Contemporary Issues in Economic Assessments of Interventions in Primary Care

Presented By:
Elbert Huang, M.D., M.P.H., F.A.C.P.; Robert Nocon, M.H.S.; Ming Tai-Seale, Ph.D., M.P.H.; Cheryl D. Stults, Ph.D.; Colleen Payton, M.P.H., C.H.E.S.

Moderated By:
Rebecca Roper, MS, MPH, Director, Practice-Based Research Network Initiative, Agency for Healthcare Research and Quality

Sponsored by the AHRQ PBRN Resource Center
July 29, 2014
Agenda

• Welcome and introductions

• Presentations
  ▶ Brief Q&A session following each presentation

• Q&A session with all presenters

• Instructions for obtaining CME credits

Note: After today’s webinar, a copy of the slides will be e-mailed to all webinar participants.
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Methods for Economic Assessment of Practice Improvement Interventions in Safety Net Primary Care Settings

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Robert Nocon, MHS
Senior Health Services Researcher
The University of Chicago
Methods for Economic Assessment of Practice Improvement Interventions in Safety Net Primary Care Settings

Agency for Healthcare Research and Quality (AHRQ) Practice Based Research Network Webinar

July 29, 2014
Goals for Today

• Describe three approaches for economic assessment of primary care interventions
• Highlight key questions and challenges for you to consider in your own work
• Show brief snapshots/examples from our work
Controlling health care costs is the fundamental domestic policy challenge facing the United States...Physicians [edit: all providers] must commit themselves to act like the captain of the health care ship and take responsibility.

Emanuel EJ, Steinmetz A. July 2013
Intervention Settings

- 65 clinics in 5 states implemented PCMH model over 4 years (‘09-’13)
- Facilitated practice transformation ("coaching") model

- 6 clinics in a regional diabetes QI collaborative (‘09-ongoing)
- Emphasis on community engagement and provider/patient education on shared decision-making

- National QI collaborative among HRSA health centers
- Began in 1998 and reached >900 health centers by 2007
3 Types of Cost Questions for Primary Care Interventions

1. Cost of intervention
   – What resources were used in planning and conducting the intervention?

2. Cost of patient care
   – How has the cost of patient care changed as a result of the intervention?

3. Organization finances
   – How has the organization’s financial performance changed as a result of the intervention?
Question 1: Cost of Intervention

• What resources were used in planning and conducting the intervention?
• Challenge: Contemporary primary care interventions are extremely complex:
  – Multi-factorial and multi-year
  – Changing over time (intentionally and not)
  – Running in starts and stops
  – Subject to personnel turnover
  – Occurring in context of other interventions
  – Intense competing demands for resources/attention
Tips for Assessing Intervention Cost

• Break down complexity
  – Ask about individual parts of projects
  – Collect data as frequently as is reasonable

• Count effort, including missteps

• Understand context
  – Are there related efforts and how have they affected the intervention?
  – Robust qualitative interviews and discussion of non-financial costs/benefits
  – Many non-financial costs are critical to decision-makers (e.g. morale/burnout)
Snapshots of Example Data Collection Tools

• Intervention Activity Survey
  – Outlines major components of intervention and breaks out staffing/time and purchases
  – Administered annually (if possible)

• Qualitative Interview guide
  – Asks intervention leads and providers/staff about costs/benefits of the intervention
A. PROJECT ACTIVITIES

The Improving Diabetes Care project invites your clinic to try many different activities to improve the care of patients with diabetes. We have listed all of the major project activities, to our knowledge, that have been implemented at your center, as well as key clinic staff that have been involved. If there are any activities listed below that you and the listed contact at your center are not familiar with, please contact [Name], Project Manager, at [email] or [phone].

