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
INTRODUCTION: Hello everyone, and welcome today’s webinar, 21st Century Challenge for Healthy Aging; Balancing Living Well with the Reality of Multiple Chronic Conditions.

Before we get started, I would like to go over a few items so you know how to participate in today’s event. You can join the audio for today’s conference by selecting “mic and speaker” and listening via your computer or headset. You may also join by phone by selecting the telephone option and dialing into the webinar.

You will have the opportunity to submit text questions to today’s presenters by typing your questions into the questions pane of the control panel. You may send in your questions at any time during the presentation. We will collect these and address them during the Q&A session at the end of today’s presentation.

Please note that a recording of today’s presentation will be made available to you on December the 18th. At this time, I will turn the presentation over to Nora Super.

MS. SUPER: Good afternoon, everyone. This is Nora Super and I’m the Executive Director of
the White House Conference on Aging. And I’m delighted to welcome you to our webinar today on the topic of Balancing Living Well with the Reality of Multiple Chronic Conditions.

This is the first webinar of the White House Conference on Aging and we’re delighted to have so many registrants. We have over 1,500 people registered for this, so we know that we have lots of interest.

We’d like to hear from everyone, so as was mentioned, please start thinking of your questions now. We will go through all of the speakers first and their presentations before we answer questions, but feel free to send us questions while the presentations are going on so that we can have some in the queue to get started right away. We’ll devote the last 15 minutes of the webinar to responding to these questions.

Let me take a moment to introduce our speakers. Today we’re delighted to have Anand Parekh who is the Deputy Assistant Secretary for Health at the U.S. Department of Health and Human Services. He has held this position since 2008.

Through this position, he’s developed
and implemented national initiatives focused on prevention and wellness and on care-management for individuals with multiple chronic conditions.

Briefly, in 2007, he was delegated the authorities of the Assistant Secretary of Health for overseeing 10 public health program offices, including the U.S. Public Health Service Commission Course. He is an internist by training, a Fellow of the American College of Physicians and an Adjunct Assistant Professor in Medicine at Johns Hopkins University.

After we hear from Dr. Parekh, we’ll turn to Dr. Rob Schreiber who is the Medical Director of Evidence-based Programs at Hebrew SeniorLife of Harvard Medical School. Dr. Schreiber is Medical Director of this program, which is an organization funded by the John A. Hartford Foundation and the Tufts Health Plan Foundation.

He served as Physician and Chief, and Chief Medical Officer of Hebrew SeniorLife in Boston Massachusetts from 2004 to 2012. He is faculty member of the Institute for Aging Research at Hebrew SeniorLife and is working to connect research to healthcare systems clinical venues.

He also serves on the faculty at
Harvard Medical School and is a Senior Leader of the Practice Change Leaders Program which mentors physicians, nurses and social workers to improve the care of older adults and their health systems.

And our final speaker will be Dr. Cynthia Boyd, who’s an Associate Professor, Division of Geriatric Medicine and Gerontology, Department of Medicine with Johns Hopkins University. She’s a core faculty member there and the Roger C. Lipitz Center for Integrated Healthcare.

Dr. Boyd is jointly appointed in the Department of Health Policy and Management. She is also a Robert Wood Johnson Physician Faculty Scholar. She trained in internal medicine, geriatric medicine and epidemiology.

Dr. Boyd’s main interest includes the clinical care of comorbid chronically ill and frail older adult both chronically and during acute illness, such as hospitalization. Currently, she’s working on projects such as Treatment Burdens Among Older Adults with Multi-Morbidity, and that means, for those lay people, those who have multiple chronic conditions, and also working on diabetes and other competing risks for improving care of the elderly.
So with that, I’d like to turn it over to our speakers and beginning with Dr. Parekh.

**DR. PAREKH:** Thank you so much, Nora, for the introduction and your leadership of the 2015 White House Conference on Aging. I’m honored to be a part of this Inaugural Webinar and to join so many of you today.

Today’s focus is on the growing population with multiple, or two or more chronic conditions and ensuring that these individuals can optimize their healthcare and health choices as they age.

Three factors; the aging of the population, the continued existence of risk factors, such as obesity and tobacco use and advances in modern medicine have really led to an increasing number of Americans with more than one chronic condition. In fact, the most common chronic condition today in this country is not heart disease or diabetes or Alzheimer’s or cancer. Rather, it is multi-morbidity. Knowledge of this now requires a paradigm shift in how we address and tackle chronic conditions.

Specially, the challenge for this country, vis-à-vis, multiple chronic conditions from a
prevalent standpoint is over one in four adults in this country have multiple chronic conditions. And two in three Medicare beneficiaries and Medicaid beneficiaries with disabilities have multiple chronic conditions. In terms of access, one in six who are uninsured have multiple chronic conditions, which makes the Affordable Care Act that much more important to help this population gain access to care and remain healthy.

