Improving Healthcare Access for All Texans During and After COVID-19

DATE: November 10, 2020 PRESENTED BY: JENNIFER DEVOE, MD, DPHIL; SAULTZ PROFESSOR AND CHAIR, OHSU FAMILY MEDICINE

Greater primary care supply is associated with lower population mortality.

Accessible, affordable, continuous primary care is foundational.

The National Academy of Science, Engineering, and Medicine has launched a consensus study on Implementing High-Quality Primary Care.

JAMA Internal Medicine | Original Investigation

Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015

Sanjay Basu, MD, PhD; Seth A. Berkowitz, MD, MPH; Robert L. Phillips, MD, MSPH; Asaf Bitton, MD, MPH; Bruce E. Landon, MD, MBA; Russell S. Phillips, MD

IMPORTANCE Recent US health care reforms incentivize improved population health outcomes and primary care functions. It remains unclear how much improving primary care physician supply can improve population health, independent of other health care and socioeconomic factors.

OBJECTIVES To identify primary care physician supply changes across US counties from 2005-2015 and associations between such changes and population mortality.

DESIGN, SETTING, AND PARTICIPANTS This epidemiological study evaluated US population data and individual-level claims data linked to mortality from 2005 to 2015 against changes in primary care and specialist physician supply from 2005 to 2015. Data from 3142 US counties, 7144 primary care service areas, and 306 hospital referral regions were used to investigate the association of primary care physician supply with changes in life expectancy and cause-specific mortality after adjustment for health care, demographic, socioeconomic, and behavioral covariates. Analysis was performed from March to July 2018.

MAIN OUTCOMES AND MEASURES Age-standardized life expectancy, cause-specific mortality, and restricted mean survival time.

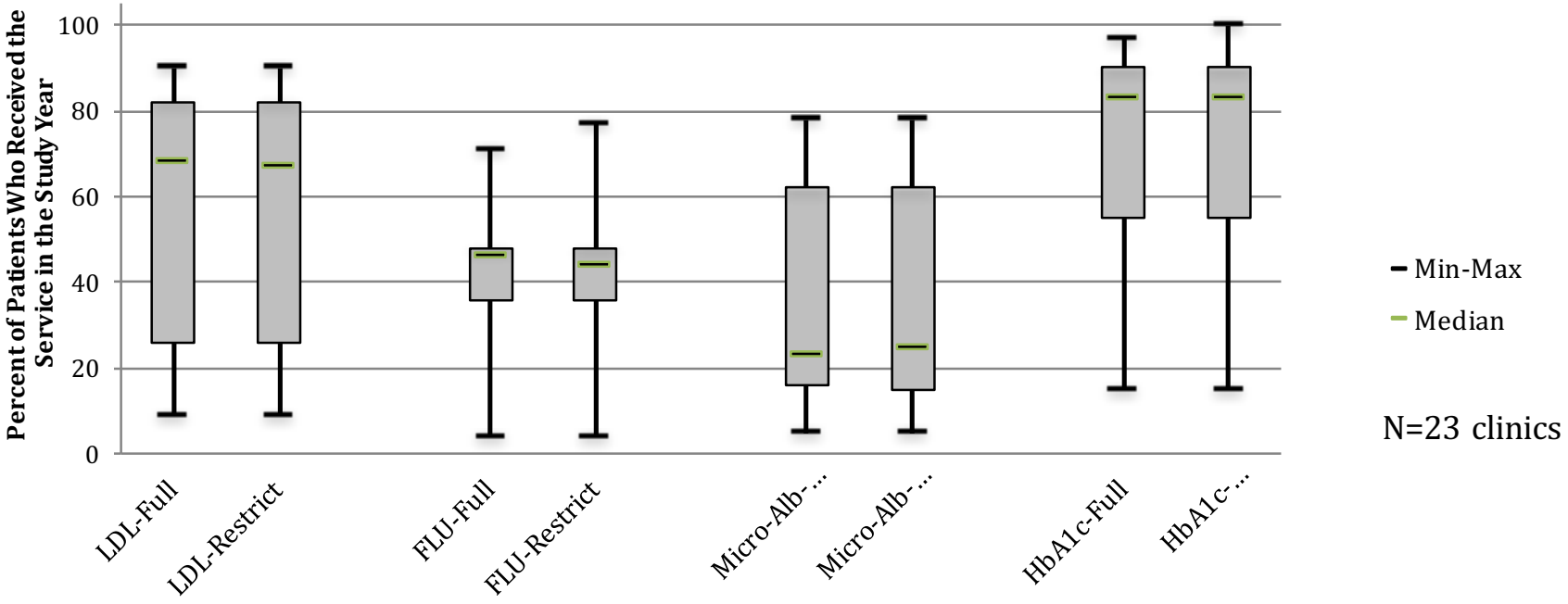
RESULTS Primary care physician supply increased from 196 014 physicians in 2005 to 204 419 in 2015. Owing to disproportionate losses of primary care physicians in some counties and population increases, the mean (SD) density of primary care physicians relative to population size decreased from 46.6 per 100 000 population (95% CI, 0.0-114.6 per 100 000 population) to 41.4 per 100 000 population (95% CI, 0.0-108.6 per 100 000 population), with greater losses in rural areas. In adjusted mixed-effects regressions, every 10 additional primary care physicians per 100 000 population was associated with a 51.5-day

