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Establishing a Measurement Framework for Multiple Chronic Conditions

Steering Committee In-person Meeting

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

Monday, August 8, 2011
8:30 am - 3:30 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

Monday, August 8, 2011
8:00 am – 3:30 pm (Eastern)

AGENDA

Meeting Objectives:

- Finalize definition of multiple chronic conditions (MCC)
- Establish guiding principles for measurement
- Finalize the multiple chronic conditions conceptual model
- Prioritize key measure concepts areas
- Discuss path forward and policy implications of framework

8:00 am **Breakfast**

8:30 am **Welcome, Introductions, and Overview of Meeting Objectives**
Barbara McCann and Caroline Blaum, Steering Committee Co-Chairs

8:45 am **Finalize the MCC Definition**
Caroline Blaum
- ✧ *Presentation of final draft definition based on committee feedback*
- ✧ *Discussion and questions*
- ✧ *Opportunity for public comment*

9:15 am **Guiding Principles for MCC Measurement**
Barbara McCann
Karen Adams, Vice President, National Priorities, NQF
- ✧ *Presentation of guiding principles for measurement based on methodology workgroup web meeting*
- ✧ *Data source implications*
- ✧ *Discussion and questions*

11:15 am **Break**

11:30 am **Finalize MCC Conceptual Model**
Caroline Blaum
Cynthia Boyd, Erin Giovannetti, and Bruce Leff, Johns Hopkins University
- ✧ *Presentation of final model based on committee feedback*
- ✧ *Discussion and questions*
- ✧ *Opportunity for public comment*

12:30 pm **Working Lunch**

1:00 pm **Finalize MCC Key Measure Concept Areas**
Caroline Blaum
Aisha Pitman, Senior Program Director, NQF

- *Presentation of MCC key measure concept areas mapped to the National Quality Strategy based on committee feedback*
- *Prioritization of key measure concept areas*
- *Discussion and questions*
- *Opportunity for public comment*

2:30 pm **Path Forward: Policy Implications of MCC Framework**
Barbara McCann

- *Applying the MCC framework in the current policy environment*
- *Consideration of key policy drivers (e.g. payment, benefit design, public reporting, accreditation/certification)*
- *Discussion and questions*

3:15 pm **Next Steps**
Aisha Pitman

3:30 pm **Adjourn**

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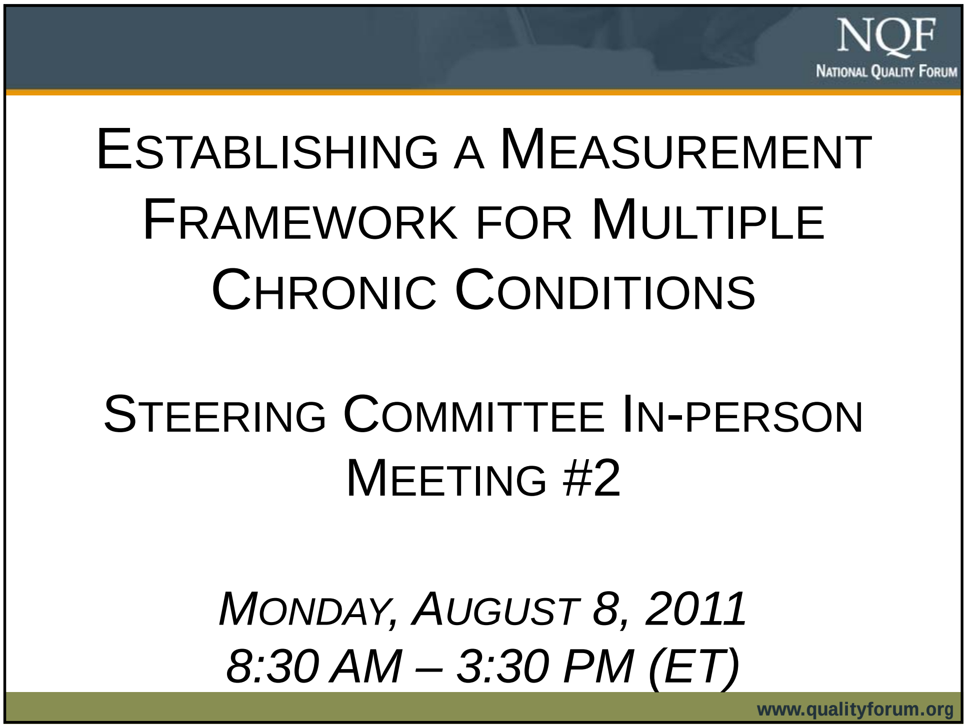
Tab 5 .... Strategic Opportunities
Tab 6 .... July 8th In-person Meeting Summary

TAB 1

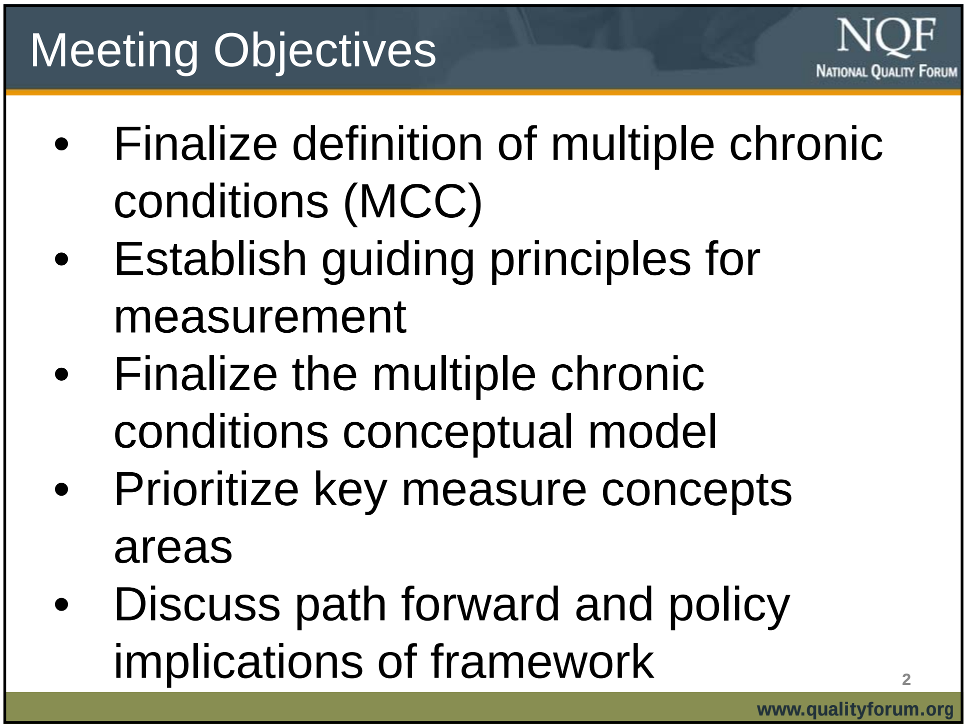
PowerPoint Presentation



ESTABLISHING A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS

STEERING COMMITTEE IN-PERSON MEETING #2

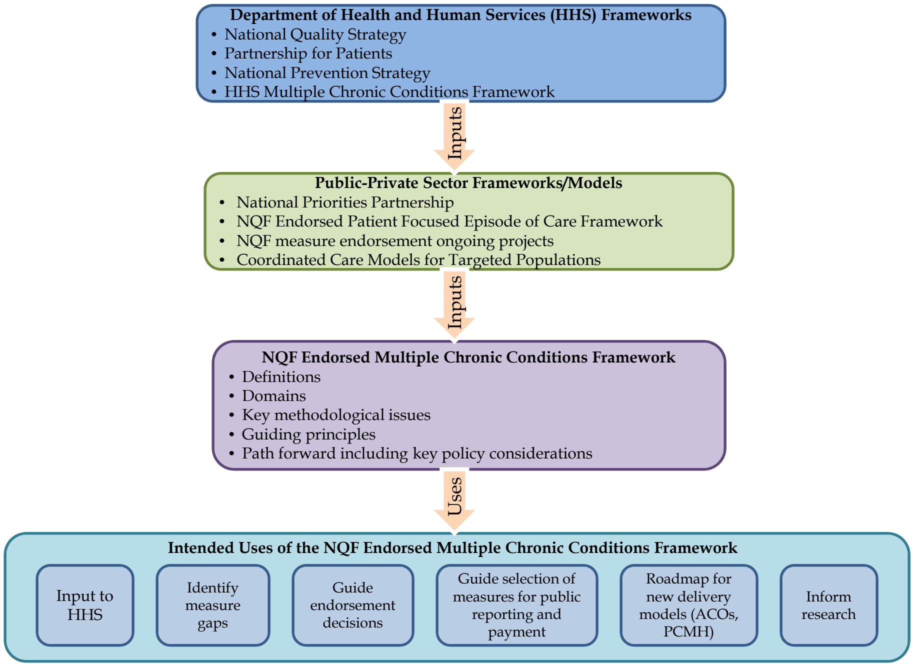
MONDAY, AUGUST 8, 2011
8:30 AM – 3:30 PM (ET)



