2015
WHITE HOUSE
CONFERENCE ON AGING
WEBINAR

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

Thursday, December 12, 2014

1 **INTRODUCTION:** Hello everyone, and
2 welcome today's webinar, 21st Century Challenge for
3 Healthy Aging; Balancing Living Well with the Reality
4 of Multiple Chronic Conditions.
5 Before we get started, I would like to
6 go over a few items so you know how to participate in
7 today's event. You can join the audio for today's
8 conference by selecting "mic and speaker" and
9 listening via your computer or headset. You may also
10 join by phone by selecting the telephone option and
11 dialing into the webinar.
12 You will have the opportunity to submit
13 text questions to today's presenters by typing your
14 questions into the questions pane of the control
15 panel. You may send in your questions at any time
16 during the presentation. We will collect these and
17 address them during the Q&A session at the end of
18 today's presentation.
19 Please note that a recording of today's
20 presentation will be made available to you on December
21 the 18th. At this time, I will turn the presentation
22 over to Nora Super.
23 **MS. SUPER:** Good afternoon, everyone.
24 This is Nora Super and I'm the Executive Director of

1 the White House Conference on Aging. And I'm
2 delighted to welcome you to our webinar today on the
3 topic of Balancing Living Well with the Reality of
4 Multiple Chronic Conditions.
5 This is the first webinar of the White
6 House Conference on Aging and we're delighted to have
7 so many registrants. We have over 1,500 people
8 registered for this, so we know that we have lots of
9 interest.
10 We'd like to hear from everyone, so as
11 was mentioned, please start thinking of your questions
12 now. We will go through all of the speakers first and
13 their presentations before we answer questions, but
14 feel free to send us questions while the presentations
15 are going on so that we can have some in the queue to
16 get started right away. We'll devote the last 15
17 minutes of the webinar to responding to these
18 questions.
19 Let me take a moment to introduce our
20 speakers. Today we're delighted to have Anand Parekh
21 who is the Deputy Assistant Secretary for Health at
22 the U.S. Department of Health and Human Services. He
23 has held this position since 2008.
24 Through this position, he's developed

1 and implemented national initiatives focused on
2 prevention and wellness and on care-management for
3 individuals with multiple chronic conditions.
4 Briefly, in 2007, he was delegated the
5 authorities of the Assistant Secretary of Health for
6 overseeing 10 public health program offices, including
7 the U.S. Public Health Service Commission Course. He
8 is an internist by training, a Fellow of the American
9 College of Physicians and an Adjunct Assistant
10 Professor in Medicine at Johns Hopkins University.
11 After we hear from Dr. Parekh, we'll
12 turn to Dr. Rob Schreiber who is the Medical Director
13 of Evidence-based Programs at Hebrew SeniorLife of
14 Harvard Medical School. Dr. Schreiber is Medical
15 Director of this program, which is an organization
16 funded by the John A. Hartford Foundation and the
17 Tufts Health Plan Foundation.
18 He served as Physician and Chief, and
19 Chief Medical Officer of Hebrew SeniorLife in Boston
20 Massachusetts from 2004 to 2012. He is faculty member
21 of the Institute for Aging Research at Hebrew
22 SeniorLife and is working to connect research to
23 healthcare systems clinical venues.
24 He also serves on the faculty at

1 Harvard Medical School and is a Senior Leader of the
2 Practice Change Leaders Program which mentors
3 physicians, nurses and social workers to improve the
4 care of older adults and their health systems.
5 And our final speaker will be Dr.
6 Cynthia Boyd, who's an Associate Professor, Division
7 of Geriatric Medicine and Gerontology, Department of
8 Medicine with Johns Hopkins University. She's a core
9 faculty member there and the Roger C. Lipitz Center
10 for Integrated Healthcare.
11 Dr. Boyd is jointly appointed in the
12 Department of Health Policy and Management. She is
13 also a Robert Wood Johnson Physician Faculty Scholar.
14 She trained in internal medicine, geriatric medicine
15 and epidemiology.
16 Dr. Boyd's main interest includes the
17 clinical care of comorbid chronically ill and frail
18 older adult both chronically and during acute illness,
19 such as hospitalization. Currently, she's working on
20 projects such as Treatment Burdens Among Older Adults
21 with Multi-Morbidity, and that means, for those lay
22 people, those who have multiple chronic conditions,
23 and also working on diabetes and other competing risks
24 for improving care of the elderly.

1 So with that, I'd like to turn it over
2 to our speakers and beginning with Dr. Parekh.
3 **DR. PAREKH:** Thank you so much, Nora,
4 for the introduction and your leadership of the 2015
5 White House Conference on Aging. I'm honored to be a
6 part of this Inaugural Webinar and to join so many of
7 you today.
8 Today's focus is on the growing
9 population with multiple, or two or more chronic
10 conditions and ensuring that these individuals can
11 optimize their healthcare and health choices as they
12 age.
13 Three factors; the aging of the
14 population, the continued existence of risk factors,
15 such as obesity and tobacco use and advances in modern
16 medicine have really led to an increasing number of
17 Americans with more than one chronic condition. In
18 fact, the most common chronic condition today in this
19 country is not heart disease or diabetes or
20 Alzheimer's or cancer. Rather, it is multi-morbidity.
21 Knowledge of this now requires a paradigm shift in how
22 we address and tackle chronic conditions.
23 Specially, the challenge for this
24 country, vis-à-vis, multiple chronic conditions from a

