
Look through the Lens of Chronic Care – the Promise of Quality Measurement and Value-Based Care

Value Incentives & Systems Innovation Collaborative

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Key Points

1. Current Systems are Failing our Patients and Providers
2. Quality Measures are Based Upon Single Disease Specific Guidelines with Limited Evidence about Applicability and Relevance for those with Multiple Chronic Conditions
3. Care of the patient with Multiple Chronic Conditions Requires Eliciting Patient Priorities/Preferences
4. Value-Based Care must Recognize Care Coordination, Teams and Social Supports
5. Payment Methods must Stimulate and Support Transformation – Including Pay for Quality, Workforce Development and Leadership by those with MMC expertise
6. Fee for Service & Description and Valuation of Work Remain Relevant
7. We must examine why we measure/pay, how we measure/pay and the impact on patient care and our communities, avoiding the “best doc” myth

NQF Multiple Chronic Conditions Measurement Framework May 2012

Multiple Chronic
Conditions
Measurement
Framework

MAY 2012



Persons with multiple chronic conditions 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.^{b,c}

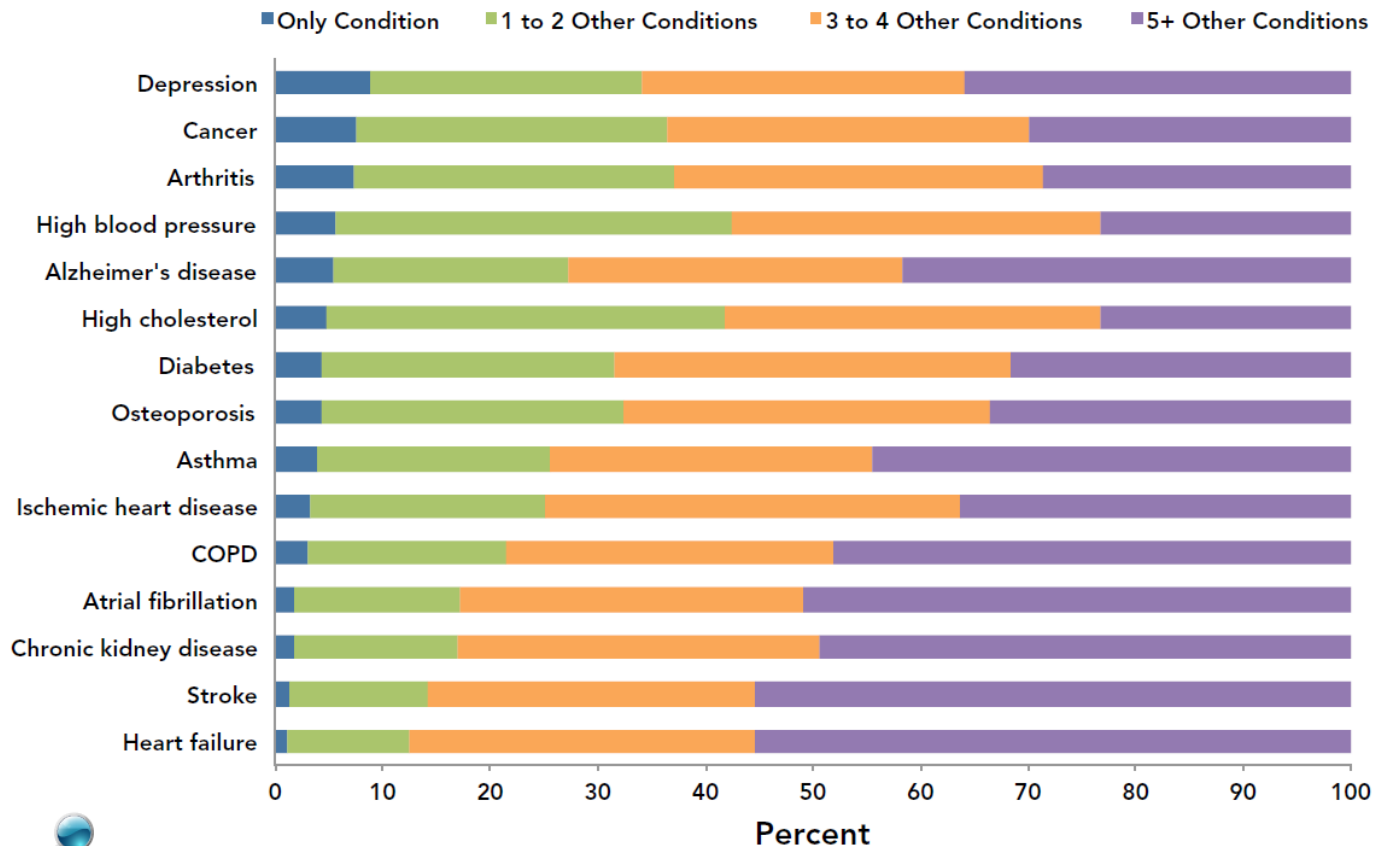
Assessment of the quality of care^d provided to the MCCs population should consider persons with two or more concurrent chronic conditions that require ongoing clinical, behavioral,^e or developmental care from members of the healthcare team and act together to significantly increase the complexity of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

