2015 White House Conference on Aging Webinar

21st Century Challenge for Healthy Aging: Balancing Living Well with the Reality of Multiple Chronic Conditions

December 11, 2014

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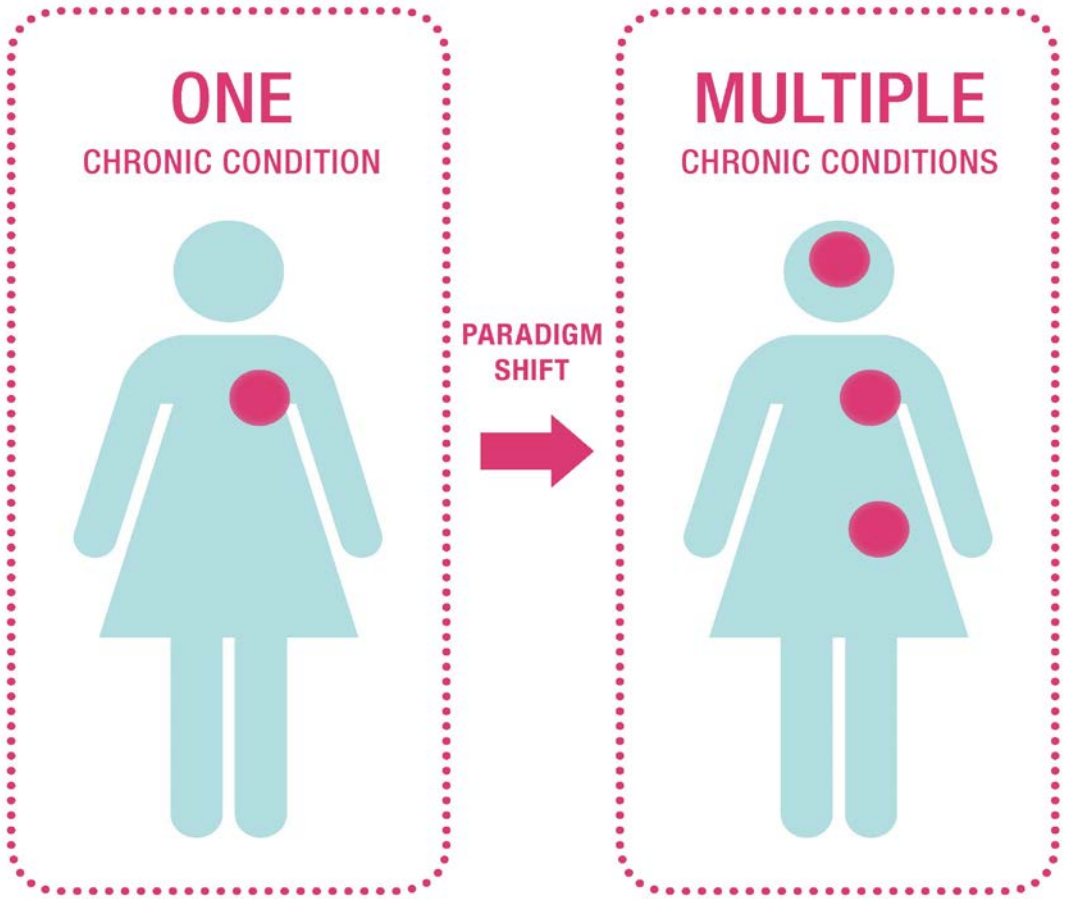
“The most common chronic condition experienced by adults is multimorbidity, the coexistence of multiple chronic diseases or conditions.”

Tinetti et al, JAMA, 2012



U.S. Multiple Chronic Conditions Challenge

Prevalence

- 26% of adults have MCC
- 66% of fee-for-service Medicare beneficiaries have MCC
- 67% of Medicaid beneficiaries w/ disabilities have 3 or more conditions

Access

- 16% of the uninsured have MCC

Outcomes

- As the number of conditions increase, so does the frequency of mortality, poor functional status, hospitalizations, readmissions, and adverse drug events

Costs

- 71% of US health care costs are for individuals with MCC
- 93% of Medicare expenditures are for individuals with MCC