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description of Activity</th>
<th>Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large group collaborative meetings/quarterly</td>
<td>Meeting with other clinics also participating in the Improving Diabetes Care project in order to share ideas and learn from each others' experiences in improving diabetes care</td>
<td>[Clinic contact 1]</td>
</tr>
<tr>
<td>meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QI team meetings</td>
<td>Meeting internally with the Improving Diabetes Care project team</td>
<td>[Clinic contact 2]</td>
</tr>
<tr>
<td>Diabetes group visits</td>
<td>Developing and running group visits for patients with diabetes</td>
<td>[Clinic contact 3]</td>
</tr>
<tr>
<td>Wallet medication cards</td>
<td>Developing and implementing wallet-sized medication cards for patients</td>
<td>[Clinic contact 1]</td>
</tr>
<tr>
<td>Referrals tracking</td>
<td>Studying the process and outcomes of referrals to outside health care providers</td>
<td>[Clinic contact 1]</td>
</tr>
<tr>
<td>Community outreach events</td>
<td>Participating in community outreach events with Improving Diabetes Care Project, such as health fairs and CAN TV tapings</td>
<td>[Clinic contact 1]</td>
</tr>
</tbody>
</table>
4. **Wallet Medication Cards**

It is our understanding that [Health Center] developed and implemented wallet-sized medication cards that patients could discuss with their providers, and use at home. Please answer the questions below regarding the time that went into this activity and the staff members who participated.

B17. Apart from regular QI team meeting time, how much **total time** was spent on the entire medication card project? This may include, but is not limited to, such activities as developing the concept for the medication cards, designing the cards, producing the cards, distributing them to patients, and educating patients about them. List the name or position of each staff member involved in the process, and the total hours each staff member spent since the start of the project.

<table>
<thead>
<tr>
<th>Name / position of staff member</th>
<th>Total hours spent on the medication cards</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Clinic contact 1]</td>
<td>15</td>
</tr>
<tr>
<td>[Clinic contact 2]</td>
<td>8</td>
</tr>
</tbody>
</table>


## Intervention Assessment - Qualitative Interview Guide

### Discussion Topics
- Impact on patients
- Impact on providers and staff
- Impact on the clinic overall
- Sustainability

### Example Questions
- Has the project affected the clinic’s reputation in the community?
- Do you think that the project has attracted new patients?
- Do you think that the project has affected provider productivity (positively or negatively)?
- What parts of the project are the most costly?
Example Work

- Community Health Center perspectives on cost
- Broad survey of 74 HCs + 5 in-depth case studies
- High variation in intervention financial costs within the same initiative
- Non-financial costs and benefits carried heavy weight with clinic leaders

Question 2: Cost of Patient Care

• How has the cost of patient care changed as a result of the intervention?

• Challenges:
  – Patient care costs are distributed across organizations (specialists, hospitals) and time
  – Investments in primary care may have benefits in “downstream” utilization outcomes
  – The most costly types of patient care can be rare among a general primary care population (e.g. inpatient admissions)
Tips for Assessing Cost of Patient Care

• Data from an integrated provider network may be ideal, but hard to find
• Claims data from a common payer can cover large portion of patients
  – Medicare / Medicaid / large insurer
  – Challenge: identifying your intervention patients in claims
• Consider focus analysis on subgroups most likely have high cost outcomes (e.g. chronically ill)
• Understand the scope and limits of your data source. For example:
  – Out of network utilization
  – Delay/difficulty of obtaining/analyzing claims
Example Work

- Analysis of text messaging primary care intervention using health plan data
- Intervention targeted toward health system employees
- University health plan data captured >90% of utilization
- Net cost savings (8.8%) after accounting for intervention costs

Question 3: Organization Finances

• How has the organization’s financial performance changed as a result of the intervention?

• Challenges
  – Clarifying the conceptual link between intervention and organization finances:
    • Healthcare organizations are paid in different ways and even different ways within the same organization
    • Intervention must be large enough to have an impact on overall organization finances
  – Difficult to find standardized data sources across multiple organizations
Example Work

- Do clinics that rate higher as medical homes experience higher operating costs?
- Data from HRSA UDS - a health center reporting database that includes financial measures (operating cost)
- 10-point higher PCMH score (0-100 scale) was associated with a 5% higher operating cost (more than the average health center margin)

Thank You

- Elbert Huang – ehuang@medicine.bsd.uchicago.edu
- Robert Nocon – rnocon@medicine.bsd.uchicago.edu
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Today’s Presenters

