Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models

Presenters:

Subject Matter Experts

- **Lisa Schilling, RN, MPH** – Chief Quality and Integration Officer, Contra Costa Health
- **Robert L. Phillips, MD, MSPH** – Executive Director, The Center for Professionalism & Value in Health Care
- **Barbara L. McAneny, MD, FASCO** – Chief Executive Officer, New Mexico Oncology Hematology Consultants and Former President, American Medical Association – (Previous Submitter - *MASON – Making Accountable Sustainable Oncology Networks* proposal)
- **Sarah Hudson Scholle, MPH, DrPH** – Principal, Leavitt Partners

Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models

Lisa Schilling, RN, MPH

Chief Quality and Integration Officer, Contra Costa Health

Identifying Appropriate Performance Measures for PB-TCOC Clinical Performance Outcomes

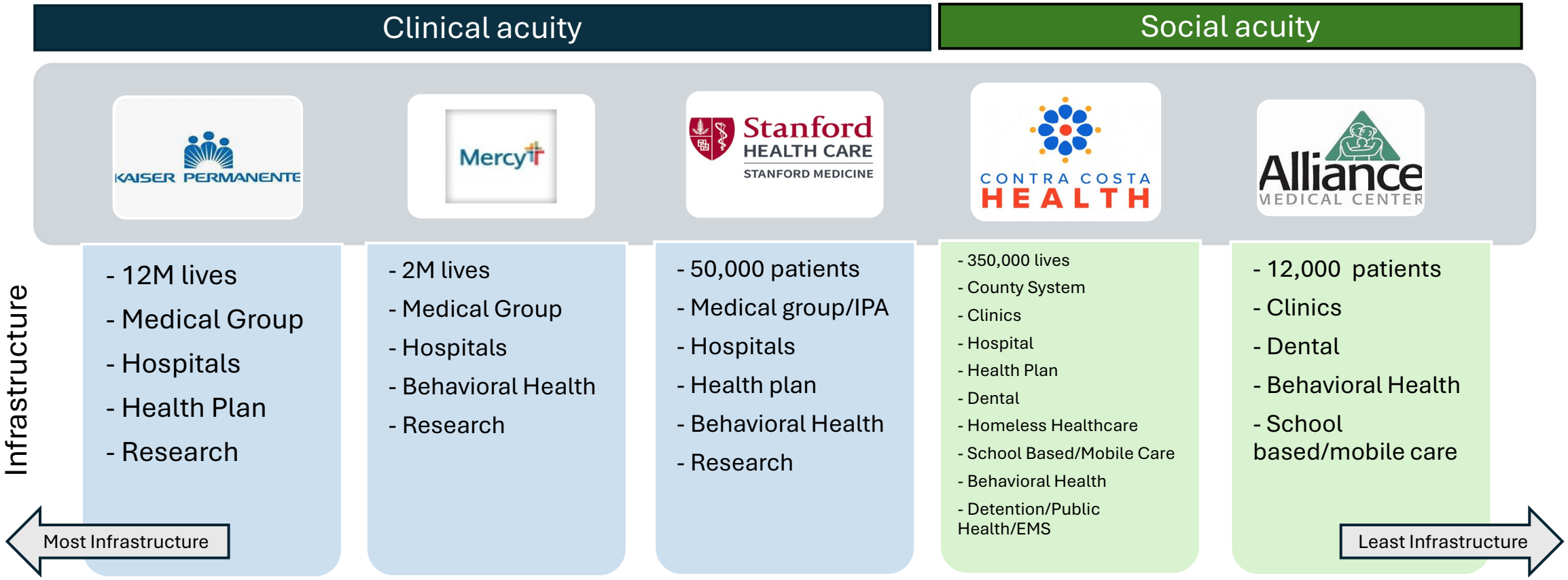
Lisa Schilling, RN MPH CPHQ
Chief Executive Officer, Schilling and Associates Inc.
Chief Quality Officer, Contra Costa Regional Medical Center and Clinics

September 17, 2024

Disclosure

- I am currently an executive with Contra Costa Health
- Perspectives shared are my own

Perspective on Population Health and Total Cost of Care



	Kaiser Permanente	Mercy	Stanford	Contra Costa	Alliance
Learning	Internal	Internal	Vizient	Safety Net Institute	Redwood Collaborative
Measures	Episode treatment groupers Risk adjustment, observed: expected Clinical pathways, variation analysis Provider rating, Access			Process and intermediate outcome measures Provider rating, Access, SDOH NCQA, QIP, HRSA	

Meaningful Measure Considerations

- Measure what matters – reduce overall number
- Streamline measures and operational definitions
- Establish improvement targets for year-over-year performance
- Concurrent data reporting by organization, group and provider for learning

Meaningful Measure Considerations

Quality (Safe, Timely, Equitable, Effective, Efficient, Patient Centered)

- Overuse: Choosing wisely
- Misuse: ED visits for ambulatory sensitive conditions, readmissions
- Appropriate use: Ambulatory sensitive conditions, care coordination
- Specialty care: Time to appointment, diagnostic - choosing wisely
- Episode of care: Journeys for specific high-volume or high-value conditions
- Population outcomes: Mortality, morbidity, PRO health status (risk-adjust including SDOH)

Measures to develop

- Patient safety: Diagnostic reliability (structural) [1,2]
- Patient reported experience and outcomes: Patient trust in healthcare (community trust index) [3]
- Equity (race, ethnicity, income/SDOH needs)

Provider and Group Level Metrics

- Prioritize greatest areas of impact: prevention, pregnancy, behavioral health, chronic condition management, high-acuity care