Invited Commentary

Supplemental content

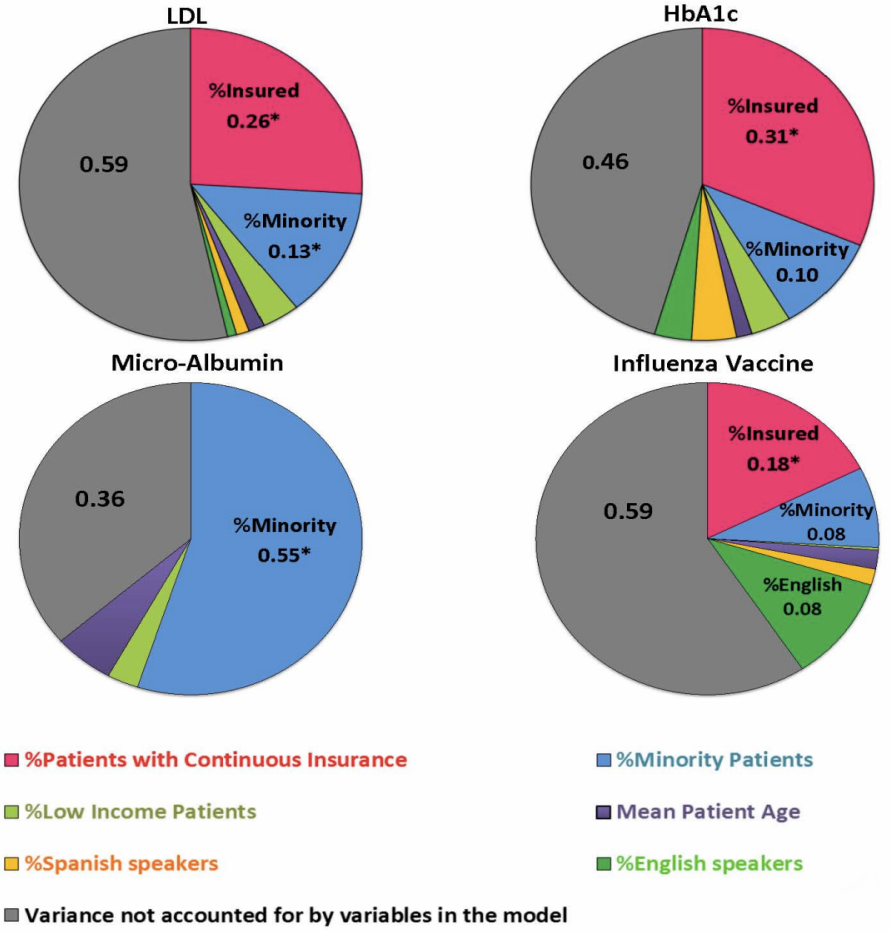
Basu S, Berkowitz SA, Phillips RL, et al. Association of primary care physician supply with population mortality in the United States 2005-2015. *JAMA Internal Medicine* 2019;179(4):506-514.

In the OCHIN network of community health centers, we identified wide variability in the quality of diabetes care being provided.



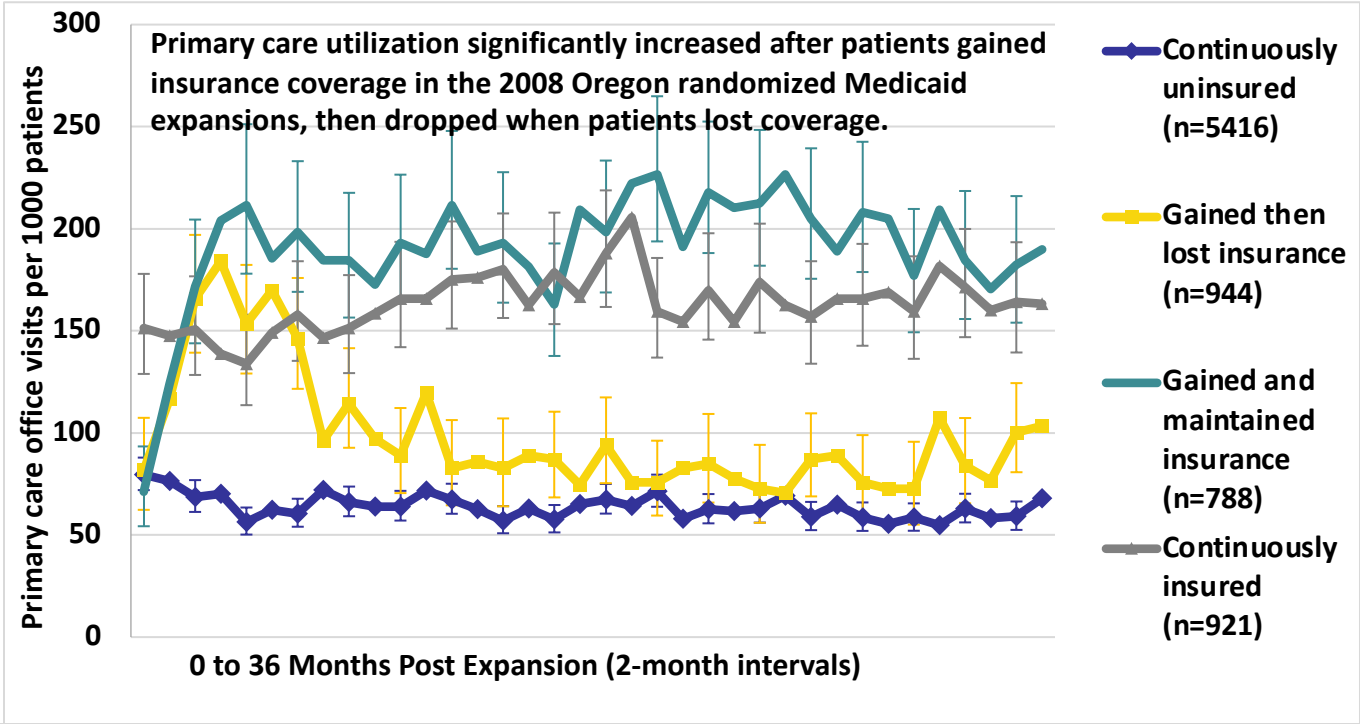
Bailey S, O'Malley J, Gold R, Heintzman J, Likumahuwa S, DeVoe J. Diabetes care quality is highly correlated with patient panel characteristics. *Journal of the American Board of Family Medicine.* 2013;26(6):669-679.