1 prevalent standpoint is over one in four adults in
2 this country have multiple chronic conditions. And
3 two in three Medicare beneficiaries and Medicaid
4 beneficiaries with disabilities have multiple chronic
5 conditions. In terms of access, one in six who are
6 uninsured have multiple chronic conditions, which
7 makes the Affordable Care Act that much more important
8 to help this population gain access to care and remain
9 healthy.
10 Third, in terms of outcomes, all of
11 those outcomes we care about from mortality, poor
12 functional status, hospitalizations, readmissions,
13 adverse drug events; all of these increase as the
14 number of conditions on average increase. And fourth,
15 care for individuals with multiple chronic conditions
16 account for a disproportionate share of healthcare
17 costs.
18 Given this challenge four years ago,
19 the U.S. Department of Health and Human Services
20 launched the strategic framework on multiple chronic
21 conditions to provide a roadmap for the public and
22 private sectors to improve the health of this
23 population.
24 Individuals with multiple chronic

1 conditions are a very diverse group. On the spectrum
2 of heath, some are independent and ambulatory, while
3 others have functional limitations and substantial
4 healthcare utilization. The multiple chronic
5 conditions strategic framework supports the theme that
6 all individuals with multiple chronic conditions,
7 irrespective of where they are on this spectrum, can
8 age healthier.
9 Specifically, there are four goals of
10 the strategic framework as you see here. The first is
11 to foster healthcare and public health systems change.
12 The second is to maximum the use of proven self-care
13 management, really to empower individuals. The third
14 is to provide better tools and information to
15 healthcare public health and social service workers,
16 really to equip providers. And the fourth is to
17 facilitate research to fill knowledge gaps to enhance
18 research.
19 Both the public and private sector have
20 helped over the last several years to implement this
21 strategic framework. On this slide are selected
22 examples of actions undertaken by Health and Human
23 Services.
24 For example, for goal one, starting in

1 2015, the Centers for Medicare and Medicaid Services,
2 or CMS, will begin for the first time to pay providers
3 separately for the non-face-to-face chronic care
4 management of patients with multiple chronic
5 conditions. CMS is also testing new care models
6 through the Independence-at-Home demonstration, for
7 example. Eight thousand frail Medicare beneficiaries
8 with multiple chronic conditions and functional
9 limitations are receiving home-based primary care.
10 This really flips the care-delivery
11 model on its head. Instead of patients going to care;
12 here, care comes to patients.
13 Related to goal two, HHS is supporting
14 evidence-based community prevention and wellness
15 programs. For example, over 200,000 older U.S.
16 residents, the majority with multiple chronic
17 conditions, have completed a chronic disease self-
18 management program through the administration for
19 community living. We know that these programs can
20 improve health and quality of life and decrease
21 emergency room visits and hospitalizations.
22 For goal three, HHS is expanding
23 professional education and training in conjunction
24 with our office and health resources and services

1 administration. An interprofessional curriculum for
2 multiple chronic condition education and training is
3 being developed and will be disseminated to providers.
4 And finally, for goal four, the Food
5 and Drug Administration has recently announced a
6 policy to more closely examine populations included in
7 clinical trials of new drug applications to discourage
8 unnecessary exclusion and encourage inclusion of
9 individuals with multiple chronic conditions.
10 This really adds to FDA's long-standing
11 interest to increase the inclusion of older adults in
12 clinical trials. And related to patient-centered
13 outcomes research, our agency for Healthcare Research
14 and Quality has created a nationwide multiple chronic
15 condition research network. And our National
16 Institute of Health has issued seven new funding
17 opportunities focused on this population since 2010,
18 so there is a tremendous about of activity ongoing.
19 In conclusion, living well with chronic
20 diseases increasingly means living well with multiple
21 chronic diseases. With the complexity of the American
22 elderly population increasing, it's that much more
23 important to better understand the wishes and goals of
24 these individuals so that care choices can be

1 optimized for them.
2 And now, as Nora mentioned, we'll move
3 to two speakers who are leaders in the field helping
4 to implement the goals of this strategic framework.
5 Dr. Schreiber will discuss how community-based
6 organizations help individuals with multiple chronic
7 conditions age healthier, and then Dr. Boyd will then
8 discuss how patient-centered outcomes research can
9 help individuals with multiple chronic conditions age
10 healthier. First, we'll turn it over to Dr.
11 Schreiber.
12 DR. SCHREIBER: Thank you, Dr. Parekh.
13 Today I will be discussing the value proposition of
14 community-based organizations and optimizing the
15 health of individuals with multiple chronic
16 conditions. The Patient Protection Affordable Care
17 Act is leading health systems to deliver value-based
18 healthcare, emphasizing prevention and wellness
19 interventions, as we've heard.
20 The Health and Human Services strategic
21 framework helps promote community-based organizations
22 to develop partnerships with medical care providers
23 with the mutual goal of promoting health aging and
24 preventing the development of frailty, disability and

1 functional limitations. Approaches to help this
2 particular population stay healthier and safer while
3 decreasing their cost of care will be the focus of
4 this presentation.
5 The expanded chronic care model seen
6 here represents a conceptual framework for improving
7 the health of populations with chronic illness. A key
8 component of this model involves prepare proactive
9 community partners integrating with prepared proactive
10 practice teams working with an informed and activated
11 patient. Community-based organizations traditionally
12 focus on providing individuals with long-termed
13 service support as well as helping them improve self-
14 management skills.
15 Due to the changing healthcare
16 environment, area agencies on aging are now starting
17 to mirror changes employed by healthcare systems
18 through the use of decision support, information
19 systems and self-management strategies leading to
20 redesign of care delivery. Improved and sustainable
21 outcomes can be achieved if partnerships develop and
22 work in an integrated and coordinated fashion which
23 promotes the activation of individuals with multiple
24 chronic conditions.

