



USING EVIDENCE TO INFORM POLICY MAKING



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INFORMING HEALTH POLICY STARTS WITH:



The right data



Getting to the right people



At the right time

WHAT WE DO

- Conduct health policy research and evaluation
- Translate research
- Leverage federal and state data resources to inform policy
- Support states implementing the ACA and payment/delivery system reform
- Train researchers & policy analysts

RESEARCH AREAS

- Health Insurance
- Access to Care
- Medicaid
- Behavioral Health
- Health Disparities/Safety Net Financing
- Payment and Delivery System Reform
- Monitor & Evaluation of the ACA



STATE DATA TO INFORM POLICY

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Accessible On-Line Data Resource

STATE HEALTH COMPARE

Explore Data About

< Share Email Download Data

Use **State Health Compare** to create customized reports for state-level health estimates

Explore the Data >

Data Highlight

Since 2000, U.S. **sales of the opioid painkiller oxycodone tripled**. In six states—KS, NY, OK, TN, UT, WY—they have **grown more than 5 times**.

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State Health Compare has 50 indicators on a broad range of health topics:

Health Insurance Coverage

- Coverage Type
- Workers in Establishments that Offer Coverage

Cost of Care - Dollars

- People with High Medical Care Cost Burden
- Average Annual ESI Premium
- Employee Contributions to Premiums
- High Deductible Plans
- Medicaid Expenses as Percent of State Budget
- Costs of Potentially Preventable Hospitalizations

Cost of Care - Behavior Changes

- Made Changes to Medical Drugs
- Trouble Paying Medical Bills
- Needed but Delayed Medical Care
- Needed but Did Not Get Medical Care

Health Behaviors

- Adult Binge Drinking
- Adult Obesity
- Adult Smoking
- High School Obesity
- High School Smoking
- High School Physical Activity
- Opioid-Related Drug Poisoning Deaths
- Sales of Opioid Painkillers

Outcomes

- Chronic Disease Prevalence
- Activities Limited due to Health Difficulty
- Cancer Incidence
- Health Status
- Premature Death

Access to Care

- Adults that could get Medical Care when needed
- Adults with Personal Doctor
- No Trouble Finding Doctor
- Told that Provider Accepts Insurance
- Had Usual Source of Medical Care

Utilization of Care

- Had General Doctor or Provider Visit
- Had Emergency Department Visit
- Spent the Night in a Hospital

Quality of Care

- Adult Cancer Screenings
- Adult Potentially Preventable Hospitalizations
- Child Potentially Preventable Hospitalizations
- Child Vaccinations

Public Health

- Weight Assessment in Schools
- School Nutrition Standards Stronger than USDA
- Schools Required to Provide Physical Activity
- Smoke Free Campuses
- Cigarette Tax Rates
- Public Health Funding

Social and Economic Factors

- Adult Educational Attainment
- Children Considered to be Poor
- Income Inequality
- Unemployment Rate

Data sources: the American Community Survey (ACS), the Current Population Survey (CPS), the Behavioral Risk Factor Surveillance System (BRFSS), the National Health Interview Survey (NHIS), the Healthcare Cost and Utilization Project (HCUP), the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), and other sources.

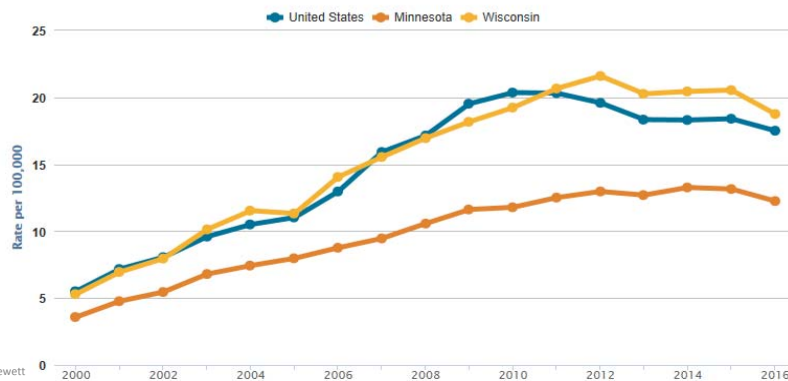
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Prescription opioid painkiller sales in kilograms per 100,000 people, oxycodone and hydrocodone

State: 3 Selected
Oxycodone / Hydrocodone: Oxycodone
Timeframe: 2000 to 2016
Data Type: Rate per 100,000



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Deep Dive on Opioid-Related Deaths


June 2017

The Opioid Epidemic: National Trends in Opioid-Related Overdose Deaths from 2000 to 2015

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SUMMARY
This brief examines the United States' opioid epidemic, analyzing trends in overdose deaths from heroin and other opioids, such as prescription painkillers, Valium and Xanax. It also looks at differences in opioid deaths by age, race/ethnicity and education.