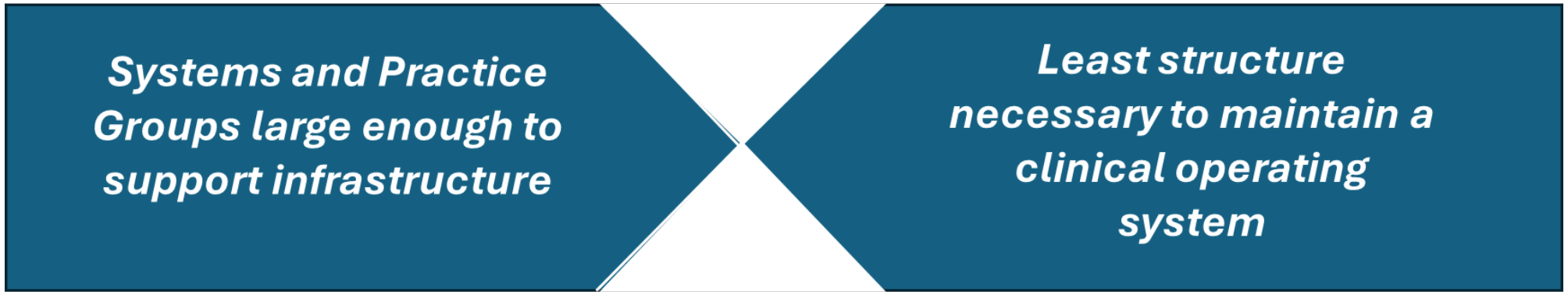
- Provider: process (prevention) and intermediate outcome (control of disease, early- stage diagnosis) , high and low outlier (volume sensitive), care experience (provider rating, CG-CAHPS)

- Group/system: episode of care, population-based risk adjusted outcomes, overuse, access, care experience, equity (clinical pathway, condition specific or episode treatment groupers)

CG-CAHPS: CAHPS Clinician and Group Survey

Infrastructure Enabling Population Management

- Population cohorts (e.g., panels, comparative data sets)
- Enterprise data warehouse: advanced analytics, risk stratification
- Financial, cost accounting integration
- Structured safety and learning systems to adopt evidence-based practices
- Centralized operations: case management, call center, clinical documentation integrity, integrated EHR



Consideration for Incentives

Incentive	Focus	Lever
Structural Incentives	Over time group into populations, support infrastructure, safety, learning system, diagnostic safety structural measures	Public and private organizations (e.g. OCHIN, state health departments) HHS-HRSA
Pay for Performance/ Directed Payment Programs	Provider level process (prevention, access) and intermediate outcomes (disease control, early diagnosis)	State-based initiatives, collaboratives
Advanced Payment Models and population-based payments	Reduce reliance on billable visits, leverage payment for outcomes among population (PBPM) for provider groups – increase incentive for performance against specific measures (preventive screen, early intervention, intermediate outcomes). PMPM wrap payment up-front in addition to health plan payment with penalty for low performance.	Health centers receive a base encounter payment from the health plan and an up-front supplemental capitated PMPM wrap payment from the state. Apply “gates” and “ladder” approaches to move system performance [9]

Appendix

Acknowledgement: Special thank you to advisors

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University of Pittsburg School of Public Health

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Retired President, Kaiser Permanente Southern California and Hawaii

Elise Pomerance MD, MPH

Chief Health Officer, Population Health Learning Center

References

1. Burden of serious harm from diagnostic error in the USA BMJ, Quality and Safety, July 17, 2023.
2. Developing the Safer Dx Checklist of Ten Safety Recommendations for Health Care Organizations to Address Diagnostic Errors, Jt Comm Journal, Volume 48, Issue 11, November 2022, Pages 581-590. Developing the Safer Dx Checklist of Ten Safety Recommendations for Health Care Organizations to Address Diagnostic Errors - ScienceDirect
3. Community Trust Index, April 2024. Community-Trust-Index-Framework-1.2.pdf (communityengagementhub.org)
4. Measuring the trustworthiness of healthcare organizations and systems MillbankQ, 2022 Jun; 345-346.
5. The Case for Capitation, James, Brent C. et al Harv Bus Rev. 2016 Jul-Aug.
6. James B and LA Savitz.“How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts.” *Health Affairs*, 30(6):1185-91, 2011.
7. Analytical Methods for a Learning Health System, Stoto M., et al; EGEMS, 2017; 5(1), 31. Analytical Methods for a Learning Health System: 4. Delivery System Science - PMC (nih.gov)
8. California FQHC APM California Federally Qualified Health Center Alternative Payment Model: Implementation Guide (chcf.org)
9. DHCS FQHC APM Model FQHC APM September 2022 Overview