1 This shift in care delivery is
2 illustrated in this slide. On top, the healthcare
3 system has been incentivized to care for acute illness
4 and treat chronic disease exacerbation rather than
5 preventing illness and promoting wellness. This
6 reactive medical care approach has resulted in
7 medicalization of healthcare and has often been siloed
8 from community-based organizations who often deal with
9 populations having other challenges including
10 substance abuse, mental illness, dementia and
11 development disabilities.
12 The bottom of this slide shows how area
13 agencies on aging helps shift this focus to support
14 proactive preventive interventions based in the
15 community and centered on what the patient at home
16 wants. They develop longitudinal relationships and
17 are not vested in any particular component of the
18 healthcare delivery system. This approach focuses on
19 what matters most to the individual.
20 In particular, area agencies on aging
21 can serve as boundary spanners providing a bridge for
22 the individual to connect with healthcare providers,
23 social service and community-based organizations
24 resulting in improved health while maintaining the

1 individual's independence in the community. This need
2 was highlighted by a 2011 Robert Wood Johnson
3 Foundation Survey of a thousand primary care
4 physicians.
5 Eighty-five percent of these physicians
6 understood that individual social needs directly
7 contributed to poor health. However, four out of five
8 physicians were not confident they could meet these
9 social needs, thereby hurting their ability to provide
10 quality care.
11 It was also noted that one in seven
12 prescriptions were given for social needs and that
13 psychosocial issues were commonly treated as physician
14 concerns. This gap where psychosocial environmental
15 needs directly contribute to poor health is where
16 community-based organizations are best able to show
17 their value.
18 The traditional scope of community-
19 based organizations have been on long-term service
20 supports, shown on the left side of this slide, which
21 assist individuals to live independently in their
22 community. New approaches for integration of these
23 organizations and to healthcare have been facilitated
24 by the Administration on Community Living and state

1 aging and disability agencies. These include the
2 following four areas highlighted.
3 Managing chronic diseases are
4 significantly improved by using the Stanford Chronic
5 Disease Self-Management programs and other evidence-
6 based and counseling programs. Activating Patients is
7 also being promoted using evidence-based care
8 transitions programs and person-centered care
9 planning.
10 Preventing hospital admissions is
11 occurring widely through community-care transition
12 programs, care-coordination, fall-prevention programs
13 and other interventions as listed. And lastly,
14 avoiding long-term stays in nursing homes have been
15 greatly enhanced by programs such as Money Follows the
16 Person and preadmission reviews.
17 One important and evolving role of area
18 agencies on aging in preventing hospital readmissions
19 that are associated with poor health outcomes are
20 demonstrated above. One such agency, Elder Service Of
21 Merrimack Valley in Lawrence, Massachusetts has
22 demonstrated a significant and sustained decrease in
23 hospital readmissions with its six hospital partners.
24 At baseline, the average for 30-day

1 readmissions at the end of July 2013 was 18.3 percent,
2 but it is declined and stabilized at 16 percent this
3 year. This has been the result of using quality
4 improvement techniques involving the Care Transitions
5 Program in addition to using a health information
6 technology tool called Care-At-Hand. This tool
7 effectively helps non-clinical workers identify
8 conditions that can lead to readmissions through a
9 decision support checklist that is contained on a
10 handheld device.
11 An electronic alert is sent to a
12 supervising nurse who can intervene and activate the
13 appropriate part of the care system. The chart on the
14 right shows the estimated net savings from prevented
15 admissions and was recently highlighted in the Agency
16 for Healthcare Research and Quality Innovations
17 Exchange.
18 Another model approach on how
19 community-based organizations can partner with
20 healthcare systems is through disseminating evidence-
21 based programs. The Healthy Living Center of
22 Excellence is a partnership between Elder Services of
23 Merrimack Valley and Hebrew SeniorLife, a healthcare
24 provider in Boston. It promotes the integration of

1 evidence-based self-management programs within the
2 healthcare delivery system through system-wide
3 collaborations, including community-based partners,
4 healthcare providers, insurance plans, government
5 agencies, foundations and for-profit organizations.
6 Key features of this model include a
7 state-wide disease management coalition involving over
8 60 community-based organizations, utilizing a website
9 and universal license which allows for scalability.
10 There is a centralized referral and technical
11 assistance system that provides quality assurance.
12 There are multiple programs that occur
13 in many different settings. The center is seeking
14 diversification of program funding to ensure
15 sustainability of these programs by integrating them
16 in medical homes, accountable cure organizations, dual
17 eligible plans and other shared-risk pilots.
18 Elder Services of the Merrimack Valley
19 has other measures and outcomes which have promoted
20 healthier and safer aging in the community, and I will
21 highlight just a few. Similar outcomes are being
22 achieved by many other community-based organizations
23 across the country. In care transitions, there has
24 been a 25 percent increase in referrals to visiting

1 nursing agencies due to recognition of significant
2 medical needs that were not addressed on hospital
3 discharge.
4 A pilot was just completed where 12
5 participants had integration of behavioral health
6 interventions integrated into care transitions. This
7 resulted in a 91 percent reduction in depression
8 scores in three months and no readmission to the
9 hospital in 90 days.
10 Another example involved elder services
11 care coordination teams significantly decreasing the
12 length of stay in the nursing home for individuals
13 with multiple chronic conditions. This has also been
14 accomplished utilizing the adult disability resource
15 center for the disability community.
16 The agency staff's ability to manage
17 chronic disease has been enhanced, and they are now
18 practicing at the top of their license through quality
19 improvement processes and programs. These include
20 trans-disciplinary learning sessions with medical
21 providers in attendance and decision support from care
22 transition teams. The Care-At-Hand tool now allows a
23 care transitions nurse to manage at least twice the
24 number of patients with better outcomes.

