Research and Education in the Post Health Reform Era

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The Patient Protection and Affordable Care Act is signed into law
Threading the Needle on Health Reform
About 50% of Primary Care Clinicians oppose the bill.

- Why?
• It went too far
  – Will further bankrupt and overwhelm system
• It didn’t go far enough
  – No tort reform
  – No correction of sustainable growth rate
• It really didn’t go far enough
  – Anything short of a single payer system will fail
So is the Affordable Care Act a good thing?
Key Provisions in the ACA

2010 – The provisions already in place protect some consumers from losing insurance due to:

• Pre-existing conditions in children
• Technical errors on applications
• Reaching life-time limits (new plans)
• Insurance denials
Some 2010 Provisions Improve Quality and Lower Costs

- Small business tax credits
- Fills Medicare prescription donut hole
- Eliminates co-pays for preventive care (new plans)
- Establishes $15 billion Prevention and Public Health Fund
Some 2010 Provisions Increase Access to Affordable Care

- Provides options for uninsured with pre-existing conditions
- Young adults can stay on parent’s insurance till age 26
- Provides coverage options for early retirees
Some 2010 Provisions Will Help Increase the Primary Care Workforce

• Scholarships and loan repayment
• Increased federal matching to state Medicaid programs
• Increased payment to rural clinicians
• Strengthening community Health Centers
Some 2011 Provisions Address Quality and Cost

• Prescription drug discounts for seniors
• Creates new payment for annual wellness visits
• Establishes a new Center for Medicare and Medicaid Innovation
• Establishes the Community Care Transitions Program to reduce readmissions
• Establishes the Independent Payment Advisory Board – charged with extending life of the Medicare Trust Fund
Some 2011 Provisions Address Insurance Company Accountability

• Requires that 85% of all premium dollars be spent on health care (80% for smaller plans)
Some 2012 Provisions Address Quality and Cost

- New hospital payments to emphasize quality incentives
- Encourages establishment of Accountable Care Organizations
Some 2013 Provisions Increase Access to Affordable Care

• Requires state Medicaid plans to pay primary care clinicians no less than 100% of Medicare rate for 2013 and 2014
Some 2014 Provisions Provide Key Consumer Protections

- Eliminates exclusions based on pre-existing conditions
- Eliminates annual limits
2014 – The Culminating Moment – Expanding America’s Insurance Roles

• Establishes tax credits to help middle class with incomes 133% to <400% of poverty level to help them purchase insurance
• Establishes health insurance exchanges
• Increases small business tax credits
• Medicaid eligibility expanded to include individuals earning <133% of poverty level
  — Completely federally funded for first 3 years
  — 90% in subsequent years
• The individual mandate: obtain basic insurance or pay a fee
2015: One More Provision Addressing Quality and Cost

- Physician payment tied to quality:
  higher quality $\rightarrow$ higher payment
  lower quality $\rightarrow$ lower payment

Adapted from http://www.healthcare.gov/law/about/order/byyear.html
In Short, the ACA is Nothing Short of Amazing
If We Can Actually Do It….Without Going Broke
What will it take for a health care delivery system that has been specifically designed to attract as many insurance dollars as possible, to transform itself to spend dollars only for necessary care
We Must:
Shift payment for incentives for all stakeholders from volume to quality
Have an adequate number of prepared primary care clinicians
Partner with communities and the public health world to combat the root causes of chronic disease
Dramatically alter how we educate the medical workforce
Define and study questions that matter
An analysis of more than 50 years of research funding from the NIH suggests that it has helped to avert up to 1.35 million deaths per year from: cardiovascular disease, stroke, cancer and diabetes

Menton, KG et al.  www.pnas.org/cgi/
NIH funding has had a dramatic positive effect on public health
......or not
The Research Engine
And shouldn’t we ultimately judge the success of our research enterprise by the health outcomes of our population?
“When you break down the Big Four cancers by stages, long-term survival for advanced cancer has barely budged since the 1970’s”

Clifton Lee Fortune Magazine March 22, 2004
“Through 2004, the cancer community published 150,855 experimental studies. ...on mice
“... Many more cancer deaths can be averted by concerted action to control tobacco and obesity, by redoubling efforts in mammography and colorectal cancer screening, and by enacting policies to close gaps in access to cancer detection and treatment services”
Funding for clinical research is 1/3 of NIH budget

Funding for true translational research, far lower
Making a living seeking NIH and CIHR funding through the current peer review process can be a scary and frustrating experience.
I wonder what is was like...

