Listening Session 1: *What Do We Want to Measure in PB-TCOC Models, and How?*

Presenters:

Subject Matter Experts

- **Thomas Sequist, MD, MPH** - Chief Medical Officer, Mass General Brigham
- **David Meltzer, PhD, MD** - Chief of the Section of Hospital Medicine, Director, Center for Health and the Social Sciences, and Chair, Committee on Clinical and Translational Science, University of Chicago; and Fanny L. Pritzker Professor of Medicine, Department of Medicine, University of Chicago Harris School of Public Policy and the Department of Economics – (Previous Submitter - Comprehensive Care Physician Payment Model (CCP-PM) proposal)
- **Franklin Gaylis, MD, FACS** - Chief Scientific Officer, Genesis Healthcare Partners; Executive Medical Director, Unio Health Partners; and voluntary Professor, Urology, University of California San Diego

Listening Session 2: *Issues Related to Selecting and Designing Measures for PB-TCOC Models*

Presenters:

Subject Matter Experts

- **Krishna G. Ramachandran, MBA, MS** - Senior Vice President, Health Transformation and Provider Adoption, Blue Shield of California
- **Dana Gelb Safran, ScD** - President and Chief Executive Officer, National Quality Forum
- **Vivek Garg, MD, MBA** - Chief Medical Officer, Primary Care, Humana
- **Sai Ma, PhD, MPA** - Director, Enterprise Clinical Quality, Elevance Healt

Listening Session 1: What Do We Want to Measure in PB-TCOC Models, and How?

Thomas Sequist, MD, MPH

Chief Medical Officer, Mass General Brigham

PB-TCOC and Quality Measurement

Tom Sequist, MD
Chief Medical Officer, Mass General Brigham
Professor of Medicine and Health Care Policy, Harvard Medical School

What Are We Hoping to Achieve

- Best patient outcomes (survival, functional status, wellbeing)
- Best experience (including service, respect, dignity, and empathy)
- Equity in everything we do

With as little waste as possible

What Have We Achieved

- Slow improvements in translation of evidence-based care and outcomes improvement
- Limited transition to a high functioning service industry
- Persistent and even worsening inequities

Focus on total cost of care independent of our guiding principles

Challenges and Solutions

- ACOs have many competing priorities

- Long term planning around finances and clinical goals (outcomes, experience, equity) may not converge

On the ground confusion around the direction of incentive programs

The Donabedian Model of Quality

THE
MILBANK QUARTERLY
A JOURNAL OF PUBLIC HEALTH
AND HEALTH CARE POLICY

Evaluating the Quality of Medical Care

AVEDIS DONABEDIAN

THIS PAPER IS AN ATTEMPT TO DESCRIBE AND evaluate current methods for assessing the quality of medical care and to suggest some directions for further study. It is concerned with methods rather than findings, and with an evaluation of methodology in general, rather than a detailed critique of methods in specific studies.

Donabedian A. Milbank Memorial Fund Quarterly, 1966.

Outcome

"Outcomes [recovery, restoration of function and survival], by and large, remain the ultimate validators of the effectiveness and quality of medical care."

Process

"…one is interested…in whether what is now known to be "good" medical care has been applied."

Structure

"…the settings in which [the process of care] takes place and the instrumentalities of which it is the product."

How To Promote Patient Outcomes in PB-TCOC Over VBP

- Evaluate programs for inclusion of Outcomes>Process>Structure
- Clarity around what is a quality measure versus a utilization or access measure
- Synchronize and be inclusive for hospital and ambulatory metrics
- Ambulatory specialty care versus primary care

How To Promote Experience in PB-TCOC Over VBP

- Value communication, coordination, and empathy
- Focus on objective reports of care over subjective ratings of care

How To Promote Equity in PB-TCOC Over VBP

- Obsess over closing equity gap in outcomes
- Improve the data
- Avoid metrics solely related to creating equity improvement plans
- Thoughtful risk adjustment around reimbursement and outcomes

Listening Session 1: What Do We Want to Measure in PB-TCOC Models, and How?

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Chief of the Section of Hospital Medicine, Director, Center for Health and the Social Sciences, and Chair, Committee on Clinical and Translational Science, University of Chicago; and Fanny L. Pritzker Professor of Medicine, Department of Medicine, University of Chicago Harris School of Public Policy and the Department of Economics

Previous Submitter - Comprehensive Care Physician Payment Model (CCP-PM) proposal

Measuring Desired Characteristics and Outcomes of PB-TCOC Models: What Features Do We Want to Measure?

David Meltzer, MD, PhD

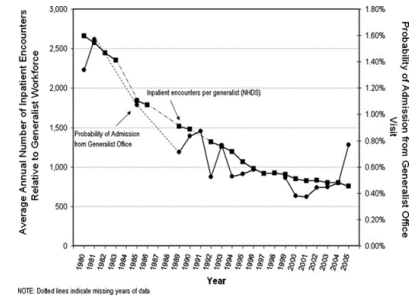
Fanny Pritzker Professor of Medicine, Economics and Public Policy

The University of Chicago

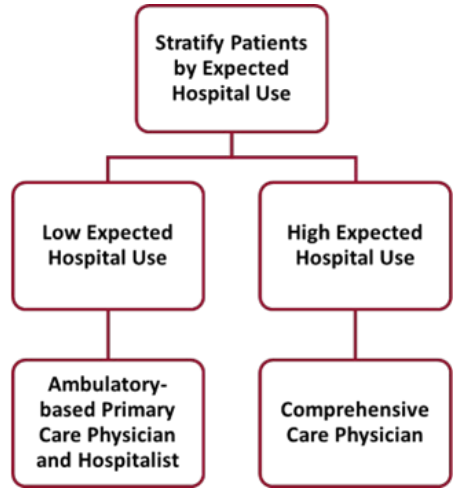
March 25, 2024

Background: David Meltzer, MD, PhD

- MD (practicing general internist (PCP and hospitalist)), PhD in Economics
  - Professor of Medicine, Economics and Public Policy, Chief of Hospital Medicine, University of Chicago
  - Member, National Academy of Medicine
- Research focus on value of medical specialization
  - Used inpatient general medicine services as opportunity for natural experiment
  - Studied hospitalists; limited evidence for improved outcomes
  - Found hospitalists grew due to falling hospital vs. ambulatory volume for PCPs

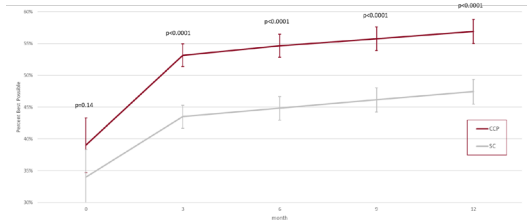


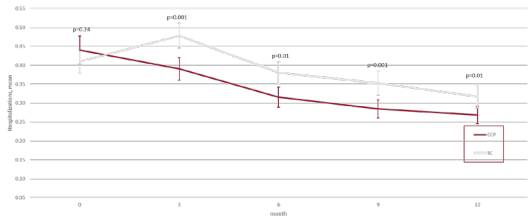
- Developed Comprehensive Care Physician (CCP) model in which PCPs focus practice on patients at increased risk of hospitalization to care for them in and out of the hospital
  - Studied through several randomized trials at the University of Chicago Medicine (UCM) on Chicago's South Side
  - Highly competitive health care market that serves a large socioeconomically vulnerable population



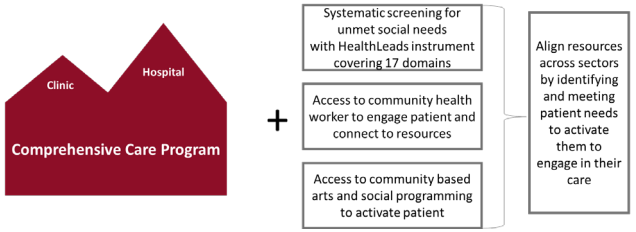
Comprehensive Care Physician (CCP) Model Studies

- CMMI-funded 2,000 person randomized clinical trial (RCT) of CCP vs. standard care (SC) at UCM in Medicare patients at increased risk of hospitalization
  - PCP rating increases from 20th percentile nationally to 95th (vs. 80th for SC)
  - 15% decrease in hospitalization
    - 30% decrease ($p<0.05$) in non-Dual-eligibles
    - 10% decrease (N.S.) in Dual-eligibles





  - Smaller effects in duals due to:
    - Artifact due to 2-fold greater retention of high-risk patients in traditional Medicare vs. managed care in CCP vs SC in context of Illinois Medicare Medicaid Alignment Initiative (MMAI)
    - Need to address unmet social need
  - CCP-Payment Model (PMPM fee) recommended for limited scale testing by PTAC, Sept. 2018
- RWJF-funded development of Comprehensive Care, Community and Culture Program (C4P) to screen for unmet social need, address via CHW, activate patients via community-based program



- PCORI-funded 3,000 person RCT of C4P vs. CCP vs. Partners-like Care Coordination Program
  - Interim results find C4P reduces hospitalization vs. CCP for duals and least “activated” patients

Goals of Performance Measures in PB-TCOC Models?