Importantly, from an individual's perspective the presence of MCCs would:

- affect functional roles and health outcomes across the lifespan;
- compromise life expectancy; or
- hinder a person's ability to self-manage or a family or caregiver's capacity to assist in that individual's care.

Co-Morbidity is Common

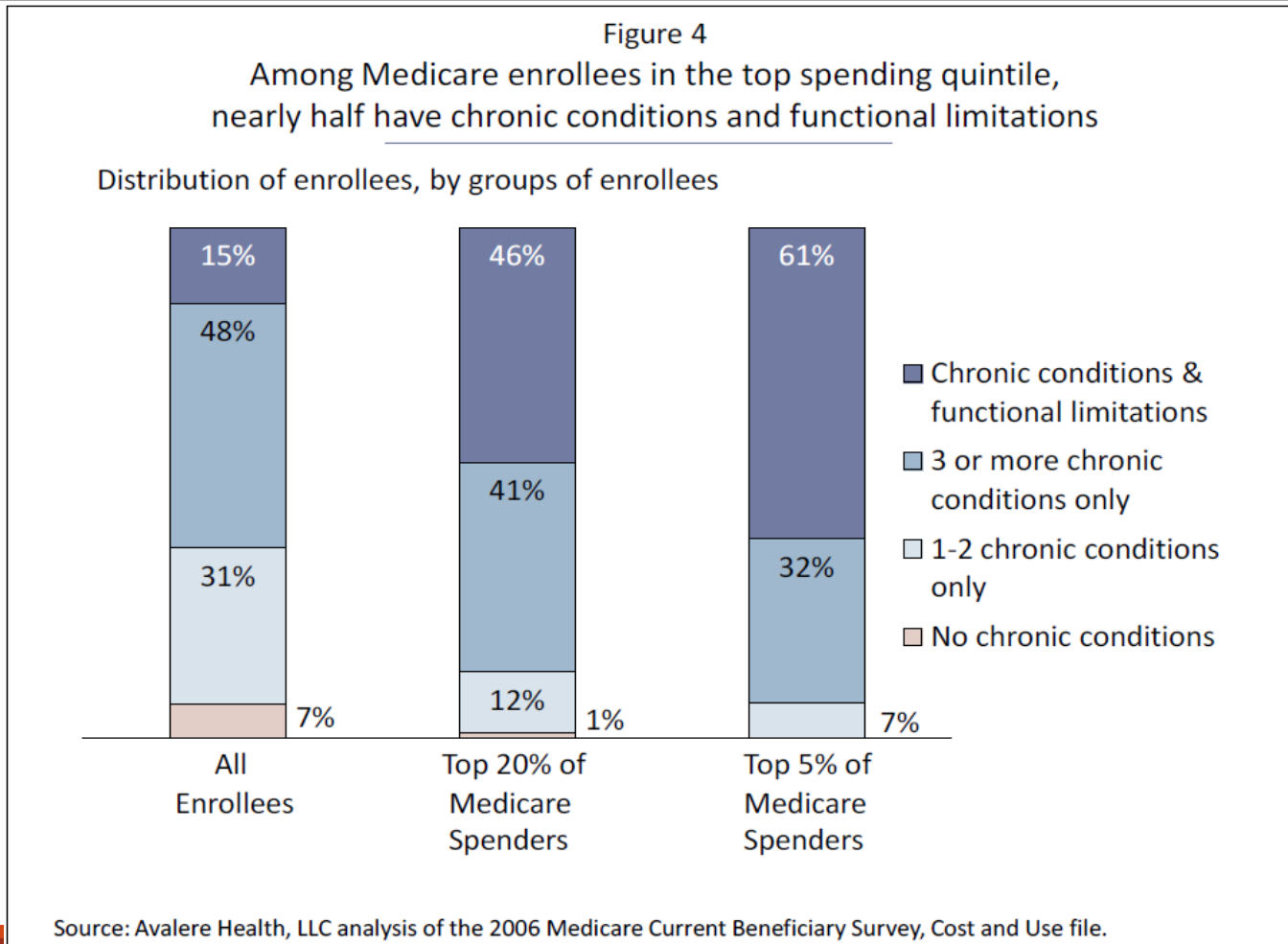
Figure 4.1 *Co-morbidity among Chronic Conditions for Medicare FFS Beneficiaries: 2010*



