



# NQF

## NATIONAL QUALITY FORUM

### Establishing a Measurement Framework for Multiple Chronic Conditions

### Steering Committee In-person Meeting

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*Washington Marriott at Metro Center  
775 12th Street, NW  
Washington, DC*

*Friday, July 8, 2011  
8:30 am - 4:30 pm (Eastern)*

# THE NATIONAL QUALITY FORUM

## MULTIPLE CHRONIC CONDITIONS STEERING COMMITTEE IN-PERSON MEETING

Washington Marriott at Metro Center  
775 12th Street, NW  
Washington, DC

Friday, July 8, 2011  
8:00 am – 4:30 pm (Eastern)

### AGENDA

#### Meeting objectives:

- Reach consensus on a definition of multiple chronic conditions
- Refine the key issues to be addressed in the MCC framework
- Develop an initial MCC conceptual model
- Define the domains in the MCC framework

- |                |  |
|----------------|--|
| <b>8:00 am</b> | <b>Breakfast</b>   |
| <b>8:30 am</b> | <b>Welcome, Introductions, and Overview of Meeting Objectives</b><br><i>Barbara McCann &amp; Caroline Blaum, Steering Committee Co-Chairs</i> <ul style="list-style-type: none"><li>✧ <i>Disclosure of Interests – Ann Hammersmith, NQF General Counsel</i></li></ul>  |
| <b>8:45 am</b> | <b>Developing a Multiple Chronic Conditions Measurement Framework</b><br><i>Caroline Blaum</i> <ul style="list-style-type: none"><li>✧ <i>Overview of Steering Committee's charge and scope of work</i></li><li>✧ <i>Intended uses of the MCC framework</i></li><li>✧ <i>Timeline and deliverables schedule</i></li><li>✧ <i>Discussion and Questions</i></li></ul>  |
| <b>9:00 am</b> | <b>Discussion of Homework Exercise and Emerging Key Themes</b><br><i>Caroline Blaum</i><br><i>Aisha Pittman, NQF</i> <ul style="list-style-type: none"><li>✧ <i>Results of homework exercise</i></li><li>✧ <i>Prioritize key issues</i></li><li>✧ <i>Discussion and Questions</i></li></ul>  |
| <b>9:30 am</b> | <b>Defining Multiple Chronic Conditions</b><br><i>Barbara McCann</i><br><i>Cynthia Boyd, Johns Hopkins University (JHU)</i> <ul style="list-style-type: none"><li>✧ <i>Defining "Multiple Chronic Conditions" for the purpose of developing a measurement framework for MCC</i></li><li>✧ <i>Considerations of MCC sub-populations</i></li><li>✧ <i>Reach consensus on the definition of Multiple Chronic Conditions</i></li><li>✧ <i>Discussion and Questions</i></li><li>✧ <i>Opportunity for Public Comment</i></li></ul> |

# THE NATIONAL QUALITY FORUM

11:00 am	<b>Break</b>
11:10 am	<b>Developing a Conceptual Model for Measurement of Performance in People with MCCs</b> <i>Caroline Blaum</i> <i>Karen Adams, NQF</i> <i>Erin Giovannetti and Bruce Leff, JHU</i> <ul style="list-style-type: none"><li>✧ <i>Evolution of the NQF-endorsed Patient-focused Episode of Care Framework</i></li><li>✧ <i>Conceptual Model for Measurement of Performance in People with MCCs</i></li><li>✧ <i>Discussion and Questions</i></li><li>✧ <i>Opportunity for Public Comment</i></li></ul>
12:30 pm	<b>Working Lunch</b>
1:00 pm	<b>Discussion of Framework Domains</b> <i>Barbara McCann</i> <ul style="list-style-type: none"><li>✧ <i>Identification of essential components and subcomponents for measuring efficiency for people with MCCs</i></li><li>✧ <i>Discussion and Questions</i></li><li>✧ <i>Opportunity for Public Comment</i></li></ul>
2:00 pm	<b>Measurement Approaches for MCCs</b> <i>Caroline Blaum</i> <ul style="list-style-type: none"><li>✧ <i>Measures across providers and sites of care</i></li><li>✧ <i>Cross-cutting measures and non-disease specific approaches to quality</i></li><li>✧ <i>Discussion and Questions</i></li></ul>
3:00 pm	<b>Break</b>
3:15 pm	<b>Methodological and Data Source Considerations</b> <i>Barbara McCann</i> <ul style="list-style-type: none"><li>✧ <i>Identification of methodological and data collection issues moving forward</i></li><li>✧ <i>Discussion and Questions</i></li><li>✧ <i>Opportunity for Public Comment</i></li></ul>
4:00 pm	<b>Next Steps</b> <i>Aisha Pitman</i> <ul style="list-style-type: none"><li>✧ <i>Upcoming web meeting on July 29<sup>th</sup></i></li></ul>
4:15 pm	<b>Adjourn</b>

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**TAB 1**

*PowerPoint Presentation*

# ESTABLISHING A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS

## STEERING COMMITTEE IN-PERSON MEETING

*FRIDAY, JULY 8, 2011  
8:30 AM – 4:30 PM (ET)*

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### Meeting Objectives

- Reach consensus on a definition of multiple chronic conditions
- Refine the key issues to be addressed in the development of the MCC framework
- Develop an initial MCC conceptual model
- Define the domains in the MCC framework

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## MCC Steering Committee



<b>Caroline S. Blaum, Co-Chair</b>	<b>Barbara McCann, Co-Chair</b>
Mary Barton, AHRQ	Cynthia Boyd, Johns Hopkins University School of Medicine
Margaret L. "Meg" Campbell, Detroit Receiving Hospital	Amina Chaudhry, Substance Abuse and Mental Health Services Administration
Leona Cuttler, Rainbow Babies and Children's Hospital	Michael Farber, Department of Vermont Health Access
Christina Farup, Debuy, Inc. /Johnson & Johnson	Daniel Forman, Brigham and Women's Hospital
Andrew Guccione, George Mason University	Seena Haines, Palm Beach Atlantic University
Emma Hoo, Pacific Business Group on Health	Gail Hunt, National Alliance for Caregiving
Thomas E. Kottke, HealthPartners	Joseph Laver, St. Jude Children's Research Hospital
Kyu Rhee, IBM Corporation	Robert J. Rosati, Visiting Nurse Service of New York
Dennis Saver, Primary Care of the Treasure Coast	Jeffrey Thompson, DSHS Washington State Medicaid
Barbara Turner, University of Pennsylvania School of Medicine	
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## Developing a Multiple Chronic Conditions Measurement Framework

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## Purpose

This project seeks to achieve consensus through NQF's Consensus Development Process (CDP) on a measurement framework for assessing the efficiency of care—defined as quality and costs—provided to individuals with multiple chronic conditions (MCCs).

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## Scope

- Establish definitions, domains and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCCs;
- Adapt the NQF-endorsed Patient-focused Episodes of Care Measurement Framework for patients with MCCs;
- Build upon the National Quality Strategy, HHS's Multiple Chronic Conditions Framework and the work of other private sector initiatives; and
- Support the development and application of measures.

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# Timelines and Deliverables

Proposed Activity/Deliverable	Timeline
Committee In-person Meeting #1	July 8, 2011
Draft Commission Paper	July 22, 2011
Committee Web Meeting #2	July 29, 2011
Committee In-person Meeting #2	August 8, 2011
Final Commission Paper	September 30, 2011
Committee Web Meeting #3	December 2, 2011
Draft Framework Report	December 5, 2011
Public Comment	Late December 2011 – January 2012
Final Framework Report	Early February 2012
Member Voting	March 2012
CSAC Consideration and Board Endorsement	April 2012

## Establishing a Measurement Framework for Multiple Chronic Conditions

**Department of Health and Human Services (HHS) Frameworks**

- National Quality Strategy
- Partnership for Patients
- National Prevention Strategy
- HHS Multiple Chronic Conditions Framework

Inputs

**Public-Private Sector Frameworks/Models**

- National Priorities Partnership
- NQF Endorsed Patient Focused Episode of Care Framework
- NQF measure endorsement ongoing projects
- Coordinated Care Models for Targeted Populations

Inputs

**NQF Endorsed Multiple Chronic Conditions Framework**

- Definitions
- Domains
- Key methodological issues
- Guiding principles
- Path forward including key policy considerations

Uses

### Intended Uses of the NQF Endorsed Multiple Chronic Conditions Framework

Input to HHS

Identify measure gaps

Guide endorsement decisions

Guide selection of measures for public reporting and payment

Roadmap for new delivery models (ACOs, PCMH)

Inform research

## Intended Uses of the MCC Framework

- Provide input to HHS
- Inform measure development and identify endorsement gaps
- Guide selection of measures for public reporting and payment
- Roadmap for new delivery models (ACOs, PCMH)
- Inform research

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## HHS' Multiple Chronic Conditions Framework

1. Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions
2. Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions
3. Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions
4. Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions

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Strategy 3.A.2. Identify, develop, endorse and use key quality metrics, in the form of performance measures, to promote best practices in the general care of individuals with MCC

Strategy 1.A.1 Define and identify populations with MCC broadly, and MCC subgroups with specific clusters of conditions, and explore focusing care models on the subgroups at high risk of poor health outcomes

Strategy 1.D.1 Encourage the meaningful use of electronic health records, personal health records, patient portals, and clinical registries to improve care for individuals with MCC

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Any questions regarding our  
scope and purpose?

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## Discussion of Homework Exercise and Emerging Key Themes

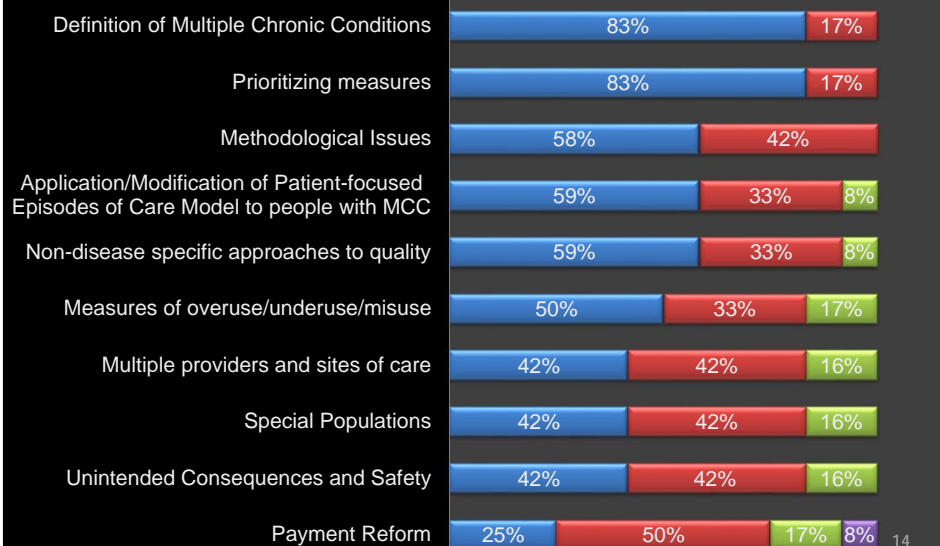
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### Key Issues to Consider

n=12; response rate=57%

■ Strongly Agree ■ Agree ■ Disagree ■ Strongly Disagree



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## Emerging Themes from the Assignment

