

# Hemophilia Management via Data Collection and Reporting: Initial Findings from the Comprehensive Care Sustainability Collaborative

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## ABSTRACT

**BACKGROUND:** Despite being a rare disorder, hemophilia represents a significant driver of health care resource utilization and requires expert hematologic and multidisciplinary services to achieve optimal outcomes. Since their inception nearly 40 years ago, hemophilia treatment centers (HTCs) have served as centers of excellence in providing the intensive care and ancillary services necessary for this unique patient base; however, the full capabilities of these centers may be underused in the current framework of managed care, largely because of a lack of communication and information shared between payers and HTC stakeholders.

**PROGRAM DESCRIPTION:** In an effort to enact tangible change toward improving the quality of care for bleeding disorders, the National Hemophilia Foundation developed an ongoing initiative among 18 leading clinicians and managed care decision makers called the Comprehensive Care Sustainability Collaborative (CCSC). The primary aim of the CCSC is to develop a framework for quality improvement pilot programs that can be replicated across the United States between payers and HTCs to facilitate cost-effective hemophilia management by integrating the HTC comprehensive care model.

**OBSERVATIONS:** After CCSC committee members shared perspectives on care delivery, quality, and value, actionable data points were reviewed at length in order to develop meaningful metrics to facilitate information sharing between HTC and payer stakeholders. The following pragmatic measures will be reported by HTCs and payers via a series of pilot programs (reporting group is indicated in brackets): (a) patient classification by diagnosis (type, severity, and inhibitor status) [HTC]; (b) total cost of clotting factor [payer]; (c) prescribed factor dose/dispensed dose/patient weight ( $\pm$  range) [payer and HTC]; (d) emergency department visits/hospitalizations [payer and HTC]; (e) home infusion of clotting factor (%) [HTC]; (f) total cost per patient [payer]; and (g) patient contacts (e.g., clinic visits, follow-ups, telemedicine, and e-mail) [HTC].

**IMPLICATIONS:** Routine information sharing between HTCs and payer stakeholders is paramount to improving the quality and reducing the cost of hemophilia care, and the CCSC initiative provides a unique forum for such dialogue. Over the course of several consensus meetings, the CCSC has rigorously developed a set of quality improvement and cost management metrics. These metrics will be used in a first-of-its-kind series of pilot projects that are anticipated to forge innovative collaboration between payers and HTCs so as to improve outcomes in the management of bleeding disorders.

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## What is already known about this subject

- Hemophilia is characterized by extremely high per patient health care resource utilization that is realized through specialty drug (i.e., clotting factor replacement therapy) costs and services (e.g., hospitalizations) related to the high morbidity associated with the disease.
- Hemophilia treatment centers (HTCs) represent excellence in the management of hemophilia, delivering multidisciplinary, comprehensive care that has demonstrated significant improvements in patient outcomes.
- Current trends in managed care indicate a robust trend towards improving the quality of care and thereby managing costs, with specific measures and performance-related metrics serving as the fulcrum.

## What this study adds

- The Comprehensive Care Sustainability Collaborative (CCSC) initiative provides a forum to address the reported gaps in communication between payers and HTCs, since ongoing discussions between these 2 groups are paramount to increasing quality of care.
- The CCSC has rigorously developed a set of quality improvement and cost management metrics for use in a first-of-its-kind series of pilot projects that are anticipated to forge innovative collaboration between payers and HTCs.

