What's New in Multiple Chronic Conditions? A 2012 Update

HOSTED BY THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tuesday, December 11, 2012

1:00 PM - 2:00 PM EST

HHS Strategic Framework on Multiple Chronic Conditions (MCC)

ANAND PAREKH, M.D., M.P.H.
DEPUTY ASSISTANT SECRETARY FOR HEALTH
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS)

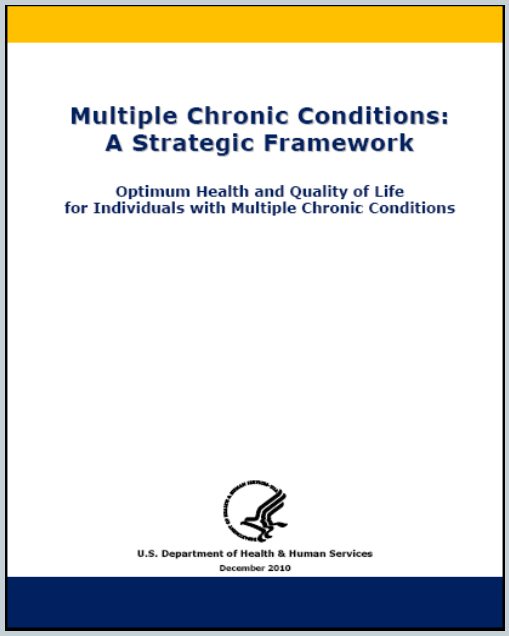
Background

- An increasing number of Americans have multiple chronic conditions (MCC)
- This trend poses challenges for individuals, their caregivers, and the health care and public health systems
- Current systems continue to be structured around individual chronic conditions resulting in fragmentation of care, sub-optimal outcomes, and high preventable costs

HHS Role and Response

- HHS administers a large number of federal programs directed toward preventing and managing chronic conditions
- The Affordable Care Act further supports prevention and care management of chronic conditions
- HHS launched the "Strategic Framework on Multiple Chronic Conditions" in 2010 to ensure a coordinated response to the challenge of MCC
- The public and private sectors are implementing the Framework

Overarching Goals of the HHS Framework



1. Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions

2. Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions

3. Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions

4. Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions

Photos: http://www.sxc.hu

Current HHS Efforts Goal 1: Foster health care and public health systems changes

Sample Activities:

- Independence at Home Demonstration
- Medicaid Health Homes (comprehensive primary care)
- Care Transitions Program
- Primary & Behavioral Health Care Integration Program

Current HHS Efforts Goal 2: Maximize the use of proven self-care management

Sample Activities:

- **Chronic Disease Self-Management Programs**
- **Self-Management Alliance**
- **Medication Adherence**

Current HHS Efforts Goal 3: Provide better tools and information

Sample Activities:

- **National Quality Forum MCC Measurement Framework**
- **Incorporation of Co-morbidities in Clinical Practice Guidelines**

Current HHS Efforts Goal 4: Facilitate research to fill knowledge gaps

Sample Activities:

- Pilot Study on External Validity of Clinical Trials
- Patient-Centered Outcomes Research
- MCC Data Initiative

MCC Database

Inventory of Multiple Chronic Conditions Activities
Database of Programs, Tools, and Research Initiatives to Address the Needs of Individuals with Multiple Chronic Conditions

- Home
- Browse by
  - MCC Framework Goal
    - (1) Foster health-care and public health system changes
    - (2) Maximize use of proven self-care management and other services
    - (3) Provide better tools and information to health care professionals who deliver care
    - (4) Facilitate research to fill knowledge gaps
  - Organization
  - Setting of Care
- View All Activities

Welcome

The MCC Inventory is a searchable database of more than 250 activities that support one or more goals, objectives, and strategies contained in the HHS MCC Strategic Framework. Activities included in this database represent activities funded by HHS and other federal agencies, as well as the private sector.

This database is not an exhaustive list of all of the activities currently underway in the public and private sectors to address the needs of individuals who have MCC. It is a compilation of activities identified in an environmental scan of the literature, publicly-available Web sites and information obtained from each of HHS' operating divisions.

To view summaries of MCC programs, tools, research and other activities, use the browse options in the left navigation bar.

Learn more about how to search this site.

Learn more about how activities were identified for inclusion in this database.

Additional Resources

HHS MCC Initiative

- HHS MCC Strategic Framework
- Innovative Profiles of MCC Activities (Coming soon)

AHRQ's MCC Research Network
CMS Innovation Center
CMS Chronic Conditions Data Page
SAMHSA's Co-Occurring Center of Excellence

Contact us with any general questions, comments, or information on



Dr. Thomas Reilly

Deputy Director

Center for Medicare and Medicaid Innovation

Centers for Medicare and Medicaid Services (CMS)

