CHCF

Advancing Health Equity Through Primary Care Policy

Priorities and Recommendations for California

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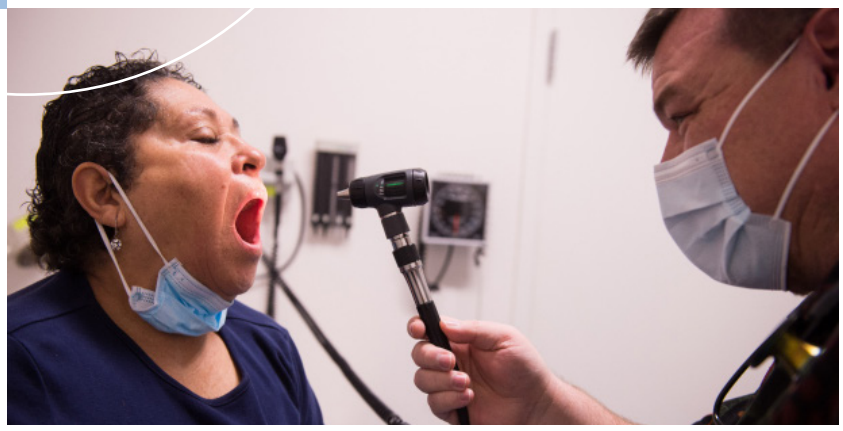

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About This Report

In fall 2023, the California Health Care Foundation and Mathematica brought together 30 experts to recommend state policies that would significantly improve access to quality primary care for all Californians, particularly those in underserved communities. This report outlines the priorities and recommendations that emerged from that process.

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About the Foundation

The California Health Care Foundation 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.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Primary Care's Unique Attributes

Primary care is the provision of health care services by clinicians who are accountable for addressing a large majority of personal health care needs, including physical, behavioral, and social needs. Ideally, these services are integrated and accessible, and are provided by primary care teams that develop sustained, trusting partnerships with patients over time.[1] 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 clinical pharmacists.

Primary care is typically the first point of health care access for a person experiencing new symptoms or concerns. Primary care includes preventive services, acute care, and ongoing management of chronic and comorbid physical and behavioral health conditions.[2] Ideally, 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, and 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 and ability to help address and mitigate the impact of local social, physical, and structural determinants of health.[3]

Introduction: Centering Equity in Primary Care

The unique attributes of primary care (see box above) 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.[4] As such, primary care is foundational to a high-functioning health care system and essential to any discussion of health equity.[5] Yet despite decades of evidence demonstrating the essential role of primary care in improving health equity, primary care is often absent in policy conversations about advancing health equity in California. Chronic inattention from state and federal policymakers and industry leaders has limited investment, resulting in a depleted workforce and weakened infrastructure. As a result, health indicators across the state have slipped, and troubling disparities persist (see box on next page).

Lagging Health Indicators

The United States spends less on primary care (about 5% of total health care spending) than other industrialized democracies. Investments in primary care have declined over the past decade, both in California and nationally, putting many primary care practices into crisis. Generations of underinvestment have resulted in access challenges, workforce shortages, and uneven quality of care. For example:

- The share of Californians experiencing difficulty in finding medical care has doubled in the past decade.[6]
- Eleven million Californians, nearly a third of the state's population, live in a federally designated Primary Care Health Professional Shortage Area (HPSA), with rural communities and minority populations disproportionately affected by the shortage. Nearly two-thirds of those who live in HPSAs identify as Latino/x, Black, or American Indian and Alaska Native, highlighting the disparate impact of workforce shortages on communities of color.[7]
- Compared to the recommended 60 to 80 primary care physicians (PCPs) per 100,000 population, rural communities in California have significantly fewer, as little as 41 PCPs per 100,000.[8]
- California ranks 44th in the nation for prevention and treatment and is among the poorest-performing states in our nation for completed preventive care, including the following: children with a preventive medical and dental visit, adults with all age- and gender-appropriate cancer screenings, and adults with diabetes who had an annual HbA1c test.[9]

Racial and social concordance between physicians and their patients leads to increased trust and greater patient satisfaction.[10] Latinos/x are the most underrepresented group in California's health workforce — most notably, in medicine.[11] While 39.5% of the population identifies as Latino/x, only 8% of physicians and surgeons in California are Latino/x.[12]

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.[13]

National and State Efforts to Strengthen Primary Care

In recent years, momentum has grown across the US to strengthen the fragile primary care infrastructure. As California continues to experience a demographic shift, there is an urgency to address long-standing health inequities and to prevent new ones from developing as a result of inaction. In 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) published a consensus study report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, which serves as a compelling call to develop and expand collaboration and provides a blueprint for increasing primary care policy leadership, action, and accountability at the federal level.[14] To demonstrate their ongoing commitment to implementation, NASEM has established a standing committee of experts in primary care delivery, research, and policy to serve an ongoing advisory role as the federal government increases its focus on strengthening primary care.[15]

As a direct result of the NASEM's leadership, the US Department of Health and Human Services (HHS) launched a new primary care initiative in 2021 and has committed to an HHS-wide approach to advancing actions to strengthen primary care.[16] The Milbank Memorial Fund has begun publishing a national Primary Care Scorecard to track progress,[17] and individual states such as Massachusetts and Virginia have followed suit with state scorecards to monitor the health of their primary care infrastructure. Meanwhile, across the US, 17 states have adopted legislation to track, report, and ultimately increase investments in primary care.[18]

California is also gaining momentum around strengthening primary care. The state has made enormous investments in primary care workforce development in recent years, and has launched a major effort, through the new Office of Health Care Affordability (OHCA), to make health care more affordable while increasing the proportion of total health care spending directed toward primary care and behavioral health.

As California embraces the charge to revitalize and invest in primary care, it is imperative to anchor the state's efforts around equity. A confluence of health and social crises in the last several years has 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 for some populations while benefiting others.[19] Within California, increased attention has focused on deep and long-standing structural health inequities for people of color; people with low incomes; people living in rural areas; people with disabilities; and people who identify as lesbian, gay, bisexual, transgender, and queer.[20] 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.[21] These same factors have created inequities in access, treatment, and patient experience across the health care delivery system and the urban/rural divide.[22] A rapid demographic shift has occurred over the last decade such that California has a significantly smaller proportion of White residents, and much larger percentages of Latino/x and Asian, Native Hawaiian, and Pacific Islander residents.[23] Further, more than a quarter of Californians are immigrants — from dozens of nations, the highest percentage of any state — bringing a level of diversity across multiple dimensions.[24] Especially important in California is language access: California residents speak more than 200 languages, 44% of households speak a language other than English, and 19% report speaking

As California embraces the charge to revitalize and invest in primary care, it is imperative to anchor the state's efforts around equity.

English "less than very well."[25] As California's population continues to diversify, equally dramatic shifts in the workforce and other sectors have occurred, and disparities in socioeconomic status, well-being, and health outcomes remain stark.[26]

The Imperative of Language Access

Language access, including medical interpretation and translation services, is particularly important in California, whose population of 39 million people — including 11.4 million immigrants[27] — speak more than 200 languages and dialects,[28] making it one of the most linguistically diverse regions of the world. California's Medicaid program, Medi-Cal, supports 18 concentration and threshold languages.[29] Language concordance between clinicians and patients not only increases trust and patient satisfaction but simultaneously decreases poor clinical outcomes due to miscommunication.[30] Over 40 different languages are spoken by California's health workforce well enough to provide care.[31] Spanish is the most underrepresented language in the health workforce.

Primary Care Summit

In response to these challenges, in March 2023, the California Health Care Foundation (CHCF) sponsored the report *Primary Care's Essential Role in Advancing Health Equity for California*, which outlines the large body of evidence demonstrating primary care's essential contribution to advancing health equity and calls for new ways of thinking and acting to collectively strengthen primary care across the state with the intentional goal of reducing health and social inequities.[32]

In September 2023, to build consensus around policy recommendations, prioritize next steps, and catalyze collective action, CHCF sponsored Mathematica to host the Summit on Primary Care Policy to Advance Health Equity. This current report outlines the crucial steps toward building consensus on policy recommendations to strengthen primary care and advance health equity in California. It includes the following:

- An overview of the Summit on Primary Care Policy to Advance Health Equity (Section 2)
- A summary of the summit outcomes, including consensus reached by participants on three foundational policies to strengthen primary care, 10 specific high-priority policy recommendations, and a three-part approach to increase leadership and accountability to ensure progress (Section 3)
- An accountability mechanism (Section 4)

In addition, Appendix A contains detailed descriptions of the 10 policy recommendations that summit participants collectively identified as high priority for California. Appendix B describes the policy prioritization activity that took place during the summit. And Appendix C identifies the relevant actors for each of the 10 policy recommendations.

For readers interested in approaches and tools to advance health equity within the delivery system (practice focused, with a quality improvement lens), the authors recommend reviewing *A Toolkit to Advance Racial Health Equity in Primary Care Improvement*,, published in 2022.

Description of the Summit on Primary Care Policy to Advance Health Equity

Building on recent state and national efforts to strengthen primary care, the California Health Care Foundation sponsored Mathematica to host a Summit on Primary Care Policy to Advance Health Equity, with the goal of reaching consensus on primary care policy priorities for California and catalyzing collaborative action. The summit was an all-day event held in person in Oakland, California. Summit participants included 30 policy thought leaders, including experts in primary care and health equity from California, such as state officials, consumer advocates, community leaders, providers, and patient representatives (see the Acknowledgments section above for the full list). To provide perspective from other states with demonstrated success in building primary care capacity and infrastructure in pursuit of equity, participants also included representatives from the federal government and the Commonwealth of Virginia.

Outcomes of the Summit on Primary Care Policy to Advance Health Equity

During the Summit on Primary Care Policy to Advance Health Equity, participants called for California to strengthen primary care and advance health equity through intentional policy actions by multiple actors across the state, using a coordinated approach that focuses intentionally on equity in all policies. Specifically, participants reached broad consensus on the following, which are described below:

- Three foundational policies required to strengthen primary care and advance health equity
- Ten priority policy recommendations specific to five primary care topics: community engagement, workforce development, access to care, data standards and sharing, and payment
- A three-part approach to increase leadership and accountability to ensure progress

The proposed policy recommendations will need to be considered at different levels of policymaking and funded and enacted across a wide range of settings. Some recommendations constitute an expansion of existing services or approaches, while others represent innovative and completely new ways to deliver services. Some recommendations are already underway, supported by historic investments from state government. However, as of the writing of this report, California is experiencing a budget deficit and there are proposals to reduce spending in many of these areas.

