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Improving Outcomes for High-Risk, High-Cost Patients:

Considerations for Spreading Models

Institute of Medicine Workshop on Value & Science-Driven Health Care
Washington, DC

July 7, 2015

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Some lessons from recent work

- Improving outcomes is hard and takes time
- We have evidence that SOME models CAN improve outcomes for SOME patients
- We need more work to distill which models to scale
  - Key program features
  - Successful targeting approaches
  - Supports (data feedback, technical assistance [TA], and financial incentives)
- We know some factors that could help scale models
  - Substantial financial incentives
  - Multipayer support, if payers coordinate and align funding, TA, data feedback, staff support, and reporting requirements
  - Adaptation of data and TA to reflect considerable diversity of practices, health systems, markets, patients, etc.
  - Monitoring/auditing function (if funder bears risk) to ensure programs are implemented

Patient targeting matters

Example: Medicare Coordinated Care Demonstration (MCCD)

- Care management provided by external organizations
- Only 2 of 11 programs reduced hospitalizations for all (already high-risk) enrollees
- But 4 did so (by 11% a year from 2002 to 2008) for higher-risk enrollees (defined by prior utilization *and* chronic condition)

Brown, Randall, Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol Razafindrakoto. "Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients." *Health Affairs,* vol. 31, no. 6, June 2012, pp. 1156-1166.

Peikes, Deborah, Greg Peterson, Randall S. Brown, Sandy Graff, and John P. Lynch. "How Changes in Washington University's Medicare Coordinated Care Demonstration Pilot Ultimately Achieved Savings." *Health Affairs,* vol. 31, no. 6, June 2012, pp. 1216-1226.

Details of the model matter

Care coordinators in the four MCCD programs were more likely to:

1. **Have frequent face-to-face contact with patients (~ once/month)**
2. **Build strong rapport with patients' physicians through (some) face-to-face contact at hospital or office**
3. **Use behavior-change educational techniques to help patients increase adherence to medications and self-care**
4. **Know when patients are hospitalized and provide support for transition home ('transition care light')**
5. **Act as a communications hub among providers and between patient and providers**
6. **Provide medication management by obtaining reliable information about patients' medications and having access to pharmacists or medical director**

Early lessons about scaling from CMS's Comprehensive Primary Care Initiative (CPC)

- **Medicare, Medicaid, and 29 private payers support primary care redesign**

  - **~500 practices with ~2,100 clinicians in 7 regions**
  - **Serving ~2.5 million patients (1.6 million of these are attributed to practices)**
  - **Promising effects in year 1: Potentially cost neutral**
  - **Too early to expect or confirm favorable findings**
  - **Nonetheless, many lessons for spreading interventions**

Taylor, Erin Fries, Stacy Dale, Deborah Peikes, Randall Brown, Arka Ghosh, Jesse Crosson, Grace Anglin, Rosalind Keith, Rachel Shapiro, and contributing authors. "Evaluation of the Comprehensive Primary Care Initiative: First Annual Report." Prepared for the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Princeton, NJ: Mathematica Policy Research, January 2015.

Strong, understandable financial incentives help gain traction with providers

- Payment that is substantial and affects a sizable share of the practice's patients provides a strong incentive for participation and retention
  - For CPC, multipayer support made this attractive to payers and practices
  - Total CPC payment to the median practice was $226,000 ($70,000 per clinician) in program's first year (19% of 2012 total practice revenue)
  - Minimal attrition so far
  - Funders need to make sure that payments reach practices that are part of systems
- To motivate practices, shared savings and other performance payments should be
  - Understandable to practices
  - Linked to their actions and changes
  - Paid relatively soon after improvements
- Practices worry about sustainability of non-reimbursable services and staff when an initiative ends
  - Care management
  - Quality improvement

Considerations for data feedback

- Providers need regular feedback, but timing can involve tradeoffs
  - Data feedback gives many practices their first look at their patients' utilization from the larger health care system
  - Feedback can fuel quality improvement (QI)
  - Need to balance practices' rapid-cycle QI needs (especially for acute care use) with time needed for accurate claims data (from enough runout) and cost of producing the reports
- Data for QI often focus on trends, without a rigorous comparison group, leading to different inferences than evaluation estimates
- Patient-level data allow practices to drill down and examine specific patients' cases
- Practices want:
  - Specialist cost and quality data to guide referrals
  - Comparisons of their own outcomes to those of similar practices for context
- Less is more
  - Focus on a reasonable number of measures that reflect both utilization/cost and quality
  - Unaligned feedback from multiple plans can result in information overload and no action
- Many practices need TA to interpret and act on the data
  - Practices and systems vary in data orientation, sophistication
  - Practices need to figure out what is actionable

Considerations for technical assistance and collaborative learning networks

- Provide specific tactics. While some programs want to avoid being too prescriptive, many practices want step-by-step instructions, tools, and resources.
- Be nimble and responsive to practice needs.
- Tailor TA. Practices' needs vary widely (depending on baseline practice functioning and resources, system versus independent ownership, rural versus urban location, etc.).
- Balance resource constraints. Practices value individualized in-person TA, but it is costly.
- Incentivize exemplars to teach their peers. Practices value peer learning and networking, but TA providers need to find exemplars—and sometimes convince them—to share.

Teaching leadership and teamwork may be key

- **Technical assistance on leadership and teamwork may help spread interventions**
- **Practices that spread the work to the entire practice team were more successful in implementing it**
- **Otherwise, there is too much burden on the clinician champion, lack of a learning organization culture, and unclear roles and responsibilities**

General thoughts about scaling

- How to recruit systems, practices, patients?
  - How large does the financial incentive need to be?
  - How hard can the reporting requirements be?
  - How will the model fit with other efforts and initiatives providers may participate in?
- How to counteract incentives to cherry-pick or drop patients?
- Should services be restricted to high-risk patients?
- How can an intervention be adapted for different contexts, and how will it affect outcomes?
  - Leadership
  - Staff
  - Market
  - Patient mix

How to monitor a scaled program

- If providers do not bear risk, payers will need to monitor or audit program implementation to make sure they are getting what they are paying for
- Monitoring will require management information systems or data reporting
- Also requires some knowledge of the key components of the model and ways to document its delivery
- Auditing may be less costly to run, but gives funder less control

Thank You

- The studies described here were supported by
  - The Centers for Medicare & Medicaid Services
  - The Robert Wood Johnson Foundation's Health Care Financing Organization
  - The Medicare Chronic Care Practice Research Network

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