In The Beginning...
The first research project
The effect of deception in a group of educationally naïve humans
The apple
God thought...

“Hmm, this is research involving human subjects. Now, that’s a first.”
Wanting to do this right, God sought the approval of the interplanetary group of responsible top brass
Benefit: Knowledge

Risk: Death
Dear God:

Fascinating and innovative! But the title is not working for us. Too long and “researchy”. And we definitely don’t get the apple. Why not something exotic, like....
The Pomegranate
God prepared a resubmission
The effect of deception in a group of educationally naïve humans
The **Effect of Deception in a group of Educationally Naïve humans**

...or.........
The EDEN Project
The apple
The Pomegranate
Dear God:

We are writing to you about the EDEN project. We LOVE it!!!!! But what’s the deal with the pomegranate... Why not something more simple and delicious - like...
The apple
God responded

“But the Angels are the ones who wanted the pomegranate”
That was the Angels from California. We sent the resubmission to a different review group.
The apple is BACK!
Human beings’ insatiable drive to acquire new knowledge was confirmed
God thought

“We need a neater way to investigate questions about human behavior”
A neater way to investigate questions about human behavior
A Neater way to Investigate questions about Human behavior

....or.........
NIH
And I wonder if there really is an interplanetary group of responsible top brass
An interplanetary group of responsible top brass
An Interplanetary Responsible top Brass
IRB

... maybe there is
NIH Funding 2006

99.59%

0.41%

Family Medicine

All Other Departments
NIH Funding 2007

99.58%

0.42%

Family Medicine

All Other Departments
NIH Funding 2008

99.57%

0.43%

Family Medicine

All Other Departments
Students interested in becoming researchers don’t choose family medicine.
“Only 1.4% of medical students graduating from MD/PhD programs from 2000 – 2006 chose family medicine as their career paths – by far the lowest of any specialty”

Seeharsen DA, Weaver SP. Fam Med 2009
Andrioie DA et al. JAMA 2008
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Family medicine research infrastructure has no business model
Department Chairs should divert surplus or profit from clinical work to support research infrastructure. But we have no clinical surplus or profit.
Clinical research is really, really hard to do
And population based research in the community is a bear!
“...clinical research has become increasingly difficult to do and...the scientific community ...must recast its entire system of clinical research”

http://nihroadmap.nih.gov
Experiments take longer. Publications are delayed. Costs are high.
Academic Health Centers invest in surer research bets
Compare the recruitment “packages” for Chairs of Pathology to Chairs of Family Medicine
I boldly negotiated a reduction in the planned budget cut.
And the number one obstacle to growing Family Medicine research is ...
Academia continues to question the value of primary care services and, thus, primary care research.
The undervaluing of primary care came to an end on March 23, 2010
“Amidst the debate about health care reform, there appears to be near unanimity around the fact that a reformed U.S. health care system requires at it’s foundation a robust system of primary care.”

One central harsh reality is stoking the fires of a change in our health care enterprise
Despite spending more on health care research than any nation on earth, the US remains the least healthy high resource country.
And the epidemic of over-eating and sedentary living threatens progress for all the major killers
The US is the 9th heaviest nation on earth...

...resulting in 30% of our rising health care costs
Tobacco use has declined...

...but percent of new adolescent smokers has stabilized
The seeds of a research revolution have been sown
There Are Four Components to the Research Revolution

- Promotion of clinical research – the NIH Roadmap
- Investment in high-risk research
- The dream of personalized medicine
- Creation of a new infrastructure for translational research
  - Clinical and Translational Science Awards
Plan Do Study Act

- Practice transformation demands measurement
- Proven practices must be disseminated
- New collaborations are needed
• Initiate the research process at the start of practice transformation
  – An over-arching IRB covering Medical Home development
  – Separate IRB’s for each sub-project
The Scientist and the Clinician
Practice Based Research Networks (PBRN’s) are one of the vital tools to answering the full spectrum of translational research questions - They require more federal support
Every practice should consider joining a PBRN
Service Research
- An emerging opportunity
What Is Service Research?