Influencers of primary care policy in California traditionally include public agencies and political leaders; purchasers, large employers, and employer groups; payers and health plans; provider groups and associations; organized labor unions; health workforce education and training providers; patient and consumer advocacy groups; philanthropies; and academic researchers (see Appendix C). By presenting a wide range of high-priority policy recommendations with concrete action steps, the authors hope that a variety of influencers will work — independently and together — to implement the needed changes. Importantly, the authors elevate the imperative for a new set of influencers — those who historically have not been represented in primary care policymaking and whose voices have not been part of the discourse on priority setting in primary care policy. These are the influencers whose engagement will be transformative to the narrative, and whose activation stands to shift the conversation around high-quality primary care delivery to align with the needs of all Californians. The authors underscore that people with lived experiences

— those directly affected by primary care policy implementation (and those it has historically failed to serve) — will be engaged in actively identifying strategies and approaches to eliminating the existing inequities. Other key actors with insights that can drastically improve the current delivery system and its programs include health equity thought leaders, advocates, and champions.

Three Foundational Policies for Success

Summit participants took part in a policy prioritization exercise (described further in Appendix B) and reached agreement that three policies to strengthen primary care and advance health equity were foundational to all others. These policies address long-standing structural determinants of health inequities, including financial disincentives for primary care providers to serve low-income Californians, chronic under-resourcing of primary care, and marginalization from primary care policymaking of those groups most affected by the policies. Although California has made some recent progress in each of these foundational areas, much more work is needed.

Foundational Policy #1: Sustainably increase Medi-Cal primary care provider payments to remove financial disincentives to serving Californians with low incomes.

Primary care access is limited among populations with low incomes in part because Medi-Cal fee-for-service physician reimbursement for primary care had historically been low, at approximately 76% of Medicare rates.[33] Lower rates plus a heavy administrative burden cause many practices to decline to accept Medi-Cal patients, because payment does not cover the practice's cost to provide high-quality care. This is a health equity issue because more than two of every three Medi-Cal enrollees are people of color,[34] 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.[35] Effective January 1, 2024, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) increased payment to 87.5% of Medicare, an important shift in the right direction.[36]

Foundational Policy #2: Increase the proportion of health care spending directed toward primary care to enable sustained, systemwide investment in primary care services and supports; and establish transparent and enforceable timebound spending targets for public and private payers, to ensure resources are sufficient for the provision of high-quality, equitable primary care for all Californians.

Strengthening primary care infrastructure and rebuilding the primary care workforce will require investment. In 2024, the Office of Health Care Affordability will establish a statewide definition of primary care services and providers, identify mechanisms to measure the percentage of total health care expenditures allocated to primary care, and set spending benchmarks that consider current and historic underfunding of primary care services; develop benchmarks with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments toward supporting and facilitating innovation and care improvement in primary care; and promote improved equitable, high-quality outcomes for primary care.[37] These activities will allow stakeholders in California to understand current spending levels and patterns, and work together toward a common investment goal. OHCA has proposed a statewide absolute benchmark of 15% of total medical expense allocated to primary care across all payers, lines of business (commercial, Medicare Advantage, and Medi-Cal), and populations by 2034.[38] A final rule is expected late in 2024 for implementation in 2025. Unlike other states pursuing primary care investment targets, OHCA's targets will be advisory.

If progress toward established targets is not met, the state should consider adding enforcement mechanisms, such as those present in Colorado, Delaware, and Rhode Island.[39]

Foundational Policy #3: Create meaningful engagement of people with lived experiences of discrimination in all California state primary care policymaking and governance bodies to identify impediments to health equity and generate solutions. Honor their community wisdom through equitable acknowledgment and compensation for their time.

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 people who experience language barriers, people with limited English proficiency, people with lived experience of poverty, people with mental illness or substance use disorders, people with disabilities, and children. As an example, DHCS recently launched its Medi-Cal Member Advisory Committee, which is aligned with the state's efforts to ensure members have an active voice in shaping its policies and programs.[40]

Ten Priority Policy Recommendations

In addition to the three foundational policies, summit participants identified 10 priority policy recommendations across five areas of impact. Implementing these policies would put California on the right track over the next two to three years to strengthen primary care and advance health equity across the state. Each of these priority policy recommendations is considered in detail — including background and context, key considerations, and opportunities for action — in Appendix A.

Engage the Community to Share and Shift Power

Policy Priority #1: Provide technical support for primary care practices and community-based organizations to establish partnerships and working relationships in order to (a) understand the pressing social needs in the community and how these contribute to health outcomes in their patient panels and the larger local community; (b) learn about existing services (e.g., information and referral services, housing programs, case management, and home and community-based services, which help keep older adults and people with disabilities in their own homes) that are available to meet those social needs; and (c) integrate services with community-based organizations to ensure that traditionally underserved populations (e.g., those who are living in rural areas, who are unhoused or incarcerated, with mental illness or substance use disorders) have access to high-quality primary care and social care.

Policy Priority #2: Provide technical support to practices and communities to make primary care practice-based or community-based patient and family advisory councils (PFACs) standard practice across the state. PFACs should include people who reflect the diversity of the populations served and people most harmed by health inequities, and should be designed as a collaborative endeavor among patients, family members, staff, clinicians, and leaders to affirm what is working well in the primary care practice, identify opportunities for improvement, and codesign practice improvement efforts.

Enhance Education and Training

Policy Priority #3: Expand and scale health professions pipeline and pathway programs (including postbaccalaureate programs) to recruit, prepare, and mentor students from historically and systematically excluded communities (especially

rural communities) and cultural backgrounds for careers in primary care.

Policy Priority #4: Reduce debt burden for primary care professionals by offering (a) educational scholarships, subsidies, and loan repayment programs targeted to primary care professionals who train or work in underserved communities, including rural areas; (b) apprenticeships that offer opportunities for people seeking careers in primary care to learn while they earn with on-the-job training; and (c) accelerated education programs that allow primary care professionals to complete their education and training faster and join the workforce sooner.

Policy Priority 5: Direct state investments to educational institutions that can demonstrate they are producing health professionals consistent with state goals on diversity and representation in primary care.

Policy Priority 6: Support and scale the role that community health workers, promotores, and community health representatives play in primary care delivery to advance health equity and to increase the connection of primary care providers to the communities they serve. This includes (a) prioritizing and incentivizing hiring people with lived experience; (b) providing career ladders for community health workers, promotores, and community health representatives; (c) establishing sustainable funding mechanisms in primary care settings; and (d) facilitating partnerships between primary care providers and community-based organizations.

Expand Access

Policy Priority 7: Establish or expand community health centers in areas with primary care shortages, and work with community groups and community leaders to ensure the new health center sites and services are designed to meet community needs. This includes (a) identifying a state entity to assess and prioritize areas for new community health center sites relative to need at the state level; (b) providing financial support for start-up or expansion of community health centers; and (c) streamlining the licensing process for building or expanding community health centers.

Improve Data Standards and Sharing

Policy Priority 8: Develop and adopt standards to collect, share, and responsibly use comprehensive, self-reported data on patients' identities and health and social needs across primary care, public health, community, and social service organizations with mechanisms to ensure that people most harmed by health inequities are involved in the oversight of data collection, use, and sharing.

Design Payment for Equity

Policy Priority 9: Implement alternative payment models (APMs) that center equity by (a) accounting for a patient's individual clinical and social risk factors and community-level socioeconomic status; (b) rewarding reductions in health inequities, not only overall improvement for the population as a whole; and (c) providing financial resources sufficient to enable integration of behavioral health, social services, public health, and community partnerships into clinical practice.

Policy Priority 10: Evaluate health care benefit design with an equity lens, beginning with a focus on populations with low incomes, which are disproportionately from communities of color, by (a) implementing income-adjusted premium cost sharing; (b) reducing out-of-pocket costs for members and employees and their families; and (c) proactively educating members and employees on no-cost preventive care services available through their coverage or plan.

Three-Part Approach to Increase Leadership and Accountability

Summit participants agreed that progress on strengthening primary care and advancing health equity will happen only if we hold our systems, ourselves, and each other accountable. Drawing on the NASEM recommendations and the experiences of HHS and the Commonwealth of Virginia, the following three-part approach to increasing leadership and accountability in California garnered wide support among summit participants: (1) a task force on primary care and health equity, (2) a California state scorecard on primary care and health equity, and (3) an office for primary care within the state government. While all three parts of this approach are critical to ensure accountability, the approach is designed to be flexible in terms of the key players involved and the sequence in which the parts are implemented.

Task Force on Primary Care and Health Equity

The population of California looks markedly different from much of the rest of the US and drastically different in the last decade, reflecting a level of racial, ethnic, and linguistic diversity that implores us to deliver care differently. Summit participants agreed on the importance of establishing a new task force in California that would engage existing and previously unrepresented groups to work together to strengthen primary care and advance health equity. Critically, the task force must include and involve insights and perspectives of the very people most impacted by the socioeconomic and health inequities created by systemic failures of the current system of care delivery. The purpose of the task force would be to ensure action and accountability — generating evidence, monitoring and tracking progress toward goals, and creating a system for real-time course correction. Specifically, establishing and implementing a task force whose focus would be to collectively review and make sense of reports, evidence, and scorecards would set California on a path to effectively eliminating existing inequities. A task force on primary care and health equity would not only allow the state to track progress, develop new policy recommendations, and help set priorities; it would also represent the critical missing piece in the current infrastructure.

Such an innovative task force could take many forms. It could be a public-private model that provides a seat at the table for representatives of state government agencies or the state legislature. Alternatively, the task force could function entirely external to state government. Either way, the task force would be composed of primary care and health equity thought leaders from across California, including consumer advocates, lived-experience experts, community leaders, and patient representatives.

The Virginia Task Force on Primary Care, originally developed in response to the COVID-19 pandemic, is an example of an advisory body designed to foster collaboration, action, and accountability to improve primary care.[41] 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.

At the national level, the NASEM report called for a primary care advisory committee that would inform federal policymaking through regular guidance and recommendations.[42] As a direct result, in 2024, NASEM established a Standing Committee on Primary Care to maintain surveillance of the primary care field and serve as a focal point for discussions on federal primary care policy priorities.[43] The NASEM standing committee is composed of 19 members who are experts in primary care delivery, research, and policy.