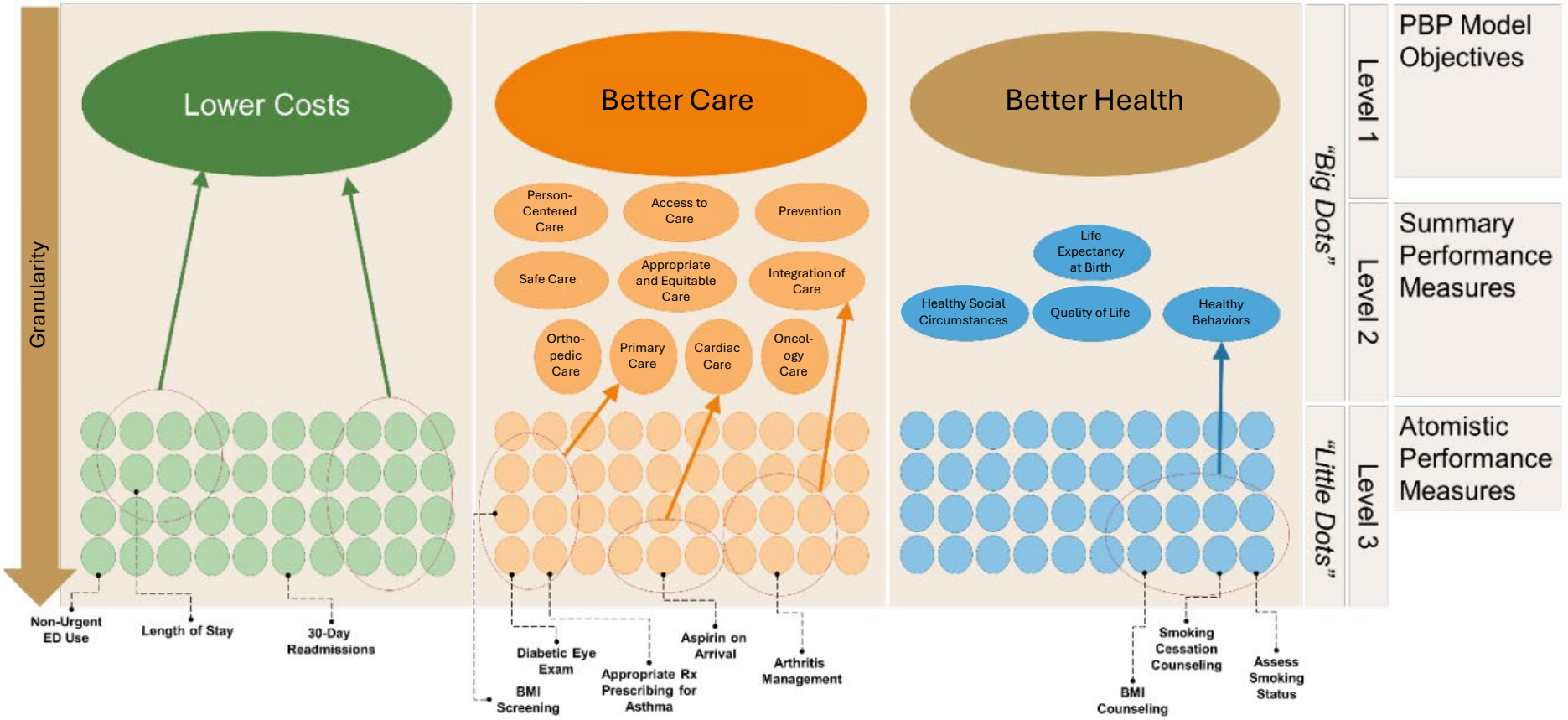
Community Trust Index

Community Trust Index – Institutional Trust	15	Yes/No	Do you think the organization is capable, in regards to helping people? Do you think the organization provides support to people in a timely manner? Do you think the organization understands the needs of the people it supports? Do you think it is easy to talk to a staff or volunteer from the organization? Do you feel comfortable making a complaint to a staff or volunteer? Do you think the organization provides useful information on [insert a relevant context] to people? Do you think the organization provides the right kinds of assistance to the people it supports? Do you think the organization puts the people it supports and their needs first, above anything else? Do you think the organization provides support to people who need it most? Do you think the organization provides support to all people without discrimination? Do you think the organization respects people's cultures and personal beliefs? Do you think the organization asks local communities what support they need? If the organization made a big mistake in how they provide support to people, do you think it will share it publicly? Do you think the organization is independent of the government? Do you think the organization is responsible in how its funds are spent?

Community Trust Index, April 2024. Community-Trust-Index-Framework-1.2.pdf (communityengagementhub.org)

System vs. Provider Performance Measures

Figure 3: Measures by Purpose Area



Source: HCP LAN PB Payment Model Performance Measurement, 2016.

Listening Session 2: *Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models*

Robert L. Phillips, MD, MSPH

Executive Director,
The Center for Professionalism & Value in Health Care

Performance Measures and Health Equity

Robert L. Phillips, MD MSPH
Executive Director
The Center for Professionalism & Value in Health Care
American Board of Family Medicine
September 17, 2024

THE CENTER FOR PROFESSIONALISM & VALUE IN HEALTH CARE

Measurement strategies for PB-TCOC models to support equity?

- Access
- Continuity
- Comprehensiveness
- Person Centered Primary Care Measure
- Trust?

The 2021 Primary Care NASEM report calls for measures that are:

- meaningfully parsimonious,
- fit for purpose,
- aligned to internal and external motivations of actors,
- and supportive of primary care value functions.

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Equity-related performance measures to measure health disparities and monitor improvements?

The example of Continuity

- **Significantly lower**
  - Total costs
  - Hospitalizations
  - ED Visits
  - Overuse of Healthcare
  - **Mortality**

- **Significantly higher**
  - Cancer screening
  - Childhood health screenings
  - Vaccinations
  - Medication adherence
  - Early disease diagnosis
  - **Patient Satisfaction**
  - **Physician Satisfaction**

one of the explanations of why other countries have better health outcomes than we do

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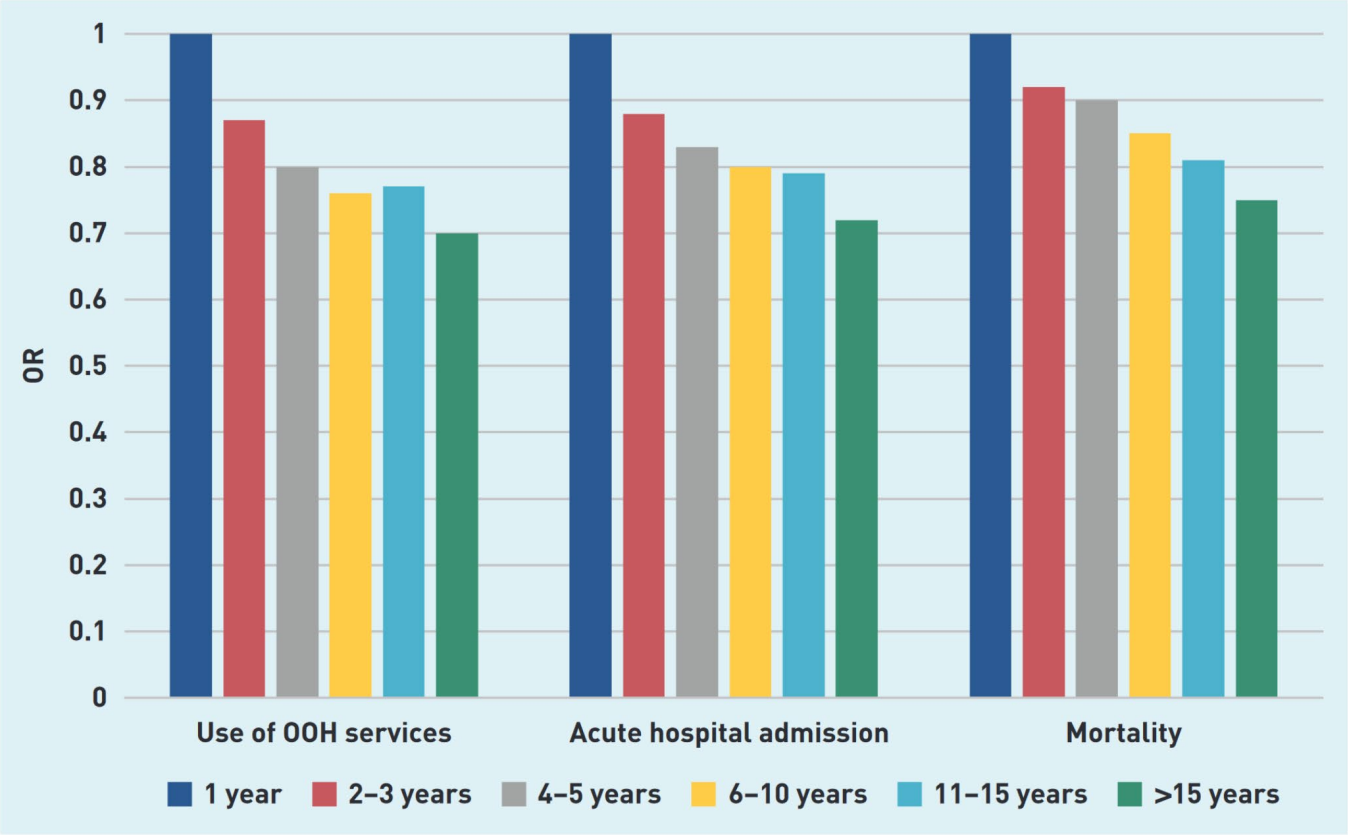