Third, in terms of outcomes, all of those outcomes we care about from mortality, poor functional status, hospitalizations, readmissions, adverse drug events; all of these increase as the number of conditions on average increase. And fourth, care for individuals with multiple chronic conditions account for a disproportionate share of healthcare costs.

Given this challenge four years ago, the U.S. Department of Health and Human Services launched the strategic framework on multiple chronic conditions to provide a roadmap for the public and private sectors to improve the health of this population.

Individuals with multiple chronic
conditions are a very diverse group. On the spectrum of health, some are independent and ambulatory, while others have functional limitations and substantial healthcare utilization. The multiple chronic conditions strategic framework supports the theme that all individuals with multiple chronic conditions, irrespective of where they are on this spectrum, can age healthier.

Specifically, there are four goals of the strategic framework as you see here. The first is to foster healthcare and public health systems change. The second is to maximize the use of proven self-care management, really to empower individuals. The third is to provide better tools and information to healthcare public health and social service workers, really to equip providers. And the fourth is to facilitate research to fill knowledge gaps to enhance research.

Both the public and private sector have helped over the last several years to implement this strategic framework. On this slide are selected examples of actions undertaken by Health and Human Services.

For example, for goal one, starting in
2015, the Centers for Medicare and Medicaid Services, or CMS, will begin for the first time to pay providers separately for the non-face-to-face chronic care management of patients with multiple chronic conditions. CMS is also testing new care models through the Independence-at-Home demonstration, for example. Eight thousand frail Medicare beneficiaries with multiple chronic conditions and functional limitations are receiving home-based primary care.

This really flips the care-delivery model on its head. Instead of patients going to care; here, care comes to patients.

Related to goal two, HHS is supporting evidence-based community prevention and wellness programs. For example, over 200,000 older U.S. residents, the majority with multiple chronic conditions, have completed a chronic disease self-management program through the administration for community living. We know that these programs can improve health and quality of life and decrease emergency room visits and hospitalizations.

For goal three, HHS is expanding professional education and training in conjunction with our office and health resources and services
administration. An interprofessional curriculum for multiple chronic condition education and training is being developed and will be disseminated to providers. And finally, for goal four, the Food and Drug Administration has recently 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 multiple chronic conditions.

This really adds to FDA’s long-standing interest to increase the inclusion of older adults in clinical trials. And related to patient-centered outcomes research, our agency for Healthcare Research and Quality has created a nationwide multiple chronic condition research network. And our National Institute of Health has issued seven new funding opportunities focused on this population since 2010, so there is a tremendous about of activity ongoing.

In conclusion, living well with chronic diseases increasingly means living well with multiple chronic diseases. With the complexity of the American elderly population increasing, it’s that much more important to better understand the wishes and goals of these individuals so that care choices can be
optimized for them.

And now, as Nora mentioned, we’ll move to two speakers who are leaders in the field helping to implement the goals of this strategic framework. Dr. Schreiber will discuss how community-based organizations help individuals with multiple chronic conditions age healthier, and then Dr. Boyd will then discuss how patient-centered outcomes research can help individuals with multiple chronic conditions age healthier. First, we’ll turn it over to Dr. Schreiber.

DR. SCHREIBER: Thank you, Dr. Parekh. Today I will be discussing the value proposition of community-based organizations and optimizing the health of individuals with multiple chronic conditions. The Patient Protection Affordable Care Act is leading health systems to deliver value-based healthcare, emphasizing prevention and wellness interventions, as we’ve heard.

The Health and Human Services strategic framework helps promote community-based organizations to develop partnerships with medical care providers with the mutual goal of promoting health aging and preventing the development of frailty, disability and
The expanded chronic care model seen here represents a conceptual framework for improving the health of populations with chronic illness. A key component of this model involves prepare proactive community partners integrating with prepared proactive practice teams working with an informed and activated patient. Community-based organizations traditionally focus on providing individuals with long-termed service support as well as helping them improve self-management skills.

Due to the changing healthcare environment, area agencies on aging are now starting to mirror changes employed by healthcare systems through the use of decision support, information systems and self-management strategies leading to redesign of care delivery. Improved and sustainable outcomes can be achieved if partnerships develop and work in an integrated and coordinated fashion which promotes the activation of individuals with multiple chronic conditions.
This shift in care delivery is illustrated in this slide. On top, the healthcare system has been incentivized to care for acute illness and treat chronic disease exacerbation rather than preventing illness and promoting wellness. This reactive medical care approach has resulted in medicalization of healthcare and has often been siloed from community-based organizations who often deal with populations having other challenges including substance abuse, mental illness, dementia and development disabilities.

The bottom of this slide shows how area agencies on aging help shift this focus to support proactive preventive interventions based in the community and centered on what the patient at home wants. They develop longitudinal relationships and are not vested in any particular component of the healthcare delivery system. This approach focuses on what matters most to the individual.