Measuring both outcomes and care process are goals of performance measures in PB-TCOC

- **We want to improve outcomes** (including controlling costs) **and patient satisfaction so we must measure them if we wish to improve them but there are reasons for concern:**
  - Improving measured outcomes for populations may be most easily accomplished by sacrificing them for subgroups
  - Improving measured outcomes may be more readily accomplished by avoiding high-risk/cost patients
  - Linking performance measures to payment can disincentivize measure improvement (e.g., E vs. VG patient experience, outreach efforts for response rates)
  - Idea that PB-TCOC will improve care and/or reduce costs is a hypothesis; alternatives exist (e.g., FFS reform, competition)

- **Measuring how care is provided is critical to achieving goals of performance measurement**
  - As a mechanism to temper over-emphasis on outcomes and incentives for selection/gaming of system
  - To test hypotheses about how to improve care
  - To increase the likelihood care practices that improve outcomes are followed
  - May wish to pay for process as paying for process vs. outcomes depends on the degree of confidence in the validity of each

- **Other goals of performance measures? And what strategies are effective?**
  - Measure effects in subgroups, esp. vulnerable ones given program design (e.g., high-cost patients)
  - Causal inference; RCTs, demonstration projects w/ robust controls, clean natural experiments, avoid programmatic interference
  - Mitigate risks in payment models (e.g., selection, rewarding suboptimal processes, e.g., care coordination vs. defragmentation)
  - Advance patient centered care and the science of its measurement (e.g., goal attainment)

Goals of Performance Measures in PB-TCOC Models? (continued)

- **Measuring patient experience, population health, costs**
  - Overall concerns
    - All outcomes in vulnerable subgroups, defined by medical, social and payment-based risk factors, including market structure
    - Retention of vulnerable subgroups
    - Outcomes of persons who transition
    - Outcomes of the population (e.g., county or other relevant definition of “market”)
  - Domain-specific concerns
    - Patient experience: minimal (e.g., HCAHPS top-coding) vs. aspirational (e.g., goal attainment)
    - Population health: hard to move general health measures, greater focus on disease-specific measures – perhaps linked to identified clinical opportunities, mental health?
    - Costs: Not just Medicare A/B or costs to Medicare (managed care), costs to Medicaid, medical stakeholders (e.g., MCOs, providers) and non-medical stakeholders (e.g., jails, housing)
- **Measuring work life of health care providers**
  - Relationship with patients, colleagues, provider organizations, payers, policy makers
  - Continuity

Appendix

References

- David O. Meltzer and Gregory W. Ruhnke. Redesigning Care For Patients At Increased Hospitalization Risk: The Comprehensive Care Physician Model, Health Affairs 2014 33:5, 770-777
- David Meltzer, et al. Effects of a Comprehensive Care Physician (CCP) Program on Patient Satisfaction, Health Status, and Hospital Admissions in Medicare Patients at Increased Risk of Hospitalization: Initial Findings of a Randomized Trial https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/23609
- The Comprehensive Care Physician Payment Model (CCP-PM) https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/180036/ProposalUniversityofChicagoMedicine.pdf
- Comprehensive Care Institute https://www.comprehensivecareinstitute.org/
- David Meltzer, Original Sin and U.S. Health Care Reform, Annals of Internal Medicine, Jan 21, 2020. https://www.acpjournals.org/doi/10.7326/M19-3894

Listening Session 1: *What Do We Want to Measure in PB-TCOC Models, and How?*

Franklin Gaylis, MD, FACS

Chief Scientific Officer, Genesis Healthcare Partners; Executive Medical Director, Unio Health Partners; and voluntary Professor, Urology, University of California San Diego

Implementing a Pay for Performance Quality Improvement Payment Model: So easy yet so difficult!

Franklin Gaylis MD, FACS
Executive Medical Director, Unio Health Partners
Chief Scientific Officer, Genesis Healthcare Partners
Voluntary Professor, Dept. Urology, UCSD

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Introduction

Background on Genesis Healthcare Partners (medical group):

- 13 years in operation
- Currently have a 110 physicians
- Located throughout California
- Have experience with 2 ACOs and a novel Pay-for-Performance pilot

Type of Quality Improvement Intervention:

- Cost-effective care delivery best practices for improving treatment of low-risk prostate cancer (PCa)
- Meaningful performance measures
- Provide feedback on provider performance (transparency)
- Pay-for-Performance (P4P)

Implications for Population-Based Total Cost of Care Models

- Identifying meaningful specialty-related performance measures
- Organization-level measures vs. provider-level measures – a hybrid model

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Prostate Cancer (PCa): an opportunity to improve quality of care

Relevance to the patient:

- **Most common** non skin cancer in men in the US and the **second leading cause of cancer deaths.**
- **Overtreatment** of **low-risk PCa** (indolent disease) results in **more harm** (urinary incontinence and sexual dysfunction) than good.
- Despite recommendations to adopt **conservative management > 20 years** ago, both the **adoption and quality** (follow up) of active surveillance for low-risk PCa are **suboptimal.**

Equity (1):

- PCa **disproportionately affects Black men**: more aggressive disease and higher mortality rates compared to White men.
- Black men experience **less access to PCa treatment, longer delays** between diagnosis and treatment.
- Responsible factors: health care system **mistrust**, poor physician- patient **communication, lack of patient knowledge** on PCa and treatment options,

Relevance to the Population:

- Accounts for 21% of all new cases of cancer
- **Cost** of $18.53 billion in 2020 – a 56.3% increase from 2010 - and an $8.4 billion loss in productivity between men and their spouses. **(2-4)**

Ref:@

1 Lillard JW, Jr, Moses KA, Mahal BA. Racial disparities in Black men with prostate cancer: A literature review Cancer 2022;128:3787-3795.

2 R. Siegel, K. Miller, A. Jemal, Cancer statistics, 2016, CA Cancer J. Clin 2016;66(1):7-30. doi: 10.3322/caac.21332. Epub 2016 Jan 7.

3 Mariotto AB, Yabroff KR, Shao Y, et al. Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst 2011;103:117–128. doi:10.1093/jnci/djq495

4 Rizzo JA, Zyczynski TM, Chen J et al. Lost labor productivity costs of prostate cancer to patients and their spouses: Evidence from US National Survey data. J Occup Environ Med. 2016 Apr;58(4):351-8. doi: 10.1097/JOM.0000000000000621.

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News & Analysis

Medical News & Perspectives

It Takes an Average of 17 Years for Evidence to Change Practice—the Burgeoning Field of Implementation Science Seeks to Speed Things Up

Rita Rubin, MA

JAMA April 25, 2023 Volume 329, Number 16

THE JOURNAL of UROLOGY®
www.auajournals.org/journal/juro

JU Forum

Using Implementation Science to Improve Patient Care

(1)

- "the journey from study results to adoption of proven interventions historically takes 17 years".(2)
- "health services and outcomes research increasingly shows our best treatment advances may not be implemented effectively in diverse settings and populations, resulting in inequitable access and effectiveness of care".
- "We in urology and medicine have major problems with implementation".

1. Using Implementation Science to Improve Patient Care. Vol. 210, 577-579, October 2023
2. Morris ZS..J R Soc Med.2011;104(12):510-520.

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Chronology of Genesis Healthcare Partners (GHP) Quality Improvement Interventions

2011 – GHP formed from 10 urology practices; 25 providers
Objective: mitigate overtreatment of low-risk PCa

2022 – Collaborate with the Prostate Cancer Active Surveillance Project (PCASP) and United Healthcare

Implemented **passive education** → **minimal improvement**

Implemented anonymized **physician audit and feedback** → **significant improvement** in AS for low-risk PCa

Implemented **Transparent physician audit and feedback and Pay-4-Performance** value-based model → **even more improvement**

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Active Surveillance of Prostate Cancer in a Community Practice: How to Measure, Manage, and Improve?

Franklin Gaylis, Edward Cohen, Renee Calabrese, Hilary Prime, Paul Dato, and Christopher J. Kane

Table 2. AS adoption per individual physician per NCCN criteria: comparative reporting of method 3

Method 3 —NCCN Period	AS Adoption Rate, NCCN August 24, 2011-August 23, 2012	AS Adoption Rate, NCCN August 24, 2012-August 23, 2013	AS Adoption Rate, NCCN August 24, 2013-August 23, 2014
Dr. A	0%	18%	
Dr. B	40%	25%	44%
Dr. C	13%	44%	67%
Dr. D	47%	50%	75%
Dr. E	50%	40%	50%
Dr. F		75%	100%
Dr. G	0%	0%	20%
Dr. H	50%	75%	100%
Dr. I	20%	50%	
Dr. J	50%		
Dr. K	0%	0%	50%
Dr. L	67%	0%	
Dr. M	10%	83%	
Dr. N	0%	20%	
Dr. O	73%	50%	80%
Dr. P	9%	25%	0%
Dr. Q	50%	50%	
Dr. R	29%	43%	67%
Dr. S	0%	50%	100%
Dr. T	20%	8%	50%
Dr. U	33%	50%	100%
Dr. V	67%	N/A	75%
Dr. W	67%	75%	50%
Overall	**32%**	**39%**	**58%**

Key

<33%	Poor
34%-66%	Suboptimal
>66%	Optimal
N/A	0/0, No qualifying AS patients

Gaylis F, Cohen E, Calabrese R, et al. Active surveillance of prostate cancer in a community practice: how to measure, manage, and improve? Urology. 2016; 93:60.

Anonymized reporting

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P4P Collaborative (GHP-PCASP-UHC) Performance Measurement: building on our prior experience (1)

Measure	Definition	Practice-Level Benchmark
#1: **Documentation**	EHR-embedded template/structured note documenting risk and management in a structured format to promote physician-directed risk stratification and document patient management	90%
#2: **Observational Management**	Initial selection of active surveillance or watchful waiting (conservative management) for patients with LR PCa, defined as the absence of definitive local treatment for more than 6 months	75%
#3: **Confirmatory Testing: PSA**	≥2 PSA tests per year	75%
#4: **Confirmatory Testing: Repeat prostate biopsy**	Obtaining a surveillance biopsy within 18 months of the diagnostic biopsy for LR PCa patients on AS	75%
Abbreviations: EHR=electronic health record; AS/WW=active surveillance/watchful waiting; LR=low-risk; PCa=prostate cancer		

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Payment incentive was determined by the GHP group meeting all 4 quality measure thresholds and paid to the group (not to individual physicians).