Service-Research is a method of research based on collaborative efforts with communities, community service agencies, and government to design, implement, and evaluate programs addressing an important need.
Much service research focuses on how to deliver proven interventions to hard to reach populations
New Design and Analysis Methods are Needed

• Evaluations usually require, at a minimum, multi-method approaches, both qualitative and quantitative
• Design methods, such as sequential cluster analysis, (comparing different clusters to each other as opposed to individuals), are often required.
• Professional researchers are a must
Service-Research relies on a diverse set of federal and non-federal funders

- Not-for-profit community service agencies
- Foundations
- AHRQ
- CDC
These grants and contracts almost universally rely on collaborations

- The Academic Health Center may or may not be permitted to be the applicant
The CDC Mission Statement

“CDC’s mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats”

www.cdc.gov
“State Supplemental Funding for Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System”

Eligible Applicants: States
“HIV Prevention Projects for Community Agencies”

Eligible Applicants: Non-profit organizations (other than institutions of higher education)
Barriers

• Funding looks different than the NIH RO1 mechanism
  – Dollars may be less
  – Spread over more collaborators
  – Indirects are often less attractive
Barriers

• Thus, AHC’s need different structures to compete for, attract and afford Service-Research grants and contracts
  – Interdisciplinary centers that are prepared to implement programs, provide service and evaluate projects in multiple areas
Myths

“Service-Research isn’t research”

“It’s not intellectually challenging”

“It doesn’t generate new knowledge”
Challenges

Sustainability — A challenge for most public health programs

Dissemination — Hard to find the business model
Service-Research – Business Model

Often requires flexibility to conduct projects in a variety of areas

Funding per project is often low
Indirects are often low

Thus, funding from multiple projects is often necessary
Service-Research without careful evaluation leading to publication

..............is just service
Service-Research REQUIRES teams

− Make sure that professional researchers are a part of the team
The New Research Team

physical therapists
behavioral scientists
anthropologists
occupational therapists
biostatisticians
social marketers

public health scientists
legal experts
the public
basic researchers
nurses
epidemiologists
community leaders
patients
clinicians

...and many more
There is not enough NIH & CIHR money to fund all important research.

Service-Research offers an important opportunity to enhance our research capacity.
Receiving your marching orders:
What role will each of us need to play in the education and research revolution?
Health care reform, health care research and health care education reform are inexorably linked
Are academic health centers capable of redesigning the education of health care professionals?
The Jury is Out
What Might A Re-designed Medical School Look Like?
Every academic medical center would define its mission as providing care for the region they serve.
What Might A Re-designed Medical School Look Like?

1. Admissions to medical school would explicitly value interest in service and receptiveness to primary care and community service

2. The percentage of teaching on each topic would parallel the disease burden of the condition

3. All students would have repeated exposure to primary care, from basic care through fourth year
4. Bashing of medical specialties would not be tolerated

5. Promotion criteria for teaching would explicitly value working in teams and communities

6. Innovative, interprofessional teaching would replace teaching in silos
7. Students would participate in care provided by interprofessional teams in innovative, transforming hospitals, practices.

8. Students would be charged with helping to assess quality and outcomes.

9. All students would join with communities to assess and address an important community need.
What Can We Do To Catalyze These Changes?

1. Most importantly, we must provide highly effective and efficient evidence-based health care

2. We must transform our own practices
   - Implement team-based care
   - Measure and report quality

Value innovation:
   - Try lots of different methods and approaches
   - Take responsibility for care of the practice’s entire population
What Can We Do To Catalyze These Changes? (cont’d)

3. Design and conduct research that matters
4. Find a way to include students in what we’re doing
If You Build It, They Will Come
To Colorado – Lead the nation!
The Charge to Every Primary Care Clinician

- To **teach** a new model of care, we must provide care in the new model

- To study comparative effectiveness, we must implement new approaches worthy of evaluation
A revolution in health care has begun

It cannot succeed without us
Primary care is the bridge between...

- Public Health
- Community Engagement
- Clinical Care Delivery