In particular, area agencies on aging can serve as boundary spanners providing a bridge for the individual to connect with healthcare providers, social service and community-based organizations resulting in improved health while maintaining the
individual’s independence in the community. This need was highlighted by a 2011 Robert Wood Johnson Foundation Survey of a thousand primary care physicians.

Eighty-five percent of these physicians understood that individual social needs directly contributed to poor health. However, four out of five physicians were not confident they could meet these social needs, thereby hurting their ability to provide quality care.

It was also noted that one in seven prescriptions were given for social needs and that psychosocial issues were commonly treated as physician concerns. This gap where psychosocial environmental needs directly contribute to poor health is where community-based organizations are best able to show their value.

The traditional scope of community-based organizations have been on long-term service supports, shown on the left side of this slide, which assist individuals to live independently in their community. New approaches for integration of these organizations and to healthcare have been facilitated by the Administration on Community Living and state
aging and disability agencies. These include the following four areas highlighted.

Managing chronic diseases are significantly improved by using the Stanford Chronic Disease Self-Management programs and other evidence-based and counseling programs. Activating Patients is also being promoted using evidence-based care transitions programs and person-centered care planning.

Preventing hospital admissions is occurring widely through community-care transition programs, care-coordination, fall-prevention programs and other interventions as listed. And lastly, avoiding long-term stays in nursing homes have been greatly enhanced by programs such as Money Follows the Person and preadmission reviews.

One important and evolving role of area agencies on aging in preventing hospital readmissions that are associated with poor health outcomes are demonstrated above. One such agency, Elder Service Of Merrimack Valley in Lawrence, Massachusetts has demonstrated a significant and sustained decrease in hospital readmissions with its six hospital partners.

At baseline, the average for 30-day
readmissions at the end of July 2013 was 18.3 percent, but it is declined and stabilized at 16 percent this year. This has been the result of using quality improvement techniques involving the Care Transitions Program in addition to using a health information technology tool called Care-At-Hand. This tool effectively helps non-clinical workers identify conditions that can lead to readmissions through a decision support checklist that is contained on a handheld device.

An electronic alert is sent to a supervising nurse who can intervene and activate the appropriate part of the care system. The chart on the right shows the estimated net savings from prevented admissions and was recently highlighted in the Agency for Healthcare Research and Quality Innovations Exchange.

Another model approach on how community-based organizations can partner with healthcare systems is through disseminating evidence-based programs. The Healthy Living Center of Excellence is a partnership between Elder Services of Merrimack Valley and Hebrew SeniorLife, a healthcare provider in Boston. It promotes the integration of
evidence-based self-management programs within the healthcare delivery system through system-wide collaborations, including community-based partners, healthcare providers, insurance plans, government agencies, foundations and for-profit organizations.

Key features of this model include a state-wide disease management coalition involving over 60 community-based organizations, utilizing a website and universal license which allows for scalability. There is a centralized referral and technical assistance system that provides quality assurance.

There are multiple programs that occur in many different settings. The center is seeking diversification of program funding to ensure sustainability of these programs by integrating them in medical homes, accountable cure organizations, dual eligible plans and other shared-risk pilots.

Elder Services of the Merrimack Valley has other measures and outcomes which have promoted healthier and safer aging in the community, and I will highlight just a few. Similar outcomes are being achieved by many other community-based organizations across the country. In care transitions, there has been a 25 percent increase in referrals to visiting
nursing agencies due to recognition of significant medical needs that were not addressed on hospital discharge.

A pilot was just completed where 12 participants had integration of behavioral health interventions integrated into care transitions. This resulted in a 91 percent reduction in depression scores in three months and no readmission to the hospital in 90 days.

Another example involved elder services care coordination teams significantly decreasing the length of stay in the nursing home for individuals with multiple chronic conditions. This has also been accomplished utilizing the adult disability resource center for the disability community.

The agency staff’s ability to manage chronic disease has been enhanced, and they are now practicing at the top of their license through quality improvement processes and programs. These include trans-disciplinary learning sessions with medical providers in attendance and decision support from care transition teams. The Care-At-Hand tool now allows a care transitions nurse to manage at least twice the number of patients with better outcomes.
Long-term service supports are being enhanced by building and leveraging supportive housing models. This has resulted in decreased admissions for at-risk individuals through community care coordination that is culturally competent and individually centered and directed.

In summary, I have described the key roles community-based organizations can play in ensuring individuals with multiple chronic conditions age healthier in the community. These organizations serve as boundary spanners leading to improved patient safety and quality through trans-disciplinary collaboratives that occur across the care continuum.

This is their value proposition to the healthcare system, and this could be enhanced by using the Health and Human Services strategic framework of multiple chronic conditions to optimize health outcomes of the populations they serve. I will now turn the webinar over to Dr. Cynthia Boyd.

