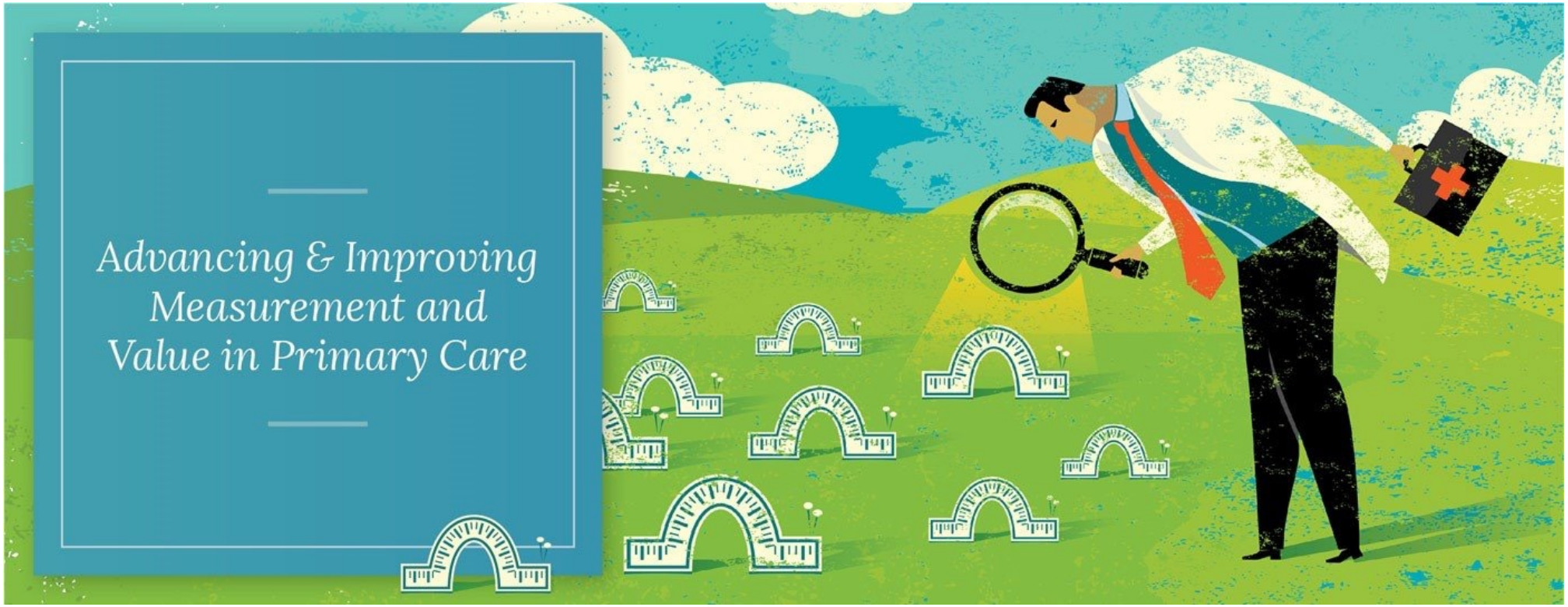
STARFIELD SUMMIT



THE CENTER FOR PROFESSIONALISM & VALUE IN HEALTH CARE

VIRGINIA CENTER FOR HEALTH INNOVATION

V-BID CENTER FOR VALUE-BASED INSURANCE DESIGN UNIVERSITY OF MICHIGAN

Welcome!

- We will begin shortly.
- **Please make sure your microphone is muted unless you are speaking/presenting.**
- If you would like to ask a question or make a comment, please utilize the "raise hand" function or type in the chatbox.
- When introducing yourself during the roll call, please share your name, organization and position. We also invite you to share **one thing you hope the Starfield Summit V sessions will accomplish**.
- We will keep this very brief so that we maximize our meeting time. Thank you!

Poll Everywhere Instructions

- We will be utilizing the Poll Everywhere platform today.
- In preparation to submit your poll question responses, please register by computer or cell phone.
- Register by Computer: **pollev.com/chs** (link in chat)
- Register by Cell Phone: **Text "CHS" to 22333**

Roll Call: Advisory Committee Members

- **Joel Andress, PhD** | ESRD Measures Development Lead, Division of Quality Measurement, CMS
- **Derek Baughman, MD** | Chief Resident, WellSpan Good Samaritan Hospital Family Medicine
- **Howard Beckman, MD, FACP, FACH, FNAP** | Clinical Professor of Medicine, Family Medicine and Public Health Science, URMC; Senior Consultant, Common Ground Health
- **Susannah M. Bernheim, MD, MHS** | Associate Professor; Director, Quality Measurement Programs (CORE); Assistant Clinical Professor, Section of General Internal Medicine; Core Faculty, Robert Wood Johnson Clinical Scholars Program
- **Beth Beudin-Seiler, PhD** | Health Care Research Analyst, Systems Research and Initiatives Group, Altarum
- **Arlene Bierman, MD, MS** | Director , Center for Evidence and Practice Improvement, AHRQ
- **Roger Bush, MD** | Primary Care Provider, Pike Market Medical Clinic, ABIM and ABFM Board Member
- **Daniel Carey, MD, MHCM** | Senior Vice President & Chief Medical Officer of the Physician Enterprise, Providence
- **Adrianne Casebeer, PhD, MPP, MS** | Director, Clinical Analytics and Trend, Humana
- **Michael Chernew, PhD** | Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School
- **Marcos Dachary** | Principal, SVP of Sales & Growth, Milliman MedInsight
- **Gwen Darien** | Executive Vice President for Patient Advocacy and Engagement, National Patient Advocate Foundation
- **Adam Elshaug, MPH, PhD** | Director, Centre for Health Policy & Chair, Melbourne School of Population and Global Health (MSPGH) and Melbourne Medical School (MMS), University of Melbourne

Roll Call: Advisory Committee Members

- **Ishani Ganguli, MD, MPH** | Assistant Professor, Harvard Medical School; Internal Medicine, Brigham and Women's Hospital
- **Rick Glazier** | Senior Core Scientist, Institute for Clinical Evaluative Sciences, Canada
- **Neeta Goel, MD** | Chief Medical Officer, Ambulatory Services, Inova Health System
- **Larry A. Green, MD** | Distinguished Professor of Family Medicine & Epperson-Zorn Chair for Innovation in Family Medicine and Primary Care, University of Colorado; Chair, ABMS Board of Directors
- **Diane Harper, MD, MPH, MS** | Professor, University of Michigan; NAPCRG; President, Board of Directors, NAPCRG
- **Aparna Higgins** | Senior Policy Fellow, Duke-Margolis Center for Health Policy
- **Lauren S. Hughes, MD, MPH, MSc, FAAP** | State Policy Director, Farley Health Policy Center, University of Colorado Anschutz Medical Campus; Associate Professor of Family Medicine, Department of Family Medicine, University of Colorado; ABFM
- **Karen Johnson, PhD** | Vice President, Division of Practice Advancement, AAFP
- **John Keats** | Market Medical Executive, Cigna Health Care
- **Reid Kiser, MS** | Director, Division of Quality Measurement, CMS
- **Alex Krist, MD, MPH** | Professor & Associate Professor, Family Medicine and Population Health, VCU Health; Co-Director, Virginia Ambulatory Care Outcomes Research Network (ACORN); Director, Community Engaged Research, Center for Clinical and Translational Research
- **Bruce E. Landon, MD, MBA, MSc** | , Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Professor of Medicine and Practicing Internist, Beth Israel Deaconess Medical Center
- **Cheryl Larson** | President & CEO, Midwest Business Group on Health
- **Wendy Levinson, MD** | Chair, Choosing Wisely Canada