Meeting Objectives

- Finalize definition of multiple chronic conditions (MCC)
- Establish guiding principles for measurement
- Finalize the multiple chronic conditions conceptual model
- Prioritize key measure concepts areas
- Discuss path forward and policy implications of framework

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

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- 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

Finalize the Definition of Multiple Chronic Conditions

TAB 2

MCC Updated Definition

Persons with multiple chronic conditions are defined as having two or more concurrent chronic conditions that collectively have a significant adverse effect(s) on health status, function or quality of life and that require complex health care management or coordination. [1] [2]

MCC Updated Definition continued

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[1] In the context of this definition, chronic conditions encompass a spectrum of disease and other clinical (e.g. obesity), behavioral (e.g. problem drinking), and developmental (e.g. learning disabilities) conditions. Additionally, the social context in which a person lives (e.g. homelessness) is also considered an important influencing factor.

[2] A complication associated with a primary diagnosis would also meet the requirement of two or more concurrent conditions (e.g. cystic fibrosis in children with an associated complications such as pancreatic insufficiency)

MCC Updated Definition continued

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Assessment of the quality of care[3] provided to the MCC population should consider measures targeting two or more concurrent chronic conditions requiring ongoing clinical, behavioral[4] or developmental care from trained professionals and that act together to significantly increase the complexity of management and coordination of care— including but not limited to potential interactions between conditions and treatments. Importantly, from an individual's perspective this would:

- Affect functional roles and health outcomes across the lifespan;
- Compromise life expectancy; and
- Hinder a patient's ability to self manage or a family or caregiver's capacity to assist in that individual's care.

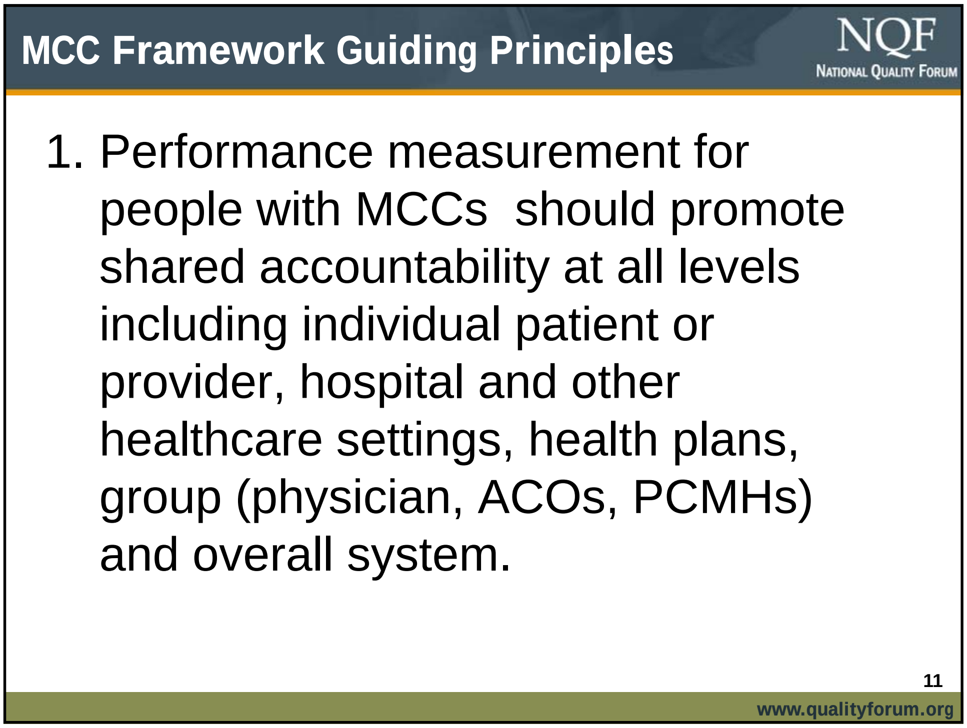
MCC Updated Definition continued

[3] Quality of care is defined by the IOM six aims: safe, timely, effective, efficient, equitable and patient centered.

[4] Behavioral includes mental health and substance use illness.

Guiding Principles for MCC Measurement Approaches

TAB 3



MCC Framework Guiding Principles

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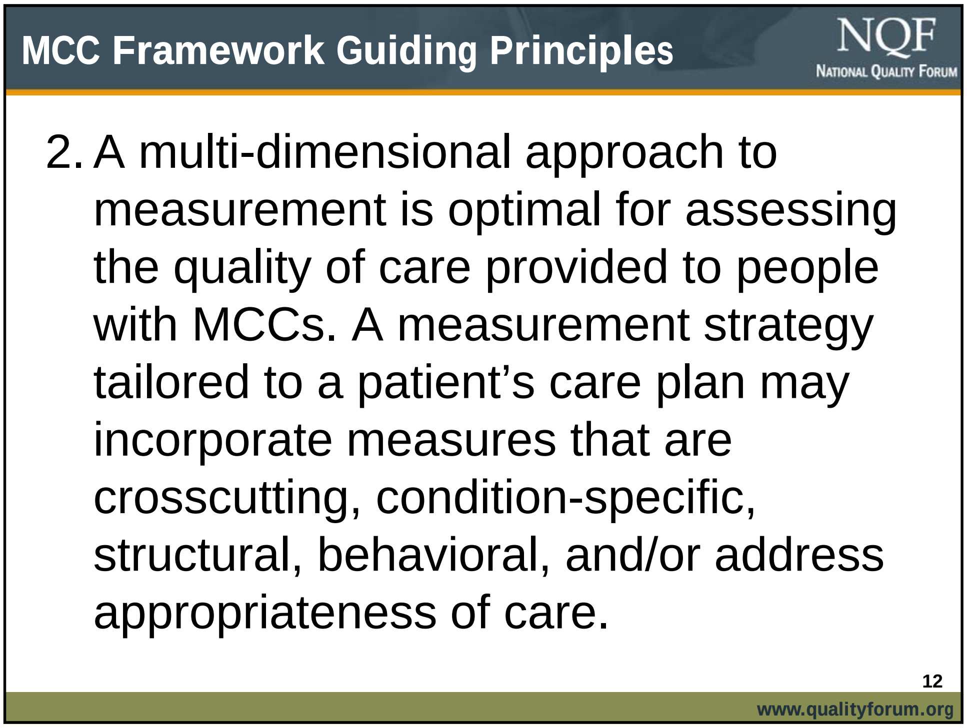
1. Performance measurement for people with MCCs should promote shared accountability at all levels including individual patient or provider, hospital and other healthcare settings, health plans, group (physician, ACOs, PCMHs) and overall system.



