PCMH Evaluations: Key Drivers of Program Success and Measurement Development

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PCMH Evaluations: Key Drivers of Program Success and Measurement Development

Bob Phillips, MD MSPH
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Objectives

• PCMH evaluations: evidence of key drivers of success or failure
• PCMH Measurement development (MACRA)
• Informing the PCPCC Outcomes & Evaluation Center
Speakers

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President - Bailit Health Purchasing

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Senior Natural Scientist – RAND
Measuring What Matters In Primary Care
Eugene Rich and Ann O'Malley
October 6, 2015
Measuring Primary Care’s Value

“Community Vital Signs”: Incorporating geocoded social determinants into electronic records to promote patient and population health

Andrew W Bazemore¹, Erika K Cottrell²,³, Rachel Gold⁴, Lauren S Hughes⁵, Robert L Phillips⁶, Heather Angier³, Timothy E Burdick⁴,⁷, Mark A Carrozza⁸, Jennifer E DeVoe²,³

ABSTRACT

Social determinants of health significantly impact morbidity and mortality; however, physicians lack ready access to this information in patient care and population management. Just as traditional vital signs give providers a biometric assessment of any patient, “community vital signs” (Community VS) can provide an aggregated overview of the social and environmental factors impacting patient health.
Medicare Access and CHIP Reauthorization Act

• Merit-Based Incentive Payment System
• Alternative Payment

• Measures become even more important
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Presentation at the Patient-Centered Primary Care Collaborative Fall Conference

November 11, 2015

Early Lessons from the Comprehensive Primary Care Initiative (CPC)

• Four-year multipayer model launched by CMS with 31 public and private payers in October 2012

• At the end of 2014, 479 practices with ~2,200 clinicians in 7 regions, serving ~2.8 million patients (1.1 million of whom are attributed)

• Tests advanced primary care in five areas:
  - Access and continuity
  - Planned care for chronic conditions and preventive care
  - Risk-stratified care management
  - Patient and caregiver engagement
  - Coordination of care across the medical neighborhood

• CPC provides three supports to practices
  – Enhanced payment (median $226,000 [$70,000 per clinician]) in PY 2013 (19% of 2012 total practice revenue) and shared savings
  – Feedback reports and data files
  – Technical assistance and collaborative learning networks
Practices Worked Hard in CPC’s First Two Years to Start Changing Care Delivery

• Most practices met CMS’s required milestones

• Work related to risk stratification, care management, and shared decision making was particularly challenging

• Biggest improvements so far have been made in risk-stratified care management
  – From 2012 to 2014, self-reported approach to delivery improved from 4.6 to 9.7 (on a 12-point scale)

• As expected at this stage of the initiative, there is more work to do, and more diffusion through practices’ clinicians and staff is needed

• Despite transformation efforts, only 11% of CPC physicians reported moderate to extreme burnout in the first year (comparable to comparison physicians)
  – 5% of other staff in CPC practices reported moderate to extreme burnout
CPC Had a Promising Impact on Medicare Fee-for-Service Beneficiaries in First Year

• Too early to expect or confirm findings—interpret with caution

• In first year, CPC reduced total monthly Medicare FFS expenditures—excluding care management fees—relative to comparison group by $14 per beneficiary (or 2%)

• This offset a large part of Medicare’s monthly care management fees, which averaged $20 per beneficiary at that time

• Expenditure cost impacts were primarily driven by reductions in hospitalizations and outpatient ED visits
Drivers of Program Success Vary

• Goal: Find what works for which types of practices and which types of patients

• Analytically, this is hard to determine, but we do know that:
  – Practices in systems face different challenges than independent practices
  – Health information exchange with hospitals/EDs, specialists, and other providers is critical
  – Many practices struggle with functionality of electronic health records (EHRs), and develop inefficient workarounds
Practices Need Financial and Learning Support

- Practices need enhanced payments to provide care management and additional services, and maintain EHRs
- Many practices need learning support to change care delivery
- It is important to stratify practices by their diverse needs and tailor learning
- Practices don’t want overly prescriptive requirements, but many do want step-by-step instructions, tools, and resources
- Practices value individualized in-person technical assistance (TA), but cost considerations require other strategies too
- Practices value peer learning and networking, so TA providers need to find exemplars - and sometimes convince them – to take the time to share their stories
- AHRQ has resources on practice facilitation, including a new curriculum to train coaches who work with practices
Teaching Teamwork May Be Key

• Practices that spread the work to the entire practice team—with clear roles and responsibilities—report that implementing CPC is easier.

• Otherwise, there is too much burden on the clinician champion.

• This requires leadership and a learning organization culture.