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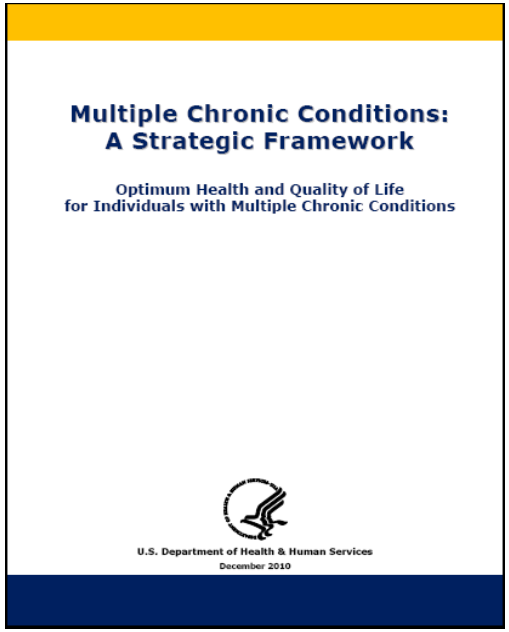
Sources: Anderson, RWJF, 2010; Kronick, CHCS, 2009; Lee, JGIM, 2007; Machlin, AHRQ, 2011; Vogeli, JGIM, 2007; Ward, PCD, 2013; Warshaw, Generation, 2006; Wolff , Arch Intern Med, 2002; http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Maps_Charts.html; http://www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

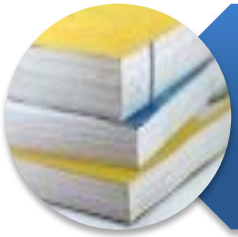
Goals of the Strategic Framework on Multiple Chronic Conditions



http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf
http://www.hhs.gov/ash/initiatives/mcc

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

Photos: http://www.sxc.hu

Selected HHS Implementation Activities

Goal 1

- Payment for Chronic Care Management – Starting in 2015, Centers for Medicare & Medicaid Services (CMS) will pay providers separately for chronic care management of patients with MCC.
- Testing New Care Models – Through the Independence at Home demonstration at CMS, 8,000 frail Medicare beneficiaries with MCC and functional limitations are receiving home-based primary care.

Goal 2

- Evidence-based Community Programs - 200,000 older US residents, the majority with MCC, have completed a Chronic Disease Self-Management Program through Administration for Community Living programs.

Goal 3

- Professional Education & Training – In conjunction with the Health Resources Services Administration, an interprofessional curriculum for MCC education and training is being developed and will be disseminated to providers.

Goal 4

- External Validity of Clinical Trials – Food & Drug Administration announced a policy to more closely examine populations included in clinical trials of new drug applications to discourage unnecessary exclusion and encourage inclusion of individuals with MCC.
- Patient-Centered Outcomes Research – Agency for Healthcare Research & Quality created a nationwide MCC Research Network and the National Institutes of Health has issued 7 new funding opportunities focused on the MCC population since 2010.

Living well with chronic diseases increasingly means, living well with multiple chronic diseases

The Value Proposition of Community-Based Organizations in Optimum Health of Individuals with Multiple Chronic Conditions

Robert J. Schreiber MD

Medical Director of Evidence Based Programs, Hebrew SeniorLife

Medical Director of the Massachusetts's Healthy Living Center of Excellence

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Elder Services of the Merrimack Valley, Inc.