MCC Framework Guiding Principles

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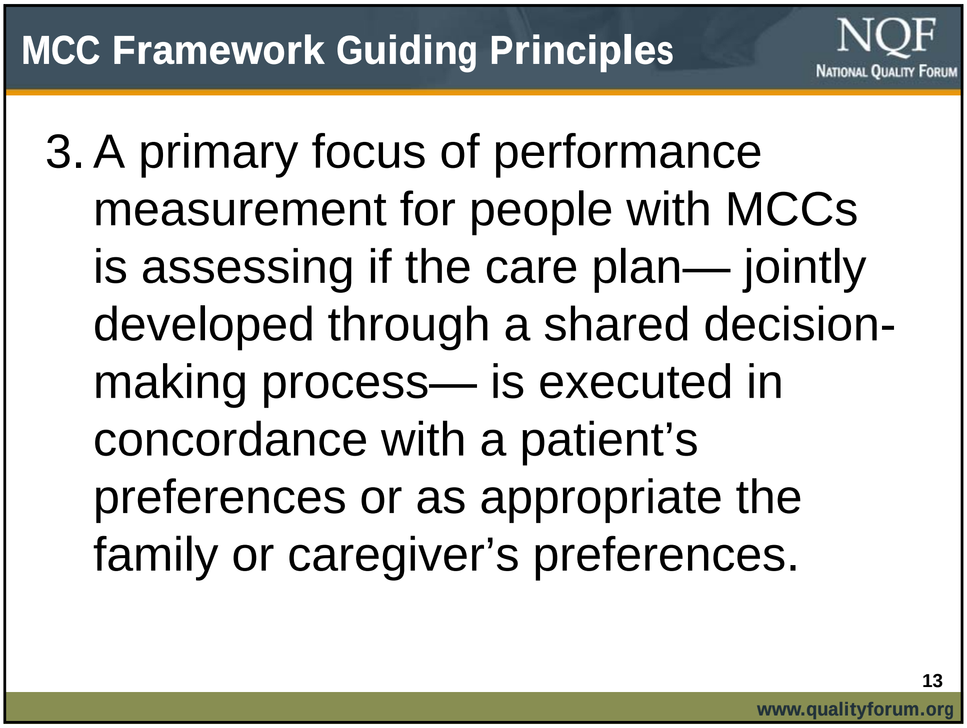
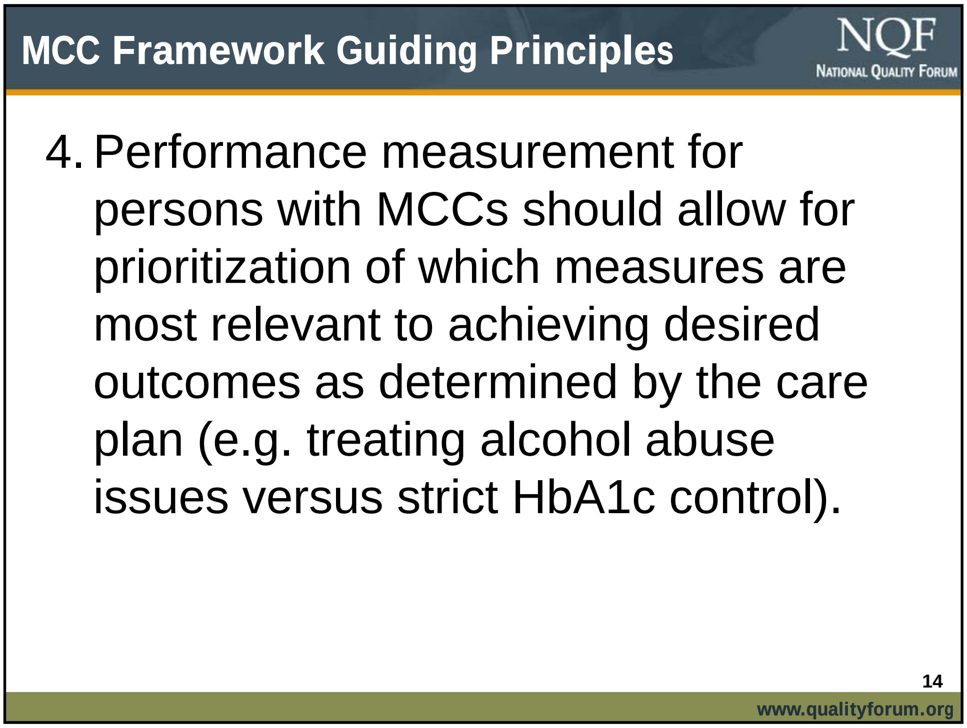
2. A multi-dimensional approach to measurement is optimal for assessing the quality of care provided to people with MCCs. A measurement strategy tailored to a patient’s care plan may incorporate measures that are crosscutting, condition-specific, structural, behavioral, and/or address appropriateness of care.



MCC Framework Guiding Principles

3. A primary focus of performance measurement for people with MCCs is assessing if the care plan— jointly developed through a shared decision-making process— is executed in concordance with a patient’s preferences or as appropriate the family or caregiver’s preferences.



MCC Framework Guiding Principles

4. Performance measurement for persons with MCCs should allow for prioritization of which measures are most relevant to achieving desired outcomes as determined by the care plan (e.g. treating alcohol abuse issues versus strict HbA1c control).

MCC Framework Guiding Principles

5. Performance measures should ideally assess care provided over extended periods of time and change over time.

MCC Framework Guiding Principles

6. Performance measures should be inclusive of the MCC population rather than use denominator exclusions to remove the MCC population from measure specifications. The complexities of the MCC populations should be addressed through stratification and risk adjustment as appropriate.
   A. Stratification of measures is preferred to risk adjustment for people with MCCs. In addition to stratifying the MCC population, additional areas for stratification include disability, cognitive impairments, life expectancy, illness burden, shadow conditions or dominant conditions, SES, and race and ethnicity. The lack of data available for stratification is a barrier that will need to be addressed.
   B. Risk adjusting measures should be used with caution as risk adjustment methodologies may result in the unintended consequence of not identifying and monitoring serious gaps in care for the MCC population.

MCC Framework Guiding Principles

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- Collectively, do the guiding principles address the key methodological considerations for measurement for people with MCCs?
- Do any of the draft principles require further refinement?
- Are there any principles that are missing?

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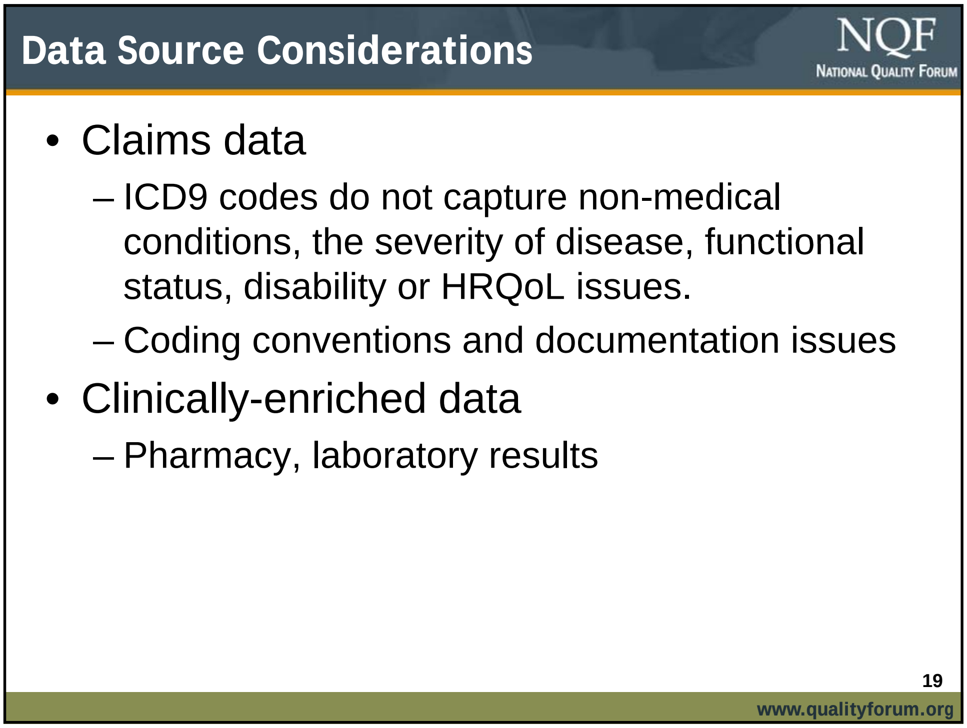
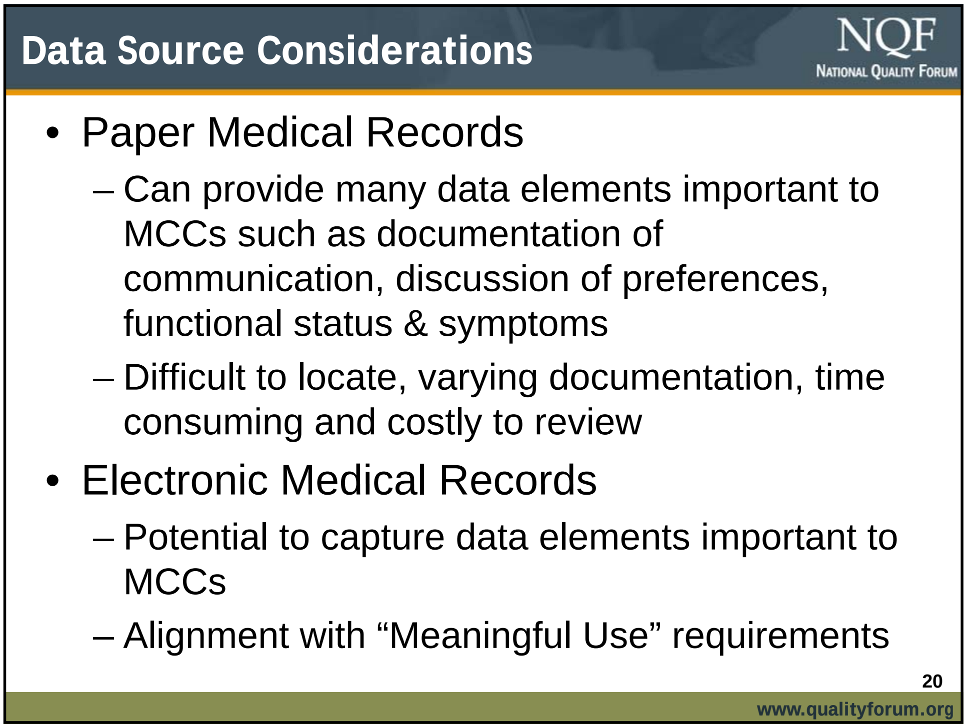
Discussion of Data Source Considerations