Hemophilia is a severe bleeding disorder resulting from the lack of vital clotting factor that has historically caused profound morbidity and mortality.<sup>1</sup> Because of the availability of specific clotting factors as pharmaceutical products, persons with hemophilia have an improved potential to live a normal lifespan. In addition, hemophilia commands a disproportionate share of health care dollars despite the remarkably low incidence and prevalence of the disease.<sup>1,2</sup> While it affects only approximately 20,000 Americans, hemophilia remains an important driver of resource utilization, primarily realized through specialty drug expenditures on clotting factor concentrate and related products that far exceed pharmacy spending in many other chronic disease states.<sup>2-5</sup> Medical service claims for patients with hemophilia A—a subtype of hemophilia that accounts for the majority of disease burden in terms of incidence and related costs—are approximately 20 times higher than those for the average commercial plan member.<sup>2</sup> Although drug claims (i.e., medication/clotting factor) account for the bulk of these costs,

hospitalizations and emergency department (ED) visits also contribute to costs, with improperly managed hemophilia being characterized by relatively high rates of morbidity and mortality. In addition, clinical complications may arise from a variety of issues, including, but not limited to, bleeding episodes, joint disease, and inhibitor development. As a result of these characteristics, a diagnosis of hemophilia necessitates a lifetime of intensive management and care strategies delivered by an expert multidisciplinary team to achieve optimal outcomes.<sup>1</sup>

Recognizing that individuals with bleeding and clotting disorders had difficulty obtaining quality care because of the rarity and complexity of their disease, the Health Resources and Services Administration (HRSA) established a nationwide hemophilia treatment center (HTC) network in the mid-1970s. HTCs were designated as the centers of excellence in the treatment of bleeding disorders, concentrating disease-specific expertise and simultaneously improving access to care and outcomes. Because of the specialized care and routine monitoring required by patients with bleeding disorders, HTCs receive financial support through limited federal funding and, in many cases, discounted drug pricing under the 340B designation.

Since their inception nearly 40 years ago, HTCs have served as federally recognized comprehensive treatment facilities for patients with bleeding and clotting disorders. In this role, HTCs provide family-centered, comprehensive care delivered by an integrated, on-site multidisciplinary team of experts that are dedicated to the management of hemophilia.<sup>6</sup> The effectiveness of the HTC model has been documented through studies conducted by the HRSA and the Centers for Disease Control and Prevention. In 1985, approximately 10 years after inception of the HTC network, an HRSA analysis showed that the number of patients with hemophilia regularly receiving comprehensive care increased by 326%, and the number of patients with the ability to self-treat or receive care at home increased by 390%.<sup>7</sup> A resultant effect on burden of disease outcomes was noted, with a 73% reduction in missed school/work days during the same period. Similarly, the Hemophilia Surveillance Study documented a 40% decrease in mortality among patients treated at HTCs.<sup>8</sup> Among the 2,950 patients followed over 3 years, care received within the HTC network was associated with a 40% lower relative risk of mortality and a 40% lower relative risk of hospitalization than care received in other settings.<sup>8,9</sup>

Such improvements in care quality and clinical outcomes have been primary aims of managed care organizations since their inception in the twentieth century. As with all chronic conditions, payers are motivated by the tenets of preventive medicine and coordinated care in the management of hemophilia. In this manner, quality of care is of utmost importance to managed care stakeholders in the prevention of worsening illness for the well-being of plan members and to manage costs while protecting their organizations against extraordinary

catastrophic claims. For hemophilia management, competitive drug acquisition pricing and the dispensing of clotting factor concentrate through contracts with specialty pharmacies have been used as means of cost containment. Until recently, limited discourse has taken place between payers and HTCs. Meanwhile, HTCs, which often depend on federally designated 340B pharmacy programs to support the provision of a wide breadth of ancillary services, rely on the support and patronage of health care payers and purchasers for ongoing sustainability.<sup>10</sup>

340B pharmacy programs represent an integrated pharmacy model featuring a patient-centered clotting factor management and distribution approach with rigorous oversight and unsurpassed connectivity between pharmacy professionals and prescribers.<sup>11</sup> Furthermore, the unit pricing on clotting factor replacement products afforded by 340B discounting is passed on to payers in many cases, allowing HTCs to compete with specialty pharmacies in terms of drug costs. For many HTCs, 340B pharmacy programs are the primary source of revenue supporting the cost of day-to-day operations.<sup>10</sup>

The aforementioned dynamics, coupled with the juxtaposition of payers and HTCs in the new value-driven, accountable health care environment, represent a prime opportunity for collaboration with the purpose of quality improvement. Payer and HTC stakeholders' goals are already aligned in terms of striving for care optimization and cost management, and HTCs currently collect the data necessary to support such a quality improvement initiative. However, until recently, no designated forum or formal framework for this type of undertaking existed.

