Research-informed health care reform: turning data into information to guide policy and improve health outcomes

Bob Phillips, MD MSPH
Andrew Bazemore, MD MPH
Robert Graham Center

- Health Services and Policy Research Center in Washington, DC
- American Academy of Family Physicians
- Editorial independence
- research and analysis to inform
  - the Academy in its public policy work
  - provide a family medicine perspective to policy deliberations in Washington
Goals today

• Offer some examples of how evidence informed US Health Reform – and where it came up short
• Offer an example of timely evaluation used to avoid poor decisions
• Review web-based data and mapping tools – Visual display of data to inform resource allocation
• Opportunity for Australia
Evidence Not Always Welcome

“Reason is six-sevenths of Treason”

James Thurber
APHCRI Partnerships

- APHCRI origins: Graham Center one model
- 5 year fellow exchange that led to build of web-based data and mapping platform
  - $2.6 million investment to build platform for research, informing Medicare Locals, and informing policy
- APCHRI = good partner for Australia’s academic community to translate research into policy
The Australian Experiment: How Primary Health Care Organizations Supported the Evolution of a Primary Health Care System

Caroline Nicholson, MBA, GAICD, GradDipPhyt
Claire L. Jackson, MD, MBBS, MPH, FRACGP, John E. Marley, MD, MBChB, FRACGP
and Robert Wells, BA

Primary health care in Australia has undergone 2 decades of change. Starting with a vision for a national health strategy with general practice at its core, Australia established local meso-level primary health care organizations—Divisions of General Practice—moving from focus on individual practitioners to a professional collective local voice.

The article identifies how these meso-level organizations have helped the Australian primary health care system evolve by supporting the roll-out of initiatives including national practice accreditation, a focus on quality improvement, expansion of multidisciplinary teams into general practice, regional integration, information technology adoption, and improved access to care. Nevertheless, there are still challenges to ensuring equitable access and the supply and distribution of a primary care workforce, addressing the increasing rates of chronic disease and obesity, and overcoming the fragmentation of funding and accountability in the Australian system. (J Am Board Fam Med 2012;25:818–26.)

Keywords: Australia, Health Care Reform, Primary Health Care
Patient Protection and Affordable Care Act

• Will Insure more people ~ 30-32 million (?)
• Prioritize primary health care
  – Expand community health center capacity
  – Primary care incentive payments
  – Accountable Care Organizations and Patient Centered Medical Home
  – Practice change facilitation
1 in 3 nonelderly people were uninsured sometime in the last year.

87 million people

18,000 deaths annually due to uninsurance—IOM, 2004
Increase Access to Primary Care

• Double Capacity of Community Health Centers
  – Currently serve ~20 million
  – Goal of 40 million by 2015

• Increase National Health Service Corps
  – More than doubles the investment
  – Loan repayment for service
  – Locates them in underserved areas
Primary Care Incentive Payments

$560 Million in 2011

• Graham Center research = most rural physicians not eligible, broader scope

• Regulation fix helped ($100MM) but it is still broken
What if we used the Definition of Primary Care for Incentives?
<table>
<thead>
<tr>
<th>Primary Care Definition Elements</th>
<th>How to measure and use for payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>first contact care</strong></td>
<td>Family medicine, general internal medicine, general pediatrics and geriatrics (claims-based or NPI)</td>
</tr>
<tr>
<td><strong>continuity of care</strong></td>
<td>Patients who see this physician/clinic get the plurality of their care there (claims-based)</td>
</tr>
<tr>
<td><strong>comprehensive care</strong></td>
<td>Breadth and depth of ICD-9 codes used by physicians in Medicare claims</td>
</tr>
<tr>
<td><strong>coordinated care</strong></td>
<td>Patients who see more than 3 physicians are seen by a PCP or PC practice at least every 6 months</td>
</tr>
<tr>
<td><strong>Bridges personal, family, and community</strong></td>
<td>Undetermined</td>
</tr>
</tbody>
</table>
Better Way of assigning Primary Care Incentive Payments?

