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

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?

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
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
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


- Comprehensive Care Institute https://www.comprehensivecareinstitute.org/

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
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
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: @

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
Using Implementation Science to Improve Patient Care

• “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”.

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

2012

Implemented passive education → minimal improvement

2013

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

2014

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

2022

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

Today

Anonymized reporting
#4: Confirmatory Testing: 
Repeat prostate biopsy  

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Practice-Level Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: <strong>Documentation</strong></td>
<td>EHR-embedded template/structured note documenting risk and management in a structured format to promote physician-directed risk stratification and document patient management</td>
<td>90%</td>
</tr>
<tr>
<td>#2: <strong>Observational Management</strong></td>
<td>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</td>
<td>75%</td>
</tr>
<tr>
<td>#3: <strong>Confirmatory Testing: PSA</strong></td>
<td>≥2 PSA tests per year</td>
<td>75%</td>
</tr>
<tr>
<td>#4: <strong>Confirmatory Testing: Repeat prostate biopsy</strong></td>
<td>Obtaining a surveillance biopsy within 18 months of the diagnostic biopsy for LR PCa patients on AS</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Abbreviations: EHR=electronic health record; AS/WW=active surveillance/watchful waiting; LR=low-risk; PCa=prostate cancer*

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

### MEASURE 2

**2022 - 2 interventions:**
- **P4P program**
- **Transparent physician audit and feedback**

<table>
<thead>
<tr>
<th>Group 1</th>
<th>AS/WW</th>
<th>Radiation</th>
<th>Surgery</th>
<th>Conservative Adoption %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician A</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>75%</td>
</tr>
<tr>
<td>Physician B</td>
<td>4</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician C</td>
<td>2</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician D</td>
<td>0</td>
<td>1</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Physician E</td>
<td>5</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician F</td>
<td>7</td>
<td>1</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Physician G</td>
<td>1</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician H</td>
<td>3</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician I</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>78%</td>
</tr>
<tr>
<td>Physician J</td>
<td>0</td>
<td>1</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Physician K</td>
<td>7</td>
<td>2</td>
<td></td>
<td>78%</td>
</tr>
<tr>
<td>Physician L</td>
<td>4</td>
<td>8</td>
<td></td>
<td>55%</td>
</tr>
<tr>
<td>Physician M</td>
<td>3</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician N</td>
<td>1</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician O</td>
<td>8</td>
<td></td>
<td></td>
<td>89%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2</th>
<th>24</th>
<th>1</th>
<th>96%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician P</td>
<td>8</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician Q</td>
<td>5</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician R</td>
<td>4</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician S</td>
<td>2</td>
<td>1</td>
<td>67%</td>
</tr>
<tr>
<td>Physician T</td>
<td>7</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 3</th>
<th>46</th>
<th>3</th>
<th>4</th>
<th>87%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician U</td>
<td>3</td>
<td>1</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Physician V</td>
<td>8</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician W</td>
<td>6</td>
<td>1</td>
<td></td>
<td>86%</td>
</tr>
<tr>
<td>Physician X</td>
<td>1</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Physician Y</td>
<td>10</td>
<td>1</td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Physician Z</td>
<td>7</td>
<td>1</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Physician AA</td>
<td>0</td>
<td>1</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Physician AB</td>
<td>9</td>
<td>1</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Physician AC</td>
<td>0</td>
<td>1</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Physician AD</td>
<td>2</td>
<td></td>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

| 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
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.

<table>
<thead>
<tr>
<th>Measure 1: Risk Assessments within 3 months of Biopsy</th>
<th>Overall</th>
<th>Non-UHC</th>
<th>UHC Non-P4P</th>
<th>UHC P4P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>70% (590/845)</td>
<td>67% (516/766)</td>
<td>92% (45/49)</td>
<td>97% (29/30)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 2: Adoption of Conservative Management for Low Risk</th>
<th>Overall</th>
<th>Non-UHC</th>
<th>UHC Non-P4P</th>
<th>UHC P4P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83% (125/150)</td>
<td>82% (108/132)</td>
<td>93% (13/14)</td>
<td>100% (4/4)</td>
</tr>
</tbody>
</table>

Physician adherence to performance measures 1 and 2 according to payer
Overall provider adherence to measure 2 by year

Measure 2 Overall

- 2019: 65.5%
- 2022: 83%
- 2023: 86%
- 2024: 92%
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:
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.
## Commonly Reported Urology Measures

### More Commonly Reported

<table>
<thead>
<tr>
<th>Measure</th>
<th>Urologists Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQUA26 - Benign Prostate Hyperplasia (BPH): Inappropriate Lab &amp; Imaging Services for Patients with BPH</td>
<td>88</td>
</tr>
<tr>
<td>AQUA8 - Hospital admissions or infections within 30 days of TURUS Biopsy</td>
<td>45</td>
</tr>
<tr>
<td>QPP 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>37</td>
</tr>
</tbody>
</table>

### Less Frequently Reported

<table>
<thead>
<tr>
<th>Measure</th>
<th>Urologists Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q104 - Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High-Risk Prostate Cancer</td>
<td>25</td>
</tr>
<tr>
<td>Q250 - Radical Prostatectomy Pathology Reporting</td>
<td>9</td>
</tr>
<tr>
<td>MUSIC1 - Prostate Cancer: Active Surveillance</td>
<td>2</td>
</tr>
<tr>
<td>MUSIC2 - Prostate Cancer: Follow-Up Testing for patients on active surveillance for at least 30 months</td>
<td>2</td>
</tr>
</tbody>
</table>