1 Long-term service supports are being
2 enhanced by building and leveraging supportive housing
3 models. This has resulted in decreased admissions for
4 at-risk individuals through community care
5 coordination that is culturally competent and
6 individually centered and directed.
7 In summary, I have described the key
8 rolls community-based organizations can play in
9 ensuring individuals with multiple chronic conditions
10 age healthier in the community. These organizations
11 serve as boundary spanners leading to improved patient
12 safety and quality through trans-disciplinary
13 collaboratives that occur across the care continuum.
14 This is their value proposition to the
15 healthcare system, and this could be enhanced by using
16 the Health and Human Services strategic framework of
17 multiple chronic conditions to optimize health
18 outcomes of the populations they serve. I will now
19 turn the webinar over to Dr. Cynthia Boyd.
20 **DR. BOYD:** Thank you. I'm very pleased
21 to participate today and to tell you about improving
22 health and healthcare for people living with multiple
23 chronic conditions through patient-centered outcomes
24 research.

1 As we've heard earlier today, it is
2 very important that we consider not just how to treat
3 one illness, but that we think about the person living
4 with many conditions. Disease in isolation is the
5 exception and not the rule.
6 Within the large population of older
7 adults with multiple chronic conditions, there remains
8 great variability in both what the specific conditions
9 are that people have, their severity and how the
10 conditions effect people's lives and function.
11 Much of how we practice medicine and
12 design healthcare has been based on knowledge that has
13 been gained about individual diseases. When we
14 combine what we know about single conditions and apply
15 it to someone with multiple, this is often less
16 evidence-based. Doing this within people with
17 multiple chronic conditions can also be overwhelming
18 for patients and their loved ones and may also be
19 harmful.
20 Guidelines are designed to be based on
21 a rigorous evaluation of the quality of evidence from
22 clinical trials and other studies and are intended to
23 inform but not dictate the care that doctors and other
24 clinicians provide.

1 On the next slide, I'm going to show
2 you the treatment regimen that may result from using
3 single disease-focused guidelines to inform care for
4 an older woman in her late seventies with five common
5 chronic conditions including arthritis, high-blood
6 pressure, diabetes, osteoporosis and chronic
7 obstructive pulmonary disease.
8 Using guidelines, we've tried to make
9 the recommended treatment regime as simple as possible
10 and to avoid potential harms that can arise from
11 interactions between therapies for different
12 conditions. And yet, as you can see, it's not easy
13 living with multiple chronic conditions. This
14 treatment regime includes 12 medications and 19
15 different doses per day with a significant amount of
16 other types of treatments and interventions also.
17 This treatment regime is not unlike
18 that of many of the patients I see. It raises the
19 critical question, which of these recommendations are
20 actually most important for the individual person;
21 which are most likely to help the person achieve the
22 goals and outcomes that matter to them?
23 Attaining person-centered care requires
24 that we respect the diverse decision-making

1 preferences that older adults and often their loved-
2 ones have, that we minimize harms and focus on what
3 matters to the person, that we support the context in
4 which people manage their health. And we
5 appropriately use evidence from studies to inform, not
6 dictate care.
7 Doing so requires us to shift from the
8 perspective of thinking that one condition is more
9 important or central than another, or that we do that
10 in some sort of sequence. The reality is that the
11 conditions and treatments all end up overlapping and
12 affecting each other.
13 For example, if we think of a person
14 living with heart failure and chronic kidney disease
15 and diabetes who has had a couple of recent falls, we
16 could think about each condition sequentially. But
17 the reality is that we really want to think about that
18 person in terms of what matters to them in the context
19 of their lives and recognize that those conditions are
20 a piece of that.
21 In 2012, the American Geriatric Society
22 developed a roadmap describing guiding principles to
23 approach the care of older adults with multiple
24 chronic conditions. These were that we want to elicit

1 and incorporate patient preferences into medical
2 decision-making for older adults with multiple chronic
3 conditions, recognizing that family and social support
4 play a vital role in both the day-to-day management of
5 health conditions and in decision-making.
6 Recognizing the limitations of the
7 evidence-based, we want to interpret and apply the
8 medical literature specifically to this population of
9 older adults with multiple chronic conditions. We
10 want to frame clinical management decisions within the
11 context of risks, burdens, benefits and prognosis for
12 older adults with multiple chronic conditions.
13 We want to consider treatment
14 complexity and feasibility when making clinical
15 management decisions for older adults with multiple
16 chronic conditions. And we want to use strategies for
17 choosing therapies that optimize benefits, minimize
18 harm and enhance quality of life for this population.
19 So, what do clinicians need to do in
20 order to best care for people living with multiple
21 chronic conditions? We need to think beyond diseases
22 and recognize that conditions such as urinary
23 incontinence or falls are very important. And we need
24 to recognize the diversity in health status within the

1 very large population of people with multiple chronic
2 conditions.
3 There are those, for example, with
4 significant difficulties with functional activities of
5 daily living and those who are at risk of such
6 functional decline in the future.
7 We must be cognizant of the challenges
8 of the evidence-base that we have had for this
9 population which has, in the past, often excluded
10 older adults, and particular older adults with
11 multiple chronic conditions from the studies that
12 evaluate the effectiveness of treatments and other
13 interventions.
14 For any person in front of us, we want
15 to be able to maximize the use of therapies likely to
16 benefit them and minimize the use of therapies that
17 are either likely to harm them or that are not going
18 to benefit them. But we have to do this in such a way
19 that recognizes that the person's values and
20 preferences regarding the burdens, risks and benefits
21 may change our assessment of what the right things to
22 do are for someone.
23 For the last several years, a large
24 group of people have been working hard on how we can

1 translate research from clinical studies into practice
2 for people with multiple chronic conditions. How do
3 we need to transform this process of translation in
4 light of the population of people with multiple
5 chronic conditions?
6 We can better design studies and
7 analyze their data so that we can gain knowledge about
8 what is effective for this population by ensuring that
9 these people are involved in research, enrolled in
10 trials, and that we analyze data to validly inform the
11 care of people with multiple chronic conditions.
12 Emphasizing the evidence-base is
13 important so that we learn from all research studies,
14 not just any one individual study. But we can also
15 better synthesize the evidence-base in order to inform
16 care of this particular population. These evidence
17 synthesis should inform the way we develop clinical
18 practice guidelines, which are then meant to inform
19 the practice of healthcare providers.
20 Best guidance is necessary in order to
21 inform clinical decisions for individuals like the
22 patient pictured here so that we can make the
23 decisions that are best for her. This will also need
24 to inform the way we integrate care across multiple