Stop smoking by visiting us at www.shadac.org

INTRODUCTION
The number of annual deaths from opioid overdoses in the United States has tripled during the past 15 years, from 12,000 in 2000 to 32,000 in 2015.¹ Most of these deaths involved opioids, including heroin and prescription painkillers.² Although the incidence of opioid-related deaths has grown for more than a decade, the problem began drawing substantially more attention from policymakers, the news media, and the public since 2011, when the U.S. Centers for Disease Control and Prevention (CDC) declared overdose from prescription painkillers an "epidemic." More recently, heroin use has received increasing attention as deaths related to the illegal cousin of prescription painkillers more than tripled between 2010 and 2015.³ This brief provides high-level information about opioid and opioid addiction, presents the historical context for the epidemic of opioid-related addiction and mortality in the United States, and examines trends in opioid-related mortality across the country and among population subgroups.

COMPLICATIONS BRIEF
To more effectively compare rates of state-level (and county-level) overdose deaths, visit www.shadac.org/OverdoseBrief

Addictive properties of opioids
To better understand the development of the opioid crisis, it is important to recognize the additive properties of opioids and the relationship between different opioid types. Generally, there are three kinds of opioids: 1) natural opiates, like morphine, which are made from the opium poppy plant; 2) semi-synthetic opioids, like hydrocodone and oxycodone, which are chemically derived from natural opiates; and 3) fully synthetic opioids, like fentanyl, which are chemically related to natural opiates but are typically much more potent. Chemically "blended" opioids, such as heroin, are similar to legal opioid painkillers, such as oxycodone and hydrocodone.⁴ All of these opioids stimulate the same opioid receptors in the reward centers in the brain, creating similar feelings of euphoria.⁵ Repeated use of opioids can affect the chemistry and wiring of the brain, causing addiction that prompts people to crave and use opioids habitually and can cause symptoms of withdrawal if people stop using opioids.⁶

Because all opioids act similarly in the same parts of the brain, someone who is chemically dependent on a prescription opioid painkiller and unable to obtain it may switch to an illegal opioid, such as a heroin, to relieve their cravings or withdrawal symptoms. In fact, studies have shown that many people who use heroin or misuse prescription opioids began with "legitimate" prescriptions for their own pain treatment or obtained those painkillers from friends or family members with prescriptions.⁷ For example, a national study found that 80 percent of people who reported using heroin also reported earlier misuse of prescription opioids.⁸ Research also shows that people often advance from misuse of prescription opioids to heroin because heroin provides stronger effects and is often less expensive than prescription opioids.⁹

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Despite widespread increases in non-heroin opioid death rates, individual state death rates and the magnitude of their increases varied widely. In 2015, Nebraska's rate of 2.8 non-heroin opioid deaths per 100,000 people was the lowest in the U.S., while West Virginia's was the highest, more than 10 times larger, at 29.4 deaths. Additionally, statistically significant increases ranged from an increase of 11 deaths per 100,000 people in California from 2.7 in 2000 to 13.8 in 2015 to an increase of 26.7 deaths in West Virginia (from 2.7 in 2000 to 29.4 in 2015) (Figure 3).

Figure 3: States with the Largest Significant Increases in Non-Heroin Opioid Death Rates, 2000-2015

State	Deaths per 100,000 people		
	2000	2015	Change
West Virginia	2.7	29.4	+26.7
Texas	2.2	28.7	+26.5
Rhode Island	3.2	21.4	+18.2
Ohio	1.8	17.3	+15.5
Massachusetts	4.2	20.2	+16.0

Although nearly all states have experienced significant increases in death rates from non-heroin opioids, certain regions of the U.S. have been more severely affected than others. Of the 17 states with death rates significantly higher than the U.S. rate, five are clustered in New England (CT, MA, NH, RI, VT), and eight are clustered in a region of Midwestern and Southern states (IN, OH, MI, MO, NC, TN, WV) (Figure 4).