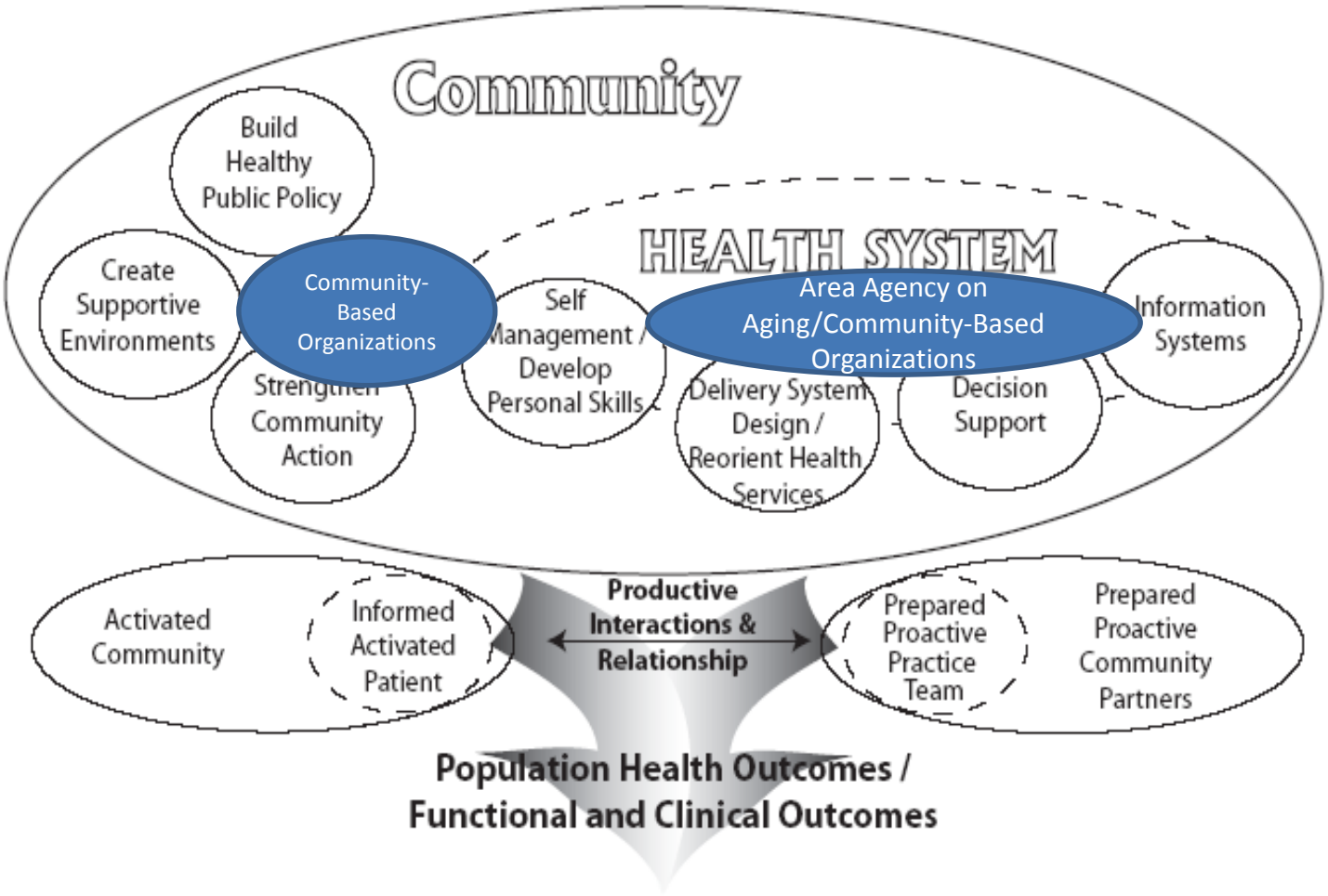
Choices for a life-long journey

The Power to Redefine Aging.