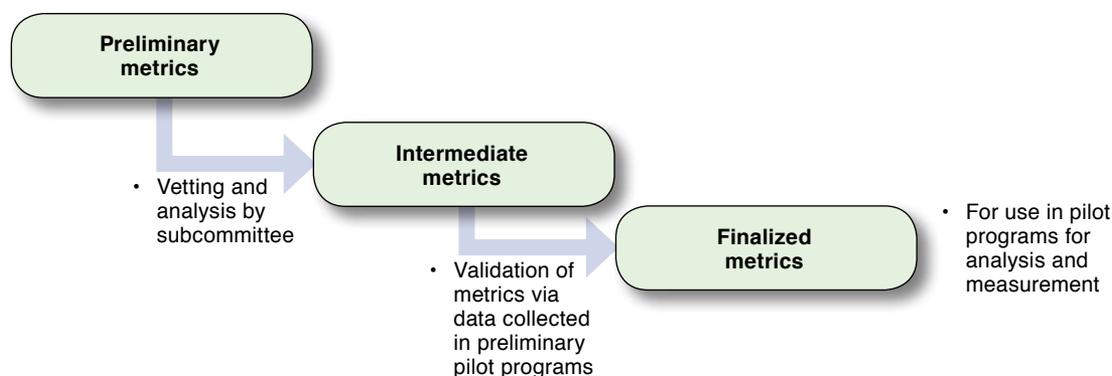
Considering the high drug acquisition costs associated with specialty products such as clotting factor concentrate and the significant morbidity and mortality related to inadequate treatment, optimal hemophilia management is in the best interest of all stakeholders. Because health care is provided and funded by a varied group of stakeholders with limited open discourse, the National Hemophilia Foundation (NHF) in conjunction with Impact Education, LLC, developed the Comprehensive Care Sustainability Collaborative (CCSC).

The primary goal of this innovative initiative was to develop a framework for future replicable pilot programs with collaboration between payers and HTCs to support the provision of HTC-delivered, high-quality care in order to reduce the overall direct medical expenditures associated with hemophilia.

### **Program Description**

Clinical and administrative HTC leadership, as well as representatives from NHF, the Hemophilia Alliance, the American Thrombosis and Hemostasis Network (ATHN), and payers/managed care organizations, were recruited to participate in the CCSC (10 HTC representatives and 8 payer representatives; see Appendix A, available in online article). Through a series of consensus meetings, a multistep process was undertaken to develop quality metrics for use in CCSC pilot programs. HTC and payer

FIGURE 1 CCSC Metric Development Process



CCSC = Comprehensive Care Sustainability Collaborative.

representatives began by presenting relevant perspectives and data describing the clinical and economic burden of bleeding disorders, current barriers to optimal care, and the value of the comprehensive care and integrated pharmacy models currently employed by HTC. To facilitate information sharing between HTCs and payers, proposed quality metrics underwent 3 separate rounds of revisions. Specifically, metrics were formulated to lend support to the concept that effective hemophilia disease management through HTCs improves outcomes and reduces unnecessary health care costs and utilization (e.g., ED visits and hospitalizations).

In the inaugural consensus meeting, CCSC members developed 2 preliminary sets of metrics—one reported by HTCs and another reported by payers—to enhance information sharing between the 2 parties and provide a foundation for future pilot programs. Working directly with a subcommittee of CCSC attendees, Impact Education, LLC, evaluated the proposed metrics to determine if modifications were necessary. In vetting these metrics for HTCs and payers, a cross-sectional survey of stakeholders from each party (7 HTCs, 5 payers) was conducted using a Likert-type scale. Respondents were asked to rate each measure as being “vital,” “ideal,” or “unnecessary” (see Appendix B, available in online article). In addition, subcommittee respondents were queried as to whether they would modify an individual metric or approve it without further changes. If a member of the subcommittee deemed a modification necessary, it was requested that he or she specify the changes required to make the metric logically sound for capturing the desired data.