- Scope (At what level of detail do we work and at what level should we stop?)
- Provider burden (How can we reduce provider burden and refrain from introducing new burden?)
- MCC framework needs to consider the whole lifespan
- Crosscutting measures versus disease specific
- Payment Reform is too far to consider within this framework

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## Defining Multiple Chronic Conditions

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## Framework Components

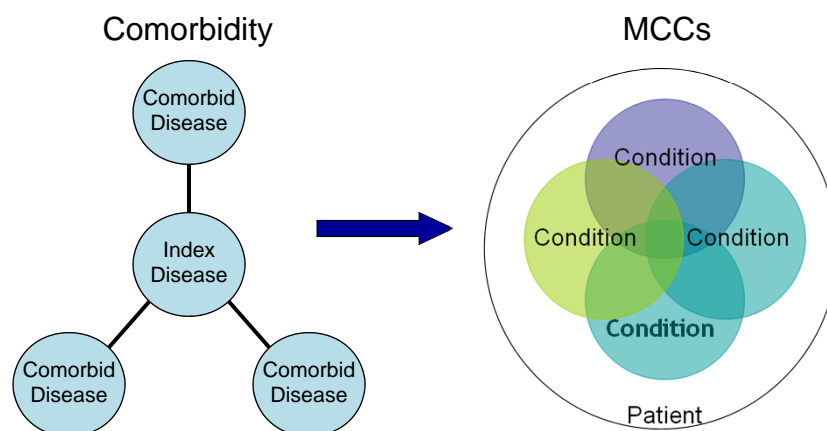
### ➤ Definitions (Q1, 8)

- Domains
- Key methodological issues
- Guiding principles
- Path forward including key policy considerations

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## Ways to think about people with MCCs



*Boyd, CM and Fortin M, Public Health Reviews, In Press 2011.*

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## MCC Definition Considerations

### Definitions of Multiple Chronic Conditions:

- HHS MCC Framework: 2 or more concurrent chronic conditions
- AHRQ “complex” patients definition: 2 or more chronic conditions where each condition may influence the care of other conditions through limitations of life expectancy, interactions between therapies, difficulties in establishing adequate care coordination, or direct contraindications

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## MCC Definition Considerations

- Burden of disease (e.g. severity of disease)
- Commonly co-occurring conditions (e.g. mental health)
- Considerations of dominant conditions (e.g. cancer)
- Non-disease specific factors (e.g. frailty, obesity, and disabilities)
- Consideration of disparities (e.g. age, race/ethnicity)

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- Children with medical complexity
  - Substantial service needs
  - Chronic and severe conditions
  - Functional limitations
  - High health care use
- Does the definition of children with MCCs differ from adults?

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- End of life
- Institutionalized
- Disabled Adults
- Older Adults

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## Steering Committee to Refine Definition of MCC

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## Straw-man MCC Definition

- 2 or more concurrent chronic conditions
- Each condition may influence the care of other conditions
  - Limitations of life expectancy
  - Interactions between therapies
  - Difficulties in establishing adequate care coordination
  - Direct contraindications

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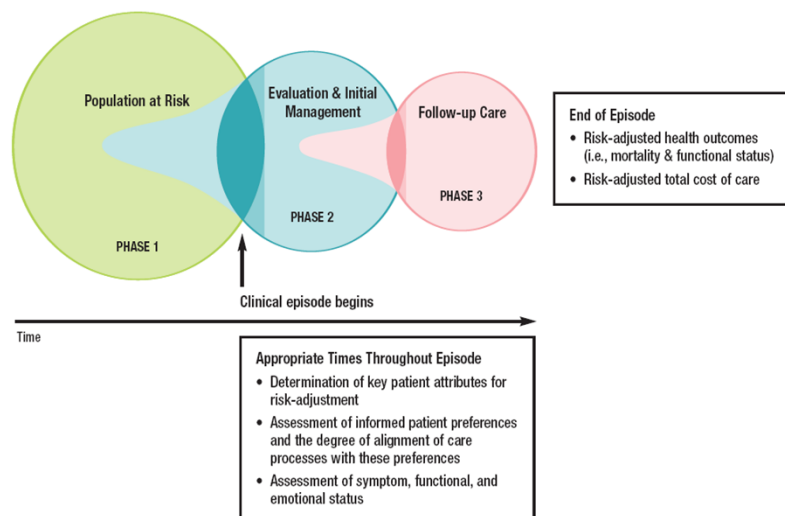
# Developing a Conceptual Model for MCC

(Q2.3)

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## Generic Episode of Care



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## Episode Approach: Strengths

- Patient-focused orientation
  - Follows the natural trajectory of care over time
- Directed at value
  - Quality, costs, and patient preferences
- Emphasizes care coordination
  - Care transitions and hand-offs
- Promotes shared accountability
  - Individual, team, system
- Addresses shared decision making
  - Attention to patient preferences
- Needed to support fundamental payment reform

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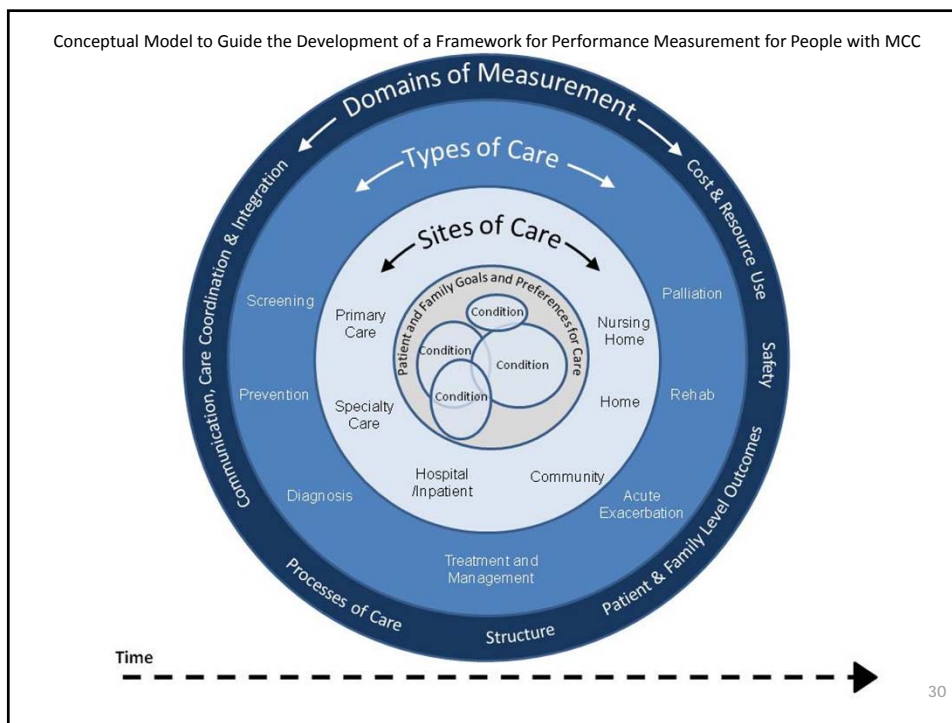
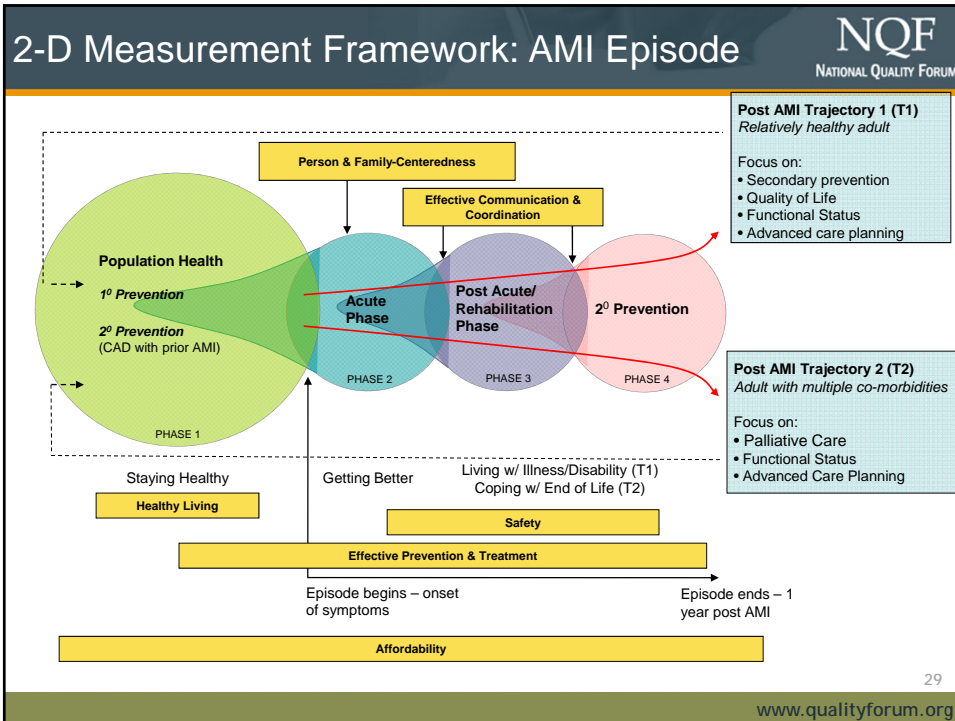
## Episode Approach: Limitations

Inability, at least currently, to:

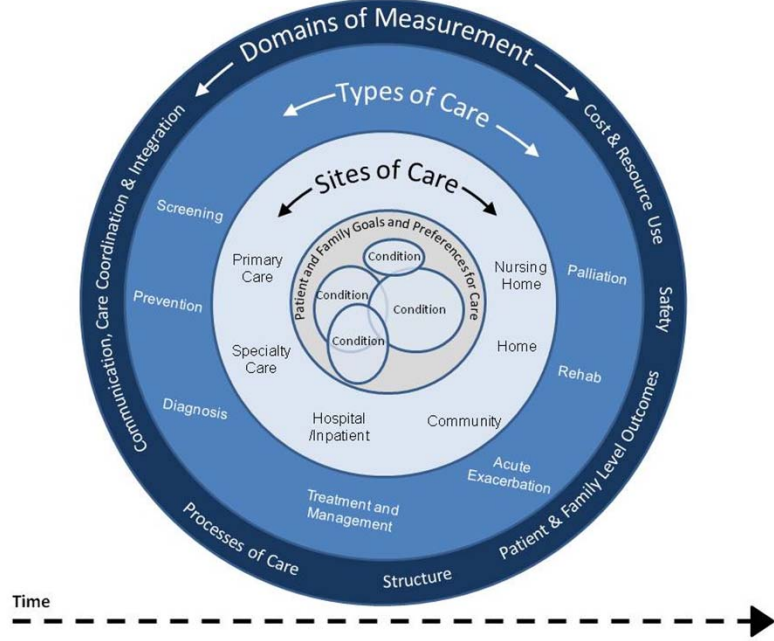
- Address appropriateness of care
- Adequately risk adjust for different populations
- Sort out patients with multiple chronic conditions
- Facilitate comparisons among organizations