Roll Call: Advisory Committee Members

- **John Mafi, MD, MPH** | Associate Professor of Medicine, Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine, UCLA; Affiliated Adjunct Physician Policy Researcher in Health Policy, RAND Corporation
- **Silas Martin** | Senior Director, Market Access Scientific and External Strategy, Johnson & Johnson
- **Ibe Mbanu, MD, MBA, MPH** | Senior Medical Director, Advocate Aurora Health
- **Mark McClellan, MD, PhD** | Robert J. Margolis Professor of Business, Medicine, and Policy, & Founding Director, Duke-Margolis Center for Health Policy, Duke University
- **David Mirkin, MD** | Chief Medical Officer, Milliman MedInsight; Principal, Physician Healthcare Management Consultant, Milliman
- **Nora Mueller, PhD, MAA** | Staff Fellow, AHRQ
- **Amy Mullins, MD, CPE, FAAFP** | Associate Medical Director, Optum
- **Warren P. Newton, MD, MPH** | President & Chief Executive Officer, ABFM
- **Patrick O'Malley, MD, MPH, MACP** | Director, National Center for Excellence in Primary Care, AHRQ
- **Denise Pavletic, MPH, RD** | Deputy Director, Clinician Measures, The Center for Professionalism and Value in Healthcare
- **Lars Peterson, MD, PhD** | Vice President of Research, ABFM
- **Robert L. Phillips, MD, MSPH** | Executive Director, The Center for Professionalism and Value in Health Care
- **Barbra Rabson, MPH** | President and CEO, Massachusetts Health Quality Partners
- **Eugene Rich, MD** | Senior Fellow, Mathematica
- **Michelle Rockwell, PhD, RD** | Assistant Professor, Virginia Tech Carilion School of Medicine; Research Associate/Practice Facilitator, Carilion Clinic

Roll Call: Advisory Committee Members

- **Dana Gelb Safran** | President & CEO, National Quality Forum
- **David Schmitz, MD** | Professor and Chairman, Department of Family and Community Medicine, University of North Dakota School of Medicine and Health Sciences
- **Michelle Schreiber, MD** | Deputy Director for Quality and Value, Center for Clinical Standards and Quality, CMS
- **Bruce Sherman, MD, FCCP, FACOEM** | Medical Director, Employers Health Coalition
- **Corinna Sorenson, PhD** | Director, Margolis Scholars Program in Health Policy and Management
- **Jason Spangler, MD, MPH, FACPM** | Executive Director, Global HTA Policy Strategy & Engagement, Amgen
- **Katy Spangler** | Co-Director, Smarter Health Care Coalition; Principal, Spangler Strategies
- **Christina Stasiuk, DO, FACOI** | Market Medical Executive, Cigna Mid-Atlantic Region
- **Lauren Vela** | Director Health Care Transformation, Walmart
- **Kara Odom Walker, MD, MPH, MSHS** | Vice President & Chief Population Health Officer, Nemours Children's Health System
- **Elizabeth Wolf, MD, MPH** | Assistant Professor, Department of Pediatrics, Division of General Pediatrics and Emergency Care, VCU Health

Planning Committee

- **Beth A. Bortz, MPP** | President & CEO, Virginia Center for Health Innovation
- **Andrew Bazemore, MD, MPH** | Senior Vice President of Research and Policy, ABFM
- **A. Mark Fendrick, MD** | Professor, University of Michigan; Director, VBID Center
- **Stephen A Horan, PhD** | Founder & CEO, Community Health Solutions
- **Saraya A. Perry, MPA, MNM** | Project Coordinator, Virginia Center for Health Innovation
- **Dana Price, MS, CHCP** | Grants Manager, ABFM
- **Jill Shuemaker, RN, CPHIMS** | Clinician Measure Director, The Center for Professionalism & Value in Health Care

Agenda

Topic	Activity	Time (approximate)
Welcome	Beth Bortz, MPP, and Andrew Bazemore, MD, MPH will lead the opening segment to include a welcome, introductions, and a review of the purpose and workplan for the summit.	2:00-2:20
Setting the Context	Mark Fendrick, MD and Michael Chernew, PhD will review insights from the field on addressing low-value care (LVC) in primary care settings, including the impact of LVC, ways of identifying LVC, and options for structuring payment and policy to encourage LVC reduction.	2:20-3:10
Break		3:10-3:25
Member Insights (Small Group Discussion)	In this segment we'll invite members to participate in small-group discussions about opportunities and challenges for measuring LVC in primary care settings.	3:25 – 4:10
Member Insights (Full Group Sharing)	In this segment we'll welcome everyone back to the full group, and use a group polling activity to generate rapid feedback on your top-of-mind insights and ideas from the small-group discussion period. We'll also invite feedback from members and presenters on strategic insights emerging from these results.	4:10 – 4:40
Measures that Matter: Where LVC Fits	Andrew Bazemore, MD, MPH will briefly react to and reflect on the LVC measure conversation in the context of Center for Professionalism & Value in Health Care efforts to advance Measures that Matter and a parsimonious MVP suite for Primary Care	4:40-4:50
Wrap-Up and Next Steps	Beth Bortz, MPP will summarize the key take-aways from the day, preview next steps in our workplan, and seed ideas for attendees to consider before the next of our serial Starfield Summit.	4:50 – 5:00

Starfield Summit V: Advancing & Improving Measurement and Value in Healthcare

- The Virginia Center for Health Innovation (VCHI) in partnership with the ABFM Center for Professionalism and Value in Health Care and the University of Michigan VBID Center, was awarded an AHRQ conference grant to convene the 5th Starfield Summit.

- Of the existing hundreds of tests and procedures identified as unnecessary, there is a desperate need to form consensus on which LVC measures matter most to all stakeholders – to payors, academics, clinicians, policymakers, and patients, especially those in priority populations.