1 providers who often care for people with multiple
2 chronic conditions, and the way that we integrate care
3 for the person so that we choose those possibly
4 recommended things that we choose those that are
5 actually most important for that person.
6 This better translation of research
7 into practice for this population is also necessary to
8 determine the best ways to measure or evaluate the
9 quality of care that is provided to older adults.
10 Next, I'm going to tell you briefly
11 about a new research project that we are embarking on
12 rescinding from the patient-centered Outcomes Research
13 Institute. With our stakeholder team, we are going to
14 identify high priority clinical questions and outcomes
15 for people with multiple chronic conditions and the
16 loved ones in their lives.
17 We will synthesize the evidence-base to
18 support the development of clinical practice
19 guidelines that can better inform patient-centered
20 care for people with multiple chronic conditions. And
21 we will finally develop method guidance for others for
22 how to do this to help other organizations who conduct
23 systematic reviews and who develop clinical practice
24 guidelines.

1 Such patient-centered research for
2 older adults with multiple chronic conditions is
3 important to ensure that individuals with multiple
4 chronic conditions age healthier and get the best
5 possible healthcare. I thank you for your attention
6 and I look forward to the questions.
7 **MS. SUPER:** Thank you so much for these
8 excellent presentations. I certainly learned a lot.
9 I wanted to note for those of you who joined a little
10 late, this is the first of a series of webinars the
11 White House Conference on Aging will be conducting
12 over the next few months. And we are excited at the
13 White House to focus on four major areas for our
14 conference in 2015.
15 The one that where we are looking at
16 retirement security, healthy aging, long-term services
17 and supports and elder justice, so it's the prevention
18 of abuse, neglect and financial exploitation of
19 elders. This topic is very important to help older
20 people learn how to live with multiple chronic
21 conditions and live well and healthier into later
22 years.
23 The first question I wanted to address
24 that many of you sent in is wanting to know if you'll

1 be able to get the slides. So I'll just say right now
2 that yes, we will have the slides available, as well
3 as a recording of the webinar because we know some
4 folks have wanted to get in and our registration was
5 full. Those will be sent to everyone who's registered
6 next week, so a week from today, on Thursday, the
7 17th.
8 The first question I'm going to direct
9 to Dr. Parekh, you gave us some really interesting
10 information about the prevalence of multiple chronic
11 conditions. What do we know about racial and economic
12 disparities of multiple chronic conditions?
13 **DR. PAREKH:** Thanks, Nora, for that
14 important question. So, I think, in general, we know
15 that individuals in lower social economic status
16 groups and in certain racial and ethnics groups are
17 more likely to have chronic conditions. Now, related
18 to individuals with multiple chronic conditions,
19 specifically, I think we're still learning more.
20 So one of our offices here at Health
21 and Human Services are Assistant Secretary for
22 Planning and Evaluations Office, or ASPE, has recently
23 published results of a project that's identified data
24 and methods and topics for research on exactly this,

1 on health disparities and multiple chronic condition
2 populations. And it is also assessing the potential
3 utility of existing data systems and datasets so we
4 can really get at multiple chronic condition
5 disparities research.
6 So I think we'll see more attention and
7 focus on this area, so we hope to learn more soon and
8 then start to address these disparities that are
9 likely quite real.
10 **MS. SUPER:** Thank you for that
11 response. Dr. Schreiber, this question is for you.
12 What preventive measures are being introduced to the
13 aging population today as they relate to managing
14 multiple chronic conditions?
15 **DR. SCHREIBER:** Thank, Nora, for that
16 question, a very good one. So there are a multitude
17 of preventive measures, and a lot of them do focus on
18 the role of the individual becoming much more engaged
19 and activated in their care. Oftentimes, one of the
20 key determinants of what makes a difference is what
21 matters most to the individual. By giving people the
22 opportunity to deal with the challenges that they face
23 and the tools that they need to be able to problem
24 solve, they oftentimes can direct their own care and

1 work with their care team to develop a plan that's
2 effective in managing their issues.
3 In particular, the self-management
4 programs that we discuss that are part of the
5 framework as well as, in my discussion, are really
6 critical and important factors in terms of helping
7 people who do have chronic illness prevent progression
8 of those diseases or from developing new ones. And
9 the individual, by learning how to set goals, overcome
10 barriers, problem solve, and how to take complex
11 problem and challenge it if they have to break it down
12 to the small bite size pieces is really critical.
13 What we also find is, by getting people
14 to realize that they actually have a lot of control
15 over the outcomes of their illnesses, they become much
16 more physically active. Physical activity is probably
17 the most important preventive measure that anybody can
18 do regardless of what chronic illness they have. And
19 so, in fact, most people become very active and
20 develop activity plans based on their goals.
21 And lastly, I would say that the other
22 piece that's really important is people actually take
23 charge, they become the captains of their healthcare
24 ship. And they become much more compliant and also

1 much more engaged with their medical providers in
2 terms of communicating more effectively.
3 **MS. SUPER:** There’s a lot of questions
4 coming in now, so I want to direct one to Dr. Boyd.
5 Dr. Boyd, you mentioned the importance of things such
6 as treating the older person as a whole person and
7 addressing many of the issues that affect them with
8 managing multiple chronic conditions.
9 We have one of our listeners ask, what
10 can be done when a condition is inappropriately
11 attributed to age? In other words, I think the idea
12 that people have been told that, oh, that's just
13 because you're getting older that you have this issue.
14 How can we help health professionals or others, and
15 especially the people themselves understand what are
16 conditions they really do need to have treated and are
17 treatable?
18 **DR. BOYD:** I think that’s a great
19 question. So I think that, first off, preparing for
20 visits with healthcare professionals in terms of being
21 willing to ask those questions such as that one,
22 specifically, of them.
23 So while certainly there are age-
24 related changes as we get older, many times the