California State Scorecard on Primary Care and Health Equity

> *"Scorecards have the potential to catalyze organizing and accountability, but they must be paired with resources, strategy, and persistence. Measurement efforts must be accompanied by effective communication of findings to the public and policy makers, linking data with public experiences for impactful advocacy and social accountability. This is the foundation for building powerful coalitions that can advocate for change."* [44]
>
> – Measuring the Health of PrimaryCare: Lessons from US and Global Scorecards, HealthAffairs Forefront, 2024

In 2023, as a direct result of the call by NASEM for increased accountability for primary care progress at the national level, the Milbank Memorial Fund, in partnership with the Physicians Foundation and the Robert Graham Center, released the first national scorecard on primary care. That same year, in an effort to track the health of the primary care infrastructure within their states, the Massachusetts Center for Health Information and Analysis and Massachusetts Health Quality Partners published the Massachusetts Primary Care Dashboard, and the Virginia Center for Health Innovation released the Virginia Primary Care Scorecard. HHS is developing a federal primary care dashboard to monitor the health of the US primary care system and the impact of actions HHS takes to strengthen primary care.

To support the transparency and effectiveness of a coordinated effort to advance health equity, a similar effort is needed in California. This would allow a broad range of partners — and, importantly, the community — to easily access current data on primary care and health equity in California. A state scorecard can address policy questions such as these: Which geographic areas of the state need immediate action to address health inequities? What aspects of primary care policy (e.g., access, workforce, payment) require focused attention in the state? How does California compare to the rest of the US on a variety of primary care and equity metrics?

Office for Primary Care Within State Government

> *"In the US federal government, no single agency oversees primary care, collects consistent data about its clinicians and performance, or considers how it is integral to achieving the nation's health goals. This gap creates a fundamental lack of understanding of what primary care is and what its capacities and capabilities are. The absence of a comprehensive perspective on primary care creates invisibility and confusion in federal policy."* [45]
>
> – Strengthening Primary Care to Improve Health Outcomes in the US—Creating Oversight to Address Invisibility, JAMAHealth, 2022

The 2021 NASEM report calls for increased leadership within the federal government to focus attention on strengthening the primary care infrastructure across the US. As a direct result, HHS Assistant Secretary for Health Admiral Rachel L. Levine, MD, announced the formation of the Initiative to Strengthen Primary Health Care, led out of her office and spanning multiple HHS divisions (e.g., the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the National Institutes of Health,

the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Indian Health Service).[46]

In 2021, the New Mexico legislature created a Primary Care Council within its Human Services Department to increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers, and reduce overall health care costs statewide.[47]

Similarly, in California, focused, sustained leadership is needed to ensure that primary care remains at the forefront of conversations around advancing health equity in the state. Although much is happening across state government (such as increasing primary care investment, bolstering the primary care workforce, and transforming the Medi-Cal primary care delivery system), increased coordination among these efforts could improve their impact. This could be aided by the appointment of an individual primary care leader, supported with adequate resources and provided authority to coordinate across government departments and to develop a statewide strategy to strengthen primary care with health equity as the goal.

Conclusion

Primary care is in crisis across the nation. California, in particular, is a state in dire need of new approaches to identifying, characterizing, and addressing the needs of a uniquely diverse population. Leadership is needed by a variety of actors (Appendix C). Failure to act in a way that is fully responsive to and reflective of the changing face of the communities that make up the state will not only result in persistent health inequities, but will also create new ones. The human and financial cost can be mitigated with action and strategies that center the experiences of the people most impacted by the policies. The challenges outlined in this report are complex and long-standing and, in many cases, are the direct result of chronic inattention, underinvestment, and marginalization of those most in need. The policy recommendations put forward are likewise complex, and each requires not just the crafting of a solution with concrete action steps but a new and different type of leadership and accountability — and sustained resources — to enact, maintain, and monitor change over time.

Appendix A. Ten Priority Policy Recommendations

For each policy recommendation, the authors use a definition of high-quality primary care that assumes the integration of physical and behavioral health.

Policy Recommendation #1

Provide technical support for primary care practices and community-based organizations to establish partnerships and working relationships in order to

- understand the pressing social needs in the community and how these contribute to health outcomes in their patient panels and the larger local community;
- learn about existing services (e.g., information and referral services, housing programs, case management, and home and community-based services, which help keep older adults and people with disabilities in their own homes) that are available to meet those social needs; and
- integrate services with community-based organizations to ensure that traditionally underserved populations (e.g., those who are living in rural areas, who are unhoused or incarcerated, with mental illness or substance use disorders) have access to high-quality primary care and social care.

Background and context

High-quality primary care is ideally embedded in the community and involves collaborating with community-based organizations to meet patients' social needs. Unfortunately, both primary care practices and community-based service organizations are chronically under-resourced, and historically, they have been siloed from one another — therefore limiting their ability to work together. Both types of organizations will require technical and financial resources that enable them to develop and sustain meaningful partnerships.

Key considerations

A variety of policy, payment, and practice barriers stand in the way of partnerships between community-based organizations and primary care practices. Understanding those barriers and addressing them is essential to developing partnerships that can flourish in the long run. One such implementation barrier is the cultural divide between primary care practices and community-based service organizations. Staff in these settings use different terminology and operate in different ways, which can complicate efforts at collaboration.

A one-size-fits-all statewide approach is unlikely to succeed due to regional differences. For example, primary care practices in an urban community may need guidance in navigating among the different community-based organizations, whereas practices in a rural area may need assistance with access because the number of community-based organizations available may be severely limited. Additionally, health and social service organizations that are locally rooted are often those that have cultivated community trust and have a deep understanding of local needs.

Strong, sustained leadership is critical, and success often depends on a particular champion. In some communities, leadership may be provided by a community coalition, but such a coalition can be challenging to develop and maintain.

Opportunities for action

Strong partnerships between primary care practices and community-based organizations help ensure that health-related social needs can be addressed in a way that is integrated and accessible to all. To foster these partnerships, it will be important to do the following:

- **Develop, cultivate, and maintain payment and financing mechanisms designed to foster strong and sustainable partnerships.** Traditional fee-for-service payment mechanisms that pay for physicians

to deliver services do not support coordination with community-based organizations. Payment mechanisms for Federally Qualified Health Centers, such as the prospective payment system, are similarly limited. Several state and federal efforts are currently underway to provide financial and structural support for partnerships between primary care and community-based organizations, such as these:

- Community care hubs have been well described and promoted by the US Department of Health and Human Services (HHS) as regional centers that assist primary care and other clinical practices and health plans in contracting with community-based services to share information, coordinate care, and address social determinants of health. A California example is the Alameda County Care Connect Initiative.
- California's Medi-Cal redesign effort, also known as CalAIM (California Advancing and Innovating Medi-Cal), included the Providing Access and Transforming Health (PATH) initiative. PATH provides start-up funding and technical assistance to build the capacity of on-the-ground partners, such as community-based providers and community-based organizations, to participate as Enhanced Care Management and Community Support providers contracted with Medi-Cal managed care plans.[48]

- **Anticipate and address the needs and challenges of community-based and health system partners to make collaboration more effective.** One early lesson from the PATH initiative is that organizations interested in participating as Enhanced Care Management or Community Support providers often face a steep learning curve regarding what it takes to contract with and get paid by managed care plans in order to deliver services under Medi-Cal. Smaller community-based organizations (CBOs) are especially daunted by the administrative hurdles and by the uncertainty as to whether payments for services will sustain participation in Medi-Cal. PATH's Technical Assistance Marketplace is beginning to address these challenges. Since the marketplace fully opened in early 2023, CBOs seeking technical assistance have focused questions on the nuts and bolts of payment and becoming sustainable. Community care hubs can be a useful strategy to support these smaller organizations and scale access across the state. On the clinical side, practice transformation, quality improvement, and coding and billing resources focused on health and social care integration can be useful to support practices, including smaller, independent practices, to advance equity and address health-related social needs through clinical-community partnerships.
- **Explore other potential sources of funding for primary care practices.** For example, the new Department of Health Care Services (DHCS) Equity and Practice Transformation Payments Program will provide millions of dollars to participating primary care practices to transform care delivery to better meet the needs of the state's diverse Medi-Cal enrollee population. Communities may also benefit from resources available through the California Accountable Communities for Health Initiative or from joining their regional Collaborative Planning and Implementation workgroup.

Policy Recommendation #2

Provide technical support to practices and communities to make primary care practice-based or community-based patient and family advisory councils (PFACs) standard practice across the state. PFACs should include people who reflect the diversity of the populations served and people most harmed by health inequities, and should be designed as a collaborative endeavor among patients, family members, staff, clinicians, and leaders to affirm what is working well in the primary care practice, identify opportunities for improvement, and codesign practice improvement efforts.

Background and context

Engaging patients and families as partners for primary care practice improvement is an important strategy toward delivering high-quality, patient- and family-centered care and improving health and health equity. Patients and families have perspectives and insights about access, the experience of care, and community resources that can inform workflow, care and communication processes, outreach, design of the facility, use of technology, and training of the staff — producing solutions that work for patients, families, staff, and clinicians.

One way to engage patients and their families in primary care practice improvement is through a patient and family advisory council (PFAC) — a group of patients and family members working collaboratively with providers and staff to share insights and serve as valued partners.[49] As these partnerships with patients and families are increasingly recognized as optimizing health and bringing value to health care, payers/purchasers and accreditors are making PFACs a standard. For example, the National Committee for Quality Assurance Patient-Centered Medical Home Recognition includes the requirement that a primary care practice have a PFAC or have several patients from the practice serving on a large health system's PFAC. The Accreditation Council for Graduate Medical Education has recently established a new standard conveying the expectation that each family medicine practice site for residency teaching will have a patient advisory committee to address community health needs more effectively. In addition, health systems across California — such as Kaiser Permanente, UCLA Health, UCSF Health, some county health systems, and Stanford Health Care — actively support PFACs, but these PFACs are not necessarily specific to primary care.[50] Federally Qualified Health Centers have a statutory requirement to have a majority of patient/consumer members on their governing boards.

As more primary care practices create or expand PFACs,[51] it is important to recognize that primary care practices and their PFACs require technical and financial support to ensure that they are well positioned for meaningful impact and positive change.