Norway

25% reduction in likelihood of dying this month

http://bjgp.org/content/early/2021/10/04/BJGP.2021.0340.abstract

Longitudinality matters

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How can social determinants be incorporated in benchmarks and risk adjustment?

- We have focused most on how to increase resources to practices caring for the underserved.
  - Small Area Deprivation Indices work well for this
  - Two in current use correlate well with individual social risk (Census/Stanford)
  - Basu et al estimate that practices need **$60-$93 pmpm** to address social needs (beyond social service eligibility)
- **Will you giveth *and* taketh away**? Adjust payments to meet social needs and penalize for worse outcomes?
- Small Area Deprivation Indices could also serve for risk adjustment but with accountability for improvement

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Accounting for Social Risks in Health Payments

- Clinicians caring for disadvantaged populations require increased funding to address social needs;
- Payment adjustments should be adjusted sufficiently to address social needs;
- Accountability for funding reaching practices and serving patients is needed but without increased clinician burden; and
- Policy targets must include improved health outcomes and equity, not just overall savings.

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A Future Policy That Accounts for Social Risk in CMS Payments Should...

- Reduce burden for providers, payers, states and reduce inequities between states created by the current process
- Reduce gaming of risk adjustment
- Titrate funding to address social needs
- Create accountability for addressing social needs

Medicare & Medicaid Workshops

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At what level should social determinants of health be incorporated into benchmarks (patient-level, area-level)? Challenges and/or benefits

We believe small-area deprivation indices work best:

- No burden
- Low geographic fallacy with select measures
- Whole Population (not dependent on making visits)
- More reliable (patient level varies throughout year)
- Aligns payment with measure adjustments, helps practices focus on highest risk patients

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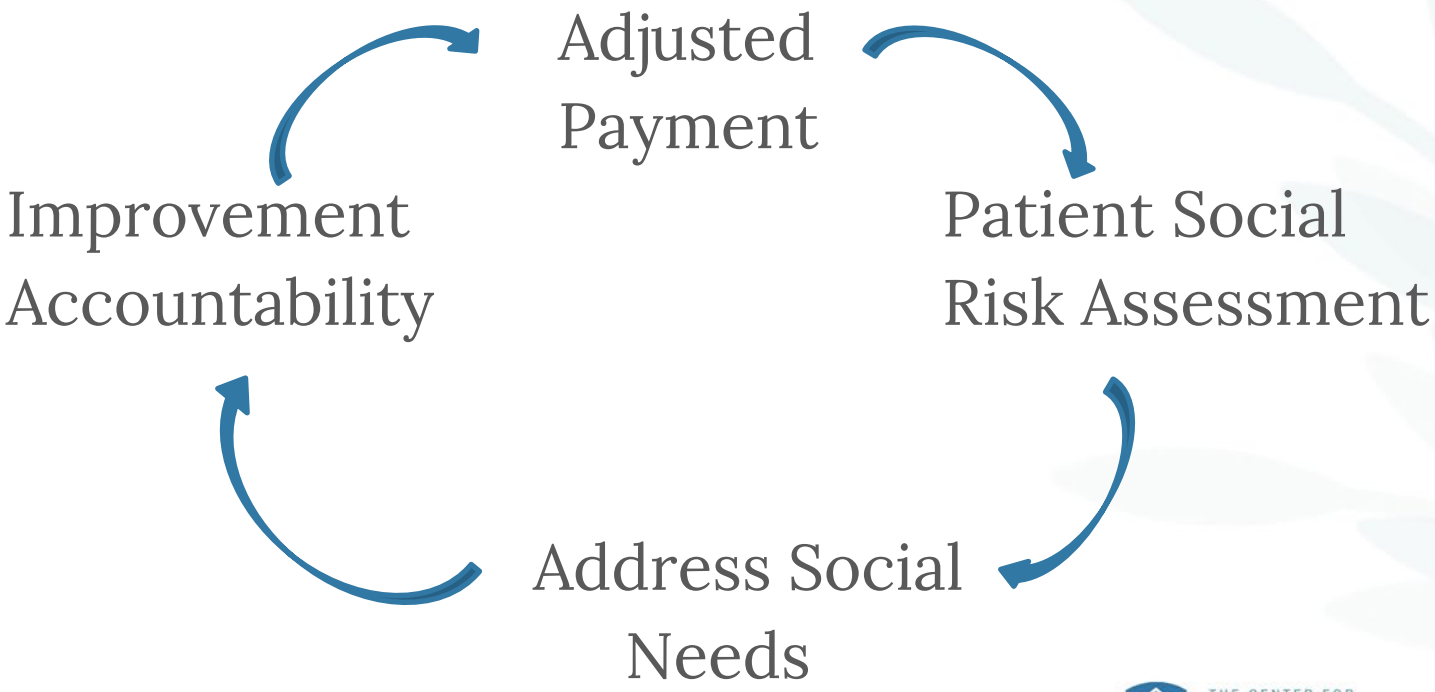
Virtuous Cycle



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Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models

Barbara L. McAneny, MD, FASCO

Chief Executive Officer, New Mexico Oncology Hematology Consultants and Former President, American Medical Association

(Previous Submitter - *MASON – Making Accountable Sustainable Oncology Networks* proposal)

PTAC

Barbara McAneny MD FASCO MACP

CMMI recipient COME HOME 2012-2015

Submitted MASON (Making Affordable Sustainable Oncology Networks) 2017

The Mission of CMMI: Improve quality and lower costs
Is it working?