Ref (1): Gaylis FD. J Urol 2021; 207: 171.

MEASURE 2

2022- **2 interventions**:

- **P4P** program
- **Transparent** physician **audit and feedback**

	AS/WW	Radiation	Surgery	Conservative Adoption %
Group 1	**55**	**14**	**3**	**76%**
Physician A	3	1		75%
Physician B	4			100%
Physician C	2			100%
Physician D	0	1		0%
Physician E	5			100%
Physician F	7		1	88%
Physician G	1			100%
Physician H	3			100%
Physician I	7	1	1	78%
Physician J	0		1	0%
Physician K	7	2		78%
Physician L	4	8		33%
Physician M	3			100%
Physician N	1			100%
Physician O	8	1		89%
Group 2	**24**		**1**	**96%**
Physician P	8			100%
Physician Q	3			100%
Physician R	4			100%
Physician S	2		1	67%
Physician T	7			100%
Group 3	**46**	**3**	**4**	**87%**
Physician U	3		1	75%
Physician V	8			100%
Physician W	6	1		86%
Physician X	1			100%
Physician Y	10		1	91%
Physician Z	7	1		88%
Physician AA	0		1	0%
Physician AB	9	1		90%
Physician AC	0		1	0%
Physician AD	2			100%
Total	**125**	**17**	**8**	**83%**

Legend
Greater than or equal to 75%
Below 75%

Physician adoption of conservative management for patients with low-risk prostate cancer

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Additional interventions:

- Meetings with office managers to promote physician's incorporation of structured templates or notes into their workflow.
- Reminder of physicians with outstanding or incomplete templates via e-mail 1 month and 10 days before the due date.
- Called or e-mail the physician to confirm the physician's receipt and understanding
- Monitored the data input following a reminder e-mail or phone call using the PBI dashboards.

	Overall	Non-UHC	UHC Non-P4P	UHC P4P
Measure 1: Risk Assessments within 3 months of Biopsy	**70%** (590/845)	**67%** (516/766)	**92%** (45/49)	**97%** (29/30)
Measure 2: Adoption of Conservative Management for Low Risk	**83%** (125/150)	**82%** (108/132)	**93%** (13/14)	**100%** (4/4)

Physician adherence to performance measures 1 and 2 according to payer

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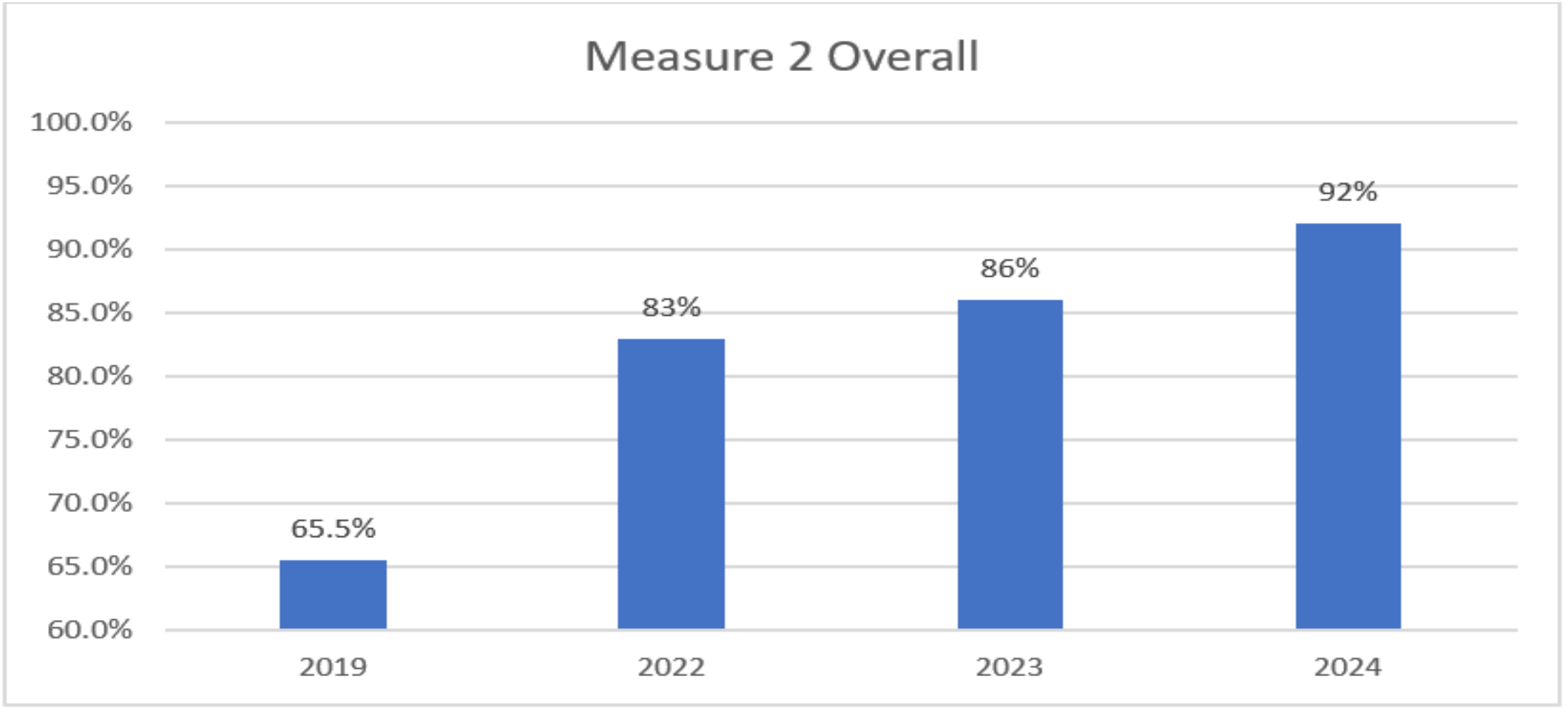
Overall provider adherence to measure 2 by year



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Cost of Implementation and Savings potential

- Automated electronic data capture and analytics system required a **one-time cost of $222,090 to build the platform;** EHR template creation, data capture process implementation, automatically-refreshed dashboards, analytics.

- Costs of initial radical treatment versus conservative management of PCa are 4 to 5 times greater(1)

- Increasing the rate of conservative management from 65.5% to 83%, as observed in our study, would **reduce the average 3-year cost per-patient by more than 25%.**

- Given the nearly 300,000 men diagnosed with prostate cancer in the United States each year, (2) among whom approximately 60,000 to 75,000 have LR disease, (2-4) the potential cost savings to payors is considerable.

- **Estimated total cost reduction by $150 million to $200 million over 3 years** (with time, more men -> active Rx)

Reference:

1. Trogdon JG et al. Total Medicare Costs Associated With Diagnosis and Treatment of Prostate Cancer in Elderly Men. JAMA Oncol. 2019;5(1):60-66. doi:10.1001/jamaoncol.2018.370
2. Siegel RL et al. Cancer statistics, 2024. CA Cancer J Clin. 2024;74(1):12-49. doi:10.3322/caac.21820
3. Herget KA et al. Recent decline in prostate cancer incidence in the United States, by age, stage, and Gleason score. Cancer Med. 2016;5(1):136-141. doi:10.1002/cam4.549
4. Wenzel M et al. Increasing rates of NCCN high and very high-risk prostate cancer versus number of prostate biopsy cores. Prostate. 2021;81(12):874-881. doi:10.1002/pros.24184

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Addressing challenges related to implementing performance measures

- Physician agreement on the measures – relevance.
- Ease of implementation – minimize physician effort (templates/structured notes), change group culture and buy-in (requires leadership to drive change).
- Defining measures and thresholds (took 2 years to agree on the measures and thresholds).
- Reporting mechanism: significant IT investment to capture (measure) and report.
- Cost.