Based on this analysis and subsequent follow-up with NHF leadership and subcommittee members, 2 sets of revised intermediate metrics were developed for use in preliminary pilot programs in each group. These intermediate metrics were tested by CCSC members in external preliminary pilot

programs conducted at HTCs and managed care organizations to further delve into their validity and viability before the formulation of finalized metrics to be used in larger-scale pilot programs going forward (Figure 1).

### Observations

Among the key findings of the CCSC inaugural consensus meeting was that the range of care and services delivered through HTCs are far more comprehensive and intricately inclusive than previously assumed. The HTC multidisciplinary approach to comprehensive care for hemophilia entails continuous supervision of all medical and psychological aspects of the condition affecting the patient and family. Furthermore, care is facilitated by the HTC team’s “24-7” availability via clinic visits, telephone support, and consultation with ED staff. Psychosocial and educational support offered by the HTC staff takes a wide range of issues into consideration, such as academic and vocational guidance and insurance-related concerns.

From the perspective of managed care, the most prominent revelation was that payers require *standardized* metrics to determine value. The ability of the HTCs to provide data pertaining to these metrics lends value to HTC communications with payers and managed care organizations. Furthermore, to improve the ability of the HTCs to contract with and be included in provider networks, payers need information to demonstrate HTC capabilities in decreasing the plans’ cost of care for hemophilia. Specialty drug expenditures remain the predominant component of these expenditures—up to 90% of hemophilia costs are driven by factor concentrate—and HTCs were demonstrated as offering competitive pricing via their 340B specialty pharmacy programs (when applicable).<sup>12,13</sup>

Hemophilia-related data metrics and pilot program parameters were developed to support clinical decision making. Metrics were sought to be specific, reportable, relevant,

and timely, while also being achievable, actionable, adaptable, and audience specific. HTC stakeholders noted that many of the center-reported data elements can be captured via the ATHN Clinical Manager—a web-based database application currently being used to collect patient data in a standardized format at approximately 130 federally funded HTCs and governed through a data use and business agreement between the HTC and/or its parent institution and ATHN. Payer members noted the potential pitfalls of a pilot program from the perspective of pooling and sharing data in light of the Health Insurance Portability and Accountability Act and how such considerations would be received by their institutional review boards. Overall, the general consensus of the CCSC was that the pooling and sharing of data is a surmountable obstacle, provided that the intent and expectations are clearly defined at the outset. Furthermore, the payer members were essentially unanimous in stating that seeking a demonstrable reduction of factor use and/or cost as a whole will likely be adequate to foster willingness on the part of plans to share data.

Five HTC members and 2 payer members conducted preliminary pilots within their organizations to further evaluate the viability of the proposed intermediate metrics, which were largely similar to the preliminary set of metrics. The intermediate metrics evaluated by HTC members included the following:

- Patient classification (type, severity, and inhibitor status)
- Number of joint bleeding events per month (as a surrogate for joint-related surgeries and/or other claims associated with hemophilia)
- Prescribed factor dose as IU/kg/dose
- Number of prescription units ordered versus units dispensed
- Number of prescription units dispensed (if HTC supplies the factor concentrate)
- Mean percentage from the prescribed dose
- Bleed-related days of school/work missed (for consideration in future expansion of the CCSC to patient-reported outcomes [PROs])
- Number of all types of HTC encounters per patient (e.g., clinic visits, telephone contacts or telemedicine, emails, and text messages)

In addition, the following intermediate metrics were evaluated by payer members:

- Units used and cost for each unique factor (as a means of accounting for the number of inhibitor patients)
- Number of prescription units dispensed (if payer requires use of non-HTC-based specialty pharmacy for provision of factor concentrate)
- Cost of factor use per month per unique patient
- Number of hospitalizations with a primary or secondary diagnosis of bleeding and associated cost of hospitalization
- Number of ED visits with a primary or secondary diagnosis of bleeding and associated cost of ED visits

- Total paid cost per patient with a hemophilia/bleeding disorder diagnosis.