Minimal cost changes

Lots of benefit for IT consultants

Some improvement in quality

Focus on the metrics by data analysts

Is this the quality patients actually care about?

Increased consolidation

Original assumption was that consolidation would increase quality and lower costs: Reality is the opposite

Selected Models

- BPCI (bundled payment for care improvement)
- BPCI, Advanced Model
- ESRD Care Model
- ESRD Treatment Choices Model
- Kidney Care Choices Model
- Comprehensive Primary Care Plus
- Primary Care First
- Accountable Health communities (Screen for SDOH)

Oncology Models

COME HOME

Oncology Care Model

Enhancing Oncology Model

COME HOME: how did it work?

- Robust use of health IT systems (EMR, PMS, lab systems, etc.)
- An ongoing relationship with a personal oncologist to provide first contact and continuous, comprehensive care
- Physician-led team-based care, where every member of the team works at the top of their license
- Patient and Family orientation, with Patient Education on how a patient can best benefit from the new system
- Integrated and coordinated care with automated real-time decision support system to provide aggressive symptom management
- Evidence-based medicine and performance measures to assure quality and safety and generate true outcomes data
- Enhanced access, such as late hours and same-day appointments
- Payment models to recognize the value-add of a medical home

DIFFERENCE-IN-DIFFERENCES ESTIMATES FOR CORE MEASURES BY CANCER TYPE FOR IOBS

Exhibit 8.7: Difference-in-Differences Estimates for Core Measures by Cancer Type for IOBS[†]

	DID Estimate [95% Confidence Interval]						
Outcome Measures	Overall (n=7,326)	Breast Cancer (n=3,108)	Colorectal Cancer (n=972)	Lung Cancer (n=1,880)	Lymphoma (n=684)	Melanoma (n=288)	Pancreatic Cancer (n=394)
Hospitalizations (per 1,000)	2 [-7, 11]	-7 [-17, 3]	**26 [-2, 54] ***	-9 [-36, 17]	18 [-14, 51]	19 [-29, 67]	14 [-51, 80]
ED Visits (per 1,000)	**-10 [-20, 1]****	**-16 [-28, -3] ****	-12 [-37, 13]	-14 [-39, 10]	**29 [-3, 62] ***	19 [-34, 72]	-27 [-87, 34]
30-day Readmissions (per 1,000)	**-4 [-8, 0]***	**-3 [-7, 1] ***	0 [-12, 12]	**-19 [-33, -5] ****	8 [-10, 3]	9 [-12, 30]	-12 [-50, 24]
ACS Hospitalizations (per 1,000)	**-3 [-7, 1]***	**-5 [-9, -1] ****	-2 [-12, 8]	-5 [-18, 8]	8 [-3, 20]	14 [-5, 33]	**-21 [-45, 2] ***
Total Cost of Care (per patient)	**-$673 [-$1,186, -$159]****	**-$742 [-$1,189, -$296] *****	$296 [-$1,703, $2,296]	-$555 [-$2,173, $1,063]	-$1,735 [-$4,790, $1,320]	-$391 [-$3,643, $1,859]	$282 [-$3,531, $4,095]

*** p<0.01; ** p<0.05; * p<0.1*

[†]Model-based estimates for cost estimated using population-averaged longitudinal models with log link and gamma distribution. Binary measures estimated using population-averaged longitudinal logit models.

"HCIA Disease-Specific Evaluation", NORC, Eighth Quarterly Report.

ACOs

- Medicare Shared Savings Program
- Pioneer ACO
- Next Generation ACO
- Medicare ACO Track1+
- Advanced Payment ACO
- ACO Investment Model

ACOs have not increased access to primary care

Number of Primary care physicians is declining 68.4/100k to 67.2/100k

15% of all residents in primary care are practicing 3-5 years after residency

AMA: primary care is the top 6 specialties with burnout 52=58%

The Physicians Foundation: Health of US primary Care, 2024 scorecard

My take on ACOs:

- Minimal savings
- Taught systems how to cherry pick and lemon drop
- Inadequate rewards for physicians made it a race to the bottom
- Focused on population health to the exclusion of urgent needs
- Increased consolidation
- Medicare DisAdvantage
  - $612 B 2007-2024, MedPAC*
  - $82B 2023
  - 9% less $ on services

*Source: MedPAC Report - https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf

Quality Measures

Access

- Days from phone call to appointment
- Days from first visit to treatment plan
- Same day visits
- Team at the top of license

Cost

- Hospitalization and ED usage
- Only items under physician control
- Site of service

Outcomes

- Pathway compliance
- Need new risk assessment process using AI not coding HCCs

Patient satisfaction

- No show rates
- Wait times
- Beware the opioid example
- Return visits

My message to CMMI/PTAC:No Silver Bullet

- Rethink physician practices at risk
  - Do we want accountability or money?
  - Unintended consequences
  - Driving consolidation
  - Do not put physicians in the position of choosing patient or practice
- Trust physicians to know where the waste is
- Pathways created by specialty societies and academic
- Surgical payment is forcing consolidation and needs to be rethought
- Do a thousand Pilot programs
  - Expand what works and drop what did not
  - One size does not fit all:
- Use AI tools to determine accurate pricing
  - Cannot do a bundle until you know the price of the components

My suggestions for the CMMI model of the future: MASON

- Focus on specialists and attribute patients by major disease
  - Minimal gains in savings from primary care
  - Specialty care done well can save a lot more money (80:20 rule)
- Use AI to determine optimal costs of optimal care
- Encourage pathways as the quality measure
- Access to care is a quality measure
- Remove risk as a requirement but substitute accountability
- Hold physicians accountable ONLY for the care they control
- Allow different models for different specialties and communities

Listening Session 2: Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models

Sarah Hudson Scholle, MPH, DrPH

Principal, Leavitt Partners

DEVELOPING A BALANCED PORTFOLIO OF PERFORMANCE MEASURES FOR PB-TCOC MODELS

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

Sarah Hudson Scholle, MPH, DrPH

September 17, 2024

LEAVITT PARTNERS
An HMA Company

Key Points

- Person-centered care should be the benchmark for quality, and effective use of patient-reported data can enable person-centered care.
- The Alliance for Person-Centered Care formed to facilitate the collection and use of patient-reported data in clinical care and quality programs.
- Key components of a person-centered performance measurement strategy:
  - Start with what matters to patients.
  - Rebalance measures with a focus on value, equity, and innovation.
  - Invest in sustainable implementation and improvement.