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Commonly Reported Urology Measures[1]

In 2020, AUA identified 13,352 urologists providing direct patient care in the U.S.[2]

	More Commonly Reported			Less Frequently Reported				
Prostate Cancer	AQUA26 - Benign Prostate Hyperplasia (BPH): Inappropriate Lab & Imaging Services for Patients with BPH Reported by **88 urologists**	AQUA8 - Hospital admissions or infectious complications within 30 days of TRUS Biopsy Reported by **45 urologists**	QPP 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients Reported by **37 urologists**	Q104 - Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High-Risk Prostate Cancer Reported by **25 urologists**	Q250 - Radical Prostatectomy Pathology Reporting Reported by **9 urologists**	MUSIC4 - Prostate Cancer: Active Surveillance / Watchful Waiting for Low-Risk Prostate Cancer Patients Reported by **2 urologists**	MUSIC11 - Prostate Cancer: Follow-Up Testing for patients on active surveillance for at least 30 months Reported by **2 urologists**	
				Q462 - Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy Q476 - Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia				Reported by **0 urologists**
Urology	Q119 – Diabetes: Medical Attention for Nephropathy Reported by **777 urologists**	Q048 – Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women 65 and Older Reported by **772 urologists**	Q050 – Urinary Incontinence: Plan of Care for Urinary Incontinence in Women 65 and Older Reported by **544 urologists**	AQUA14 – Stones: Repeat Shock Wave Lithotripsy (SWL) Within 6 Months of Initial Treatment Reported by **191 urologists**	AQUA15 - Stones: Urinalysis Performed Before Surgical Stone Procedures Reported by **87 urologists**	Q432 - Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair Reported by **16 urologists**	Q433 - Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair Reported by **14 urologists**	AQUA18 - Non-Muscle Invasive Bladder Cancer: Early Surveillance Cystoscopy for Non-Muscle Invasive Bladder Cancer Reported by **1 urologist**
Cross-Cutting	Q236 - Controlling High Blood Pressure Reported by **5,092 urologists**	Q226- Tobacco Use: Screening and Cessation Intervention Reported by **3,481 urologists**	Q134 - Screening for Depression and Follow-Up Plan Reported by **2,884 urologists**	Q128 - Body Mass Index (BMI) Screening and Follow-Up Plan Reported by **1,288 urologists**	Q130 - Body Documentation of Current Medications in the Medical Record Reported by **922 urologists**	Q238 Use of High-Risk Medications in Older Adults Reported by **862 urologists**		
	Q047 - Advance Care Plan Reported by **430 urologists**	Q317 - Screening for High Blood Pressure and Follow-Up Document Reported by **405 urologists**	Q374 - Closing the Referral Loop: Receipt of Specialist Report Reported by **236 urologists**	Q321 - CAHPS for MIPS Clinician/Group Survey Reported by **214 urologists**	Q431 - Unhealthy Alcohol Use: Screening & Brief Counseling Reported by **128 urologists**	Q358 - Patient-Centered Surgical Risk Assessment and Communication Reported by **7 urologists**		

Final Thoughts

- Implementation of **QI program using specific interventions** (transparency, payment incentive) has great potential.
- **Challenges include:**
  1. **scaling** such programs across the country (only 1 large group participated – GHP).
  2. **broad acceptance by other payers** (only UHC participated. 5 others would not participate).
- **Government** should take the lead and **encourage private payors** to follow suit.
- Programs need to be **practical, relevant and easy to implement.**
- **Funding** to implement such programs is critical as startup expenses are significant.
- Perhaps **Pay-for-Reporting** (measuring and reporting = Hawthorne Effect)

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Appendix Slides

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Cost effectiveness of Active Surveillance compared to Active Treatment (3); it's nuanced!

- AS represents a **cost-effective** management strategy during the **initial years** after PCa diagnosis.

- However, based on data from the ProtecT trial (1,2) **beyond 6 years RP and RT become cost-effective** due to the lower metastatic rate of treatment as well as the continued costs of biopsy and treatment crossover of AS.

Ref; 1. Hamdy FC, Donovan JL, Lane JA et al: 10-Year outcomes after monitoring, surgery, or radiotherapy for localized prostate cancer. N Engl J Med 2016; 375: 1415.
2. Donovan JL, Hamdy FC, Lane JA et al: Patientreported outcomes after monitoring, surgery, or radiotherapy for prostate cancer. N Engl J Med 2016; 375: 1425.
3. Sharma V, Wymer KM, Borah BJ, Cost-Effectiveness of Active Surveillance, Radical Prostatectomy and External Beam Radiotherapy for Localized Prostate Cancer: An Analysis of the ProtecT Trial Vol. 202, 964-972, November 2019 J. Urol.

unio HEALTH PARTNERS

Listening Session 2: *Issues Related to Selecting and Designing Measures for PB-TCOC Models*

Krishna G. Ramachandran, MBA, MS

Senior Vice President, Health Transformation and Provider Adoption,
Blue Shield of California

Issues Related to Selecting and Designing Measures for PB-TCOC Models

Krishna Ramachandran

SVP, Health Transformation & Provider Adoption

Blue Shield of California

March 2024

Blue Shield of California

We are rebels with a cause

We are a non-profit, tax-paying health plan on a mission to create a healthcare system that is worthy of our family and friends and sustainably affordable for everyone.

7,500+
employees

4.8M
Californians served across all 58 counties

$24B
in revenue

$97M
Invested in communities

Pay for Value Strategy Overview

VISION

Blue Shield of California's pay for value strategy is focused on alternative payment models that deliver high quality care, lower costs, create an exceptional member and provider experience and ultimately achieves optimal health and well-being for all Californians

Goal Focus Areas

Philosophy

1. Fee-for-service is a broken system, and we need to drive transformative changes to payment.
2. High quality care can also be efficient care.
3. Build trust and improve the relationship with providers by paying them for the right work.
4. Incentives must improve outcomes in an equitable manner.

Challenges providers face in improving measure performance

1. Volume and variability of measures
2. Engaging Specialists
3. Accurate and actionable analytics
4. Patient attribution and risk stratification

Overcoming challenges related to performance can be supported by…

…partnering with purchasers, providers, and payers on harmonizing measures

…collaborating with specialty associations

…investing in technologies to manage data and create actionable analytics

…embedding analytics into provider workflows

California Advance Primary Care Initiative: a novel concept to drive measure harmonization

Multi-payer commitments to align, standardize investment & innovation across primary care networks in California

California Quality Collaborative

Integrated Healthcare Association

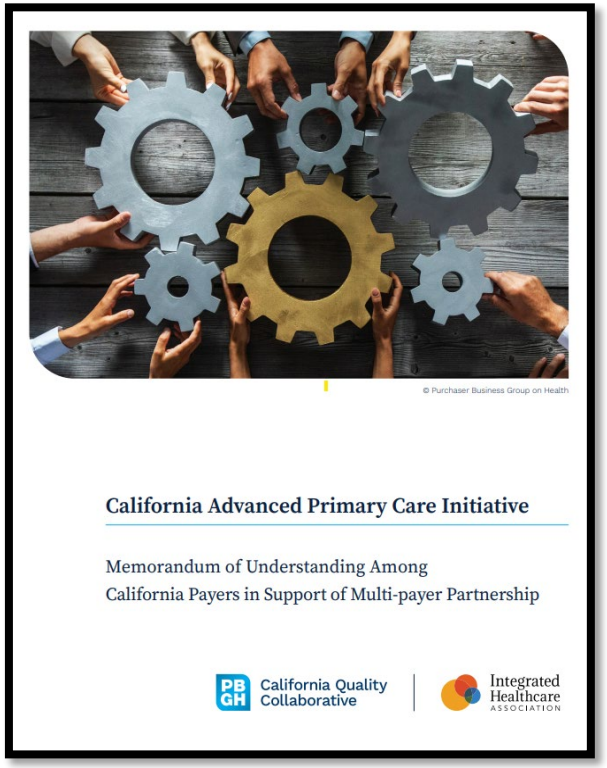
blue california

health net

aetna

Anthem

- Quality Measures
- Practice Transformation
- Increased Investment
- Payment Innovation