Data Source Considerations

- Claims data
  - ICD9 codes do not capture non-medical conditions, the severity of disease, functional status, disability or HRQoL issues.
  - Coding conventions and documentation issues
- Clinically-enriched data
  - Pharmacy, laboratory results



Data Source Considerations

- Paper Medical Records
  - Can provide many data elements important to MCCs such as documentation of communication, discussion of preferences, functional status & symptoms
  - Difficult to locate, varying documentation, time consuming and costly to review
- Electronic Medical Records
  - Potential to capture data elements important to MCCs
  - Alignment with “Meaningful Use” requirements

Data Source Considerations

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- Survey data
  - For example, CAHPS, Family Evaluation of Hospice Care
- Patient Health Records
  - Patient-reported outcomes data such as functional status or HRQoL are not routinely collected or available as standardized data
  - Critical for people with MCCs to assess the patient-centeredness of care

Data Source Considerations

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- Given the strengths and limitations of different data sources what can be done in the short-term and long-term to address data needs for people with MCCs?

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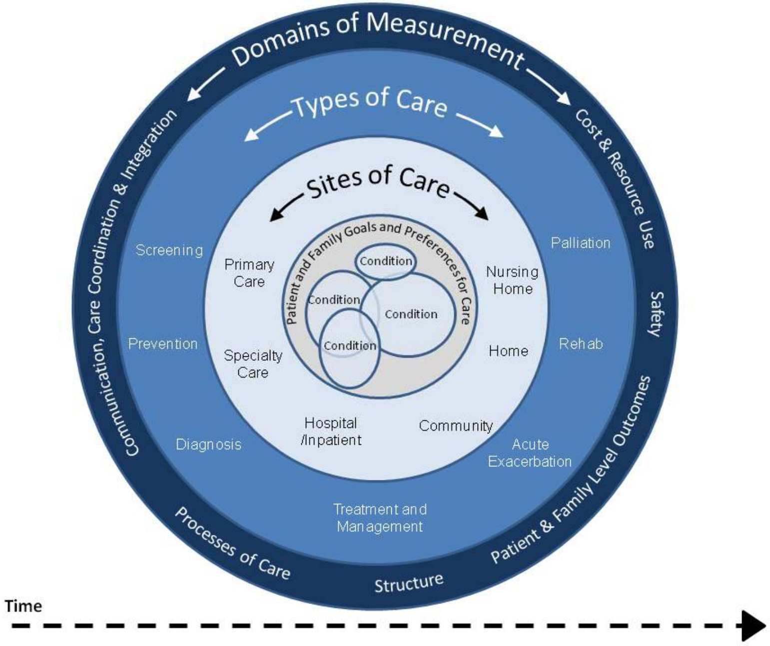
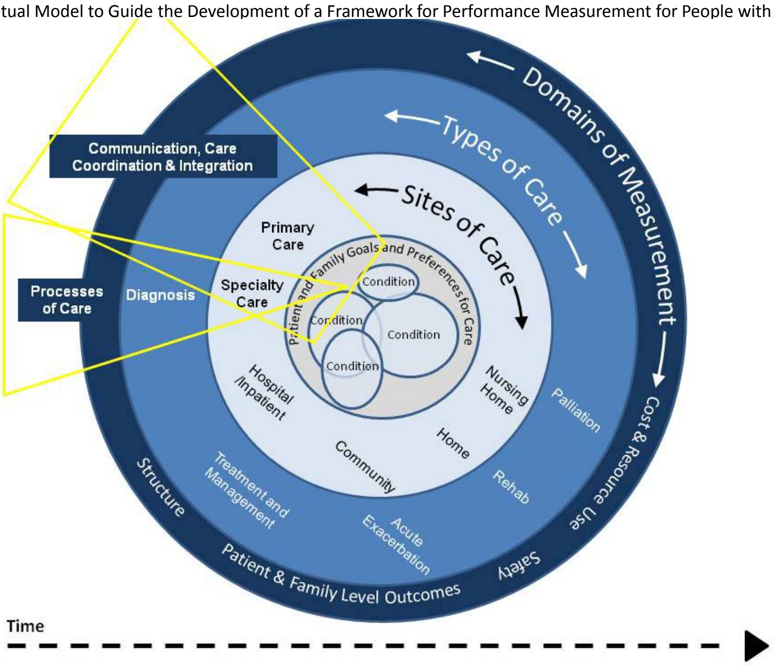
Developing a Conceptual Model for MCC

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



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



MCC Framework Key Measure Concept Areas

TAB 4

MCC Framework Key Measure Concept Areas

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas for MCC
Effective communication and coordination of care	• Care plans in use • Seamless transitions between multiple providers and sites of care • Shared accountability that includes patients, families, and providers • Clear instructions/simplification of regimen • Integration between community & healthcare system • Access to patient centered medical home
Person and family centered care	• Patient, family, caregiver experience of care • Shared decision-making • Self-management of chronic conditions, especially multiple conditions
Making quality care more affordable	• Access to quality care particularly a primary care provider that can offer adequate time & attention • Reasonable patient out of pocket medical costs and premiums • Healthcare system costs as a result of inefficiently delivered services, particularly ER visits, poly-pharmacy, hospital admissions
Enable healthy living (Optimize Function)	• Quality of life/patient family perceived challenge in managing illness or pain • Social support/connectedness, to include ability to work • Community/social factors • Depression/substance abuse/mental health
Make care safer	• Preventable admissions and readmissions • Inappropriate medications, proper medication protocol and adherence • Reduce harm from unnecessary services
Prevention and treatment for leading causes of mortality	• Patient outcomes • Missed prevention opportunities – primary, secondary, tertiary

Questions

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- Do these measure concepts capture what is most important for assessing the quality of care for people with MCC?
- Are there any measure concept areas missing?

