



# How to tell if your vendor’s claims are valid: Part Five

*Inaccurate marketing claims and outcomes reports are proliferating. The Validation Institute has staked out a position as the leader in assisting/promoting vendors and consultants in the “Integrity Segment” of the healthcare services market.*

*How can you tell if your adviser is in the Integrity Segment? The easiest way: did they send you to this series or did you have to find it on your own?*

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Part Five is really two parts in one. The first half offers you questions to ask the vendor. It is best to ask them in person, but in an RFP as well. ([Part Six](#) will cover how to write an RFP, but it will be focused mostly on making respondents’ outcomes claims valid and comparable.)

The second half looks at the latest fad, which is vendors getting themselves peer-reviewed in academic journals. You will learn to distinguish true peer reviewed publications from ads disguised as peer review. [Peer review itself has come under fire, too.](#) That means you should consider even the best peer review to be a minimum threshold, rather than a substitute for your own critical thinking.

## **Questions to ask the vendor**

[Spoiler Alert] The first question is specifically about the Validation Institute.

### **(1) “Are these outcomes claims validated by the Validation Institute?”**

A full list of validated organizations [can be found here](#). In descending order, the responses you will get will be as follows:

- “Yes.”
- “We have already contracted for validation and it should be completed soon.”
- “We aren’t validated by them because no one has ever asked us to.” (A good rejoinder here is: “So you are proposing that we be penalized because no one knows what questions to ask you?”)
- “We’ve been validated by actuaries.”

The last one takes us right into Question #2.



**(2) “Do your actuaries warrant their work, so that they will agree in writing to be held responsible if indeed it can be shown to be invalid?”**

Few actuaries ever stand behind their work. (The Validation Institute does, of course, with its [Credibility Guarantee](#).)

[As in this hilarious three-part series](#), vendors pay actuaries to “show savings,” not to determine whether indeed there are savings. Who would hire an actuary who wouldn’t support their product? Or, to put it another way:

“You know that point solution you paid me to validate? It doesn’t save money,” said no actuary ever.

If in fact the vendor insists that the actuaries did this validly, ask to talk to the actuaries. You will find that they relied upon at least one of the fallacies in the first three installments [\[1\]](#) [\[2\]](#) [\[3\]](#) of this curriculum:

- Comparing participants to “matched” non-participants
- Only measuring people who pre-identified as having the condition in question or being high-risk or having a high Hb a1c to begin with
- Measuring against “trend”

You will also probably also find that there is no relationship between the change in health status and the change in claimed costs., the subject of [Part Four](#) in this series.

But the next question will determine whether the emperor has no clothes. This may be asked of whoever did the analysis, whether it’s an actuary or not. The question is a template. We’ll use diabetes as an example, since that is a popular point solution.

**(3) “What was the rate of primary-coded diabetes admissions per 1000 before you instituted the program and what is the rate now?”**

Care to bet they will not know?

Somehow, though, they are sure there were savings by reducing admissions. They just don't know how or why, because they can't know how much the diabetes admissions rate declined without knowing the starting point or the ending point.

They will probably say they can't get the data. A good follow-up question might be to ask how, if they don't have the data and don't know what the starting point or the endpoint is, they are so sure they got savings.

Here is a trick question, meaning one that any actuary should be able to answer, but most can't: "What is the approximate diabetes admission rate in the commercially insured population, per 1000 covered people?" The answer is about 1. (You read that right.)

So if, for example, they got a reduction of 10% in the admission rate, they would reduce admissions by 0.1 for every 1000 covered people. Figure \$30,000 per admission. That creates a reduction in cost of \$3 per covered person per year.

That example was diabetes. If you do musculoskeletal, there will be more opportunity to reduce utilization, beyond hospital admissions. Therefore, as opposed to just asking what the reduction in admissions is, you might even ask the vendor which procedure and test codes they typically tally to determine the reduction in utilization of high-cost procedures and tests. Then you can measure the change in those procedure codes, for the entire population.

