LAN Summit Session Transcript

9B: Preliminary Recommendations On Performance Measurement

[Audio begins at 16:05]

[Dana Safran]
Good morning. come in and get seated. We're going to take another moment for people to get settled and then we'll get underway.

[Presentation begins at 17:50]

Sound check, we're good. Yea, great ok good morning everybody! Thank you so much, uh… you are in the breakout room for our discussion about performance measurement. Uh…which is uh…I think um… among two very newly released uh... white papers from the LAN. The other one uh… just having come from the uh… Clinical Episodes Work Group. This one coming from the Population Based Payment Work Group. Um… I'm Dana Safran I have the um… privilege of co-chairing the population based work group with Glenn Steele and um… we have a really terrific panel planned for you this morning. Um… here are our uh... objectives for this session. We're going to take uh… the first few minutes um... where I'll provide for you an overview, of the um... the paper that we just released including the basic assumptions and principles that we set out underlying that work and then importantly the recommendations that we've made. Then we'll engage each of our three panels who I'm going to introduce to you in a moment, and ask each of them to answer two questions. The first question is from their prospective as a stakeholder in this work uh... because they do represent a broad spectrum of stakeholders from consumer um… to um… purchaser, and um… regional collaborative, uh… to uh... payers. From their prospective, what do they hear in the recommendations that they think holds really important promise, with respect to performance measurement in population based payments? And the second questions is um... what do they think are the greatest barriers uh... to implementing these recommendations? And any ideas they have for how to address those barriers. So those are the questions that our uh… tremendous panel will be discussing then we'll have time at the end uh... at least 15 minutes and 20 if we can eek It out. For some Q and A with this very large interested audience, we're thrilled that you're here ha-ha. We're thrilled that you're here, we want you to know we are recording this session. We're going to be using it in a webinar fashion to help folks uh… be more aware of what this white paper has uh… proposed and in order to engage feedback and comments. But we're delighted that you're here to give us your initial feedback and comments and uh... hopefully you'll follow up um... and formalize those through uh... the portal. Um… so before I turn to um... the, the content of the paper let me take a moment to introduce our panel to you.

First sitting uh… closest to me is Andrew Sperling. Andrew is Director of Federal Legislative Advocacy for the National Alliance on Mental Health. Um… in that role Andrew directs all the legislative advocacy work of the National Alliance on Mental Health and for over 20 years Andrew has dedicated his career to uh… the um… advocacy and service around mental health issues and public policy. Sitting next to Andrew is Elizabeth Mitchell. Elizabeth is President/CEO of The Network for Regional Healthcare Improvement, better known as NRHI. NRHI comprises uh… what's the number Elizabeth?

[Elizabeth Mitchell]
Almost 40 members

[Dana Safran]
Almost 40, regional health improvements collaboratives throughout the country and is tremendous resource for taking the kind information that comes out of the LAN and helping to make it real on the ground with payers, providers, consumer organizations. Elizabeth has been the CEO at NRHI since 2013. Prior to that, from 2008 to 2013 she was the CEO of the Maine Health Management Coalition. Which is one of the most successful regional health improvement collaboratives in the country and uh… Elizabeth also serves on the LAN Guiding Committee. And then finally uh… next to Elizabeth on her left side is Jean Moody-Williams. Um… Jean is Deputy Center Director at CMS for the center for clinical standards and quality. Um… Jean has a clinical background as a nurse and also a Maters in Public Policy. In her role at CMS she leads uh… a team of over 400 employees with a 3-billion-dollar annual budget. Working on quality improvement programs and stage renal disease, quality measurement, um… and clinical standards. Um… prior to joining CMS, Jean worked as an executive in a number of state and private entities, but all focused over her career on the important work of quality improvement. So a tremendous panel of broad representation of the important stakeholders for this work. Um… and let me now take just a few minutes to give you an overview of uh… the performance measurement white paper. Starting with uh… the principles that we put forward, and then telling you about uh… the recommendations. Um… I am hopeful that you can see the uh… the words on this screen, but I'll share the highlights with you and the materials will be available through the LAN website. So, we outlined four principles related to performance measurement. First is of course that performance measurement is foundational to the success of population based payment models; for those of you who were here yesterday, we talked a great deal about this. That you know without performance measurement, um… in these models, in the episode uh… models. In fact, performance measurement of the LAN's work overall, we don't know where we are, we don't know if we're succeeding at our goals. So, performance measurement really is foundational to the success of PBP models. Um… given our hopes that these models will help us accomplish the three-part aim of better care, better health, and lower costs. Um… because population based payment models address the full continuum of care. The measure sets themselves, have to span the full continuum of care. Again those of you who were here yesterday who heard couple of sessions where we talked about the uh… PBP work group understand, that our focus is on payment models that sit in categories three and four, and the where the provider has agreed to be accountable for the full continuum of care. Not for a single condition or procedure and the care around that, that's the work that Lew Sandy is leading through the Clinical Episodes Group, but these are models where providers agree to be accountable for a population from preventative care all the way through end of life care, and everything in between. The cost, quality, and outcomes of that care. The third principle that we put forward is that the measures required for the long term success is sustainability of these models are fundamentally different from the measures used in traditional fee for service payment models. I'll say quite a bit more about that but that's an important principle here. Umm. We were quick though to underscore that does not mean you know we should stop the presses and um…until we have these more outcomes oriented measures that the measure we have to day um… are not adequate quite, quite not so. We believe and we say uh… emphatically a number of times in the report, that the measure available today are an excellent start um… but we used this paper as an opportunity to paint a picture for the measures that are needed going forward. Um… and we aim to

draw some bridges between where we are today and we hope to go to uh… provide some ideas for how to get there. Um... so we'll cover that in a moment, the fourth and final principle is that the use of performance measurement for payment in population based payment models has to create meaningful incentives for systems to advance better results for patients and populations. So, uh… that's probably very basic and clear point, that because these measure are used in population based payment models for payment. The incentives around these measures have to be structured in a way will indeed accomplish the goals improving care for patients.