**DR. BOYD:** Thank you. I’m very pleased to participate today and to tell you about improving health and healthcare for people living with multiple chronic conditions through patient-centered outcomes research.
As we’ve heard earlier today, it is very important that we consider not just how to treat one illness, but that we think about the person living with many conditions. Disease in isolation is the exception and not the rule.

Within the large population of older adults with multiple chronic conditions, there remains great variability in both what the specific conditions are that people have, their severity and how the conditions effect people’s lives and function.

Much of how we practice medicine and design healthcare has been based on knowledge that has been gained about individual diseases. When we combine what we know about single conditions and apply it to someone with multiple, this is often less evidence-based. Doing this within people with multiple chronic conditions can also be overwhelming for patients and their loved ones and may also be harmful.

Guidelines are designed to be based on a rigorous evaluation of the quality of evidence from clinical trials and other studies and are intended to inform but not dictate the care that doctors and other clinicians provide.
On the next slide, I’m going to show you the treatment regimen that may result from using single disease-focused guidelines to inform care for an older woman in her late seventies with five common chronic conditions including arthritis, high-blood pressure, diabetes, osteoporosis and chronic obstructive pulmonary disease.

Using guidelines, we’ve tried to make the recommended treatment regime as simple as possible and to avoid potential harms that can arise from interactions between therapies for different conditions. And yet, as you can see, it’s not easy living with multiple chronic conditions. This treatment regime includes 12 medications and 19 different doses per day with a significant amount of other types of treatments and interventions also.

This treatment regime is not unlike that of many of the patients I see. It raises the critical question, which of these recommendations are actually most important for the individual person; which are most likely to help the person achieve the goals and outcomes that matter to them?

Attaining person-centered care requires that we respect the diverse decision-making
preferences that older adults and often their loved-ones have, that we minimize harms and focus on what matters to the person, that we support the context in which people manage their health. And we appropriately use evidence from studies to inform, not dictate care.

Doing so requires us to shift from the perspective of thinking that one condition is more important or central than another, or that we do that in some sort of sequence. The reality is that the conditions and treatments all end up overlapping and affecting each other.

For example, if we think of a person living with heart failure and chronic kidney disease and diabetes who has had a couple of recent falls, we could think about each condition sequentially. But the reality is that we really want to think about that person in terms of what matters to them in the context of their lives and recognize that those conditions are a piece of that.

In 2012, the American Geriatric Society developed a roadmap describing guiding principles to approach the care of older adults with multiple chronic conditions. These were that we want to elicit
and incorporate patient preferences into medical
decision-making for older adults with multiple chronic
conditions, recognizing that family and social support
play a vital role in both the day-to-day management of
health conditions and in decision-making.

Recognizing the limitations of the
evidence-based, we want to interpret and apply the
medical literature specifically to this population of
older adults with multiple chronic conditions. We
want to frame clinical management decisions within the
context of risks, burdens, benefits and prognosis for
older adults with multiple chronic conditions.

We want to consider treatment
complexity and feasibility when making clinical
management decisions for older adults with multiple
chronic conditions. And we want to use strategies for
choosing therapies that optimize benefits, minimize
harm and enhance quality of life for this population.

So, what do clinicians need to do in
order to best care for people living with multiple
chronic conditions? We need to think beyond diseases
and recognize that conditions such as urinary
incontinence or falls are very important. And we need
to recognize the diversity in health status within the
very large population of people with multiple chronic conditions.

There are those, for example, with significant difficulties with functional activities of daily living and those who are at risk of such functional decline in the future.

We must be cognizant of the challenges of the evidence-base that we have had for this population which has, in the past, often excluded older adults, and particular older adults with multiple chronic conditions from the studies that evaluate the effectiveness of treatments and other interventions.

For any person in front of us, we want to be able to maximize the use of therapies likely to benefit them and minimize the use of therapies that are either likely to harm them or that are not going to benefit them. But we have to do this in such a way that recognizes that the person’s values and preferences regarding the burdens, risks and benefits may change our assessment of what the right things to do are for someone.

For the last several years, a large group of people have been working hard on how we can
translate research from clinical studies into practice for people with multiple chronic conditions. How do we need to transform this process of translation in light of the population of people with multiple chronic conditions?

We can better design studies and analyze their data so that we can gain knowledge about what is effective for this population by ensuring that these people are involved in research, enrolled in trials, and that we analyze data to validly inform the care of people with multiple chronic conditions.

Emphasizing the evidence-base is important so that we learn from all research studies, not just any one individual study. But we can also better synthesize the evidence-base in order to inform care of this particular population. These evidence synthesis should inform the way we develop clinical practice guidelines, which are then meant to inform the practice of healthcare providers.