Key considerations

PFACs can be situated at different levels within the health care system. PFACs' need for support depends on their level and resources available to them. For example, single, small primary care practices are often unable to sustain meaningful engagement of a PFAC, as they are not equipped to support the needed infrastructure. For these practices especially, having a PFAC available at the community level — or embedded within a larger health system — can prove effective, as the same PFAC members can codesign solutions across multiple areas, and the commitment to facilitating the PFAC is shared by the larger entity. PFACs situated within larger health systems need encouragement to focus on primary care problem-solving, so that all attention is not drawn to hospital and specialty care.

Financial resources and technical assistance are needed to establish and sustain the proper infrastructure to facilitate a meaningful relationship between the advisory council and the primary care team it is advising. It is imperative that PFACs be representative of the communities they serve and include people most harmed by health inequities.[52] To facilitate PFAC participation among diverse groups of patients and family members — including populations with lower incomes that may be disproportionately burdened by costs associated with participation (e.g., the cost of transportation or

child care) — council members should be compensated for their contributions, whenever possible. In addition, efforts should be made to reduce other barriers to participation (e.g., by facilitating transportation, providing interpretation and translation services, and using telecommunication).[53]

Technical support should include preparing both the practice leadership team and the council members for the partnership. Practice leaders need to be prepared on how to meaningfully partner with people most harmed by health inequities to strengthen primary care and improve health equity. For each topic addressed by the council, members should be oriented to the problem and provided with meaningful context, including the practice's goals. A long-term plan for regular, meaningful engagement and codesign should be established.

Opportunities for action

To support the spread of PFACs throughout the state and ensure they represent the diversity of the populations being served, it will be important to do the following:

- **Establish a sustainable source of funding for primary care–focused PFACs across the state.** Establishing reliable partnerships requires up-front investment and sustained funding over time.[54] Currently, funding derives from grants, local government contributions, hospital systems, and the resulting gains in pay-for-performance.[55] Health plans are an important source of funding to launch new PFACs and sustain them over time. Beginning in 2024, the Provider Directed Payments under DHCS's Equity and Practice Transformation Payments Program could support the implementation of PFACs at participating practices.[56]
- **Promote community care hubs and/or the federal Primary Care Extension Program** to provide the technical assistance infrastructure to support PFACs, especially for small, independent primary care practices.
- **Develop a central repository of resources to guide partnerships with PFACs specific to primary care.** This could prove useful for health systems or practices until more formal technical assistance is available. As a starting point, there are many relevant resources available from the UCSF Center for Excellence in Primary Care and the Institute for Patient- and Family-Centered Care:
  - Partnerships in Ambulatory Care
  - Building Trust and Confidence Through Partnerships
  - DEI and PFACs

  The National Partnership for Women & Families and Patient & Family Centered Care Partners (PFCCpartners) can also serve as resources to guide partnerships with PFACs.
- **Consider creating incentives for the development of PFACs** by incorporating quality measures, grant requirements, and alternative payment models.

Policy Recommendation #3

Expand and scale health professions pipeline and pathway programs (including postbaccalaureate programs) to recruit, prepare, and mentor students from historically and systematically excluded communities (especially rural communities) and cultural backgrounds for careers in primary care.

Background and context

To advance health equity through high-quality primary care, professionals on the primary care team must reflect the diversity of the communities they serve. Because the health professions pathways can be long and arduous, with a high rate of attrition, pipeline and pathway programs work to recruit, prepare, and mentor students — and their families — from an early age. Nurturing interest in primary care, specifically, requires concerted effort.

Key considerations

Several successful pathway and pipeline programs in California encourage students from historically and systematically excluded communities (especially rural communities) and cultural backgrounds to pursue careers in the health professions, but most are agnostic to specialty. Efforts to help develop, nurture, and sustain interest in primary care, specifically, require leadership from primary care professionals and advocates. According to experts in the field, college is commonly the earliest stage at which students begin to differentiate between specialties and consider pursuing a career in primary care. Although each student has their own perspective and personal motivations, overall the most compelling reasons for pursing primary care may be the opportunity to develop enduring relationships with patients and families over time and the ability to impact population health through partnership with the community. Contact with — and mentorship from — primary care professionals who find their practice personally and professionally fulfilling is key to nurturing and sustaining this interest throughout the course of the training pathway.

Sufficient and consistent resources and staffing are needed to sustain successful pathway and pipeline programs. Funding for these programs needs to require accountability, including tracking individual students as they progress in their careers, to ensure that students are having positive experiences with primary care and to allow for scale and spread of programs with a proven record for success.

Opportunities for action

Opportunities exist to increase students' exposure to primary care in structured, positive ways, both within existing programs and through development of new programs. All efforts should prioritize engagement with students from historically and systematically excluded communities, geographies, and cultural and linguistic backgrounds. Specific opportunities include the following:

- **Develop a statewide primary care mentorship program,** complete with training and tools for potential mentors, that builds on existing efforts. Several statewide organizations, such as the California Primary Care Association, the California Academy of Family Physicians, and MiMentor, already have mentoring programs and could collaborate. To ensure that students have positive experiences with primary care requires ongoing feedback and engagement from student participants to assess the quality of their experiences.
- **Embed in existing pathway programs more structured programming specific to primary care,** including clinical rotations in community health settings and rural areas, workshops, networking, and mentorship. Require feedback and engagement from student participants to assess the quality of their experiences with primary care. One example of this type of programming can be found in the California Area Health Education Center Scholars Program in Community Health, which requires both didactic and community-based clinical training, a community-based health project, and completion of evaluations or surveys both during and after the program. Existing pathway programs that should emphasize primary

care — and should be encouraged to provide extra points for funding consideration if they do focus on it — include the following:

- The California Department of Health Care Access and Information (HCAI)'s Health Professions Careers Opportunity Program, which provides funding to public and private nonprofit universities and colleges and health professions training programs to "provide comprehensive academic enrichment, career development, mentorship, and advising in order to support underrepresented individuals as students to pursue health careers."
- The California Medicine Scholars Program, which "aims to strengthen educational pathways so students can successfully advance from community college to medical school, and secure meaningful internship and volunteer healthcare experiences along the way."
- Public postbaccalaureate programs, many of which are specifically designed to help socioeconomically or educationally disadvantaged students become more competitive applicants to health professions schools. Two main types of postbaccalaureate programs exist: those that enhance or augment a student's academic record and those for students who are changing careers. Postbaccalaureate programs are offered at both California State University and University of California systems.

- **Encourage Song-Brown and CalMedForce, two California state programs that fund primary care residency training programs, to include and weight as a scoring criterion that primary care residents provide outreach and mentorship to college students or other students in pathway programs within their community.** Best practices around these efforts can be shared across programs and with potential grant applicants.
- **Develop a statewide primary care marketing strategy,** including informational videos and advertising, to inform and inspire students from historically and systematically excluded communities and cultural backgrounds to consider primary care careers. Include marketing to adults with options for nontraditional pathway entry, such as those in the military, from prison, who are unhoused, or who have jobs in other service industries.
- **Create and provide ongoing funding for a statewide repository or registry of programs** that would be a resource for anyone looking to enter the primary care career pathway as well as a hub for programs to network, collaborate, and share resources. Data on program outcomes could be collected, highlighting successful programs and sharing best practices.

Policy Recommendation #4

Reduce debt burden for primary care professionals by offering

- educational scholarships, subsidies, and loan repayment programs targeted to primary care professionals who train or work in underserved communities, including rural areas;
- apprenticeships that offer opportunities for people seeking careers in primary care to learn while they earn with on-the-job training; and
- accelerated education programs that allow primary care professionals to complete their education and training faster and join the workforce sooner.

Background and context

To advance health equity through high-quality primary care, professionals on the primary care team must reflect the diversity in communities they serve. Because training for the health professions is long and often expensive, financial supports are essential for ensuring that those from underrepresented backgrounds, and especially low-income households and first-generation-to-college families, pursue and sustain health education. Financial supports reduce both the psychological and financial burden of taking on debt. Shortening the length of training time is another method of decreasing this debt burden, while having the additional benefit of increasing the health workforce more rapidly.

Key considerations

A student's financial or socioeconomic background can be a significant barrier to pursuing a career in primary care. Studies have shown medical and dental school debt has grown by 172% and 117%, respectively, in the last few decades,[57] and the average debt load currently exceeds $200,000 for physicians and is nearly $300,000 for dentists.[58] Economically disadvantaged students often have many fewer resources available to them, whether from their local school system or from their own family, and may lose confidence in their ability to complete a career path in the health professions when faced with major financial stressors and accumulating educational debt.[59] There is often a significant gap between the actual cost of education and financial aid awarded. Even with the cost of tuition covered, expenses such as transportation, child care, and the overall high cost of living in California can make higher education unattainable; this is especially true for people who live in rural areas and must relocate or commute long distances in order to attain health education or training. Additionally, students working to support themselves (and often their families) often must forgo the extra opportunities that support their applications to higher education and training, such as research, test preparation, and unpaid internships. Students from lower-income households and immigrant families may also be expected to support other family members, further limiting the time or money they have available to invest in personal education. Scholarships can be an effective way to motivate and support students in their pursuit of a primary care career. Additional aid in the form of loan repayment programs should also be made available to cover the costs that scholarships and other subsidies did not.

Accelerated training programs reduce the time required to graduate and often admit students from the regions that they are designed to serve, providing training within those settings with the hope that graduates will choose to work in those regions after graduation. Not only does this reduce student debt burden by reducing the amount of tuition paid and accelerating the graduate's ability to earn in their desired profession, but it also positively impacts access in those regions in addition to the overall diversity of the health workforce. Many accelerated training programs also provide students with academic support and career planning throughout their training.

Further opportunities for decreasing both the time and financial investment of training and education exist in developing apprenticeship tracks for some primary care roles, particularly entry-level positions. This would

enable individuals needing to work full-time an opportunity to enter the health workforce, providing needed experience for those who want to progress. More advanced education and training programs could use lived and work experiences, such as apprenticeships, to reduce the number of credits or hours needed for graduation.