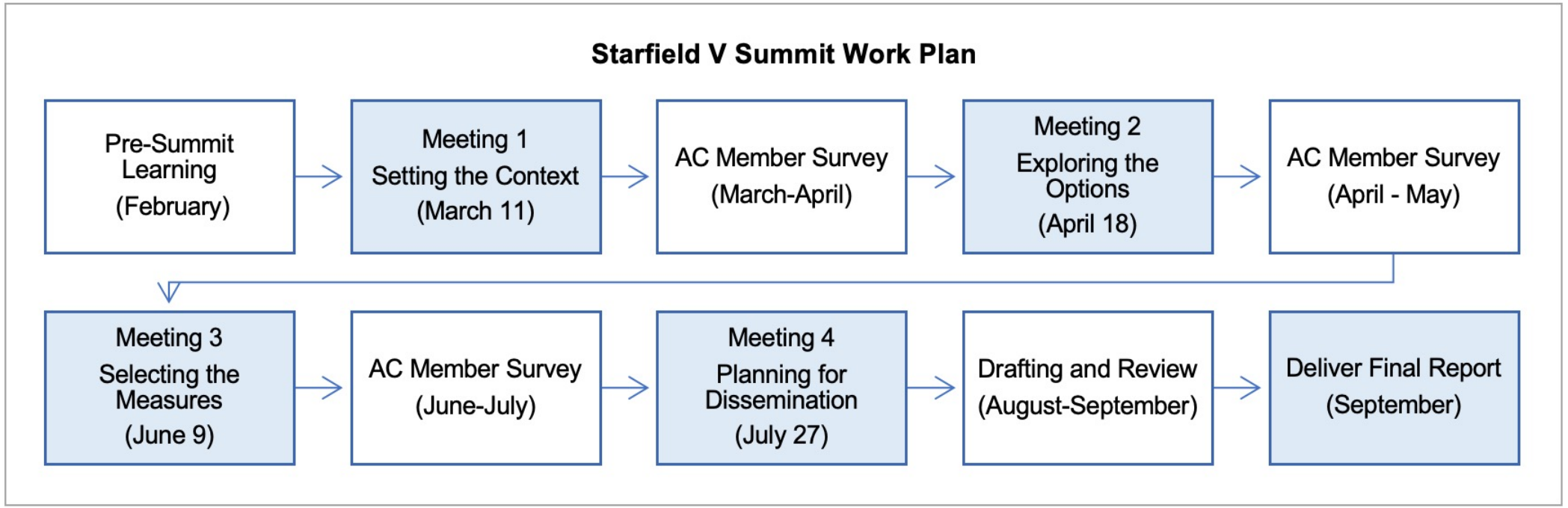
- The Starfield Summit is an essential next step in our efforts to achieve primary care measurement consensus specific to the provision of low value care.

Summit Purpose

Starfield Summit V and its summary writings will:

- frame primary care LVC in the context of overall payment reform;
- review current LVC recommendations and develop criteria for evaluating LVC measures;
- establish feasibility for LVC measure implementation;
- achieve consensus on a concise set of LVC indicators specific to primary care, and
- disseminate the selected measure set for widescale implementation.

Workplan


Starfield V Summit Work Plan
Pre-Summit Learning (February)
Meeting 1 Setting the Context (March 11)
AC Member Survey (March-April)
Meeting 2 Exploring the Options (April 18)
AC Member Survey (April - May)
Meeting 3 Selecting the Measures (June 9)
AC Member Survey (June-July)
Meeting 4 Planning for Dissemination (July 27)
Drafting and Review (August-September)
Deliver Final Report (September)

Website Tour

Setting the Context: Addressing Low-Value Care (LVC) in Primary Care Settings

A. Mark Fendrick, MD & Michael E. Chernew, PhD

Health Care Costs Are a Top Issue For Patients, Purchasers and Policymakers: Solutions must protect consumers, reward providers and preserve innovation

- Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
- Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions
- Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

Setting the Context:
Change the health care cost discussion from "How much" to "How well"

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services and in the wrong places
- Underutilization of high-value care persists across the entire spectrum of clinical care leading to poor health outcomes
- Provider and consumer-facing initiatives aimed to increase high value (i.e. cost-effective) clinical services will typically increase total medical spend in the short term

How to Pay for More Generous Coverage and Use of High Value Care?

- Lower prices – dream on
- Increase premiums – politically not feasible
- Raise deductibles and copayments – ‘tax on the sick’

How to Pay for More Generous Coverage and Use of High Value Care? Reduce Spending on Low Value Care

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 29, NO. 11: DESIGNING INSURANCE TO IMPROVE VALUE IN HEALTH CARE

Applying Value-Based Insurance Design To Low-Value Health Services

A. Mark Fendrick, Dean G. Smith, and Michael E. Chernew

AFFILIATIONS

PUBLISHED: NOVEMBER 2010 No Access

https://doi.org/10.1377/hlthaff.2010.0878

Creating ‘Headroom” to Pay for More High-Value Care Identifying /Removing Unnecessary Services

- Unlike delay for cost offsets from improved quality, savings from waste elimination are immediate and substantial
- Despite efforts to identify, measure and report unnecessary care, reduction of low value services has proven challenging

How to Pay for More Generous Coverage and Use of High Value Care? Reduce Spending on Low Value Care

- Identify – USPSTF D Rated Services, *Choosing Wisely* Starfield Summit V,

How to Pay for More Generous Coverage and Use of High Value Care? Reduce Spending on Low Value Care

- Identify
- Measure – e.g., Milliman Health Waste Calculator

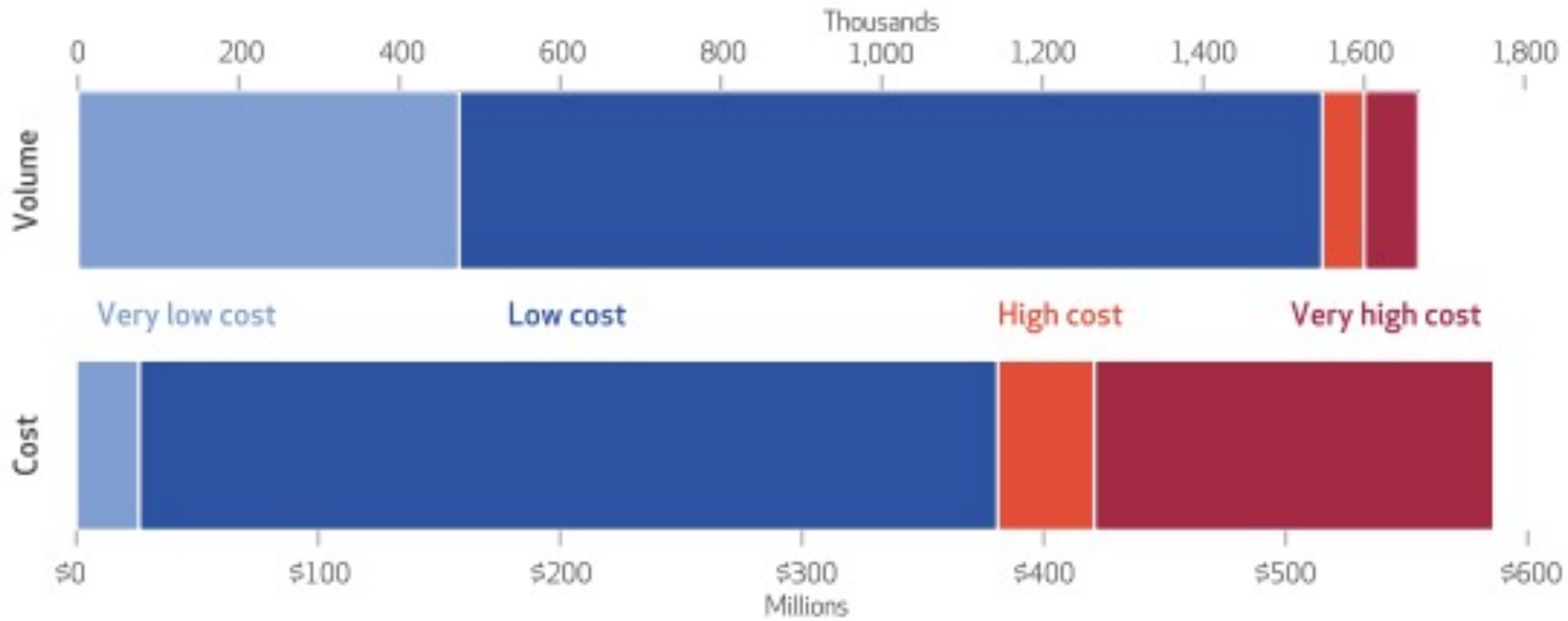
By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DOI: 10.1377/hlthaff.2017.0385
HEALTH AFFAIRS 36,
NO. 10 (2017): 1701–1704

