FEDERAL POLICY
SELF MANAGEMENT & MULTIPLE CHRONIC CONDITIONS

KIM KUEBLER DNP, APRN, ANP-BC
ADVANCED DISEASE CONCEPTS LLC

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National Practice and Policy Conference

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- March 26-28th, 2015
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- Interdisciplinary attendees
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OBJECTIVES

- Define the escalating demographics of the largest, fastest growing and costliest patient population in the US health care system;
- Identify and describe the current federal initiatives targeting multiple chronic conditions and self management
- Indicate how federal initiatives influenced the development and establishment of an underserved community based self-management program for patients with multiple chronic conditions.

FEDERAL HEALTH POLICY

Health Policy Directs:

- *Clinical Practice*
- *Evidence Based Practice Guidelines*
- *Reimbursement Criteria*
- *Research Focus and Funding*
- *Optimal Patient Outcomes*
- *Standard of Care*

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THE US AGING POPULATION

The United States is in the midst of a major demographic shift. In the next four decades, people aged 65 and older will make up the largest percentage of the population

Board on Mathematical Sciences and Their Applications · Division on Engineering and Physical Sciences Committee on Population · Division of Behavioral and Social Sciences and Education, 2012

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THE US AGING POPULATION

The ratio of people aged 65 and older to people aged 20-64 will rise by 80%

Board on Mathematical Sciences and Their Applications · Division on Engineering and Physical Sciences
Committee on Population · Division of Behavioral and Social Sciences and Education, 2012

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THE US AGING POPULATION

The oldest of the 80 million baby boomers reached age 65 in 2011

Living longer with increased disability

Institute of Medicine (IOM), 2012

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THE US AGING POPULATION

Currently, 75% of Americans are living with and dying from more than one symptomatic chronic condition.

IOM, 2012; US Dept of HHS, 2014

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CHRONIC CONDITIONS

Most people experience a slow insidious disease trajectory, with progressive debility and are at high risk for limited physical functioning, reduced social and interpersonal productivity and poor quality of life.