Best guidance is necessary in order to inform clinical decisions for individuals like the patient pictured here so that we can make the decisions that are best for her. This will also need to inform the way we integrate care across multiple
providers who often care for people with multiple chronic conditions, and the way that we integrate care for the person so that we choose those possibly recommended things that we choose those that are actually most important for that person.

This better translation of research into practice for this population is also necessary to determine the best ways to measure or evaluate the quality of care that is provided to older adults.

Next, I’m going to tell you briefly about a new research project that we are embarking on rescinding from the patient-centered Outcomes Research Institute. With our stakeholder team, we are going to identify high priority clinical questions and outcomes for people with multiple chronic conditions and the loved ones in their lives.

We will 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. And we will finally develop method guidance for others for how to do this to help other organizations who conduct systematic reviews and who develop clinical practice guidelines.
Such patient-centered research for older adults with multiple chronic conditions is important to ensure that individuals with multiple chronic conditions age healthier and get the best possible healthcare. I thank you for your attention and I look forward to the questions.

**MS. SUPER:** Thank you so much for these excellent presentations. I certainly learned a lot. I wanted to note for those of you who joined a little late, this is the first of a series of webinars the White House Conference on Aging will be conducting over the next few months. And we are excited at the White House to focus on four major areas for our conference in 2015.

The one that where we are looking at retirement security, healthy aging, long-term services and supports and elder justice, so it’s the prevention of abuse, neglect and financial exploitation of elders. This topic is very important to help older people learn how to live with multiple chronic conditions and live well and healthier into later years.

The first question I wanted to address that many of you sent in is wanting to know if you’ll
be able to get the slides. So I’ll just say right now that yes, we will have the slides available, as well as a recording of the webinar because we know some folks have wanted to get in and our registration was full. Those will be sent to everyone who’s registered next week, so a week from today, on Thursday, the 17th.

The first question I’m going to direct to Dr. Parekh, you gave us some really interesting information about the prevalence of multiple chronic conditions. What do we know about racial and economic disparities of multiple chronic conditions?

**DR. PAREKH:** Thanks, Nora, for that important question. So, I think, in general, we know that individuals in lower social economic status groups and in certain racial and ethnics groups are more likely to have chronic conditions. Now, related to individuals with multiple chronic conditions, specifically, I think we’re still learning more.

So one of our offices here at Health and Human Services are Assistant Secretary for Planning and Evaluations Office, or ASPE, has recently published results of a project that’s identified data and methods and topics for research on exactly this,
on health disparities and multiple chronic condition populations. And it is also assessing the potential utility of existing data systems and datasets so we can really get at multiple chronic condition disparities research.

So I think we’ll see more attention and focus on this area, so we hope to learn more soon and then start to address these disparities that are likely quite real.

MS. SUPER: Thank you for that response. Dr. Schreiber, this question is for you. What preventive measures are being introduced to the aging population today as they relate to managing multiple chronic conditions?

DR. SCHREIBER: Thank, Nora, for that question, a very good one. So there are a multitude of preventive measures, and a lot of them do focus on the role of the individual becoming much more engaged and activated in their care. Oftentimes, one of the key determinants of what makes a difference is what matters most to the individual. By giving people the opportunity to deal with the challenges that they face and the tools that they need to be able to problem solve, they oftentimes can direct their own care and
work with their care team to develop a plan that’s effective in managing their issues.

In particular, the self-management programs that we discuss that are part of the framework as well as, in my discussion, are really critical and important factors in terms of helping people who do have chronic illness prevent progression of those diseases or from developing new ones. And the individual, by learning how to set goals, overcome barriers, problem solve, and how to take complex problem and challenge it if they have to break it down to the small bite size pieces is really critical.

What we also find is, by getting people to realize that they actually have a lot of control over the outcomes of their illnesses, they become much more physically active. Physical activity is probably the most important preventive measure that anybody can do regardless of what chronic illness they have. And so, in fact, most people become very active and develop activity plans based on their goals.

And lastly, I would say that the other piece that's really important is people actually take charge, they become the captains of their healthcare ship. And they become much more compliant and also
much more engaged with their medical providers in terms of communicating more effectively.

**MS. SUPER:** There’s a lot of questions coming in now, so I want to direct one to Dr. Boyd. Dr. Boyd, you mentioned the importance of things such as treating the older person as a whole person and addressing many of the issues that affect them with managing multiple chronic conditions.

We have one of our listeners ask, what can be done when a condition is inappropriately attributed to age? In other words, I think the idea that people have been told that, oh, that’s just because you're getting older that you have this issue. How can we help health professionals or others, and especially the people themselves understand what are conditions they really do need to have treated and are treatable?

**DR. BOYD:** I think that’s a great question. So I think that, first off, preparing for visits with healthcare professionals in terms of being willing to ask those questions such as that one, specifically, of them.