Collaborating for insights and influence in specialty care

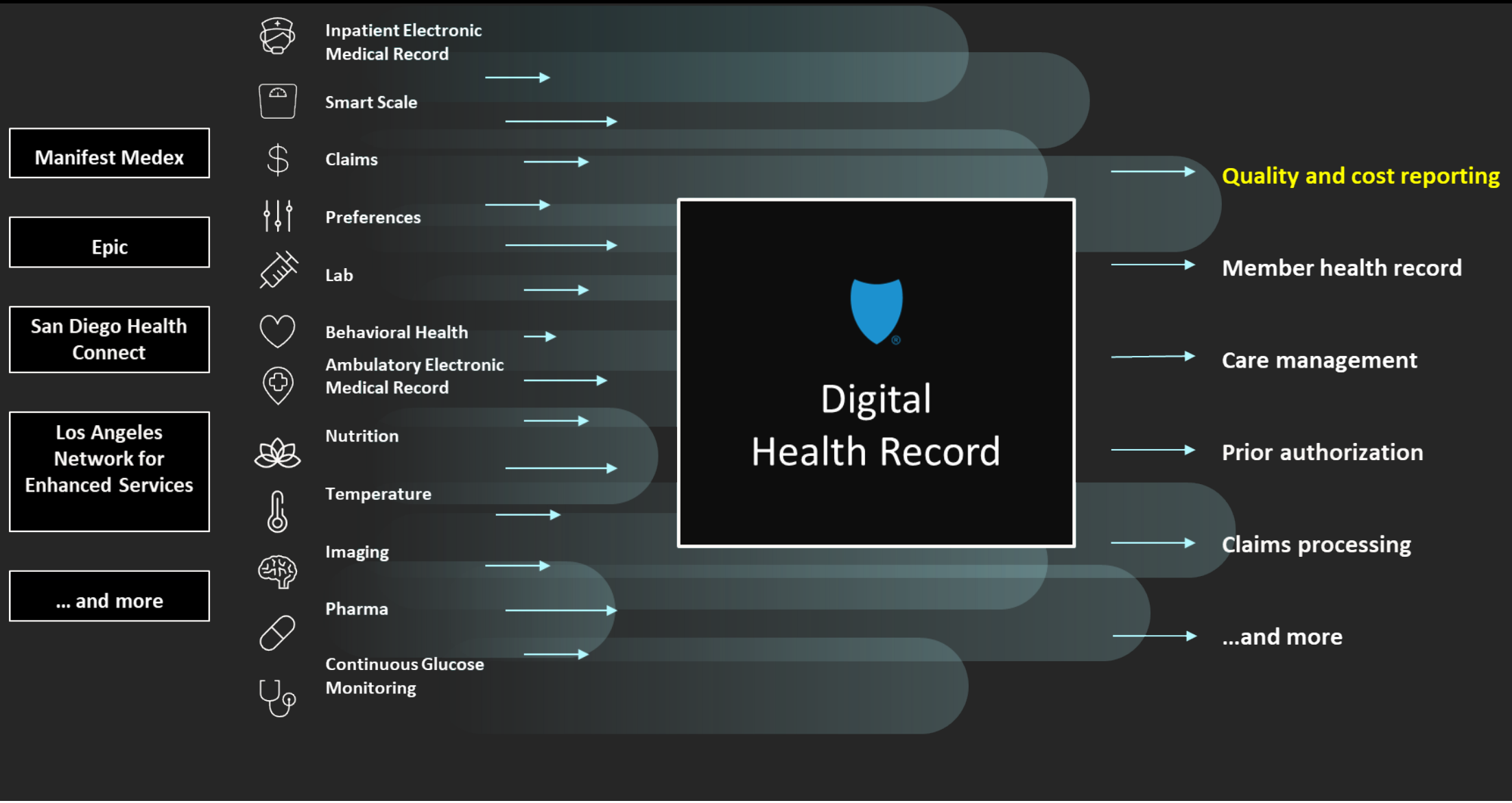
AMERICAN COLLEGE of CARDIOLOGY

CALIFORNIA MEDICAL ASSOCIATION

CALIFORNIA COA ORTHOPAEDIC ASSOCIATION

NATIONAL QUALITY FORUM
Driving measurable health improvements together

Investing in our digital health record to bridge gaps in data and create actionable analytics



Three key takeaways

1. Harmonizing measures with purchasers, providers, and payers

2. Ensuring we have the right measures for specialty care providers through collaboration

3. Investing in actionable analytics so providers can focus on delivering healthcare

Listening Session 2: *Issues Related to Selecting and Designing Measures for PB-TCOC Models*

Dana Gelb Safran, ScD

President and Chief Executive Officer,
National Quality Forum

NATIONAL QUALITY FORUM
Driving measurable health improvements together

Advancing Quality Measures & Methods for Value Based Payment Success

Dana Gelb Safran, ScD
President & CEO, National Quality Forum
Chief Scientific Officer, The Joint Commission

Physician–Focused Payment Model Technical Advisory Committee (PTAC)
25 March 2024

NATIONAL QUALITY FORUM

Voices from the Field (Feb 2024)

"Measurement should improve quality, inform choice, and ideally not add to cost of care. These criteria are not being met"

"It takes too long and costs too much to develop new measures"

"Measure cacophony"

"There are not enough outcomes measures to deliver on the promise of value in value-based care"

"Too many measures!"

"Doesn't facilitate choice for patients"

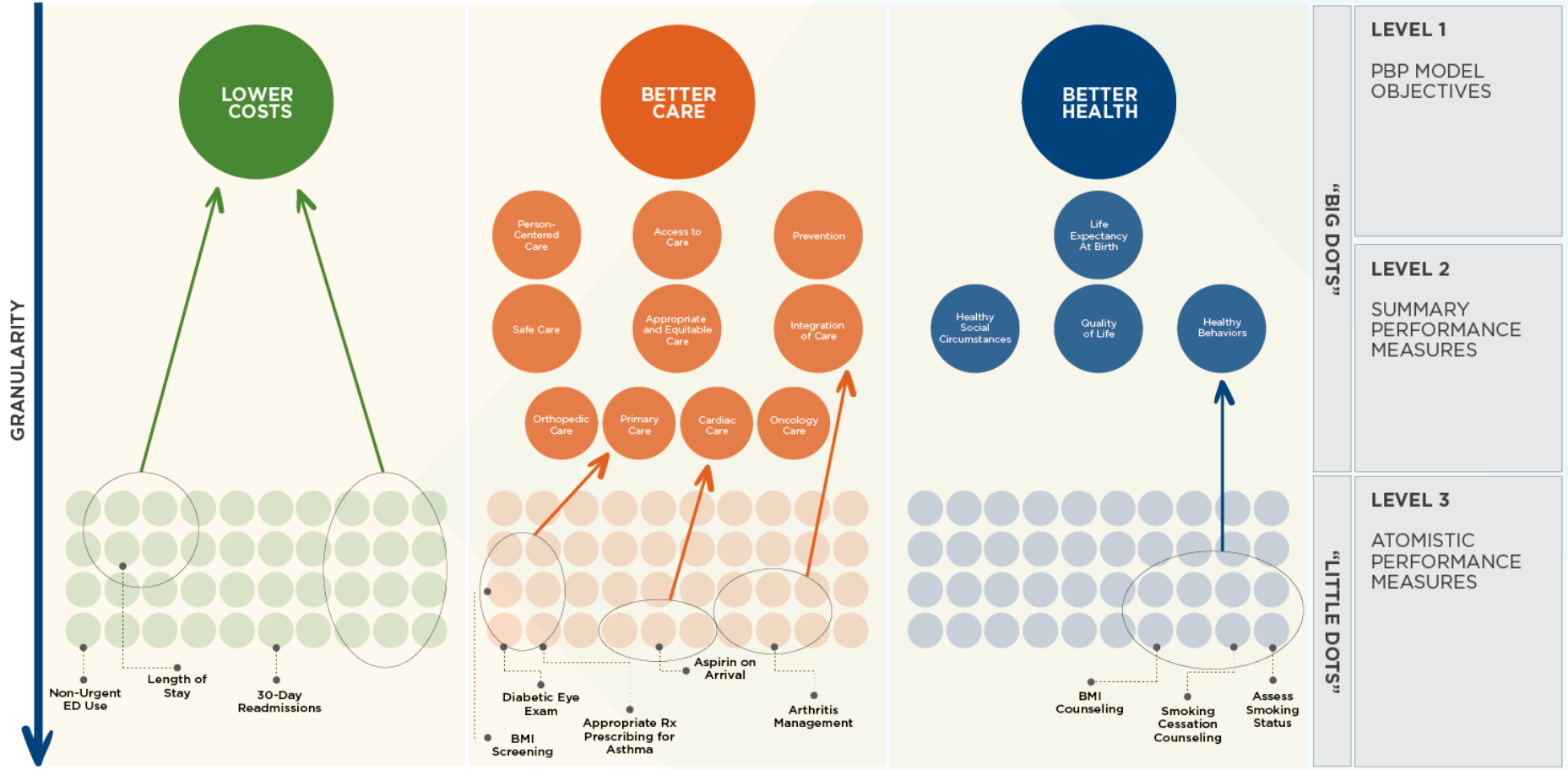
"Too much focus on what is measurable versus what is important for patient care"

"Burdensome without benefit"

NATIONAL QUALITY FORUM

APMs Demand a Shift to "Big Dot" Measures

HCPLAN
Health Care Payment Learning & Action Network



Source: Health Care Payment Learning & Action Network; The MITRE Corporation. *Accelerating and Aligning Population-Based Payment Models: Performance Measurement*. Washington, DC: The MITRE Corporation; 2016.

***Recommendation**:* To support the long-term success and sustainability of population-based payment models, future state measures must be based, as much as possible, on results that matter to patients (e.g., functional status) or the best available intermediate outcomes known to produce these results

NATIONAL QUALITY FORUM

Alternative Quality Contract (AQC) Measure Set (2007)

MASSACHUSETTS

Measures & Methods Required to Optimize VBP Results

- Measures representing **outcomes that matter**
- **Data sources** that increase clinical value of the information while reducing burden
- **Units of measurement** that support accountability and improvement
- **Alignment** of measures, measure sets and methods within and across payers
- **Incentive structures** that enable multi-year goal-setting and motivate ongoing improvement

	AMBULATORY	HOSPITAL

PROCESS	• Preventive screenings
	• Acute care management
	• Chronic care management
	  • Depression
	  • Diabetes
	  • Cardiovascular disease
		• Evidence-based care elements for:
		  • Heart attack (AMI)
		  • Heart failure (CHF)
		  • Pneumonia
		  • Surgical infection prevention

OUTCOME	• Control of chronic conditions
	  • Diabetes
	  • Cardiovascular disease
	  • Hypertension
	Triple weighted
		• Post-operative complications
		• Hospital-acquired infections
		• Obstetrical injury
		• Mortality (condition –specific)

PATIENT EXPERIENCE	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)

NATIONAL QUALITY FORUM

Aligned Innovation

Accelerating Progress Toward a Next Generation of Measures for VBP

Prospective Alignment

- Multistakeholder National Coalition of public & private sector payers, purchasers and providers
- Align on highest-priority measure gaps
- Agree to retire 2+ measures for every new measure added

Patient-Centered Outcomes

- Patients and clinicians define the results that matter most
- These become the Outcome Measure Concepts for development

Broad Diverse Provider Involvement

- Large diverse provider partners for measure development & testing
- Represent all care settings and patient populations
- Identify and proactively address clinical and operational barriers to use

Timeframe

- 24 months end-to-end
- As opposed to traditional measure development (typically 6+ years)

Accreditors/Policy

- **Centers for Disease Control and Prevention (CDC)**
  Abby Viall
- **Centers for Medicare & Medicaid Services (CMS), CMMI**
  Susannah Bernheim
  Liz Fowler
- **Centers for Medicare & Medicaid Services (CMS), CCSQ**
  Michelle Schreiber
- **Centers for Medicare & Medicaid Services (CMS), CMCS**
  Jessica Lee
  Deirdra Stockmann
- **Centers for Medicare & Medicaid Services**
  Liz Goldstein
- **The Joint Commission**
  David Baker
- **National Committee for Quality Assurance (NCQA)**
  Eric Schneider
- **Health Resources and Services Administration (HRSA), MCHB***
  Maura Dwyer
  Catherine Vladutiu