We discovered that variability in the quality of diabetes care was highly correlated with a clinic's patient panel, including the percent of patients without continuous health insurance and other characteristics in the clinic population.

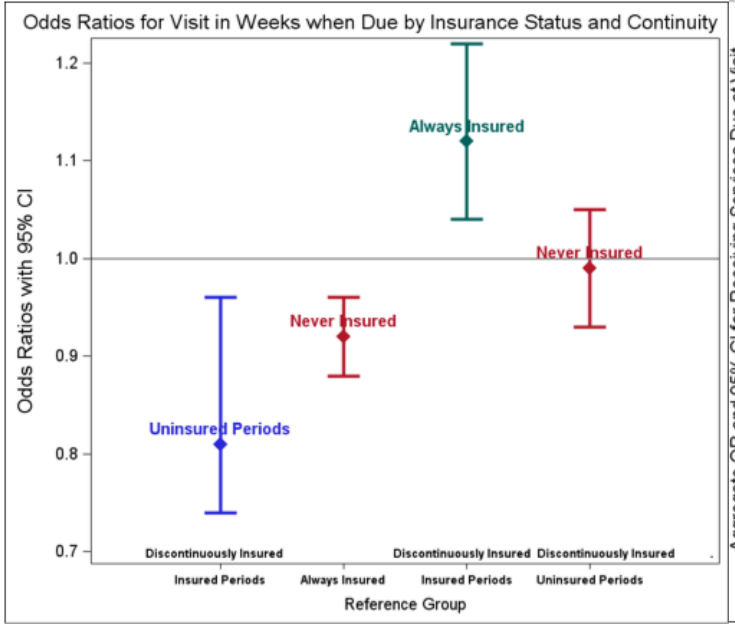


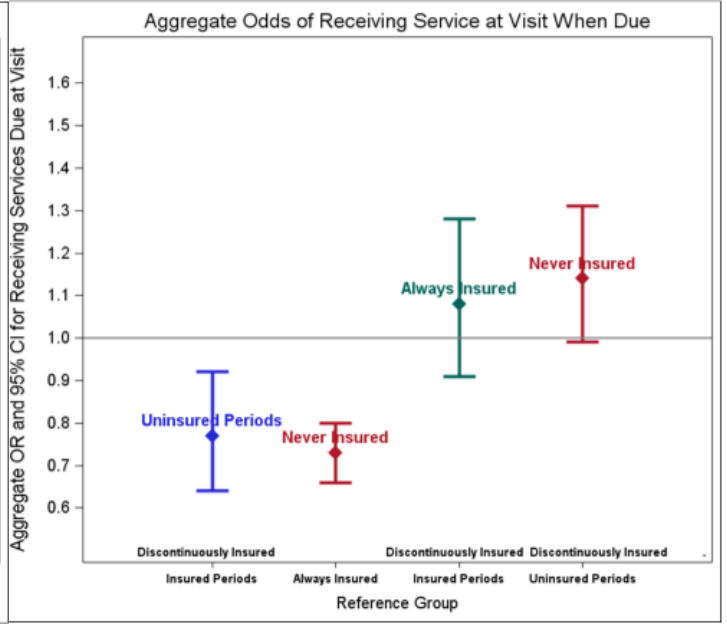
Bailey S, O'Malley J, Gold R, Heintzman J, Likumahuwa S, DeVoe J. Diabetes care quality is highly correlated with patient panel characteristics. *Journal of the American Board of Family Medicine.* 2013;26(6):669-679. doi: 10.3122/jabfm.2013.06.130018.

What happens when patients gain and lose health insurance coverage?



Hatch B, Bailey SR, Cowburn S, Marino M, Angier H, DeVoe JE. (2016) Community Health Center Utilization Following the 2008 Medicaid Expansion in Oregon: Implications for the Affordable Care Act. *American Journal of Public Health*, April 2016, Vol. 106, No. 4: 645–650.