So while certainly there are age-related changes as we get older, many times the
symptoms and the issues that our patients are raising are not attributable just to the aging process, that they are either related to a specific disease or that they are rising for multifactorial reasons, that the person is experiencing something as a result of impairments or changes across multiple organ systems.

And thinking about the problems that people are facing in this frame makes it easier to figure out potential solutions, and not just solutions that are targeted at one disease or one underlying condition, but those that might work across the systems. And I think Dr. Schreiber, noting the importance of physical activity and the benefits that that can have for people across multiple systems is just one example of the shift in frame that I think is beneficial for older adults.

MS. SUPER: Thank you. Dr. Schreiber, I am combining a couple of different questions. You talked about the importance of community-based organizations and how they help to deliver critical support services. We have a question. We do have three medical doctors on the line, which we’re happy to have, but there are some non-medical care providers who are asking how they can provide support to adults
with regard to multiple chronic conditions.

    We’ve had some questions about where
does nutrition fit into this, basic such as hydration
and concerns like just transportation to getting to
your doctor’s appointment in the first place. Can you
talk a little bit about how community-based resources
might help in that?

    DR. SCHREIBER: Yes, I’d love to, Nora,
and I think that’s a great question. It’s funny how
things sort of come around. But I remember over 20
years ago when I first came to Massachusetts and one
of the first phone calls I made was to an area agency
on aging, and it had just happened to be elder
services, to ask them how we can work together to
provide much better support to the people that I would
be caring for in the community with multiple chronic
conditions.

    A lot of the important work that has to
be done has to happen in the community. And non-
medical care providers actually understand much more
effectively what are the challenges individuals face
and are able to actually leverage resources; whether
it’s coming up with problem-solving on transportation
issues, nutritional issues, economic issues, safety
issues in the environment, how can they make certain that people are safe, and also dealing with other issues involving family members.

These people are properly poised to really understand what matters most to individuals. What has oftentimes not happened is, we don’t get that communication back in the medical community, and we don’t speak about those issues because we’re dealing with a lot of multiple chronic conditions and trying to deal with those illnesses.

But the non-medical provider actually has a bird’s eye view and can take holistic view. And if we can actually utilize them to help empower individuals to become more engaged, to become more activated, to help them overcome problem-solving through motivational interviewing and then getting them to become more involved in managing their illness -- in fact, what we’ve seen with the biggest successes is when we have a successful partnership between community-based organizations and the medical provider system, we actually get the better outcomes.

And so they really are poised to help deal with the majority of issues that people are really challenged with, and they can't really deal
with those medical issues unless some of these non-
medical situations are dealt with first.

MS. SUPER: Great. Thank you for that
response. Dr. Parekh, you mentioned in the beginning
several of the initiatives that we’re studying at HHS
and that were started under the Affordable Care Act.
Some of our listeners are well aware of all the
changing delivery system and payment system models
that are currently being piloted all across the
country.

How do you think an accountable care
organization or bundled payment may impact these
approaches to multiple chronic conditions?

DR. PAREKH: Nora, thanks for that
question. I think it’s very important. As you’ve
mentioned, there are an array of now alternative
payment models that are being catalyzed by the
Affordable Care Act and accountable care
organizations, and bundled payments are two types of
these.

And I think, as we have heard about in
today’s webinar, people with multiple chronic
conditions have multiple conditions, they have
multiple providers and multiple medications. What is
really needed is care coordination, care management, integrated care. And that's really what bundled payments try to do. They try to incentivize providers so providers can better collaborate in caring for individuals who are complex, who have many conditions.

So I think this will continue to be a growing trend, these alternative payment models, and I think they can really benefit this population. Already for Medicare -- ACOs, for example -- there are several hundred Medicare ACOs serving several millions of Medicare beneficiaries.

So as these new alternative payment models demonstrate improved outcomes and lower costs for individuals with multiple chronic conditions, I think you’ll continue to see this trend increase.

**MS. SUPER:** Great. Thank you for that response. Picking up on that theme about coordinating care, Dr. Boyd, could you address the question we have from one of our listeners on how can we better coordinate multiple specialists dealing with multiple chronic conditions? What if we’re still dealing with the fee-for-service systems?

This listener talks about how people are driven from one to another without much
coordination. What can we do to improve that?

**DR. BOYD:** I think that's a great question. So I think that's what Dr. Parekh was just speaking about, about how we want health systems to redesign to think about the whole person is really a vital piece of that. He described that very well, so I think I’ll focus on the issue of how can we at a more local level or for an individual patient or a family member try to achieve this.

I think that the paradigm shift that Dr. Parekh mentioned at the beginning is really important here, that we need to transform the way that we deliver care so that multiple different providers involved in someone’s care are not operating as silos, in terms of really focusing on one or maybe two of someone’s condition, either recognizing how those intersect with the other conditions that the person has, and also how what they’re doing might intersect with what other providers are telling them to do.