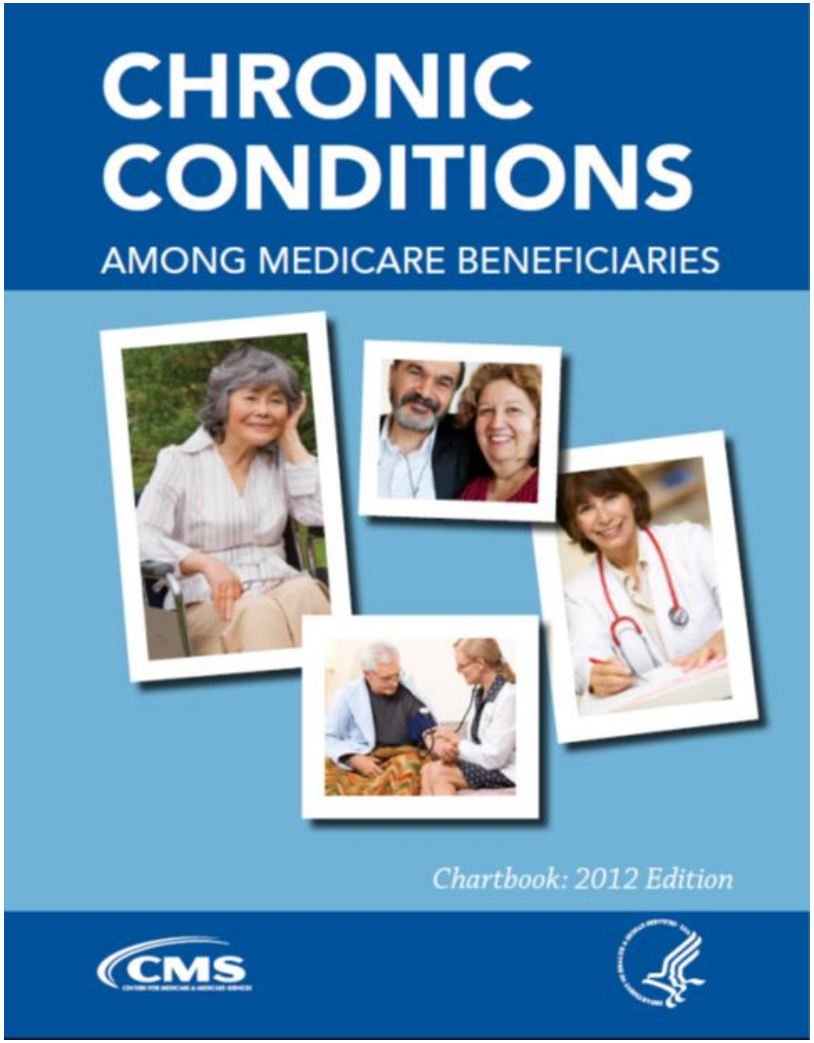
Highlights of Key Accomplishments Focused on MCC

- Analytics on chronic conditions among Medicare beneficiaries
  - The Office of Information Products and Data Analytics
- The Independence at Home demonstration
  - Center for Medicare & Medicaid Innovation
- The Medicaid state plan “Health Home” option
  - Center for Medicaid, CHIP, and Survey & Certification

CMS Analytics on MCC

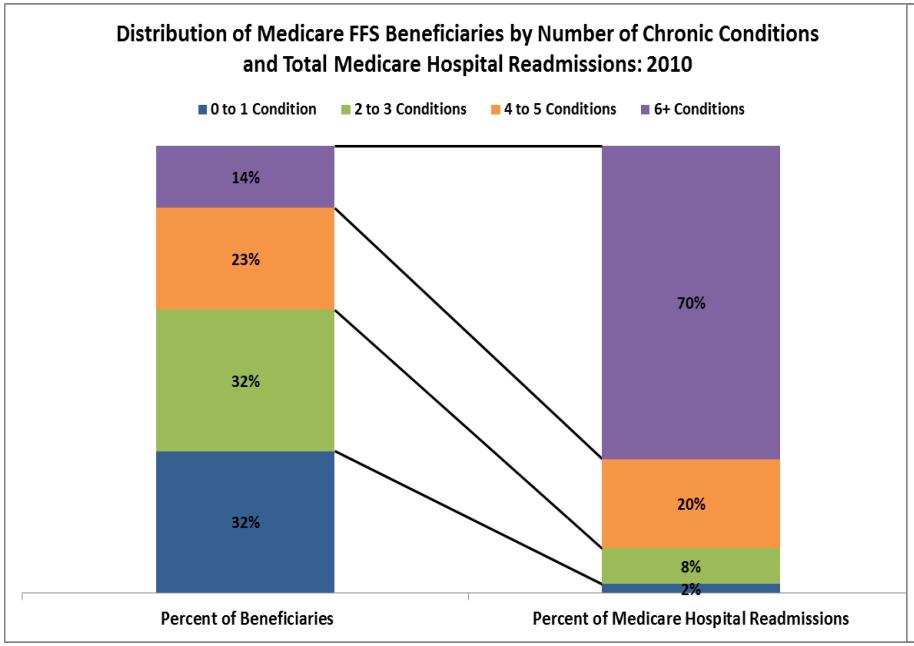
www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html

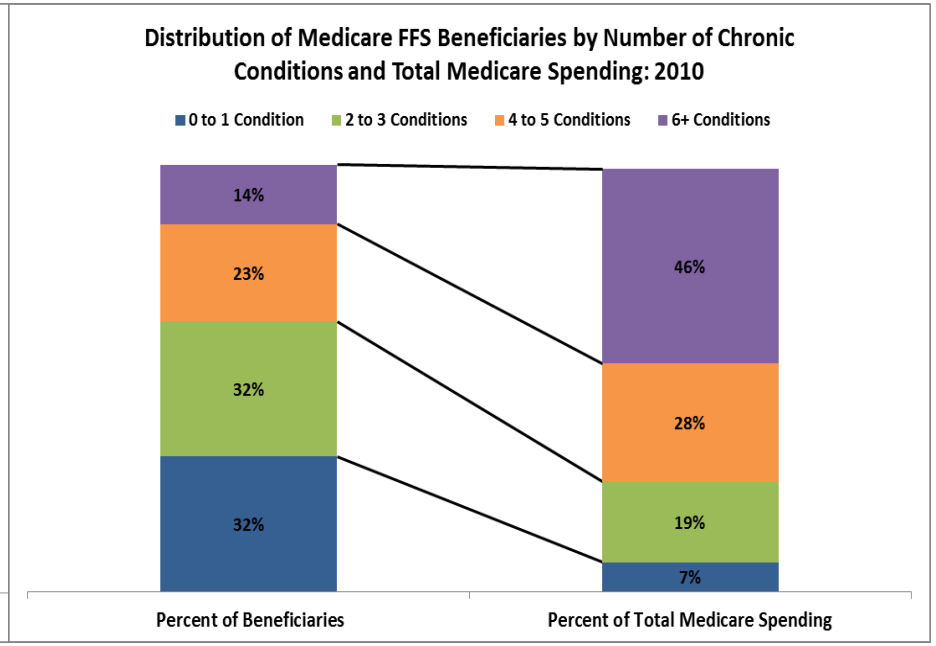
- Updated chartbook on Chronic Conditions Among Medicare Beneficiaries
- State reports on the prevalence of MCC with utilization and spending for the years 2007-2011
- Dashboard on chronic conditions and MCC for Medicare beneficiaries – examine states, dual eligibility status and more (planned release in *December 2012*)