“The most common chronic condition experienced by adults is multimorbidity, the coexistence of multiple chronic diseases or conditions.”

Tinetti et al. JAMA 2012.

Most of Highest Utilizers (top 5%) have Functional Limitations



It is not Easy Living with MCC

Time	Medications	Non-pharmacologic Therapy	All Day	Periodic
7 AM	Ipratropium MDI Alendronate 70mg weekly	Check feet Sit upright 30 min. Check blood sugar	Joint protection Energy conservation	Pneumonia vaccine, Yearly influenza vaccine
8 AM	Eat Breakfast HCTZ 12.5 mg Lisinopril 40mg Glyburide 10 mg ECASA 81 mg Metformin 850mg Naproxen 250mg Omeprazole 20mg Calcium + Vit D 500mg	2.4gm Na, 90mm K, Adequate Mg, ↓ cholesterol & saturated fat, medical nutrition therapy for diabetes, DASH	Exercise (non-weight bearing if severe foot disease, weight bearing for osteoporosis) Muscle strengthening exercises, Aerobic Exercise ROM exercises	All provider visits: Evaluate Self-monitoring blood glucose, foot exam and BP Quarterly HbA1c, biannual LFTs Yearly creatinine, electrolytes, microalbuminuria, cholesterol Referrals: Pulmonary rehabilitation
12 PM	Eat Lunch Ipratropium MDI Calcium+ Vit D 500 mg	Diet as above	Avoid environmental exposures that might exacerbate COPD Wear appropriate footwear	Physical Therapy DEXA scan every 2 years Yearly eye exam
5 PM	Eat Dinner	Diet as above		Medical nutrition therapy
7 PM	Ipratropium MDI Metformin 850mg Naproxen 250mg Calcium 500mg Lovastatin 40mg		Albuterol MDI pm Limit Alcohol Maintain normal body weight	Patient Education: High-risk foot conditions, foot care, foot wear Osteoarthritis COPD medication and delivery system training Diabetes Mellitus
11 PM	Ipratropium MDI			

Boyd et al. JAMA 2005;294:716-724

And we have limited knowledge on how to provide the best care.....