Estimating the Costs of Supporting Primary Care Transformation: Shared Medical Appointments

Ming Tai-Seale, Ph.D., MPH
Senior Scientist
Palo Alto Medical Foundation Research Institute

Cheryl D. Stults, PhD
Research Sociologist
Palo Alto Medical Foundation Research Institute
Estimating the Costs of Supporting Primary Care Transformation: Shared Medical Appointments

Cheryl Stults
Sean McClellan
Laura Panattoni
Ming Tai-Seale

Funding: AHRQ 1R03HS022631 (PI Tai-Seale) and the Richard and Susan Levy Family Foundation
Shared medical appointments (SMAs) or group visits = medical visits where multiple patients are simultaneously seen by a physician in a group setting
Example of Shared Medical Appointment (SMA) Spatial Arrangement
SMAs Help

• Access to care in climate of primary care shortage

• Practice productivity

• Provider satisfaction

• Patient satisfaction

• Clinical outcomes


Barriers to SMA Implementation

• Financial/administrative hurdles

• Adequate staffing for SMAs

• Adequate facilities/resources

• Provider motivation to use SMAs

• Patient expectations for care


2 Stults, C. D., et al. Shared Medical Appointments: A Promising Innovation to Improve the Patient-Physician Relationship and Ease Primary Care Shortage. Presentation at HMORN 2014 annual meeting
What is the human resource cost of developing and implementing a program to support SMAs?

Once established, what is the human resource cost of adding a new SMA, specifically on cancer survivorship?
“Because with SMAs, it looks very simple from the top view, at 40,000 feet; but when you drill down at ground level, there are a lot of variations; there’s a lot of things to consider; there’s a lot of moving parts.”

- SMA Program Coordinator
Activity Based Costing $^{1,2}$

- Completed activities or tasks
- Personnel involved
- Time spent on each activity
- All development and implementation human resource costs were included. Other costs such as materials (e.g. podiums, computers, copies) or room use were excluded
- To maximize generalizability, costs were calculated as time spent on each activity by each employee multiplied by the 2013 Bureau of Labor Statistics national median wage


Setting

• A large multispecialty group practice in Northern California
  – 27 different SMAs across the organization between 2000 and 2013

• In-depth key informant interviews
Development Timeline for Program to Support SMAs

January 2000- June 2010
- Physician Champion

Dec 2009- June 2010
- SMA Coordinator

July 2010- April 2012
- SMA PROGRAM
  - Physician Champion
  - SMA Coordinator
  - Medical Assistant Scribe
  - Operations Lead

May 2012- Present
- Expansion of SMA PROGRAM
  - Department Coordinator
  - 1 additional MA scribe
  - 3 Patient Service Representatives

Cancer Survivorship SMA
Activities and Time Spent by Each Employee in Developing and Implementing a SMA Program

**Physician Champion**
- 84 hr x $90 (md. wage) = $7,546
- Research on SMAs (16 hr.)
- Development of SMA related materials (40 hr.)
- Planning meeting with SMA coordinator and operations (5 hr.)
- Meeting with SMA consultant (5 hr.)
- Meetings with SMA coordinator (18 hr.)

**SMA Coordinator**
- 1255 hr x $44 (md. wage) = $54,869
- Development of and research for the SMA program (1,211 hr.)
- Planning meeting with Physician Champion and operations (5 hr.)
- Meeting with SMA consultant (5 hr.)
- Meetings with Physician Champion (18 hr.)
- Develop referral and tracking tool in electronic health record (10 hr.)
- Training clinical staff (6 hr.)

**Medical Assistant Scribe**
- 16 hr x $14 (md. wage) = $228
- Develop referral and tracking tool in EHR (10 hr.)
- Training clinical staff (6 hr.)

