Common Sense with a Flourish: Primary Health Care for Rural Oregon

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OHSU Family Medicine
Goals

- To explain health reform in America as a work in progress
- To explore the characteristics of a high-quality, cost effective health care system for rural Oregon
- To explain why functional rural health care depends on re-engineering primary care
- To outline what each of us must do at this key time in history to make health reform successful
Health reform efforts by government

- State efforts to cover children
- State efforts to support the safety net
  - Rural Hospital designation
  - Rural provider tax credits
- State efforts to stimulate delivery system reform-2009
  - Oregon Health Authority
  - Oregon Health Policy Board
- Federal efforts to support the safety net
  - National Health Service Corps
  - Community and Rural Health Centers
  - Critical Access Hospitals
- Federal efforts to achieve universal coverage
  - Medicare and Medicaid- 1965
  - Clinton health reform efforts- 1992
  - The Patient Protection and Affordable Care Act-2009
Good things about the Oregon Health Authority

- Defines the health of the public as its primary goal
- Attempts to use the state’s purchasing power to stimulate market changes
- Establishes a goal of patient-centered medical (health) homes, a metaphor for delivery system reform
- Establishes a public process to define the PCMH
- Attempts to make state government more efficient by increasing the value of health care dollars spent
Questions about the Oregon Health Authority

- Can the state afford it?
- Do we have the political will?
- How will the health plans respond?
- How will the delivery system adapt?
- Do we have the right workforce?
- Can we overcome individualism and care for communities?
Good things about federal health reform

- Extends coverage to 32 million people
- Subsidies to low income people - expands Medicaid
- First dollar coverage of preventive care
- Phasing out of the Medicare “donut hole”
- Prohibition of pre-existing condition exclusions
- Allows children to stay on parents health plan until age 26
- Health insurance exchanges
- Patient-centered Outcomes Research Institute
- $11 billion of new funding for CHC’s

Geyman J. 2010
Questions about federal health reform

- Will it contain cost of care?
  - Patient-Centered Medical Homes
  - Accountable Care Organizations

- How will it control premium increases?
  - Insufficient competition for health plans
  - Insurance exchanges are untested
  - Insurance reforms have hedges

- How will it achieve universal coverage?

- How will it preserve and improve quality?

- Will it increase bureaucracy?

- Will the individual mandate survive legal challenge?

- Do we have the right workforce?

Geyman J. 2010
What would a high-quality, cost effective health care system for rural Oregon look like?
Idealized health care for rural Oregon

- Would create a healthy population by promoting healthy communities and individuals
- Would care for everyone
- Would deliver the highest quality care as defined by the best scientific evidence
- Would be accountable for producing excellent outcomes
- Would eliminate waste and assure affordability
- Would be economically sustainable over the long term
Health Care for the Community

- Adult population
- Adults with illness or injury
- Adults consulting physician
- Hospitalized adults
- Referred adults
- Adults in tertiary care

White, Williams, Greenberg, 1961
Demographic trends in rural America

- Aging population- dependent on Medicare funding
- Fewer health professionals
- Dependent on primary care
- Dependent on generalist providers
- Most medical practices are small businesses
- Absent or poor mental health system
- 30-40 million newly insured people will overwhelm the system
Health Professional Shortage Areas (HPSA) - Primary Health

HPSA Clinician Priority Scores

HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians.

Scores range from 1 to 25.

Higher scores equal greater priority.

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; July 6, 2010.

Note: Alaska and Hawaii not shown to scale
Where do family physicians practice?

Current PCHPSAs

Without FPs

Health Professional Shortage Areas (HPSA) - Mental Health

HPSA Clinician Priority Scores

HPSA Scores:
- 19 - 25
- 14 - 18
- 8 - 13
- 1 - 7
- Proposed Withdrawal or No Data Provided

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; July 6, 2010.

Note: Alaska and Hawaii not shown to scale.

HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25. Higher scores equal greater priority.
Primary Care in America is in Crisis

- **Quantity problems**
  - Poor student interest
  - Hostile reimbursement system
  - Too dependent on physicians

- **Quality problems**
  - Poor information systems
  - Poor communication systems
  - Shrinking scope of practice
  - Segregated training programs produce individuals rather than teams
Figure 4. Active Patient Care Primary Care Physicians per 100,000 Population by Degree Type, 2008

State Median = 80.1

Sources: July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008). Physician data are from the AMA Physician Masterfile (December 31, 2008).
Figure 7. Percentage of Active Physicians Who Are Age 60 or Older,* 2008

Source: AMA Physician Masterfile (December 31, 2008)

* Physicians whose age was unknown (n = 1,122) are excluded.
Map 4. Medical and Osteopathic Students per 100,000 Population, 2008-2009 Academic Year

Source: Medical enrollment data are from the AAMC Data Warehouse STUDENT file. Osteopathic enrollment data are from Osteopathic Medical College Information Book: 2010 Entering Class. July 1, 2008 population estimates are from the U.S. Census Bureau.
Figure 8. Students Enrolled in Medical or Osteopathic School for the 2008-2009 Academic Year Per 100,000 Population

Sources: Medical enrollment data are from the AAMC Data Warehouse STUDENT file as of December 9, 2008, accessed online at http://www.aamc.org/data/facts/2008/schoolenrl0308.htm (August 12, 2009). Osteopathic enrollment data are from Osteopathic Medical College Information Book: 2010 Entering Class, accessed online at http://www.aacom.org/resources/bookstore/clb/Pages/default.aspx (August 05, 2009). July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008).

* State does not have a medical or osteopathic school.
Figure 11. In-State Matriculation to Medical School for the 2008-2009 Academic Year


* State does not have a medical school.

1 The data shown here are for students in medical schools only. Students attending osteopathic schools are excluded.
Map 6. Residents and Fellows in ACGME-Accredited Training Programs per 100,000 Population, 2008

Source: July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008). Physicians in ACGME-accredited programs are from the 2009 AAMC/AMA National GME Census.
Map 7. Residents and Fellows in ACGME-Accredited Primary Care Programs per 100,000 Population, 2008

Source: July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008). Physicians in ACGME-accredited primary care programs are from the 2009 AAMC/AMA National GME Census.
Figure 13. Residents and Fellows on Duty as of August 1, 2008 in ACGME-Accredited Primary Care Programs per 100,000 Population by Degree Type

Sources: July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008). Physicians in ACGME-accredited primary care programs are from the 2009 AAMC/AMA National GME Census.
Family Medicine
Positions Offered & Filled with U.S. Seniors in March 1999 – 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Positions Offered</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>1999</td>
<td>3,265</td>
<td>62.0%</td>
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<tr>
<td>2000</td>
<td>3,206</td>
<td>57.2%</td>
</tr>
<tr>
<td>2001</td>
<td>3,096</td>
<td>49.0%</td>
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<tr>
<td>2002</td>
<td>2,983</td>
<td>47.4%</td>
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<tr>
<td>2003</td>
<td>2,940</td>
<td>42.0%</td>
</tr>
<tr>
<td>2004</td>
<td>2,884</td>
<td>41.5%</td>
</tr>
<tr>
<td>2005</td>
<td>2,782</td>
<td>40.7%</td>
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<tr>
<td>2006</td>
<td>2,727</td>
<td>41.5%</td>
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<tr>
<td>2007</td>
<td>2,621</td>
<td>42.2%</td>
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<tr>
<td>2008</td>
<td>2,654</td>
<td>44.2%</td>
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<tr>
<td>2009</td>
<td>2,555</td>
<td>42.4%</td>
</tr>
<tr>
<td>2010</td>
<td>2,630</td>
<td>45.0%</td>
</tr>
</tbody>
</table>

Filled U.S. Seniors

- 1999: 2,024
- 2000: 1,833
- 2001: 1,516
- 2002: 1,413
- 2003: 1,234
- 2004: 1,198
- 2005: 1,132
- 2006: 1,132
- 2007: 1,107
- 2008: 1,172
- 2009: 1,083
- 2010: 1,184

Lines in the diagram represent:
- Blue: Positions Offered
- Red: Filled U.S. Seniors
Federal Support for Primary Care Education

Figure. Title VII, Section 747 Funding Over Time

Figure: Total appropriation of Title VII funding over time, adjusted to 2008 dollars.  

