Welcome!

This month's newsletter provides an overview of multiple chronic condition measures as a part of the Measures Types series. Every edition includes links to the CMS Blueprint (the version in use at the time of publication), as well as a calendar of upcoming events and opportunities.

We hope you find this newsletter useful and we welcome any feedback or suggestions to make it even better. Please send comments or suggestions for future newsletters to MMSSupport@battelle.org.

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Measure Type Series
Multiple Chronic Condition Measures

According to the Centers for Disease Control and Prevention (CDC), nearly 71 percent of total health care spending in the United States is associated with care for Americans with more than one chronic condition. One in four Americans has multiple chronic conditions (MCC) such as hypertension, arthritis, diabetes, depression, and lung disease. In 2011, the Centers for Medicare & Medicaid Services (CMS) found that Medicare beneficiaries with MCC were the heaviest users of healthcare services. For those with six or more chronic conditions, two-thirds were hospitalized during 2010 and they accounted for about half of Medicare spending on hospitalizations. However, very few measures exist[i] that are specifically designed to evaluate the quality of care provided to this population of healthcare users.

Recognizing the importance of care for individuals with MCC, the U.S. Department of Health & Human Services (HHS) contracted with the National Quality Forum (NQF) to develop a measurement framework for persons with MCC. The NQF MCC Measurement Framework defined MCC as follows:

Persons with MCC are defined as having two or more concurrent chronic conditions that collectively have an adverse effect on health status, function, or quality of life and that require complex healthcare management, decision making, or coordination.

Though persons with MCC represent a growing proportion of society who use an increasingly greater amount of healthcare services, there are not enough existing quality measures to adequately promote best practices for the care of individuals with MCC. Current quality measures are largely based on performance standards derived from clinical practice guidelines for management of specific diseases[ii]. The randomized clinical trials used in clinical practice guideline development focus mainly on single diseases to produce robust guidance for specific disease treatments. Patients with MCC have often been excluded from the evidence-generating clinical trials that form the basis of many clinical practice guidelines.

Assessment of the quality of care provided to the MCC population should consider persons with two or more concurrent chronic conditions that require ongoing clinical, behavioral, or developmental care from members of the healthcare team and whose conditions act together to significantly increase the complexity of management and coordination of care—including, but not limited to, potential interactions between conditions and treatments[iii].

Two examples of current MCC focused measures include: NQF 2606 and NQF 2888.

- NQF 2606: Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg), is an outcome measure focused on maintaining positive cardiovascular outcomes in individuals with both mental health conditions and diabetes.

- While NQF 2888, Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions, recognizes that individuals with MCC are at high risk for unplanned hospital admissions.

For future measure development, The NQF Framework identified that quality measures for persons with MCC should be guided by several principles. Quality measures should:

- Promote collaborative care among providers
- Consider various types of measures (an MCC measure is not a distinct type, it may be a structure, process, or outcome measure and is often crosscutting) that address appropriateness of care
- Prioritize optimum outcomes that are jointly established by considering patient preferences
- Address shared decision making
- Assess care longitudinally
- Be as inclusive as possible
- Illuminate and track disparities through stratification and other approaches
- Use risk adjustment for comparability (of outcome measures only) with caution, as it may obscure serious gaps in quality of care
- Standardize inputs from multiple sources, particularly patient-reported data.

Attribution (crediting good outcomes to the appropriate provider) and data collections can be complicating factors for MCC measure developers and implementers. Since multiple conditions usually means multiple providers, it becomes difficult to determine should be credited for good outcomes and which provider gave inadequate care when the treatment for one condition might exacerbate the other. These issues may require a more aggregated level of analysis such as at a provider group level or population rather than individual level. Since beneficiaries with MCC see multiple providers, it would be more appropriate to measure and attribute the outcomes for the population to the care provided by the team of providers. Additionally, there may be difficulties gathering data systematically, especially for this population. Particularly, patient-reported data for multiple chronic conditions may be challenging to collect because of the interacting conditions. For example, it might be difficult to collect fatigue data from a person with both chronic lung disease and history of stroke, because each condition may contribute to a patient's fatigue, and it may be complicated to assess the contribution of each disease to that fatigue. Interpretation of different types of data is needed, as the data may come from multiple providers, multiple sources, in multiple formats, and over extended periods. It is important for measure developers to standardize data collection methods.

Despite these challenges, measures dedicated to improving health outcomes for individuals with MCC have the potential to dramatically improve the quality and affordability of care for individuals and communities.

References

[i] National Quality Forum. Multiple Chronic Conditions Measurement Framework, May 2012.

[ii] Tinetti ME, Bogardus ST, Agostini JV. Potential pitfalls of disease-specific guidelines for patients with multiple conditions. New England Journal of Medicine. 2004;351:2870–4.

[iii] National Quality Forum. Multiple Chronic Conditions Measurement Framework, May 2012.

Upcoming Events

All times shown are Eastern Time zone

- Inpatient Hospital Quality Programs: Payment Updates and Overview Webinar on October 11, 2017 at 2:00 - 3:00 PM
  - Register for the event here
- Whose Report? What Report? Where Did You Get Webinar on October 18, 2017 at 10:00 AM and 2:00 PM
  - Register for the event here
- 2016 Annual QRURs Webcast on October 19, 2017 at 1:30 - 3:00 PM
  - Register for the event here
- Digital Quality Summit on November 1-2, 2017 in Washington, DC
  - Register for the event here

Upcoming Opportunities

Opportunities for Public Comment on quality measures
- End-Stage Renal Disease Emergency Department Visits
  - Public Comment period opens on October 13, 2017 and closes on November 13, 2017.

  Please check the CMS Quality Measures Public Comment Web Page for current Public Comment announcements and summary reports.

Opportunities to participate in a Technical Expert Panel (TEP)
- Development, Reevaluation, and Implementation of Outcome and Efficiency Measures
  - The TEP nomination period opened on September 5, 2017 and closes on October 13, 2017.

- Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
  - The TEP nomination period opened on October 9, 2017 and closes on October 27, 2017.

  Please check the CMS Quality Measures Call for TEP Web Page for current TEP membership lists and meeting summaries.

New to the listserv or missed a month? Find all our announcements as well as printer-friendly versions of past newsletters [here](#).

Please send comments and suggestions to MMSSupport@battelle.org.