<table>
<thead>
<tr>
<th></th>
<th>Percent of Physicians Meeting Threshold</th>
<th></th>
<th></th>
<th>All Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comprehensive</td>
<td>Continuity</td>
<td>Coordination</td>
<td></td>
</tr>
<tr>
<td>Non-Hospitalist PC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
<td>80%</td>
</tr>
<tr>
<td>GIM</td>
<td>86%</td>
<td>93%</td>
<td>93%</td>
<td>77%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>94%</td>
<td>100%</td>
<td>95%</td>
<td>88%</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP</td>
<td>95%</td>
<td>88%</td>
<td>93%</td>
<td>81%</td>
</tr>
<tr>
<td>GIM</td>
<td>94%</td>
<td>90%</td>
<td>94%</td>
<td>81%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>61%</td>
<td>100%</td>
<td>100%</td>
<td>61%</td>
</tr>
</tbody>
</table>
ACOs and Patient Centered Medical Homes

- An ACO is “a set of physicians and hospitals that accept joint responsibility for the quality of care and the cost of care received by the ACO's panel of patients.”

- The Patient Centered Medical Home is a medical practice that furnishes primary care, conducts care management, has a formal quality improvement program, has 24-hour patient access, maintains advance directives, and has a written understanding with each beneficiary that it is the patient’s medical home.

- MedPAC regards medical homes as building blocks of effective accountable care organizations.

Your Medicare Locals could be ACOs (with better grasp of who they serve)

Personal health

Population health

Public health

ACO
Illinois Medicaid Medical Home Experiment

- Insurance program for uninsured, low income families
- Mostly women and children
- Medical Home launch 2005/2006
  - Weak ACO features
- 2.6 million beneficiaries
- Graham Center evaluation funded by the Commonwealth Fund
Reduced Hospitalizations

Medicaid hospitalization days 2004 - 2010

units: per 1,000 full time equivalent enrollees
Bending the Cost Curve

Figure. Medicaid saving with distribution effect 2004 - 2010

- medicaidsave1: medicaid saving using 2006 enrollee distribution
- medicaidsave2: medicaid saving using current year enrollee distribution

unit: $1,000,000
ACO impact on quality

• Necessary focus on primary care and outpatient disease/complex care management
• Designing programs to meet patients where they are, make access and behavior change easier, facilitate continuous relationships
• Continuous feedback
  – to system, clinics, providers
  – Encourage curiosity, innovation, plan-do-study-act cycles
  – System resources for testing solutions (failure is ok)
• Move to population focus but translate to personal health
• Develop relationships with public health to solve problems that affect health
Data and Mapping Tools
(the cool stuff)
Data Visualization as effective Communication
The Broad Street Pump
Primary Health Care in the Community Context
Community Oriented Primary Care

Drs. Sidney and Emily Kark
early 1940s

Developed COPC into a model of community engagement for improving health South Africa, Australia, Israel….the US
OHIO: PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS IF FAMILY PHYSICIANS WERE WITHDRAWN

10th Congressional District
2002 County Primary Care HPSA Status After Withdrawal
- HPSA/Becomes Full HPMA
- Remains Partial HPMA
- Not a HPMA

Prepared by the Robert Graham Center:
Policy Studies in Family Medicine and Primary Care
Data Source: 2003 Area Resource File
(U.S. Department of Health and Human Services)
Residency Footprint

Virginia Commonwealth University Residency Graduates
“Footprinting” Training Sites – Residency & Medical School Social Accountability

Graduate Practice Characteristics: 160 Graduates

<table>
<thead>
<tr>
<th>Practicing in District of Columbia</th>
<th>Graduates Practicing in HPSA’s*</th>
<th>Graduates Practicing in Rural Areas</th>
<th>Graduates Practicing in Rural District of Columbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 (11%)</td>
<td>41 (26%)</td>
<td>9 (6%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Localizing & Translating Complex Analysis...
Why should we support you? So many of your patients come from outside of DC.”
(Washington DC City Council)

Unity Service Area (2007)

N= 77,400
(Service Area Threshold 70%)
“Why have 2 sites in the same neighborhood?”

(Washington DC City Council)
Target: Federal Agency, State Planners, Community Health Center Grantee

Can instantly visualize any geography in the United States
Exploring Safety Net Gaps and Overlap at the Small Area Level
How has service changed over 2-Years?
What % of Low-Income population remains unserved?
Where are the Low-Income Not Served?
Also permits export and sharing of maps, data by user

Allowing planner or potential grantee to model impact of new clinic
Understanding Small Area Poverty Thresholds
Areas where 15% of population lives below Poverty
US Medicare Hospital Region Compare Tool in HealthLandscape in 24 hours in response to National Academies of Science GoViral Challenge
www.MedSchoolMapper.org
HL-Australia: Informing Primary Health Care Reform & the Quantum Shift to Population Based Health Care