Figure 4: State Rates of Non-Heroin Opioid-Related Deaths, 2015



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DATA AND METHODS TO INFORM AND EVALUATE PAYMENT AND DELIVERY SYSTEM REFORM

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Data Sources and Methods to Assess Delivery System and Payment Reform

Case studies

In-depth review of advanced payment models for MACPAC; Study of care coordination costs associated with Minnesota Health Care Home for state of Minnesota

Qualitative, semi-structured interviews

Evaluation of the State Innovation Model (SIM) in Minnesota, interviews with SIM organizations about accomplishments, outcomes, and sustainability

Claims data analysis

Use of Minnesota's All-Payer Claims Database (APCD) to assess the impact of Minnesota's Medicaid ACO/Integrated Health Partnerships (IHPs) on Total Cost of Care and Quality Outcomes

Surveys

Designed surveys to assess provider and user perceptions of Accountable Communities for Health (ACHs) and e-health interventions under the State Innovation Model (SIM)

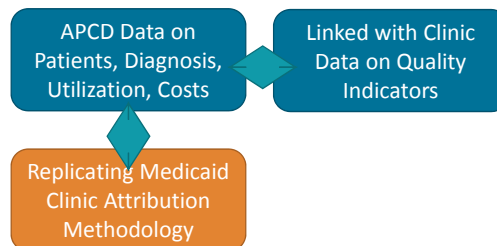
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State evaluation of MN State Innovation Model – Medicaid ACO using All-Payer Claims Database (APCD) Data

- Trend and difference-in-difference analysis comparing participating and non-participating clinics
- Study Timeframe: 2012-2014
- Key Outcomes
 - Utilization: Primary care, specialist, ED, hospitalizations
 - Total Cost of Care: Standardized based on reported costs
 - Quality: Five optimal care rates used by IHP program



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SHADAC Health Information Exchange User Survey

Purpose: To assess impacts of Health Information Exchange (HIE) on:

- Provider workload
- Patient workflow
- Data Privacy and Security
- Services delivery

Timeframe: May 2017

Key Domains:

- Current use of HIE
- Impact on care quality and providers' work
- Provider satisfaction with HIE

MINNESOTA ACCOUNTABLE HEALTH MODEL

Welcome to the SIM Minnesota HIE User Survey

To what extent do you currently have the ability to electronically communicate/share health information with any of the following? This does not include communication by fax, non-secure email or view/download access from another organization's EHR. For each entity, check all that apply.

	Communication/Sharing Capability					
	Not at all	Able to send electronic information to	Able to receive electronic information from	Able to find (query) electronic information	Able to integrate information received electronically into our EHR or record system	Don't Know
Other providers within your organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinics and hospitals outside your organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long Term Supports and Services providers outside your organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Public Health providers outside your organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Able to interoperate



EVIDENCE TO ASSESS IMPACT OF THE AFFORDABLE CARE ACT (ACA) IN KENTUCKY



Impact of the ACA in Kentucky

5 domains of health and healthcare

- Coverage
- Access
- Cost
- Quality
- Health Outcomes

Use of Multiple Data Sources to tell a Comprehensive Story

Mixed-methods study

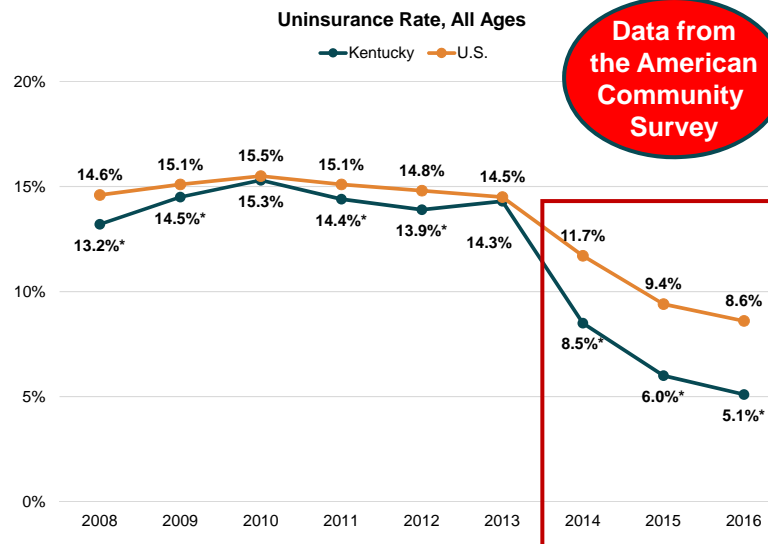
- **Quantitative:** Federal surveys, state administrative data, Kentucky Health Reform Survey
- **Qualitative:** Focus groups with Medicaid beneficiaries and key actor interviews (*third year not funded*)