Um… so this slide here um… I realize that um... the, the little black type ha-ha, under there is something that neither you or nor I can read from where we stand, but I'll tell you what those um… what those say. But the main thing here is for you to get the visual. Which I know you can get from wherever you sit or stand. Um... this relates to the point that I mentioned a moment ago, that's so important to the paper that we have put forward and that is that the measures needed in uh… fee for service payment and the measures that have grown up under fee for service payment are fundamentally different from the measures that we ultimately believe are needed in population based payment models. The measures that have grown up under fee for service are quite granular, they deal with individual clinical processes. Almost always in a particular care setting, almost never across care settings, or at the system level. Almost always focused on a particular specialty, not across um… and so we call those the little dot measures and that's what's meant to be illustrated at level 3. Now little dot measures will remain very, very important. They'll be very important measures to help providers who are in these models, improve on the bigger dot measures that I'm gonna share with you in a moment. Um... but we just believe that ultimately they don't need to be the stuff of the incentive programs that comprise population based payment. So things like uh… as um… the, the black type face is pointing, as for non-arrival and as for non-discharge and diabetic eyes exams all of these really important things to do to achieve good outcomes with patients that have the conditions that those process measures are pointing to. But our point is um… those no longer need to be the measures ultimately of uh… what the incentives are comprised off in population payment models. Those should be the measures that provider organizations are using to direct their actions in or to achieve uh… positive outcomes for patients, that their accountable for. So, how do we get to bigger dot measures and what do we mean by bigger dot measures? Well, probably the best example of the big dot measure is over on the cost side. Um… total cost of care is probably the ultimate big dot measure, right? It is a measure where we have an all-encompassing way to evaluate the cost of care. And, so you'll notice on the uh… this graph, that we don't, we only have that level 1 big dot measure, lower costs, and the little dot measures the level 3 measure that might be used to help uh… providers uh… improve on total cost of care. But we don't have as we do in the other two domains, level 2 measures. Because when you have the perfect big dot measure, you don't need anything more in the middle. Um… but unfortunately, for quality and for health we don't have an analogous big dot measure to what we have in total cost of care. Um… and so what propose in this document is that's what is needed in quality and in health are level 2 big dot measures. We envision these being of 2 broad types, some of them will be focused on conditions and some of them will be focused on cross cutting issues like access to care, integration of care, health care disparities, care matched with patients' goals. Um… and that in each of these level 2 big dot measures will be a set of outcome measures that um... that help us to measure that construct. Um… so I'll say more about that as we go along, but that's, that's, the framework that we worked with for how we believe that measurement ought to proceed. And just now to reiterate what I said about um… about the existing measures. Um… what we say in this paper is that the core measure sets that are available today

including the recently announced uh… collaborative, core measure sets through the AHIP and CMS quality care collaborative. Um… are ideally suited as the place to begin in populations based payment. Um… and that we could've envision those core measure sets being used in a way they become level 2 measures uh… for population based payment. Uh… all the while as we develop the more outcomes oriented measures that we envision and emphasize in this report. So, that's a kind of important overview of the um…one of the main uh… things that we say in this paper and how the paper really proposes that the field of performance measurement needs to develop in order to support the success of population based payment. Let me now go through some of our specific recommendations. Um… and we can refer back to that uh… diagram. Because I think they'll help to illustrate it um… as you get some of the specifics. So, the first recommendation is 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; for example, functional status or the best available intermediate outcomes known to produce these results. Uh… so going back just for a moment to um… our diagram; opps… in level two for example part of what we describe in the paper around the kinds of condition specific, big dot measures that we envision. Um… is outcome measures of three broad types, outcomes for that condition that deal with acute complications of treatment or the lack of treatment, outcomes that are patient reported, dealing with functional status, pain, wellbeing, and outcomes that address the extent to which the condition has been controlled or is progressing. Um… including mortality related to the condition. So those 3 broad domains of outcomes are what we envision could comprise big dot measures. For example, for cancer care, for cardiovascular care, um… and for other conditions. Another important point that we make in the paper though is, that while for payment purposes those big dot measures will be needed at the system level and for broad topic like cancer or cardiovascular care. For patients and for purchasers, they're going to need us to unpack that big dot measure down to some of its components in order for it to be useful to inform provider choice in purchasing. So let's use the example of oncology care, imagine that we have a big dot measure that's comprised of the 3 types of outcomes that we talked about for cancer acute complications of treatment, patient reported, uh… outcomes, functional status, wellbeing, pain, etc. and um… control of the condition progression to death. Um… now a patient doesn't just want to know how the system is doing on cancer care and they certainly just don't just want to know cancer overall. A patient wants to know breast cancer, or prostate cancer, or colon cancer, or lung cancer. So we're gonna have to be able to unbundle that big dot to those levels and the patient probably wants to know within that system um… which providers actually have the best outcomes. Uh… and so we do not address the issue of getting all the way down to the individual clinician level because that presents some complexities around adequate sample size, risk adjustments, and so forth. But we acknowledge that with these dual uses of the measure set, both for payment which will be at the system level and for transparency and for uh… consumer choice and purchaser choice um… there are somewhat different needs served by uh… the measurement framework that we have tried um… put forward. Ok, um… our recommendation number two, because fragmentation across population based payment models can undercut success. Reliance on poor measure sets is valuable. However, the inadequacy volume and process orientation of existing measures necessitates ongoing innovation. So I think we've already really addressed that point, right? There are core measure sets we've heard a great deal over these last two days at this conference about the value of alignment. Alignment still allowing uh… innovation on top, so um… uh… that's an important concept. But alignment so that uh… the example we've heard over and over, again over these last two days. So that you don't have situations where providers in a population based payment models uh… with