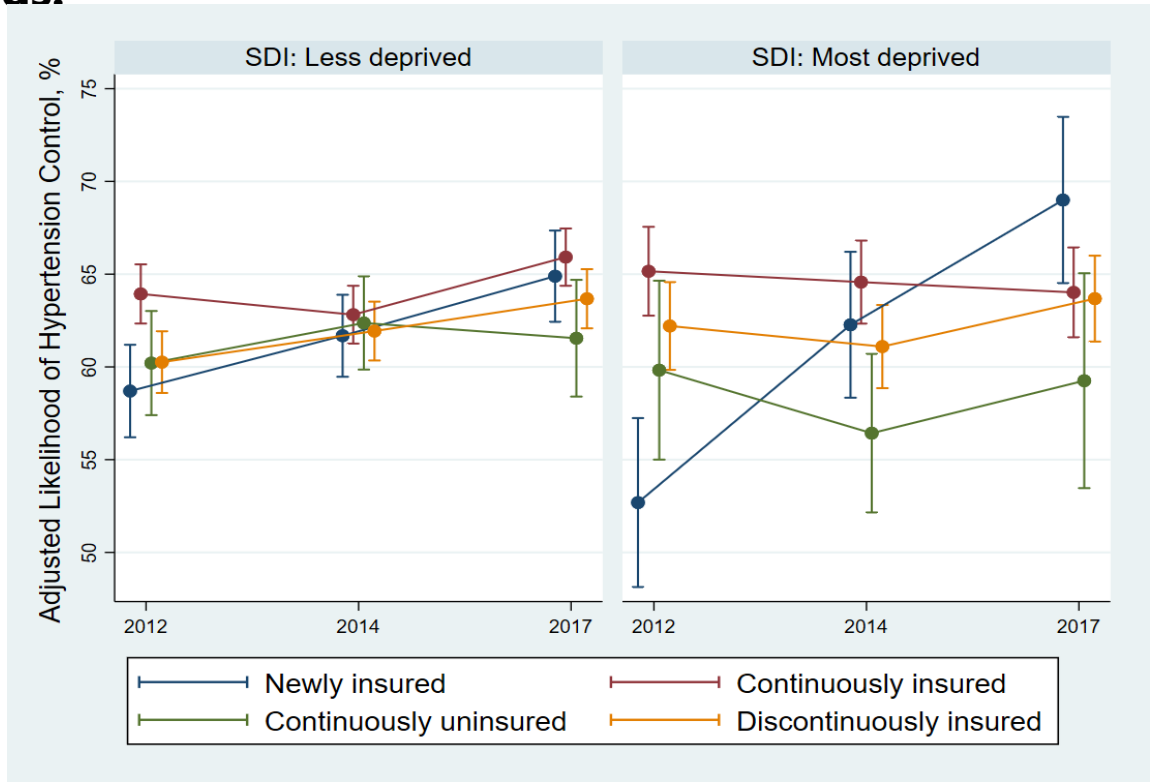


Lack of insurance was associated with *fewer primary care visits*, resulting in *lower odds of a clinic visit when a service was due* (Figure 1).

When patients did come in for an office visit in periods when services were due, lack of insurance was also associated with *lower odds of receiving services due at the visit* (Figure 2).

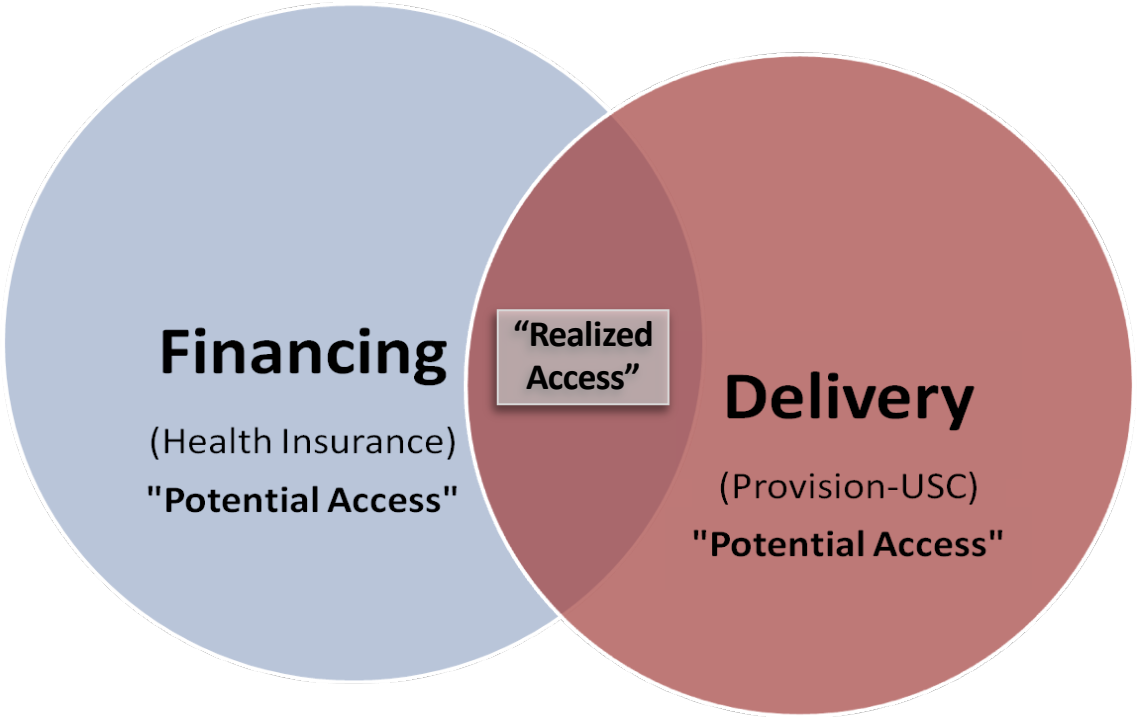
Bailey SR, O'Malley JP, Gold R, Heintzman J, Marino M, DeVoe JE. Receipt of diabetes preventive services differs by insurance status at visit. *American Journal of Preventive Medicine*. 2015 Feb;48(2):229-233.

Among adults, gaining insurance was associated with a 16% improvement in hypertension control among patients living in the most deprived neighborhoods.



Angier H, Green B, Fankhauser K, Marino M, Huguet N, Larson A, DeVoe JE. Role of health insurance and neighborhood-level social deprivation on hypertension control following the Affordable Care Act. *Social Science & Medicine* 2020. Early release, on-line at https://doi.org/10.1016/j.socscimed.2020.113439

Having both health insurance and a usual source of care (USC) is associated with the lowest percentage of unmet needs.



DeVoe JE, Tillotson CJ, Lesko SE, Wallace LS, Angier H. 2011. The Case for Synergy between a Usual Source of Care and Health Insurance Coverage. *J Gen Intern Med*. 26(9):1059-66.