Payers & Purchasers

- **America's Health Insurance Plans (AHIP)**
  Danielle Lloyd
- **Business Group on Health**
  Jim Winkler
- **The Leapfrog Group**
  Missy Danforth
- **Purchaser Business Group on Health (PBGH)**
  Rachel Brodie
- **Willis Tower Watson (WTW)**
  Jeff Levin-Scherz

Patient / Consumer Advocacy Groups

- **National Patient Advocate Foundation**
  Alan Balch
- **Patient & Family Centered Partners, Inc.**
  Libby Hoy
- **Mental Health America***
  Jessica Kennedy
- **Fountain House***
  Joshua Seidman

Health Information Technology

- **Office of the National Coordinator of Health Information Technology (ONC)**
  Micky Tripathi
- **Civitas**
  Julie Sonier (Minnesota Community Measurement)
- **Epic Systems**
  Hannah Bond
  Anthony Corso
- **Oracle Health, Cerner**
  Nasim Afsar

Professional Societies

- **National Association of Medicaid Directors**
  Clara Filice (MassHealth)
  Linda Shaughnessy (MassHealth)
- **American Medical Association (AMA)**
  Heidi Bossley
  Frederick Chen
  Koryn Rubin
- **American College of Obstetricians and Gynecologists (ACOG)***
  Erin Alston
- **American Psychiatric Association***
  David Kroll

Aligned Innovation: Cycle 1
Multistakeholder Advisory Council (MAC)

Asterisk (*) denotes SME participants for Cycle 1 measure development

NATIONAL QUALITY FORUM

Advancing Clinically-Sourced Measures While Reducing Burden

- Supporting ONC's continued evolution of USCDI/USCDI+ such that data elements required for measurement are easily extracted/reported through FHIR and available for quality algorithms
- Leveraging AI methods – including NLP – for quality measurement will enable continued use of EHR workflows that include a combination of narrative entries and structured fields
- Advancing the integration of standardized Patient Reported Outcome Measures (PROMs) into EHRs with automated longitudinal tracking and clinically useful information displays
- Pioneering standards by which to evaluate quality measures derived with AI/NLP methods

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VBP Quality Measure Set Implementation: Key Success Factors

- Offer a continuum of performance targets rather than a single cutoff or "cliffs"
- Set absolute, not relative, benchmarks
- Set benchmarks for a multi-year period to allow for planning
- Ensure quality earning potential is enough to be "worth it"
- Including efficiency-tinged quality measures may be worthwhile even with shared savings
- Align measure sets across providers, payers and programs
- Ability to track performance against targets should be near real-time

Let’s Talk!

NATIONAL QUALITY FORUM

http://www.qualityforum.org

Appendix: Definitions (Slide 7)

- **ONC:** Office of the National Coordinator for Health Information Technology
- **USCDI/USCDI+:** United States Core Data for Interoperability/United States Core Data for Interoperability Plus Quality
- **FHIR:** Fast Healthcare Interoperability Resources
- **NLP:** Natural Language Processing
- **EHR:** Electronic Health Record

Listening Session 2: *Issues Related to Selecting and Designing Measures for PB-TCOC Models*

Vivek Garg, MD, MBA

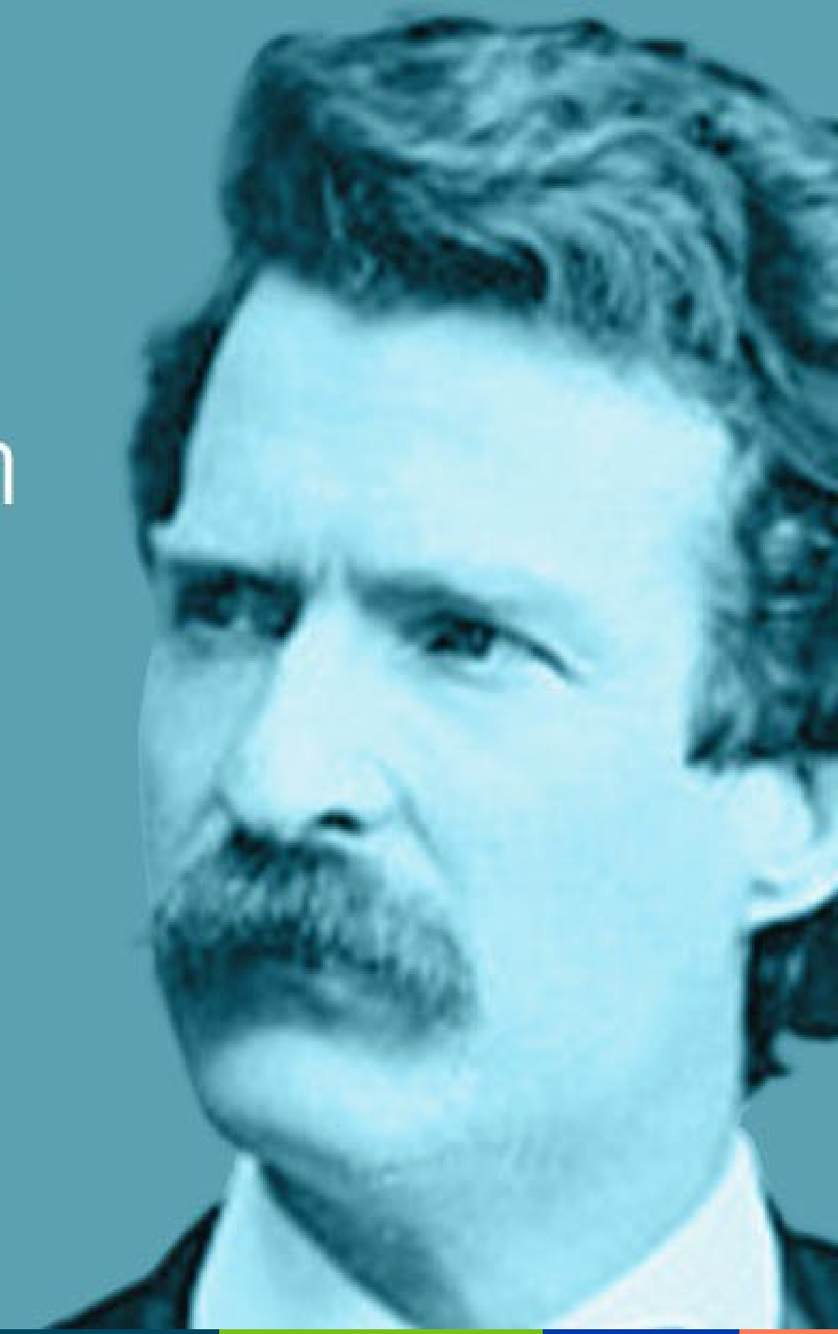
Chief Medical Officer, Primary Care, Humana

Developing and Implementing Performance Measures for Population-Based Total Cost of Care (PB-TCOC) Models - Patient & Caregiver Experience

Vivek Garg, MD, MBA
Chief Medical Officer, CenterWell & Conviva Primary Care
March 25th, 2024

"Data is like garbage. You'd better know what you are going to do with it before you collect it."

Mark Twain



Many value-based care practices create a balanced scorecard to focus PCPs on panel management & population impact

Example of a Balanced Scorecard in Value-Based Primary Care For Seniors

Domain	Example Metrics	Targets	Weighting
Engagement	• Panel Engagement Rate	90%+ patients with clinical encounter in past 12 months	10%
Patient Experience & Satisfaction	• Net Promoter Score	NPS > 80 with progressive increase over time	20%
Clinical Quality	• STAR-related HEDIS measures • Other Practice Clinical Quality Metrics	4.5+ STAR performance on HEDIS measures	20%
Population Outcomes & Cost	• Acute Hospital Utilization • ER Utilization • All Cause Readmissions	Varies depending on population mix, historical trend, and regional benchmarks	30%
Panel Size / Productivity	• Engaged panel size	Varies depending on population mix, practice tenure, panel size expectations by role & care model, growth and retention	20%

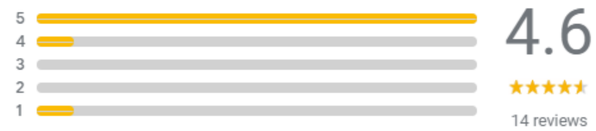
- Bonus tied to balanced scorecard, ranges ~15-25% of annual salary
- Physicians align with these metric domains conceptually, but expect hands-on education, accurate real-time reporting, and intervention support
- Data timeliness, comprehensiveness, and accuracy across payers a substantial barrier to real-time, actionable data
- Striking the right balance between precision of metrics (e.g., level of clinician & practice control) vs overall population impact is a key success factor
- Too many metrics can quickly extinguish utility of any metric

Customer service & loyalty insights illuminate patient experience in real-time, but require intentional practice infrastructure & systems to make actionable

Practice Online Reviews

CenterWell Senior Primary Care
4.6 ★★★★½ (14) · Geriatrician
915 S Rainbow Blvd · (702) 803-3852
Closed · Opens 8 AM
Medicare accepted
Has online care

Review summary



"Dr. Fihn and the **staff** at this **location** are fantastic." ★★★★★

"I highly recommend this **place**." ★★★★★

R "CenterWell Senior Primary **Medical Care** has exceeded my expectations." ★★★★★

Practice Net Promoter Score (NPS)

Example Net Promoter Score
86

n-size 20,000

Promoter 90% Passive 6% Detractor 4%

What Else Re: Experience:

I have been in the medical field in Florida for the past 36 years and have never been to a more caring primary doctor who cares who follows thru in his treatment to his patients. He should be commended for being a fabulous doctor.