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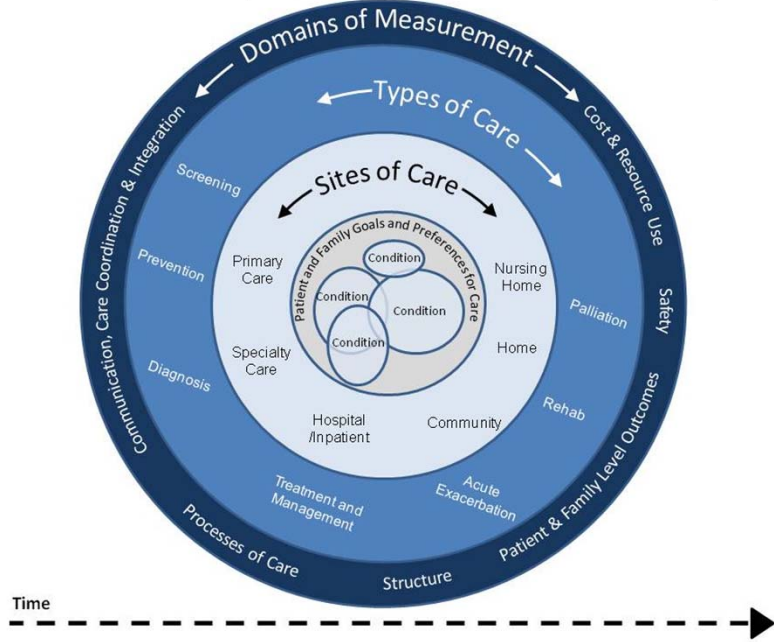


Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



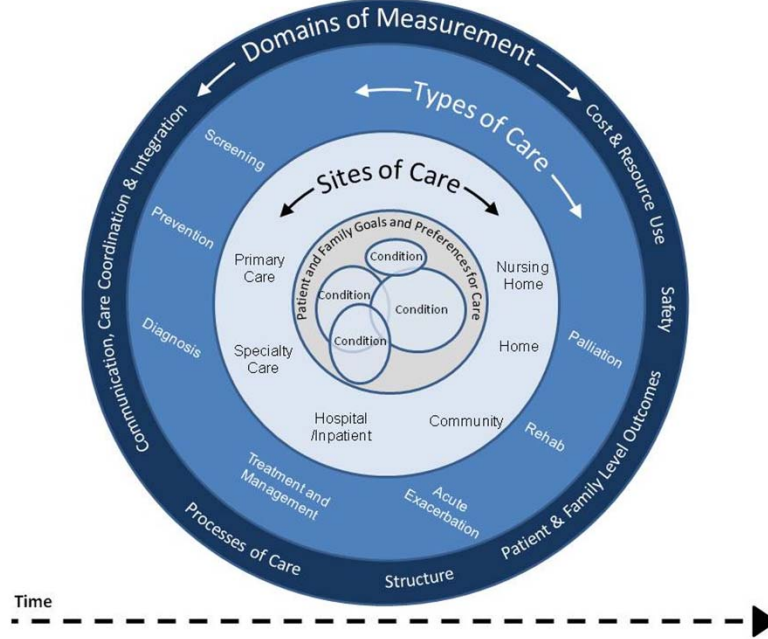
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



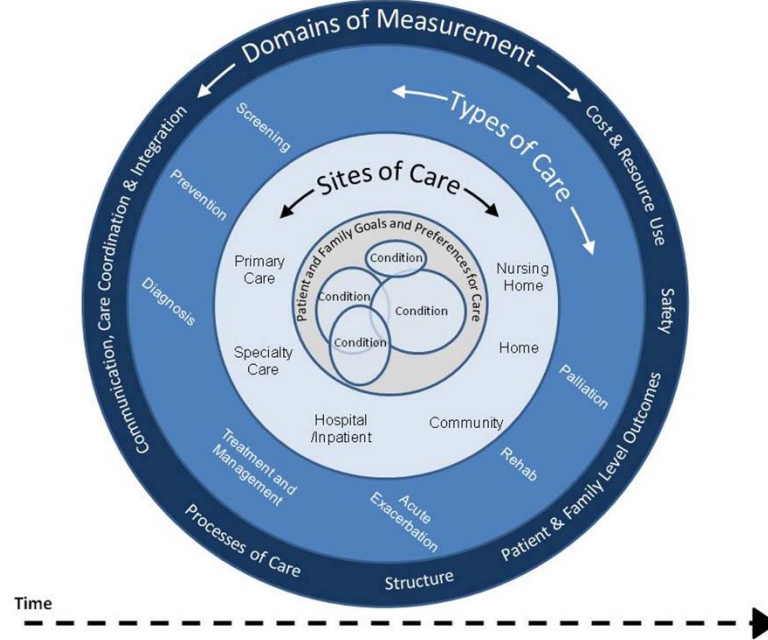
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



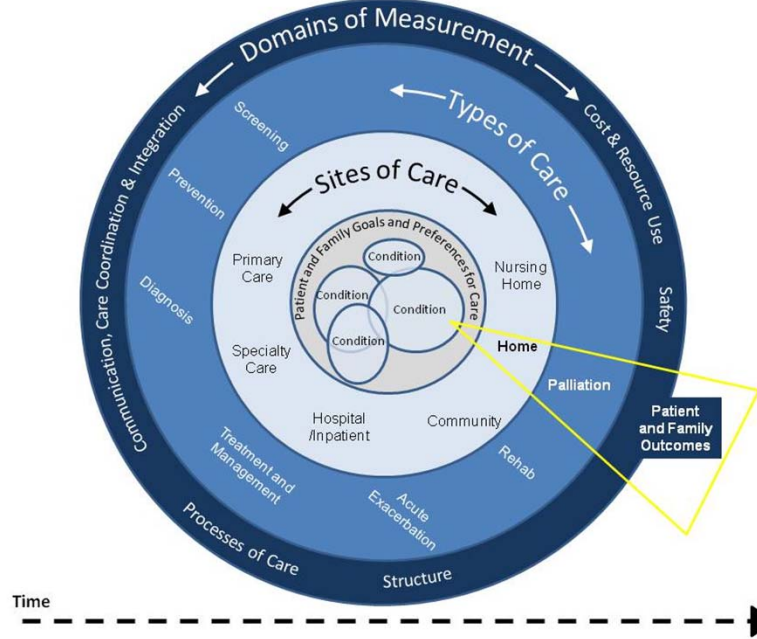
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



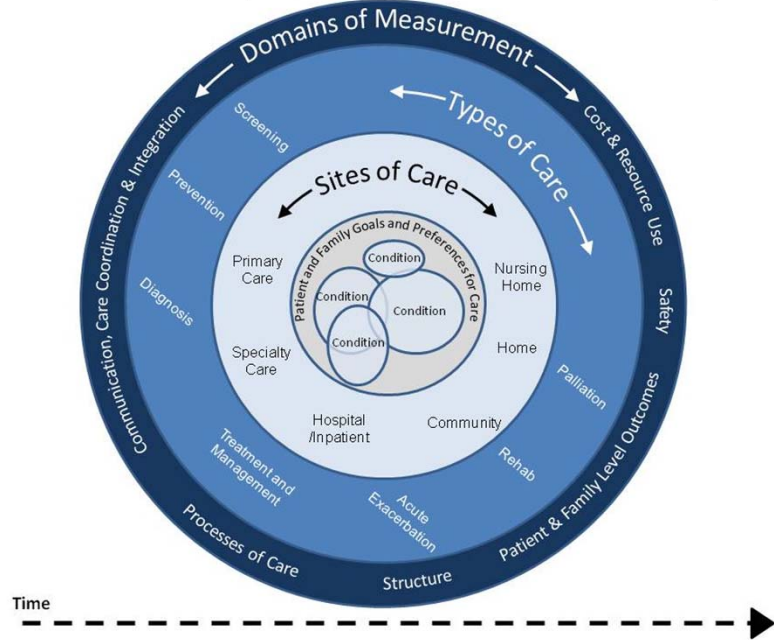
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



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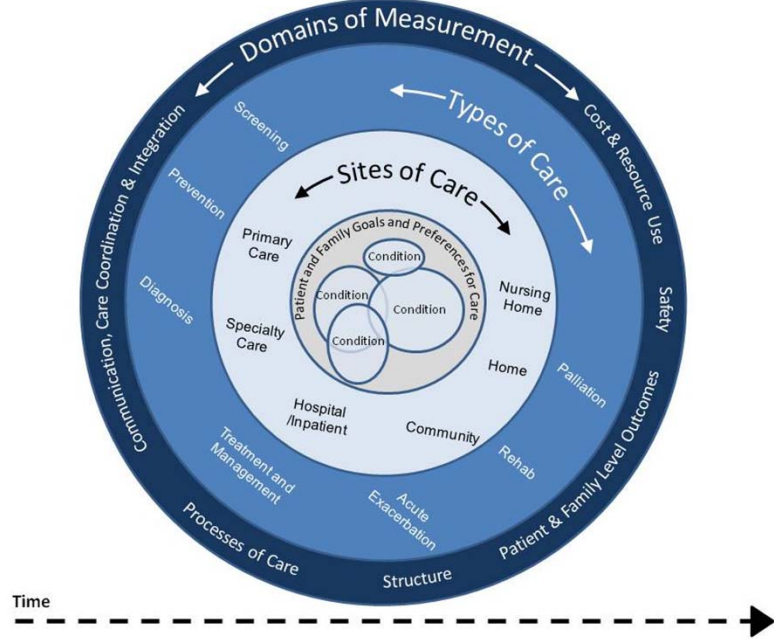
Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



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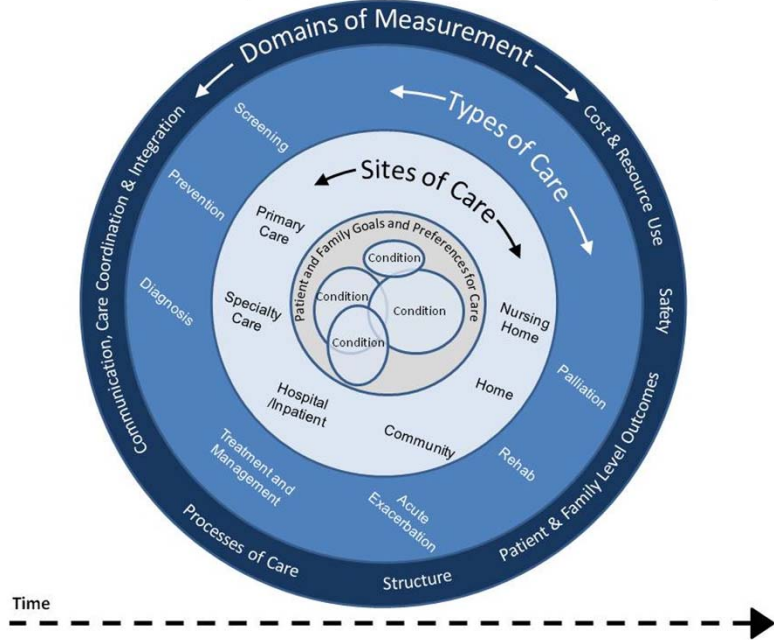