“Bridging the gap between where the quality metric ends and real life begins…”

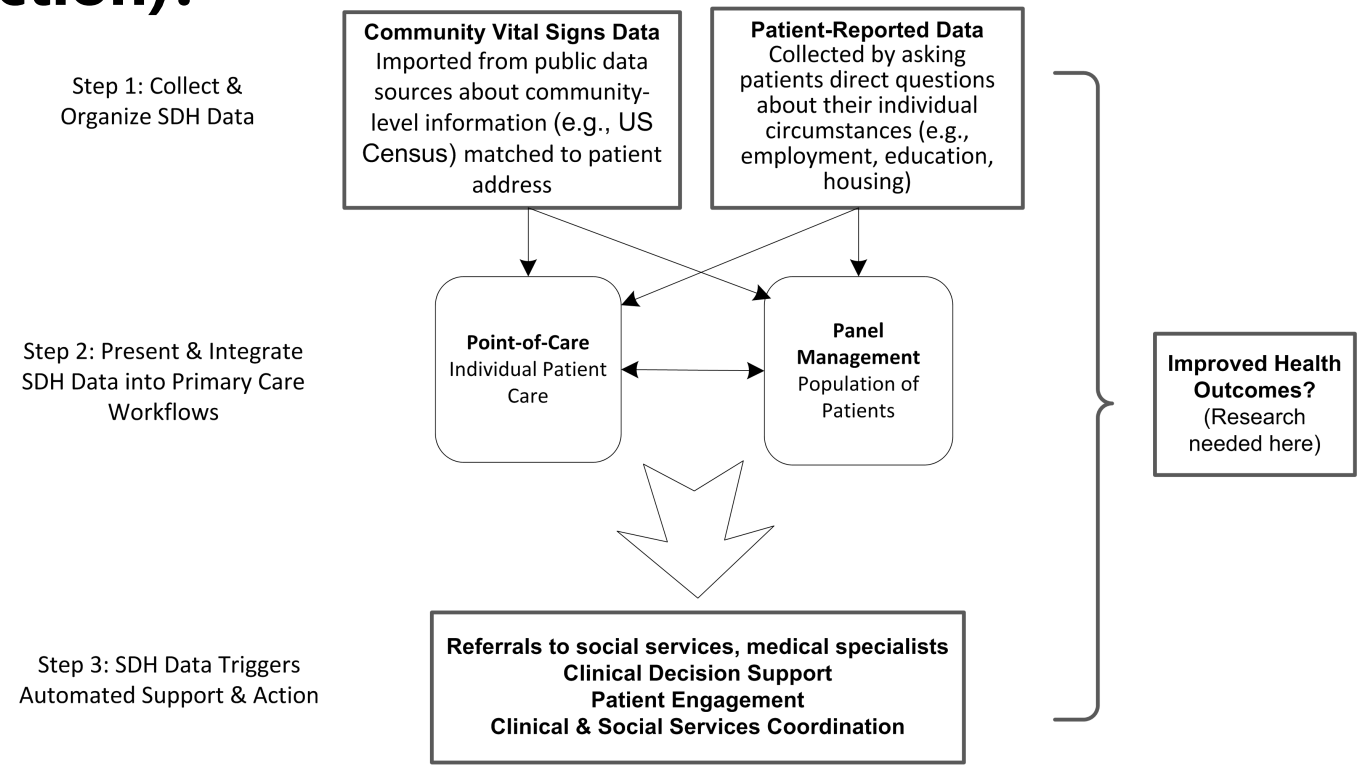
A few weeks ago, I was pouring over the latest evidence-based guidelines for treating hypertension… On the surface, the guidelines seemed straight forward. We should add a third medication…

When we looked for evidence to assure us that this recommendation was the best one for a patient with co-morbid obesity, asthma, generalized anxiety disorder, depression, and polycystic ovary disease, we found very little. Further, we reviewed quality metric parameters for how primary care physicians are assessed in adequately lowering a patient’s cardiovascular disease risk and found no guidance in how to factor in her history of adverse childhood experiences (ACEs), unstable housing, unemployment, and food insecurity in assessing how much the addition of a new anti-hypertensive medication might lower her risk for cardiac disease…

It reminds me of the famous phrase in the poem “Where the Sidewalk Ends” by Shel Silverstein: “There is a place where the sidewalk ends and before the street begins…” In my primary care practice, I often feel like I am in that place where the quality metric ends and real life begins

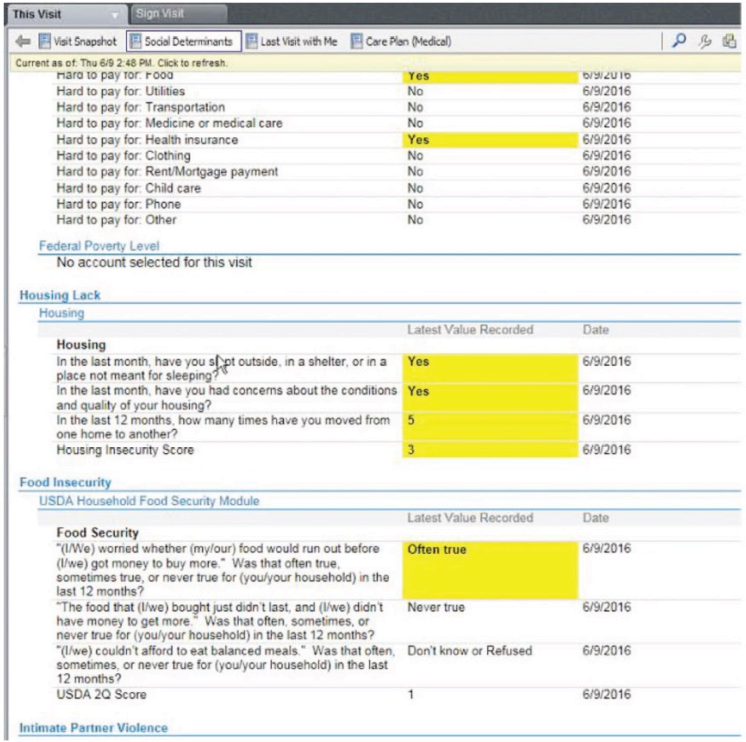
DeVoe JE. Bridging the Gap Between Where the Quality Metric Ends and Real Life Begins—A Trusting Relationship. *JAMA Intern Med.* 2020; 180(2):177-178. https://doi.org/10.1001/jamainternmed.2019.5132