- Reviewed 9 CPGs for chronic conditions
- Most single disease CPGs fail to give adequate guidance for older patients with multimorbidity

Issue	Is Criteria Addressed?
Attention	Limited
Quality of Evidence	Limited
Specific recommendations	Most address treatment of index disease in presence of single other conditions
Time needed to treat	Limited
Quality of life	Limited
Trade-offs in goals of therapy	Not at all
Patient preferences	Limited
Burden	Limited

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Boyd et al. JAMA 2005;294:716-724

Approach to the evaluation and management of the older adult with multimorbidity.

Inquire about the patient's *primary concern* (and that of family and friends, if applicable) and any additional objectives for visit.

Conduct a *complete review* of care plan for person with multimorbidity.
OR
Focus on *specific aspect* of care for person with multimorbidity.

What are the current medical conditions and interventions?
Is there adherence to and comfort with treatment plan?

Consider patient preferences.

Is relevant *evidence* available regarding important outcomes?

Consider prognosis.

Consider *interactions* within and among treatments and conditions.

Weigh *benefits* and *harms* of components of the treatment plan.

Communicate and *decide* for or against implementation or continuation of intervention/ treatment.

Reassess at selected intervals: for benefit, feasibility, adherence, alignment with preferences.

Why Measure? Why “P4P”?

Improve Care/Promote a Quality Culture

Focus on Key Conditions

Accountability to Public

Identify Opportunity/Barriers/Best Practices

Reward Performance

Reward Improvement

Recognize CQI Staff

Fund the QI Infrastructure

Support Care Delivery System Transformation

Why Measure? Why “P4P”?

Improve Care/Promote a Quality Culture

Focus on Key Conditions

- Single Disease Focus

Accountability to Public

- At what level?
- By what Measure?

Identify Opportunity/Barriers/Best Practices

Reward Performance

- By what measure?
- Care for disadvantaged or complex is more difficult

Reward Improvement

Recognize CQI Staff

Fund the QI Infrastructure

Why Change Payment?

Recognize Value over Volume

Recognize/support Proven Models of Care (PACE, GRACE, IAH)

Remove Silos (Parts A/B, Medicare/Medicaid) and Create Opportunity for Care Alternatives (eg Longterm Community Social Supports)

Align Incentives

Shift Risk

Incentivized Care Coordination

Incentivize Teams and Efficient Practice Design

Create SYSTEMS of Care

Sustain Primary Care, Promote PCMH in those systems and Integrate Behavioral Health

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Incentivized Care Coordination and Reduction of Complications

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Concerns – It Matters How Measures Affect Payment

Care for those with MCC is under valued today

- Geriatric Training Reduces Salary
- Medicare and especially Medicaid are Low Payers
- Care Coordination, Non Face to Face is not adequately recognized
- Electronic Records and Measurement Burden are potentially lethal

Risk Adjustment Can Help in Cost (HCC)

- Requires sufficient population size
- Concerns about adjustments in Quality
- Lessons from No Child Left Behind

Patient Preferences Require Recognition

- CAHPS as a common pathway for MCC

Why FFS Still Matters

Need to recognize work and productivity in all systems

Need to recognize work and productivity not presently accounted for

Transforming payment today allows the building blocks for systems of care to develop – FFS still dominates

Significant Changes include:

- Transitional care Management
- Chronic Care Management/Complex CCM
- Advance Care Planning
- Cognitive Assessment and Care Plan Services

Potential Future Changes

- Care management of acute episodes, Integrated BH, Medication Therapy Management in the PCMH

Recommendations

Measure (including structural) and pay for:

- Person Centered Care: Comprehensive Assessment; Eliciting Preferences
- Engagement and Self Management: Care Plan; Open Notes; How's Your Health; CAHPS; Meeting person specific goals
- Care Coordination: RNCM; Future NCQA Measures; TCM; Readmission Rates

Add functional Assessment to coded elements

- HCC and Risk Adjustment
- A major person centered outcome
- Predictor Life Expectancy

Support the development of Key Services often lacking

- In home palliative care; medical staff model at SNF/Post Acute; BH integration; Teams including pharmacists and community services

Create/Require organizations to support these changes

Appreciation

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