Benefits of using patient-reported data

- Shared decision-making aligned to patients' goals.
- Improved patient expectations about their likely experiences and outcomes from treatment.
- Empowered patients that self-monitor during recovery.
- Facilitated communication between physicians and patients about what matters most to patients.
- Enhanced treatment by having PROMs embedded in the patients' electronic health record.
- Reduced disparities in access, treatment, and outcomes for previously underserved racial and ethnic groups.

Liu et al, 2024, NEJM Catalyst

What can facilitate accountable care relationships?

Effective use of patient-reported data can enable person-centered care.

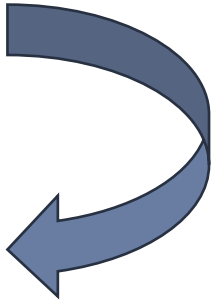
PATIENTS FEEL EMPOWERED

CLINICAL TEAMS ARE BOUGHT IN

TOOLS MAKE IT EASY & EQUITABLE

THERE ARE POLICY INCENTIVES

THE INVESTMENTS PROVIDE VALUE



All stakeholders derive benefit from a high-functioning, person-centered, equitable, value-based system of care.

Alliance for Person-Centered Care

Advancing Quality, Measuring What Matters

Phreesia

MASSACHUSETTS

AMERICAN PSYCHOLOGICAL ASSOCIATION

IEC

DCI Dialysis Clinic, Inc. A Not-For-Profit Corporation

FOUNTAIN HOUSE

cacp the center to advance consumer partnership

HEALING WORKS® FOUNDATION INNOVATING WHOLE PERSON CARE

THE LARRY A. Green Center

NCQA

NPAF National Patient Advocate Foundation

ICHOM

Camden Coalition

Johnson&Johnson

national partnership for women & families

HealthLinc YOUR COMMUNITY HEALTH CENTER®

Defining Terms

The Alliance uses the term “patient-reported data” instead of “patient-reported outcome”

Concept	Definition	Example
Patient-Reported Outcome (PRO)	What gets measured. The status of a person’s health condition that comes directly from the patient.	Knowledge, Skills and Confidence in Self-Management.
Patient-Reported Outcome Measure (PROM)	How PROs are measured. The tools/instruments used to collect data.	Patient Activation Measure.
Patient-Reported Outcome Performance Measure (PRO-PM)	How PROs are calculated. A way to aggregate the information from patients into a reliable, valid measure of performance.	Gains in Patient Activation Measure (PAM) Scores at 12 Months.

Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001. PMID: 25057539.
Table adapted from https://www.qualityforum.org/Publications/2021/11/Building_a_Roadmap_From_Patient-Reported_Outcome_Measures_to_Patient-Reported_Outcome_Performance_Measures_-_Final_Technical_Guidance_Report.aspx

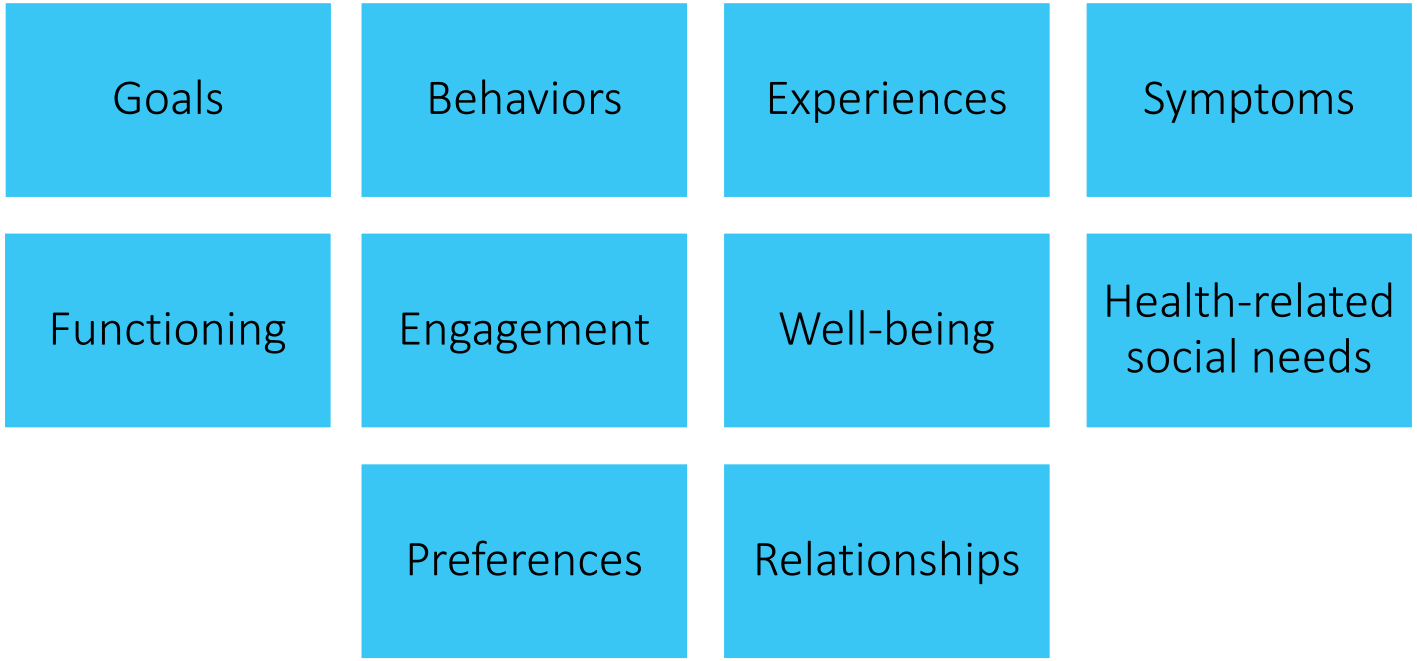
Definitions Guiding the Alliance

The Alliance focuses on patient-reported data across a broad range of topics.

