Measuring the impact of PCMH on utilization, cost and efficiency

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Goal of workgroup

- Identify measures that either alone or in combination could address the question: Does introducing a patient-centered medical home reduce cost and/or improve efficiency?
- Provide recommendations about “core” and supplemental measures that could be adopted by evaluators to increase alignment and make meta-learning possible
- Note: we focused on payer perspective but recognize that primary care practice perspective is also important

Some Principles of Measurement

- A logical connection must exist between PCMH elements and each measure
- Measures and proxies should be evidence-based
- Some variation in measurement will be appropriate because not all PCMH pilot studies are the same
- Changes in patient care and health status take time to accrue – intermediate measures should be considered to capture “leading indicators” of improvement

What We Used to Construct Our Logic Model

- Many different ideas about the medical home – what it is conceptually and in concrete terms
- Most pilots that are being evaluated now use the NCQA criteria as the organizing framework
- We looked to the high-level categories of NCQA PCMH criteria as the levers that PCMH interventions will affect
- Literature review on impact of those levers on utilization, cost, and efficiency

Elements of PCMH Pilots that Might Affect Cost and Efficiency

- Payment incentives: payments to support infrastructure and P4P related to cost or quality
- Access enhancements: expanded access during the day/week, scheduling, patient health records and email, phone consults
- Informed care management: registries, patient education, care management for high-risk populations, e-prescribing
- Coordination of care: referral and test tracking, management of care transitions

Utilization Measures Recommended to Address Efficiency Questions

- All denominated in member months:
  - Primary care visits
  - Specialist visits
  - Screening and diagnostic tests
  - Prescription drugs
  - *Emergency department visits (all and ambulatory-care sensitive)
  - *Hospitalizations (all and ambulatory-care sensitive)
  - *Re-admissions

* Indicates moderate level of evidence to support PCMH impact on these measures

Cost Measure Recommendations

- Cost per case (episode) – calculated using standard episode grouper software – with embedded case-mix adjustment, requires severity adjustment
- Costs per member per month – requires case-mix and severity adjustment
- Summary measures should be calculated for entire enrolled population as well as subsets of patients who are likely to benefit more from the PCMH (patients with chronic illness such as diabetes, heart failure)

Practice and Plan Implementation Costs

- As a general matter implementation costs for both plans and practices should be counted to judge net benefit of interventions
- Careful cost accounting would be needed to judge true incremental costs to practices of transforming practice
- Few evaluations appear to be tracking these types of costs

Summary

- PCMH pilots are being evaluated in a range of settings with varying designs
- Common measurement will not only allow for more powerful conclusions through meta-analysis but allow for inferences about differences
- Complexity of the intervention and desired outcomes needs to be taken into account in measure selection