**Operations Lead**
- 5 hr x $46 (md. wage) = $232
- Planning meeting with SMA coordinator and Physician Champion (5 hr.)
Total Time and Costs by Employee Type in Developing and Implementing a SMA Program

SMA program development: time and costs, by role

<table>
<thead>
<tr>
<th>Role</th>
<th>Time, hours</th>
<th>National median hourly wage, $</th>
<th>Total Cost, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>84.0</td>
<td>90</td>
<td>7,546</td>
</tr>
<tr>
<td>SMA Coordinator</td>
<td>1255.0</td>
<td>44</td>
<td>54,869</td>
</tr>
<tr>
<td>Operations Lead</td>
<td>5.0</td>
<td>46</td>
<td>232</td>
</tr>
<tr>
<td>MA scribe</td>
<td>16.0</td>
<td>14</td>
<td>228</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1360.0</strong></td>
<td></td>
<td><strong>62,874</strong></td>
</tr>
</tbody>
</table>

Notes: Estimated wage based on national median hourly wages.
## Total Time and Costs by Activity in Developing and Implementing a SMA Program

<table>
<thead>
<tr>
<th>SMA program time and costs for activities before and during implementation</th>
<th>Total time, hours</th>
<th>Cost, $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-implementation (up to June 2010)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of and research for the SMA program</td>
<td>1,211.0</td>
<td>52,945</td>
</tr>
<tr>
<td>Research on SMAs</td>
<td>16.0</td>
<td>1,437</td>
</tr>
<tr>
<td>Development of SMA-related materials, including referral and tracking tool in EHR and recruitment flyers</td>
<td>40.0</td>
<td>3,593</td>
</tr>
<tr>
<td><strong>Implementation (July 2010 to March 2012)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting with physician champion, SMA coordinator, and Operations lead</td>
<td>15.0</td>
<td>900</td>
</tr>
<tr>
<td>Meetings with physician champion and SMA coordinator</td>
<td>36.0</td>
<td>2,404</td>
</tr>
<tr>
<td>Meetings with SMA consultant</td>
<td>10.0</td>
<td>668</td>
</tr>
<tr>
<td>Develop referral and tracking tool in electronic health record</td>
<td>20.0</td>
<td>580</td>
</tr>
<tr>
<td>Training clinical staff</td>
<td>12.0</td>
<td>348</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,360.0</td>
<td>62,874</td>
</tr>
</tbody>
</table>
## Activities and Time Spent by Each Employee in a Cancer Survivorship SMA

**Physician**
- Recruitment (1 hr.)
- Initial planning meeting (1.5 hr.)
- Creation of Business Plan (5 hr.)
- Rooming and personnel logistics (5 hr.)
- Training (20 hr.)
- Researching and developing material (40 hr.)

72.5 hr x $90 (md. wage) = $6,513

**SMA Coordinator**
- Recruits Physician (1 hr.)
- Initial Meeting (1.5 hr)
- Trains Physician (2 hr.)
- Finalizes rooming and personnel logistics (2 hr.)
- Research and development of materials in SMA (4 hr.)

10.5 hr x $44 (md. wage) = $459

**Operations Lead**
- Help develop business plan (1 hr.)
- Present at directors meeting (1 hr.)
- Rooming and personnel logistics (2 hr.)

4 hr x $46 (md. wage) = $185

**Medical Assistant Scribe**
- Develop referral and tracking tool in EHR (2 hr.)

2 hr x $14 (md. wage) = $28

**EHR Developer**
- Develop referral and tracking tool in EHR (2 hr.)

2 hr x $43 (md. wage) = $86
## Total Time and Costs by Employee Type in a Cancer Survivorship SMA

Cancer survivorship SMA: implementation time and costs, by role

<table>
<thead>
<tr>
<th>Role</th>
<th>Time, hours</th>
<th>National median hourly wage, $</th>
<th>Total Cost, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>72.5</td>
<td>90</td>
<td>6,513</td>
</tr>
<tr>
<td>SMA Coordinator</td>
<td>10.5</td>
<td>44</td>
<td>459</td>
</tr>
<tr>
<td>Operations lead</td>
<td>4.0</td>
<td>46</td>
<td>185</td>
</tr>
<tr>
<td>Medical assistant</td>
<td>2.0</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>HER developer</td>
<td>2.0</td>
<td>43</td>
<td>86</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91.0</strong></td>
<td></td>
<td><strong>7,271</strong></td>
</tr>
</tbody>
</table>