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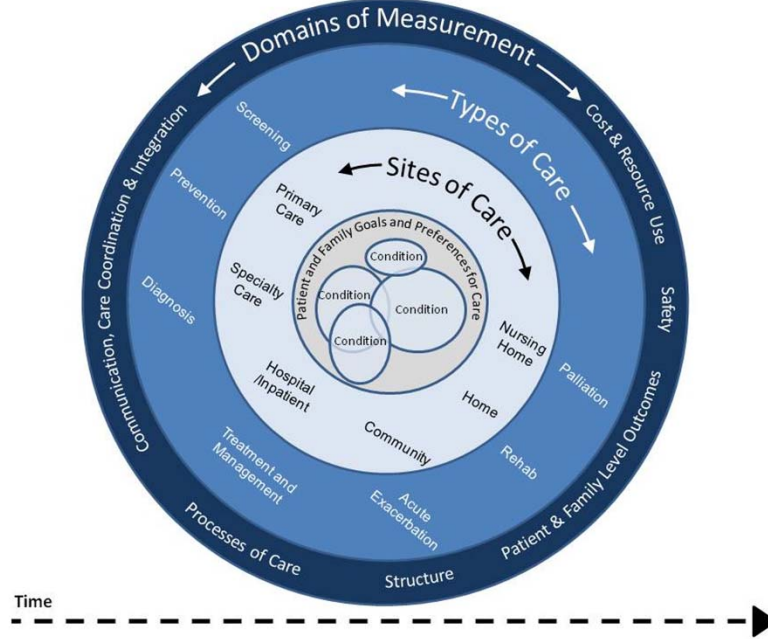
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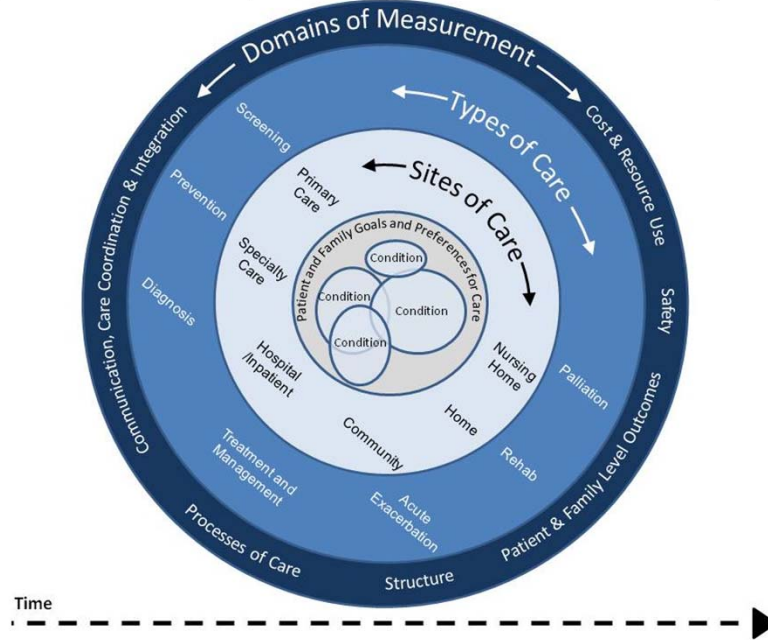


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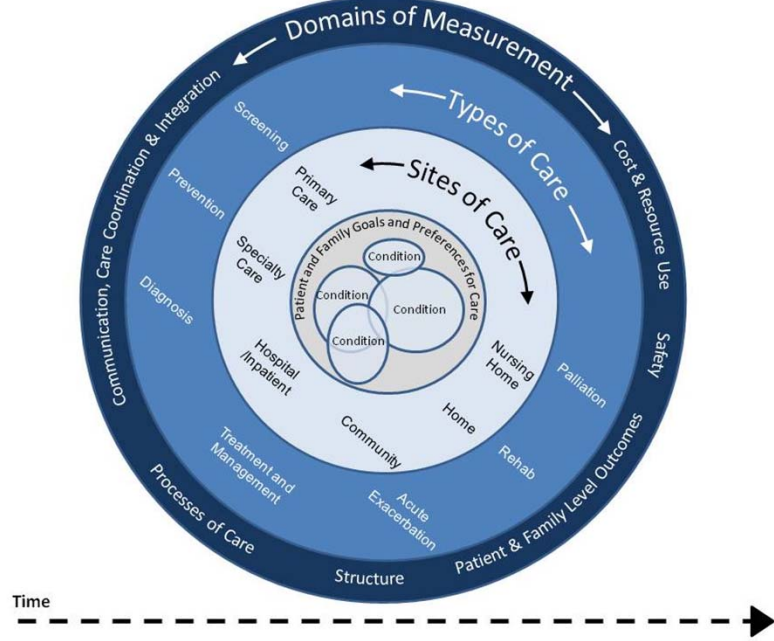
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



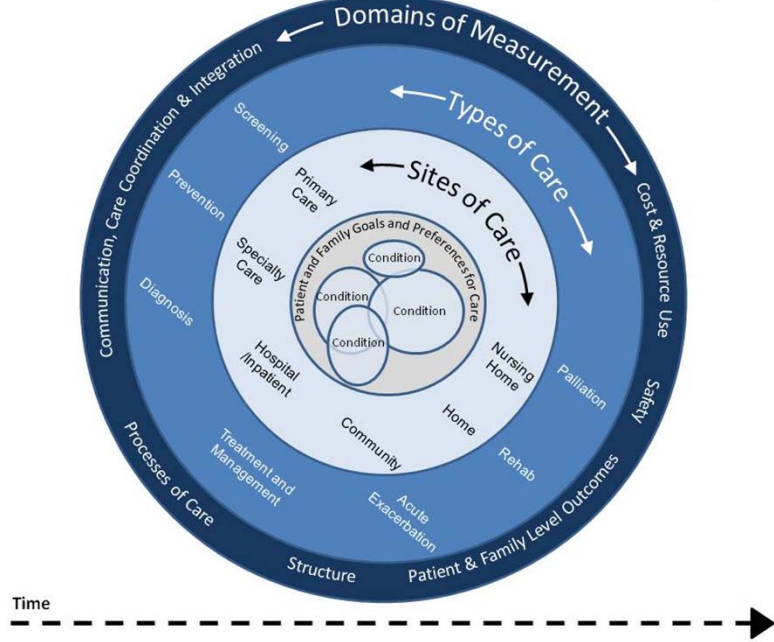
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



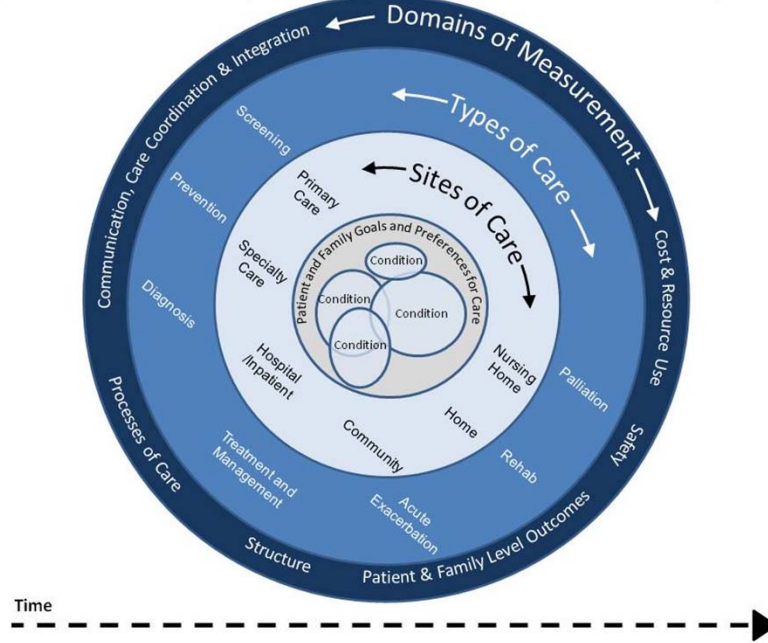
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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



