

Evaluating the Patient-Centered Medical Home: Potential and Limitations of Claims-Based Data

Deidre Spelliscy Gifford, MD, MPH

Director, Rhode Island Chronic Care
Sustainability Initiative

May 4, 2010



What is CSI RI?

- Multi-stakeholder collaboration resulting in a multi-payer payment pilot and demonstration of the Patient-Centered Medical Home
- Convened by RI Office of the Health Insurance Commissioner
- Began July 2006



Participants in CSI Collaboration:

- **Payers** (representing 67% of insured residents)
 - Medicaid; all RI-based commercial payers (Blue Cross & Blue Shield of Rhode Island,, United HealthCare – New England, Tufts Health Plan) Neighborhood Health Plan of Rhode Island
- **Purchasers** (including 70,000 self-insured residents)
 - The two largest private sector employers (Care New England, Lifespan) Rhode Island Medicaid, State Employees - health benefits program, Rhode Island Business Group on Health
- **Providers**
 - Largest primary care provider organizations (including Community Health Centers and hospital based clinics), Rhode Island Medical Society, RI AAFP, RI ACP
- **State**
 - Office of the Health Insurance Commissioner, Department of Human Services, Department of Health
- **Technical Experts**
 - Department of Health; Quality Improvement Organization



Key Program Elements: Practices and Patients

	Phase 1: Oct. 2008 – Sept. 2010	Phase 2: April 2010 – March 2012	Total
Number of Practices	5	8	13
Number of Patients covered by PMPM	24,279	21,791	46,070
Total patients in pilot practices (includes estimated 35% FFS Medicare)	37,352	33,525	70,877
Number of Providers	28	35	63



Key program elements: Contracts

- Plan responsibilities:
 - Attribution of patients to practices
 - Pay \$3 PMPM for all members
 - Provide salary and benefits for Care Managers in practice
 - **Provide data and feedback on utilization**
 - Support project infrastructure



Key program elements: Contracts

- Practice responsibilities:
 - Achieve Level 1 NCQA recognition by 9 months into pilot
 - Level 2 NCQA by 18 months
 - **Report clinical quality measures from EMR/registry in 3 conditions beginning Q2 of pilot**
 - Participate in training collaborative
 - Hire and utilize nurse care manager



“Formal” Program Evaluation

- Meredith Rosenthal and colleagues, Harvard School of Public Health (*Funded by Commonwealth*)
 - Will look for evidence that:
 - Organizations providing care adopt components of the patient-centered medical home model (NCQA PPC-PCMH)
 - Intervention has an impact on patients, including changes in care processes, outcomes and experiences of care (claims and patient survey)
 - Intervention is associated with changes in the cost of care (claims)
 - Qualitative information on experience of PCMH adoption (professional staff surveys)



7

CSI RI: Quarterly clinical measurement

- Coronary Artery Disease (CAD)
 - Beta blocker post-MI
 - Smokers advised to quit
- Diabetes
 - Hgb A1c <7%
 - BP < 130/80
- Depression
 - % adults screened in measurement year



8

Quarterly utilization measures (by practice)

Inpatient (excluding mental health and substance abuse and maternity and delivery)

- Inpatient admissions per 1000
- Inpatient days per 1000
- Average inpatient length of stay
- Inpatient per person cost trend (compared to same quarter of previous year)

Inpatient mental health and substance abuse

- Inpatient admissions per 1000
- Inpatient days per 1000
- Average inpatient length of stay
- Inpatient per person cost trend (compared to same quarter of previous year)

ED Use

- ED visits per 1000
- # of members with multiple ED visits (within 90 days)
- ED per person cost trend (compared to same quarter of previous year)

Pharmacy

- % generic of total utilization

Outpatient specialty and primary care

- Primary care visits per 1000
- Specialty care visits per 1000
- Radiology procedures per 1000
- Behavioral health per 1000



Measure Selection:

- Clinical measures:
 - Reviewed state's disease cost and prevalence data (diabetes, depression, Coronary Artery Disease selected)
 - Drew from national measure sets (except Depression screening)
 - Specific measures selected by consensus of coalition