Prioritization of Key Measure Concept Areas

- Each member has 6 dots
- Place dots on the measure concept areas you believe are of the highest priority
- Once voting has finished we will review and discuss the results of the prioritization

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Prioritization of Key Measure Concept Areas- Results

Key Measure Concept Areas for MCC- Prioritization to be determined during meeting

- Care plans in use
- Seamless transitions between multiple providers and sites of care
- Shared accountability that includes patients, families, and providers
- Clear instructions/simplification of regimen
- Integration between community & healthcare system
- Access to patient centered medical home
- Patient, family, caregiver experience of care
- Shared decision-making
- Self-management of chronic conditions, especially multiple conditions
- Access to quality care particularly a primary care provider that can offer adequate time & attention
- Reasonable patient out of pocket medical costs and premiums
- Healthcare system costs as a result of inefficiently delivered services, particularly ER visits, poly-pharmacy, hospital admissions
- Quality of life/patient family perceived challenge in managing illness or pain
- Social support/connectedness, to include ability to work
- Community/social factors
- Depression/substance abuse/mental health
- Preventable admissions and readmissions
- Inappropriate medications, proper medication protocol and adherence
- Reduce harm from unnecessary services
- Patient outcomes
- Missed prevention opportunities – primary, secondary, tertiary

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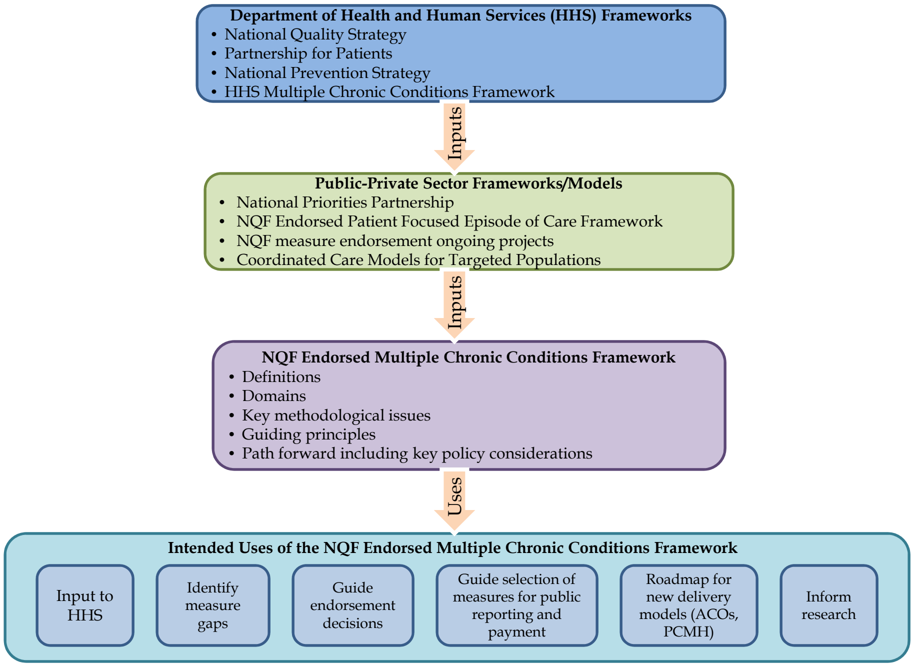
Path Forward: Policy Implications of MCC Framework

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

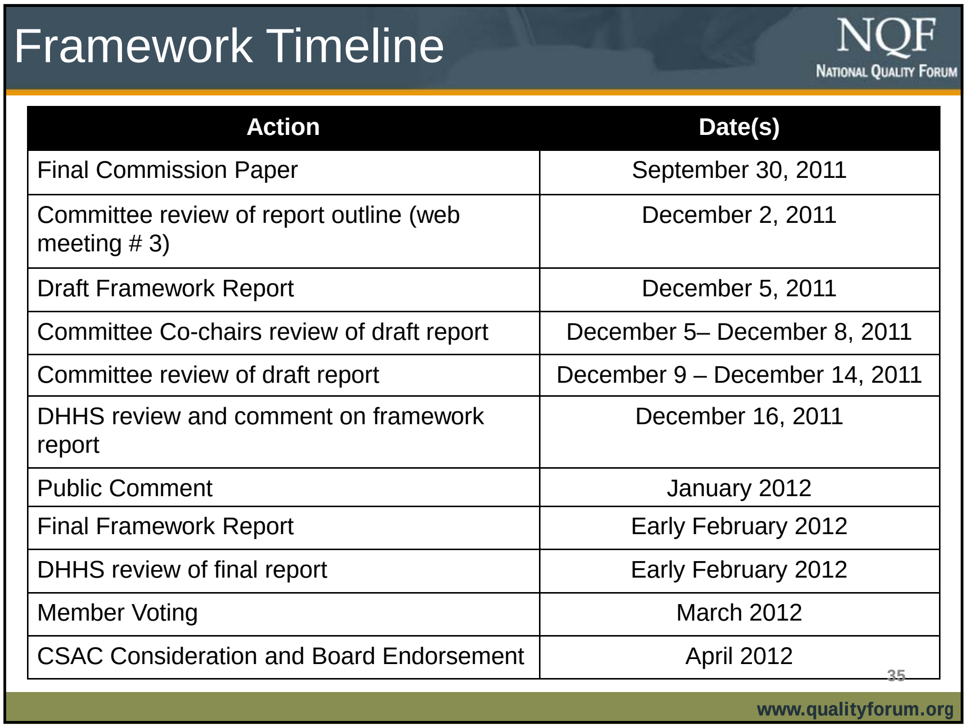
Intended Uses of the NQF Endorsed Multiple Chronic Conditions Framework

- 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

Consideration of Key Policy Drivers

- In the context of the current policy environment how can the MCC framework guide and inform these key policy drivers?
  - Payment models
  - Benefit Design
  - Public Reporting
  - Accreditation/certification
  - Other policy drivers?
- What are our opportunities for achieving alignment with other initiatives (e.g. NPP, MAP)

Next Steps



Framework Timeline

Action	Date(s)
Final Commission Paper	September 30, 2011
Committee review of report outline (web meeting # 3)	December 2, 2011
Draft Framework Report	December 5, 2011
Committee Co-chairs review of draft report	December 5– December 8, 2011
Committee review of draft report	December 9 – December 14, 2011
DHHS review and comment on framework report	December 16, 2011
Public Comment	January 2012
Final Framework Report	Early February 2012
DHHS review of final report	Early February 2012
Member Voting	March 2012
CSAC Consideration and Board Endorsement	April 2012

TAB 2

Definition of Multiple Chronic Conditions

Draft Definition of Multiple Chronic Conditions

Persons with multiple chronic conditions are defined as having two or more concurrent chronic conditions that collectively have a significant adverse effect(s) on health status, function or quality of life and that require complex health care management or coordination.[1] [2]

Assessment of the quality of care[3] provided to the MCC population should consider measures targeting two or more concurrent chronic conditions requiring ongoing clinical, behavioral[4] or developmental care from trained professionals and that act together to significantly increase the complexity of management and coordination of care— including but not limited to potential interactions between conditions and treatments. Importantly, from an individual's perspective this would:

- Affect functional roles and health outcomes across the lifespan;
- Compromise life expectancy; and
- Hinder a patient's ability to self manage or a family or caregiver's capacity to assist in that individual's care.

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[1] In the context of this definition, chronic conditions encompass a spectrum of disease and other clinical (e.g. obesity), behavioral (e.g. problem drinking), and developmental (e.g. learning disabilities) conditions. Additionally, the social context in which a person lives (e.g., homelessness) is also considered an important influencing factor.

[2] A complication associated with a primary diagnosis would also meet the requirement of two or more concurrent conditions (e.g., cystic fibrosis in children with an associated complications such as pancreatic insufficiency)

[3] Quality of care is defined by the IOM six aims: safe, timely, effective, efficient, equitable and patient centered.

[4] Behavioral includes mental health and substance use illness.