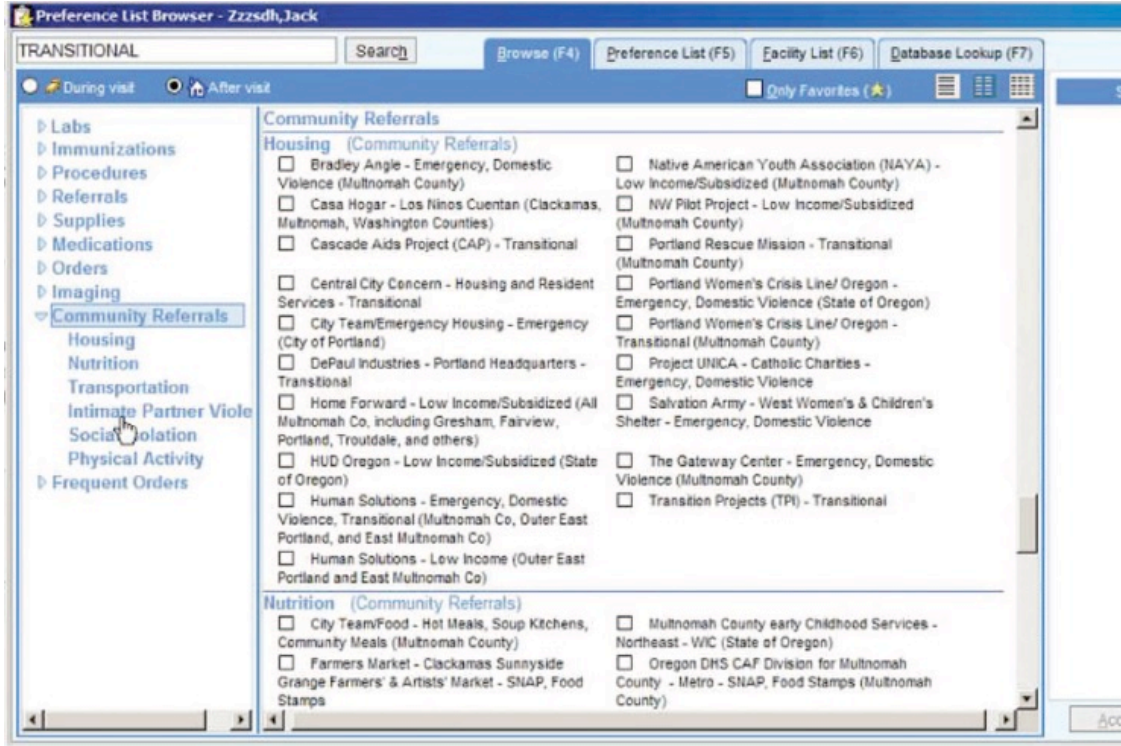
How can we use new IT and data infrastructure to integrate SDH data into the healthcare settings (AND take action)?



DeVoe JE, Bazemore AW, Cottrell EK, Likumahuwa-Ackman S, Grandmont J, Spach N, Gold R (2016). Perspectives in Primary Care: A Conceptual Framework and Path to Integrating Social Determinants of Health Into Primary Care Practice. *Annals of Family Medicine*,

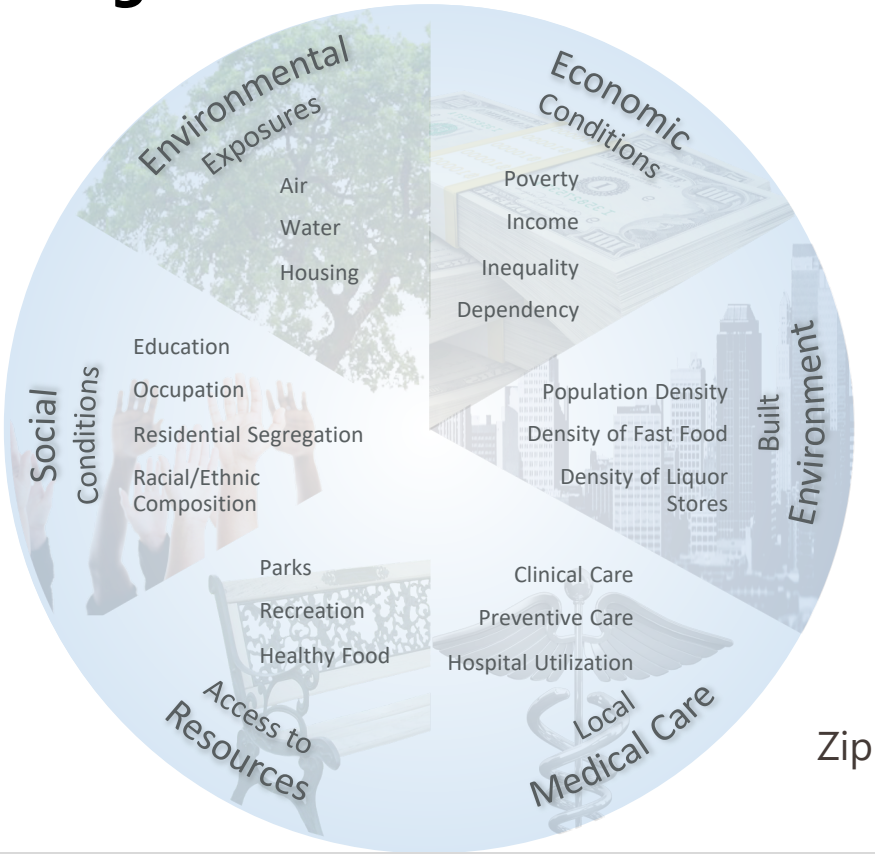
How can we most effectively collect and use individual-level social determinants of health information in actionable ways?





Gold R, Cottrell E, Bunce A, et al. Developing Electronic Health Record Strategies Related to Health Center Patients' Social Determinants of Health. *Journal of the American Board of Family Medicine.* 2017; 30:428-447.