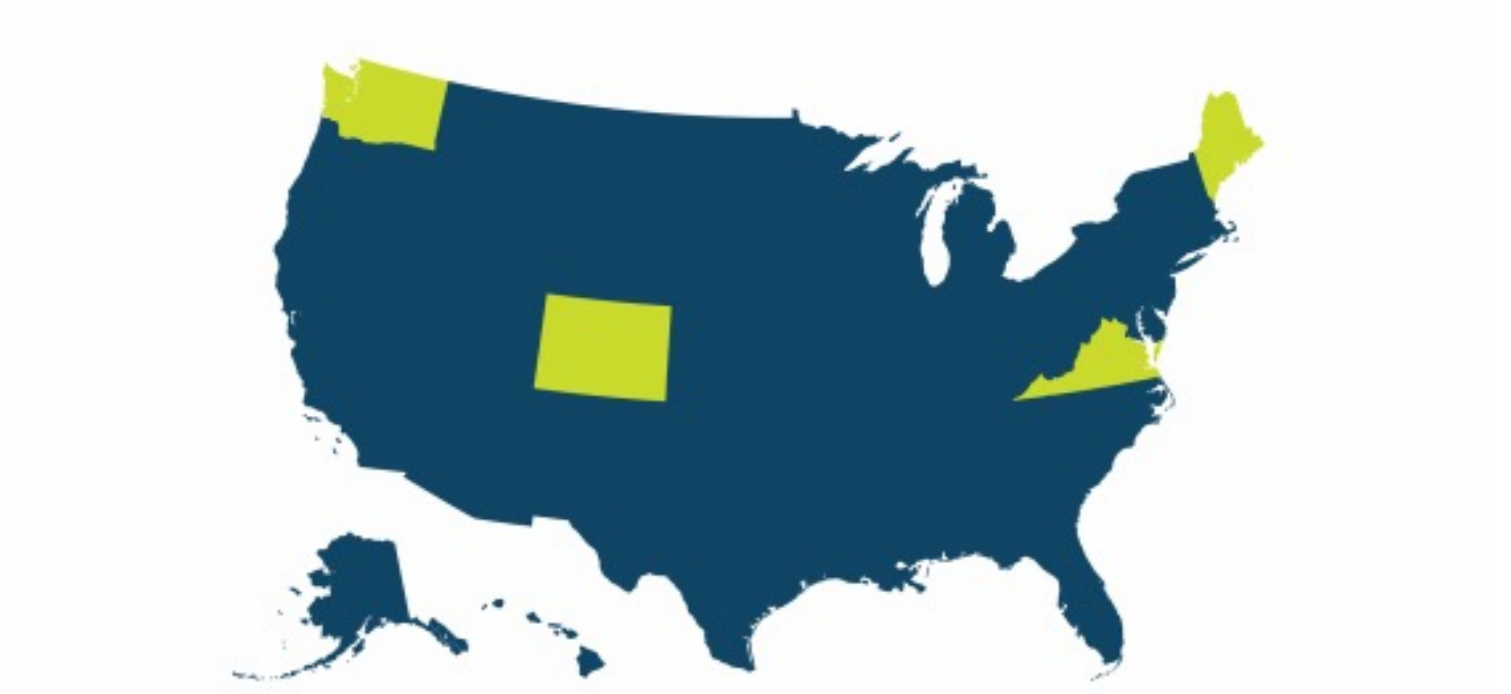
DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