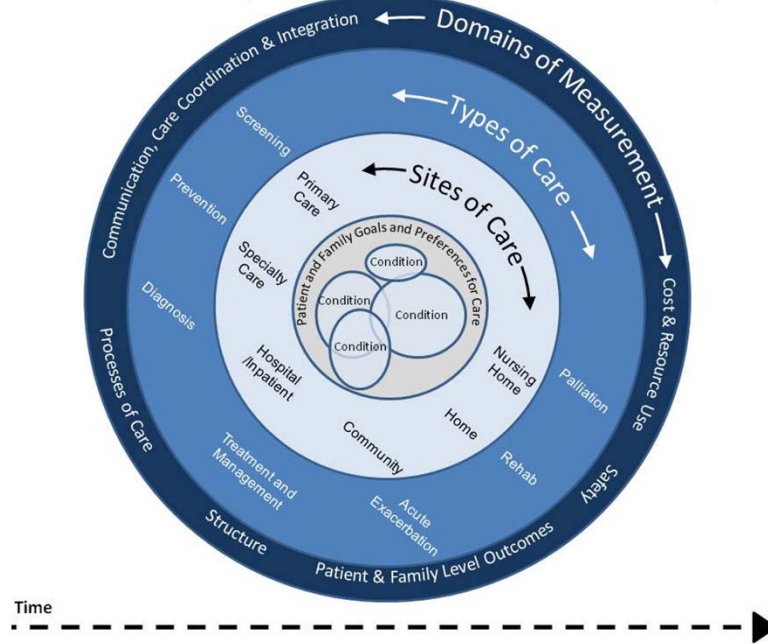
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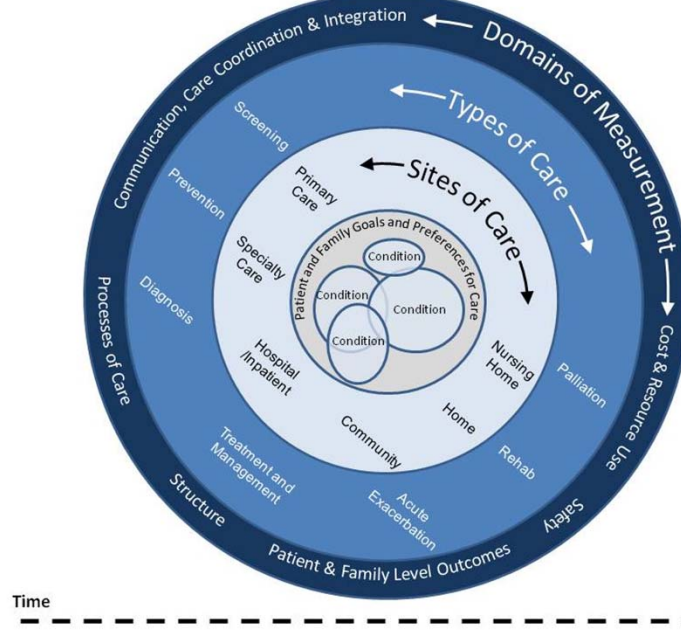
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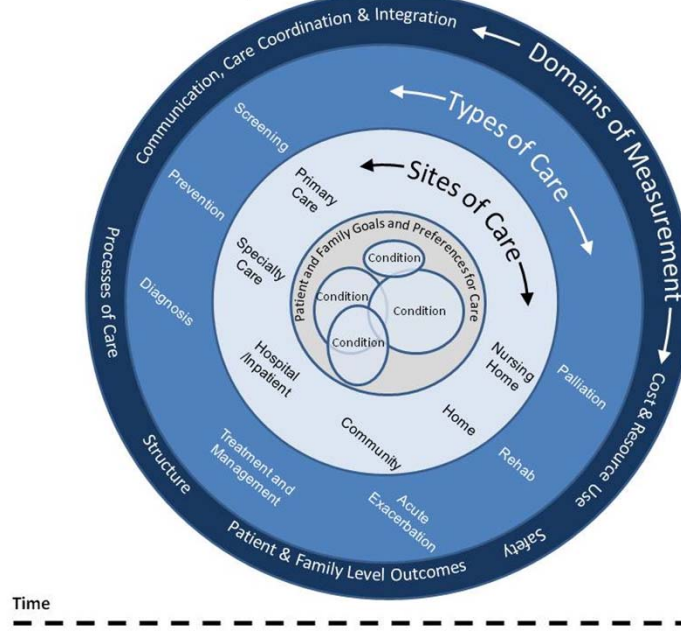
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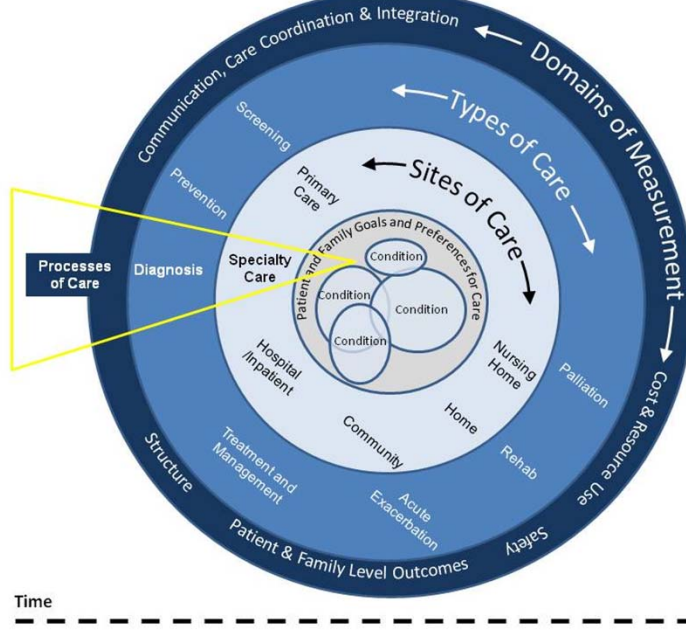
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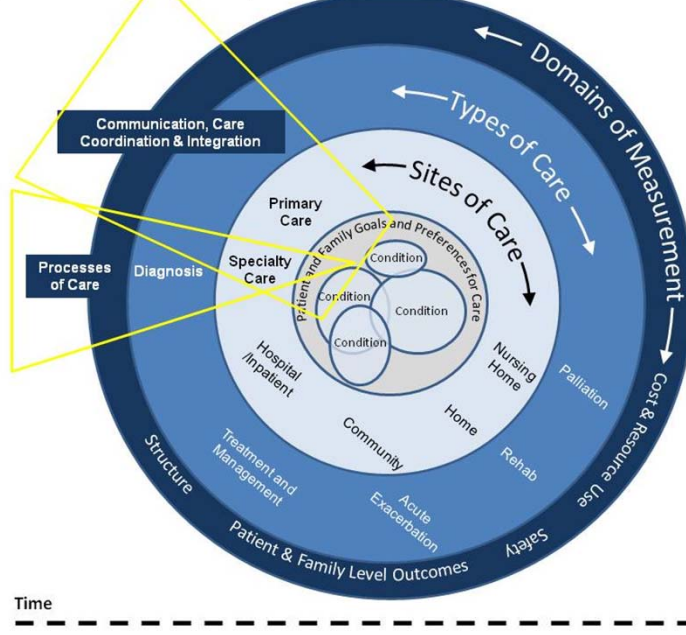


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Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCC



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# Framework Domains

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## Framework Components

- Definitions
  - **Domains (Q2.1, 6, 7)**
- Key methodological issues
- Guiding principles
- Path forward including key policy considerations

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## Patient-Focused Episodes: Framework Domains

- Patient-level outcomes (better health)
  - Morbidity and mortality
  - Functional status
  - Health-related quality of life
  - Patient experience of care
- Processes of care (better care)
  - Technical
  - Care coordination/transitions
  - Decision quality – care aligned with patients' preferences
- Cost and resource use (less overuse, waste, misuse)
  - Total cost of care across the episode
  - Patient opportunity costs

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## MCC Framework Domains

HHS's National Quality Strategy: 6 Priorities	Proposed MCC Framework Domains
Making care safer	• Safety
Person and family engagement	• Patient and family level outcomes
Communication and coordination	• Care coordination and integration
Prevention and treatment	• Process of care • Structure • Patient and family level outcomes
Enable healthy living	
Making quality care more affordable	• Cost and resource use

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- Are there additional domains we need to consider?
- Where do we consider infrastructure/HIT in the model?

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## Measurement Approaches for MCCs

**(Q3,5)**

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## Goals of Measurement Approach

- Measures across providers and sites of care
  - MCC patients are more likely to move across multiple sites of care and have multiple providers
- Cross-cutting, non-clinical measures
  - Patient-focused care
  - Function, quality of life, goal attainment

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## Considerations

- The care plan across settings/providers
  - How does the plan move?
  - Who updates and maintains the plan?
- Promoting shared accountability
  - Incorporating patient activation and self-management
  - Incorporating family engagement

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Do you agree with the  
overarching measurement  
approaches?

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Methodological and Data  
Source Considerations

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## Framework Components

- Definitions
- Domains
- **Key methodological issues (Q4)**
- Guiding principles
- Path forward including key policy considerations

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## Methodological Considerations

- Risk-adjustment and stratification
- HIT-related considerations
  - Attribution
  - Data source
- Measure considerations
  - Age or Morbidity Cut-offs/Altered Targets
  - Denominators
  - Exceptions
  - Composite measures
  - Prioritizing measures

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## Next Steps

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## Next Steps

- Meeting Dates
  - Web Meeting #2 on July 29<sup>th</sup>
  - In-person Meeting #2 on August 8<sup>th</sup>
  - Web Meeting #3 on December 2<sup>nd</sup>

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## **TAB 2**

### ***Overview of Project: Committee Charge***

*Project Background*

*Project Timeline*

# A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS

## PURPOSE

This project seeks to achieve consensus on a measurement framework for assessing the efficiency of care—defined as quality and costs—provided to individuals with multiple chronic conditions (MCCs) in order to encourage the development and application of performance measures that address the complex circumstances of this population.

## BACKGROUND

Patients with multiple chronic conditions (MCCs) represent a growing segment of the population, and currently include over one quarter of the U.S. population.<sup>1,2</sup> Despite the growing prevalence of individuals with MCCs, these patients are largely not addressed by available quality measures.

Uses of condition-specific performance measures for pay-for-performance programs, public reporting, or quality improvement may result in poor quality care and even harm to patients with MCCs, as well as provide misleading feedback for their physicians.<sup>3</sup> Therefore, NQF-endorsed measures that cross clinical care settings and are meaningful to patients are particularly germane to this population.

## SCOPE

Under the guidance of a multi-stakeholder steering committee NQF will develop a patient-centric measurement framework for individuals with MCCs. Specifically the framework will:

- Establish definitions, domains and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCCs
- Adapt the NQF-endorsed Patient-focused Episodes of Care Measurement Framework for patients with MCCs who have overlapping episodes of care; addressing the population at risk, the interplay among multiple evaluation and initial management stages and the unique nature of follow-up care.
- Build upon the National Quality Strategy, HHS's Multiple Chronic Conditions Framework and the work of other private sector initiatives such as the National Priorities Partnership.
- Support the development and application of measures by identifying measure gaps, guiding endorsement decisions, guiding selection of measures for public reporting and payment programs and informing research.

## PROCESS/TIMELINE

This project includes the development of a framework which will be proffered for NQF endorsement as a national voluntary consensus standard. Agreement will be developed through NQF's Consensus Development Process (CDP). This project involves the active participation of representatives from across the spectrum of healthcare stakeholders and will be guided by a Steering Committee.

## FUNDING

This project is supported under a contract provided by the Department of Health and Human Services.

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<sup>1</sup> <http://www.hhs.gov/ophs/initiatives/mcc/index.html>.

<sup>2</sup> Kenneth E. Thorpe and David H. Howard *The Rise In Spending Among Medicare Beneficiaries: The Role Of Chronic Disease Prevalence And Changes In Treatment Intensity* Health Affairs, September/October 2006; 25(5): w378-w388.

<sup>3</sup> Mary E. Tinetti, Sidney T. Bogardus, Jr., and Joseph V. Agostini *Potential Pitfalls of Disease-specific Guidelines for Patients with Multiple Conditions* NEJM, December 30, 2004; 351;27 2870-2874.

# A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS

## Multiple Chronic Conditions Framework Timeline

Milestone	Completion Date
<b>6.3 Multiple Chronic Conditions Measurement Framework</b>	
<b>6.3.1 Select Commissioned Paper Author(s)/Consultant(s) and Develop Work Plan</b>	
<b>6.3.2 Multi-stakeholder Steering Committee</b>	
<i>DHHS Opening Meeting to Obtain Input on Key Issues</i>	<i>5/13/2011</i>
Committee Web Meeting #1: Kick-off and In-person Meeting 1 Preparation	6/9/2011
In-person Committee Meeting #1: Identifying key issues and core concepts of the framework	7/8/2011
Committee Web Meeting #2: Review Progress and In-person Meeting 2 Preparation	7/29/2011
In-person Committee Meeting #2: Review of draft commissioned paper and begin framework development	8/8/2011
Committee Web Meeting #3: Review Draft Framework	12/2/2011
Committee Web Meeting #4: Review comments and complete framework	Target date: 2/8/2012
<b>6.3.3 Commissioned Paper</b>	
Complete first draft of Commissioned Paper	7/22/2011
<i>DHHS review of Draft Commissioned Paper</i>	<i>7/29/2011</i>
Complete Final Commissioned Paper	9/30/2011
<i>NQF and DHHS review and comment on Final Commissioned Paper</i>	<i>10/7/2011</i>
Incorporate comments and finalize Commissioned Paper	10/11/2011
<b>6.3.4: Complete MCC Measurement Framework Report</b>	
Complete Draft Framework Report	12/5/2011
<i>DHHS Review and Comment on Framework Report</i>	<i>12/16/2011</i>
Member (30-day) and public (21-day) comment period	1/25/2012
<i>DHHS Review of Final Report</i>	<i>2/17/2012</i>
Final Report and ballot to NQF Members for vote	3/6/2012
CSAC consideration and Board endorsement	4/14/2012
Appeals (30-day)	5/14/2012

**TAB 3**

***Multiple Chronic Conditions Measurement Framework  
Key Issues Document***



Updated June 7, 2011

Illustrative Key Questions and Issues for Multiple Chronic Conditions Measurement Framework