TAB 3

Guiding Principles for MCC Measurement Approaches

DRAFT MCC Framework Guiding Principles Key Thematic Areas

1. Performance measurement for people with MCCs should promote shared accountability at all levels including individual patient or provider, hospital and other healthcare settings, health plans, group (physician, ACOs, PCMHs) and overall system.
2. A multi-dimensional approach to measurement is optimal for assessing the quality of care[1] provided to people with MCCs. A measurement strategy tailored to a patient's care plan may incorporate measures that are crosscutting[2], condition-specific, structural[3], behavioral[4], and/or address appropriateness of care[5].
3. A primary focus of performance measurement for people with MCCs is assessing if the care plan— jointly developed through a shared decision-making process— is executed in concordance with a patient' preferences or, as appropriate, the family or caregiver's preferences.
4. Performance measurement for persons with MCCs should allow for prioritization of which measures are most relevant to achieving desired outcomes as determined by the care plan (e.g. treating alcohol abuse issues versus strict HbA1c control).
5. Performance measures should ideally assess care provided over extended periods of time and change over time.
6. Performance measures should be inclusive of the MCC population rather than use denominator exclusions to remove the MCC population from measure specifications. The complexities of the MCC populations should be addressed through stratification and risk adjustment as appropriate.
    a. Stratification of measures is preferred to risk adjustment for people with MCCs. In addition to stratifying the MCC population, additional areas for stratification include disability, cognitive impairments, life expectancy, illness burden, shadow conditions or dominant conditions, SES, and race and ethnicity. The lack of data available for stratification is a barrier that will need to be addressed.
    b. Risk adjusting measures should be used with caution as risk adjustment methodologies may result in the unintended consequence of not identifying and monitoring serious gaps in care for the MCC population.

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[1] Quality of care is defined by the IOM six aims: safe, timely, effective, efficient, equitable and patient-centered.

[2] Crosscutting or "universal" measures can be generalized across a variety of conditions including a single disease with multi-organ system ramifications (e.g. cystic fibrosis). Example measure concepts include: care coordination & integration, shared decision making, medication reconciliation, functional status, HRQoL, and screening & assessment.

[3] Structural measures assess if essential infrastructure (e.g. team-based care, registries, EHRs) is in place to support integrated approaches to care management.

[4] Measures targeting major behavioral health risk factors such as obesity, smoking, alcohol and substance abuse, diet/ nutrition, and physical activity.

[5] For example, measures that assess overuse of services such as imaging; however acknowledging that evidence-based guidelines for people w MCCs is not well developed in this area.

TAB 4

MCC Framework Key Measure Concept Areas

MCC Framework Key Measure Concept Areas

HHS's National Quality Strategy Priorities	Key Measurement Areas for MCC	Sample Measures
Effective communication and coordination of care	• Care plans in use • Seamless transitions between multiple providers and sites of care • Shared accountability that includes patients, families, and providers • Clear instructions/simplification of regimen • Integration between community & healthcare system • Access to patient centered medical home	• 3-item care transition measure (CTM-3) • 30 day post hospital discharge care transition composite measures for AMI, heart failure, and pneumonia • Medication reconciliation post-discharge (MRP) • Timely transmission of transition record • Follow-up after hospitalization for mental illness • Proportion of patients with a chronic condition that have a potentially avoidable complication • ADHD: follow up care for children prescribed ADHD medication • Persons whose healthcare providers always gave them easy-to-understand instructions of how to take care of their illness • PCMH engages in activities to understand and meet the cultural and linguistic needs of patients/families • PCMH collaborates to develop individual care plan, including treatment goals, written plan of care, and assessment and addressing of barriers • Children/children with special healthcare needs with effective care coordination and with access to a medical home
Person and family centered care	• Patient, family, caregiver experience of care • Shared decision-making • Self-management of chronic conditions, especially multiple conditions	• Hospice patients who didn't receive care consistent with EOL wishes • Composites of patient experience related to access to care, doctor communication and office staff • Patient-centered hospital care— pain management, responded when needed help, and explained medications • Persons whose healthcare providers always involved them in decisions about their health care as much as they wanted • Older adults w/ one or more chronic conditions who report

		confidence in managing their conditions
Making quality care more affordable	• Access to quality care particularly a primary care provider that can offer adequate time & attention • Reasonable patient out of pocket medical costs and premiums • Healthcare system costs as a result of inefficiently delivered services, particularly ER visits, poly-pharmacy, hospital admissions	• Percent of people under 65 with out-of-pocket medical and premium expenses >10 percent of income • Percent of households without adequate budget for healthcare expenses • Adults under 65 insured all year, not underinsured • People unable to get or delayed in getting needed medical care, dental care, prescription medications • Annual healthcare expenditures: per capita— national and state, and as a percentage of gross domestic and gross state product • Average annual percent growth in health care expenditures--national and state
Enable healthy living (Optimize Function)	• Quality of life/patient family perceived challenge in managing illness or pain • Social support/connectedness, to include ability to work • Community/social factors • Depression/substance abuse/mental health	• Tobacco Use Assessment & Cessation Intervention • Counseling on Physical Activity in Older Adults • Body Mass Index in Adults • Body Mass Index Ages 2-18 years • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • Children who Live in Communities Perceived as Safe • Children who go to Schools Perceived as Safe • Change in QOL for children with special healthcare needs • Long stay NH residents w/mod-severe pain; w/ depressive symptoms • Inadequate social support • Healthy behavior index (smoking, nutrition, exercise) • Proportion of persons engaging in binge drinking during the past month
Make care safer	• Preventable admissions and readmissions • Inappropriate medications, proper medication protocol and adherence	• 30-day readmissions for: AMI, heart failure, pneumonia • ED visits for children with asthma (pending endorsement) • Fall Risk Management in Older Adults • All-cause readmission index

	• Reduce harm from unnecessary services	• Hospital admissions for ambulatory sensitive conditions (CHF, diabetes, pediatric asthma) • Hospital-acquired conditions—all-cause harm • Hospital acquired conditions—individual HAC measures • Adults 65 and older who receive potentially inappropriate medications
Prevention and treatment for leading causes of mortality	• Patient outcomes • Missed prevention opportunities – primary, secondary, tertiary	• Chronic disease under control—diabetes, high blood pressure, cholesterol • Breast Cancer Screening • Colorectal Cancer Screening • Childhood Immunization Status • Pneumonia Vaccination Status for Older Adults • Hypertension (PQI 7) • Hyperlipidemia (Primary Prevention) • Secondary Prevention of Cardiovascular Events – Use of Aspirin or Antiplatelet Therapy • Promoting Healthy Development Survey (PHDS) • Access to healthy foods • Access to recreational facilities

TAB 5

Strategic Opportunities

National Priorities Partnership Input on Strategic Opportunities

(shaded items are considered highest-leverage and are discussed in more detail in the full report)

	Domain	Strategic Opportunity
1	Federal and Public-Private Program Alignment Strategy	Using the National Quality Strategy (NQS) as a guiding framework, develop a comprehensive alignment strategy across private and public programs, including: a. standardized measures and data standards; b. value-based purchasing and payment; c. public reporting of performance data (e.g.,, expanding the Compare websites to include measures related to the NQS goals; d. accreditation, certification, and regulatory requirements; e. all federal strategies, e.g., the National Prevention Strategy and agency-specific strategies; f. maintenance of certification (e.g., through incorporation of patient experience, shared decisionmaking, preventive care, and patient safety modules); g. program evaluation for all federal/state programs (e.g., Beacon, CVE, QIO, MonAHRQ, PCORI, HIT meaningful use, hospital community benefits) to align resources around common NQS goals.
2	Community Supports	Develop incentives and assist stakeholders at the community-level to identify areas in need of improvement based on the National Quality and National Prevention Strategies, and through resources such as the MATCH County Health Rankings or regional performance/variation data. Assist communities in identifying and in implementing evidence-based programs and policy interventions.
3	Addressing Major Cost Drivers	Beginning with NPP-identified areas of overuse, facilitate multistakeholder collaboration (including professional boards and societies, nursing, pharmacy, and others) to identify, publish, and communicate appropriateness guidelines for high-volume, high-cost, and high-variation service, and identify ways to leverage through benefit design, non-payment policies/penalties, malpractice reform, etc.
4	Informed Consumer Decisionmaking	Improve the ability of consumers (and other parties) to make informed/shared decisions regarding healthcare, including the selection of health plans, providers, and treatments by: a. expand efforts to develop tools that allow effective use of performance measurement to make cost- and quality-conscious decisions; and b. effectively communicating information on the evidence base of the effectiveness of treatments and procedures that are major cost drivers and of limited or minimal benefit, including options for serious advanced illness and end-of-life care.
5	Administrative Simplification	Eliminate administrative inefficiencies and waste through alignment of program requirements and through process reengineering, including: a. addressing multiple public/private billing and payment systems; and b. eliminating unnecessary and duplicative or redundant documentation for proviers and for patients.