Use and cost of low-value services in Virginia in 2014, by quartiles of cost

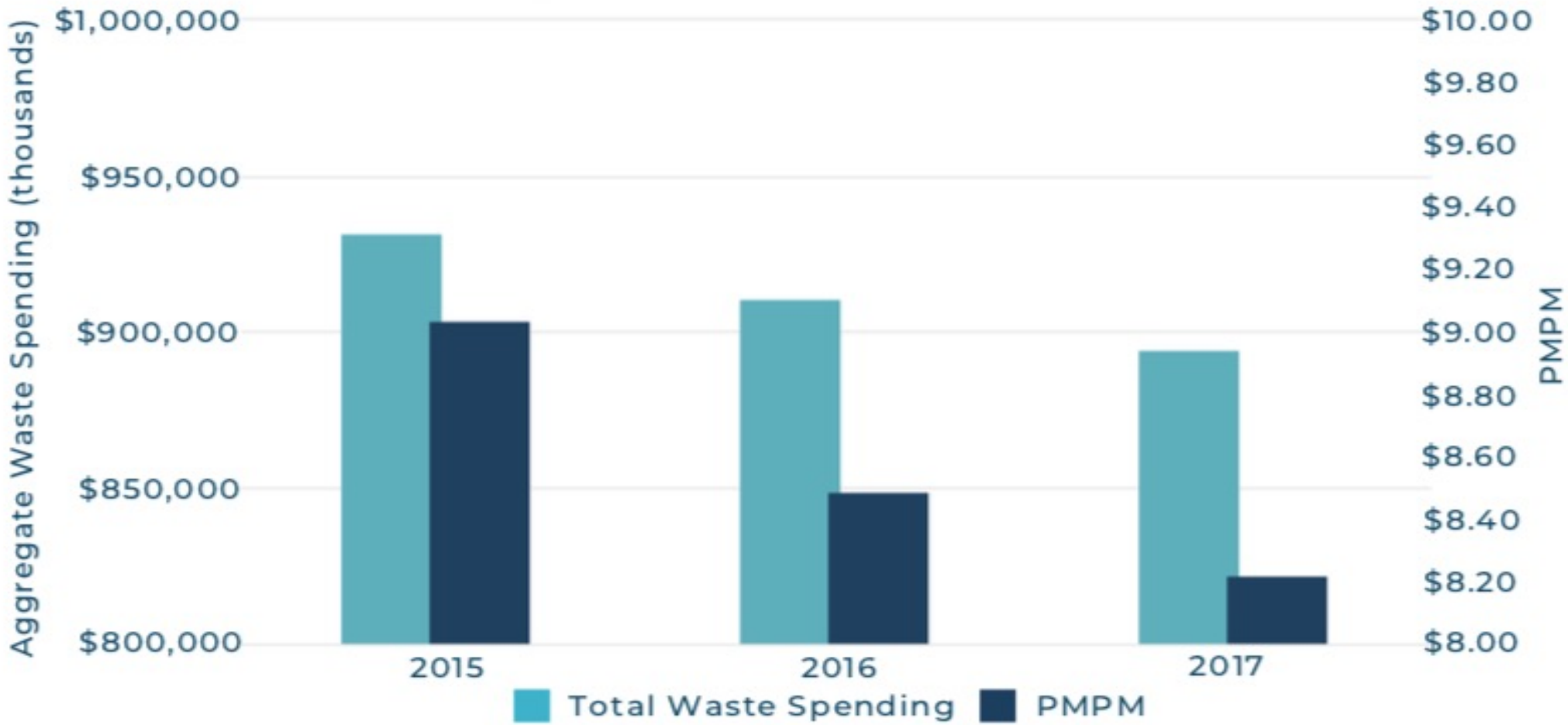


Utilization and Spending on Low-Value Medical Care Across Four States



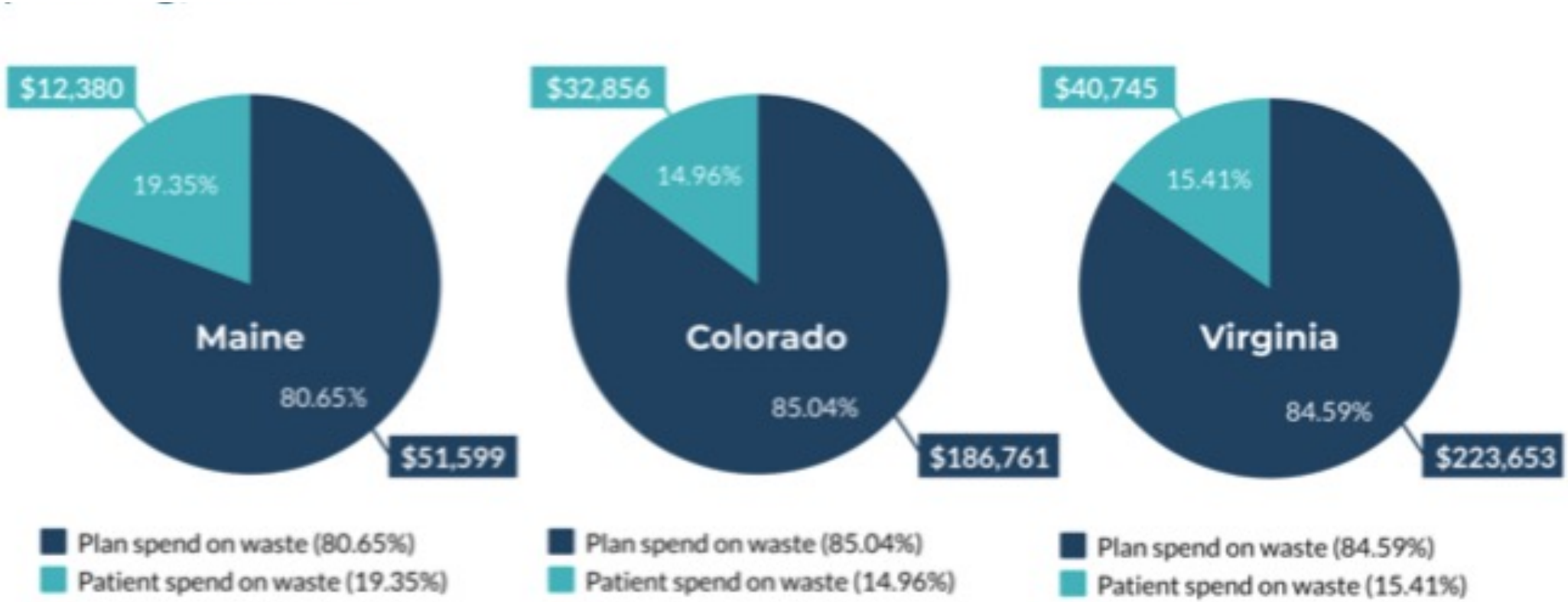
https://vbidhealth.com/docs/States-LVC-Paper-FINAL-Draft(1).pdf

Total Spending on 47 Low-Value Services by Four States in Medicaid and Commercial Plans, 2015-2017



Notes: this figure shows total spending (sum of plan and patient spending) on the 47 low-value services for commercial and Medicaid only, across three years for all four states: Colorado, Maine, Virginia, Washington.

Spending on 47 Low-Value Services in Medicaid and Commercial Plans in 2017 by Patients and Plans



Notes: spending in thousands $. These figures only represent Maine, Colorado, and Virginia. Washington did not separately report patient and plan spending, estimated allowed spending based on standard pricing for Medicaid and commercial plans

Spending on "Top 10" Commercial and Medicaid Low-Value Services by Volume in 2017

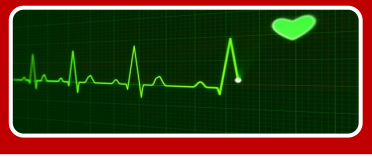
2017	Total Spend on "Top 10" LVC Services	PMPM	% Total Medicaid and Commercial Waste Spending
Maine	$49,659	$6.67	78%
Washington*	$278,236	$8.69	80%
Colorado	$160,125	$5.65	73%
Virginia	$179,322	$4.37	68%
Total	$667,343	$6.13	70%

*Notes: total spending in thousands $. PMPM = total spending on the top 10 services divided by total member months (Appendix 3) provided by the states for 2017. These data only include Medicaid and commercial spending. *Washington does not report plan and patient spending separately.*

Addressing Low-Value Care (LVC) in Primary Care Settings: Top 10 Measured Low Value Services by Volume, Utah

Utah
Annual Resting EKGs
Antibiotics for Acute Upper Respiratory and Ear Infections
Preoperative Baseline Laboratory Studies
PSA
Opiates in acute disabling low back pain
Cervical Cancer Screening in Women
Routine general health checks
Imaging tests for eye disease
25-OH-Vitamin D deficiency
NSAIDs for hypertension, heart failure or CKD

Multi-Stakeholder Low Value Care Task Force Identifies 5 Commonly Overused Services Ready for Action



1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

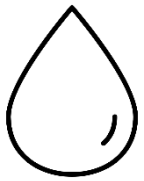
2. Population Based Vitamin D Screening

3. PSA Screening in Men 70+

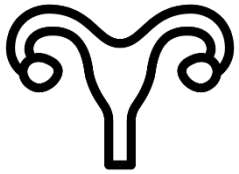
4. Imaging in First 6 Weeks of Uncomplicated Low Back Pain