Opportunities for action

To meet the health needs of all individuals in California, it is essential to increase the size and diversity of the primary care workforce. Reducing the debt burden of primary care workers is one way to help achieve this goal. California has some programs in place that address this issue. Specific opportunities for additional action include the following:

- **Increase internship opportunities in primary care settings,** particularly within community health centers. Embed in these programs opportunities for mentorship and networking. Health Career Connection is an example of an organization providing internship opportunities to college students, many of whom get hired permanently after the internship.
- **Develop apprenticeship tracks, enabling students to both learn and earn with on-the-job training.** Include opportunities for advancement beyond entry-level positions by accepting lived and work experiences for educational and training credit. Though not in health care, the State Bar of California recently approved a Law Office Study Program through which students can work and study within a law office or judge's chambers instead of attending law school. Similar health care apprenticeships could be modeled after this one.
- **Provide scholarship funding to individuals throughout the course of the training pathway,** including direct support to defray the costs of living and other nonacademic expenses (such as transportation, child care, and test preparation), and tie it to service in primary care. One example of a successful program is the Joint Admission Medical Program, a Texas program that provides undergraduate and medical school scholarships, summer stipends, clinical enrichment opportunities, test preparation, and guaranteed admission to medical school. Consider tying scholarships to service in underserved areas, as is done in the Health Resources and Services Administration (HRSA)'s National Health Service Corps Scholarship Program, and require payback if the student's service obligation is not met.
- **Support schools providing graduate degrees (NP, PA, MD, MPH) in offering free tuition for service in primary care.** The Kaiser Permanente Bernard J. Tyson School of Medicine has offered free tuition to its first five graduating classes.
- **Expand access to accelerated programs,** such as Accelerated Competency-Based Education in Primary Care, a program at the UC Davis School of Medicine offering a three-year MD pathway for students committed to primary care careers, and the California Collaborative Model for Nursing Education, an academic progression path from an associate's degree to a Bachelor of Science in nursing utilizing dual enrollment that accelerates academic and career advancement for nurses.
- **Sustain and consider expansion of existing loan repayment programs for primary care professionals in California,** such as those sponsored by HCAI and Physicians for a Healthy California.

Policy Recommendation #5

Direct state investments to educational institutions that can demonstrate they are producing health professionals consistent with state goals on diversity and representation in primary care.

Background and context

California suffers from a shortage of primary care professionals. In fact, almost one-third of Californians live in a Primary Care Health Professional Shortage Area (HPSA), disproportionately affecting rural and minority communities.[60] Further, Black Americans, Latinos/x, American Indians and Alaska Natives, and Native Hawaiians and Pacific Islanders are underrepresented in medicine, nursing, dentistry, pharmacy, and other health professions.[61] This is despite strong evidence supporting the importance of diversity and representation on equitable health outcomes. For example, according to a 2018 report on the lived experiences of learners and physicians with disabilities, "When health care providers have life experience that more closely matches the experiences of their patients, patients tend to be more satisfied with their care and to adhere to medical advice. This effect has been seen in studies addressing racial, ethnic, and sexual minority communities when the demographics of health care providers reflect those of underserved populations."[62] To strengthen primary care and advance health equity, the state's investments in education should aim to increase both the size and the diversity of the primary care workforce.

Key considerations

State goals on the diversity of — and specialty composition of — the health workforce need to be clearly established. To track progress relative to these goals, specific metrics need to be developed, and these data need to be collected and analyzed on a regular basis. Without knowledge of the current primary care workforce landscape and how it differs from state goals, it is difficult to determine the impact of state policies.

One upstream strategy for increasing the diversity of and influencing the specialty composition of health professionals is through the education and training of the next generation. Health professional schools determine who is admitted, as well as how students are supported throughout their training, both of which can affect the demographics and specialty choice of program graduates.

Holistic review during the admissions process is one widely used strategy to increase the diversity of graduates.[63] Holistic review considers the whole applicant as opposed to limiting the review to traditional metrics such as test scores and GPA. Since the 2023 Supreme Court decision mirroring California Proposition 209 (1996), banning the use of race as a selection criterion for admission to universities, the Association of American Medical Colleges has become a major proponent of holistic review, defining it as "mission-aligned admissions or selection processes that take into consideration applicants' experiences, attributes, and academic metrics as well as the value an applicant would contribute to learning, practice, and teaching."[64] Holistic review allows institutions to consider students with demonstrated interest in primary care as well as groups traditionally underrepresented in medicine by acknowledging an applicant's sexual and gender identity, languages spoken, disability status, rurality, and experiences specific to geographic place in addition to race and ethnicity. Even with holistic review in place, however, each educational institution weighs admissions criteria based on that institution's mission and values. While all public universities and public medical schools in California use a holistic review process, the demographics of their student bodies vary considerably, highlighting the need for stronger incentives to increase the diversity and representation of admitted students.

In addition to determining whom they will train, health professions schools are also responsible for nurturing and supporting students throughout the course of their training until graduation. Students from backgrounds underrepresented in medicine can be assisted with longitudinal academic, social, and financial supports. Future practice decisions can be influenced, for example, by exposure to longitudinal curricula that run throughout the length of the students' training.[65]

For instance, the PRIME-LC program is a five-year combined-degree medical school program at UC Irvine that aims to train physicians to meet the needs of under-resourced Latino/x communities. After the first nine years of this program (2009–2018), over 60% of graduates pursued residencies in primary care, with 63% reporting that more than half of their patients are Latino/x and 70% reporting that over half of their patients are low-income.[66] As a comparison, in 2020 the national average of physicians working in primary care was 31%.[67]

There are examples of California educational institutions making progress in increasing the diversity of the health workforce and increasing the number of graduates pursuing primary care. UC Davis School of Medicine is a nationally recognized example of how a concerted effort to increase diversity within the student body can be successful, as it has the third most diverse student body in the country and has made great strides to address the state's shortage of physicians in rural and lower-income communities. In 2022, 43.5% of students enrolled were underrepresented in medicine. Moreover, UC Davis School of Medicine also reports high proportions of students choosing to practice in primary care specialties.[68] Similarly, in academic year 2023–24, 44% of the UC Riverside School of Medicine's first-year students were from backgrounds underrepresented in medicine, including 73% having ties to inland Southern California.[69] Rewarding educational institutions like UC Davis and UC Riverside Schools of Medicine, or specific educational track programs such as PRIME-LC, for aligning with the state's goals will help them sustain these efforts and may encourage other institutions to adjust their own policies.

Opportunities for action

Specific actions to help achieve state goals on diversity and representation in primary care include the following:

- Develop clear statewide and regional health professions diversity and specialty composition goals and corresponding metrics. Routinely collect and analyze data to track progress and reassess need. Provide funding for evaluation of programs to measure progress made toward meeting state goals, and align state funding with those programs that most closely match or are making the most improvements toward established goals.
- Require public colleges and universities to track and disclose detailed information about their student populations throughout the primary care pathway, including the following:
  - Undergraduate educational background of admitted students and graduates (e.g., number of students graduating from the California Community College system)
  - Demographics of students and graduates
  - Socioeconomic background of students and graduates
  - Geographic diversity of students and graduates
  - Which specialties graduates choose to pursue and what specialty they ultimately practice after completing training
  - Languages spoken by students and graduates, including all 18 Medi-Cal threshold languages
- Develop strategies to create more diverse and representative admissions committees and faculties across health professional schools. Include training on implicit bias for all admissions committee members.
- Sponsor a convening of University of California nursing and medical school leaders to expand and spread best practices in implementing holistic review processes that prioritize recruitment of individuals from underrepresented populations and communities of need.
- Support and expand existing programs with a proven track record of success, such as the UC PRIME programs. Model any new training track programs on existing successful programs, with emphasis on meeting the established statewide diversity and specialization goals and reducing shortages in rural areas and other HPSAs. Include sustainable funding for existing programs, expansion, and evaluation.

Policy Recommendation #6

Support and scale the role that community health workers, *promotores,* and community health representatives play in primary care delivery to advance health equity and to increase the connection of primary care providers to the communities they serve. This includes

- prioritizing and incentivizing hiring people with lived experience;
- providing career ladders for community health workers, promotores, and community health representatives;
- establishing sustainable funding mechanisms in primary care settings; and
- facilitating partnerships between primary care providers and community-based organizations.

Background and context

High-quality primary care requires coordination of care both in and beyond the four walls of the health care facility and requires a connection to, and understanding of, the communities served. This kind of proactive care coordination and community outreach and engagement benefits from a diverse interprofessional team with new tools, capabilities, and workers. Community health workers, promotores, and community health representatives (CHW/P/Rs) are frontline public health workers who are trusted members of, and/or have a deep understanding of, the community served.[70] The ability of CHW/P/Rs to establish trusting relationships makes them uniquely positioned to bridge the divides between the health care system and diverse communities to achieve health equity.[71] There is strong evidence to support the ability of CHW/P/Rs to increase access to primary care services, reduce hospitalizations, support the health care needs of people with chronic conditions, and reduce health care spending.[72]

Key considerations

Recognizing the role that CHW/P/Rs can play in advancing health equity, state and federal leaders are taking action to expand the CHW/P/R workforce throughout the safety-net delivery system. In California, there has been a statewide, cross-agency commitment to growing and supporting CHW/P/Rs, including initiatives from HCAI, the California Labor and Workforce Development Agency's Health Workforce Development Council, and CalAIM. As of July 1, 2022, managed care plans can provide CHW/P/R services as a benefit for Medi-Cal members.[73] This is a major advancement toward ensuring sustainable funding for the CHW/P/R services in the health care system. Additionally, Governor Newsom has allocated substantial funding to support the CHW/P/R workforce through recruitment, training, and certification.[74]

Although these efforts have resulted in more CHW/P/R agencies increasing their engagement with the traditional health sector and there continues to be optimism, there have been a variety of challenges on the path to implementation. HCAI was aiming to have a state-issued CHW/P/R certification program ready in early 2024 but, after conducting stakeholder engagement, has decided to pause the certification program to allow for additional dialogue.[75] Additionally, use of the CHW/P/R benefit within Medi-Cal has been slow to roll out. Accelerating progress in these and other areas will be essential for maximizing the benefit of CHW/P/Rs in care and community settings.

Opportunities for action

There are many opportunities to sustain the state's cross-agency commitment to addressing these challenges. Ongoing engagement with the CHW/P/R Policy Coalition, CHW/P/R employers, state and national associations of CHW/P/Rs such as the National Association of Community Health Workers (NACHW), and CHW/P/Rs themselves is critical to advance the meaningful implementation of policy changes. Specific actions that can be taken to support scaling of the CHW/P/R workforce include the following:

- **Articulate cross-agency CHW/P/R workforce goals** that recognize the diversity of the roles and environments that CHW/P/Rs work in to improve the health

of individuals and communities. Include a plan for each agency to incorporate CHW/P/Rs into their payment models, and intentionally create CHW/P/R jobs within their agency workforce.