• AHRQ will release a paper this winter on how to ensure team-based care is patient centered.
Practices Need Support to Use Data Feedback

• Data feedback is valuable
  – Gives many practices their first look at their patients’ utilization from other providers
  – Allows practices to drill down and examine specific patients’ cases
  – Can fuel quality improvement activity
  – Must be actionable and timely

• Practices want:
  – Timely data, especially at the patient level
  – Data that are coordinated across payers
  – Specialist cost and quality data to guide referrals
  – Comparisons of their outcomes to those of similar practices for context
  – Examples of successful exemplar practices

• Less is more
  – Too many measures and unaligned feedback from multiple payers can lead to information overload and no action

• Many practices need tailored TA to interpret and act on the data
  – Except in large systems, most practices lack in-house expertise on working with data
For More Information

- Debbie Peikes
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- AHRQ’s PCMH portal
  Pcmh.ahrq.gov

- CMMI's CPC website

- CPC first annual report
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Evaluating What?
Evaluating What?

- We oversimplify when we talk about the effectiveness of “the medical home.”

- Medical home initiatives vary in design **greatly** within and across states.
  - Philosophy
  - Payment support and incentives
  - Transformation support (if transformation is even a goal)
  - Health information support

- Primary care provider organizations vary too.
  - Organization type
  - Organization size
  - Resources
  - Leadership
Three Different “Effective” PCMH Initiatives

1. Colorado
2. Maryland (CareFirst)
3. Vermont
Colorado PCMH: Building Medical Neighborhoods

Key Program Components:

- Specialist compacts to define shared responsibilities
- Robust practice transformation support to build PCMHs and medical neighborhoods
- PCP Transformation into PCMH
- Test and referral tracking & care coordination across the care continuum

Also…intensive transformation support, innovative technology interventions
CareFirst: Financial Incentives & Data Support

- Total care of patients is to be provided, organized, coordinated and arranged through small panels of PCPs
- Panels as a team are accountable for aggregate quality and cost outcomes of their pooled population
- Savings against the panel’s pooled global budget target are shared with the panel providers
- All supports in Total Cost and Care Improvement programs are designed to assist panels to get better results
- Lower cost trends cannot be achieved or maintained without improved overall quality
Vermont Blueprint for Health: Intensive Local Community-Based Model

Components of the Blueprint

1. Advanced Primary Care Practices (PCMHs)
2. Community Health Teams
3. Community-Based Self-Management Programs
4. Multi-insurer Payment Support
5. Health Information Infrastructure
6. Evaluation and Reporting Systems
7. Learning Health System Activities
Takeaway: Different Combinations of Variables Can Produce Success…

“All roads lead to Rome”

“THERE ARE MANY ROADS TO MECCA.”

HUGH HEFNER
…or Failure

So let’s *really* scrutinize the successes and replicate their features.
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Medical Home Evaluations: Why Do They Seem To Disagree?

Mark W. Friedberg, MD, MPP

November 11, 2015

PCPCC 2015 Annual Fall Conference
There is no such thing as “The Medical Home”

• But there are medical homes

• Best not to assume two people talking about “the medical home” are talking about the same thing

• First question to ask: *Do you mean medical home as a model of practice, or as an intervention applied to primary care practices?*

• Some studies evaluate models, others evaluate interventions
Key ingredients of medical home interventions

• **New resources for primary care practices**
  – Technical assistance, coaching
  – In-kind contributions
  – Enhanced payment, many possible forms:
    • Per member per-month supplemental payment
    • Shared savings
    • Fee-for-service rate “uplift”

• **New requirements for primary care practices**
  – Practice transformation / adopt new capabilities
  – Demonstrate “medical homeness”
Relationship between intervention, model, and patient care

- Intervention applied
- Some practices adopt model, to varying extents
- Changes in patient care
Relationship between intervention, model, and patient care

- Intervention applied:
  - Some practices adopt model, to varying extents
  - Changes in patient care

- Intervention not applied:
  - Some practices still might adopt model
  - Changes in patient care

@MWFriedberg  #PCPCC2015
Medical home interventions with different recipes can produce different results

Southeast PA

Original Investigation
Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care

Mark W. Friedberg, MD, MPP; Eric C. Schneider, MD, MSc; Meredith B. Rosenthal, PhD; Kevin G. Volpp, MD, PhD; Rachel M. Werner, MD, PhD

Northeast PA

Original Investigation
Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care

Mark W. Friedberg, MD, MPP; Meredith B. Rosenthal, PhD; Rachel M. Werner, MD, PhD; Kevin G. Volpp, MD, PhD; Eric C. Schneider, MD, MSc
What could explain these differences?

Nature (aka, context)

- Practices “right-sized” in the northeast
- Prior experience with care management
- Practice culture at baseline
- More community health centers, underserved populations in southeast
- Fewer hospitals in northeast
- All northeast practices had EHRs at baseline
What could explain these differences?

**Nurture (aka, intervention design)**

- More emphasis on early medical home recognition in southeast
- PMPM $ earmarked for care management in northeast
- Greater care management support from plans in northeast
  - Rapid data feedback on utilization
- Shared savings in northeast
We can use evidence to refine medical home interventions

• Within 2-3 years, the results of another 20-30 pilots should be published, including 3 giant CMS pilots

• Heterogeneity creates opportunity
  – Different intervention “recipes” may lead to different outcomes
  – Evaluations will help us identify the key ingredients

• Growing evidence to identify the best medical home interventions and how to tailor them to local context
Thank you

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Resources:


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