How can we integrate neighborhood level clinical and social data? Does adjusting for these factors matter?

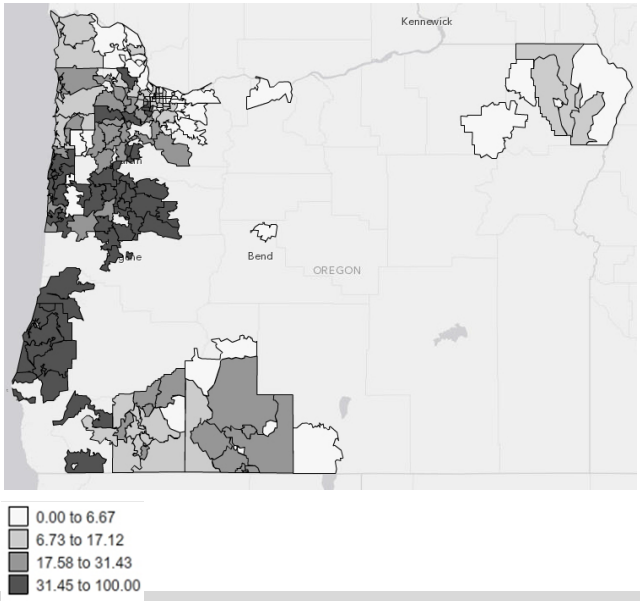


Available by either
County, Census Tract, or
Zip Code Tabulation Area

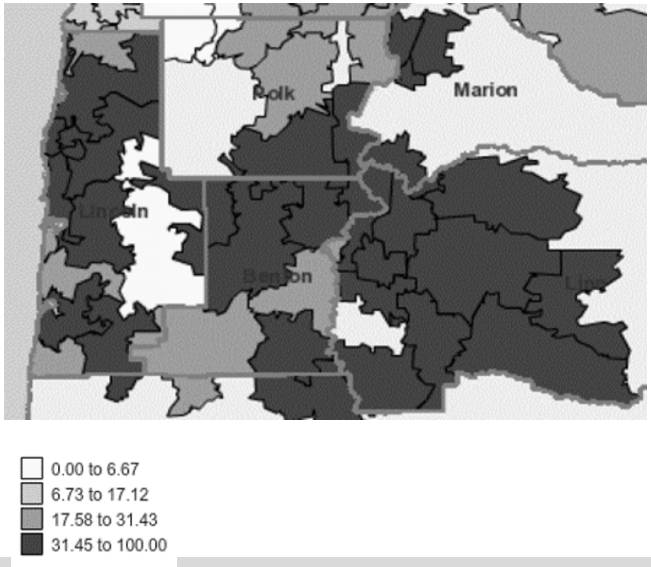
Bazemore AW, Cottrell EK, Gold R, et al. "Community Vital Signs": Incorporating geocoded social determinants into electronic health record to promote patient and population health. *Journal of the American Medical Informatics Association.* 2016;23(2):407-412.

It is not just about bringing the data into the electronic health record. How can we use geospatial tools aggregating clinical and community data to inform partnerships with community organizations?

Percent of children without insurance: 0-18 years of age with at least one visit to an OCHIN PBRN clinic in 2011



Areas with High Rates of Children without Insurance in OCHIN and Median Household Income Rates by Oregon County (Lincoln, Polk, Benton, Marion)



Angier H, Likumahuwa S, Finnegan S, Vakarcs T, Bazemore A, Carrozza M, DeVoe JE. (2014) Using Geographic Information Systems to Identify Communities in Need of Health Insurance Outreach within the OCHIN Practice-based Research Network. J Am Board Fam Med. 2014 Nov-Dec;27(6):804-10.

OHSU

"The incompatibility of patient-centered care with fee-for-service payment"

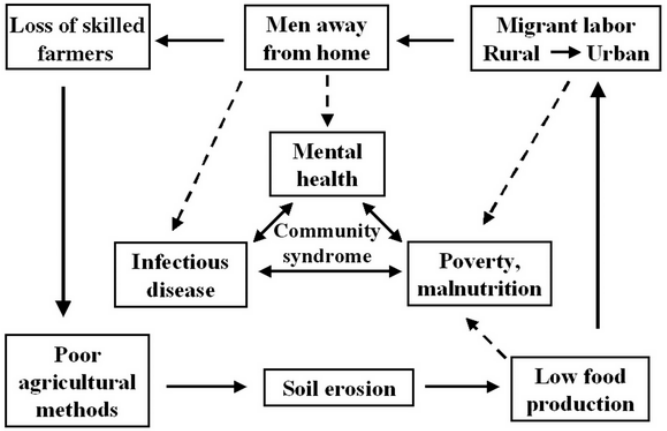
As the primary care team entrusted with the care of this patient…Our team's efforts to address her social and emotional needs improved her health and enabled her to be more safe and comfortable while continuing to live independently at home…

She needed us to do more in areas where there were few (if any) healthcare resources available. There was no easy way to receive payment for our team's work to address her social determinants of health - the paperwork and extra bureaucratic hurdles were barriers too large to surmount…

Given that most primary care practices are still reimbursed fee-for-service, choosing to provide patient-centered care in this way often comes with significant financial losses. The heroic work being done by primary care teams to keep patients and communities safe during the COVID-19 pandemic, while jeopardizing the financial survival of their practices, is shining a bright spotlight on this perverse dichotomy. These teams should be trusted with a predictable, prospective budget… Increasing flexibility to allow teams to deliver needed services might just improve the quality of the care provided and the population's health outcomes, while also decreasing the downstream costs.

DeVoe J. The incompatibility of patient-centered care with fee-for-service payment. *JAMA Intern Med*. 2020; published on-line September 28, 2020.