In this proof-of-concept stage, the HTCs and payer members reported on the data collected according to the intermediate metrics and shared their experiences and insights to the CCSC at the third on-site meeting to further refine the metrics. In terms of the merits of the individual intermediate metrics, after application in a real-practice setting, the utility and practicality of various measures were either affirmed or called into question. Other than the standard measure capturing patient classification according to disease-specific characteristics, the advisors maintained prescribed dose versus dispensed dose (i.e., assay variance) among the most basic and crucial metrics (and one that is already monitored by many HTCs and payers). The need for additional information captured via a new metric—percentage of patients performing home-based self-infusion—was also identified and unanimously deemed practical for capture by HTC stakeholders. This measure presumably speaks directly to health care spending, since the home was unanimously identified by the advisors as the least costly site of care for infusion.

In terms of measures singled out for exclusion, the metric tracking bleed-related days of school/work missed was deemed useful but relatively impractical at this point, since many centers do not track such PROs. Likewise, HTC advisors found the metric for tracking joint bleeding events particularly troubling for a number of reasons. Specifically, in some centers serving remote populations, up to 95% of patients log their bleed information and often do so incorrectly; thus, self-reported data are not always reliable to differentiate between types of bleeds or other sources of pain (e.g., arthritis flare). HTC members also noted that type/site of bleed may be difficult to track for centers working through an outside specialty pharmacy and requires further interactions and contacts with their specific vendors. As a result, the joint bleed metric was eliminated, while the metric for ED visits and hospitalizations was maintained as a more pragmatic measure for tracking serious bleeding events and bleed-related complications. Conversely, data capture proved to be relatively simple on the part of payers, who were identified as being in an optimal position to capture cost components. The intermediate metrics were also individually refined according to the findings of the preliminary pilot programs. Units of measure was identified as a potential issue, as not all clotting factor prescriptions are listed as U/kg/dose; instead, the prescriptions may be listed as number of vials per assay in some centers. Based on these and other considerations, the 2 sets of intermediate metrics were consolidated into a single set of finalized metrics divisible according to reporting group, with some metrics intended for reporting by both HTCs and payers (Table 1).

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**TABLE 1** Final HTC- and Payer-Reported Metrics for Use in Pilot Programs