1 symptoms and the issues that our patients are raising
2 are not attributable just to the aging process, that
3 they are either related to a specific disease or that
4 they are rising for multifactorial reasons, that the
5 person is experiencing something as a result of
6 impairments or changes across multiple organ systems.
7 And thinking about the problems that
8 people are facing in this frame makes it easier to
9 figure out potential solutions, and not just solutions
10 that are targeted at one disease or one underlying
11 condition, but those that might work across the
12 systems. And I think Dr. Schreiber, noting the
13 importance of physical activity and the benefits that
14 that can have for people across multiple systems is
15 just one example of the shift in frame that I think is
16 beneficial for older adults.
17 **MS. SUPER:** Thank you. Dr. Schreiber,
18 I am combining a couple of different questions. You
19 talked about the importance of community-based
20 organizations and how they help to deliver critical
21 support services. We have a question. We do have
22 three medical doctors on the line, which we're happy
23 to have, but there are some non-medical care providers
24 who are asking how they can provide support to adults

1 with regard to multiple chronic conditions.
2 We've had some questions about where
3 does nutrition fit into this, basic such as hydration
4 and concerns like just transportation to getting to
5 your doctor's appointment in the first place. Can you
6 talk a little bit about how community-based resources
7 might help in that?
8 **DR. SCHREIBER:** Yes, I'd love to, Nora,
9 and I think that's a great question. It's funny how
10 things sort of come around. But I remember over 20
11 years ago when I first came to Massachusetts and one
12 of the first phone calls I made was to an area agency
13 on aging, and it had just happened to be elder
14 services, to ask them how we can work together to
15 provide much better support to the people that I would
16 be caring for in the community with multiple chronic
17 conditions.
18 A lot of the important work that has to
19 be done has to happen in the community. And non-
20 medical care providers actually understand much more
21 effectively what are the challenges individuals face
22 and are able to actually leverage resources; whether
23 it's coming up with problem-solving on transportation
24 issues, nutritional issues, economic issues, safety

1 issues in the environment, how can they make certain
2 that people are safe, and also dealing with other
3 issues involving family members.
4 These people are properly poised to
5 really understand what matters most to individuals.
6 What has oftentimes not happened is, we don't get that
7 communication back in the medical community, and we
8 don't speak about those issues because we're dealing
9 with a lot of multiple chronic conditions and trying
10 to deal with those illnesses.
11 But the non-medical provider actually
12 has a bird's eye view and can take holistic view. And
13 if we can actually utilize them to help empower
14 individuals to become more engaged, to become more
15 activated, to help them overcome problem-solving
16 through motivational interviewing and then getting
17 them to become more involved in managing their illness
18 -- in fact, what we've seen with the biggest successes
19 is when we have a successful partnership between
20 community-based organizations and the medical provider
21 system, we actually get the better outcomes.
22 And so they really are poised to help
23 deal with the majority of issues that people are
24 really challenged with, and they can't really deal

1 with those medical issues unless some of these non-
2 medical situations are dealt with first.
3 **MS. SUPER:** Great. Thank you for that
4 response. Dr. Parekh, you mentioned in the beginning
5 several of the initiatives that we're studying at HHS
6 and that were started under the Affordable Care Act.
7 Some of our listeners are well aware of all the
8 changing delivery system and payment system models
9 that are currently being piloted all across the
10 country.
11 How do you think an accountable care
12 organization or bundled payment may impact these
13 approaches to multiple chronic conditions?
14 **DR. PAREKH:** Nora, thanks for that
15 question. I think it's very important. As you've
16 mentioned, there are an array of now alternative
17 payment models that are being catalyzed by the
18 Affordable Care Act and accountable care
19 organizations, and bundled payments are two types of
20 these.
21 And I think, as we have heard about in
22 today's webinar, people with multiple chronic
23 conditions have multiple conditions, they have
24 multiple providers and multiple medications. What is

1 really needed is care coordination, care management,
2 integrated care. And that's really what bundled
3 payments try to do. They try to incentivize providers
4 so providers can better collaborate in caring for
5 individuals who are complex, who have many conditions.
6 So I think this will continue to be a
7 growing trend, these alternative payment models, and I
8 think they can really benefit this population.
9 Already for Medicare -- ACOs, for example -- there are
10 several hundred Medicare ACOs serving several millions
11 of Medicare beneficiaries.
12 So as these new alternative payment
13 models demonstrate improved outcomes and lower costs
14 for individuals with multiple chronic conditions, I
15 think you'll continue to see this trend increase.
16 **MS. SUPER:** Great. Thank you for that
17 response. Picking up on that theme about coordinating
18 care, Dr. Boyd, could you address the question we have
19 from one of our listeners on how can we better
20 coordinate multiple specialists dealing with multiple
21 chronic conditions? What if we're still dealing with
22 the fee-for-service systems?
23 This listener talks about how people
24 are driven from one to another without much

1 coordination. What can we do to improve that?

2 **DR. BOYD:** I think that's a great

3 question. So I think that's what Dr. Parekh was just

4 speaking about, about how we want health systems to

5 redesign to think about the whole person is really a

6 vital piece of that. He described that very well, so

7 I think I'll focus on the issue of how can we at a

8 more local level or for an individual patient or a

9 family member try to achieve this.

10 I think that the paradigm shift that

11 Dr. Parekh mentioned at the beginning is really

12 important here, that we need to transform the way that

13 we deliver care so that multiple different providers

14 involved in someone's care are not operating as silos,

15 in terms of really focusing on one or maybe two of

16 someone's condition, either recognizing how those

17 intersect with the other conditions that the person

18 has, and also how what they're doing might intersect

19 with what other providers are telling them to do.