- **Educate providers about the role of CHW/P/Rs and the potential return on investment**, and encourage them to hire CHW/P/Rs as part of their care teams and/or prescribe these services.
- **Provide technical assistance and supports to new Medi-Cal providers** such as community-based providers that are poised to provide the CHW/P/R Medi-Cal benefit but are not accustomed to the complexities of the Medi-Cal system.
- **Encourage Federally Qualified Health Centers (FQHCs), which employ an estimated 20% of the state's CHW/P/Rs, to scale their CHW workforce**, given their role as critical primary care providers in the state's safety net.[76]
- **Expand the availability of training for managed care plans and health care employers** to deepen their understanding of the role of CHW/P/Rs in advancing health equity and repairing systemic harms, and also support appropriate training and supports for CHW/P/Rs who are working in health care settings.
- **Ensure that financing mechanisms can effectively support the cost of providing CHW/P/R services** and thriving wages for the workforce, with specific consideration given to the 2024 Medicare Physician Fee Schedule, which allows for new services and new sites of care, as a benchmark.
- **Develop CHW/P/R career development programs** that are grounded in an understanding of the needs and preferences of CHW/P/Rs (e.g., ensuring a sustainable career ladder based on proficiencies).[77] The cost of career advancement should be incorporated in sustainable financing models.[78]
- **Support deepened understanding of opportunities to blend funding** to increase the financial sustainability of these CHW/P/R programs.
- In connection with CalAIM, community-based organizations, health plans, and DHCS, **explore opportunities such as community care hubs and increased partnerships** between community-based organizations and FQHCs.
- **Continuously seek and include CHW/P/R feedback and input** on policies, systems integration, and career ladder opportunities that will impact the CHW/P/R sector of the state health workforce through a standing advisory committee.

Policy Recommendation #7

Establish or expand community health centers in areas with primary care shortages, and work with community groups and community leaders to ensure the new health center sites and services are designed to meet community needs. This includes

- identifying a state entity to assess and prioritize areas for new community health center sites relative to need at the state level;
- providing financial support for start-up or expansion of community health centers; and
- streamlining the licensing process for building or expanding community health centers.

Background and context

Community health centers (CHCs) — including tribal health centers and public hospital system clinics — are clinics located in underserved areas that offer low-cost medical, dental, behavioral health, substance abuse, and pharmacy services. They play an important role in providing access to high-quality primary care throughout the state, providing care to patients regardless of their ability to pay. CHCs are administered by people from the local community, including board members composed of existing patients and community representatives, and often offer additional services such as education, outreach, advocacy, and translation services. Some CHCs receive federal funding from the Health Resources and Services Administration (HRSA) and, in turn, must comply with federal requirements. According to the California Primary Care Association (CPCA), in 2022 there were 1,276 CHC sites in California serving over 7.7 million patients.[79] This is equivalent to one in five Californians, though Medi-Cal patients comprised 58% of the CHC patient population. Of the almost 25 million billable encounters in 2022, 65% were for medical reasons, while dental and behavioral health visits made up 12% each of those encounters.

CHCs are a key component in advancing health equity because of their ability to respond directly and immediately to the needs of the community, particularly as those needs change. This was clearly evidenced during the COVID-19 pandemic, when CHCs had to pivot to providing communities with COVID-19–related care in addition to other health services despite diminished operational capacity.[80] Because of their foundation in the local community, CHCs are also uniquely positioned to treat the "whole person" and address the social determinants of health. They help provide access to nutritious foods, build community and social support, help people cultivate life and employment skills, and share and shift power to community members by supporting civic engagement and providing employment opportunities.[81]

Key considerations

Although there have been many new CHCs established in California over the past 15 years, especially following the passage of the Affordable Care Act, there currently is no state entity that considers the location of CHC sites relative to current population need. There is the California Primary Care Office (PCO) within HCAI, which is responsible for providing data and supporting calculations around need for individual CHC applicants, but it does not assess need for CHCs on a statewide basis. Because of this, there is no indication or consideration of CHC service gaps either on a state or regional level. Furthermore, as populations have shifted over time due to, for example, gentrification and migration, previous areas of need may no longer be under-resourced, and areas currently designated as median- or high-income may have hidden pockets of need. Without having current data on gaps in health center access points — along with characteristics of existing CHCs, such as their size, the services they provide (including dental health and behavioral health), language access, and compliance with the Americans with Disabilities Act — it is difficult to suggest regional or statewide policies.

When there is a clear need established for additional CHC services, central planning needs to be balanced with local dynamics. Local organizations and residents should be contacted and engaged in all decisionmaking processes to determine how to fill the gaps in a way that best serves the community. Churches, community hubs, schools, community centers, service organizations, tribal leaders, and business managers can help establish sustainable CHCs and examine which local, state, and/or federal policies are creating barriers. Medi-Cal health plans also have a role to play as they are newly required by DHCS to conduct populational health needs assessments and develop plans to reinvest in local communities. By assessing existing local resources, communities can consider whether a new health center should be built or if expansion of an existing center is a possibility. Often, supporting expansion of an existing organization with a proven track record makes more sense than developing an entirely new entity.

One of the biggest hurdles in building a new CHC or expanding an existing one is the bureaucracy involved in the licensing process, which can take over a year. The CPCA has also identified building codes and standards as a particular challenge. For example, similar standards are required for hospital-based clinics and CHCs despite the latter not having in-patient care. Private medical offices and county clinics are not held to the same building standards as CHCs, and there is no published safety data supporting the existing building code. Intermittent clinics, defined as "a clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week,"[82] showed that they posed no increased threat to safety while increasing access to care when the 40-hour limitation was dropped during the COVID-19 pandemic. The many restrictions around building and expanding CHCs, such as the time limitation for intermittent clinics, need to be reevaluated with a lens toward improving equity and access.

Understanding the pressures involved in running a successful CHC is essential. California currently has more CHCs than any other state, sometimes with two existing in the same block, so competition for resources can be high. Some CHC sites have limited hours or lack the full range of services, such as behavioral health and dental care. Primary care workforce shortages are concerning statewide and particularly acute in CHCs, which are often understaffed. For instance, it can take over two years to hire or replace a physician. Additionally, wage increases, particularly from the wage compression that has occurred after increased minimum wage mandates, cannot be offset simply by raising rates. Once a CHC is up and running, any application for rate changes can take 18 months or longer to be approved and can expose the CHC to scrutiny over costs, posing the risk of rate decreases. CHCs must rely on any reserve funding or alternative fundraising available to support them during this application process.

Opportunities for action

CHCs are uniquely positioned to improve equitable access to primary care services for people who lack affordable or accessible care, but there are noteworthy obstacles to establishing new CHC sites. To mitigate these challenges, state and federal leaders should consider the following actions:

- **Identify a state entity to assess and prioritize communities in need of new CHC sites.** While there are efforts underway at the CHC, local, and health plan levels to conduct needs assessments, a statewide approach is needed to support equitable allocation of resources to establish and expand new CHC sites and services. The state entity could map HPSAs against the location of CHC sites annually.
- In areas where primary care gaps exist, **work with Medi-Cal health plans, local organizations, and community leaders to determine how to best fill those gaps.** Consider whether existing services and resources should be expanded or if new services are needed.
- **Provide financial support for CHC start-up or expansion** — including building or remodeling — in areas of demonstrated primary care shortage.
- **Reduce and streamline the licensing process for building and expanding CHCs.** Consider adjusting building code requirements, particularly for existing structures, and increasing or eliminating the time requirement for intermittent clinics.

Policy Recommendation #8

Develop and adopt standards to collect, share, and responsibly use comprehensive, self-reported data on patients' identities and health and social needs across primary care, public health, community, and social service organizations with mechanisms to ensure that people most harmed by health inequities are involved in the oversight of data collection, use, and sharing.

Background and context

The delivery of high-quality primary care should be supported by comprehensive patient-level data to shed light on the multitude of factors that influence health beyond simply the health care provided. For example, data on health outcomes and health and other social services disaggregated by various categories of demographic characteristics (e.g., age, sex, race, ethnicity, language, sexual orientation, gender identity, and disability status) would provide insight into disparities among various groups and where additional intervention is needed to close the gap. Currently, however, these data are collected across multiple systems that have different standards for each data element and operational requirements. Efficiently using data and reducing redundancy in data collection across systems will require standards for data elements and mechanisms for the systems to talk and share data with each other.

Key considerations

Factors beyond health care that influence the health of an individual can be considered in two categories: (1) demographic characteristics and (2) social circumstances, which are shaped by social and structural drivers of health equity. Demographic data include age, race and ethnicity, sexual orientation, gender identity, preferred language, and disability status. For some racial/ethnic groups there are subpopulations, and these distinctions need to be captured. Data for patient-level social needs include housing instability, education barriers, unemployment and underemployment, food insecurity, transportation problems, utility problems, and more.

Parts of a person's demographics, such as race and ethnicity, are social constructs that influence how other people and systems interact with the person and how the person conversely interacts with other people and systems. These interactions with people and the environment can have profound impacts on a person's health, such as whether they feel able to seek health care, whether they enjoy easy access to health care, and if they are treated differently than others with different demographic characteristics or social circumstances when they do seek health care. These interactions can also influence a person's access to and use of other opportunities and social services that impact health, such as housing, food, education, and employment. As such, they are important to document and monitor, so patients can be connected with supporting services, as needed. Documenting data that reflect multiple and intersectional identities allows for better tailoring, coordinating, and provision of whole-person care for individuals from diverse backgrounds. With patients' awareness and consent, these data can also inform quality improvement.

The federal government recently launched the Fast Healthcare Interoperability Resources to set standards for sharing data between different health organization systems. Not all health systems have met these standards, and other non-health social sector systems might not yet use them. Furthermore, having these standards alone also does not necessitate that various systems capture the same type of information on demographics, health, and social needs (even if not in the same format).

To facilitate the secure and appropriate exchange of health and social services information, California has implemented the CalHHS Data Exchange Framework (DxF) — the first-ever statewide data sharing agreement — to give providers a clear understanding of a patient's full health history and the information needed to provide safe, effective, whole-person care. While many health care organizations were required to commence data sharing by January 31, 2024, California-based primary care practices, especially practices with fewer

than 10 providers, will need guidance and ongoing operational, technical, and technological support to participate in this landmark data sharing initiative. Smaller practices and clinics will have until January 31, 2026, to fully implement the DxF.