Payer-Reported Metrics	HTC-Reported Metrics
<b>Cost of factor</b> <ul style="list-style-type: none"> <li>• Total factor cost</li> <li>• Total factor cost per patient</li> <li>• Site of care                             <ul style="list-style-type: none"> <li>◦ Facility (hospital/ED)</li> <li>◦ Ambulatory (infusion center, physician's office, HTC)</li> <li>◦ Home/self</li> </ul> </li> </ul>	<b>Patient classification</b> <ul style="list-style-type: none"> <li>• Diagnosis (A or B)                             <ul style="list-style-type: none"> <li>◦ Severity (mild, moderate, or severe)</li> <li>◦ Inhibitor status (yes or no)</li> </ul> </li> </ul>
<b>Prescribed dose/dispensed dose/weight (± range) when dispensed via a specialty pharmacy</b> <ul style="list-style-type: none"> <li>• Product</li> <li>• Total units</li> <li>• U/kg</li> <li>• Units dispensed</li> <li>• Prescribed dose/dispensed dose                             <ul style="list-style-type: none"> <li>◦ ± 10% according to MASAC guidelines; payers desire ± 5%</li> </ul> </li> </ul>	<b>Prescribed dose/dispensed dose/weight (± range) when dispensed at an integrated HTC pharmacy</b> <ul style="list-style-type: none"> <li>• Product</li> <li>• Total units</li> <li>• U/kg</li> <li>• Units dispensed</li> <li>• Prescribed dose/dispensed dose                             <ul style="list-style-type: none"> <li>◦ ± 10% according to MASAC guidelines; payers desire ± 5%</li> </ul> </li> </ul>
<b>ED visits/hospitalizations</b> <ul style="list-style-type: none"> <li>• With hemophilia listed as the first or second diagnosis code (i.e., in the first 2 lines of the claim)</li> </ul>	<b>ED visits/hospitalizations</b> <ul style="list-style-type: none"> <li>• With hemophilia listed as the first or second diagnosis code (i.e., in the first 2 lines of the claim)</li> </ul>
<b>Total cost per patient</b> <ul style="list-style-type: none"> <li>• Total cost of pharmacy claims</li> <li>• All other medical claims costs</li> <li>• Total cost per patient</li> </ul>	<b>Home infusion (%)</b> <ul style="list-style-type: none"> <li>• Percentage of patients/families independently infusing at home</li> <li>• Percentage of patients/families infusing at home with nursing assistance</li> </ul>
	<b>Patient contacts (e.g., in person, telephone, e-mail)</b> <ul style="list-style-type: none"> <li>• Comprehensive care visits</li> <li>• Other visits</li> <li>• Case management contacts</li> <li>• Collaboration with other providers</li> </ul>

ED=emergency department; HTC=hemophilia treatment center; MASAC=Medical and Scientific Advisory Council.

Taking the finalized metrics a step further, the overall design of the upcoming pilot programs was discussed as the next step as the CCSC initiative moves forward. Initial steps for launching these pilot programs will include presentation of a protocol and budget to the institutional review board or the office of projects and grants for the individual payers. The panel members agreed that the pilot programs should be adaptable and tailored to the needs of the individual payers and that data elements and the frequency of collection/reporting are key components that need to be established from the outset. The use of an outcomes group or data clearinghouse in the pilot process was noted as being a factor likely to enhance timely uptake of the initiative; accordingly, NHF has taken steps toward securing such an agency for the impending pilot programs.

### Implications

Hemophilia is characterized by extremely high per patient health care resource utilization, realized through specialty drug (i.e., clotting factor replacement therapy) costs and services (e.g., hospitalizations) related to the high morbidity associated with the disease. As a means of mitigating the morbidity, mortality, and costs associated with bleeding disorders, HTCs represent centers of excellence, which have delivered multidisciplinary and comprehensive care, and have demonstrated significant improvements in patient outcomes. At the same time,

current trends in managed care indicate a robust trend towards improving the quality of care and thereby managing costs, with specific measures and performance-related metrics serving as the fulcrum. However, gaps in communication between payers and HTCs are cited by both groups of stakeholders, making ongoing discussions between the 2 groups paramount to increasing the quality of care—the CCSC initiative provides a forum for such dialogue. Thus far, the CCSC has rigorously developed a set of quality improvement and cost management metrics for use in a first-of-its-kind series of pilot projects that are anticipated to forge innovative collaboration between payers and HTCs.

Comprehensive, patient-centered care provided through an HTC is essential to improving outcomes for patients with hemophilia and other bleeding disorders. In addition, the cost of services delivered within the HTC and, more specifically, the cost of clotting factor replacement therapy provided through the HTC integrated pharmacy model are at least competitive and often lower than those offered through payers' contracted specialty pharmacies. Using the metrics developed by the CCSC as a starting point, HTCs and payers should have adequate means to bridge the communication gaps cited previously. HTCs currently report the majority of data elements necessary for a value proposition to payers, but the forthcoming series of CCSC-sponsored pilot programs will optimize

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payer-HTC collaboration. Further steps towards creating a sustainable business model that is fair and favorable to all parties involved will require additional consideration and planning as a potential focal point of future CCSC analyses.