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Impact of the ACA on Uninsurance: US, KY



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*Statistically significant change at 95% level.
Source: SHADAC analysis of American Community Survey

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Products based on multiple data sources

Medicaid Services

During the past quarter (July-September 2016), Medicaid covered thousands of needed services for traditional income-based and ACA Medicaid expansion enrollees ages 19-64.



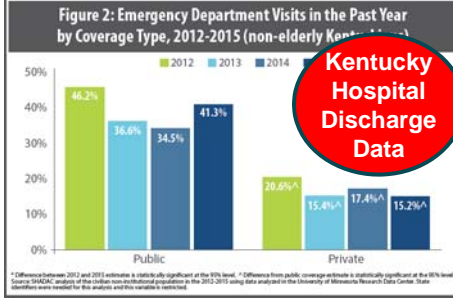
Breakout of Substance Use Treatment

Traditional Income-Based Medicaid
ACA Medicaid Expansion

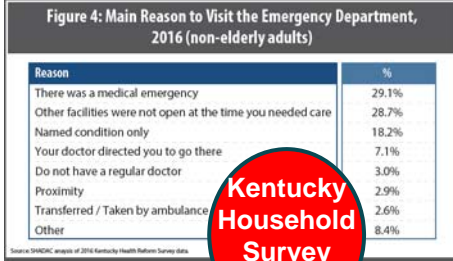
Diabetes Screenings

4,495 Diabetes screenings were covered by Medicaid for traditional income-based and expansion enrollees ages 19-64.

Kentucky Medicaid Utilization Data



Kentucky Hospital Discharge Data



Kentucky Household Survey Data

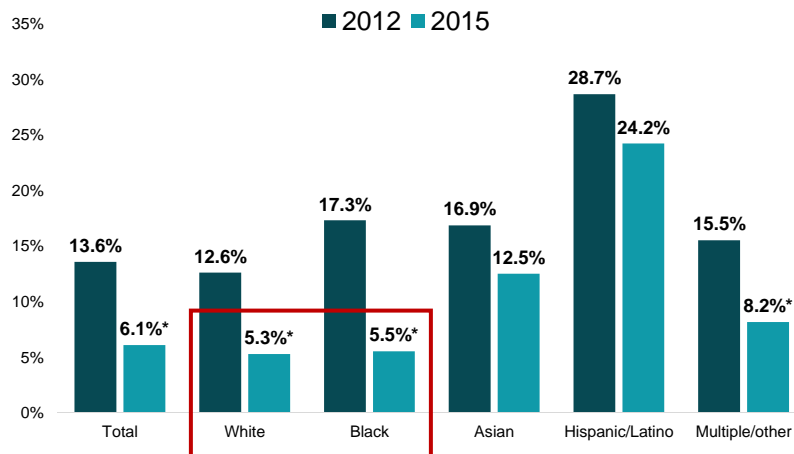
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Disparities in Coverage between Blacks and Whites Eliminated

Kentucky Uninsurance Rates by Race/ethnicity



*Statistically significant change at 95% level.
Source: SHADAC analysis of American Community Survey

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LESSONS LEARNED

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Messaging, Communication, and Planning

Goals and messaging



- Balance-controlling message and allowing for independent voice – *watch out for the politics and set expectations up front*
- Sometimes easier for contractor to convey difficult message, must be grounded in rigorous findings

Communication



- Meet regularly with partners
- Advisory committees for key stakeholders, data holders

Planning-this work takes TIME



- Build in time for back and forth on draft products
- Time for data access – *IRB, DUAs, Data Aggregation, Data Releases*

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Optimal Dissemination

- Use of Multiple formats
 - Some comprehensive in-depth analysis, some higher level overview of key themes
 - Issue Briefs
 - Chart Books
 - Data Snapshots
 - Infographics
 - Full Reports
 - Blogs
- BUT...keep same “look and feel”
- Leverage in-house *and* partner organization’s communication infrastructure
 - Coordinate a dissemination schedule
 - Roll out pieces over time
- Use Social Media platforms!



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