20 And so, I think in order to get to the

21 next level, we need to have all providers, not just

22 primary care physicians or not just geriatricians, but

23 really all providers really begin to think about

24 patients with multiple chronic conditions and their

1 role as part of that larger holistic fear.
2 So some of the ways that I think we can
3 begin to do that are through better communication and
4 sharing of their records by tracking in our notes and
5 our communication with each other, what those outcomes
6 are that are important to people and how they inform
7 the care plan that people are on, and really opening
8 the lines of communication so that there are
9 conversations as we arrive at what someone's treatment
10 plan or care plan should be.
11 I think that the role of there being
12 some sort of a quarterback, and those can be many
13 different types of providers, to really facilitate and
14 make sure that that coordination is happening across
15 providers is very important.
16 And I think that, as Dr. Schreiber
17 mentioned, the role that patients and their families
18 or their loved ones can take in terms of recognizing
19 that navigation of the healthcare system and asking
20 questions about how the overall picture fits together,
21 I think, is also very important in moving us all
22 towards better coordination of care for people with
23 multiple chronic conditions.
24 **MS. SUPER:** Thank you, Dr. Boyd. I

1 appreciate that answer. And we have a couple of
2 questions that I'll ask Dr. Schreiber to first
3 address, and then either of the other doctors if
4 they'd like to add.
5 Just a little bit about the definition
6 of a multiple chronic condition. We've had some
7 people write in about, does that include people with
8 spinal cord injuries or other physical disabilities?
9 And another asked about sensory impairments. So how
10 do we look into some other disabilities in
11 coordinating chronic conditions in your definition?
12 **DR. SCHREIBER:** That is a really great
13 question, and I think there are a multitude of
14 definitions depending on the literature that you look
15 at. But it really is individuals that have had at
16 least some type of impairment. It could be physical,
17 it could be mental. But any type of impairment that
18 impedes their ability to do those activities of daily
19 living, those things that are necessary, as well as
20 independent activities of daily living in terms of
21 higher level functions that needs to be addressed one
22 way or the other.
23 So people with physical disabilities
24 and spinal cord injuries, yes that would be a chronic

1 condition. There are some that are more significant
2 than others, and it depends on the individual as well.
3 You can have an individual with diabetes, heart
4 failure, as well as kidney disease and be running and
5 very active. And then you can have others that are
6 near a dialysis and are very inactive. So it really
7 depends on the individual and other factors, as well.
8 But, in fact, some multiple chronic
9 conditions are just multiple issues, and it can cover
10 many different areas.
11 **MS. SUPER:** Great. Thank you. And I'm
12 going to turn it to Dr. Parekh to add something and
13 also follow up with another question that sparked
14 conversation about how does mental health issues
15 factor into caring for chronic conditions. So Dr.
16 Parekh, if you wanted to add something else to the
17 definition, but then dealing specifically with people
18 with geriatric mental health issues.
19 **DR. PAREKH:** Great. Thanks so much.
20 So I think, in general, it's important to know for
21 Health and Human Services Initiative focused on this
22 population. As Dr. Schreiber mentioned, we look at
23 chronic conditions very inclusively. So a standard
24 definition of chronic condition is essentially a

1 condition that lasts a year or longer and requires
2 either ongoing care or causes limitations in
3 activities of daily living.
4 So we've been quite inclusive in
5 considering chronic physical conditions, mental
6 illnesses, cognitive impairment disorders, substance
7 abuse disorders. So we've made it really a point to
8 be inclusive. And as Dr. Schreiber mentioned, really
9 any long-term impairment is included here.
10 I think that the issue, Nora, that you
11 brought up related to geriatric syndromes and mentals
12 is absolutely critical, because the individuals who
13 are older who have both chronic physical conditions as
14 well as mental illnesses have that much more in terms
15 of their health and well-being that needs to be looked
16 after and coordinated. Mental illnesses can
17 exacerbate chronic physical conditions as well as vice
18 versa.
19 Several of our agencies here at HHS,
20 including SAMHSA, or Substance Abuse and Mental Health
21 Services Administration, for example, have started new
22 programs in the communities to better integrate
23 primary and behavioral health. So that one-stop
24 shopping, if you will, at the same visit, both

1 physical health conditions as well as behavioral
2 health conditions can be addressed. And these models
3 have been shown to be quite promising.
4 There are also an array of pilot
5 studies and demonstrations that Medicare and Medicaid
6 are also looking at that really are trying to
7 integrate primary care and behavioral health, because
8 this is a very complicated population, one with
9 substantial needs. And coordination is quite
10 critical.
11 **MS. SUPER:** Great. Thank you for that
12 response. Dr. Boyd, you talked a lot about how it's
13 not easy living with multiple chronic conditions.
14 Your slide showing what a patient with multiple
15 chronic conditions, if they followed all the evidence-
16 based guidelines would have to do on a daily basis,
17 and it's a bit overwhelming.
18 You talked a bit about decision
19 support, but we have a question from Mikhail asking
20 how can technology such as social media and blogs
21 assist in raising awareness about multiple chronic
22 conditions, helping people have behavioral
23 modification or help with their management of their
24 disease. Can you address that question?