Notes: Estimated wage based on national median hourly wages.
Total Time and Costs by Activity in a Cancer Survivorship SMA

<table>
<thead>
<tr>
<th>Activities</th>
<th>Total time, hours</th>
<th>Cost, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit physician</td>
<td>2.0</td>
<td>134</td>
</tr>
<tr>
<td>Initial planning meeting</td>
<td>3.0</td>
<td>200</td>
</tr>
<tr>
<td>Creation of business plan</td>
<td>7.0</td>
<td>542</td>
</tr>
<tr>
<td>Rooming and personnel logistics</td>
<td>9.0</td>
<td>629</td>
</tr>
<tr>
<td>Training clinical staff</td>
<td>22.0</td>
<td>1,884</td>
</tr>
<tr>
<td>Research and development of material for SMA</td>
<td>44.0</td>
<td>3,768</td>
</tr>
<tr>
<td>Develop referral and tracking tool in EHR</td>
<td>4.0</td>
<td>114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91.0</strong></td>
<td><strong>7,271</strong></td>
</tr>
</tbody>
</table>
## Total Time and Costs by Activity in a Cancer Survivorship SMA

Cancer survivorship SMA: Time and costs for activities before and during implementation

<table>
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<tr>
<th>Activities</th>
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<td>3,768</td>
</tr>
<tr>
<td>Develop referral and tracking tool in HER</td>
<td>4.0</td>
<td>114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91.0</strong></td>
<td><strong>7,271</strong></td>
</tr>
</tbody>
</table>
Discussion

• Physician champion spent several years conducting SMAs before beginning the program so had experiential knowledge

• We estimate that the human resource cost to develop and implement a program to support SMAs was $62,874.

• The SMA coordinator spent the most time (1,255 hr.) and cost the most ($54,869).

• The most time consuming activity was development of and research for the SMA program (1,211 hrs., $52,945), which was completed by the SMA coordinator.

• We estimate that the cancer survivorship SMA human resource cost was $7,271 to develop and implement.

• The physician spent the most time (72.5 hr.) and cost the most ($6,513) followed by the SMA Coordinator (10.5 hrs., $459 respectively).

• The most time consuming and costly activity was the development of the materials (44 hrs., $3,768), which was completed by the physician.
Limitations

- Largely a fee-for-service organization
- One case of clinic implementation
- Estimates based on individual self-reports
- Underestimate of time and costs
Implications

• Developing and implementing a program to support SMAs required significant time of the SMA coordinator.

• Introducing new physicians or a new type of SMA may require a relatively modest commitment of organizational resources.

• It is possible that the total time and cost could be decreased by utilizing existing materials.
What is the human resource cost of developing and implementing a program to support SMAs?

Total Employee Time= 1,360 hours
Total Employee Costs= $62,874

Once established, what is the human resource cost of adding a new SMA, specifically on cancer survivorship?

Total Employee Time= 91 hours
Total Employee Costs= $7,271
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Exploring the Costs Associated with the Implementation of the Patient-Centered Medical Home

Colleen Payton, MPH, CHES
Clinical Research Specialist
Thomas Jefferson University
Exploring the Costs Associated with the Implementation of the Patient-Centered Medical Home

Colleen Payton, MPH, CHES
Department of Family & Community Medicine
Thomas Jefferson University
Acknowledgements and Disclosures

• Patient-Centered Medical Home COST Study Team
  • George Valko, MD (PI)
  • Rob Lieberthal, PhD (Co-I)
  • Mona Sarfaty, MD, MPH (Co-I)
  • Tom Karagiannis, PharmD
  • Manisha Verma, MD, MPH

• This project was supported by grant number R03HS022630 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.
Objectives

• Outline our project’s approach to estimating the financial burden of PCMH for small primary care practices

• Describe the cost-collection tool we created for both transforming and sustaining the PCMH model
Patient-Centered Medical Home

- A leading model of primary care reform that helps shift primary care from reactive, episodic care to proactive, population health management

- Can be viewed as a solitary practice or a complement to accountable care organizations (ACOs)