And so, I think in order to get to the next level, we need to have all providers, not just primary care physicians or not just geriatricians, but really all providers really begin to think about patients with multiple chronic conditions and their
role as part of that larger holistic fear.

   So some of the ways that I think we can begin to do that are through better communication and sharing of their records by tracking in our notes and our communication with each other, what those outcomes are that are important to people and how they inform the care plan that people are on, and really opening the lines of communication so that there are conversations as we arrive at what someone’s treatment plan or care plan should be.

   I think that the role of there being some sort of a quarterback, and those can be many different types of providers, to really facilitate and make sure that that coordination is happening across providers is very important.

   And I think that, as Dr. Schreiber mentioned, the role that patients and their families or their loved ones can take in terms of recognizing that navigation of the healthcare system and asking questions about how the overall picture fits together, I think, is also very important in moving us all towards better coordination of care for people with multiple chronic conditions.

   MS. SUPER: Thank you, Dr. Boyd. I
appreciate that answer. And we have a couple of questions that I’ll ask Dr. Schreiber to first address, and then either of the other doctors if they’d like to add.

Just a little bit about the definition of a multiple chronic condition. We’ve had some people write in about, does that include people with spinal cord injuries or other physical disabilities? And another asked about sensory impairments. So how do we look into some other disabilities in coordinating chronic conditions in your definition?

**DR. SCHREIBER:** That is a really great question, and I think there are a multitude of definitions depending on the literature that you look at. But it really is individuals that have had at least some type of impairment. It could be physical, it could be mental. But any type of impairment that impedes their ability to do those activities of daily living, those things that are necessary, as well as independent activities of daily living in terms of higher level functions that needs to be addressed one way or the other.

So people with physical disabilities and spinal cord injuries, yes that would be a chronic
condition. There are some that are more significant than others, and it depends on the individual as well. You can have an individual with diabetes, heart failure, as well as kidney disease and be running and very active. And then you can have others that are near a dialysis and are very inactive. So it really depends on the individual and other factors, as well.

But, in fact, some multiple chronic conditions are just multiple issues, and it can cover many different areas.

MS. SUPER: Great. Thank you. And I’m going to turn it to Dr. Parekh to add something and also follow up with another question that sparked conversation about how does mental health issues factor into caring for chronic conditions. So Dr. Parekh, if you wanted to add something else to the definition, but then dealing specifically with people with geriatric mental health issues.

DR. PAREKH: Great. Thanks so much. So I think, in general, it’s important to know for Health and Human Services Initiative focused on this population. As Dr. Schreiber mentioned, we look at chronic conditions very inclusively. So a standard definition of chronic condition is essentially a
condition that lasts a year or longer and requires
either ongoing care or causes limitations in
activities of daily living.

So we’ve been quite inclusive in
considering chronic physical conditions, mental
illnesses, cognitive impairment disorders, substance
abuse disorders. So we’ve made it really a point to
be inclusive. And as Dr. Schreiber mentioned, really
any long-term impairment is included here.

I think that the issue, Nora, that you
brought up related to geriatric syndromes and mentals
is absolutely critical, because the individuals who
are older who have both chronic physical conditions as
well as mental illnesses have that much more in terms
of their health and well-being that needs to be looked
after and coordinated. Mental illnesses can
exacerbate chronic physical conditions as well as vice
versa.

Several of our agencies here at HHS,
including SAMHSA, or Substance Abuse and Mental Health
Services Administration, for example, have started new
programs in the communities to better integrate
primary and behavioral health. So that one-stop
shopping, if you will, at the same visit, both
physical health conditions as well as behavioral health conditions can be addressed. And these models have been shown to be quite promising.

There are also an array of pilot studies and demonstrations that Medicare and Medicaid are also looking at that really are trying to integrate primary care and behavioral health, because this is a very complicated population, one with substantial needs. And coordination is quite critical.

**MS. SUPER:** Great. Thank you for that response. Dr. Boyd, you talked a lot about how it’s not easy living with multiple chronic conditions. Your slide showing what a patient with multiple chronic conditions, if they followed all the evidence-based guidelines would have to do on a daily basis, and it’s a bit overwhelming.

You talked a bit about decision support, but we have a question from Mikhail asking how can technology such as social media and blogs assist in raising awareness about multiple chronic conditions, helping people have behavioral modification or help with their management of their disease. Can you address that question?
DR. BOYD: That's a great question.

And I feel like there were actually a couple of questions imbedded in there. So one of the things about multiple chronic conditions actually is, is that I think it has in the media and in the larger world sort of lacked in voice, lacked in advocacy groups because, by definition, there’s a great degree of heterogeneity in terms of what the conditions are.

But I think, across people with multiple chronic conditions, you may have different specific patterns. I think there are some really important commonalities and that raising the voice and the level of involvement of people living with multiple chronic conditions and those that are in any way involved in their daily lives and the management of their house actually, I think, will push us a long way towards figuring out how to really improve health for people with multiple chronic conditions.