Alliance for Person-Centered Care

Patient-reported data:

Surveys or questions that ask people about their beliefs, preferences, experiences, symptoms, functioning or other topics, without interpretation of their response by a clinician or anyone else



Planned Work to Facilitate Person-Centered Care and Use of Patient-Reported Data

Alliance for Person-Centered Care

1 | Policy Deliverables

- **Statement of Principles for Use of Patient-Reported Data**
- Investing in Patient-Reported Data
- Strategic Policy Roadmap for Transitioning to Measures Using Patient-Reported Data

2 | Data & Infrastructure Deliverables

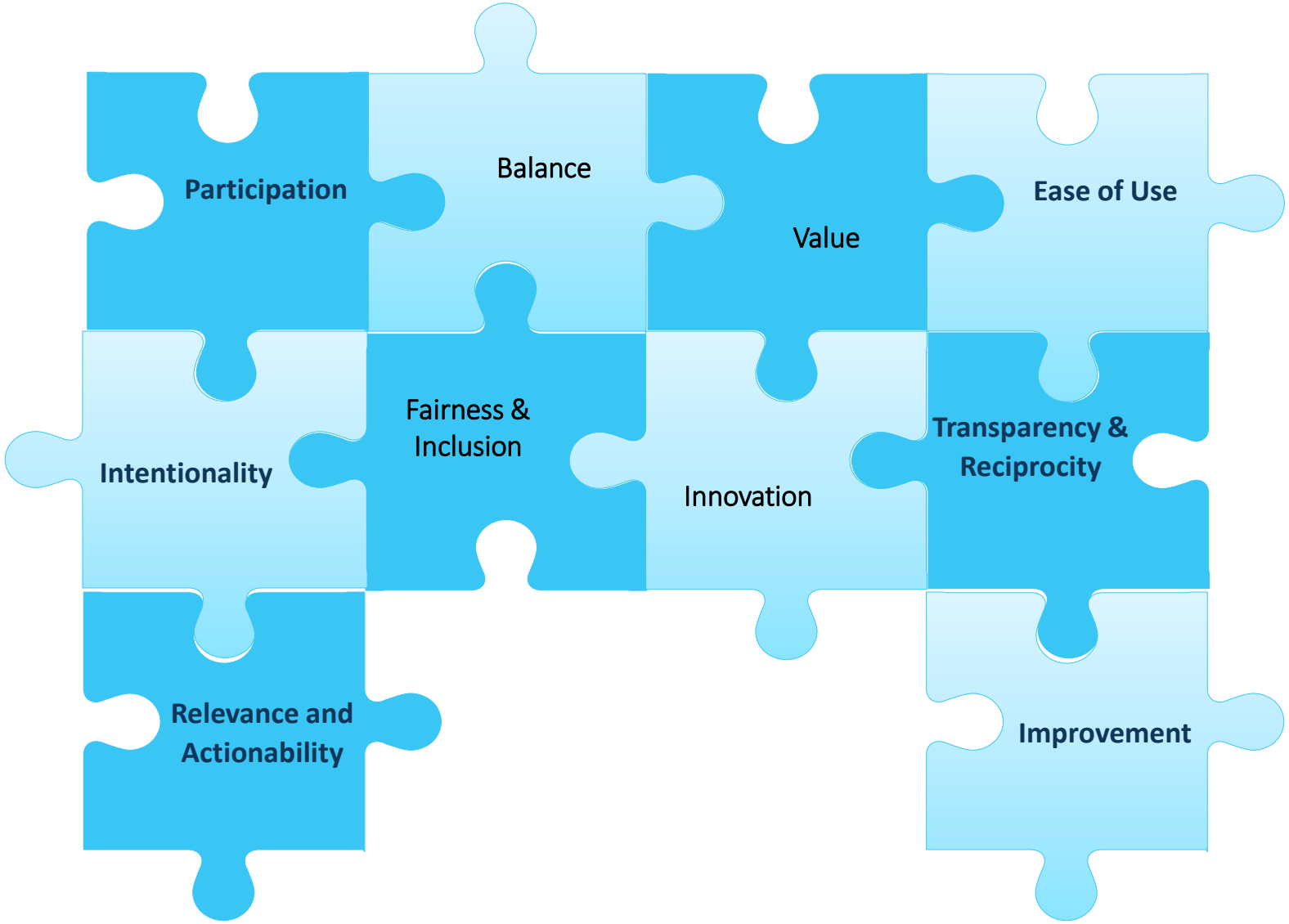
- Standards for Patient-Reported Data Collection
- Updated Interoperability Tools (e.g., FHIR Implementation Guide)

3 | Implementation Deliverables

- Playbook for Health Care Organizations
- Best Practices Guide for Clinical Teams
- Playbook for Patients

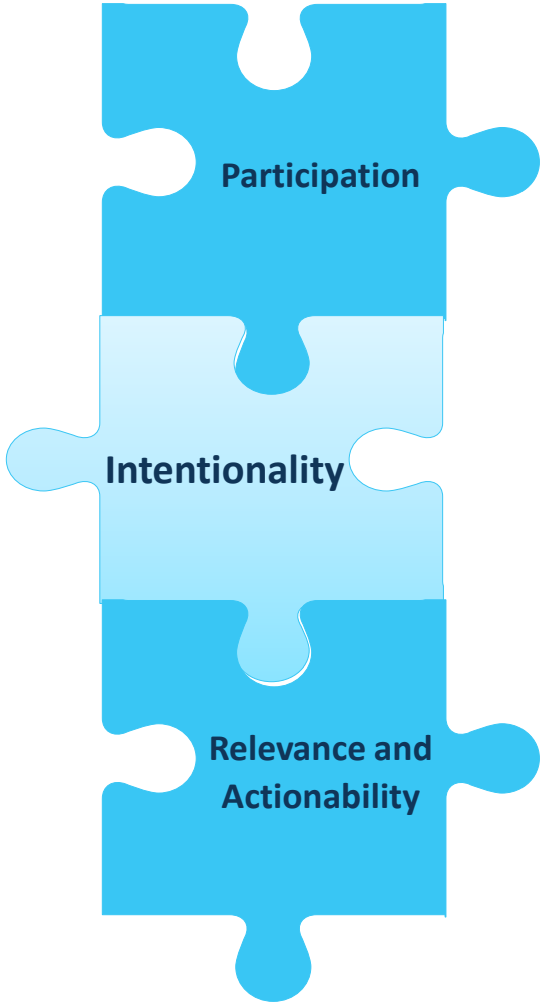
Person-centered performance measurement supports equitable, accountable care