### ***Behind the scenes of peer review***

Often, vendors will brag about being peer-reviewed. Most prospects of vendors will then assume that the data was carefully vetted and reviewed by independent highly qualified third parties before seeing the light of publication because, after all, no journal would ever publish an article that was obviously flawed, right?

Well, certainly not for free.



It turns out most journals now charge for publication, and good luck finding any disclaimers to that effect in their published articles. Even airline magazines, where the expectation of objectivity is quite low to begin with (“Waco: Visit the Texas Panhandle’s Undiscovered Jewel”), multi-page spreads are marked “(advertisement)” on every page.

Not so in clinical research. A whole industry of journals with distinguished-sounding names all using various combinations of basically the same words, like Journal of Medical Economics, has sprung up to satisfy the demand for articles by vendors who want to purchase the ability to say they are peer-reviewed.

Let’s look at that very same Journal of Medical Economics (JME). Here is their rate card.

### Fast Track

Publish in **3-5 weeks** from submission\*

- Submission to acceptance: 2-3 weeks
  - 1-2 weeks for peer review<sup>†</sup>
  - 1 week for author revision
- Acceptance to online publication: 1-2 weeks, with proofs within 5 working days and 48 hours for author review

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Cost per article: \$7000 / €6200 / £5500

### Rapid Track

Publish in **7-9 weeks** from submission\*

- Submission to acceptance: 5-6 weeks
  - 3-4 weeks for peer review
  - 2 weeks for author revision
- Acceptance to online publication: 2-3 weeks, with proofs within 10 working days

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Cost per article: \$3900 / €3400 / £3000



They aren't the only ones. Here is a list of other journals offering the same thing.

- [Biomarkers\\*](#)
- [Blood Pressure\\*](#)
- [Cancer Investigation\\*](#)
- [COPD: Journal of Chronic Obstructive Pulmonary Disease\\*](#)
- [Current Eye Research\\*](#)
- [Current Medical Research and Opinion](#)
- [Drug Development and Industrial Pharmacy\\*](#)
- [Expert Opinion on Biological Therapy](#)
- [Expert Opinion on Drug Delivery](#)
- [Expert Opinion on Drug Discovery](#)
- [Expert Opinion on Drug Metabolism & Toxicology](#)
- [Expert Opinion on Drug Safety](#)
- [Expert Opinion on Emerging Drugs](#)
- [Expert Opinion on Investigational Drugs](#)
- [Expert Opinion on Orphan Drugs](#)
- [Expert Opinion on Pharmacotherapy](#)
- [Expert Opinion on Therapeutic Patents](#)
- [Expert Opinion on Therapeutic Targets](#)
- [Expert Review of Anticancer Therapy](#)
- [Expert Review of Anti-infective Therapy](#)
- [Expert Review of Cardiovascular Therapy](#)
- [Expert Review of Clinical Immunology](#)
- [Expert Review of Clinical Pharmacology](#)
- [Expert Review of Endocrinology & Metabolism](#)
- [Expert Review of Gastroenterology & Hepatology](#)
- [Expert Review of Hematology](#)
- [Expert Review of Medical Devices](#)
- [Expert Review of Molecular Diagnostics](#)
- [Expert Review of Neurotherapeutics](#)
- [Expert Review of Ophthalmology](#)
- [Expert Review of Precision Medicine and Drug Development](#)
- [Expert Review of Pharmacoeconomics & Outcomes Research](#)
- [Expert Review of Proteomics](#)
- [Expert Review of Respiratory Medicine](#)
- [Expert Review of Vaccines](#)
- [Hospital Practice](#)
- [International Journal of Neuroscience\\*](#)
- [Journal of Asthma\\*](#)
- [Journal of Dermatological Treatment\\*](#)
- [Journal of Drug Targeting\\*](#)
- [Journal of Medical Economics\\*\\*](#)
- [Minimally Invasive Therapy & Allied Technologies\\*](#)
- [Nanotoxicology\\*](#)
- [Postgraduate Medicine](#)
- [Pharmaceutical Development and Technology\\*](#)
- [Scandinavian Cardiovascular Journal\\*](#)
- [Scandinavian Journal of Gastroenterology\\*](#)
- [The Physician and Sportsmedicine](#)

You might say: “Well, that’s a big list but now that we know articles in these journals are tainted, we’ll just trust other peer-reviewed journals instead.”

