Starfield Summit II: Health Equity Summit
Curriculum Toolkit

Access to Primary Care is Not Enough: A Health Equity Road Map
IGNITE presentation by Arlene Bierman, MD, MS

Module by Karina Atwell, MD, MPH, Elizabeth Paddock, MD, and Andrea Westby, MD

Appropriate Audience: Advanced learners

Related Modules:

- Identifying and Addressing Patients' Social and Economic Needs in the Context of Clinical Care
- Community Vital Signs: Achieving Equity through Primary Care Means Checking More than Blood Pressure
- Communities Working Together to Improve Health and Reduce Disparities
- Understanding Health Experiences and Values to Address Social Determinants of Health

Learning Objectives

After participating in this learning module, the participant will be able to:

1. Define the multidimensional concept of “access” in healthcare.
2. Identify factors that affect health other than access to care in health systems, and factors that affect access to health care other than insurance/coverage status.
3. Describe the findings in the POWER study and the implications for addressing inequities in health and healthcare
4. Understand how to apply a Health Equity Roadmap to your community and practice to improve equity in health.

Background

Does access to primary care, alone, ensure health equity? Exploring this question in a population with universal access to primary care, the Project for an Ontario Women’s Health Evidence-Based Report Card (POWER) study revealed larger and modifiable inequalities in health and functional status than in access to and quality of care. The POWER study, ultimately, concluded that health equity cannot be achieved without moving upstream and addressing the root causes of disease and barriers to care in the social determinants of health (SDoH).[5]

The concept of “access” in healthcare is multidimensional. The Institute of Medicine defines “access” as having "the timely use of personal health services to achieve the best health outcomes".[1] The classic model of access depicts health service utilization as determined by three factors: (1) individual health needs; (2) the predisposition to seek care; and (3) a range of enabling or prohibitive factors.[2] Alternative models have placed greater emphasis on broad considerations, including: the mismatch between available health services and the needs or

expectations of a population; the structural barriers posed by the health care system; and the ability of providers to provide effective care to diverse patient populations with varying needs.[3] In the era of increased focus on health equity, there are calls for an even broader holistic view of health care access that considers SDoH.

Access to health care varies based on multiple factors of identity, demographics, and status. Disparities exist at all levels of access to care, including insurance, having a consistent source of care, and primary care continuity.[4] Efforts to increase access to health care typically focus on providing health insurance or on securing a place that will care for the uninsured. Strong evidence suggests that having a usual source of care produces better health outcomes, reduces disparities, and reduces costs. The combination of health insurance and having a usual source of care has additive benefits.[5]

Yet, the POWER study reveals that this approach falls short to attain health equity and offers an actionable Health Equity Road Map.[6]

Ignite Video
Please follow the link below to view the full talk given by Arlene Bierman, MD, MS (~13min):
https://www.youtube.com/watch?v=szVMmsGRj-8

Accompanying Slides
https://static1.squarespace.com/static/56bb9997746fb9d2b5c70970/t/594a834db11be1ad785d8d2e/1498055507920/3.5+UPDATED+Bierman+Presentation.pdf

Questions for Group Discussion
After watching the talk, and reviewing some of the readings provided below, consider splitting your learners into smaller groups and facilitate discussion on the following questions:

1. What does Bierman mean when she states "access is not enough"? What are some examples that back up this statement?
2. Describe the POWER Study Gender and Equity Health Indicator Framework. Explore the various connectivity points in the model and how they interact to influence health care access and health equity.
3. Choose 3 components of the POWER Health Equity Road Map and describe how each component influences access to care and health equity.
4. How does the POWER Road Map compare to the RWJF Roadmap to Reduce Disparities (see Chin et al, below)?
5. How can the POWER Road Map be applied in settings without Universal Health Care access? What might need to change with the Road Map to work in these environments?
6. What are some ways to ensure effective implementation and dissemination of health equity interventions?

Applying an Equity Lens in Professional Practice

As you reflect on the material in this module consider how you will apply it in your professional practice by asking questions based upon the Equity and Empowerment Lens' 5Ps:

Purpose: What is the purpose of looking beyond healthcare access in addressing equity? Why does expanding healthcare access not solve the problem of health equity? What are other contributing factors?
People: Who is affected positively by utilizing a Health Equity Road Map? Who may be negatively impacted? What is the value of using Community Engaged Research (CEnR) methods, including stakeholder input, when applying a Health Equity Road Map?
Place: What aspects of your community's current approach exacerbate or reduce equity in health (distribution of resources, environmental impacts, education, economic opportunities, etc)? In what ways does the built and natural environment impact how individuals experience safety, as well as feel productive and valued?
Process: What policies, processes, or relationships would need to be addressed to effectively use a Health Equity Road Map to identify target social determinants of health in your communities to improve health?
Power: Whose voices in your communities need to be elevated in order to promote equity? Are there populations whose interests and voices are being ignored or placed above others'? How will decision-making occur and what barriers should you consider when engaging in implementing a Health Equity Road Map?

For more in depth discussion read and refer to:

- POWER: The Project for an Ontario Women's Health Evidence-Based Report. Power website. www.powerstudy.ca. Accessed May 15, 2018.
    - The home page for the POWER study provides chapters of the study report and associated resources.

- Bierman AS, Shack AR, Johns A. Achieving health equity in Ontario: opportunities for intervention and improvement. Project for an Ontario women's health evidence-based report. Ontario Women's Health Equity Report 2012. http://www.powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter13-AchievingHealthEquityinOntario.pdf. Accessed May 15, 2018.
    - This report includes a summary of findings from the POWER study, proposed interventions and opportunities, health equity monitoring approaches, POWER frameworks, and the POWER Health Equity Road Map.

