



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:

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- **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.