5. Branded Drugs When Identical Generics Are Available

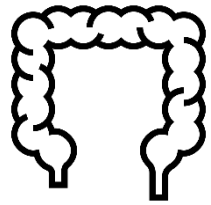
USPSTF Grade D Services Commonly Used in Medicare



Prostate cancer screening in men ≥ 70 years



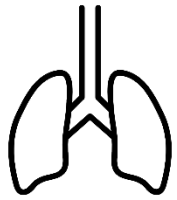
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

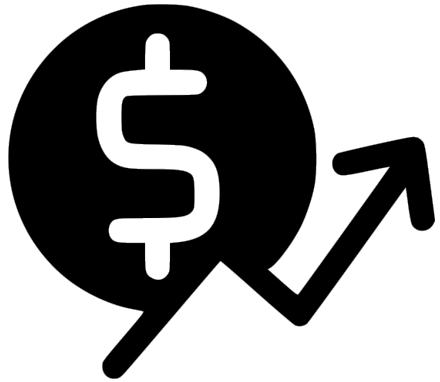
Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



Total Annual Count:

31 million

Total Annual Costs:

$478 million

Oronce CIA, Fendrick AM, Ladapo J, Sarkisian C, Mafi JN. *JGIM 2021.*

How to Pay for More Generous Coverage and Use of High Value Care? Reduce Spending on Low Value Care

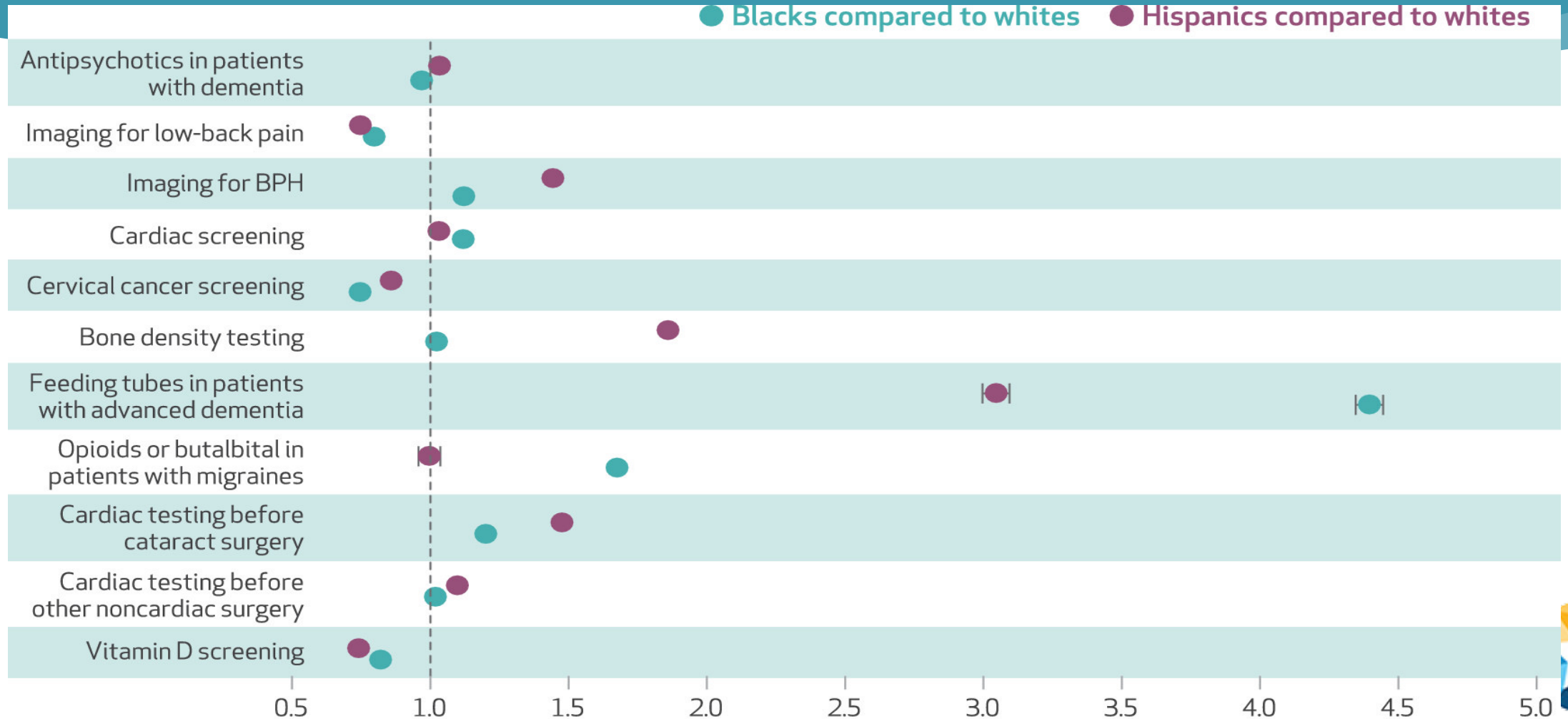
- Identify
- Measure
- Report – e.g., Smarter Care Virginia