Hebrew SeniorLife

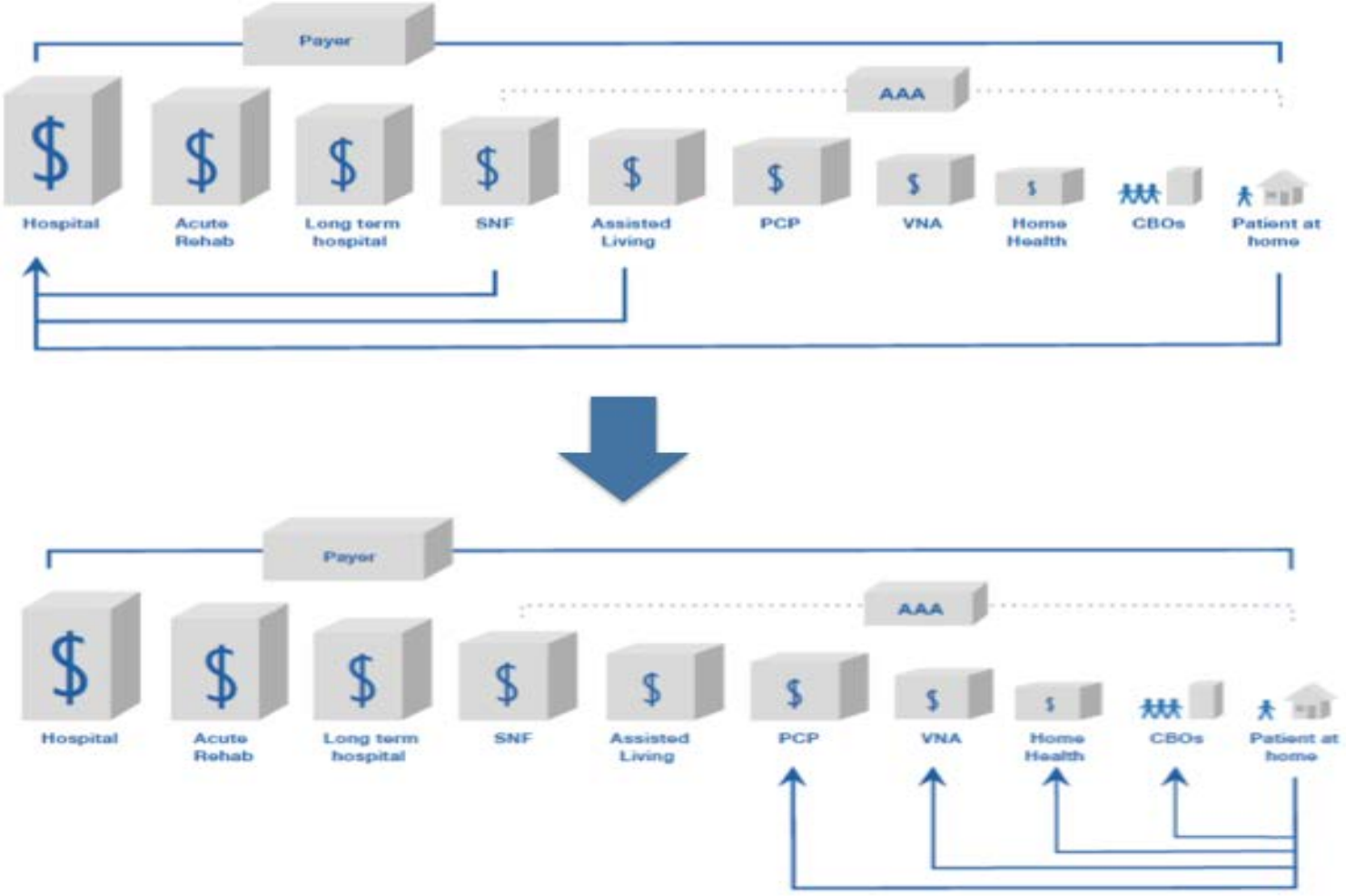
HARVARD MEDICAL SCHOOL AFFILIATE

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION



The Expanded Chronic Care Model, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