### Urology

<table>
<thead>
<tr>
<th>Measure</th>
<th>Urologists Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q119 - Diabetes: Medical Attention for Nephropathy</td>
<td>777</td>
</tr>
<tr>
<td>Q504 - Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women 65 and Older</td>
<td>544</td>
</tr>
<tr>
<td>Q556 - Urinary Incontinence: Plan of Care for Urinary Incontinence in Women 65 and Older</td>
<td>191</td>
</tr>
<tr>
<td>AQUA14 - Stones: Repeat Shock Wave Lithotripsy (SWL) Within 6 Months of Initial Treatment</td>
<td>87</td>
</tr>
<tr>
<td>AQUA15 - Stones: Unrolins Performed Before Surgical Stone Procedures</td>
<td>16</td>
</tr>
<tr>
<td>Q492 - Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair</td>
<td>14</td>
</tr>
<tr>
<td>Q433 - Proportion of Patients Sustaining a Bowel Injury at the Time of any Pelvic Organ Prolapse Repair</td>
<td>1</td>
</tr>
<tr>
<td>AQUA18 - Non-Muscle Invasive Bladder Cancer: Early Surveillance Cystoscopy for Non-Muscle Invasive Bladder Cancer</td>
<td>1</td>
</tr>
</tbody>
</table>

### Cross-Cutting

<table>
<thead>
<tr>
<th>Measure</th>
<th>Urologists Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q265 - Controlling High Blood Pressure</td>
<td>5,092</td>
</tr>
<tr>
<td>Q226 - Tobacco Use: Screening and Cessation Intervention</td>
<td>3,481</td>
</tr>
<tr>
<td>Q288 - Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>2,884</td>
</tr>
<tr>
<td>Q30 - Body Medications in the Medical Record</td>
<td>922</td>
</tr>
<tr>
<td>Q35 - Use of High-Risk Medications in Older Adults</td>
<td>862</td>
</tr>
<tr>
<td>Q47 - Advance Care Plan</td>
<td>430</td>
</tr>
<tr>
<td>Q177 - Screening for high Blood Pressure and Follow-Up Document</td>
<td>236</td>
</tr>
<tr>
<td>Q374 - Closing the Referral Loop: Receipt of Specialist Report</td>
<td>214</td>
</tr>
<tr>
<td>Q321 - CANP for MPS Clinician/Group Survey</td>
<td>128</td>
</tr>
<tr>
<td>Q331 - Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>128</td>
</tr>
</tbody>
</table>

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1. In 2020, AUA identified 13,352 urologists providing direct patient care in the U.S.
2. Confident: do not duplicate or redistribute.
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)
Appendix Slides
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.

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
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.

**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

- Quality Measures
- Practice Transformation
- Increased Investment
- Payment Innovation
Collaborating for insights and influence in specialty care
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
Blue Shield of California is an independent member of the Blue Shield Association.
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Dana Gelb Safran, ScD
President and Chief Executive Officer, National Quality Forum
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
“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!”

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

“Doesn’t facilitate choice for patients”

“Burdensome without benefit”

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

Voices from the Field (Feb 2024)
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.
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

### Alternative Quality Contract (AQC) Measure Set (2007)

<table>
<thead>
<tr>
<th></th>
<th>AMBULATORY</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESS</strong></td>
<td>• Preventive screenings</td>
<td>• Evidence-based care elements for:</td>
</tr>
<tr>
<td></td>
<td>• Acute care management</td>
<td>• Heart attack (AMI)</td>
</tr>
<tr>
<td></td>
<td>• Chronic care management</td>
<td>• Heart failure (CHF)</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>• Diabetes</td>
<td>• Surgical infection prevention</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td><strong>OUTCOME</strong></td>
<td>• Control of chronic conditions</td>
<td>• Post-operative complications</td>
</tr>
<tr>
<td></td>
<td>• Diabetes</td>
<td>• Hospital-acquired infections</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease</td>
<td>• Obstetrical injury</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
<td>• Mortality (condition –specific)</td>
</tr>
<tr>
<td></td>
<td><strong>Triple weighted</strong>*</td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT</strong></td>
<td>• Access, Integration</td>
<td>• Discharge quality, Staff responsiveness</td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>• Communication, Whole-person care</td>
<td>• Communication (MDs, RNs)</td>
</tr>
</tbody>
</table>
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

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**Aligned Innovation: Cycle 1**

Multistakeholder Advisory Council (MAC)

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

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

- 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 ★★★★☆ (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.*

*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%]

### Call Experience

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

- **Patient Service Quality**
  - 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

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

Preliminary Adult and Pediatric Universal Foundation Measures.

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

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

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

**Health care equity:** measurable at the **individual level,** **proximal** to health care outcomes, and **actionable.**

- **Prevention & access**
- **Transitions**
- **Quality of care**
- **Post-discharge**

**Societal & structural equity:** Measurable at **community level**
Socioeconomic and environmental factors: economy, labor market, neighborhood poverty, neighborhood physical conditions, housing, etc.

- **Improved equity in health outcomes**
  - 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

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

**Health care equity:** measurable at the individual level, proximal to health care outcomes, and actionable

- **Prevention & access**
- Equitable access to care

- **Transitions**
  - Equitable and timely admission and transition between care units

- **Quality of care**
  - Equitable quality of care using measures such as infection and mortality rates, and equitable experience with care

- **Post-discharge**
  - Equitable social and family support, assistance with language and health literacy during post-discharge period

Diagnose root causes along the care journey (e.g., health literacy, discrimination, HRSNs, etc.)