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Multiple Chronic Conditions: Readmissions and Per Capita Spending



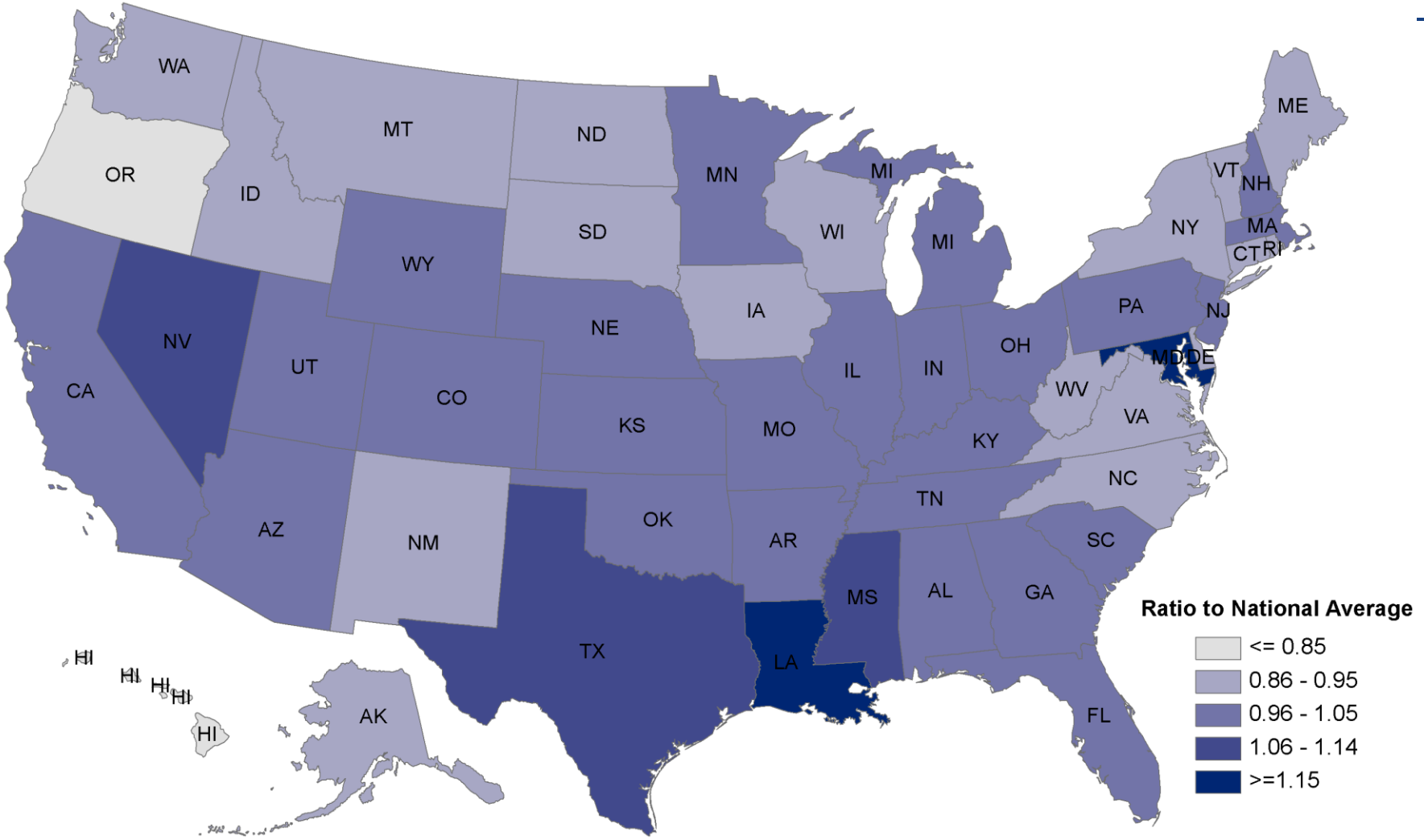


Top Five Triad Chronic Condition Combinations among Medicare FFS Beneficiaries with at Least Three Chronic Conditions: Prevalence and Per Capita Medicare Spending: 2010