*Text in italics are from NQF RFP or NQF documents.*

	Key questions	Issues to consider
1	<p><b><i>Definition of Multiple Chronic Conditions.</i></b></p> <p><i>1.1 What is the target patient population?</i></p>	<p><i>Roughly a quarter of the U.S. population has 2 or more chronic conditions. Should all be included in measures? Should disease severity be considered? What is the definition of MCC? What are the domains of the definition?</i></p> <ul style="list-style-type: none"><li>• What is the definition of MCCs? Is it the HHS definition of two or more conditions? Or might we want something more detailed like what AHRQ uses for “complex” patients? I.e.: A <b>complex patient</b> is one with two or more chronic conditions where each condition may influence the care of the other condition(s) through limitations of life expectancy, interactions between therapies, difficulties in establishing adequate care coordination, and/or direct contraindications to therapy for one condition by other conditions themselves.</li><li>• Would there be a role for thinking about morbidity burden measures?</li><li>• We may want to make the above definition include preventive services and perhaps more patient-family centered.</li><li>• How should we treat conditions that commonly co-occur? Example: would someone with Allergic rhinitis and hypertension be thought of as someone with MCCs? This may not meet the refined definition above.</li><li>• Mental health conditions are very common, across populations, and play a critical role in the management of people with MCCs.</li><li>• Classification of non-disease specific conditions/factors (e.g., frailty, obesity, disability, age, cultural and social factors)</li></ul> <p><i>How should the TBD Framework treat very common conditions that co-occur with nearly every condition (e.g., morbid obesity)?</i></p> <ul style="list-style-type: none"><li>• How should we classify other non-disease specific conditions? Example: frailty or morbid obesity.</li><li>• Is age a shadow condition which should be taken into consideration? Example: take a 35 year-old with hypertension and hyperlipidemia. If you make this an older guy, we would start to think of him as having MCCs. Age does factor into how vulnerable a person with a specific combination of conditions is to both their treatments, and their overall health care (i.e. transitions).</li></ul> <p><i>How should the TBD Framework treat certain “dominant” conditions (e.g., terminal cancer) where their recommended treatments and measures may supersede any other conditions’ recommended</i></p>

	<p>1.2 Should the target patient population be stratified into subpopulations (e.g., children/adults/older adults)?</p> <p>How will we deal with special populations?</p>	<p><i>treatments and measures?</i></p> <ul style="list-style-type: none"> <li>How should we classify a dominant condition (e.g., terminal cancer) where their recommended treatments and measures may supersede any other conditions' recommended treatments and measures?</li> </ul> <p><i>MCCs affect all Americans regardless of age, race, and other demographic characteristics. Are the measurement implications sufficiently different to warrant consideration by subpopulations? This may be especially important for outcomes measures across this heterogeneous population.</i></p> <ul style="list-style-type: none"> <li>Are there cases where certain races may be at higher risk for certain conditions?</li> <li>Are there additional measurement considerations for different races or cultures?</li> <li>Will performance measures be used to measure disparities? How does this impact measurement?</li> <li>Children may represent a unique population as children with MCCs may be more likely to have an underlying condition or event which links all of their conditions (i.e. cystic fibrosis, prematurity).</li> </ul>
2	<p><b><i>Application/Modification of Patient-focused Episodes of Care Model to people with MCC</i></b></p> <p>2.1 How should the <u>domains</u> from the Patient-focused Episodes of Care Measurement Framework be addressed? Should new domains be proposed?</p>	<p>Patient-level outcomes:</p> <ul style="list-style-type: none"> <li>Importance of outcomes may be different for age sub-populations: Example: younger patients with MCCs, preserving function and length of life very important.</li> <li>Inclusion of patient-reported outcomes</li> <li>Patient-reported survey measures are important but may be difficult for older patients. Example: Cognitive Impairment—1/2 of people over 85 have some kind of dementia. Surveys can therefore be a problem.</li> <li>Patient experience: Surveys allow for proxy/caregiver response on surveys when dementia is present or patient is a minor. May want to consider adding caregiver response when caregiver plays an important role in monitoring the patient, medication assistance etc.</li> </ul> <p>Cost and Resource Use:</p> <ul style="list-style-type: none"> <li>What is the reference period over which cost and resource use is being assessed?</li> </ul> <p>Processes of care:</p> <ul style="list-style-type: none"> <li>For an individual with MCC, “quality of care” is not just the sum of process measures for each individual chronic condition. Are there process measures which are not disease specific?</li> </ul> <p>Additional domains:</p> <ul style="list-style-type: none"> <li>Care coordination</li> <li>Patient and Family centered care</li> <li>Focus on patient-reported processes and outcomes</li> </ul>

	<p>2.2 Which <i>guiding principles</i> from the Patient-focused Episodes of Care Measurement Framework should be carried over, altered, or excluded? Should new guiding principles be proposed?</p> <p>Should efficiency be the only focus for people with MCCs?</p>	<ul style="list-style-type: none"> <li>• Goal attainment</li> <li>• Shared decision-making</li> <li>• Alignment with preferences</li> <li>• Access to care</li> </ul> <p>The Patient-focused Episodes of Care Measurement Framework includes 9 guiding principles.</p> <ul style="list-style-type: none"> <li>• We would propose that some of these principles could be reframed more broadly- to perhaps include definitions of quality and value in addition to efficiency more explicitly. We think the relationship between cost of care and quality (i.e. efficiency) and people with MCCs may not be the same as it is people without MCCs, and it may be worth making that explicit somehow.</li> <li>• An ongoing issue is the influence and inclusion of behavioral health.</li> <li>• When considering efficiency, how do we account for out-of-pocket costs to the patient and caregiver?</li> <li>• How do we account for the fact that having a willing and able caregiver at home can significantly reduce the cost of care?</li> </ul> <ol style="list-style-type: none"> <li>1. <i>Efficiency measurement is multidimensional.</i> (Efficiency of care is a measure of cost of care associated with a specified level of quality of care. “Efficiency of care” is a measure of the relationship of the cost of care associated with a specific level of performance measured with respect to the other five IOM aims of quality.)</li> <li>2. <i>The choice of measures to inform judgments on efficiency should include consideration of potential leverage.</i></li> <li>3. <i>Measures used to inform judgments on efficiency should promote shared accountability across providers and should be assigned to the smallest unit of accountability as technically feasible.</i> (Shared accountability is an even more important issue for people with MCCs.)</li> <li>4. <i>Measures used to inform judgments on efficiency should respond to the need to harmonize measurement across settings of care (and, if possible, across conditions).</i></li> <li>5. <i>Measures to inform judgments on efficiency should be used for benchmarking.</i></li> <li>6. <i>Public reporting of measures of efficiency should be meaningful and understandable to consumers and entities accountable for their care.</i> (Measures for MCCs may be more complicated and harder to understand than measures for single conditions. Need to consider providing meaningful information for caregivers as well)</li> <li>7. <i>Inappropriate care cannot be efficient.</i> (This is an issue for MCCs because there is less evidence to guide us as to what is inappropriate care – may require modification of this principle)</li> <li>8. <i>The measurement framework should achieve its intended purpose and should be monitored for</i></li> </ol>
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2.3 How should the theoretical construct of an episode of care be adapted to apply to MCCs?

*unintended consequences.* (Unintended consequences may be even more of an issue for MCCs. Need to also consider unintended consequences on caregiver or family).

9. *Measures to inform judgments on efficiency should be an integral part of a continuous learning system.*

Are there differences in how a patient might think of an episode as compared to a provider/health system?

How can we conceptualize episodes in a way that makes sense for MCC? Important to consider this because other measurement frameworks use an episodes framework and this would allow the MCC framework to be comparable. Also, any measure will need to have a reference period in which it is measured, and the Episodes Model provides a method for this, but it may not be ideal for people with MCCs.

- We reviewed three examples of applying episodes framework to chronic issues, and extrapolated to issues of MCC (each is referenced below where appropriate):
  - (D) NQF diabetes white paper (O'Connor PJ)
  - (C) Cancer NQF white paper (Hassett MH, Bach PB)
  - (SU) Substance Abuse NQF white paper (Rosen AK, McKay JR)
- Although the episodes framework may not always apply well to the overall concept of a pt with MCC, certain types of situations would fit:
  - Episodes approach is helpful in looking at care across settings, providers, and illnesses, and trying to define trigger points when quality issues are more likely to occur because of new issues or stresses in the system (C)
  - Pts with certain CC would be in the “population at risk” for other CC and becoming an MCC patient.
  - Pts diagnosed with a new CC and now a new MCC patient –the initial period of treatment and adjustment could be an episode
  - A hospitalization or other acute exacerbation/relapse of one of the CC could also be an episode and could lead to exacerbations of other CC (D)
  - A worsening of one of the CC, or development of a new complication, could also complicate other CC and their treatment
- Challenges in applying the episodes framework:
  - Care is often fragmented and very difficult to measure across providers or settings
  - Defining “appropriate” vs. “inappropriate” care much more challenging for MCCs where evidence does not apply clearly
  - In people with MCCs, the beginning of an episode of care may need to be defined differently, and an episode usually does not end or resolve (unusual for a chronic condition to go away, although there are situations where this occurs, such as diabetes resolving after bariatric

		<p>surgery for obesity).</p> <ul style="list-style-type: none"> <li>– Episodes for patients with MCCs are more cyclical: a patient would be designated as a MCC patient after a new diagnosis, and multiple exacerbations of one or more of the CC would occur with improvements but usually not resolution.</li> <li>– Population at risk is easier to define if focused on MCC person admitted for acute event (like someone getting into hospital) at risk for adverse events and transitional issues, but less so for more disease specific chronic manifestations or outpatient exacerbations.</li> <li>– Different kinds of measures might need to conceptualize episodes differently for patients with MCC</li> </ul>
3	<b>Multiple providers and sites of care</b> How do you consider multiple providers and sites of care for people with multiple chronic conditions?	<p>Patients with MCCs are probably more likely to move across multiple sites of care than patients who have only one condition (home, hospital, outpatient, specialists, primary care, rehab, nursing home, etc.)</p> <p>Patients with MCCs are also more likely to have multiple providers, and the implications of that may vary according to the site of care.</p> <ul style="list-style-type: none"> <li>• How do you develop measures that for patients who are being co-managed by team of sub-specialists with no primary care provider? Specialists are focused on different priorities for the patients and may have different approaches to care. (Methodological issue of attribution is relevant here).</li> <li>• Should efficiency be measured across sites (silos) of care (ideal) or within sites (silos) of care (more realistic currently)?</li> <li>• How can shared accountability be encouraged?</li> <li>• Number of physicians/NPs involved and role of primary vs. specialty. Who is in charge of care plan or does it “move”?</li> <li>• Who has accountability to even use the measure?</li> </ul>
4	<b>Methodological Issues</b> 4.1 How and when should there be modification of existing process measure for people with MCCs? (HEDIS, PQRI, NQF-Endorsed Measures)	<p><u>Age Cut-Offs</u></p> <ul style="list-style-type: none"> <li>• We need to have measures for all populations. Limitations and age cutoffs limit the indicators of quality available for older patients with MCC. Age is often used as a cutoff for process measures (Example: HEDIS age cutoffs for colorectal screening; diabetes has age cutoffs at 75). Age is used as a surrogate for life expectancy or health status; perhaps using a measure of health status is more appropriate. Age categories may be a result of uncertainty or a result of knowing that care SHOULD be different in an age category. Is age the right thing to be using instead of health status? We really don’t know what we should be doing for these people. When there is uncertainty you don’t want to be forcing unnecessary care on these people. Should MCC be used as a cutoff instead of age for some quality indicators? Is this practical?</li> <li>• Another approach to modification may be setting different targets for different age categories or</li> </ul>

populations of people with MCCs.