What policy and payment changes are needed to implement community-oriented primary care (COPC)? How can we translate what the Karks learned in S. Africa in the 1940s and what Geiger, Gibson, et al. learned in the US in the 1960s?



***South African Medical Journal*, 1952**

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town
Posbus 643, Kaapstad
Vol. 26, No. 6
Cape Town, 9 February 1952
Weekly 2s 6d

THE PHOLELA HEALTH CENTRE
A PROGRESS REPORT*

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Institute of Family and Community Health, Durban
and
JOHN CASSEL, B.Sc., M.B., B.Ch.
Pholela Health Centre, Bulwer, Natal

The origin and early development of this Centre, which was the first Health Centre to be established by the Union Health Department, has been described by Gear,[2] by Kark and Kark [4] and by Kark.[3, 7, 8] Following the Report of the National Health Services Commission in 1944, the government decided to establish Health Centres in various parts of South Africa. Pholela was considered a useful pilot project in this new service. Medical Officers and other staff appointed to the various newly created Health Centres were first sent to Pholela to gain experience in Health Centre practice and to study the methods evolved there. At the same time it was realized that Pholela could not remain the only teaching and investigation base in a service to be provided for various types of community in South Africa. As a result the Pholela Centre became the rural section of an Institute of Family and Community Health which was established with headquarters in Durban.[1,2,3] Established in April 1940, it is the oldest section of the Institute. After 11 years of work a further report of progress will be of interest.

THE NATURE AND EXTENT OF THE SERVICE

The essential features which have developed include care of the sick and prevention of illness by the doctor and nurse, associated with a programme of health education carried out by specially trained 'health educators' under the direction of the

The Health Centre's practice consists of a general service and a more defined family health and medical care programme.

1. *The General Service.* This is available to all who wish to use it regardless of their domicile. It includes out-patient treatment of the sick and special sessions for the care of the expectant mother and the mother with her baby. However, many patients who come to the Health Centre from neighbouring magisterial districts are encouraged to see the district surgeons and other medical practitioners in their immediate neighbourhood. In addition, Health Centre staff are often asked to assist in the control of outbreaks of epidemic diseases in neighbouring districts.

2. *The Family Health and Medical Care Programme.* This relatively intensive service was started in 1942, including 130 families with a total population of a little less than 900 persons. By gradually extending the area of this service the Centre now provides a family health and medical care programme for a population of 8,500 people in the district of Pholela.

THE RESPONSIBI

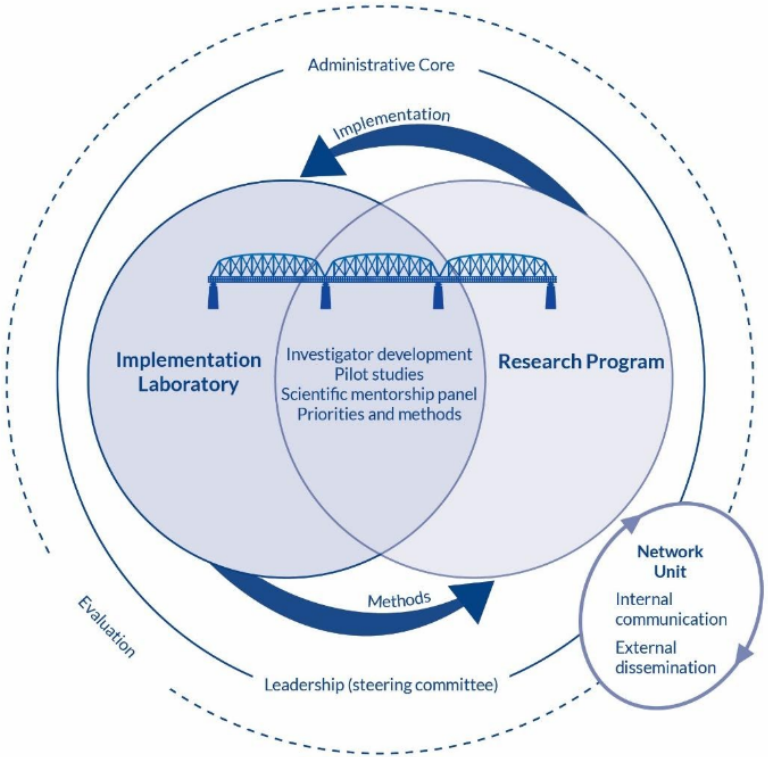
"Community-oriented primary health care brings together elements of individual, family, and community health care: It involves integration of health education, prevention and promotive health care, early detection, treatment, alleviation and rehabilitation. **It focuses on the local community in partnership between the health services and the communities served, and may involve interagency cooperation.** Clinical and epidemiological skills are brought together as complementary functions, together with other important skills. The community-oriented primary care practice team, in partnership with the community, assumes the initiatives in health promotion and care, thus widening the functions of practitioners in the community. **A central principle is that health care should be provided 'in communities, for communities, and with communities.' "**

S. Kark, E. Kark, JH Abramson, "Commentary: in search of innovative approaches to international health," AJPH 83, no. 11 (1993):1533-6. Quote on p 1534

Once we make a new discovery, how can we scale it up? Dissemination and Implementation (D&I) Research is key to our success

BRIDGE-C2 CENTER

Building Research In Implementation & Dissemination To Close Gaps & Achieve Equity In Cancer Control



https://bridgetoinnovation.org/our-initiatives/bridge-c2-center/

Acknowledgements:

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Additional support was received from OCHIN, the OHSU Department of Family Medicine, and the BRIDGE-C2 Center.

A special thank you to all of the primary care clinics and patients who are participating in this research.

And, thank you for listening!

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OHSU Family Medicine

BRIDGE-C2 CENTER
Building Research In Implementation & Dissemination To Close Gaps & Achieve Equity In Cancer Control

OCHIN

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