JAMA Internal Medicine | Original Investigation | LESS IS MORE

Low-Value Care at the Actionable Level of Individual Health Systems

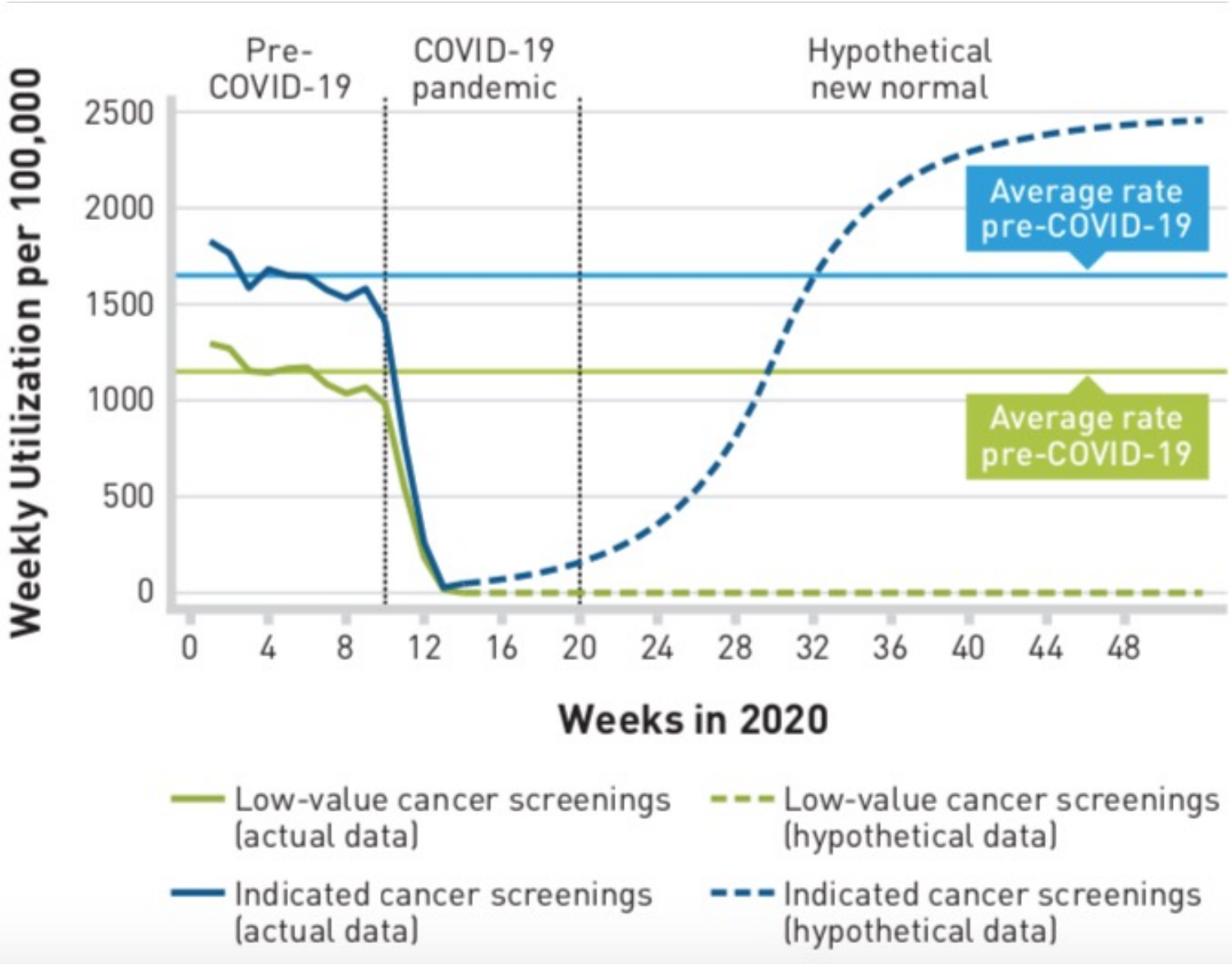
- Wide Variation in Use of Low Value Care
- Health System Traits Associated with More LVC use
  - Smaller proportion of primary care physicians
  - Not affiliated with a major teaching hospital
  - Does not have an Accountable Care Organization
  - Larger proportion of non-White patients
  - Headquartered in the South or West of United States
  - Serving areas with more health care spending

Low Value Service Worsen Health Disparities: Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites



Health Affairs. https://doi.org/10.1377/hlthaff.2016.1416

Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?



Creating 'Headroom" to Pay for More High-Value Care: Addressing Low Value Care in Primary Care Settings

- Leverage the widespread adoption of electronic health records (EHRs) to make it easier to order high-value care with simplified processes and discourage the use of low-value care with alerts
- Align patient cost-sharing with the value of the underlying services; reduce out of pocket cost on high value services and increase patient cost on low value care
- Build on existing alternative payment models that base reimbursement on patient-centered outcomes. increase reimbursement for high-value services and reduce or cease payment for known low-value care

ACA Sec 4105:
Non Payment for Selected No-Value Preventive Services

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

"(1) modify—

"(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

"(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

"(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.".

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

HHS granted authority to not pay for USPSTF 'D' Rated Services

Eliminating Low Value Care Through Payment Policy

Michael E. Chernew, PhD

Payment Approaches to Reducing LVC

- Pay for performance
- Insurer withholds/ performance guarantees
- Alternative payment models

Pay for Performance

- Carrot approach
  - Reward providers for meeting LVC performance targets
    - Low volume of low value care
    - High share of referrals to preferred specialists/ hospitals ranked in part on delivery of LVC
- Stick approach
  - Withhold payment subject to meeting low value care targets
- Issues for primary care
  - Focus on only low value primary care service
  - Focus on total LVC delivered to a panel of patients

Insurer Withholds/ Performance Guarantees

- Large employers impose performance guarantees on insurers (often reductions to fees)
  - An example would be rebates on administrative fees if spending trends exceed a threshold
- Incorporate low value care measures into those performance guarantees
  - Not all spending reductions are the same. We prefer savings when achieved through reduced low value care (or lower prices)

Alternative Payment Models

- FFS can encourage use of LVC
  - Often its profitable
- APMs (ACOs or episode payments) can alter the provider incentives
  - Lower spending (less LVC) generates bonuses
  - Higher spending (more LVC) incurs penalties
- Model design and organizational scale matter
  - How much of savings are shared
  - Is there downside risk
  - How do incentives interact w/ underlying FFS incentives
    - Greater incentive to eliminate LVC delivered by others

ACO Savings Disproportionately in Low Value Care

- Differential reduction of 0.8 low-value services per 100 beneficiaries for ACOs (vs. control)
  - 1.9% differential reduction in low-value service quantity
  - 4.5% differential reduction in spending on low-value services
- Greater reductions for ACOs providing more low-value care

Source: Schwartz et al. 2015. "Change in Low-Value Services in Year 1 of the Medicare Pioneer Accountable Care Organization Program." *JAMA Internal Medicine*.

Discussion

Break

Please remained signed in to the the Zoom meeting.

Feel free to turn off your camera and mute your mic during the break.

Small Group Discussion

- Q1. Why is it important to identify and measure LVC in primary care?
- Q.2 What are the pitfalls and unintended consequences that might lead some PCPs to resist engaging in identifying and measuring LVC?
- Q.3 How might measure design mitigate these pitfalls and unintended consequences in ways that better engage PCPs and their practices as partners in identifying, measuring, and reducing LVC?

Small Group Discussion – Breakout Rooms

- In just a moment, you will be added to a breakout room.
- A facilitator will be assigned to each breakout room to guide group members through the three discussion questions.

Member Insights: Full Group Sharing (Poll Everywhere)

- We will be utilizing the Poll Everywhere platform today.
- If you have not already done so, please register by computer or cell phone in preparation to answer the upcoming poll questions.
- Register by Computer: **pollev.com/chs** (link in chat)
- Register by Cell Phone: **Text "CHS" to 22333**

Member Insights: Full Group Sharing (Poll Everywhere)

- Q1. Why is it important to identify and measure LVC in primary care? (Please share up to three reasons you think are worth noting).
- Q2. What are the pitfalls and unintended consequences that might lead some PCPs to resist engaging in identifying and measuring LVC? (Please share up to three pitfalls/consequences you think are work noting.)
- Q3. How might we use measure design to mitigate these pitfalls and unintended consequences? (Please share up to three ideas you think are worth considering).