Five Most Prevalent Triads			Five Most Costly Triads		
Triads	Prevalence (%)	Per Capita ($)	Triads	Prevalence (%)	Per Capita ($)
High cholesterol and High blood pressure and Ischemic heart disease	33.7	$19,836	Stroke and Chronic kidney disease and Asthma	0.2	$69,980
High cholesterol and High blood pressure and Diabetes	29.9	$17,451	Stroke and Chronic kidney disease and COPD	0.8	$68,956
High cholesterol and High blood pressure and Arthritis	25.7	$18,238	Stroke and Chronic kidney disease and Depression	0.8	$65,143
High cholesterol and Diabetes and Ischemic heart disease	21.5	$25,014	Stroke and Chronic kidney disease and Heart failure	1.5	$63,242
High cholesterol and Ischemic heart disease and Arthritis	19.3	$24,539	Stroke and Heart failure and Asthma	0.3	$62,819

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Per capita Medicare spending for Medicare FFS Beneficiaries with 6 or more chronic conditions: 2011



Independence at Home Demonstration

- Three year demonstration authorized by Section 3024 of the ACA
  - Payment incentive and service delivery model that utilizes primary care teams to provide comprehensive, coordinated, continuous, and accessible care to frail and sick Medicare beneficiaries in their homes
- Independence at Home goals
  - Reduce preventable hospitalizations
  - Prevent hospital readmissions
  - Reduce emergency room visits
  - Improve health outcomes appropriate for stage of chronic illness
  - Improve efficiency of care, i.e. reducing duplicative diagnostic and laboratory tests
  - Achieve beneficiary and family care-giver satisfaction

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Independence at Home Demonstration

- Eligible beneficiaries
  - Entitled to Part A benefits and enrolled in Part B
  - Have two or more chronic illnesses and
  - Have two or more functional dependencies requiring the assistance of another person (e.g., bathing, dressing, toileting, walking, or feeding) and
  - Have had a non-elective hospital admission within the past 12 months
- Eligible practices
  - Provide 24/7 home-based primary care services and maintain electronic health records (EHR) systems
  - Coordinate health care across all treatment settings
  - May share in savings if quality measures and savings targets are achieved
  - May not participate in the Medicare Shared Savings Program

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Independence at Home Demonstration

- Demonstration active on June 1, 2012
  - 13 Sole Entity Practices & 5 Consortium Practices
- Still early in the implementation phase
  - Enrolling eligible beneficiaries that meet the legislative criteria is challenging
  - Practices working on demonstration reporting requirements

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid "Health Home" Option

- Many Medicaid beneficiaries suffer from multiple or severe chronic conditions and could potentially benefit from better coordination and management of the health and long-term services they receive.
- Established by ACA, starting January 2011, states have a new Medicaid option to provide "health home" services for enrollees with chronic conditions.
  - Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports.
  - The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

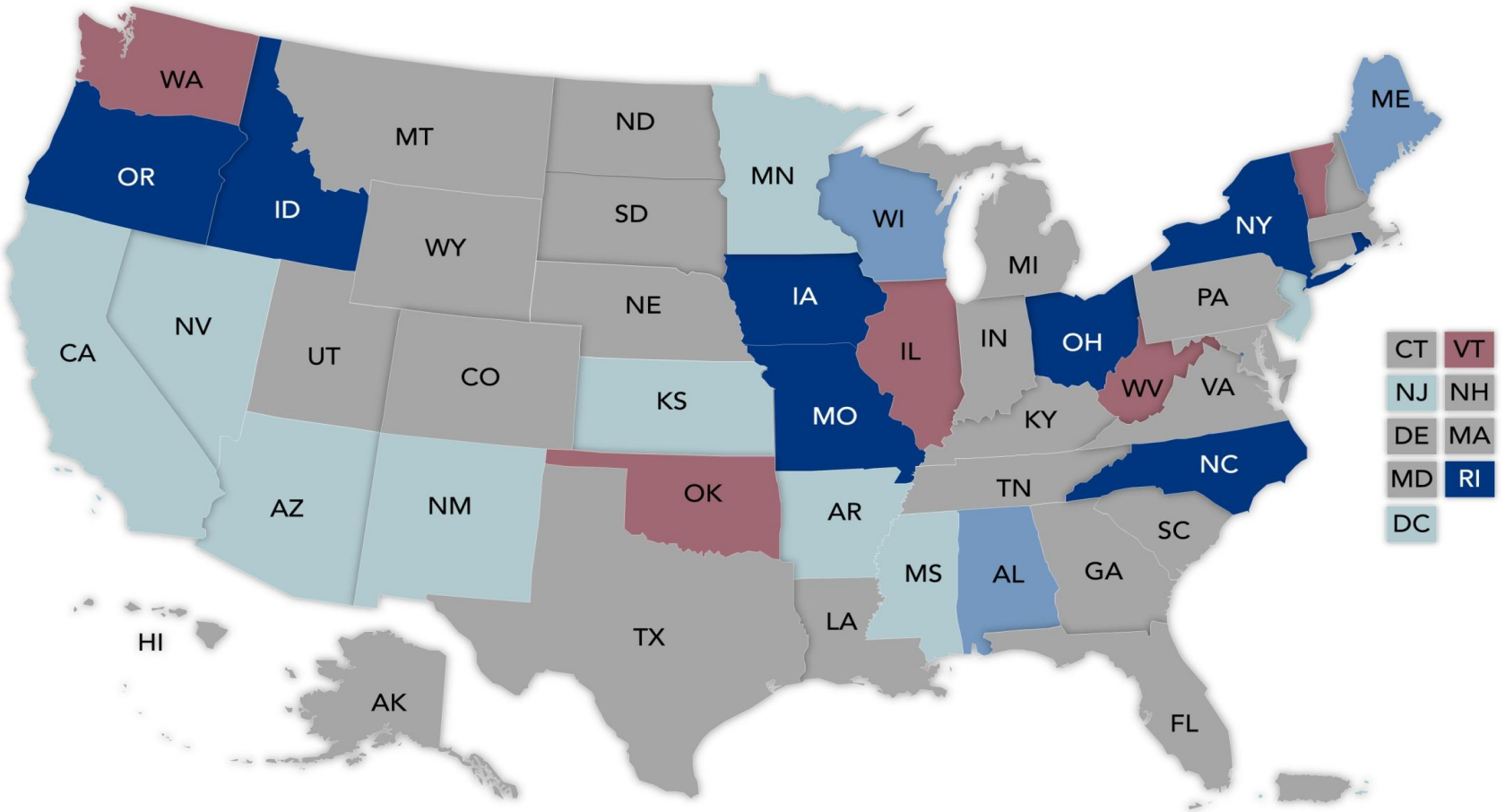
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid "Health Home" Option