### Authors

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### DISCLOSURES

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Both authors contributed equally to the concept and design of this article and to analysis and manuscript preparation.

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**APPENDIX A** CCSC Advisory Board

Board Member	Affiliation
<b>HTC Representatives</b>	
Miguel A. Escobar, MD	University of Texas Health Gulf States Hemophilia and Thrombophilia Center
Barbara A. Konkle, MD	Bloodworks Northwest and the University of Washington
Kollet Koulianos, MBA	National Hemophilia Foundation, formerly with Bleeding & Clotting Disorders Institute
Jennifer Maahs, RN, PNP, MSN	Indiana Hemophilia & Thrombosis Center
Michelle Rice	National Hemophilia Foundation
David Rushlow, LMSW	Northern Regional Bleeding Disorder Center, Munson Medical Center
Amy Shapiro, MD	Indiana Hemophilia & Thrombosis Center
Michael Tarantino, MD	Bleeding & Clotting Disorders Institute
Marisela Trujillo, MSW	University of Texas Health Gulf States Hemophilia and Thrombophilia Center
Michelle Witkop, DNP, FNP-BC	Northern Regional Bleeding Disorders Center, Munson Medical Center
<b>Payer Representatives</b>	
James Jorgenson, RPh, MS, FASHP	Visante
Richard A. Justman, MD	UnitedHealthcare
Ira Klein, MD, MBA, FACP	Aetna
Doug Lohkamp, RPh HCSC	Enterprise Pharmacy
Maria Lopes, MD, MS	Magellan Health
Neil Minkoff, MD	FountainHead HealthCare
Edmund Pezalla, MD, MPH	Aetna
Vanita K. Pindolia, PharmD, BCPS	Henry Ford Health System and Health Alliance Plan

CCSC = Comprehensive Care Sustainability Collaborative; HTC = hemophilia treatment center.

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**APPENDIX B Preliminary Metric Evaluation Survey**

Listed below are existing key markers or measures that can currently be captured by both groups of stakeholders: HTCs and payers. All data should be collected as a 12-month retrospective analysis.

These proposed measures are based on your combined input from the two CCSC consensus meetings held in Indianapolis and Boston.

In order to move forward with CCSC pilots, we need to achieve consensus on the final measures. **Please complete all sections in the survey below.**

We greatly value your support and assistance with this important initiative!

HTCs	Payers
<p><b>Number of bleeding events per month as a surrogate for joint-related surgeries and/or other claims</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>	<p><b>Count and cost for each unique factor (to help account for the number of inhibitor patients)</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>
<p><b>Prescribed factor dose as U/kg/mo</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>	<p><b>Cost of factor use/month per unique patient</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>
<p><b>Percentage of scripts written within the target range (<math>\pm 5\%</math>-10%)</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>	<p><b>Number of hospitalizations with a primary diagnosis of bleeding and associated cost of hospitalization</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>
<p><b>Number of Rx units ordered vs. units dispensed (i.e., as closely to the prescribed dose)</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>	<p><b>Number of ER visits with a primary diagnosis of bleeding and associated cost of ER visits</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>
<p><b>Days of school/work missed that are bleed-related (as a secondary phase of PROs)</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>	<p><b>Total paid costs per hemophilia patient</b></p> <p>Measurement Rating</p> <p><input type="checkbox"/> Vital <input type="checkbox"/> Ideal <input type="checkbox"/> Unnecessary</p> <hr/> <p>Measurement Description</p> <p><input type="checkbox"/> Approved as is <input type="checkbox"/> Revise as follows:</p>
<p><b>Additional and/or alternative HTC measurements that should be considered</b></p> <p><input type="checkbox"/> No, these are sufficient <input type="checkbox"/> Yes, add the following:</p>	<p><b>Additional and/or alternative payer measurements that should be considered</b></p> <p><input type="checkbox"/> No, these are sufficient <input type="checkbox"/> Yes, add the following:</p>