multiple payers have you know 300 different measures that they're managing and only 5 of them in common across their programs, right? That is the value of core measure sets um… and we believe that uh… the AHIP and CMS core measure set initiative is a tremendous start um… that helps us on that path. But uh… just as that collaborative has said, so too our work group said. The measures that we have today are not the measures that we need going forward and so where we've focused our attention in this work is, what are the measures we need going forward and how would we get there? Uh… the third recommendation is that a governance process is needed to oversee and accelerate the development, testing, and use of new high priority measures for population based payment models. This is important right? Because if we're going to uh... both need to accelerate this process and we're going to uh… want to have this happen in a way where uh… we have some hopes of alignment going forward. Um... it would be ideal to have a public private partnership. Where we've agreed on what the priority measures are that should be accelerated, priory conditions, high prevalence, high impact conditions for which we would most like to have those um… big dot level two measures available as soon as possible. Quite likely leveraging some of the work that CMS is already doing. For example, through uh… the CJR uh… program and others. Um... but we'll, we recommend the importance of a governance process to help to shepherd uh... this through. Um… fourth recommendation is that in service of a future state that employs measures that are outcomes oriented. The infrastructure nationally must be addressed to systemically capture, use, and report clinically rich and patients reported data. That's important because today um… while we have tremendous uptake of EHRs and think all of us acknowledge that EHRs in their current state and the ways that they're being used are no uh… available to us to use for the kinds of clinically rich outcomes measurement that we want. We point to the possibility of registries helping to serve that uh…. purpose and we highlight the exemplar work being done through the national quality registry network, NQRN and some of the registries within that such as the registry that has long been stewarded by the society of uh… thoracic surgeons. Um… and uh… so clinically rich and also patient reported measures. We hear increasingly and it's so gratifying; um…national broad acceptance of the importance that patient reported outcome measures have to play uh… in our performance measurement systems going forward. But, the availability of these measures and the availability of systems to actually collect them and put them in front of clinicians in the practice. Um… we're far behind, these are measures long been used in clinical trials, we know a lot about the measures and their validity. But getting them from clinical trials into the front lines for real world use um… is one of the important challenges that has to be addressed. Again here we think that leveraging some of the work, umm… that CMS has proposed through um.. its programs and where it is featuring patient reported outcomes measurement is a very good uh… way to begin this process. Um… recommendation number 5 is that providers in population based payment models should have meaningful incentives to deliver high quality care, achieve favorable outcomes, and manage the total cost of care. And we spend uh… a little bit of time and real estate in this paper actually outlining some of the practices that we think are useful to uh… defining incentives that will promote um… uh… the vision that's put forward here in recommendation five. That brings us to recommendations 6 A and B. Um... here we do try to paint a picture of some of what we believe our best practices around structuring incentives in payment models, in a way that really will promote um… and motivate continues improvement and, and uh… reaching for the highest possible goals. So what we say is that measurement systems should define performance targets in a way that way motivates ongoing improvement across the performance continuum, promote best practice sharing, avoid a forced curve that mandates winners and losers, and enables long term planning and commitment to improvement. Now there's a lot in there, uh… but part of what we're saying there and what we say in

the next two set recommendations that follow is that, wherever possible, performance measurement targets should be set in absolute terms not relative terms. What do we mean by that? Relative terms by definition mean that we're using the observed distribution and those who are below where we put our cut point are gonna lose and those who are above it are going to win. And uh... instead by defining performance targets in absolute terms what is on this measure, good performance what is on this measure, exceptional performance and rewarding across that whole continuum. We get a lot of good results out of that, um… I can say from my own experience having shepherded a performance measurement program at Blue Cross Blue Shield of Massachusetts since Uh… 2007 where we've used that approach It's done a lot of important things number one, when you have a single performance target and the provider either makes that target or misses that target and gets nothing. It's very demotivating and also creates a lot of time and process around appeals. It also, when you have a single target that's defined in relative in terms creates that tournament style uh… system that we're trying to avoid. Instead what we have found is that when you use absolute performance targets using good statistical methodologies to tell us what is the beginning of good performance, it should be rewarded. What is the outer limit of performance that is possible to achieve and reward all across that continuum. It's very motivating, you get ongoing performance improvement, and maybe among the most important things you get providers willing to share best practices with each other. To help drive improvement forward because there isn't a tournament. Because one providers' success is not going to impinge on another's. So um… those are some of the experiences that inform this recommendation. Uh… 6A says that measured targets should be set in absolute not relative terms, establish prior to the measurement period and fix for minimum of one year, but ideally for the full contract term. Again, here this is just common sense, right? This is so that providers in these contracts know what their targets are and can actually plan their resources in a way that they can work to improve across that continuum and not wonder ya know what's the target going to be next year and am I gonna be ahead, behind, how am I doing? So by having a transparent, ambitious set of performance targets that lay out good to exceptional um… and letting that be in place for a period of time; we think that's uh... the ideal practice. Uh… so uh… 6B says that measured targets should include a range of scores on each measure to enable the incentive system to reward both performance and improvement. Um… so finally recommendation 7 says that adherence to good measurements, science and implementation, for example paying attention to sample size requirements that are needed for a stable and reliable information of the provider system, or hospital, or whatever unit we are trying to measure. Demonstrated, reliable and validity national accepted measures, clinically important, and provider's opportunity to improve on measures before accountability starts. All of these are critical to achieving the desired results from performance measurement in population based payment models. Why? Because performance measurement um…. really is a tool uh… among other things, a tool for providers to use to know where are they and where they're trying to get to and uh... these are important practices in order for provides to believe that the data are meaningful, believe that the goals are actually clinically important and be motivated to uh…. to work on them. So and also in addition uh…. turning to the transparency side, if we don t adhere to good measurement science. We… and we put forward measured results that we hope to; patients will use to inform their choice or purchasers will use to inform their choice. If what's inside that measure actually isn't uh… statically sound, doesn't have enough sample to actually reflect the real performance of this provider versus that. We're putting information in front of consumers but it's not good information. So it's really important not just for the sake of provider buy-in, but for all of our stakeholders, for our purchasers who want to be paying for something that's real, uh... for our payers that want to be um…

held accountable and paying for uh… paying, paying results to their network that are real, for providers to be motivated, and for patients who using and counting on this information. To have it represent the truth, uh… that can be used to inform their choices. So, that is uh… the overview of what this um… work group has spent time over the last couple of months developing and uh… put forward as recommendations. We're going to turn now to our panel, who I've introduced to you already and um… ask them to address these two questions. Number one, from your perspective what do you hear in the Performance Measurement recommendations that's most important and valuable to your stakeholders? Um… and number 2, what do you think are the most important barriers to be addressed um… in order to realize this vision and uh… if they have thoughts on how we might address them? We're eager to hear those two. So um... I think we will start with Jean, who is uh... at the um... far right as you are looking at the panelist table and move along from there.