- Chin MH, Clarke AR, Nocon RS, Casey AA,et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *J Gen Intern Med*. 2012 Aug 1;27(8):992-1000. https://www.rwjf.org/en/library/research/2012/08/a-roadmap-and-best-practices-for-organizations-to-reduce-racial-.html. Accessed May 15, 2018.

    - The article offers a roadmap for reducing racial and ethnic disparities in care, based on systematic reviews of the literature, evaluation of promising practices, and technical assistance to healthcare organizations.

- Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics*. 2004;113(Supplement 4):1493-8.
    - This article reviews the value of a medical home, and the relationship between a medical home and insurance status. It concludes that having a medical home is associated with better individual and population-level health outcomes; with lower overall costs of care; and with reductions in disparities in health. Insurance is a facilitator, not a guarantee of a medical home.

Resources for Further Exploration

Macro: In Health Care Transformation

- Ruckert A, Huynh C, Labonte R. Reducing health inequities: Is universal basic income the way forward? *J Public Health*. 2017 Feb 2:1-5.
    - Income is considered by many to be the most important SDoH. It influences most of the other determinants. These authors argue that a universal basic income has the potential to significantly reduce health inequities.

- Carroll A. The problem with medicaid work requirements. *JAMA.* 2018;319(7):646-647.
    - Based on the authors' calculations, creating new work requirements for Medicaid would be unlikely to yield much in the way of cost savings, and many individuals might lose coverage based on the complexity of the system. The majority of those on Medicaid are already working. Those unable to find work are generally older with chronic medical conditions or functional limitations. As the US looks to rein in healthcare expenses, limiting access to Medicaid is often proposed as a solution.

- Gu H, Kou Y, Yan Z, Ding Y, et al. Income related inequality and influencing factors: a study for the incidence of catastrophic health expenditure in rural China. *BMC public health*. 2017 Dec;17(1):727.
    - In 2003, China began a healthcare reimbursement program in rural areas with the goal of reducing the risks of rural families incurring a catastrophic health expenditure (CHE). Study findings included 1) the incidence of CHE did decrease in rural areas with the reimbursement program; 2) CHE was more concentrated among the least wealthy; and 3) inequality increased during the study period. In 2010 the poorest rural families still had high risk of experiencing CHE. One interpretation of this study is that while health coverage did help decrease the number of CHEs, it did not lead to a level playing field. The poor were still at highest risk.

Meso: In Quality Improvement

- Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. The Power of Prevention: Chronic Disease…The Public Health Challenge of the 21st Century. 2009. https://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf. Accessed May 15, 2018.
    - The US spends more on healthcare than any other nations, yet our outcomes are poorer than many other nations that spend less. 75% of our health care spending is on chronic conditions. More than two-thirds of all adults believe that the U.S. healthcare system should place more emphasis on chronic disease preventive care, and more than 4 in 5 Americans (84%) favor public funding for such prevention programs.

- American Public Health Association. Better Health Through Equity. Case Studies in Reframing Public Health Work. March 2015. https://www.apha.org/~/media/files/pdf/topics/equity/equity_stories.ashx. Accessed May 15, 2018.
    - It is has become increasingly clear that we cannot eliminate health disparities without addressing the underlying SDoH. This APHA publication looks at five health departments across the country as they reorganize to address bias, injustice and inequality which frequently shape health equity and health outcomes. One of the case studies is Multnomah County, Oregon, which created the framework for the Equity and Empowerment Lens we have been using throughout this toolkit.

Micro: In Clinical Encounters- Shared Decision Making

- Berwick D. Health Care Coverage is Not Enough. We Need Delivery System Reform. *Huffington Post.* 16 July 2017. https://www.huffingtonpost.com/entry/health-care-coverage-is-not-enough-we-need-delivery-system-reform_us_596b777de4b0d6341fe98c85. Accessed May 15, 2018.
    - In this short and personal article, Don Berwick makes an argument for preserving the Affordable Care Act (ACA). In addition to expanding coverage, the ACA promoted care delivery innovations to make it safer, less expensive, and more accessible to all patients. Delivery system reform, rather than limiting who has access to care, has the potential to reduce costs by improving the quality and delivery of care.

Words and Concepts Used in this Module that are Defined in the Guidebook

- Health Equity

- The POWER study
- Health Care Access
- Universal Health Care Access

References

1. Millman M, ed. Access to Health Care in America. Washington, DC:National Academies Press; 1993 Feb 1. https://www.ncbi.nlm.nih.gov/books/NBK235888/. Accessed May 15, 2018.
2. Andersen R, Newman JF. Societal and Individual Determinants of Medical Care Utilization in the United States. *The Milbank Quarterly*. 2005;83(4):10.
3. Bierman AS , Magari ES , Jette AM , et al. Assessing access as a first step toward improving the quality of care for very old adults. *J Ambul Care Manage*. 1998; 21(3):17-26.
4. 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. Access and Disparities in Access to Health Care . Agency for Healthcare Research and Quality website.http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html. Accessed May 15, 2018.
5. Phillips R, Proser M, Green L, et al. The Importance of Having Health Insurance and a Usual Source of Care. Robert Graham Center website. Sept. 15, 2004. https://www.graham-center.org/rgc/publications-reports/publications/one-pagers/importance-insurance-care-2004.html. Accessed May 15, 2018.
6. Bierman AS, Shack AR, Johns A. Achieving health equity in Ontario: opportunities for intervention and improvement. Project for an Ontario women's health evidence-based report. Ontario Women's Health Equity Report 2012. http://www.powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter13-AchievingHealthEquityinOntario.pdf. Accessed May 15, 2018.

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