Who, What, Where

Presenter: Gordon Norman, MD, MBA
- CMO, Alere Medical, Inc.
- DMAA Board of Directors, 2003
- Quality & Research Committee, 2004; Chair, 2007
- Outcomes Steering Committee, 2005
- Financial Metrics Workgroup; Lead, 2006-07

Agenda
- Outcomes Project Background
- Work-in-progress for 2007

For more information, see www.dmaa.org
Project Context

- 2000, DM Definition developed
  - DM components include: process and outcomes measurement, evaluation, and management
- 2004, published “Green Book” & “Blue Book”
  - Dictionary of Disease Mgmt. Terminology
  - Disease Mgmt. Program Evaluation Guide
- 2005-06, Outcomes Project, Phase I
  - Dictionary of Disease Mgmt. Terminology, Version II
  - Outcomes Guideline Report, 12/06
- 2007 Outcomes Project, Phase II
Project Overview

- **Goal** – To develop a set of uniform evaluation guidelines for the disease management community to use for outcomes reporting purposes that are both defensible and practical (“GAAP for DM”)

- **Justification** – The development of a generally accepted approach, utilizing key statistical and actuarial practices, will permit health plans, employers, state and municipal governments, and others to more clearly understand the value of disease management programs
The DMAA Method
Single Standardized Approach for All DM Outcomes

“Squeezing The Bookends”

Existing Spectrum of DM Outcomes Measures/Methods

More Casual

DMAA Outcomes Project

More Rigorous

Narrower Spectrum of DM Outcomes Measures/Methods
Achieving Optimal Balance

“Suitability”
- Rigor
- Precision
- Replicability
- Evidence-based
- Bias, Confounders
- Causal Association
- Experimental Design

“Acceptability”
- Cost
- Time
- Ease
- Simplicity
- Accessibility
- Transparency
- Diverse Users
Project Timeline

- 2005 – Plenary meetings, survey development
- January 2006 – Survey distributed to all DMAA members
- May 2006 – Data Analyzed by National Opinion Research Center (NORC)
- May-September 2006 – Guideline Development
- September-October 2006 – External Feedback
- December 2006 – Release of Version I
- January 2007 – Work on Version II begins
- September 2007 – Release of Version II
Guideline Development, 2006

- Project overseen by Outcomes Steering Committee, with dedicated workgroups
  - Methods
  - Financial Measures
  - Clinical Measures
  - Additional Measures
- Iterative process for refining guideline recommendations, achieving consensus
- Input obtained from CMS, AHRQ, JCAHO, URAC, NCQA, CMSA, National Business Group on Health, National Business Coalition on Health, Kaiser Permanente, Fortune 50 employers, and many others
- Final approval by Quality & Research Committee, DMAA Board of Directors
Program Evaluation, 2006

Discussion Points

- DMAA strives in its recommendation to strike a balance between a method that has scientific rigor but that is also practical within the settings in which DM programs are implemented and evaluated.

- DMAA recognizes that a pre-post design without a credible comparison group may be unable to distinguish program effects from secular trends and confounders.

- DMAA believes that the industry needs methods to assess specific differences in populations over time, while controlling for regression to the mean, trend, and general population comparability.
Evaluation Design, 2006

Recommendations

- Pre-post evaluation design with an internal or external comparison group that is equivalent
  - Such a comparison group may not be available in applied settings

- Evaluations using a pre-post design without a comparison group should make explicit efforts to control potential biases and error
  - Potential impact of the design on the interpretation of the findings should be made clear
Evaluation Design, 2006

Recommendations (cont.)

- Identification of study and comparison groups: methods for program identification, qualification for evaluation and trend incorporate the principle of equivalence between baseline and intervention groups

- Measurement period: one year for baseline and subsequent years

- Criteria for inclusion in measurement: commercial and Medicare member population be enrolled with buyer for >= 6 months; Medicaid TANF >= 1 month
Evaluation Design, 2006

Recommendations (cont.)