[Jean Moody Williams]
Good morning everyone and thanks uh… thank you Dana and I really congratulate the work group for developing this paper which I really think cuts to the core and heart of the matter that uh..., it really is important for measurement for driving toward this population based payment in an aligned way. I think we've heard throughout the course of this conference both yesterday and today that uh… we're making a lot of progress and moving away from pure fee-for-service to alternative payment models in the forms of category 3 and 4 which this paper addresses. But we've also heard there many ways about going about doing that, using different measures, different structures, which sometimes leaves clinicians and consumers to wondering what is the true north, and how we will get there? And this paper adds to the question of where we're going, by noting that as if left as is, we will not um… uh where we are today, we will not get where we need to go with the measures that we have and that we uh… need to coordinate accountability for patient population. If we really want to look at and uh… from birth to end of life care. And CMS is one of the few payers that actually could be responsible for person from birth if they uh... come into the program covered by Medicaid and then move into the workplace and perhaps they are covered though the exchanges and then as they uh… grow older they may move into Medicare. Um… for services and then potentially move back into Medicaid as they are going throughout the long term care process, so in fact we could uh… really cover a person for a long period of time. So, how then do we begin to think about managing the health of this greater population and meeting the multiple goals that you mention including care costs then continuum, measures that matter um earning and insuring the best hand off from setting to setting in our case from program to program potentially. And then coordinating with the private payers and states and helping the beneficiary to stay at the center and all of that. So a person could interact uh… with our programs and then they could go to the private sector and back. So it is an awesome proposition um… but population based measures, that are aligned really holds the promise to really make it realistic that we can work with um… uh… managing and helping to coordinate the population. Um… it is also provided, it provides context um… that even if you aren't in the camp of population based payment and I have had some discussions with uh… those in attendance here at the conference, who may not yet be in that camp. But, at least you will have the data upon which to make those decisions of what is the best model for you for your practice to participate in? So I would say that CMS supports the PBP work group and the LANs belief that alignment around common principles and approaches across um… the public and the private sector will in fact accelerate progress and performance measure and will in fact help to transform the health care system. And I have to say that this is a positon where we're moved to over time. Um… ha-ha in the earlier days of measurement

development I thought were and I heard this stated eloquently yesterday; was more about the needs to stand CMS's programs the various settings versus what, what really looking to see what other purchasers and providers were doing and most importantly what's important to the beneficiary. But I've watched our progress over the past several years, which has really accelerated and challenged the way we set up our programs. Um… and I would say that the affordable care act had a lot to do with this as well. And um… we were a little bit conflicted about this, on the one hand we were standing up a national quality strategy that really had clear aims of better health, better care, lower cost. Uh… it had goals that moved us really towards thinking about the patient and the family as a whole. Thinking about safety, health, and wellness, at the same time we had a litany of category 2 programs that we had to stand up. I believe we had about 11 of them that we had to stand up and each one had its own set of constituents, measures, data systems, own agendas, and primarily they were process measures and then at the same time we had new models being stood up in the innovation center. Moving towards this population management and getting us toward a new uh… meaningful measurements. This new center that was leading this effort wasn't even in the same building with us and so we had the traditional measurement uh… structure going on and then the folks down the street um… and we didn't, I don't think at that time recognized the significance of each other's work. And how we would have to bring that together but as I fast forward today; I recognize that the value even in the way it unfolded, really um… gave us some really good learnings and it allows us to sit in a room like this today and look back, while at the same time looking forward. And now to the point where we have recommendations to which you spoke with some authority of this is the way we should go. So you know it really did lead us to a point of looking to see where the future lies and unlike at the start our traditional measurement team is joined at the hip with our innovation center. I sit in CCSQ, um… and you heard a lot from my innovation staff, but we really are joined at the hip, we employed a lean management system to help us to um… to really approach how we get measures to the market faster. We're working with NQF and many of you in this room are doing likewise. We've sponsored a kind of three sprints to look at how we get data on population based measurements in the community. And time will tell as we look back whether this is the right approach. But I'm really looking forward to your input today as to; you shaping the future that we will lead to as we obviously will look to these reservations to these recommendations.

And finally I just want to address the challenges to implementing the recommendations from a CMS perspective. I think there are many and most of which are addressed in the paper. Which have to do with collecting data from multiple sources including the EHR, working with multiple measures developers with some form and structure, while at the same time trying not to stifle innovation, incorporating the voice of the patients and families and care givers and engaging their care, while at the same time hearing from multiple clinicians that we are holding them responsible for things that they feel are out of their control. So having to balance all of those things, in fact we spent an extraordinary amount of time I would say in the past 3 to 4 months in the field as we're standing up MACRA and that's coming up; portions are coming out of our center. We actually been sitting in clinicians' offices, sitting with the registries, sitting with the EHR vendors, and some of what we're hearing from the clinicians is that they don't even uh… some don't believe that accountability measures in category 1, 2 or 3 are necessary and I don't believe it's because they don't think that it, they need to be held accountable; but I think at this point we haven't, they haven't seen the value of many of the measures that they been asking us. But I will say for those commercial payers in the audience one of things we did learn from the focus groups is uh… that they uh... did say that they find value in information that they're now getting