- To be eligible for health home services, Medicaid beneficiaries must have
  - At least two chronic conditions including asthma, diabetes, heart disease, obesity, mental health condition, and substance abuse disorder;
  - One chronic condition and be at risk for another;
  - Or one serious and persistent mental health condition.
- Both children and adults who meet these criteria are eligible for health home services
  - Individuals who are dually eligible for Medicaid and Medicare cannot be excluded.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Home Activity Map for 2012



	Approved Health Home State Plan Amendment (SPA)	Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island
	Health Home SPA "On the Clock" (officially submitted to CMS)	Alabama, Maine, New York (phase II), Wisconsin
	Draft Health Home SPA Under CMS Review	Illinois, Oklahoma, West Virginia
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin
	No Activity	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wyoming

Enrollees Indicating Positive Change in Their Experience of Care

- Enrollees believe their care is now better coordinated across their providers, facilities, and others social support services where they receive care, including specialists, pharmacies, and school-based services.
- Enrollees view their nurse care managers/case managers as supportive advocates who help them navigate the complexities of the health-care system and other community-based services.
- Enrollees feel the education and support provided through the program has helped them feel more empowered in understanding and managing their own health conditions.
- Some with severe mental-health conditions speak in especially strong terms about how, in many cases, their health home providers are responsible for their being alive today, due to the help they have received with their prescriptions and other therapeutic support.

Multiple Chronic Conditions Research at the National Institutes of Health

Jacqueline Corrigan-Curay, J.D., M.D.
Office of Science Policy
National Institutes of Health

National Institutes of Health (NIH)

- NIH comprises 27 different Institutes and Centers
- NIH invests more than $31 billion annually in medical research for the American people
- The goal of NIH research is to acquire new knowledge to help prevent, detect, diagnose and treat disease and disability

Informing Clinical Practice

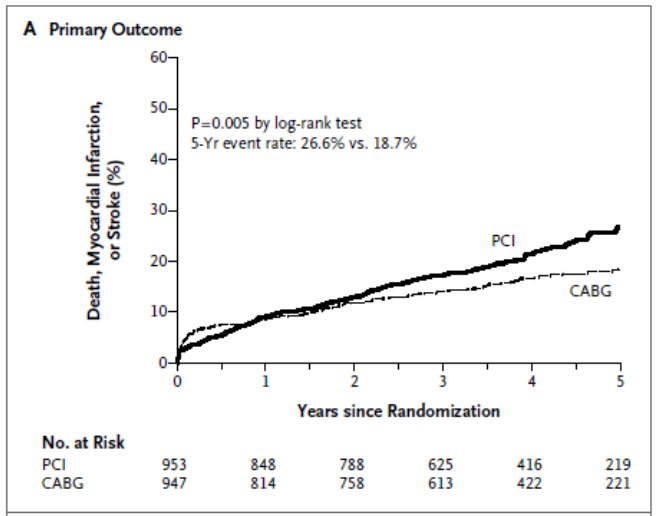
- In 2012, research supported by the National Heart, Lung and Blood Institute (NHLBI) demonstrated that adults with diabetes and multi-vessel coronary disease who underwent cardiac bypass surgery had better overall heart –related outcomes than those who underwent artery-opening procedures to improve blood flow to the heart muscle.

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Strategies for Multivessel Revascularization in Patients with Diabetes

Michael E. Farkouh, M.D., Michael Domanski, M.D., Lynn A. Sleeper, Sc.D., Flora S. Siami, M.P.H., George Dangas, M.D., Ph.D., Michael Mack, M.D., May Yang, M.P.H., David J. Cohen, M.D., Yves Rosenberg, M.D., M.P.H., Scott D. Solomon, M.D., Akshay S. Desai, M.D., M.P.H., Bernard J. Gersh, M.B., Ch.B., D.Phil., Elizabeth A. Magnuson, Sc.D., Alexandra Lansky, M.D., Robin Boineau, M.D., Jesse Weinberger, M.D., Krishnan Ramanathan, M.B., Ch.B., J. Eduardo Sousa, M.D., Ph.D., Jamie Rankin, M.D., Balram Bhargava, M.D., John Buse, M.D., Whady Hueb, M.D., Ph.D., Craig R. Smith, M.D., Victoria Muratov, M.D., M.P.H., Sameer Bansilal, M.D., Spencer King III, M.D., Michel Bertrand, M.D., and Valentin Fuster, M.D., Ph.D., for the FREEDOM Trial Investigators*



NEJM Nov. 4, 2012

Improving Care of Patients with Diabetes, Obesity and Mental Illness

- In April of 2012, the National Institute of Mental Health (NIMH) joined the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) on the funding opportunity announcement "Planning Grants for Translational Research to Improve Obesity and Diabetes Outcomes," soliciting developmental projects that target these medical conditions in people with severe mental illness.