Value Proposition of Area Agencies on Aging & Community-Based Organizations

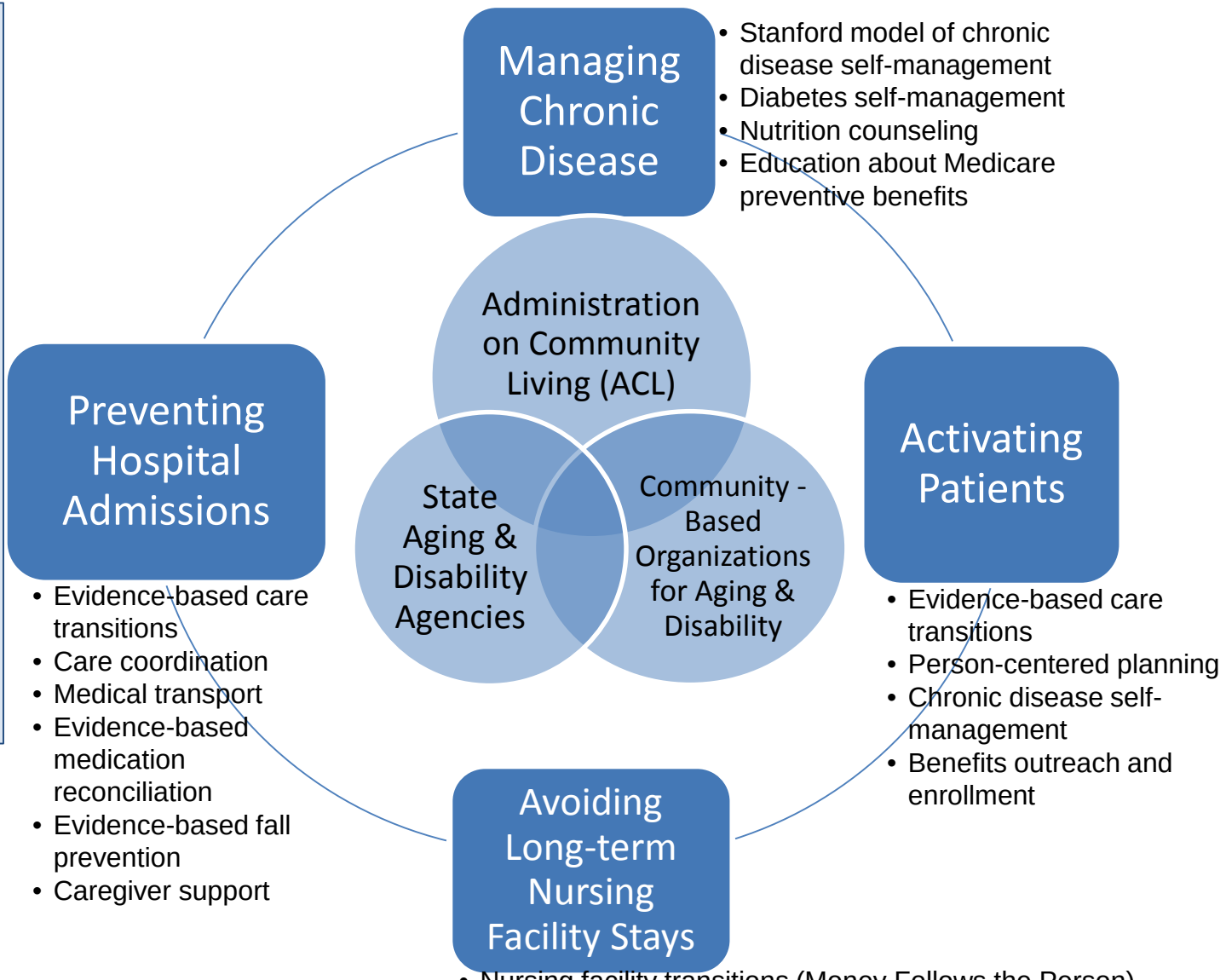


The Community-Based Organization Bridge to Improving Health of Individuals with Multiple Chronic Conditions

Integration of Community-Based Organizations into Healthcare: Optimizing Health Outcomes

Traditional <u>Scope of Long Term Services & Supports</u>

- *Home-delivered/ congregate meals*
- *Transportation*
- *Medication review*
- *Respite/Caregiver support*
- *Falls/Home risk assessments*
- *Information and assistance*
- *Personal care*
- *Employment-related supports*
- *Housing*
- *Homemaker*
- *Shopping*
- *Money management*