from many of you because you're giving them information across settings and not only that, you're giving them information about the interventions. And I used to work for a private payer and so, I don't think we would of heard that several years ago; that they wanted a payer to give them information about interventions. So I applaud you on that and obviously we need to look at that. Um… and… and … and… the last thing I'll say about the recommendation number 6, which is the one that probably gives us the most challenge, while we firmly believe that measures should move toward improvement and in fact; I'm an improvement person versus a measurement person. I use measures but uh… and we always, many times forget the purpose of measurement is improvement. And so fully support that portion of it. Um… when we get to the part of the forced curve and winners and losers and etc. Uh… we obviously want it to be win-win for everybody with the patients that's the ultimate winner. That said I would say the massive majority of our programs outside of the models are budget neutral and um… they're required so be so and so we have to be able to incentivize improvement and achievement without spending anymore more money than we would; had that program not been in place. Generally, these requirements uh… mean that we have upward and downward of adjustments but um… as we move to 3 and 4 I think and we start to show savings and start to show how things could to be done differently. CMS legislator's policymakers will think differently about that. I don't really say that as some type of pipedream. I've actually seen it if you look at the impact act. That's an uh… that is an act that passed that we're also standing up that people don't say a lot about. But the impact act does get to the uh... really to the fundamentals that you have measure across post-acute care settings and in fact requires that, that we come up with common measures to do so. So it can change and I think um… the folks in this room can help with that.

[Dana Safran]
Thanks so much Jean. Elizabeth…

[Elizabeth Mitchell]
Thank you and thank you all for being here because we really are here to hear from you. Dana and I were talking briefly during, before the start of participating in the LAN ya know., we're all volunteers, it takes an enormous amount of time but it's incredibly worthwhile because there is so much engagement and so much input and opportunities to interact, so thank you. Um… so I am gonna speak to this from the community multi stake holder perspective as Dana said; I run a network of regional collaboratives, used to run one myself. I'm so pleased with some of the recommendations here because I think they are reflective of those different perspectives. Um… all the stakeholders want cost, quality, and patient experience information. And increasingly they are demanding rightly so in my view, patients reported outcomes and functional status. So we are finally asking for the measures that I think will matter across these stakeholder groups and when we think about measurement as ya know, as Jean said we need to think about the purpose and intended use of those measures. And there are different requirements from the different audiences so patients want information to choose a provider, to choose a facility, to choose a service that might be much more granular, it might be; it may not be necessarily what the purchasers are looking for. They're looking to find out if their getting value for the increasingly vast amounts of money they're spending for their employed populations. Are they getting healthy employees who can participate in work in activities of daily living and basically just be healthy; and are they getting that the most affordable, most appropriate price. And then providers need data across patient populations, they have to be able to look beyond their clinical walls as they're being asked to take on risk. That means new relationships. I was talking to cardiologist who found himself in a bundle

and suddenly he was driving around to the local nursing homes because they had a new uh... mutually shared agenda and to able to have information, data, and measurement across these facilities, these practices is going to be essential for provider's success. We worked with some physicians when I was working in Maine who said it's not fair to ask us to go at risk and not give us any information. We can't manage without that information. So I think we're going to have to be thinking really differently about not only what information we have but what measures we use to really indicate success and um... no additional pressure on Jean I know she's really busy these days ha-ha. But MACRA is really going to accelerate this, we have the potential of uh... reallocating trillions of dollars and that's going to be based on how we define value. So, Jean you know what's going to mean yea, ha-ha. So, we really um... this is not an academic exercise we are really talking about using this, these measures for payment, for choice, and for improvement. Which I think is really exciting, but we need different views of that same data so while total cost of care might be I think, I would agree is sort of the gold standard cost measure. And I think it's important for policymakers, for purchasers that can see a population cost and also for providers. You typically want to drill down on to that, if a physician is told well actually you're high on total costs, it's not really useful until they can drill down and see why. Are more of my patients are going to the emergency room? Am I over utilizing certain procedures? So really that, the roll up to a view that providers can use and frankly consumers can use and then the drill down for specific action-ability is going to be very important. Um... we need, I totally agree we need these bigger dot measures, I think this is a very exciting direction and concept hopefully that will increase flexibility for providers. Who aren't micromanage on process but can say this is what success looks like to us. And ya know we want that innovation, we want to see what that looks like. But again being able to, an ACO quality measure is not enough because we know there's variation under there, we know every system that's good at oncology might not be good at cardiology. We need to be able to drill down further for the patient and purchaser perspective. So totally in line with the direction of these big dot measures and across those multiple domains. Um... the barriers I'm gonna limit myself here ha-ha, I think these could be big, the good news is I don't think the barriers are primarily technical. I think that um... this is doable, I think the barriers are primarily um... governance like we talked about, the infrastructure, and business. So I think with those in mind. One of the key barriers that I think is, is critical to solve is the lack of data, lack of shared data. You can't uh... manage a population without population level information. Um... total cost of care is a great example of that. We know that can be done the measure and what we would say might be the gold standard measure, has been available for almost two decades. It's not that the measures aren't there and haven't been tested but until you get access to the data to aggregate and produce it. You're not gonna go um... as far as we could. Um... that is one of my favorite measures and we have a great project going on that is testing how do you standardize this across, across regions and I think that lack of standardization is also a major barrier. Um... we don't have agreement on standard attribution, standard risk adjustment, standard patient identification, um... and when a purchaser is trying to purchase care across the county. They need to know that they are comparing apples to apples and frankly providers do as well. How do we know if performance is improving if we can't do a meaningful comparison? So, I think coming to some consensus around how we approach those questions will be very important. And then in terms of consensus who decides? I think everyone loves alignment as long as you're aligning around their measures and; but how do we say how well actually we're going to give up some of those measures 'we going to migrate in this direction. That's a hard, hard conversation and then balancing sort of the regional and national. Because priorities do vary by region based on demographics, based on ya know choric conditions in that region. So how do we maintain that flexibility

for innovation but also having some standard measures that we can really look across regions, across communities, across facilities and compare?