Graham Center 2009
OHSU’s State Appropriations

(In Thousands)

Data Sources: All information from 93-95 forward taken from State Bills. 91-93 from archived presentations
Note: Includes Lottery Dollars
Primary Care in America is in Crisis

- Quantity problems
  - Poor student interest
  - Hostile reimbursement system
  - Too dependent on physicians

- Quality problems
  - Poor information systems
  - Poor communication systems
  - Shrinking scope of practice
  - Segregated training programs produce individual rather than teams
The Patient-centered Medical Home is a transformed and enhanced system of delivering basic health care to a population of people.
The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation

**Providers**
- 333,000 primary care
  - ACP
  - AAP
  - AAFP
  - AOA
  - ABIM
  - ACC
  - ACOI
  - AHI

**Purchasers**
- Most of the Fortune 500
  - IBM
  - General Motors
  - FedEx
  - General Electric
  - Pfizer
  - Microsoft
  - Business Coalitions
  - Wal-mart
  - 80 Million lives

**Payers**
- All the nationals
  - BCBSA
  - United
  - CIGNA
  - WellPoint
  - Aetna
  - Humana
  - HCSC

**Patients**
- NCQA
- AFL-CIO
- National Partnership for Women and Families
- Foundation for Informed Decision Making
- SEIU
- AARP

The Patient-Centered Medical Home
PCPCMH Standards Committee

- Define core attributes of the patient centered primary care home.
- Establish a simple and uniform process to identify patient centered primary care homes.
- Develop uniform quality measures for patient centered primary care homes.
- Develop uniform quality measures for acute care hospital and ambulatory services.
- Develop policies that encourage growth in the numbers of primary care providers.
ACCESS TO CARE
Be there when I need you.

ACCOUNTABILITY
Take responsibility for making sure I receive the best possible health care.

COMPREHENSIVE WHOLE PERSON CARE
Provide or help me get the health care and services I need.

CONTINUITY
Be my partner over time in caring for my health.

COORDINATION AND INTEGRATION
Help me navigate the health care system to get the care I need in a safe and timely way.

PERSON AND FAMILY CENTERED CARE
Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.
Access to Care

- In person access
  - office visits

- Telephone and electronic access
  - all hours of the day
  - email and telephonic advice

- Administrative access
  - refills
  - paperwork
Accountability

- Performance improvement and public reporting
  - proof of care quality
  - continuous improvement

- Cost accountability
  - information about cost
  - cost effective practice and prescribing

- Requires advanced data systems
Comprehensiveness

- Standard, broad scope of service
  - common acute, chronic and behavioral problems
- Common procedures
- Hospital and nursing home care
- Integrated behavioral health
- Integrated specialty care
- Integration of community resources
Continuity of care

- Provider continuity
  - choice of provider

- Information continuity
  - availability of accurate information everywhere

- Geographic continuity
  - hospital
  - nursing home
  - home care
Coordination of care

- Management of data registries
  - preventive care
  - chronic disease care
- Care planning
  - written care plans
  - advance directives
- Care coordination for complex patients
- Coordination of referrals
Person and family centered care

- Communication
  - interpersonal
  - written

- Patient self-management
  - classes
  - group visits

- Measurement and improvement of patient experience and satisfaction
Figure 3: Functional Capacity of Basic, Intermediate and Advanced Primary Care Homes

**Basic Primary Care Home**
- “Foundational” structures and processes in place
- Meets all Tier 1 measures

**Intermediate Primary Care Home**
- Demonstrates performance improvement
- Additional structure and process improvements
- Meets many Tier 2 or Tier 3 measures
- Meets some “additional” measures

**Advanced Primary Care Home**
- Mature performance improvement
- Capacity to manage populations of patients
- Accountable for quality, utilization, and cost of care
- Meets most Tier 2 and Tier 3 measures and many “additional” measures
Lessons learned from the NDP

- Leadership is essential
- Build on expanding primary care’s fundamentals
- Team-based care is critical
- Focus on patient-centeredness
- Change is complex and non-linear and it takes several years
- Advanced information systems are a must
What can we do now to make rural communities more healthy?

- Maintain commitment to universal coverage
- Measure and improve outcomes of care
- Invest in the primary care, public health, and mental health workforce
  - Quantity
  - Quality
  - Discipline Diversity
    - Medicine
    - Nursing
    - Allied health
    - Mental health
    - Information science
  - Train teams to work together
- Eliminate bureaucratic overhead cost
- Build and integrate information systems
- Spend less money on medical care and more money on health and education
What can each of us do as individuals?

- Recognize the threat
- Understand that health reform is NOT just a political issue, it is a social and economic imperative
- Understand that the health of our community cannot be better than the health of its most disadvantaged members- we are all in this together
- Insist on fully functional PCMH’s in your community and help providers to meet this standard
- Purchase health insurance only from health plans that embrace and pay for PCMH’s