Opportunities for action

Sharing data across multiple systems for individuals not only decreases the burden on individuals to have to report the same information to different organizations multiple times, but it could also result in better data. To achieve the promise of California's DxF and strike the right balance between privacy and accountability, the state should take necessary steps to fully understand the landscape of privacy requirements across systems and prepare for implementing data and systems standards and data collection, including the following:

- **Discuss potential needs and uses of the data with patients, providers, and other decisionmakers.** Patients must be informed about the potential uses and sharing of data and consent to having their data used in the ways specified. Generating trust will require several key components accompanying any policy and systems changes, including awareness building through trusted messengers, transparency in data collection purposes to obtain consent, and reciprocity in terms of handing data back to communities and showing accountability to them through regular meetings and actions related to findings in the data.
- **Review best practices** in patient engagement and community accountability with data.
- **Explore various types of reporting mechanisms** (including a patient self-reporting system).
- **Ensure disaggregated data are captured for subgroups in communities of color (i.e., Asian, Native Hawaiian, and Pacific Islander and Latino/x communities).** For the Latino/x community this would include indigenous communities (Maya, Aztec, Mixtec, Zapotec, Trique); indigenous languages (Zapoteco, Chinanteco, K'iche', Nahuatl); and Latino/x subgroups (Mexican, Guatemalan, Salvadoran, Honduran, Nicaraguan, Costa Rican).
- **Consider and implement measures to protect confidentiality and deter data misuse.**
- **Promote and support the role of community-based organizations in collecting data on patients' health-related social needs (HRSNs).** To get at individual-level data, many health systems have begun to collect HRSN data. Community-based organizations in particular have several advantages in collecting HRSN data, including richer and more up-to-date information on individuals' circumstances and shifts in them.
- **Provide primary care practices and social-sector community-based organizations with proactive, ongoing operational and technical support and resources** to collect, store, use, and share HRSN data.
- **Align data** with the United States Core Data for Interoperability standards and the national, collaborative effort known as the Gravity Project, which develops consensus-based data standards to improve sharing HRSN data, as recommended by the White House's *U.S. Playbook to Address Social Determinants of Health*.
- **Support policies that enable timely and easy interagency and interorganizational data sharing while protecting privacy.** This could be similar to the federal government's Fast Healthcare Interoperability Resources but allowing for community data integration.
- **Support California policy that promotes the adoption of nonproprietary, open application programming interfaces** (including the Fast Healthcare Interoperability Resources) to facilitate the accessibility and collection of individual HRSN information.

Policy Recommendation #9

Implement alternative payment models (APMs) that center equity by

- accounting for a patient's individual clinical and social risk factors and community-level socioeconomic status;
- rewarding reductions in health inequities, not only overall improvement for the population as a whole; and
- providing financial resources sufficient to enable integration of behavioral health, social services, public health, and community partnerships into clinical practice.

Background and context

High-quality, accessible, equitable primary care requires payment designed to achieve those results.[83] Payment for primary care should be sufficient to support the adoption and maintenance of advanced primary care attributes, including the ability to assess and address patients' behavioral health and social needs. Payment for primary care should shift away from volume (fee-for-service) and toward value (prospective, outcome-based, population-based). Specifically, all payers should adopt payment models that support advanced primary care. Based on evidence of impact and aligning with the National Academies of Sciences, Engineering, and Medicine (NASEM) recommendation in *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, priority should be given to models that include three components: payment for direct patient care using a mix of risk-adjusted capitation and fee-for-service, population-based payment to support population health management, and performance-based payment based on common measures.

Within California and across the nation, many efforts are underway to shift to APMs with focus on equity. The HCAI's Office of Health Care Affordability (OHCA) has a statutory mandate to create standards for APM payer-provider contracting. With input from the Investment and Payment Workgroup, OHCA has developed a set of 10 draft standards with supporting implementation guidance — several of which focus on equity and support the specific components of this policy recommendation. One example is draft strategy #8, "**Invest in strategies to address inequities** in access and outcomes," which has three specific areas of implementation guidance[84]:

- Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.
- Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.
- Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

OHCA is targeting board approval of key APM-related provisions of statute in summer 2024.

At the national level, the Health Care Payment Learning and Action Network (HCPLAN), which created the widely used HCPLAN APM Framework, has established a Health Equity Advisory Team and created a theory of change connecting APMs with more equitable outcomes. Among the resources created is guidance for designing and implementing payment incentives to reduce health disparities in quality of care, outcomes, and patient experiences.

The CMS Innovation Center (CMMI) is a key driver of experimentation with APMs, launching more than 50 tests of payment and care models in its first 10 years. In 2021, CMMI released a retrospective review of its first decade and strategy "refresh" for the next decade that centers health equity in design and implementation of future models, aiming to "embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations."[85] In 2022, CMS launched the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, featuring the Health Equity Benchmark Adjustment (HEBA) — designed to adjust ACO financial benchmarks based on Medicare beneficiary

social needs and dual-eligibility status. While the model has encountered challenges, the intent is noteworthy. Also, in 2023, CMS announced a new, voluntary state total cost of care (TCOC) model: the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The AHEAD Model seeks to drive state and regional health care transformation and multipayer alignment, including a specific set of goals to strengthen primary care, improve care coordination, and increase screening and referrals to community resources like housing and transportation to address social drivers of health. The AHEAD Model provides a promising vehicle for California to advance the policy recommendations described above. Additional federal payment models, including Making Care Primary and ACO Primary Care Flex, may also offer opportunities.

Key considerations

The design, structure, and implementation of APMs determine how well they support high-quality primary care, and especially equitable primary care.

A common foundational need across all equity-focused APM initiatives is for complete and accurate data. Data are essential to adequately account for a patient's individual clinical and social risk factors, as well as community-level characteristics. Current data availability and systems fall far short, and significant improvements are needed to enable equity-focused APM implementation and to identify, understand, and act on disparities in care or outcomes related to a patient or population's race, ethnicity, language, sexual orientation, gender identity, or disability status.

Most important, multipayer alignment in the design and implementation of APMs — including payment mechanisms, measures, and reporting requirements — will support adoption and reduce provider burden associated with proliferating models and measures. Multipayer alignment is also critical to maximize consistency and comparability in performance measurement and to reduce reporting burden. Recently, the California Department of Managed Health Care convened a Health Equity and Quality Committee to inform identification of a set of standard health equity and quality measures along with annual benchmark standards for health plans beginning in 2023. Furthermore, California has implemented the CalHHS Data Exchange Framework (DxF) — the first-ever statewide data sharing agreement — in order to give providers a clear understanding of a patient's full health history and the information needed to provide safe, effective, whole-person care. To benefit from equity-focused APM initiatives, California-based primary care practices, especially practices with fewer than 10 providers, will need guidance and ongoing operational, technical, and technological support to participate in this landmark data sharing initiative.

Opportunities for action

Multiple efforts are underway across California and nationally to design and implement payment models that center health equity and prioritize reducing disparities in access, experience, and outcomes. These efforts can be sustained, scaled, or further improved though the following actions:

- **Seek opportunities to accelerate multipayer alignment:**
  - California's public purchasers have reached a remarkable degree of alignment with respect to key contractual provisions related to primary care for their participating payers, strengthening the signal regarding their expectations for adoption of value-based care models and performance.
  - The California Advanced Primary Care Initiative (CAPCI), a joint effort of the California Quality Collaborative (CQC) (a program of the nonprofit coalition Purchaser Business Group on Health [PBGH]) and the Integrated Healthcare Association (IHA), has created a multipayer partnership in the commercial market to enable primary care practice transformation. Payers participating in the Payment Model Demonstration Project — Aetna, Anthem Blue Cross, Blue Shield of California, and Health Net — are adopting a shared primary care payment model, accompanied by technical assistance, designed to strengthen primary care delivery. The demonstration runs through 2025. Participating payers agreed to a memorandum of understanding outlining shared goals and actions, including a value-based payment model designed to promote health equity.

- **Support participation of small and rural practices,** both to maximize access to care and to ensure the sustainability of independent practices in the face of increasing market consolidation. Small practices may need to partner with value-based enablers or aggregators or join networks to engage in APMs; this should be allowed and encouraged, where possible.
- **Emphasize the integration of behavioral health and social care** into primary care.
- **Prioritize the reduction of disparities.** For example, Covered California's 2023–2025 contract with participating qualified health plans includes extensive provisions supporting health equity and disparities reduction, including expanded demographic data collection; identifying, monitoring, and reporting on reducing disparities in care using Healthcare Effectiveness Data and Information Set (HEDIS) measures and patient-level data; disparities-reduction intervention planning and target setting; health equity capacity building; and the National Committee for Quality Assurance health equity accreditation.[86] Equity efforts are also happening in Medi-Cal through new contractual requirements.[87]

Policy Recommendation #10

Evaluate health care benefit design with an equity lens, beginning with a focus on populations with low incomes, which are disproportionately from communities of color, by

- implementing income-adjusted premium cost sharing;
- reducing out-of-pocket costs for members and employees and their families; and
- proactively educating members and employees on no-cost preventive care services available through their coverage or plan.

Background and context

Primary care is only accessible to individuals and families when it is available at a price they can afford. In California, families with low incomes are disproportionately likely to be Black and Latino/x, as poverty in America is racialized. The design of health insurance products can impact health equity, and especially access to care, through network structure configuration choices and cost-sharing mechanisms. The two most important cost-sharing mechanisms are premium costs (what an individual must pay to purchase insurance protection) and out-of-pocket costs (deductibles, copays or co-insurance amounts, and out-of-pocket maximum policies). Lowering out-of-pocket costs can improve health equity. For example, a study published in the *American Journal of Managed Care* found that removing copayments from essential medications largely eliminated racial disparities in medication adherence.

As premiums and out-of-pocket costs continue to rise, Californians struggle to keep up. In 2023, 53% of Californians said they skipped or postponed health care in the past year because of cost; and among those who skipped or postponed care, 46% say this made their condition worse.[88] Similarly, in 2023, more than one in four Californians said that they or someone in their family had problems paying medical bills in the past year. Black and Latino/x Californians are the most likely to experience problems paying for medical bills (40% and 36%, respectively), and Black and Latino/x Californians are more likely than White or Asian populations to have medical debt. Delaying needed care can negatively impact a person's health, diminish productivity and quality of life, increase future health care costs because more intensive treatments are required, and contribute to premature mortality. Unpaid medical bills can also limit future access to care, and medical debt can negatively impact other spheres of life, such as depleting most or all of a person's savings, or forcing a delay in college or a change in housing.[89] National data substantiate that Black, Latino/x, Asian, and American Indian and Alaska Native populations are more likely to face cost-related barriers to getting care, are more likely to incur medical debt, and are less likely to receive preventive services, such as vaccinations. The adverse effects of medical debt and lack of access to care have a ripple effect within communities, since family and friends are often called on to provide both financial and caregiving support.