I think there is really good news um… that this is happening in communities across the country coming to consensus, setting shared priorities, and using common measures. I think there's a lot of room to really accelerate and expand that, again I would totally agree, I think the conversations are so different CMS and private plans, and purchasers all coming together and saying we have to do something different. So I find a lot reason for hope there and um… really looking forward to hearing you thoughts on what would work and what you need.

[Dana Safran]
Thank you so much Elizabeth. Andrew let me pass you this microphone

[Andrew Sperling]
Thank you Dana, uh… Thank you I'm Andrew Sperling with the National Alliance of Mental Illness. Um… so I'm here not in my role for the organization I work for. But I was nominated to be on the Population Based Payment LAN by the organization called the Partnership to Improve Patient Care. So I try and view myself as being that patient voice and that's critical in this LAN process. And I see wave your hands Allen, uh… Allen is sort of leading the patient groups in terms of engaging with the LAN as chair of what we call the CPAG, the Consumer Patient affinity group. So, having that patient voice is critical to the work of the LAN and advancing us toward alternative payment models. So let me talk a little about performance measure what, what we as patients see as, as um… as to keep things in these seven recommendations. First of all, making that distinction between patient and consumer and the reason that is so important, is we think of patients; which I think of patients as being people that touch the health care system the health care system touches them, sometimes on a daily basis. Whereas a consumer who's out there, very healthy and not, not an enormous cost associated with them. I want to draw that distinction, cause we need to focus if we're going to get to the triple aim, we have to focus on where the real costs are. What was it Willy Sutton, why do you go rob banks? Cause that's where the money is! The cost in this system, 80 percent of it is not just chronic illness but, quite frankly poorly managed chronic illness. We have to focus on individuals that not just have one but three and four and five uh… chronic conditions uh… that they're managing at the same time. That's where the huge costs are in this system, that's where we're going to make real progress with the triple aim in terms of getting better outcomes. Uh… costs, quality addressing all of these, these, these, uh… these critical things. Um… so focusing on the recommendations of performance measures, number one has to be the most important, that's the uh… focus and results that matter to patients, functional outcomes, the things that really matter day to day in a patient's life. Particularly those individuals living with multiple chronic conditions, quite frankly to motivate them uh… toward better outcomes. To help them; the population I represent, people with mental health conditions they often are dealing with co-morbid uh… hyper tension, heart disease, diabetes, if they can't manage their underlying mental illness their ability to manage those three or four multiple chronic conditions is not going to happen. So it has to be the functional outcomes that help to manage those co-morbid chronic illnesses. Number six is very important, avoiding that fourth curve, that mandates winners and losers. We have to recognize that health plans and health systems are all starting in a different place. And if we look at the highest costing individuals in the system they're going to be focus in particular payer markets. Be that Medicaid and even within the Medicare program uh… people who are dually eligible concurrently eligible for Medicare

and Medicaid. These are the individuals most widely to be dealing with 4 and 5 chronic conditions. That typically are poorly managed and that is where the high costs are and that's where need to focus our efforts. And there you have specific plans for example, special needs plans that only enrolled dual eligibles um… they're going to be starting in a very, very different positon in terms of that patient population that they're managing. When we talk about population based payment systems we have to recognize the disparities that exist in geographic concentration, social determinists of health, those geographic areas where there are high concentrations of chronic illnesses like diabetes and heart disease. Recognize that health plans that focus on those markets are in different place, uh… then other types that may be commercial plans that are dealing with a completely different population. We have to focus on what that starting point is um… uh… so uh… so we recognize the concentrations of particular individuals that are in those plans; we move toward population based payments.

Uh… barriers to performance uh… barriers to performance measurement. Uh… here I would note effective care coordination. Again, a focus here on that population on multiple chronic conditions uh… they are touched by a lot of different providers and we had a good discussion about that yesterday afternoon in the Patient Attribution session. This is something that we struggled with on, on this particular population based payment. How to do that attribution? Who actually owns that patient? Is absolutely critical, when you got someone who's managing 3 or 4 or 5 chronic medical conditions. And then measures that might look at and find some way to look at those non health factors, that can often uh… drive costs in the system and make it difficult to manage a chronic condition. What am I talking about here? I'm talking about transportation, alright? Someone doesn't have the ability to access transportation services to get to the primary care doctor, to get to the specialty care uh… doctor, that they, the physician they been referred to. You're not going to get good outcomes. Uh… looking at for example housing, we have lots of data in uh… for people with disabilities and other types of chronic conditions; that access, that they don't have access to stable housing. Their ability to effectively manage a chronic illness is severely diminished. And we see lots of bad outcomes that happen with these populations. So, uh… we gotta make sure these measures oriented toward the triple aim and in order to do that you really got to focus on the 80 percent of health care costs that are chronic illness and more particularly poorly managed chronic illness, that we know are driving costs in the system.

[Dana Safran]
Thank you so much Andrew and, and all of you. So, now is your time, uh… we have about 15 minutes left in this session and we would love to hear your comments, your reactions, your questions. Uh… please come to the mic and say who you are and where you're from.

[Holly Stanley]
My name is Holly Stanley I'm from the Alter Institute Center Elder Care and Advanced Illness and also the American Geriatric Society. I can't tell you how thrilled I am to hear the word function, in a performance measure. That just makes my day, but I would ask, yes! I mean, this, you know… you have to realize as you get really old, function is only going to stay at a certain level, what we tend to not do with this older population is stop and say" Mr. Jones, what are you Jones for goals and preferences for care"? Instead we seem to become very paternalistic or to overly safety minded and we just do stuff. And I would encourage folks to kind of play with some language. Like what matters most to you Mr. Jones and try and to figure out a way to measure that. For example, you could even start with something as simple as like or scale where you ask that question, "what's important to you"? And then

when they come back, say "how are we doing on meeting you goals for care"? Ya know, very simple measure, but we over medicalize the care of a lot of these frail older adults at a very high cost, both emotionally and cost wise.