Charting the Course for the Future

- **In September 2012, NIMH, together with multiple other NIH Institutes and HHS agencies, brought together leading researchers who focus on medical comorbidities in patients with severe mental illness (SMI), as well as State policy and advocacy groups, to identify research gaps and discuss research questions to improve the health and longevity of people with SMI.**

Comparative Effectiveness, Health Outcomes and Costs in Persons with MCC

- **In 2012, the National Institute of Aging (NIA) together with the National Center for Complementary and Alternative Medicine issued a funding opportunity to:**
- **Assess the public health and health cost impact of specific combinations of two or more conditions in defined older populations,**
- **Identify potential differences in effectiveness and safety of different treatment regimens for patients with specific combinations of two or more conditions,**
- **Examine alterations in safety or effectiveness of a treatment for one condition related to the presence of one or more specific coexisting condition, and**
- **Identify and address methodological issues relevant to analyses of the health impact of multiple chronic conditions such as validity of data and confounding by indication.**

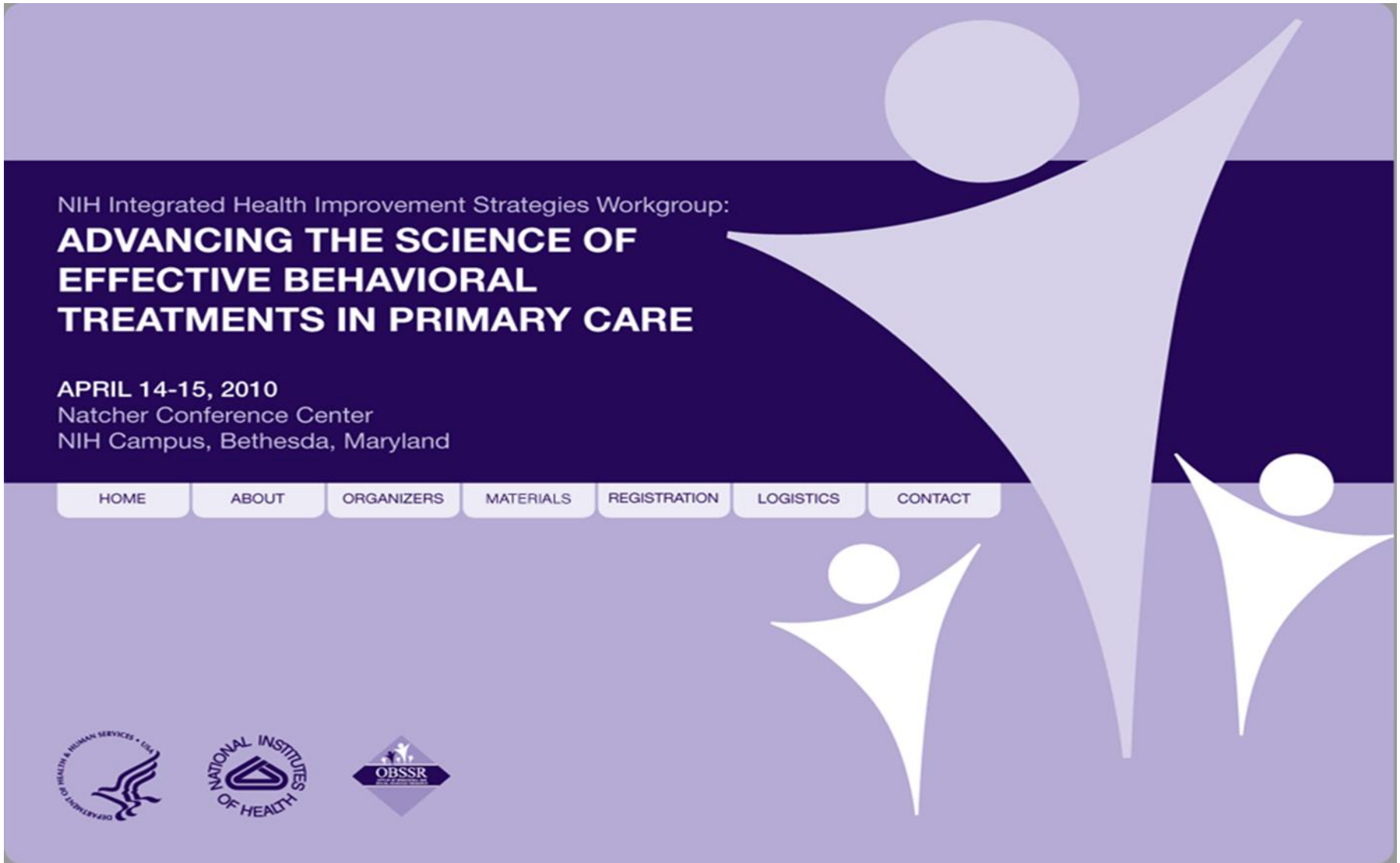
Charting the Course for the Future

Universal Health Outcome Measures for Older Persons with Multiple Chronic Conditions

*Working Group on Health Outcomes for Older Persons with Multiple Chronic Conditions**

- **In 2012 NIA sponsored a workshop to define outpatient quality measures for older patients with MCC. A summary from that activity has just been published in the Journal of the American Geriatrics Society.**

Behavioral Interventions to Address MCC in Primary Care



Behavioral Interventions to Address MCC in Primary Care

- The NIH Office of Behavioral and Social Sciences Research (OBSSR) together with several NIH Institutes announced a funding opportunity to:
  - Support research in primary care that uses a multi-disease care management approach to behavioral interventions with high potential impact to improve patient-level health outcomes for individuals with three or more chronic health conditions.
  - The approach must modify behaviors using a common approach rather than administering a distinct intervention for each targeted behavior and/or condition.