- Look back period: 12 months of measurement period as well as at least 12 months of the preceding period
- Defining a member month: members enrolled on the 15th of the month for commercial and Medicare populations when possible
- Claims Runout Period: 3 months with completion or 6 months with no completion contingent upon consistent payment patterns
Financial Metrics, 2006

Recommendations

- Financial metric: health care cost outcomes as primary metric for assessing the financial impact of the program
  - Use medical and pharmacy claims where available to calculate changes in total dollars
  - Convert to PMPM or PDMPM as desired
  - Can be used to derive ROI

- DMAA recommends using paid and/or allowed costs
  - Each has different pros/cons
  - For different settings, one or the other may be preferable
Financial Metrics, 2006

Recommendations (cont.)

- Trend: use non-chronic population for the purpose of calculating trend
  - For this purpose, non-chronic population is defined as those members not identified as having the “common chronic” conditions of diabetes, CAD, heart failure, Asthma, or COPD
  - Members with certain other conditions may be excluded from the non-chronic population if these conditions are also being managed by another disease management program outside of the five “common chronics”

- Risk adjustment: parties must agree on mutually acceptable risk adjustment method, ideally a commercially available tool
Financial Metrics, 2006

Recommendations

- Dealing with small sample sizes: as population size drops below a certain level, calculated DM financial outcomes begin to lose credibility and reliability

  - This level can be estimated using common actuarial practices or statistical power methods
  
  - The smaller the population falls below this level, the more that random variation will influence results and interfere with the credibility and reliability of the calculated outcome

  - As mutually agreed, parties may prefer to avoid this concern by choosing not to calculate financial outcomes for such small populations, or may elect to mitigate this concern by using a credibility factor approach to blending their smaller population result with some larger (typically, comparable “book of business”) population to increase the credibility of this result
Clinical Metrics, 2006

Recommendations

- Clinical Metrics: DMAA has incorporated, as a starting point, the series of ICD-9 codes established in the latest version of the DMAA Dictionary of Disease Management Terminology. Available at www.dmaa.org.

- In 2007, DMAA will develop standardized identification criteria for defining both the numerator and the denominator for an agreed list of disease-specific clinical metrics for the purpose of program evaluation.
Exclusions: DMAA recommends that there should be three types of exclusions from the evaluation for financial and utilization measures:

- Patients with conditions such as:
  - ESRD
  - HIV/AIDS
  - Transplants
  - Non-skin cancers with evidence in claims of active treatment
  - Hemophilia

- Claims for diagnoses such as: (but not the person with these claims)
  - Trauma with hospitalization
  - Skin cancers

- Stop-loss at member level; such as removing claims above $100K annually, indexed to grow at future years concurrent with an appropriate trend
Additional Metrics, 2006

Recommendations

- Consider use of one of the SF tools (e.g., SF-8™, SF-12®, SF-36®) to measure general mental and physical health status.

- Consider assessing participant satisfaction using the DMAA Standardized Participant Satisfaction survey.

- Consider inclusion of standardized measures in the behavioral categories of:
  - lifestyle behaviors
  - medication adherence
Phase I Outcomes Guidelines

What They Are

- Consensus effort to create a standardized method for determining disease management outcomes that meet suitability and acceptability requirements across a wide range of populations and circumstances
- A standardized method that is based on current industry best practices
- An effort to better manage some of the most prevalent challenges currently encountered in determining disease management outcomes in non-experimental settings
- An intermediate step in evolving practical and reliable methods to facilitate comparisons of different programs’ performance
Phase I Outcomes Guidelines

What They Are Not

- A prescriptive method that is intended to replace all other methods for determining disease management outcomes
- A formulaic recipe for “plug and play” outcomes determinations by unsophisticated disease management program reviewers
- An ideal method for all populations under all circumstances
- The last word in evolving standardized methods that facilitate interprogram and intraprogram comparisons of performance
Guideline Development, 2007

Quality & Research Committee
Chair: Gordon Norman

Outcomes Steering Committee
Co-Chairs: Sue Jennings, Don Fetterolf

Methods Refinement
Leader: David Veroff

Financial/Trend Workgroup
Leader: Gordon Norman

Wellness Workgroup
Leader: Craig Nelson

Other/Process Measures
Leader: Carter Coberley

Clinical Workgroup
Sue Jennings

DMAA/NCQA Joint Advisory Committee
Co-chairs: Sue Jennings, Joachim Roski

Conditions:
- Asthma
- COPD
- CHF
- CAD
- Diabetes
2007 Process Differences

- Rules of engagement modified by learnings about group process from last year
- Recognition that low-hanging fruit more scarce; longer meeting times, mandatory attendance rule; 2 scheduled in-person OSC meetings
- Coordination between/among groups provided by meetings of leads to review gaps, overlaps, dependencies
- Inviting consultants to participate in groups where additional expertise desired
- Broader collaboration with other shared interest entities (NCQA, URAC, JCAHO, etc.)
- Collecting continuous feedback along the way
- Industry pressure to develop comparative reporting
Phase II Outcomes Guidelines