[Dana Safran]
Yea, that's a great point and we do in the paper I think you'll see. Um… emphasize that we could emphasize it more; that care match with goals is one of those cross cutting measures that we think is extremely important.

[Unidentified Voice]
It could a time saving method…(unintelligible voice)

[Alan Balch]
So I wondered if you might elaborate a little bit more on the, So Alan Balch with the Patient Advocate Foundation. Andrew, thanks for the reference to the Consumer and Patient affinity group. I must also give a lot of credit to Debra Ness from the National Partnership for Woman & Families, for really driving; being the driving force behind setting that up, and then also Nancy LeaMond from AARP, who are the co-chairs with me in that endeavor. So wanted to make sure that's was clear to everyone. But you mentioned and I think this is a bigger challenge, you referenced it and if you could all maybe, any of one of you elaborate on a little further. You know we, we are and I was part of the, for those of you, others may have been involved in the AHIP's core measure collaborative and that's an ongoing process now with patient reported outcomes. We're trying to innovate in the health care marketplace particularly around payment models and also delivery models, but we're trying to use, and there's a whole infrastructure and process to quality measures at development. So, we're trying to innovate but we're using quality measures that are, you know 10 years old, 15 years old. Sort of the well-established and there's a good reason for that but also it highly limits, ya know? We can ya know, sort of an age, an era of patient centerness and really trying to engineer patient reported outcomes and patient engagement into these models I think we're hamstrung in some ways, by sort of what we; no offense to those who are the model, the quality measures set developers. I've done that work and I know how hard it is, I know why it is, the way it is. But how do we overcome sort of that technological lock in and really fast track if you will; some new and innovative measures into these processes when some of the benchmarks for quality measures, inclusion they have to be nationally recognized, which ya know, which usually translates into they have to be NQF endorsed or something on one of those lines. And if any of you been through that process you know how long, how arduous and long that process can take. So maybe comment on that?

[Dana Safran]
Yea, I'll be glad to comment on that as maybe the only recovering measure developer at the table ha-ha. Um… so in a, I think the Guiding Committee and CMS were really helpful in their comments on our early draft. To push us on that question ya know, we have the measures today, we have the vision that you're painting for tomorrow, which we really like. How do we get from here to there in a way that ya know doesn't take forever? And so we do point to um… some uh… approaches that we think can help to accelerate movement to this um… path. And one of those is that um… as I said, we do emphasize using the core measure sets that we have today is a very important place to start. We're far from perfect on those things and the things that are in those core measure sets are important, they're just not everything that's important. So how do we accelerate the process of developing the kinds of things

we're talking about here that are so important. Well number one, we think a process where we have public-private partnership that comes to agreement on what the priorities should be. For the fast tracking of measures for certain clinical areas. So probably starting with chronic conditions um... certainly starting with high prevalence, high impact conditions um... and then leveraging some of the um... measure development infrastructure that we already in place. But what we propose um... in the paper is that um... there actually be um... uh... a network, a national network of qualified measure developers and what makes them qualified is the number of things I, I don't have the paper in front of me so I may not remember all of them. But some of them are a demonstrated track record uh... for... doing measure development, a demonstrated track record that will be followed over time that the measures that they develop actually get used and are considered successful; whatever ways we'll judge success. And very importantly access to a network of provider organizations with whom they can do the important work of testing measures as their developed. Because um... ya know most of us who are familiar with the weeds of performance measure development and the validation process; you could think of it in 3 phases. There's the kind of initial development which typically has a pretty small unique set of providers and patients involved; kind of like a clinical trial. Phase 2 when that measure gets put into wide spread use is when you're really getting a lot of data that tells you what you need to know about that measure. Phase 3 is when that measure is ready for um... accountability uses. So we, we propose some strategies including this national uh... network of qualified measure developers, who have working with them a network of providers, who are willing and ready to be part of the process of implementing and testing and contributing to the improvement of these measures that are under development. And we suggest ways that, that phase 1 and phase 2 can be consolidated and accelerated in order to help move this forward. So, there's a, that I hope gives a flavor with an answer to your question, there's a lot of real estate in the paper actually dedicated to this question of how. How do we get from where we are today to where we're proposing to be in the future and we'll be very eager for your comments on that.

Yea please Jean.

[Jean Moody Williams]
Yea, I just wanted to agree with that on and I wanted to respond to both comments. So first on, starting with the place of consensus and alignment, I think would very helpful; when I look back at the point where we had over 60 different measures for hyper tension and you think about all the resources that went into developing those measures. Where if we were all leveraging what we were doing into a common place we probably could be a lot more further than we are right now. And on the comment about you know, asking the patient about what's important. I couldn't agree more with that, I've done a lot of work particularly with the end stage renal disease patients and when I did a panel with them and asked them what measures are important to you? And they said I just wish someone would ask me at the end of a dialysis treatment, did I feel better? Was that a good treatment for you? And we have a you know, I don't know maybe a 20-page questionnaire but that's not one of the questions.

[Elizabeth Mitchell]
Can I add also?

[Dana Safran]
Yea, please.

[Elizabeth Mitchell]
I want to agree with everything that's been said but I also wanna sort of note, one of the barriers to developing the measures that are important to patients is often funding. There isn't necessary a business case for those measures. So, I think it's important that um… there is funding in MACRA to develop new measures, I also think that there are um… regional pilots around the country where they are doing this measure development from a multi-stakeholder prospective. So you can really learn what does matter and to the extent that we can identify and elevate those hopefully that will accelerate the national work as well.

[Dana Safran]
Thank you. Yes, next.

[Jim Grulet]
Hi, Jim Grulet from AllScripts. You mentioned that the one thing that there was a big dot for was cost and we knew if all we could do is reduce cost, that's all the measure we need. I'd ask you which cost of what measured when, by whom, I mean um… if the procedure costs 10,000 dollars its paid by insurance country, company, country ha-ha. It's a lot more easy to observe than the individual payer is. So I'm just wondering what you meant, really by reducing cost and where you measure that?