Charting the Course for the Future

- In 2013, several NIH Institutes together with other federal partners, including the Department of Veteran's Affairs will host a conference to identify the scientific questions and knowledge gaps in understanding the context of patients with multiple chronic conditions.

- This activity recognizes that in addition to understanding the etiology and treatment of disease, care of patients with MCC will be informed by:
  - The patient and their family (preferences , appraisal)
  - Illness and disease (interactions with patient and family factors)
  - Health care system and providers
  - Available resources.

Strategies that May Increase Enrollment of Patients with MCC in Clinical Trials

- Conduct research at the point of care delivery
- Analyze the degree to which patients with MCC become subjects in clinical trials

http://commonfund.nih.gov/hcscollaboratory/

Conclusions

- As the largest funder of biomedical research, NIH is committed to basic and clinical research that will provide new treatments and other strategies for improving the health of all patients, including those with multiple chronic conditions.

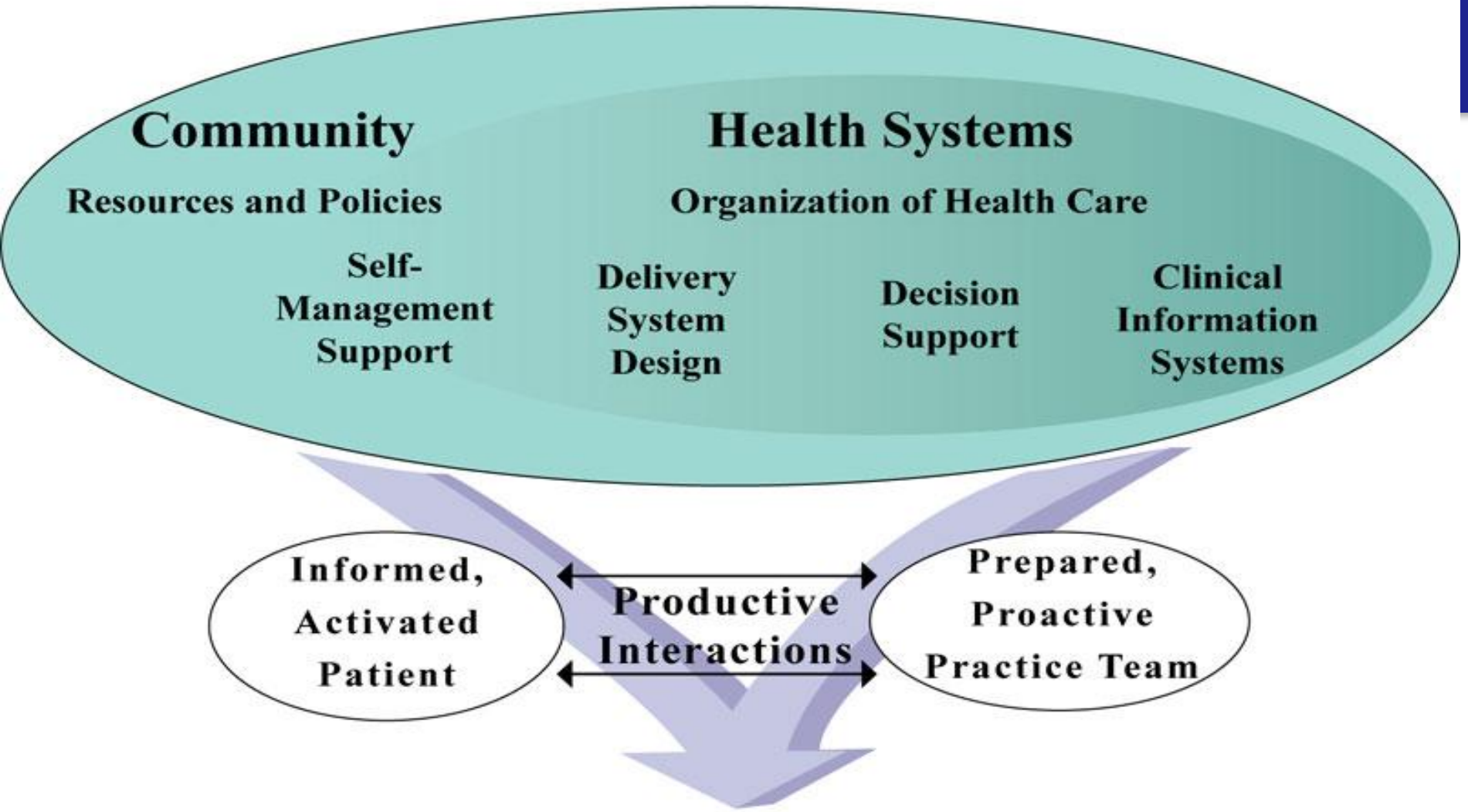
James Firman
President & CEO

HHS Strategic Framework Goal 2

Maximize the use of proven self-care management.

