The Business Case for Accurate Data on Quality and Savings in Medical Home Programs

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I. The Business Case for Evaluation
Various Groups Have an Interest in Good Evaluations

- Physicians: Transformation requires staffing and IT changes, time, and $. Will these translate into more satisfaction and $? 
- Insurers/payers: Will reduced costs cover the payments to providers and in-kind supports? 
- Patients: Will patient-centeredness and outcomes improve? Will premiums fall? 
- Various vendors: Will this movement exist 5 years from now?
The PCMH Model Carries Great Risks

- Model isn’t actually implemented

- Model is implemented, but does not work
  - Increases costs
  - Decreases satisfaction of patients
  - Decreases provider satisfaction
  - Decreases quality

- Simply proceeding without evidence may divert resources from primary care transformations that would work
One Risk
1998–2000: Claims emerge that DM generates large ROIs (2:1 was conservative)

Based on weak study designs, auto-evaluations

This created a $2.5 billion industry serving commercial and public patients

Vendors sought government $ to serve Medicare beneficiaries
But Most DM Programs Actually Increase Costs

- Since 2002: CMS evaluated disease management using multiple demonstrations
  - Random assignment
  - Objective evaluators

- Results: In almost all cases, DM bent the cost curve, but in the *wrong* direction

- Effects on quality were trivial
Medicare did not make DM a covered benefit

Although most DM models don’t work, there is evidence suggesting needed refinements:
- The right services to the right people can work
- We have identified 4 of 15 programs that were cost neutral for a high-risk subgroup among the chronically ill enrollees
- Next step is to develop protocols and test the next generation of DM

This learning could occur only with a solid research foundation
# Back to PCMH... What Can an Evaluation Deliver?

- Document whether the PCMH model was implemented
- Identify barriers and facilitators to being a medical home
- Assess effectiveness to justify investment
- Measure performance to reward providers differentially
R. Malouin (10/22/09) reports

- 19/29 (65%) demonstrations responded to survey
- 12/19 (63% of respondents) have formal evaluation plans in place
- 2/19 (10%) had not yet begun
- 8/19 (42%) are using an external evaluator
II. What Research Questions Should Be Answered?
How Do Practices Evolve into Medical Homes?

- Efforts needed to reach MH criteria (time, internal and external resources, $)
- Limits, potential of HIT
- Ease of changing staffing and workflows
- Resources required from outside the practice
- Best practices and models
  - For patient outreach, recruitment, and engagement
  - For coordination
  - For chronic care, etc.
What Is the Impact of the PCMH?

- **Disease-specific and population-based quality of care measures**
  - Process: Evidence-based care (e.g., foot exams for patients with diabetes)
  - Outcomes: Ambulatory-care sensitive complications
  - Coordination of care (harder to measure)
  - Patient satisfaction

- **Provider experience**
  - If providers are worse off, they won’t want to do this

- **Service use and cost**
  - If this isn’t cost neutral or cheaper, payers won’t play
III. Why Is Evaluation Tricky?
1. Inadequate follow-up
   - Need time to allow transformation to happen
   - Most evaluations are using only 1.5–2 years

2. Small sample sizes
   - We may erroneously find no effect because practices don’t have enough time to change or there isn’t enough sample to detect change

3. Difficulty obtaining and cross-walking all payer claims data
Threats to Credible Evidence

4. Statistical techniques do not account for clustering at the practice level
   - Not doing so will give false positives

5. The comparison group is not fair
   - At the practice level
   - At the patient level

6. Patients are not correctly attributed to their practices

7. Outcomes are not well defined and comparable across studies
IV. How to Proceed?
Suggestions to Improve the Quality of Evidence

- Do conduct an evaluation
- Use an external evaluator
- Study implementation, not just impacts
- Estimate (clustered) power in advance, using real data
- Analyze data accounting for clustering
- Use random assignment or a well-designed nonexperimental comparison group
Suggestions to Improve the Quality of Evidence

- Ensure patient attribution is accurate
- Budget resources to define outcomes and crosswalk different payers’ claims
- Show baseline equivalence of practices and patients
- Show zero effect in the baseline period
- Run longer pilots
- Follow the CMWF Evaluation Group for updates about definitions for outcomes
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