[Dana Safran]
Sure, so we are um… in we do define that in that paper. Um… total costs of care and there are some good nationally accepted measures of that. Really are measures of total spending on care. Um… it doesn't relate to what the costs were to produce that. Um… we're presuming that those somewhat inform the prices uh… though we know that uh…that's often times not the case. Um… but so, total cost of care measures that are in existence today represent um… total spending on the patient's care including the patient's share and the insurance company's share.

[Mary Jo Condit]
Hi! Mari Jo Condin with the St. Louis Area Business Health Coalition and the Midwest Health Initiative which is St. Louis's Regional Health Improvement Collaborative. Um… one of the things that we hear a lot from our physician partners, our employer partners, our consumer partners is the need for alignment and meaningfulness in measures. And so to see those two themes, so clearly illustrated in your work I think is just incredible and we're so appreciative of that. Um… a lot of times when we talk about alignment and meaningful measures. We talk about measure selection, you know and how to make measures that are selected aligned across payers, across communities, etc. Um… and we talk about the meaningfulness, the things like functional reported outcomes, but there's also kind of the um... the population that's chosen not just the measure and you talked a little bit about the need for better infrastructure. Um… to have a I would hope a single population um… from which to uh… pull uh... the results of these measures and I think when we hear from physicians um… they're so eager to get all the results across all their patients, their entire panel. Um… in a really simple and easy to use way. Because for them, that's more meaningful and that's part of alignment. I'm wondering if you could talk a little bit about that infrastructure and how that might look.

[Dana Sarfran]

Sure, I'll say a little a few things and then others here may want to because the fourth paper that will be forthcoming from the Population Based Payment work group is about data sharing. And it's really in that paper that we're addressing the issues that you're pointing to. Which we talked about a little bit yesterday in couple of the plenaries. And that is, data sharing um… is critical and a number of people have referenced it here. Um… that in order to manage a population the clinician or, or uh… provider organization has to have a 360 view of that patient and that patient's care. Um... and so that means that only data from the payer, they'll need data from the other providers who are treating that patient. All of those issues we deal with um… in the uh… forthcoming data sharing paper. The infrastructure to collect all that and share that is, I think partly to be addressed there but partly what we uh... try to outline in our paper. Um... and that is we need the clinical uh… data to be collected in ways that we can use it for measurement. That's a kind of great limiter to being able to share it ha-ha. Um… and similarly the patient reported measures. So I hope that's a helpful answer. Elizabeth or others who are working on the data sharing paper, anymore comments?

[Elizabeth Mitchell]

Sure and I have a view from our experience in this. But I do think that there is, there are a lot of cases around the country where the utility in value of aggregating this data so you do have that view across payers uh... is really um… playing out and providers in particular are saying you know we've never been able to see ya know, the cost for our entire panel and that's, that is what its need is. Oregon Quality Corporation is great example. All over the country we're starting to see this, um… so that the all payer or multi-payer claims plus HIE's and maybe bringing those together, some state wide patient experience data collection initiatives are underway. I think those hold great promise, IHA in California actually just published a suite of all three of those measures. Um… I would also just note in MACRA there are other sort of policy um… uh… directions enabled through the qualitified entity program, a little bit of a sleeper. Not yet studied that, but it really is indicating the CMS support for getting identified Medicare data into communities that already have multi payer data assembled and have demonstrated their ability to be responsible stewards for that data. So recognizing that you gotta have the populations in to be able to really manage them. So I think those signals are important.

[Dana Safran]

Great thank you Elizabeth, Ok We're almost out of time. We'll take these two last questions. We'll make the questions succinct and we'll make our answer succinct.

[Kyle Kanier]

Sure, my name is Kyle Kanier, I'm from the Colorado Health Extension System out in Denver. Wondering how this measurement, the theories can apply to kids? Ya know, so often we talk about the adults with multi-morbid conditions but the kids Um... their conditions are different and the relational aspects of their conditions to their family member's is often different too. Often very similar to how geriatrics can be too. So I'm just wondering how your framework can address these nuances.

[Dana Safran]

So I'll say that we don't deal in the paper explicitly with kids. Um… but that all the work that we outline in the paper nor do we explicit name adults ha-ha. So, uh… we're talking about the population, but all of the um... types of measures that we're talking about; I know of a great deal of work actually that's going

on around patient reported outcome measurement for kids. And it does bring in the important mention of family and the family's experience and the families have responded and even sometimes in some of the work I'm familiar with engaging teachers and coaches to provide information about the child's functional status and wellbeing. Um… so that piece is not forgotten, though it's also not called out explicitly. Last question.

[Ted Grony]
Hi thanks Ted Groony, I work with Purchasers and Consumers in Maine. Great paper, love the work you're doing. One question in reading it briefly, I saw focus on underuse and overuse, but I didn't see much in misuse. And we know that preventable medical mistakes is the third leading cause of death in America and IOM just came out last year with a finding that one out of five of us might get a misdiagnoses. They seem like larger system issues are they included in this or some other part of the LAN?

[Dana Safran]
Um… they haven't been Ted. But, you know this issue of misdiagnoses has come up a number of times over these last two days. I think it's a good one for us to consider as a cross cutting measure, the challenges of measuring it have ya know, not been lost on us. But that doesn't mean we shouldn't mention it as a really important um… area.

[Ted Groony]
How about medical errors, are they in there anywhere?

[Dana Safran]
We haven't named them specially.

[Ted Groony]
Is there a reason for that? Or there; just haven't got to it?

[Dana Safran]
Just didn't think about it until your feedback, so thank you for your feedback. So, that probably illustrates perfectly um… how valuable these conversations are. So thank you so much for being here. Um… now… ha-ha, thank you! Now there's lunch outside, of course you need to pay for it um… and next sessions begin I believe at 11:45, thank you so much.