So I think, thinking about this in terms of what people can do on blogs and social media would be really fantastic, because I think there’s much more that we don’t know than what we do know about people with multiple chronic conditions.

Just as an example, how do people with
multiple chronic conditions identify? What words would they use when they wrote about it in a blog or social media? I think that starting to hear those voices will help us figure out the really true patient-centered and person-centered ways to be talking about people with multiple chronic conditions.

I think there are a number of interesting things that are increasingly talked about. One of them is the idea of minimally disruptive medicine. The idea that we want people to be on the treatments that allow them to go and accomplish what they need to accomplish but allow them to go live the lives that they want.

Other people have talked about this in terms of figuring out what outcomes matter to people and helping them to achieve those outcomes, identifying the goals of care. And I think that all of these ways really are moving us in the direction towards what we all believe is truly person-centered care.

MS. SUPER: Great. Thank you. And I know we have many questions. We are closing in on the end of time, so I’m going to give one more question to Dr. Schreiber and one more to Dr. Parekh and then
close up. But we appreciate all the questions that people have sent and we will do our best to respond.

Dr. Schreiber, and this is picking up on what Dr. Boyd said in helping people live better with their chronic conditions. One of our listeners asked the question, as people work longer, how is the prevalence of multiple chronic conditions relevant to workplace health and wellness programs?

DR. BOYD: Great question. And I think very relevant, especially in light of the aging demographic not only here in the United States, but across the world.

One of the things that does make a difference in terms of individuals being able to be productive is staying active, whether it’s physical or mental activity. Multiple chronic conditions for people who are actively engaged that have a purpose in life can be managed a lot easier because, in fact, they have a reason to manage them.

I mean, they have specific goals that are very important to them and are able to manage that. Workplace environments, especially with the aging population, are people who have multiple chronic conditions, actually do better in those types of
environments. They have the wisdom. They have the knowledge. They have the experience.

And working with their employers, oftentimes, they’re given a little extra help in one aspect, in terms of maybe they have more need for medical appointments. They have to do that. But they get back to the employer and to the workplace in ways that, oftentimes, younger people just don’t have that knowledge-base or wisdom to do.

So in fact, as we see aging -- and if you look in communities where there are very old people that live long productive lives, such as the blue zones, there are people in their 90s and 100s that are still very active in their communities, have a purpose in life. And actually they don’t have a lot of chronic conditions because they do stay active.

And so, I think, having that purpose, having a goal and then understanding what matters most to you, you are going to be more likely to be engaged in taking care of yourself and managing those issues and being much more proactive. And it will result in a better work environment as well as a better community.

**MS. SUPER:** Great. Thank you. That
ties in so much to what we’re hearing across the country about healthy aging and how people want to really choose how to live their lives and have meaning and purpose.

The last question, and I think what all of the speakers have addressed, is, it really comes down to the patient and self-management. And the patient’s preferences and choices really have a huge difference in how they’re able to manage their chronic conditions. So I’ll ask Dr. Parekh from HHS’s perspective, how do you perceive self-management programs contributing to the decrease in multiple chronic conditions? And is the agency looking at funding these programs differently in the future?

**DR. PAREKH:** Great, Nora. Thanks so much for that question. Health management is critical to ensure that individuals who are older with multiple chronic conditions can optimize their health. Health and Human Services through the Administration for Community Living, through the Centers for Disease Control and Prevention for many years has been funding evidence-based self-management programs in the community.

Hundreds of thousands of individuals
have been reached who likely have now better outcomes and reduced healthcare utilization because of these programs. Unfortunately, the need is more than hundreds of thousands. The need is really tens of millions, and that really gets to your question of scaling.

And in the future, where we really need to go is to ensure the best evidence-based self-management programs. The way to scale them is to integrate them into healthcare and to really diversify the funding support so that more Americans who are older who have multiple chronic conditions can benefit from evidence-based self-management programs.

But self-management is a critical piece, building the skills for individuals so they have the ability to manage their conditions. Self-management incorporates care-givers as well as families as well as providers. It really takes the whole team, but the individual is really at the center of that team.

So integrating self-care into healthcare is the way we can scale self-management programs and ensure that the reach is not just to hundreds of thousands, but to the tens of millions who
need it.

MS. SUPER: Great. Thank you, Dr. Parekh, Dr. Boyd, Dr. Schreiber for your very informative presentations. This is a great Inaugural Webinar for the White House Conference on Aging done in cooperation with the Office of the Assistant Secretary for Health at HHS.

We really appreciate your attention. And please visit both of the websites that are listed for more information about anything that we talked about. We will be sending out the slides shortly to all of the folks who have registered. Thanks again for your attention. Have a great day.

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