● Doctor-Courtesy/Respect ● Recognition

Call Experience

Call Handling

- **Service Level** 80% of calls answered in 30 sec or less
- **Abandonment Rate** <5%
- **Transfer Rate** monitored

Patient Service Quality

Survey Results

- **NPS** goal 80% or higher
- **Resolution** goal 90%
- **Agent Satisfaction** goal 4/5
- **Quality** goal 90%

Center Experience

- **Patient Scheduling** effectiveness
- **Escalation turnaround time** of 24-48 hours

The CAHPS survey globally assesses patient experience & heavily influences Star ratings, but is difficult to drive concerted practice-level action from

State and national benchmarks for MA, FFS, & PDP CAHPS survey, 2023 - Final									
	Care Coordination	Customer Service	Getting Appointments and Care Quickly	Getting Needed Care	Annual Flu Vaccine	Getting Needed Prescription Drugs	Rating of Drug Plan	Rating of Health Care Quality	Rating of Health Plan
MA National	85.38	90.28	77.13	80.62	74.24	90.37	87.76	86.43	87.97
FFS National	85.28	86.88	74.82	79.72	76.72	NA	NA	84.87	83.49
PDP National	NA	NA	NA	NA	NA	88.78	81.52	NA	NA

AHRQ CAHPS Data Tool, accessed 2-26-24

Medicare Advantage & FFS CAHPS

- The MA & PDP CAHPS survey is done annually for Medicare Advantage plan enrollees by contract, and results contribute to Medicare Star ratings
- A separate CAHPS survey for Medicare FFS beneficiaries is done annually as well
- The Medicare Advantage and Medicare FFS CAHPS surveys include both plan-driven and provider-driven measures, but does not break results down into medical group-specific results to help drive visibility and action at practice level

Medical Group CAHPS

- While a medical group-specific version of CAHPS (CG-CAHPS) exists, it is not required or uniformly adopted
- MSSP and ACO REACH each require their own specific CAHPS survey oriented around Medicare beneficiaries in those programs

As a result, there is no uniform medical group focused CAHPS survey that is required or systematically done for seniors across Medicare Advantage and Medicare fee-for-service programs, limiting comprehensive patient experience data, comparisons, and trends over time, at the level of action needed (e.g., the medical group)

CMS & CMMI are focused on aligning patient experience measures via CAHPS and embedding patient-reported outcomes across government models

Perspective

Aligning Quality Measures across CMS — The Universal Foundation

Douglas B. Jacobs, M.D., M.P.H., Michelle Schreiber, M.D., Meena Seshamani, M.D., Ph.D., Daniel Tsai, B.A., Elizabeth Fowler, Ph.D., J.D., and Lee A. Fleisher, M.D.

NEJM, September 2923

The CMS Innovation Center's Approach to Person-Centered Care:
Engaging with Beneficiaries, Measuring what Matters

CMMI Webinar, September 2022

Preliminary Adult and Pediatric Universal Foundation Measures.*

Preliminary Adult and Pediatric Universal Foundation Measures.*

Domain	Identification Number and Name
Adult	
Wellness and prevention	139: Colorectal cancer screening 93: Breast cancer screening 26: Adult immunization status
Chronic conditions	167: Controlling high blood pressure 204: Hemoglobin A1c poor control (>9%)
Behavioral health	672: Screening for depression and follow-up plan 394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures
Equity	Identification number undetermined: Screening for social drivers of health

Implementing PROMs: Guiding Principles

Guiding Principle #1:	Include at least **two** patient-reported measures in new accountable care models, with at least one being a PRO-PM.
Guiding Principle #2:	CMS should support **PRO-PM development** to advance CMS' focus on outcome measures and accountability.
Guiding Principle #3:	PROMs and PRO-PMs **should be, at minimum, used as pay-for-reporting, but ideally as pay-for-performance** or as a quality rating criteria or maintenance of scores for pay-for-performance.
Guiding Principle #4:	Similar models (e.g., kidney care models) should **adopt similar PROMs and/or PRO-PMs** and **align with those used in other CMS programs**.

Suggestions for Improving Patient & Caregiver Experience Measures and Assessment

- **Create national reporting and alignment on patient & caregiver experience**
  - Drive towards a uniform, consistent, and mandatory patient & caregiver experience assessment tool and measure set across government programs & models. This would also allow for provider-driven questions on the MA & PDP CAHPS survey to be retired.

- **Make medical practices / groups the focus, not plans or CMMI models –**
  - Organize patient & caregiver experience assessment around practices / medical groups, collecting a large enough sample to report results for each practice above a certain size.
  - This enables tracking and action at the practice-level, which is necessary to take meaningful action.
  - Consider supporting and incenting practices to do the survey more frequently than annually, so they can trend data and see the benefit of actions they take in shorter cycles.
  - Consider payment adjustments or benefits to practices that deliver stellar patient & caregiver experience

- **Embed patient-reported outcome measures (PROMs) into primary care and specialty care-specific surveys**
  - Consider the Person-Centered Primary Care Measure (PCPCM PRO-PM) for primary care as an alternative or addition to CAHPS
  - Work with specialty professional societies to align on the few, meaningful PROMs for each specialty care area

- **Keep the balanced scorecard approach in mind with the Universal Foundation**
  - More emphasis needed on patient & caregiver experience – benefit to incorporating PROMs as above
  - May be worth considering a version of the Universal Foundation specific to seniors, to orient around age-friendly care and outcomes for seniors, and better assess caregiver experience & burden
  - Consider more emphasis on population outcomes & utilization and chronic conditions beyond all cause readmissions, diabetes, and hypertension

-

Thank you!

Listening Session 2: *Issues Related to Selecting and Designing Measures for PB-TCOC Models*

Sai Ma, PhD, MPA

Director, Enterprise Clinical Quality, Elevance Health

A deeper dive on advancing health and healthcare equity

Sai Ma, Ph.D.

Director, Enterprise Quality Strategy & Management,
Elevance Health

Disclaimer: The views expressed in this presentation are solely those of the presenter and do not necessarily represent those of the company.

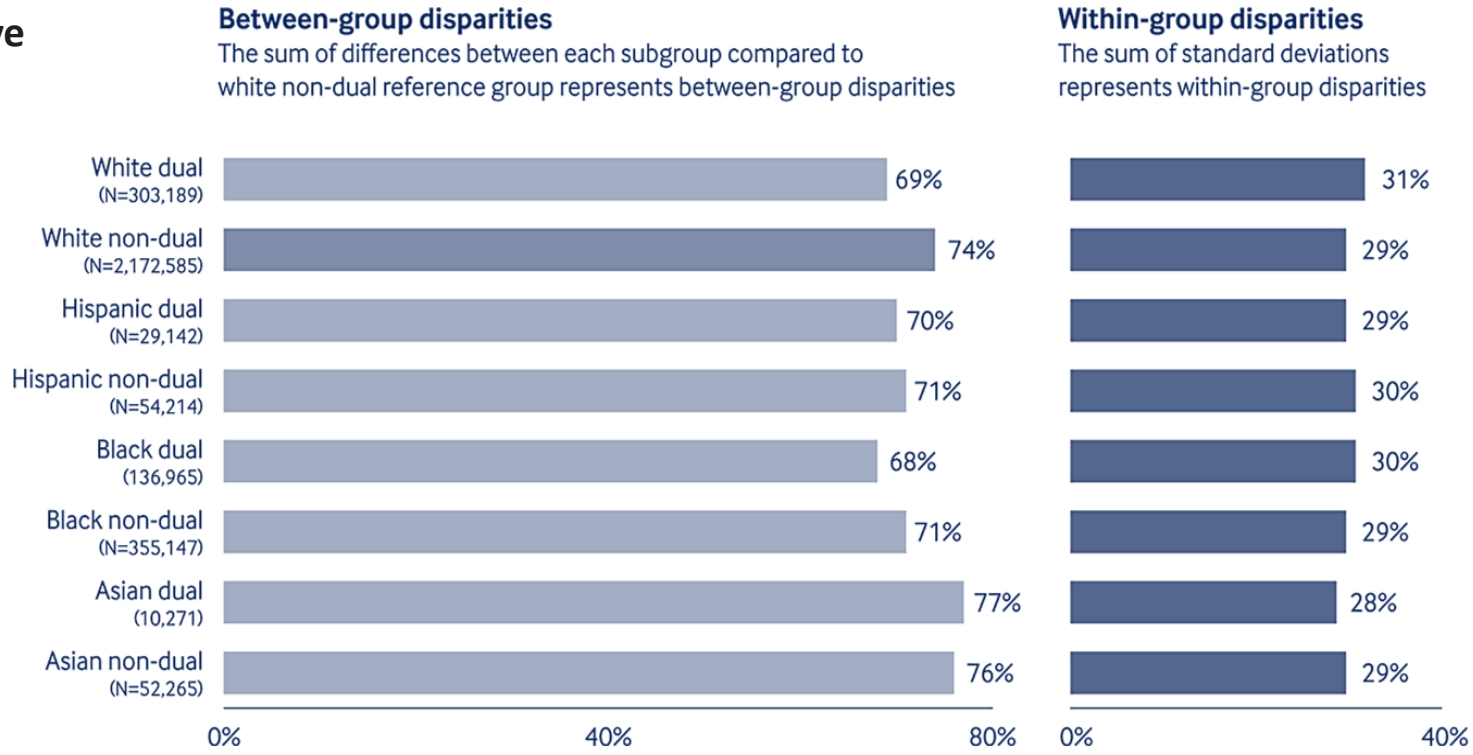
Key points

- Stratification is the first step to identify disparities, but it does not identify root causes
  - How to stratify has implications on preventing unintended consequences
- Healthcare equity contributes to health equity, but they are not interchangeable
  - Health care inequities that are **measurable** at the individual level, **proximal to health care outcomes, and actionable** are within the purview of health care organizations – should be prioritized by payers and providers
- A roadmap to identify root causes and take action
  - Diagnose inequities along care journey, and link payment to outcome measures