Work in Progress

- Methods Refinement Workgroup
  - Goal: to review work done in Phase I and identify specific areas to be refined or expanded in Phase II
  - Priorities
    - Stop-loss approach
    - Recommended evaluation design benefits
    - Population identification
    - Small sample sizes
    - Developing methods to compare disease management programs from different vendors
    - Narrative on developing an equivalent comparison
    - Program evaluation by individual disease vs. all diseases
    - Methods applied to disease outside five common chronics
Phase II Outcomes Guidelines

Work in Progress

- **Financial/Trend Workgroup**
  - Goal: to focus on trend and other areas of financial measures from Phase I needing refinement or expansion, including utilization measures
  - Priorities
    - **Trend** (refinement of 2006 recommendations)
      - Can we use relativity of historical chronic and non-chronic trends to adjust current year non-chronic?
      - If so, could we develop national database for reference?
    - **Utilization**
      - Proper role of event rates, including “plausibility measures”
    - **Risk Adjustment**
      - How to adjust for confounding factors beyond influence of DM without adjusting away intended impact?
Phase II Outcomes Guidelines

Work in Progress

- **Wellness Measures Workgroup**
  - Goal: to develop recommendations for the evaluation of wellness and total population management programs that would include both the methods of evaluation and metrics
  - Priorities
    - Process Measures
    - Behavior change/modifiable risk factors
    - Utilization/medical cost
    - Productivity/quality of life
Phase II Outcomes Guidelines

Work in Progress

- **Process Measures Workgroup**
  - Goal: to develop process measures (e.g., activity or operational metrics) for Phase II
  - This workgroup will collaborate with URAC
  - Priorities
    - Identify categories of process measures
    - Identify and define process measure categories
      - Defining member touch and various levels of touch
      - Call center operational metrics
Phase II Outcomes Guidelines

Work in Progress

Clinical Measures Workgroup

- Goal: to identify and recommend effectiveness-of-care measures for five clinical conditions suitable for both evaluation and performance comparisons
- Collaborative effort with NCQA with Joint Advisory Committee (DMAA & NCQA appointees)
- Coordinates work of individual subgroups for diabetes, asthma, CAD, COPD, heart failure

Priorities

- Don’t reinvent the wheel – adopt others’ good measures
- High degree of specificity needed for comparative reporting
- Initial focus on small measure set with later expansion
- Measures to be selected based on the ability of the DMO to affect the outcomes of the measure
Phase II Outcomes Guidelines
Work in Progress

Patient Safety and Quality Workgroup

- Goal: to recommend a set of non-disease specific patient safety and quality measures for inclusion in the Phase II Guidelines

- Priorities
  - Care Coordination
  - Medication Adherence
  - Potential to avoid adverse events
  - Functional Status
  - Quality of Life
  - Smoking
Phase II Outcomes Guidelines

Work in Progress

- Clinical Specification Workgroup
  - Goal: to recommend algorithms for defining relevant cohorts for the five conditions for the Phase II Guidelines building on earlier work in DM Dictionary
  - Necessary for comparable clinical & other outcomes (but not to be confused with operational mandate)
  - Priorities
    - Focus on Asthma, COPD, CHF, CAD, Diabetes
    - Build on good work started in DM Dictionary
    - Utilize expert consultant(s) as needed
Learnings to Date

“It’s Getting Better All the Time”

- The market is demanding the DM industry provide greater outcomes consistency and comparability
- A higher degree of specification needed for comparable outcomes metrics than for independent program evaluation
- It’s OK for operational methods/specs and evaluation methods/specs to differ
- We can’t get there in just one or two steps; this work needs continual refinement by industry stakeholders
- There’s more consensus now than previously to help drive progress toward greater standardization
- We can’t let Perfect be the enemy of Good
  - How good is good enough? Who decides?