Haha, good one. This list is just from one single publisher. This field has attracted multiple for-profit publishers, each publishing journals with more erudite-sounding titles than the others. Fact is, the vast majority of journals are now profit-making enterprises, and the vast majority of “peer-reviewed” articles are bought-and-paid-for by vendors, instead of the readers. Most of the resulting articles are known as “open-access,” for just that reason—they’re free to read.

Let's dig a little deeper to see what this means in practice, using the JME as an example. And let's see what JME published for Livongo, that the field's most respected general-interest (non-profit!) journals -- New England Journal of Medicine, the Lancet, or the Journal of the American Medical Association -- would never do.

[First, they published an article comparing participants to non-participants](#), a fallacy debunked in the [first installment](#) of this series. You could scan the entire databases of those three journals without finding a single article using non-participants as a control for participants. Nor does the Validation Institute validate such programs without a major disclaimer announcing that much or most of the differences between the two cohorts in these outcomes reports can be traced to that study design, rather than the intervention.

Next, the supplier of Livongo's diabetes strips funded the study. Livongo claims that its outcomes are in large part due to more Type 2 diabetics checking their glucose much more often, a practice that requires using more strips. This conflict of interest was not disclosed in the article.

[A headline about this study](#), with (presumably) unintended irony, announces the result:

## **Lilly-funded study shows Livongo diabetes program can save employers \$20 to \$50 per member per month**

The retrospective analysis compared more than 2,200 Livongo users with non-users at the same companies.

Next, you have to consider not just who funds the study (which the end of the article notes that Lilly did "as part of a research collaboration with Livongo Health") but who writes the study. In this case, the very end of the article discloses that all nine authors were consultants or employees of Livongo or Lilly:



C.W. has received consulting payments from Livongo and acknowledges funding from NIA K01 AG061274. J.B., W.L., S.P., and J.S. were employed by Livongo Health, and Z.Z., X.H., J.J., and E.M. were employed by Eli Lilly & Company during analysis

In all fairness to the JME, they did do actual peer review. They scaled back Livongo's original claim that participants checking their devices for blood sugar caused these cholesterol spending to decline to "program access was associated with a decrease in medical spending." Correlation, not causation. Since the categories with the biggest decreases - spending on cholesterol and hypertension - had nothing to do with how many times people measure their blood sugar, this seems like a good, albeit obvious, catch on the part of the peer reviewers.

[Nonetheless, Livongo's press release reverted to their original language not supported by peer review.](#) They re-defined "associated with" a decrease in spending as "delivered" a decrease in spending. Causation, not correlation. Whereas the major journals would have demanded a retraction/correction, none was forthcoming here.

A look at the various journals' "impact factors" - the standard measure of influence/credibility -- confirms that we may not be alone in the universe in thinking that all peer review is not created equal:

- New England Journal of Medicine: [74.6](#)
- Journal of the American Medical Association: [45.5](#)
- The Lancet: [60.4](#)
- Journal of Medical Economics: [1.8](#)

### ***The take-aways from Part Five***

Previous installments [\[1\]](#)[\[2\]](#)[\[3\]](#)[\[4\]](#) have cautioned to watch out for words and phrases like:

- "participants"
- "matched"
- "high-risk"
- "as compared to trend"



We can now add to that list more trigger words/phrases:

- “We can’t get the data”
- actuaries
- peer-review, and even (with a small “v”)
- validated

The five take-aways:

1. Ask the right questions.
2. Apply critical thinking to the answers you hear.
3. If your consultants or brokers are parroting these vendor trigger words, encourage them to take the [Validation Institute’s course](#) in Critical Outcomes Report Analysis.
4. Most importantly, use only vendors carrying the Validation Institute seal.
5. And even then, make sure to match what they tell you against what they are validated to be able to tell you, in order to be protected by the Credibility Guarantee.



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