Key considerations

While most plans are required by law to provide many preventive services with no cost sharing, primary care includes care for chronic and acute conditions. To create a benefit structure that anchors equity and supports comprehensive care, employers and plans should extend cost adjustment approaches to *all* health services and supports.

Designing health insurance plans and products with equity at the center is an important and new effort; as such, care should be taken to document impact and adjust approaches as more is learned about what is optimally supportive for different populations, settings, and goals.

Opportunities for action

All entities (public and private) providing health insurance should evaluate the structure of their offerings with an equity lens. Specific opportunities include the following:

- Actively encourage purchasers, plans, actuaries, benefits vendors, and consultants to **change benefit design in standard plans to be equity-based.**
  - **An initial step is to reduce out-of-pocket costs for lower-income members.** For example, the Self-Insured Schools of California (SISC) implemented $0 copays for the first three in-person visits with a primary care provider each calendar year and partnered with Eden Health to provide a $0 virtual primary care benefit to all SISC preferred provider organization (PPO) members. The virtual program was added as a supplement to the traditional in-person primary care to provide members with easier access to 24/7 primary care at no cost. Additionally, SISC offered all of its PPO and health maintenance organization (HMO) members $0 generic drugs at all Costco pharmacies (membership not required). By waiving member copays, SISC is eliminating cost barriers and promoting adherence to prescribed medication.
  - **A second step is to reduce income-related barriers to accessing covered benefits.** For example, in 2025, the California Public Employees' Retirement System (CalPERS) will add coverage for doulas and standardized travel and lodging when eligible services are not available locally. The travel benefit ensures that members who need to travel further than 50 miles to receive high-quality, complex medical services can afford to do so.
- **Encourage employers and plans that are implementing equity practices and policies to monitor their impact to ensure there are no unexpected or adverse consequences.** For example, California's Office of Health Care Affordability's board has approved a statewide health care spending target of 3% phased in over 5 years, in order to provide relief from double-digit health cost increases to consumers. Assuming this recommendation is adopted as state policy, health plans, purchasers, hospitals, and providers will need to implement policy recommendations to meet this spending target, while ensuring that people with lower incomes, including communities of color, are not adversely impacted by cost-containment efforts.
- **Hold health plans and large self-insured employers accountable** for reporting on income- or wage-based, racial, ethnic, and other inequities in costs, access, and health outcomes based on benefit design (including data on use of high-deductible health plans and hardship loans).

Appendix B. Description of Policy Prioritization Exercise

In advance of the Summit on Primary Care Policy to Advance Health Equity, Mathematica compiled a list of over 70 policy recommendations that could strengthen primary care to advance health equity in California. To create this list, Mathematica offered its own recommendations and drew on recommendations from published literature, gray literature, and discussion with key informants. The policy recommendations were then sorted, organized, and condensed into 29 policy recommendations across seven major topic areas (access, community collaboration, health care organization leadership, payment and spending, research and evaluation, and workforce education and training). Participants were asked to prioritize the 29 recommendations in two rounds, once individually and once as a collective. The identified priorities were condensed into three foundational recommendations and 10 additional priority policy recommendations, along with a three-part approach to increase leadership and accountability.

Appendix C. Policy Recommendations by Actor

To advance primary care and health equity in California, a variety of actors/influencers need to be engaged. Table C1 lists the 10 policy recommendations that were prioritized by the Summit on Primary Care Policy to Advance Health Equity and highlights the key actors/influencers for each recommendation.

Table C1. Policy Recommendations to Advance Primary Care and Health Equity, by Actors/Influencers

POLICY RECOMMENDATION									
1. Provide technical support for primary care practices and community-based organizations to establish partnerships and working relationships in order to (a) understand the pressing social needs in the community and how these contribute to health outcomes in their patient panels and the larger local community; (b) learn about existing services (e.g., information and referral services, housing programs, case management, and home and community-based services, which help keep older adults and people with disabilities in their own homes) that are available to meet those social needs; and (c) integrate services with community-based organizations to ensure that traditionally underserved populations (e.g., those who are living in rural areas, who are unhoused or incarcerated, with mental illness or substance use disorders) have access to high-quality primary care and social care.									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
AHRQ, HHS, CalHHS, DHCS	X	X	X	X			X	X	
POLICY RECOMMENDATION									
2. Provide technical support to practices and communities to make primary care practice-based or community-based patient and family advisory councils (PFACs) standard practice across the state. PFACs should include people who reflect the diversity of the populations served and people most harmed by health inequities, and should be designed as a collaborative endeavor among patients, family members, staff, clinicians, and leaders to affirm what is working well in the primary care practice, identify opportunities for improvement, and codesign practice improvement efforts									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
DHCS, AHRQ	X	X					X	X	

POLICY RECOMMENDATION									
3. Expand and scale health professions pipeline and pathway programs (including postbaccalaureate programs) to recruit, prepare, and mentor students from historically and systematically excluded communities (especially rural communities) and cultural backgrounds for careers in primary care.									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philanthropists	Academic Researchers
CalHHS, HCAI, CalMedForce			X		X	X		X	

POLICY RECOMMENDATION									
4. Reduce debt burden for primary care professionals by offering (a) educational scholarships, subsidies, and loan repayment programs targeted to primary care professionals who train or work in underserved communities, including rural areas; (b) apprenticeships that offer opportunities for people seeking careers in primary care to learn while they earn with on-the-job training; and (c) accelerated education programs that allow primary care professionals to complete their education and training faster and join the workforce sooner.									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philanthropists	Academic Researchers
HHS, HRSA, HCAI		X	X		X	X		X	X

POLICY RECOMMENDATION									
5. Direct state investments to educational institutions that can demonstrate they are producing health professionals consistent with state goals on diversity and representation in primary care.									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
HCAI, UC Regents			X			X		X	X

POLICY RECOMMENDATION									
6. Support and scale the role that community health workers, *promotores,* and community health representatives play in primary care delivery to advance health equity and to increase the connection of primary care providers to the communities they serve. This includes (a) prioritizing and incentivizing hiring people with lived experience; (b) providing career ladders for community health workers, *promotores,* and community health representatives; (c) establishing sustainable funding mechanisms in primary care settings; and (d) facilitating partnerships between primary care providers and community-based organizations.									
ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
CalHHS, HCAI	X	X		X	X	X	X	X	

POLICY RECOMMENDATION

7. Establish or expand community health centers in areas with primary care shortages, and work with community groups and community leaders to ensure the new health center sites and services are designed to meet community needs. This includes (a) identifying a state entity to assess and prioritize areas for new community health center sites relative to need at the state level; (b) providing financial support for start-up or expansion of community health centers; and (c) streamlining the licensing process for building or expanding community health centers.

ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philanthropists	Academic Researchers
HRSA, HCAI			X				X	X	

POLICY RECOMMENDATION

8. Develop and adopt standards to collect, share, and responsibly use comprehensive, self-reported data on patients' identities and health and social needs across primary care, public health, community, and social service organizations with mechanisms to ensure that people most harmed by health care inequities are involved in the oversight of data collection, use, and sharing.

ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philanthropists	Academic Researchers
HHS, CalHHS		X	X	X			X	X	X

POLICY RECOMMENDATION
9. Implement alternative payment models (APMs) that center equity by (a) accounting for a patient's individual clinical and social risk factors and community-level socio-economic status; (b) rewarding reductions in health inequities, not only overall improvement for the population as a whole; and (c) providing financial resources sufficient to enable integration of behavioral health, social services, public health, and community partnerships into clinical practice.

ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
DHCS, DMHC, Covered California	X	X	X	X					X

POLICY RECOMMENDATION
10. Evaluate health care benefit design with an equity lens, beginning with a focus on populations with low incomes, which are disproportionately from communities of color, by (a) implementing income-adjusted premium cost sharing; (b) reducing out-of-pocket costs for members and employees and their families; and (c) proactively educating members and employees on no-cost preventive care services available through their coverage or plan.

ACTORS/INFLUENCERS									
Public Agencies and Political Leaders	Purchasers, Large Employers, and Employer Groups	Payers and Health Plans	Provider Groups and Associations	Accelerators and Enablers	Organized Labor Unions	Health Workforce Education and Training Providers	Patient and Consumer Advocacy Groups	Philan-thropists	Academic Researchers
DHCS, Covered California	X	X			X		X		X

Source: Policy recommendations prioritized by the Summit on Primary Care Policy to Advance Health Equity, 2023.

Notes: *AHRQ* is Agency for Health Research and Quality. *CalHHS* is California Department of Health and Human Services. *DHCS* is California Department of Health Care Services. *DMHC* is California Department of Managed Health Care. *HCAI* is California Department of Health Care Access and Information. *HHS* is US Department of Health and Human Services. *HRSA* is Health Resources and Services Administration.

Actor/influencer categories are defined as follows: *Public agencies and political leaders* are legislative bodies in California as well as public agencies at the federal, state, and county levels. *Purchasers, large employers, and employer groups* are the largest and most influential private employers and public purchasers in California. *Payers and health plans* are California's largest and most influential health plans, which set service rates, collect payments, process claims, and pay provider claims. *Provider groups and associations* are large medical groups, independent practice associations, and professional associations that represent providers of health care services in California. *Accelerators and enablers* are organizations that operate in the capital markets, such as venture capital and private equity, and those that enable or accelerate the implementation and scale of high-quality primary care, including electronic health record vendors and innovators of new models of care. *Organized labor unions* are groups of workers in a trade or industry joined together in collective action to negotiate for better wages and working conditions. *Health workforce education and training providers* are public and private training programs, colleges, and universities in California. *Patient and consumer advocacy groups* are organizations that promote and protect the interests and rights of health care consumers, patients, families, survivors, and caregivers. *Philanthropies* are nongovernmental, nonprofit, charitable organizations in California with funds expended for socially useful purposes. *Academic researchers* are influential organizations in California that generate evidence and provide thought leadership to guide primary care policy.

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