THE CENTER FOR
PROFESSIONALISM & VALUE
IN HEALTH CARE

Pursuing Measures that Matter for Primary Care

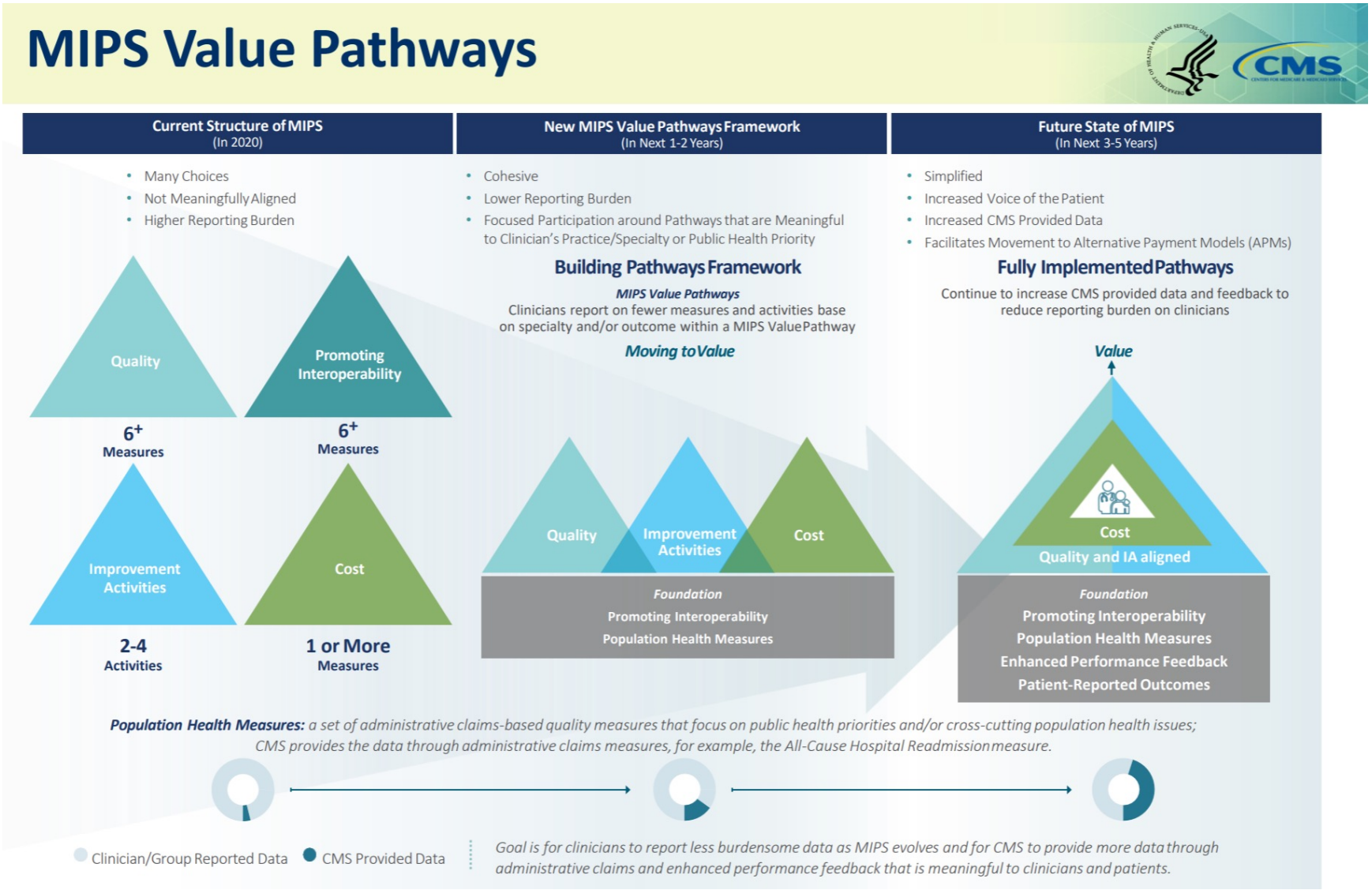
www.professionalismandvalue.org

Why should a certifying Board care about quality measures? ABMS BOD Policy 3.2.6

"It is strongly recommended that Member Boards implement an evidence-based process to identify and prioritize the key performance measure development opportunities that are most relevant to their diplomates for performance assessment…**Member Boards are encouraged to work with others to support the development of specialty-appropriate performance measures**."

Physician Fee Schedule Proposed Rule

– an opportunity for medical specialty measure development



New Measures of Primary Care

- Problem with current measures
  - Too many measures, too burdensome
  - Focused on disease care and don't recognize the higher level integrating, personalizing prioritizing functions
  - Not aligned with the foundations of primary care or the needs of patients, communities, systems

- Starting over
  - Measure is important for providing good care
  - Measure what Clinicians and Patients value
  - Make sure Low Value Care measures are meaningful for primary care

ABFM Quality Measure Development Measuring What Matters In Primary Care

Crowd-sourcing and a Starfield Summit (www.starfieldsummit.com) revealed:

- Clinicians and patients think that a lot of the same things are important
- Patients want more personalized attention
- Clinicians don't feel that what they do that is important is recognized or supported
- Employers/payers focus on cost & employee experience
- A large portion of what clinicians & patients think is important is missing from current measures
- All groups consider systemic support & integration important

New Measures of Primary Care

Person Centered Primary Care Performance Measure

Rebecca S. Etz, PhD, Stephen J. Zyzanski, PhD, Martha M. Gonzalez, Sarah R. Reves, MSN, FNP-C, Jonathan P. O'Neal, Kurt C. Stange, MD, PhD,A New Comprehensive Measure of High-Value Aspects of Primary Care, Ann Fam Med 2019;17:221-230. https://doi.org/10.1370/afm.2393.

Continuity of Care Performance Measure

Andrew Bazemore, MD, MPH, Stephen Petterson, PhD, Lars E. Peterson, MD, PhD, Richard Bruno, MD, MPH, Yoonkyung Chung, PhD, Robert L. Phillips Jr, MD, MSPH, Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations, Ann Fam Med 2018;16:492-497. https://doi.org/10.1370/afm.2308.

Low-Value Care Performance Measure

Tyler W. Barreto, Yoonkyung Chung, Peter Wingrove, Richard A. Young, Stephen Petterson, Andrew Bazemore and Winston Liaw, Primary Care Physician Characteristics Associated with Low Value Care Spending, JABFM March 2019, 32 (2) 218-225; DOI: https://doi.org/10.3122/jabfm.2019.02.180111

Comprehensiveness Performance Measure

Bazemore A, Petterson S, Peterson LE, Phillips RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. The Ann Fam Med. 2015; 13(3):206-213. http://www.annfammed.org/content/13/3/206.full

Where Low Value Care Measurement Fits

REACTIONS TO TODAY'S DISCUSSION

Wrap Up & Next Steps

Meeting 2 Preview

Meeting 2 – Exploring the Options – April 18, 2022, 1-5pm

- Review of criteria for Evaluating LVC Measures
- LVC Measures in Choosing Wisely, US Preventive Services Task Force Recommendations, US health plans, and other international efforts
- Small Group Breakouts & Full Group Sharing
- Initial Insights on Key Audiences for Disseminating LVC Measures