Stratification is the first step to advancing health equity

Methodological considerations/choices have implications on conclusions

- Quality of risk factor data
- Risk factors can interact
- Reference / benchmark
- Absolute vs. relative disparities
- Within vs. between disparities

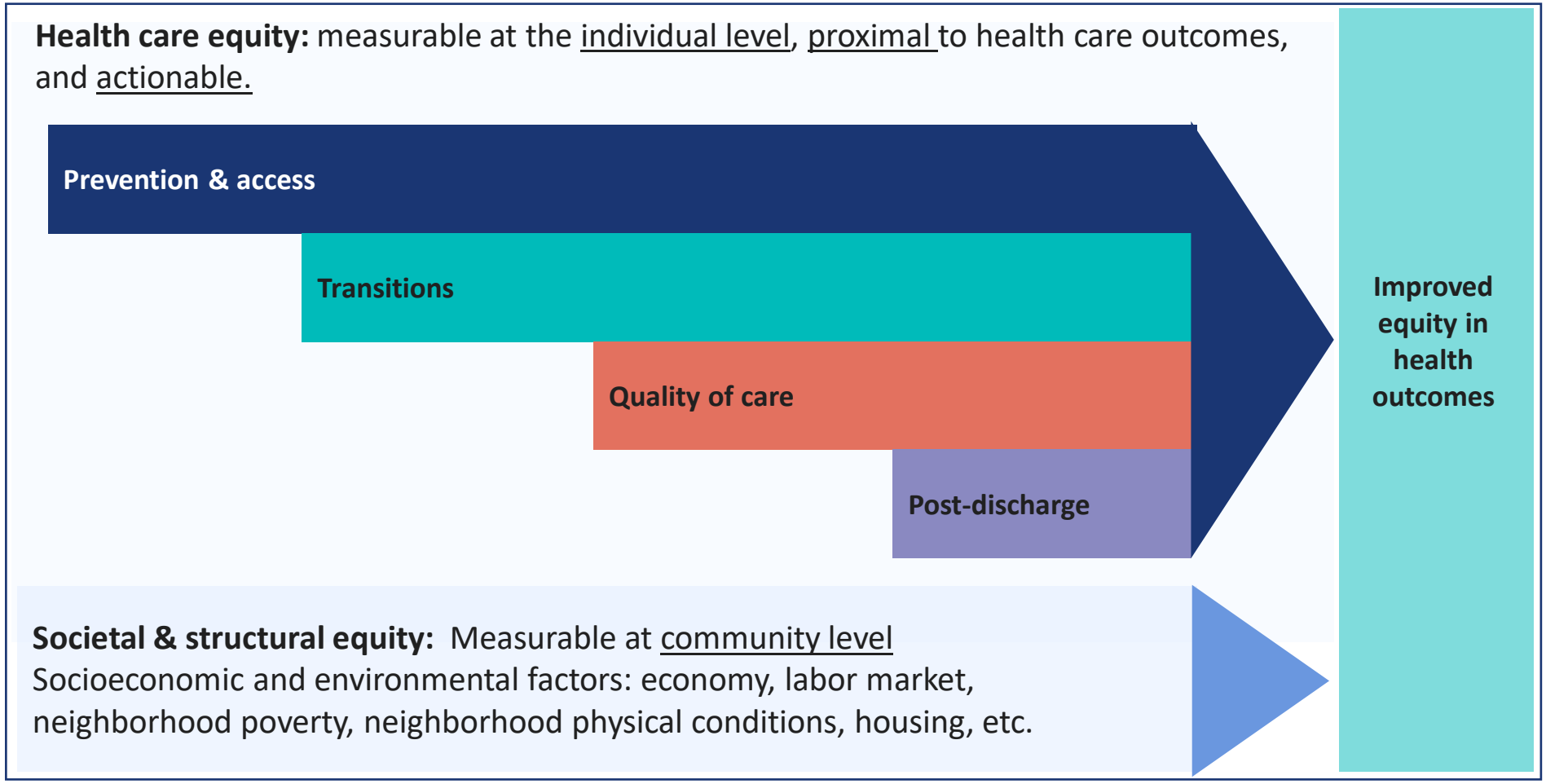


Overall rate of engagement in health behaviors (0-100%; higher indicates better)

Standard deviation of engagement in health behaviors (higher indicates more disparity)

Russell, Ma, Siddiqui, et al. Building the Foundation for Reducing Disparities in Medicare Advantage. *NEJM Catalyst*. May 2022 https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0068

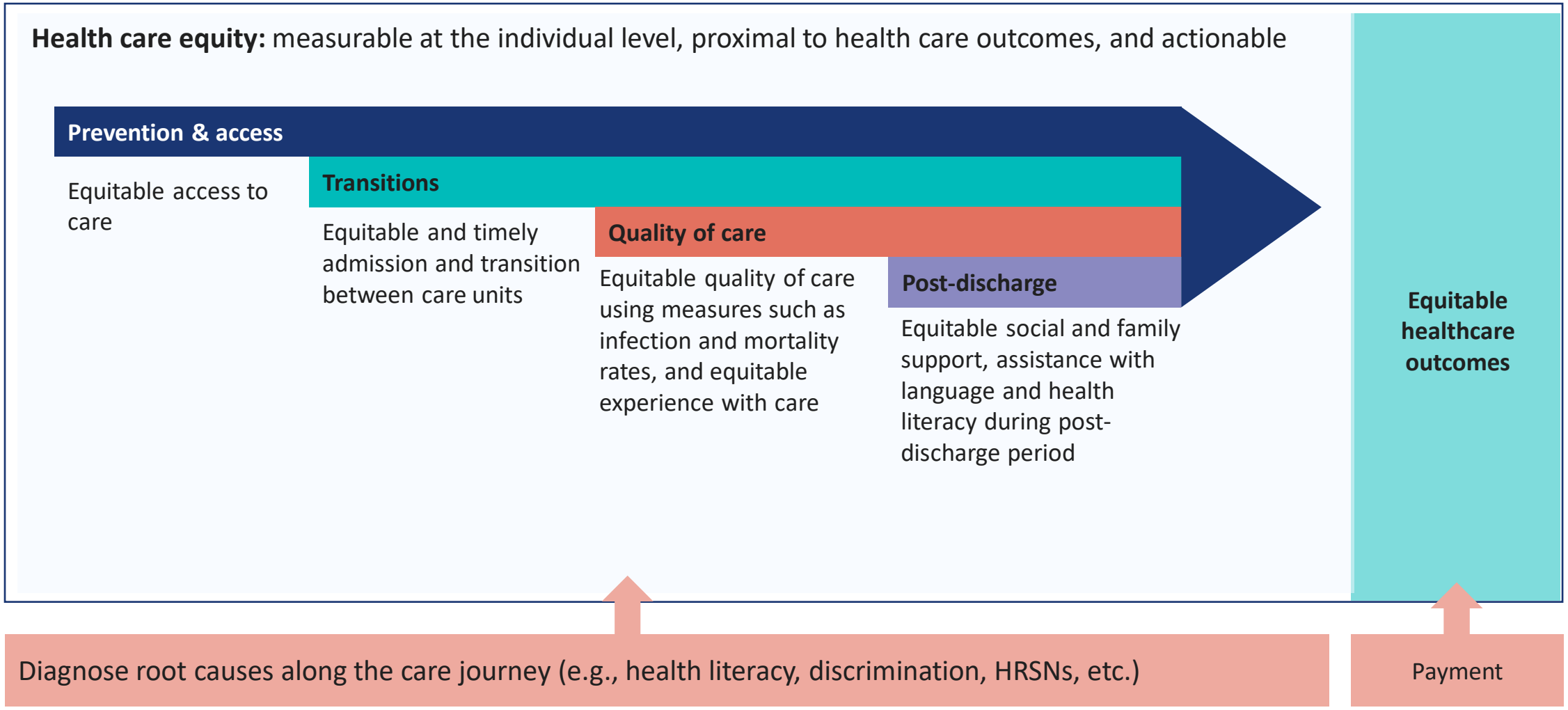
Healthcare equity contributes to health equity, but they are not interchangeable



- Health care inequities that are **measurable** at the individual level, **proximal to health care outcomes, and actionable** are within the purview of health care organizations – should be prioritized by payers and providers
- **Data on societal and structural equity are vital to the equitable distribution of resources** – can be used for payment and outcome measure risk adjustment

Ma, Agrawal, Salhi. 2023. Distinguishing Health Equity and Health Care Equity: The Role of Measurement for Health Care Organizations. *NEJM Catalyst* March 2023 https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0442

A roadmap for healthcare organizations to identify root causes of disparities and to advance healthcare equity



Ma, Agrawal, Salhi. 2023. Distinguishing Health Equity and Health Care Equity: The Role of Measurement for Health Care Organizations. *NEJM Catalyst* March 2023 https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0442