1 **DR. BOYD:** That's a great question.
2 And I feel like there were actually a couple of
3 questions imbedded in there. So one of the things
4 about multiple chronic conditions actually is, is that
5 I think it has in the media and in the larger world
6 sort of lacked in voice, lacked in advocacy groups
7 because, by definition, there’s a great degree of
8 heterogeneity in terms of what the conditions are.
9 But I think, across people with
10 multiple chronic conditions, you may have different
11 specific patterns. I think there are some really
12 important commonalities and that raising the voice and
13 the level of involvement of people living with
14 multiple chronic conditions and those that are in any
15 way involved in their daily lives and the management
16 of their house actually, I think, will push us a long
17 way towards figuring out how to really improve health
18 for people with multiple chronic conditions.
19 So I think, thinking about this in
20 terms of what people can do on blogs and social media
21 would be really fantastic, because I think there’s
22 much more that we don't know than what we do know
23 about people with multiple chronic conditions.
24 Just as an example, how do people with

1 multiple chronic conditions identify? What words
2 would they use when they wrote about it in a blog or
3 social media? I think that starting to hear those
4 voices will help us figure out the really true
5 patient-centered and person-centered ways to be
6 talking about people with multiple chronic conditions.
7 I think there are a number of
8 interesting things that are increasingly talked about.
9 One of them is the idea of minimally disruptive
10 medicine. The idea that we want people to be on the
11 treatments that allow them to go and accomplish what
12 they need to accomplish but allow them to go live the
13 lives that they want.
14 Other people have talked about this in
15 terms of figuring out what outcomes matter to people
16 and helping them to achieve those outcomes,
17 identifying the goals of care. And I think that all
18 of these ways really are moving us in the direction
19 towards what we all believe is truly person-centered
20 care.
21 **MS. SUPER:** Great. Thank you. And I
22 know we have many questions. We are closing in on the
23 end of time, so I'm going to give one more question to
24 Dr. Schreiber and one more to Dr. Parekh and then

1 close up. But we appreciate all the questions that
2 people have sent and we will do our best to respond.
3 Dr. Schreiber, and this is picking up
4 on what Dr. Boyd said in helping people live better
5 with their chronic conditions. One of our listeners
6 asked the question, as people work longer, how is the
7 prevalence of multiple chronic conditions relevant to
8 workplace health and wellness programs?
9 **DR. BOYD:** Great question. And I think
10 very relevant, especially in light of the aging
11 demographic not only here in the United States, but
12 across the world.
13 One of the things that does make a
14 difference in terms of individuals being able to be
15 productive is staying active, whether it's physical or
16 mental activity. Multiple chronic conditions for
17 people who are actively engaged that have a purpose in
18 life can be managed a lot easier because, in fact,
19 they have a reason to manage them.
20 I mean, they have specific goals that
21 are very important to them and are able to manage
22 that. Workplace environments, especially with the
23 aging population, are people who have multiple chronic
24 conditions, actually do better in those types of

1 environments. They have the wisdom. They have the
2 knowledge. They have the experience.
3 And working with their employers,
4 oftentimes, they're given a little extra help in one
5 aspect, in terms of maybe they have more need for
6 medical appointments. They have to do that. But they
7 get back to the employer and to the workplace in ways
8 that, oftentimes, younger people just don't have that
9 knowledge-base or wisdom to do.
10 So in fact, as we see aging -- and if
11 you look in communities where there are very old
12 people that live long productive lives, such as the
13 blue zones, there are people in their 90s and 100s
14 that are still very active in their communities, have
15 a purpose in life. And actually they don't have a lot
16 of chronic conditions because they do stay active.
17 And so, I think, having that purpose,
18 having a goal and then understanding what matters most
19 to you, you are going to be more likely to be engaged
20 in taking care of yourself and managing those issues
21 and being much more proactive. And it will result in
22 a better work environment as well as a better
23 community.
24 **MS. SUPER:** Great. Thank you. That

1 ties in so much to what we're hearing across the
2 country about healthy aging and how people want to
3 really choose how to live their lives and have meaning
4 and purpose.
5 The last question, and I think what all
6 of the speakers have addressed, is, it really comes
7 down to the patient and self-management. And the
8 patient's preferences and choices really have a huge
9 difference in how they're able to manage their chronic
10 conditions. So I'll ask Dr. Parekh from HHS's
11 perspective, how do you perceive self-management
12 programs contributing to the decrease in multiple
13 chronic conditions? And is the agency looking at
14 funding these programs differently in the future?
15 **DR. PAREKH:** Great, Nora. Thanks so
16 much for that question. Health management is critical
17 to ensure that individuals who are older with multiple
18 chronic conditions can optimize their health. Health
19 and Human Services through the Administration for
20 Community Living, through the Centers for Disease
21 Control and Prevention for many years has been funding
22 evidence-based self-management programs in the
23 community.
24 Hundreds of thousands of individuals

1 have been reached who likely have now better outcomes
2 and reduced healthcare utilization because of these
3 programs. Unfortunately, the need is more than
4 hundreds of thousands. The need is really tens of
5 millions, and that really gets to your question of
6 scaling.
7 And in the future, where we really need
8 to go is to ensure the best evidence-based self-
9 management programs. The way to scale them is to
10 integrate them into healthcare and to really diversify
11 the funding support so that more Americans who are
12 older who have multiple chronic conditions can benefit
13 from evidence-based self-management programs.
14 But self-management is a critical
15 piece, building the skills for individuals so they
16 have the ability to manage their conditions. Self-
17 management incorporates care-givers as well as
18 families as well as providers. It really takes the
19 whole team, but the individual is really at the center
20 of that team.
21 So integrating self-care into
22 healthcare is the way we can scale self-management
23 programs and ensure that the reach is not just to
24 hundreds of thousands, but to the tens of millions who

1 need it.

2 **MS. SUPER:** Great. Thank you, Dr.

3 Parekh, Dr. Boyd, Dr. Schreiber for your very

4 informative presentations. This is a great Inaugural

5 Webinar for the White House Conference on Aging done

6 in cooperation with the Office of the Assistant

7 Secretary for Health at HHS.

8 We really appreciate your attention.

9 And please visit both of the websites that are listed

10 for more information about anything that we talked

11 about. We will be sending out the slides shortly to

12 all of the folks who have registered. Thanks again

13 for your attention. Have a great day.

14 * * * *