When should process measures be disease-specific?

- There is frustration with repeated use of the same types of QI on specific items like foot exams for people with diabetes. When are these appropriate and useful (with modification) and when are they truly lower priority (although easier to measure)?

Stratification

- Are there other conditions which could be potential stratifying variables for reporting process measures?
- Potential ways to stratify existing process measures:
  - Disability
  - Cognitive impairment
  - Life expectancy
  - Illness burden
  - Shadow conditions
  - Dominant conditions

Risk Adjustment:

- Should process measures **ever** be risk adjusted? If so, risk of what should be the adjustment factor? (future resource use, risk of mortality, risk of harm from treatments, risk of bad outcome treatment is trying to prevent) Should risk adjustment use age, MCC, other variables which are proxies for vulnerable populations which are more likely to have MCC? Consideration of intended and unintended consequences is very important.
- What is an MCC and what is a complication when risk adjusting? There are pros and cons of general risk adjustment and adjustment for specific chronic conditions.
- Disease-specific re-hospitalization is a commonly used quality indicator. Can you risk adjust this quality indicator for a co-morbidity index? The vast majority of all patients who are re-hospitalized have more than one chronic condition. This suggests that risk adjustment for having MCC is not sufficient.
- In some settings, exception reporting may be viewed as part risk adjustment (i.e. a carve-out).

Other Methodological Issues

- Concept of vulnerable populations might be challenging here. Poverty would particularly

4.2 What are some of the methodological considerations when developing or applying



	<p>5.2 What are the important components of patient and family centered care (PFCC) which should be considered when measuring performance for individuals with MCC?</p>	<p>rely on patient self-report? Some performance measures which address non-disease specific consequences and risks of MCCs include:</p> <ul style="list-style-type: none"> <li>– Function</li> <li>– Frailty</li> <li>– quality of life (generic v. disease specific)</li> <li>– falls</li> <li>– readmission</li> </ul> <ul style="list-style-type: none"> <li>• Coordination of care can be measured by assessment of a health system or the comprehensiveness of how MCC patients are served. How do you measure this concept across sites of care?</li> <li>• Goal attainment based on shared care plan</li> <li>• Patient knowledge</li> <li>• Most individuals with MCC will have more than one medication prescribed. How do you assess polypharmacy and reconciliation, particularly in the face of uncertainty about guideline recommendations? Polypharmacy and reconciliation - not just checking the med list, but ensuring the list makes sense in terms of the MCCs the patient has and not overmedication – related to unintended consequences of therapy interaction. Consider risk of interaction/adverse event as a process measure – issue is that how much is risk is tolerable may vary by patient preference and by their clinical situation (for example, a patient with arthritis which is only helped by NSAIDs may be willing to tolerate a greater risk of bleeding if they need Aspirin/Coumadin for stroke prophylaxis than someone with less severe or less-NSAID-sensitive arthritis)</li> <li>• Appropriateness of care – related to efficiency of care and see guiding principles and over/under/misuse</li> </ul> <p><u>PFCC key elements:</u></p> <ul style="list-style-type: none"> <li>• Whole person care: explores the patients’ psychosocial as well as physical needs. The whole is bigger than the sum of the parts. You want to treat more than just the disease. Treat the disability or the person (Example: adaptive devices for vision, not just treating macular degeneration).</li> <li>• Patient focused: explores patient’s concerns</li> <li>• Shared Decision making: conveys a sense of partnership between the patient and the physician <ul style="list-style-type: none"> <li>– Focus on more than engaging patient in decision making. Includes assessing the patient’s goals and priorities for care.</li> <li>– What are the person’s highest priorities?</li> <li>– Clinicians often don’t have the information to make shared decisions (relates to overuse/misuse/underuse above)</li> </ul> </li> <li>• Encouraging Patient Activation and Self Management: active facilitation of patient’s involvement in decision making and care.</li> </ul>
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		<ul style="list-style-type: none"> <li>– Patient activation management</li> <li>– What are the characteristics of a patient who are especially amenable to increase in patient activation level (i.e. which patients are most likely to be trainable)</li> <li>– How do you assess which people in your practice are ready to change?</li> <li>– Are these process or systems measures?</li> <li>– Some measures may require coaching patients and behavior change</li> </ul> <p><u>Other Considerations</u></p> <ul style="list-style-type: none"> <li>• How do you measure the family's engagement and satisfaction with care?</li> <li>• How do you prioritize quality measures according to patient values and goals?</li> <li>• Other patient centered care measures: <ul style="list-style-type: none"> <li>– Patient education measures</li> <li>– Patient satisfaction</li> </ul> </li> <li>• Is patient satisfaction measured differently for individuals with MCC?</li> <li>• Are MCC issues included in commonly-used satisfaction measures like CAHPS (Consumer Assessment of Healthcare Plans Survey)?</li> <li>• Out-of-pocket costs for patients and families</li> </ul>
6	<b>Measures of overuse/underuse/misuse/don't know</b> How can measures of overuse / underuse / misuse be applied to patients with MCCs?	<ul style="list-style-type: none"> <li>• We know less about how to manage people with multiple chronic conditions. (Example: We don't know the best regimen for people with diabetes, COPD or heart disease and multiple other conditions).</li> <li>• Overutilization, appropriateness, duplication; more is not always better. (Example: An echocardiogram may be harmful if it distracts the physician from other things that are more important.)</li> <li>• Severity of disease measurement is challenging</li> <li>• How does presence of MCCs influence measurement of overuse / underuse / misuse, i.e. appropriate use of resources for one condition in a patient with that one condition may represent overuse / underuse / misuse for patient with that condition and many others.</li> <li>• How do issues of disparate disease severity among patients multiple conditions get factored into measures of overuse / underuse / misuse in patients with MCCs?</li> <li>• How do patient preferences for care influence measurement of overuse / underuse / misuse?</li> <li>• Does the presence of a dominant condition influence the assessment of overuse / underuse / misuse in patients with MCCs?</li> <li>• Does the presence of concordant or discordant conditions influence the risk of experiencing or the assessment of overuse / underuse / misuse in patients with MCCs?</li> </ul>
7	<b>Prioritizing measures</b>	<ul style="list-style-type: none"> <li>• Unintended consequences and potentially inappropriate care are even more important – so</li> </ul>

	<p>Are there certain measures that are more important for people with MCCs?</p> <p>Are there specific measures that target people with MCCs?</p>	<p>important to include measures that identify people at high risk of harm, and address conflicts between different CCs.</p> <ul style="list-style-type: none"> <li>• Important to include measures that help address care across MCCs.</li> <li>• Some processes will be more difficult to achieve in people with MCCs, some will be more important in people with people with MCCs, and some will be less important, and some will not be applicable.</li> </ul>
8	<p><b>Special Populations</b></p> <p>Are there sub-populations of individuals with MCC which require additional considerations?</p>	<p><u>Children with MCCs</u></p> <ul style="list-style-type: none"> <li>• Children with medical complexity are increasing in prevalence.</li> <li>• How does the definition of children with multiple chronic conditions (MCCs) differ from that of adults with MCCs? Children with medical complexity (CMC) have been defined as those with 1) substantial service needs, 2) chronic and severe conditions, 3) functional limitations, and 4) high health care use.</li> <li>• What are the similarities or differences in the attributes of ‘quality of care’ for children compared to ‘quality of care’ for adults with MCCs? Regardless of diagnoses, children with CMC share the following characteristics: 1) intensive hospital and/or community-based service needs, 2) reliance on technology, polypharmacy, and/or home care or congregate care, 3) risk of frequent and prolonged hospitalizations, and 4) an elevated need for care coordination.</li> <li>• The health and quality of life of CMC depends on the successful integration of a primary medical home with tertiary care services, transitional care facilities, rehabilitation units, the home, the school, and other community based settings.</li> <li>• How will this impact the type of performance measures that should be developed and implemented for children compared to adults?</li> <li>• There have been few well-characterized clinical efforts devoted to improving the care of children with medical complexity (CMC) or multiple chronic conditions (MCCs).</li> <li>• Are congenital abnormalities included in our definition of MCC for children?</li> </ul> <p><u>Individuals at the end-of-life</u></p> <ul style="list-style-type: none"> <li>• Palliation</li> <li>• Key is that this should not be an on/off switch for hospice but should be integrated across continuum.</li> </ul> <p><u>Disabled Adults with MCCs</u></p> <p><u>Institutionalized People with MCCs</u></p> <p><u>Older Adults</u></p>

9	<b>Payment Reform</b> What are the implications of the 'to be developed MCC' Framework for key payment reforms ( <i>e.g.</i> , bundled payments)?	<ul style="list-style-type: none"> <li>• How should the framework be used to promote patient-centered care?</li> <li>• What are the implications of the Framework for pay for performance?</li> <li>• What are the implications of the Framework for the standard (NIH) disease-specific approach to biomedical research funding?</li> </ul>
10	<b>Unintended Consequences and Safety</b> How should the Framework address unintended consequences of therapy interactions ( <i>e.g.</i> , drug regimens or procedures)?  What are potential unintended consequences of adapting or creating performance measures for people with MCCs?	<ul style="list-style-type: none"> <li>• Unintended consequences of therapies can include (1) potentially harmful consequences (safety issue) and (2) Overuse or non-efficient use of resources.</li> <li>• Topics specific to medication: polypharmacy, medication reconciliation (not just checking the med list, but ensuring the list makes sense in terms of the MCCs the patient has and not overmedication.</li> <li>• Patient safety measures - am not sure that there are specific MCC issues here, probably more of risk adjustment (<i>e.g.</i>, the population at risk for CLABSI (central line associated blood stream infection) or catheter-induced UTI (urinary tract infection) is often different and can affect performance)</li> <li>• Please see above under methodological considerations for further discussion of unintended consequences of measures.</li> </ul>

**TAB 4**

***Web Meeting Summary***



## **WEB MEETING FOR THE MULTIPLE CHRONIC CONDITIONS STEERING COMMITTEE**

**JUNE 9, 2011**

The Multiple Chronic Conditions (MCCs) Steering Committee held an open web meeting to provide an overview of the project, review the project scope, how the project aligns with existing efforts, and review and discuss key issues, including the definition of multiple chronic conditions (MCCs). A recording of the web meeting can be accessed [here](#).

### **I. WELCOME, INTRODUCTION, AND OVERVIEW OF PROJECT: COMMITTEE CHARGE**

Caroline Blaum, Co-Chair welcomed the Multiple Chronic Conditions Steering Committee and thanked them for their continued participation. Ms. Blaum reviewed the agenda items and provided an overview of the MCC project.