National Priorities Partnership Input on Strategic Opportunities

(shaded items are considered highest-leverage and are discussed in more detail in the full report)

	Domain	Strategic Opportunity
6	Payment Incentives	Align public and private contracting, purchasing, and benefit design to reward outcomes and key mechanisms, practices, and approaches to achieve the NQS goals, including: a. shifting from volume-driven, fee-for-service care toward alternative and innovative payment models (e.g., global, episode, population-based); b. implementing tiered provider networks to encourage selection of high-value providers, such as reference pricing; c. implementing formularies and supply-chain controls for high-cost devices and drugs; d. standardizing measurement while encouraging local innovation; e. developing the evidence base in critical areas (e.g., appropriateness, shared decisionmaking, patient activation, and care transitions); f. rewarding conformance to appropriate use guidelines where available and addressing medical liability protections; g. employing health information technology and meaningful use requirements for standard data collection and reporting of measures; aggregate healthcare system and public health data; and enable data sharing across settings; h. incorporating the use of registries (using patient-reported outcomes) for priority areas with high-cost/high-variation and poor outcomes and to reduce disparities; i. creating incentives to encourage redesign of care including integration and care coordination, redefine team-based care, and encourage use of technology-assisted and community-based service delivery; j. promoting increased use of technologies that help to address the needs of rural populations (e.g., telemedicine in the areas of high-risk OB, mental health, developmental disabilities); k. improving upstream healthcare workforce education to meet the demands of an evolving healthcare system; and l. fostering communication and collaboration with patients and communities.
7	Tools and Resources	a. Encourage broad use of CDC Prevention Status Reports to drive change at the state and local level, particularly implementation of identified policy indicators that emphasize the goals and measures of the NQS. b. Encourage broad use of the Community Guide in conjunction with the Guide to Clinical Preventive Services to identify evidence based interventions to improve health and prevent disease in communities. c. Develop tools and resources to assist providers/clinicians with: --assessing organizational communication; --use of advance directives; cultural sensitivity and health literacy; --use of shared decisionmaking tools; --use of data to identify certain patient populations; --use of data improve performance in their patient populations; and --identifying and linking to available community resources.

National Priorities Partnership Input on Strategic Opportunities

(shaded items are considered highest-leverage and are discussed in more detail in the full report)

	Domain	Strategic Opportunity
8	Grant Funding	Support high-need communities in seeking and obtaining available grant funding: a. Community Transformation Grants focused on tobacco-free living, active living and healthy eating, evidence-based quality clinical and preventive services, specifically for high blood pressure and high cholesterol, social and emotional wellness, and healthy/safe physical environments; b. State tobacco grants; c. Chronic Disease and Health Promotion Grants/Comprehensive Chronic Disease Prevention Program; d. SAMHSA State grants; and e. Prevention Block Grants.
9	Performance Measurement and Measurement Gaps	Fill critical measurement gaps and needs by: a. stratifying all measures of quality to highlight areas of disparities because of age, race, ethnicity; b. addressing the aggregation of measures to a population level, the need for better data collection at the community level, and the periodicity of data collection and reporting; c. furthering development and use of measures of patient reported outcomes and shared decisionmaking; d. incorporating Culturally and Linguistically Appropriate Services (CLAS) standards into measures to address health equity issues; e. coupling quality and total cost of care measures (by provider); f. identifying proximal process/structural measures tied to reducing readmissions and harm; g. identifying parallel NQS measures for all settings and priority populations (e.g., adult, pediatric, dual eligibles); and h. developing and endorsing composite measures for ABCS and healthy lifestyle behaviors at the population and provider level.
10	System Redesign	For emerging healthcare delivery or payment models: a. making accreditation or certification of care delivery organizations contingent or tiered based on performance on cost management as well as quality metrics, emphasizing performance on improving outcomes; b. incorporating identified goals and consistent cost and efficiency measures into patient-centered medical home, accountable care organization, and other emerging delivery models and standards; c. incentivizing alternatives to office visits to improve communication and coordination, e.g., e-visits (email, texting, telemonitoring) and innovative approaches to team-based care; d. incentivizing redefinition of health professional roles and scope of practice to allow for innovative approaches to care coordination and patient care; e. developing uniform standards for defining scope and cost components of episodes of care and encourage consistent approaches to reference pricing, benefit design, attribution, shared savings, and reporting requirements; and f. encouraging integrated use of health information infrastructure, including the use of health center data warehouses to assess health outcomes for the uninsured.

TAB 6

July 8th In-person Meeting Summary

NQF
NATIONAL QUALITY FORUM

IN-PERSON MEETING FOR THE MULTIPLE CHRONIC CONDITIONS STEERING COMMITTEE

JULY 8, 2011

The Multiple Chronic Conditions (MCC) Steering Committee held an open session in-person meeting on July 8, 2011.

I. WELCOME, INTRODUCTION, AND OVERVIEW OF MEETING OBJECTIVES

Barbara McCann and Caroline Blaum, Co-Chairs, welcomed the Multiple Chronic Conditions (MCC) Steering Committee members and thanked them for their participation. Ann Hammersmith, NQF General Counsel, then led the disclosures of interest by individual Committee members. Ms. McCann reviewed the objectives for the meeting, which included:

- 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, and
- Define the domains in the MCC framework.

II. DEVELOPING A MCC MEASUREMENT FRAMEWORK

Ms. Blaum provided an overview of the Committee's charge, scope of work, intended uses of the MCC framework, and the project's timeline and deliverables.

Steering Committee's Charge and Scope of Work

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 MCC. Under the guidance of a multi-stakeholder Steering Committee, NQF will develop a patient-centric measurement framework for individuals with MCC. Specifically the framework will:

- establish definitions, domains, and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCC;
- adapt the NQF-endorsed® patient-focused episodes of care measurement framework for patients with MCC 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), Partnership for Patients, National Prevention Strategy, Health and Human Services' (HHS') Strategic Framework on MCC, 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.

In developing a measurement framework for individuals with MCC, the Committee will build upon the core tenets of the NQF-endorsed 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.

Intended Uses of the MCC Framework

The intended uses of the MCC measurement framework are to provide input to HHS on MCC strategic framework and initiatives, inform measure development in selecting measures for people with MCC, identify measure gaps, guide selection of measures for public reporting and payment, serve as a roadmap for new delivery models (Accountable Care Organizations, Patient Centered Medical Homes), and inform research. Specifically, the NQF-endorsed MCC measurement framework will inform the following components of the HHS' strategic framework on 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.
- 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.

Projects Timeline and Deliverables

The timeline and deliverables under the MCC project are as follows:

- 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—Consensus Standards Approval Committee (CSAC) consideration and Board endorsement.

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

After review of the charge, scope, timeline, and deliverables, the floor was open for any questions or clarifications. Committee members indicated they understood expectations moving forward and appreciated the time spent on further elaborating on the key end users and applications of this work in the broader policy context.

III. DISCUSSION OF HOMEWORK EXERCISE AND EMERGING KEY THEMES

Aisha Pitman, NQF Senior Program Director of Strategic Partnerships, provided a brief overview of the findings from the Committee's homework assignment.

Prior to the meeting, Committee members reviewed a “Key Issues” document compiled by a research team from Johns Hopkins University that was subcontracted by NQF to assist in informing this work. Committee members then completed a brief survey to prioritize the issues they should focus on moving forward. The survey results revealed that a shared definition of MCC was a top priority and thus a critical starting point. Additional topics that ranked highly were:

- prioritizing measures into a high-leverage parsimonious set that does not increase provider burden;
- addressing methodological issues around performance measurement;
- adopting non-disease-specific approaches to quality and movement toward crosscutting measures; and
- applying the key tenets of the NQF-endorsed patient-focused episode of care model (e.g., longitudinal measurement of patient-focused outcomes and costs).

