Mental health support
- Other social needs (financial/employment, immigration)

**Vaccines**
- Language access
- Digital access
- Trusted partners brings people out
COVID Community Testing and Contact Tracing

- Established first Asian American and Pacific Islander Multi-lingual and Multi-cultural COVID community testing sites in Alameda County
- Launched first Asian American and Pacific Islander Multilingual Contact Tracing Team in Alameda County October 2020
Vaccines for our Community!
### CA Healthy Places Index leaves out important factors

<table>
<thead>
<tr>
<th>Currently In the Index</th>
<th>What’s missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Economic (poverty, median income, employed)</td>
<td>• Language access/Linguistic Isolation</td>
</tr>
<tr>
<td>• Education (higher education, high school and preschool environment)</td>
<td>• Foreign Born/Immigrant Density</td>
</tr>
<tr>
<td>• Transportation (automobile, active commuting)</td>
<td>• Cultural competence</td>
</tr>
<tr>
<td>• Social (two parent household, voting)</td>
<td>• Income to poverty ratio to account for household size</td>
</tr>
<tr>
<td>• Housing (retail, tree canopy...)</td>
<td></td>
</tr>
<tr>
<td>• Healthcare Access (insured adults)</td>
<td></td>
</tr>
<tr>
<td>• Neighborhood (alcohol availability, park access...)</td>
<td></td>
</tr>
<tr>
<td>• Clean Environment (clean air, drinking water,...)</td>
<td></td>
</tr>
</tbody>
</table>
The Challenge and Goal

To prevent being simultaneously BLAMED and OVERLOOKED for COVID19
Closing

Next Up:

- Data Office Hours, 12:30-1pm
- Check out the Virtual Exhibit Hall to connect with our sponsors
- Please click “Rate Session” to complete a quick evaluation of this session!
- Come back tomorrow for Day 3 of the CPEHN Voices for Change Conference!