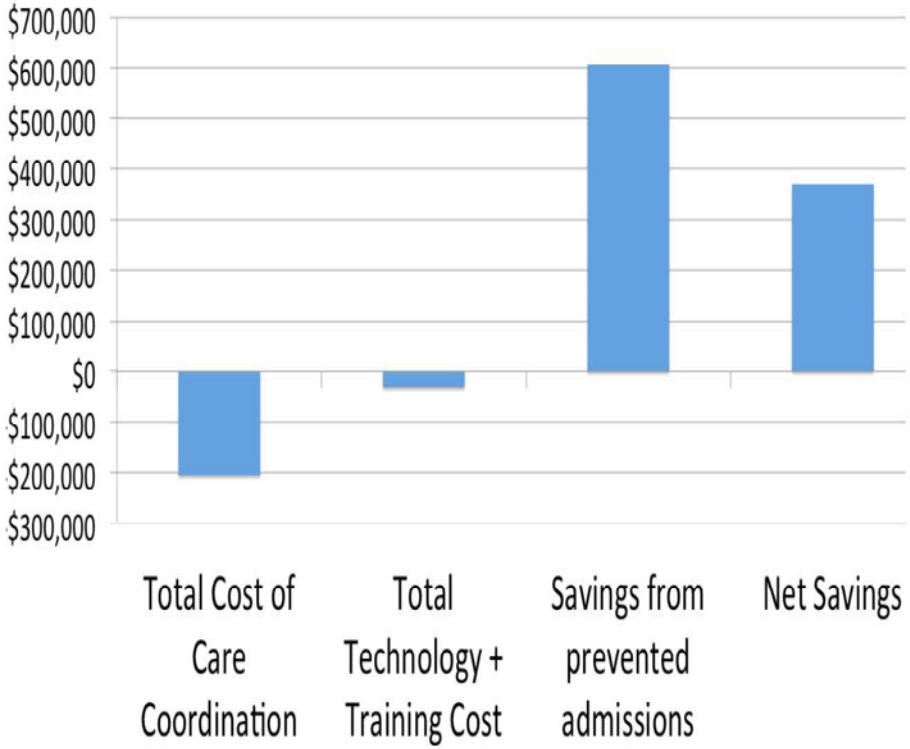


Slide from ACL

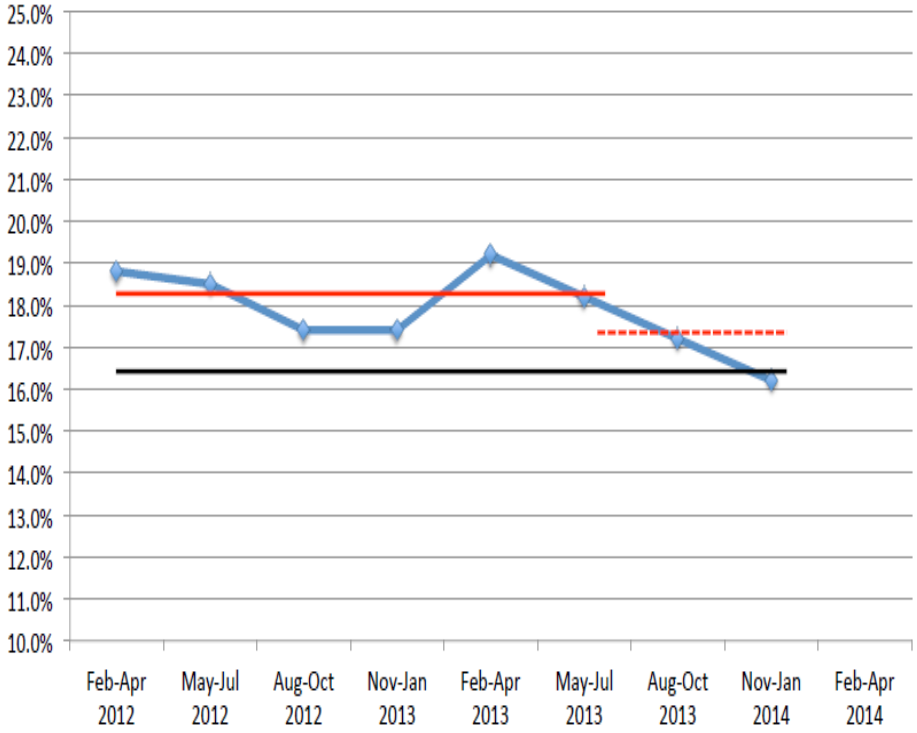
Community Care Transitions Programs Impact on Readmissions: People, Process and Technology

AHRQ HEALTH CARE
INNOVATIONS EXCHANGE
Innovations and Tools to Improve Quality and Reduce Disparitie

Estimated Net Savings



Percent of Care Transitions Program Participants Rehospitalized in 30 days



Non-clinical workers reduce costs, predict readmissions

AHRQ. Service Delivery Innovation: Community-Based Health Coaches and Care Coordinators Reduce Readmissions Using Information Technology To Identify and Support At- Risk Medicare Patients After Discharge. Rockville, MD. 2014.

the healthy living Center of Excellence

- **The Model**: The Massachusetts Healthy Living Center of Excellence will promote the integration of evidence-based self-management programs held in diverse community settings within the health care delivery system through collaboratives which include community-based organizations, health care providers and plans, government, foundations, and for-profit partners. Focus on Patient engagement