The following themes emerged from the Committee’s feedback:

- There is a need to incorporate the concept of life course into the framework, particularly to address children with special healthcare needs;
- Payment reform was viewed as an important downstream application of this framework, and therefore a detailed discussion of alternate payment models and policy implications may be out of scope for this project;
- Primary care and upstream prevention including secondary and tertiary prevention is critical to effective care and should be an integral component of this framework.

IV. DEFINING MULTIPLE CHRONIC CONDITIONS

Ms. McCann, MCC Co-Chair, and Cynthia Boyd, Associate Professor at Johns Hopkins University, provided some considerations for defining MCC.

In developing its definition of MCC the Committee built on the earlier work in the field including:

- HHS’ Strategic Framework defines MCC as two or more concurrent chronic conditions; and
- Agency for Healthcare Research and Quality’s Optimizing Prevention and Healthcare Management for the Complex Patient 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.”

Based on the Committee’s deliberations, an overarching definition was put forth, as well as an accompanying definition that further operationalized key concepts.

- Persons with multiple chronic conditions are defined as individuals having 2 or more concurrent chronic conditions* that affect the life expectancy or quality of life and are associated with complicated health needs or perceived burden of care for patient, family and providers.

* Chronic conditions includes clinical, behavioral, and social conditions

- Measures targeting the MCC population should consider 2 or more concurrent chronic conditions that require ongoing clinical/behavioral/mental/health attention and that
  - Influences care of other conditions or
  - Leads to high levels of complexity or difficulty stabilizing care coordination or
  - Affects functional roles and outcomes or
  - Leads to limitations of life expectancy or
  - Leads to contraindications or severe interactions or
  - Limitations of patient's ability to self-manage and the patients and families perceived burden.

As follow-up the NQF staff will reach out to the pediatric Committee members to further refine the definition to make it more relevant to children and will work closely with the MCC Co-Chairs and Johns Hopkins University to bring back a revised draft to the full Committee.

V. DEVELOPING A CONCEPTUAL MODEL FOR MEASUREMENT OF PERFORMANCE IN PEOPLE WITH MULTIPLE CHRONIC CONDITIONS

Evolution of the NQF-endorsed Patient-focused Episode of Care Framework

Karen Adams, NQF Vice President for National Priorities, provided a brief overview on the evolution of the NQF-endorsed patient-focused episode of care framework. This 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. The framework 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 strengths to using the framework are found in its patient-focused orientation, targeting of value, emphasis on care coordination, promotion of shared accountability, assessment of shared decisionmaking, and support of fundamental payment reform. However, there are also limitations to framework including the inability to address appropriateness of care, adequately risk adjust for different populations, directly address patients with MCC, and facilitate comparisons among organizations.

Considerations for MCC Conceptual Model

Bruce Leff and Erin Giovannetti, researchers at Johns Hopkins University, presented a conceptual model for measurement of performance in people with MCC. This model centers on a patient with multiple disease and/or conditions that overlap in varying ways. These conditions may affect the patient with greater or lesser magnitude over time. The patient can be cared for across multiple sites of care, included primary care, specialty care, hospital or inpatient care, home care, nursing home and the community, among others. At any given site of care, the patient may be utilizing one or more types of care (screening, prevention, diagnosis, treatment and management, acute exacerbation, and rehabilitation), which are not always linear and are not mutually exclusive. Performance measurement for patients with MCC requires a multi-dimensional approach, and five domains of measurement were proposed:

- **Care coordination and integration** measures assess coordination between physicians, specialties, and sites of care and integration of an overall care plan.
- **Processes of care** measures examine overuse, underuse, and misuse of recommended treatments, but may also include non-disease-specific processes of care such as medication reconciliation.
- **Structure** measures examine the presence of structural elements that support patient care and coordination, such as electronic health records, self-management support groups, or a house call program.
- **Patient- and family-level outcomes** encompasses a wide range of outcome measures most important to patients and their families including, but not limited, to health outcomes, health-related quality of life, patient and family centeredness, goal attainment, shared decisionmaking, engagement, satisfaction, access to care, self-management, education, palliation, caregiver burden, and treatment burden.
- **Cost and resource use** measures look at both the quantity of resources used and the true cost of care and issues such as efficiency and value.

The Committee was presented with considerations for the conceptual model and offered the following feedback for refining the model:

- Patient and family preferences should be more explicit,
- Consideration should be given to the provider's influence on patient perception of care,
- Incorporate end-of-life care in types of care,
- Encompass coordinated care in the model, and
- Highlight influencing factors (e.g., age, ethnicity, and social environment).

The Committee believed that the model captured the complexity of care for people with MCC and highlighted the need to prioritize measures based on importance and feasibility, and when possible, to build on existing measures adapted for this population.

VI. DISCUSSION OF FRAMEWORK DOMAINS

Ms. McCann provided an overview of the domains of the NQF-endorsed patient-focused episodes of care framework and a mapping of the domains to the NQS six priority areas. The Committee used these as building blocks in identifying core measure concepts for the MCC population. The Committee's reflections were as follows:

NQF-endorsed Patient-Focused Episodes of Care Framework Domains Modified for MCC Population

- **Patient-level outcomes** (better health) include risk-adjusted morbidity and mortality, functional status, health-related quality of life, patient and family experience of care, developmental, and usual source of care such as a primary doctor.
- **Processes of care** (better care) encompass care coordination/transitions, decision quality (care aligned with patients' preferences), patient engagement and adherence, proximal to outcomes, and technical.
- **Cost and resource use** (less overuse, waste, misuse) include patient opportunity costs, productivity return to work, and total cost of care across the episode.

NQS National Priorities Customized for MCC Population

- **Effective communication and coordination of care** should include concepts that look at care plans in use; seamless transitions between multiple providers; shared accountability that includes patients, families, and providers; clear instructions/simplification of regimen; integration between community and healthcare system; and access to patient-centered medical home.
- **Person- and family-centered care** should incorporate concepts that look at the patient, family, and caregiver experience of care; shared decisionmaking; and self-management of chronic conditions, especially multiple conditions.
- **Make quality care more affordable** should integrate concepts that look at access to quality care, particularly a primary care provider who can offer adequate time and attention; reasonable patient out-of-pocket medical costs and premiums; and healthcare system costs as a result of inefficiently delivered services, particularly emergency room visits, poly-pharmacy, and hospital admissions.
- **Enable healthy living** (optimize function) should encompass concepts that look at quality of life or patient–family perceived burden of illness or pain; social support or connectedness, including ability to work; disparities or social determinants; and depression, substance abuse, or mental health.
- **Making care safer** should consist of concepts that look at preventable admissions; reduce harm from unnecessary services; and inappropriate medications, proper medication protocol, and adherence.
- **Prevention and treatment for leading causes of mortality** should contain concepts that look at patient outcomes and missed prevention opportunities such as primary, secondary, tertiary.

Considerations for Infrastructure/Health Information Technology (HIT)

The Committee had a brief discussion about how the framework should address the changing HIT environment. Specifically, the Committee noted that the framework should consider the following efforts:

- Health Information Exchange (HIE) networks being developed by states and how measurement of MCC could be incorporated into these networks,
- The Centers for Medicare & Medicaid Services’ meaningful use of HIT programs and how those measures address patients with MCCs, and
- Patient registries and what information in them can be used to measure MCCs.

VII. METHODOLOGICAL CONSIDERATIONS

The Committee briefly discussed methodological issues pertaining to performance measurement for people with MCC and prioritized the following areas to focus its attention on providing guiding principles for the framework:

- Risk adjustment and stratification
- Age or morbidity cut-offs/altered targets
- Denominators
- Exceptions
- Composite measures
- Prioritizing measures

These issues will be explored more fully during an upcoming web meeting and during the August meeting.

VIII. NEXT STEPS

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

- July 29, 2011—web meeting methodology subgroup,
- August 8, 2011—in-person meeting, and
- December 2, 2011—web meeting.