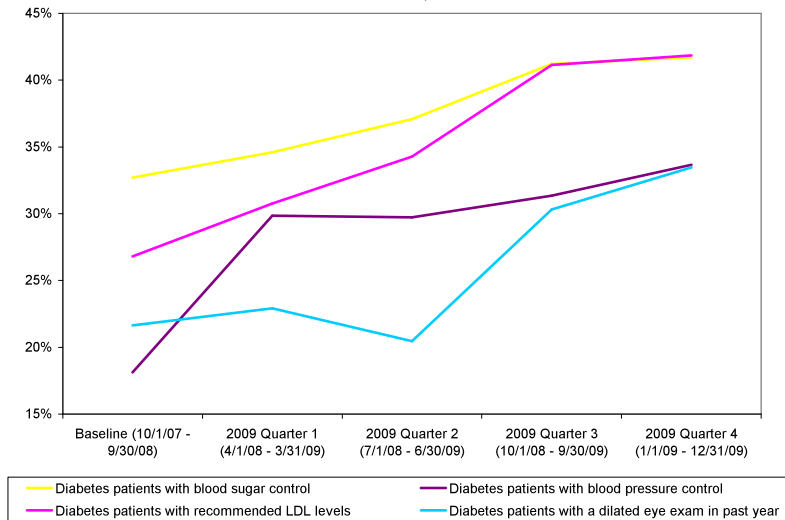
Measure Selection:

- Utilization measures
 - Driven by health plans: all health plans using same measure specs (slow)
 - Designed to “prove value” of model
 - Indirectly related to interventions (problem)
 - Approved by consensus of coalition

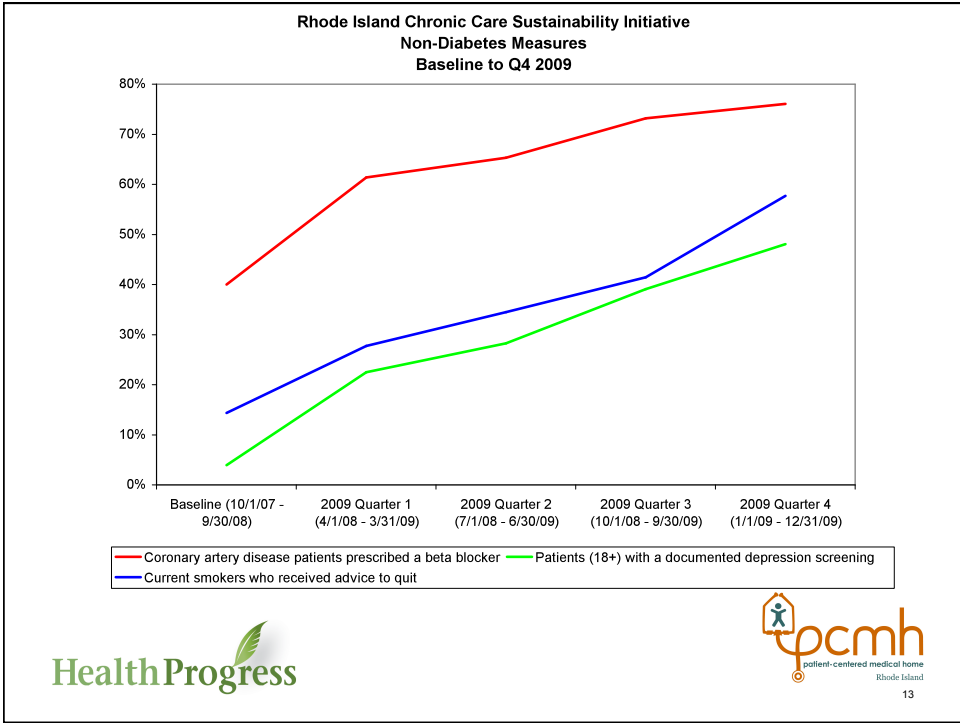


11

Rhode Island Chronic Care Sustainability Initiative
Diabetes Measures
Baseline to Q4 2009



12



EMR vs. Claims-derived quality measures

- EMR measures being used to drive improvement, evaluate trends
- EMR measures in early quarters unreliable
 - Data fields not uniform or available in EMR
 - Data entry variations across practice
 - Exclusions/inclusions difficult to operationalize in EMR

EMR vs. Claims-derived quality measures

- Providers trust EMR data more than claims to drive improvement
- EMR data are all-payer
- For first time, CSI practices are regularly reviewing internal quality measures, comparing practices and providers, and changing systems to drive improvement
 - This rarely happens with claims



Summary

- CSI RI is using a combination of claims, EMR-derived clinical measures, and surveys to evaluate the program
- Evaluation includes third party “formal” evaluation, plus on-going quarterly trend data produced by participants from a variety of sources
- All measures are identical across payers and providers. Results are public.



Contact:

Deidre S. Gifford, MD, MPH
CSI Rhode Island Project Director
Health Progress
401.541.9000
Deidre_Gifford@Brown.edu