- **Key Features:**
  * Statewide Disease Management Coalition with website and universal license
  * Centralized referral, technical assistance, learning collaborative, and quality assurance
  * Multi-program, multi-venue, across the lifespan approach
  * Diversification of funding for sustainability (Health Maintenance Organizations, Affordable Care Organizations, Foundation, etc.)
  * Evidence Based Practice integration in medical home, Accountable Care Organizations, dual eligible plans and other shared risk pilots

www.healthyaging4me.org

Process Measures/Outcomes

- Care Transitions
  - Visiting Nurse Association referrals for patients with multiple chronic conditions increased 25%
  - Behavioral health pilot avoiding readmissions
- Avoiding Long Term Nursing Home Care
  - Decreased length of stay in nursing homes
  - Work with disability community through resource center
- Managing Chronic Disease
  - Practice top of license
  - Healthy Living Center of Excellence/Evidence-Based Practices
- Long-Term Services and Supports
  - Supportive housing decreases admissions
  - Leveraging all community resources
  - Culturally competent staff, materials focus

Summary

- Area Agencies on Aging and Community-Based Organizations have a key role in ensuring individuals with multiple chronic conditions age healthier
  - Boundary spanners to the health system
  - Improve patient safety and quality
  - Optimize health through care coordination, long term service supports, care transitions and patient activation
  - Need to develop culture of quality improvement
- The HHS Strategic Framework on Multiple Chronic Conditions is a guide by which these organizations can show their value to the health care system and payers

Improving Health and Health Care of People Living with Multiple Chronic Conditions

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“Treating an Illness Is One Thing. What About a Patient With Many?”

New York Times, March 31, 2009

Image: Brendan Smialowski for the New York Times

- Disease in isolation is exception, not rule
- Variability in conditions and how they affect people’s function
- Cumulative approach of care is not evidence-based, can be overwhelming and is often harmful

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

It's Not Easy Living with Multiple Chronic Conditions

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 Exercise (non-weight bearing if severe foot disease, weight bearing for osteoporosis) Muscle strengthening exercises, Aerobic Exercise ROM exercises Avoid environmental exposures that might exacerbate COPD Wear appropriate footwear Albuterol MDI prn Limit Alcohol Maintain normal body weight	Pneumonia vaccine, Yearly influenza vaccine All provider visits:Evaluate Self-monitoring blood glucose, foot exam and BP Quarterly HbA1c, biannual LFTs Yearly creatinine, electrolytes, microalbuminuria, cholesterol Referrals: Pulmonary rehabilitation Physical Therapy DEXA scan every 2 years Yearly eye exam Medical nutrition therapy Patient Education: High-risk foot conditions, foot care, foot wear Osteoarthritis COPD medication and delivery system training Diabetes Mellitus
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		
12 PM	Eat Lunch Ipratropium MDI Calcium+ Vit D 500 mg	Diet as above		
5 PM	Eat Dinner	Diet as above		
7 PM	Ipratropium MDI Metformin 850mg Naproxen 250mg Calcium 500mg Lovastatin 40mg			
11 PM	Ipratropium MDI			

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

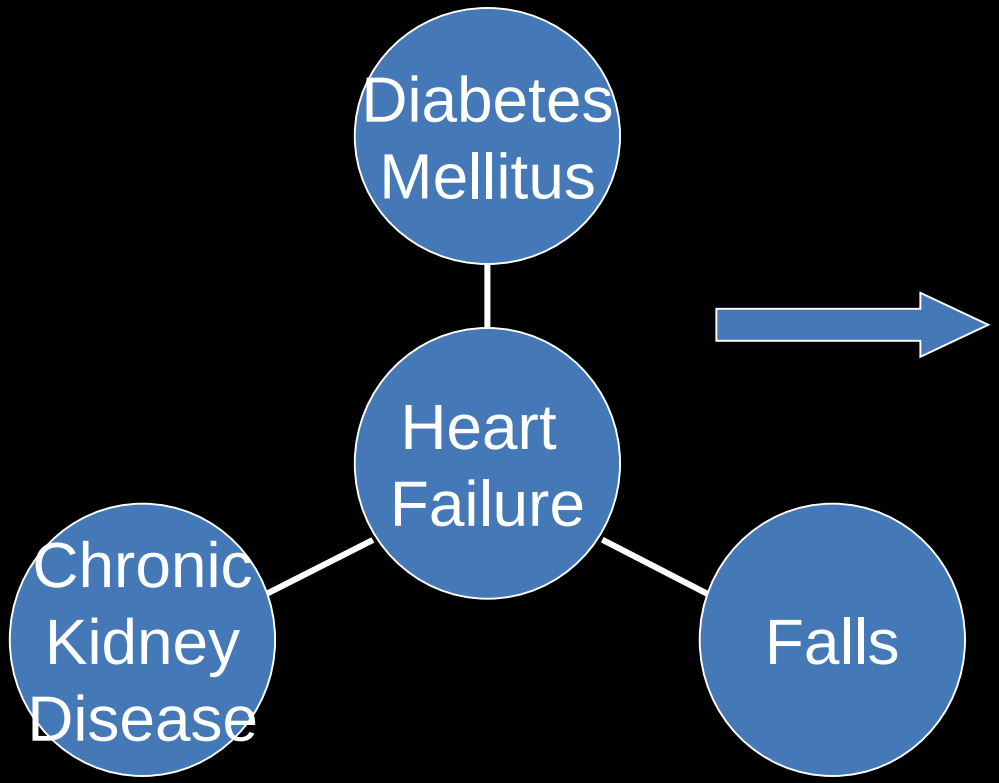
Attaining care that focuses on what people with multiple chronic conditions, and their loved ones, want requires:

