

# **Improving Outcomes for High-Risk, High-Cost Patients: Considerations for Spreading Models**

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# Some lessons from recent work

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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 criteria
- Supports (data feedback, technical assistance [TA], and financial incentives)

# Some lessons from recent work (*continued*)

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We know  
some  
factors  
can 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 or auditing** (if funder bears risk) to ensure programs are implemented as intended

# Patient targeting matters

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## Example: Medicare Coordinated Care Demonstration (MCCCD)

- 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

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For example, while all programs managed medications, care coordinators in the four successful MCCD programs were more likely to:

- Provide medication management by obtaining reliable information about patients' medications and having access to pharmacists or a medical director



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

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



- ~500 practices with ~2,100 clinicians in 7 regions
- Serving ~2.5 million patients
- 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**

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**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

# **Strong, understandable financial incentives help gain traction with providers *(continued)***

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**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

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**Providers need regular feedback, but timing can involve tradeoffs**

- Data feedback gives many practices their first look at their patients' utilization from other providers
- Patient-level data allow practices to drill down and examine specific patients' cases
- Feedback can fuel quality improvement (QI)

**Data for QI often focus on trends, without a rigorous comparison group, sometimes leading to different inferences than evaluation estimates**

**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**

# Considerations for data feedback *(continued)*

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## 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

- Information overload and no action from
  - Too many measures
  - Unaligned feedback from multiple plans

## 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

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## 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

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- **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

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- **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, or stint on care?**
- **How to encourage more services to be deployed 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

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- 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, but gives funder less control

# Thank You

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- The Medicare Chronic Care Practice Research Network

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