This project seeks to achieve agreement through NQF's Consensus Development Process (CDP) on a measurement framework for assessing the efficiency of care—defined as quality and costs— provided to individuals with MCCs. Under the guidance of a multi-stakeholder Steering Committee, NQF will develop a patient-centric measurement framework for individuals with MCCs. Specifically the framework will:

- establish definitions, domains, and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCCs;
- adapt the NQF-endorsed<sup>®</sup> patient-focused episodes of care measurement framework for patients with MCCs who have overlapping episodes of care;
- address the population at risk, the interplay among multiple evaluation, and initial management stages and the unique nature of follow-up care;
- build upon the National Quality Strategy (NQS), Health and Human Services' (HHS') MCCs framework and the work of other private sector initiatives such as the National Priorities Partnership (NPP); and
- support the development and application of measures by identifying measure gaps, guiding endorsement decisions, guiding selection of measures for public reporting and payment programs, and informing research.

Aisha Pitman, senior program director, Strategic Partnerships provided an overview of the timelines and deliverables under the MCCs project:

- July 22, 2011–draft commissioned paper\*;
- September 30, 2011–final commissioned paper;
- December 5, 2011–draft framework report;
- Late December 2011 or January 2012–public comment;
- Early February 2012–final framework report;
- March 2012–Member voting; and



- April 2012–CSAC consideration and Board endorsement.

\*NQF has subcontracted with Johns Hopkins University to develop the commissioned paper.

## **II. SETTING THE CONTEXT: ALIGNING WITH EXISTING EFFORTS**

Karen Adams, vice president of National Priorities, provided an overview of the HHS frameworks, private/public sector frameworks/models, components of a NQF-endorsed MCCs framework, and the intended uses of this framework.

### ***HHS' National Quality Strategy (NQS)***

In March 2010, the passage of the Affordable Care Act (ACA) required the Department of Health and Human Services (HHS) to develop the [National Quality Strategy](#) (NQS), and the Secretary of HHS to “*establish a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health.*” This legislation also called on HHS to “*consult with the consensus-based entity to obtain input on priorities for this National Quality Strategy, due to Congress by January 1, 2011.*” In September, HHS requested the National Quality Forum (NQF) to convene the [National Priorities Partnership](#) (NPP) to provide input on national priorities for the NQS, which included three domains: better care, affordable care, and healthy people/healthy communities; and promoted principles of improving patient-centeredness and quality, reducing disparities, and encouraging public-private sector alignment. The 2011 NQS, released on March 21, 2011, put forth six priority areas for collective action. The six national priorities include:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

HHS has requested that NPP, convened by NQF, provide further guidance on the NQS's priorities, goals, measures for tracking national progress, and strategic opportunities.

### ***Partnership for Patients: Better Care, Lower Costs***

HHS recently launched the [Partnership for Patients](#) initiative to dramatically improve patient safety across the country. The effort depends upon collective action from all stakeholders in healthcare—consumers, clinicians, hospitals, employers, health plans, states, and others—to achieve the goals of significantly reducing harm and hospital readmissions.

The two goals of this new partnership are:

# NQF

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- Keeping patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010.
- Helping patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20 percent compared to 2010.

Recognizing the need to forge strong partnerships with the private sector to advance this work, HHS has requested that NPP facilitate a shared discussion with the stakeholders of the Partnership for Patients. Specifically—and building upon NPP’s broad network and collective efforts to date in advancing patient safety—NPP will provide a quarterly open forum for the purpose of sharing updates on the progress of the Partnership for Patients, gathering input on relevant public and private sector initiatives, and identifying the key contributions each stakeholder can make to advance this important work in the near term and longer term.

### ***HHS’ MCCs: A Strategic Framework***

In December 2010, HHS developed a [strategic framework](#) to improve the health status of individuals with MCCs. To achieve optimum health and quality of life for individuals with MCCs, the framework offers these four overarching goals:

1. foster healthcare and public health-system changes to improve the health of individuals with multiple chronic conditions;
2. maximize the use of proven self-care management and other services by individuals with MCCs;
3. provide better tools and information to healthcare, public health, and social services workers who deliver care to individuals with MCCs; and
4. facilitate research to fill knowledge gaps about, and interventions and systems to benefit individuals with MCCs.

Specifically, the NQF-endorsed MCCs measurement framework will inform the following components of the HHS’ MCCs strategic framework, among others:

- Strategy 1.A.1 Define and identify populations with MCCs broadly, and MCCs subgroups with specific clusters of conditions, and explore focusing care models on the subgroups at high risk of poor health outcomes;
- Strategy 1.D.1 Encourage the meaningful use of electronic health records, personal health records, patient portals, and clinical registries to improve care for individuals with MCCs; and
- Strategy 3.A.2. Identify, develop, endorse, and use key quality metrics, in the form of performance measures, to promote best practices in the general care of individuals with MCCs.

### ***NQF Endorsed Patient Focused Episodes of Care Framework***

The [Patient-Focused Episodes of Care Framework](#) can be used to track the core components—population at risk, evaluation and initial management, and follow-up care—that must be



measured and evaluated over the course of an episode of care. These components are foundational to any assessment of efficiency, which is defined as quality and costs. This model is adaptable to multiple types of episodes, and the construct is designed to be applied to a broad set of health conditions such as acute myocardial infarction, low back pain, diabetes, cancers, and substance use illness. The following domains for performance measurement represent the essential components and subcomponents for measuring efficiency as it relates to episode of care.

- Patient-level outcomes (better health)
  - morbidity and mortality
  - functional status
  - health-related quality of life
  - patient experience of care
- Processes of care (better care)
  - technical
  - care coordination/transitions
  - decision quality—care aligned with patients’ preferences
- Cost and resource use (less overuse, waste, misuse)
  - total cost of care across the episode
  - patient opportunity costs

### **III. DEVELOPING A MCC MEASUREMENT FRAMEWORK**

In developing a measurement framework for individuals with MCCs, the Committee will build upon the patient-focused episode of care model, addressing the following components:

- key terms and definitions;
- domains for performance measurement for evaluating efficiency;
- key methodological issues;
- guiding principles; and
- key policy considerations.

The intended uses of the MCC measurement framework are:

- input to HHS on MCC strategic framework and initiatives;
- identify measure gaps;
- guide endorsement decisions in selecting measures for people with MCCs;
- guide selection of measures for public reporting and payment;
- roadmap for new delivery models (ACOs, PCMH); and
- inform research.

### **IV. DISCUSSION OF KEY ISSUES**

Cynthia Boyd an associate professor at Johns Hopkins University provided descriptive statistics of people with multiple chronic conditions, some considerations for defining the MCC population, and a brief overview of the emerging key issues.





As previously mentioned, one of the first milestones for this project is a commissioned paper that develops a conceptual model for the MCCs measurement framework. To inform the Committee's deliberations, Johns Hopkins University developed a key issues document for the Committee to react to and provide input. This paper will be used as a tool to facilitate discussion at our upcoming meeting on July 8 and will feed into the final commissioned paper.

### ***Descriptive Statistics of People with MCCs***

In considering performance measurement for people with MCCs consideration must be given to clinical practice guidelines (CPGs), as these guidelines inform the development of performance measures. CPGs are developed and emphasized for a single disease perspective. Most single disease CPGs fail to give adequate guidance for older patients with MCCs. Thus, many quality indicators (QI) are designed to address one chronic condition and be implemented for employed adults and their independents. This approach does not consider the population with MCCs as they may fall outside of the denominator for disease specific QIs, or when this population is included in the denominator population treatment based on a single condition, this may not be appropriate.

### ***Definition of MCCs***

There are a number of possible definitions for MCCs. The HHS Strategic Framework defines MCCs as two or more concurrent chronic conditions while AHRQ defines "complex" patients as having two or more chronic conditions where each condition may influence the care of other's conditions through limitations of life expectancy, interactions between therapies, difficulties in establishing adequate care coordination, or direct contraindications. In thinking about the definition of MCCs, the Committee considered the following:

- commonly co-occurring conditions;
- classification of non-disease specific conditions/factors (e.g., frailty, obesity, age, cultural, and social factors);
- disease progression and burden;
- dominant conditions (e.g., terminal cancer);
- patient-centered care;
- preventive services; and
- children with MCCs.

Some early themes that emerged from the Committee's discussion included:

- measuring non-disease specific conditions as a subpopulation;
- chronic conditions that are life limiting;
- building upon AHRQ's definition which allows for elimination of minor conditions; and
- measures that are cross-cutting for patients with MCCs, patient reported outcomes, and specific measures of functional status/impairment.

## **V. NEXT STEPS**



The Committee will review the “Key Issues” document and complete a brief survey that will help determine how they will prioritize and focus their work moving forward.

The MCCs Steering Committee will meet in person and via web several times in 2011 as follows:

- July 8, 2011—in-person meeting
- July 29, 2011—web meeting
- August 8, 2011—in-person meeting
- December 2, 2011—web meeting

## **TAB 5**

### ***Background Articles***

*Article 1: Potential Pitfalls of Disease-Specific Guidelines for Patients with Multiple Conditions*

*Article 2: Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases*

**TAB 6**

***Multiple Chronic Conditions Steering Committee Roster***

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## MULTIPLE CHRONIC CONDITIONS MEASUREMENT FRAMEWORK STEERING COMMITTEE ROSTER

**Caroline S. Blaum (Co-Chair)**

Professor, Associate Chief, Research Scientist  
University of Michigan Health System – Institute of Gerontology

**Barbara McCann (Co-Chair)**

Chief Industry Officer  
Interim HealthCare

**Mary Barton**

Scientific Director of the U.S. Preventive Services Task Force  
Agency for Healthcare Research and Quality

**Cynthia Boyd (Liaison)**

Associate Professor of Medicine  
Johns Hopkins University School of Medicine – Johns Hopkins Health System

**Margaret L. “Meg” Campbell**

Director, Nursing Research  
Detroit Receiving Hospital

**Amina Chaudhry**

Medical Officer  
Substance Abuse and Mental Health Services Administration

**Leona Cuttler**

Director, The Center for Child Health and Policy  
Rainbow Babies and Children’s Hospital – Case Medical Center

**Michael C. Farber**

Medical Director  
Department of Vermont Health Access

**Christina Farup**

Vice President, Evidence Based Medicine  
DePuy, Inc./Johnson & Johnson

**Daniel Forman**

Director, Cardiac Rehabilitation and Exercise Testing  
Brigham and Women’s Hospital, Partners Healthcare

**Andrew Guccione**

Professor and Chair, Department of Rehabilitation Sciences, College of Health and Human Services  
George Mason University

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Palm Beach Atlantic University

**Emma Hoo**

Director of Value Based Purchasing  
Pacific Business Group on Health

**Gail Hunt**

President/CEO  
National Alliance for Caregiving

**Thomas E. Kottke**

Medical Director for Evidence-Based Health  
HealthPartners

**Joseph Laver**

Clinical Director and Executive Vice President  
St. Jude Children's Research Hospital

**Kyu Rhee**

Chief Health Director  
IBM Corporation

**Robert J. Rosati**

Vice President  
Visiting Nurse Service of New York

**Dennis Saver**

Practicing Physician  
Primary Care of the Treasure Coast

**Jeffrey Thompson**

Chief Medical Officer  
DSHS Washington State Medicaid

**Barbara Turner**

Professor  
University of Pennsylvania School of Medicine

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