- respect diverse decision-making preferences,
- minimize harms and focus on what matters to the person, and
- support the context in which people manage their health
- appropriately use evidence from studies to inform, not dictate, care

Bayliss et al. Ann Fam Med 2014 (NIH/PCORI Meeting on MCCs)

Conceptual Framework

Comorbidity



Multiple Chronic Conditions

Photo by Annie Levy 2008

Adapted from Boyd and Fortin Public Health Reviews, 2011.

Approach to the Evaluation and Management of Older Adults with Multimorbidity: Guiding Principles

- Patient Preferences
- Interpreting the Evidence
- Prognosis
- Treatment Complexity and Feasibility
- Optimizing Therapies and Care Plans

http://www.americangeriatrics.org/health_care_professionals/clinical_practice/multimorbidity

AGS THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading Change. Improving care for older adults.

What Do Clinicians Need to Do to Best Care for People Living with Multiple Chronic Conditions?

- Think beyond diseases
- Recognize heterogeneity
- Be cognizant of the challenges of the evidence base for this population
- Maximize use of therapies likely to benefit
- Minimize use of therapies unlikely to benefit or likely to harm
- Incorporate patient preferences and values regarding burdens, risks, and benefits

A Stakeholder Derived Framework for Translation of Research into Practice for People with Multiple Chronic Conditions

Study Design and Analysis → **Systematic Review and Meta-Analysis** → **Clinical Practice Guideline Development** →

- **Clinical Decision-Making**
- **Integrated Care**
- **Measurement of Quality of Care**

Puhan et al. Effective Health Care 2013, Giovannetti et al AJMC 2013, Dugoff et al. J Healthcare Quality 2013, Yu et al BMC Medicine 2013, Puhan M et al BMC Res Method 2012, Yu et al Thorax 2014, Boyd et al Effective Health Care 2012, Goodman et al Ann Fam Med 2014, Uhlig et al. JGIM 2014, Trikalinos et al. JGIM 2014, Weiss et al JGIM 2014, Boyd and Kent JGIM 2014.

Informing Patient-Centered Care for People with Multiple Chronic Conditions

- With our stakeholder team of investigators*,
  - identify high-priority clinical questions and outcomes for people with Multiple Chronic Conditions, and
  - synthesize the evidence base to support the development of clinical practice guidelines that can better inform patient-centered care for people with multiple chronic conditions
  - develop refined methods guidance for systematic reviewers and guideline developers

**Patients, Caregivers, Kaiser Permanente National Guideline Program, Institute for Social and Preventive Medicine, Zurich, Johns Hopkins University*

Funded by the Patient-Centered Outcomes Research Institute

Conclusion

- Patient-centered outcomes research for older adults with multiple chronic conditions
  - Important to ensure that individuals with multiple chronic conditions age healthier

Photo by Julie Turkewitz 2011

Questions and Answers

- For More Information on the 2015 White House Conference on Aging, visit http://whitehouseconferenceonaging.gov/
- For More Information on the HHS Initiative on Multiple Chronic Conditions, visit http://www.hhs.gov/ash/initiatives/mcc/