- **Facilitate self-care management**
- **Facilitate home and community-based services**
- **Provide tools for medication management**

The Chronic Care Model



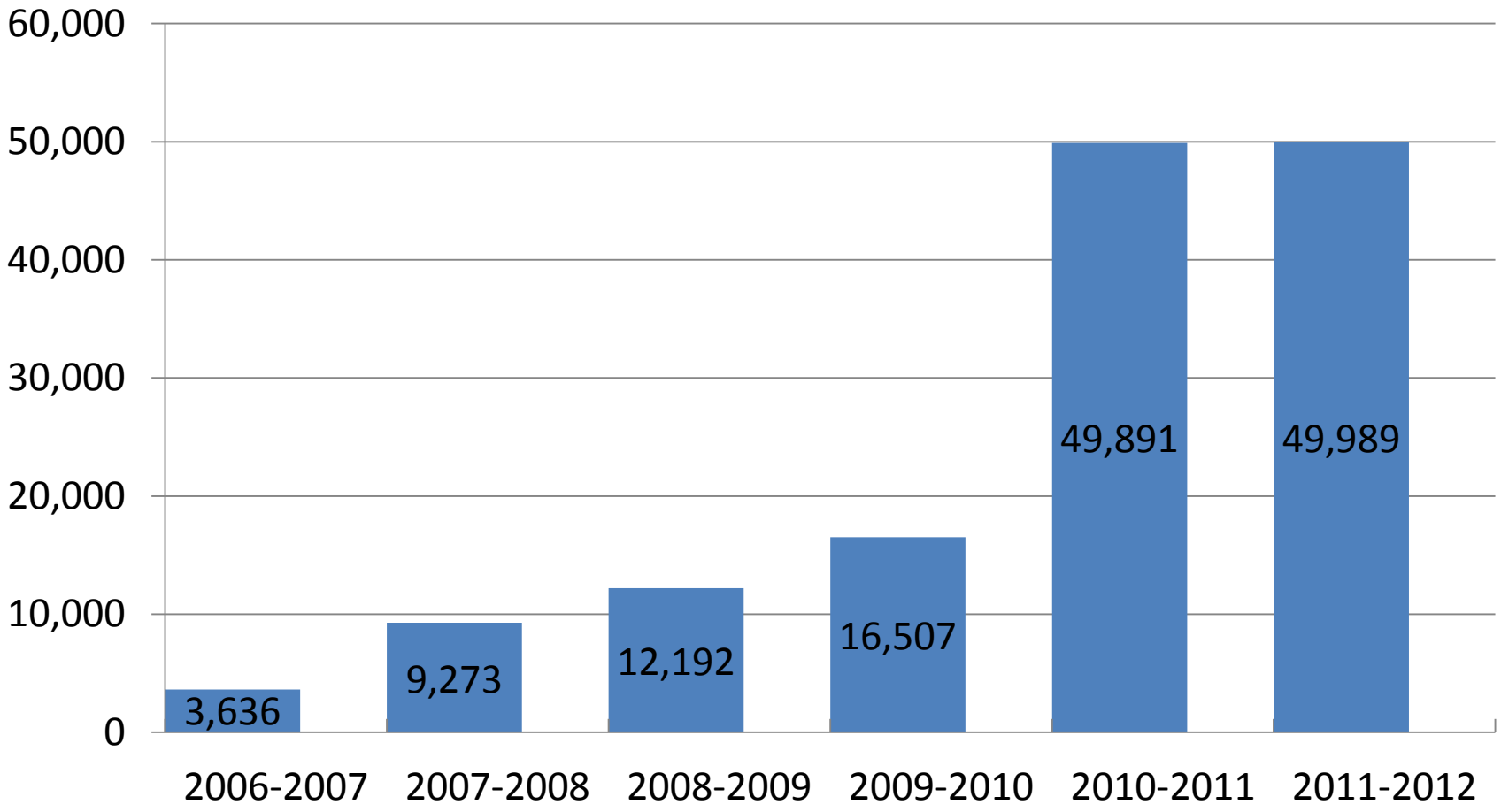
Improved Outcomes

Developed by The MacColl Institute

Why Self Management Matters

ncoa
National Council on Aging

Recent Successes: More than 140,000 Enrolled in Chronic Disease Self-Management Program



National Council on Aging

The Opportunity and the Challenge

- **Opportunity:** To leverage the capacity and expertise of the aging services network and other community organizations to deliver CDSMP and other evidence-based programs in ways that will improve health outcomes and reduce costs.
- **Challenge:** To forge cost-effective, scalable partnerships between the aging network and health providers and insurers to achieve these outcomes.

Self Management Alliance (SMA)

- **Who We Are:** A tri-sector alliance (non-profits, business and government) dedicated to achieving Goal 2 of the HHS MCC framework.
- **Our Vision:** Self-management broadly defined and inclusive of family and other caregivers, is at the heart of improving the health and quality of life of individuals living with multiple chronic conditions.
- **2020 Objective:** Evidence-based self-management will be an integral part of health for people with MCC's.

Keys Strategies of the Self Management Alliance

- Common Agenda
- Shared Measurement Systems
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Support

Based on principles described in *Collective Impact* by Kania and Kramer in the December 2010 issue of *Stanford Social Innovations Review*

Self-Management Alliance Goals

- Establish a shared measurement framework for self-management
- Leverage resources to build a national network
- Increase awareness and activate individuals with MCC

Self-Management Alliance Goals

- Develop and maintain a skilled workforce
- Address critical gaps in knowledge
- Create a national dialogue on medication management
- Develop a supportive policy environment

For more information and to get connected

Self Management Alliance: please visit www.ncoa.org/sma or email sma@ncoa.org

ACL/AoA initiatives to scale evidence-based programs: please visit www.ncoa.org/improve-health/chronic-conditions

National Council on Aging

What's New in Multiple Chronic Conditions? A 2012 Update

Questions & Answers

Thank you for participating.

What's New in Multiple Chronic Conditions? A 2012 Update

HOSTED BY THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS Initiative on Multiple Chronic Conditions
http://www.hhs.gov/ash/initiatives/mcc/