- Has demonstrated improvements in quality
  - Remains a work in progress

- Cost remains an open question
Small Practices and Costs of Transformation

• Smaller practices represent a large proportion of primary care in the US

• The success of the PCMH model may rest on its uptake by small practices across the US

• Many of the costs of practice transformation are upfront fixed costs

• Smaller practices in particular may not have the economies of scale or resources to absorb these costs
Specific Aims and Study Design

- Administered survey adapted from NCQA 2011 Accreditation Guidelines to 11 PCMHs in southeastern Pennsylvania

- Conducted semi-structured interviews to identify the clinical activities associated with each element of transformation

- Created a taxonomy of costs reflecting clinical activities and insights from the PCMH implementation process

- Developed a tool to facilitate cost-collection from each practice
Examining Heterogeneity in our Sample

<table>
<thead>
<tr>
<th>Practice Characteristics</th>
<th>Proportion of Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCQA recognition (2011)</strong></td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>3 out of 11</td>
</tr>
<tr>
<td>Level II</td>
<td>3 out of 11</td>
</tr>
<tr>
<td>Level III</td>
<td>5 out of 11</td>
</tr>
<tr>
<td><strong>Financial affiliation</strong></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>6 out of 11</td>
</tr>
<tr>
<td>Academic medical center</td>
<td>2 out of 11</td>
</tr>
<tr>
<td>Another organization (FQHC grantee)</td>
<td>3 out of 11</td>
</tr>
<tr>
<td><strong>Primary type of insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Medicare / Managed Medicare</td>
<td>3 out of 11</td>
</tr>
<tr>
<td>Medicaid / Managed Medicaid</td>
<td>2 out of 11</td>
</tr>
<tr>
<td>Private (commercial) insurance</td>
<td>5 out of 11</td>
</tr>
<tr>
<td>Uninsured</td>
<td>1 out of 11</td>
</tr>
</tbody>
</table>
Preliminary Findings: Survey and Interviews

- Practices identified themselves as a PCMH using the framework laid out by the NCQA 2011 Standards.

- Despite similarities in size, small practices in southeastern PA differ in terms of composition and financial characteristics.

- Practices faced different financial burdens while transforming to a PCMH.
## Findings: Financial Burden

<table>
<thead>
<tr>
<th>Practice Responses</th>
<th>Proportion of Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think you could have transformed to a PCMH without the Chronic Care Initiative?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 out of 11</td>
</tr>
<tr>
<td>No</td>
<td>8 out of 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Unforeseen Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Staff Hires</td>
</tr>
<tr>
<td>EMR and/or Software</td>
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<tr>
<td>New Technology</td>
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<tr>
<td>Training Existing Staff</td>
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<td>Reimbursement or Financing Concerns</td>
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Cost Taxonomy—Taking a Deeper Dive into Each Cost Domain

- **PCMH Activity Pillar**
  - One or more NCQA recognition criteria

- **NCQA Application Process**
  - Time spent completing application + cost of application + cost of maintaining recognition

- **Practice Culture Costs**
  - Cost of staff dissatisfaction + cost of disruption - cost offsets
Attribute the Cost of Inputs into PCMH within Each Domain

• Type of input—labor vs. capital

• Attribution—direct vs. indirect costs

• Timing—one time vs. ongoing
  • I.e. transformation and sustaining the model

• Net costs—cost offsets (e.g. productivity gains, incentives, and quality dollars)
Limitations

• Generalizability concerns
  • Most of our practices were part of a PCMH learning collaborative and can be viewed as early adopters
  • Primary care market in southeastern PA may be different than other markets across the US

• Cost-collection tool created retrospectively
  • Sample practices already received NCQA recognition
  • Hard to discern certain activities/roles retrospectively
Health Policy Implications and Summary

• Can the PCMH model be applied to small practices?
  • If so, which type of small practice?

• Future tools and studies assessing PCMHs should be modeled after the NCQA Standards

• Small practices will be able to identify the costs of their transformation process to a PCMH using the cost-collection tool we developed

• Policymakers will be able to better determine appropriate reimbursements and financial incentives based on the cost data we collect
How to Submit a Question

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- Questions will be read aloud by the moderator.
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