- Start with what matters to patients
- Rebalance measures with a focus on value, equity and innovation
- Invest in sustainable implementation and improvement



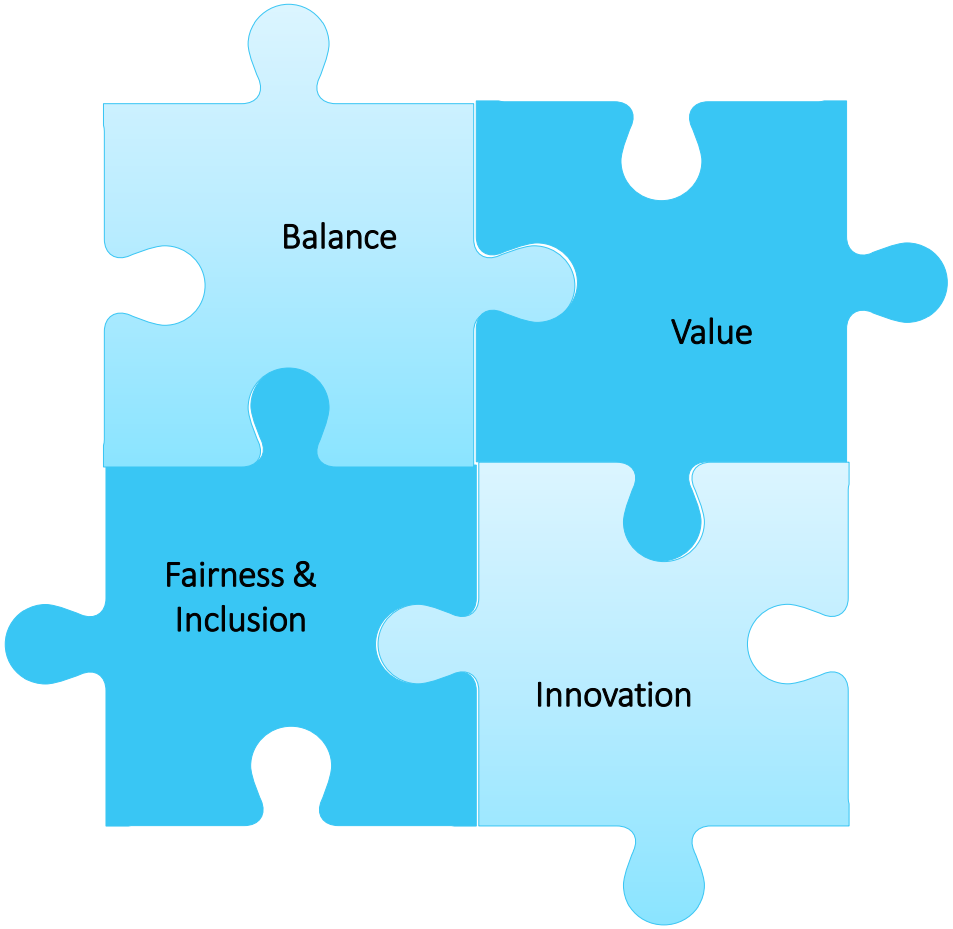
Start with what matters to patients

- The use of PROMs and PRO-PMs requires changes in attitudes, workflows, infrastructure, and ideally in care and outcomes, because those changes are needed to create a more person-centered health care system.
- Patients and families should have leadership roles in defining measurement topics that matter, guiding decisions about measures, and designing approaches for data collection and use.
- Patient-reported data should be collected with a clear purpose.
- Data should be collected on topics that matter to patients and that inform clinical care.



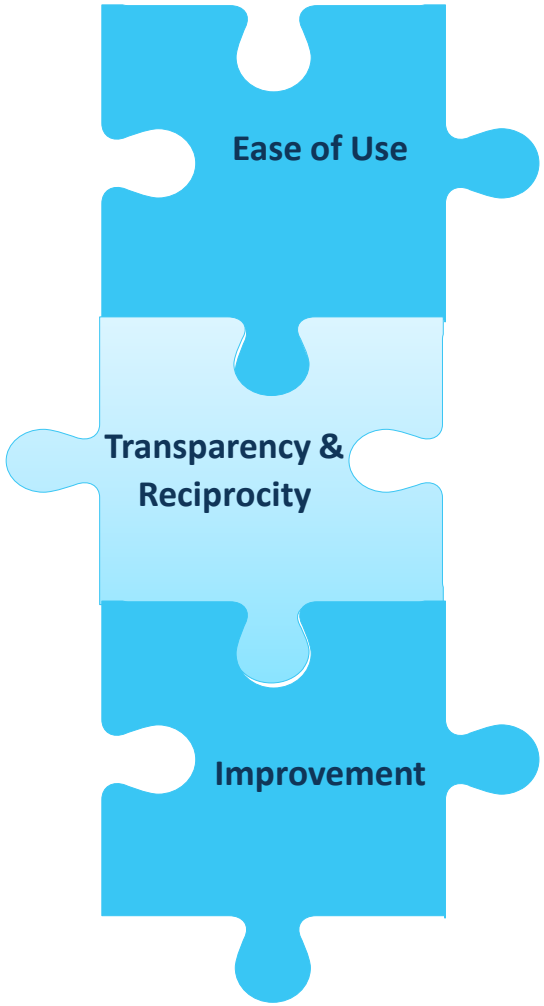
Rebalance measures by removing legacy measures and encouraging focus on value, equity, and innovation

- Measures should generate data and insights that have an impact on the outcomes that are important to patients and clinicians.
- This means removing legacy measures with less information and value to outcomes.
- General measures should be used where possible and specific measures where needed.
- Measure selection should prioritize measures with the potential to meaningfully address disparities and to address the needs of specific groups (e.g., those who have complex needs or have been historically marginalized).
- Because the development of PRO-PMs is still a new field, pathways are needed to encourage innovation in quality measurement.



Invest in sustainable implementation and improvement

- New measurement approaches require investments, and the resources needed for these measures should be considered in the context of the full reporting burden of quality measurement.
- Measures should be designed with ease of use in mind, even if the end result is not “easy” to use.
- The purpose of data collection is clear to patients and clinical teams, and the data are available to them.
- Because the use of PROMs in clinical settings is underutilized, opportunities for learning and improving performance and outcomes are essential.



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Alliance for Person-Centered Care