Institutes of Medicine, 2012

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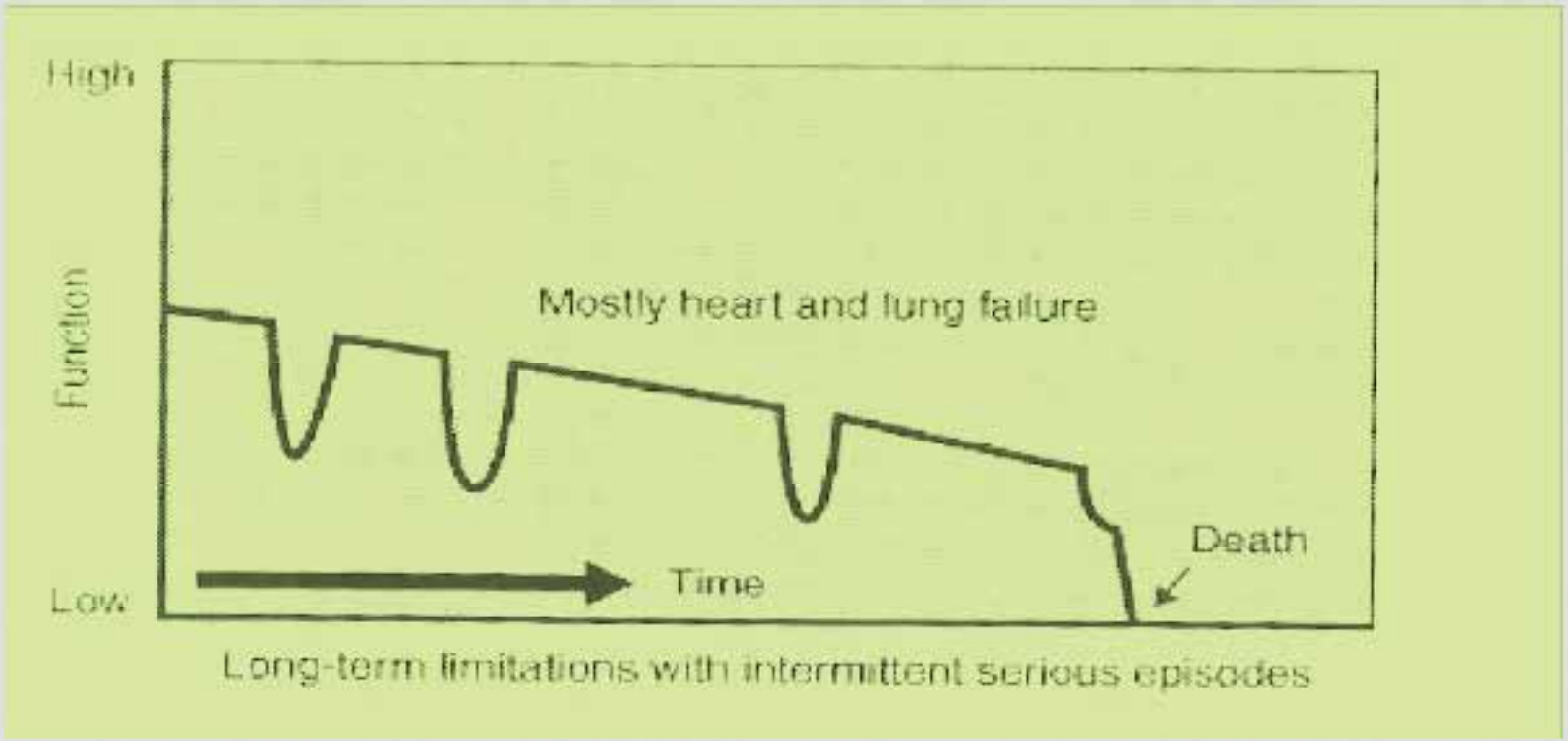
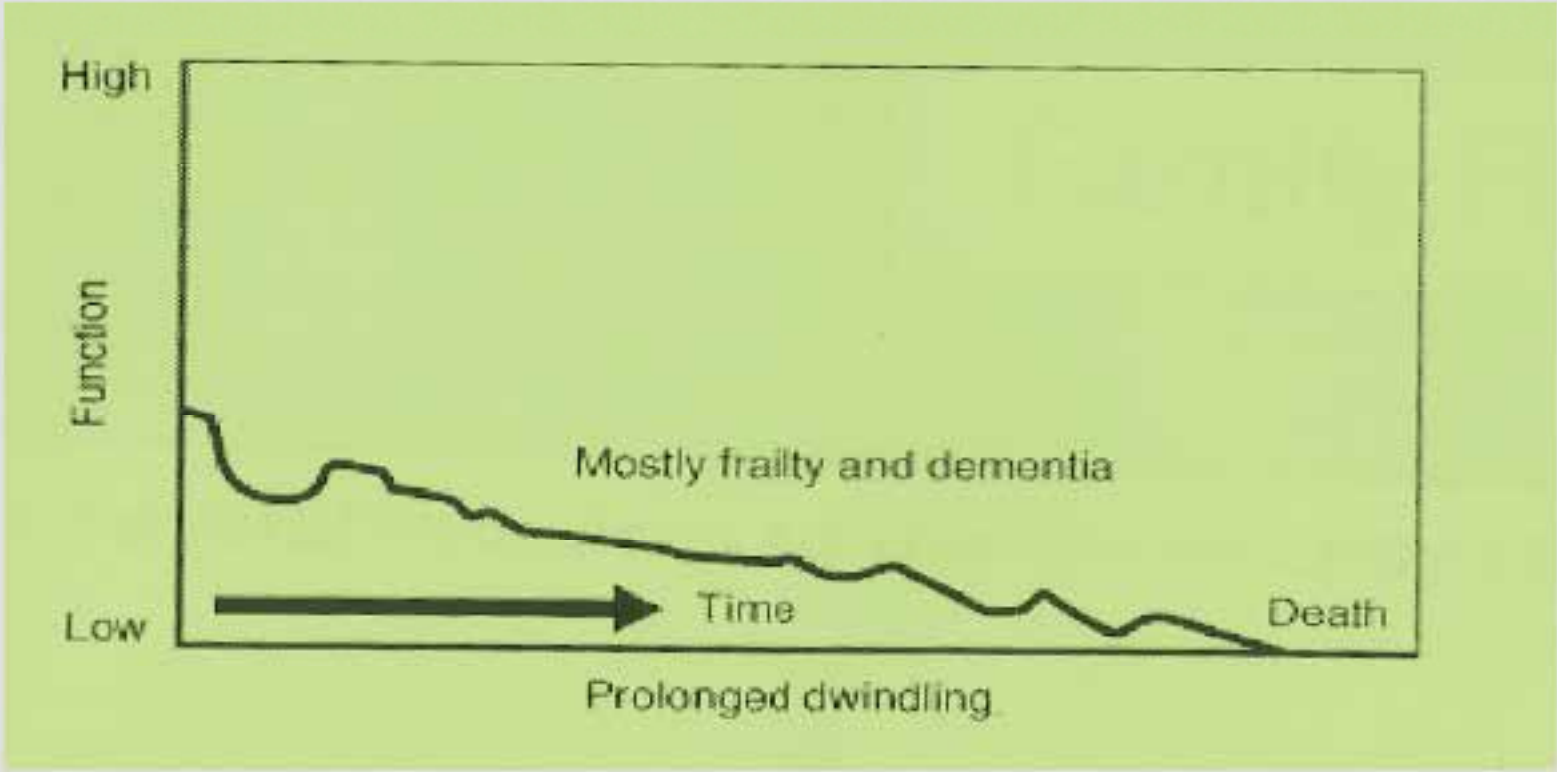
CHRONIC DISEASE TRAJECTORY

CHF and COPD Exacerbations



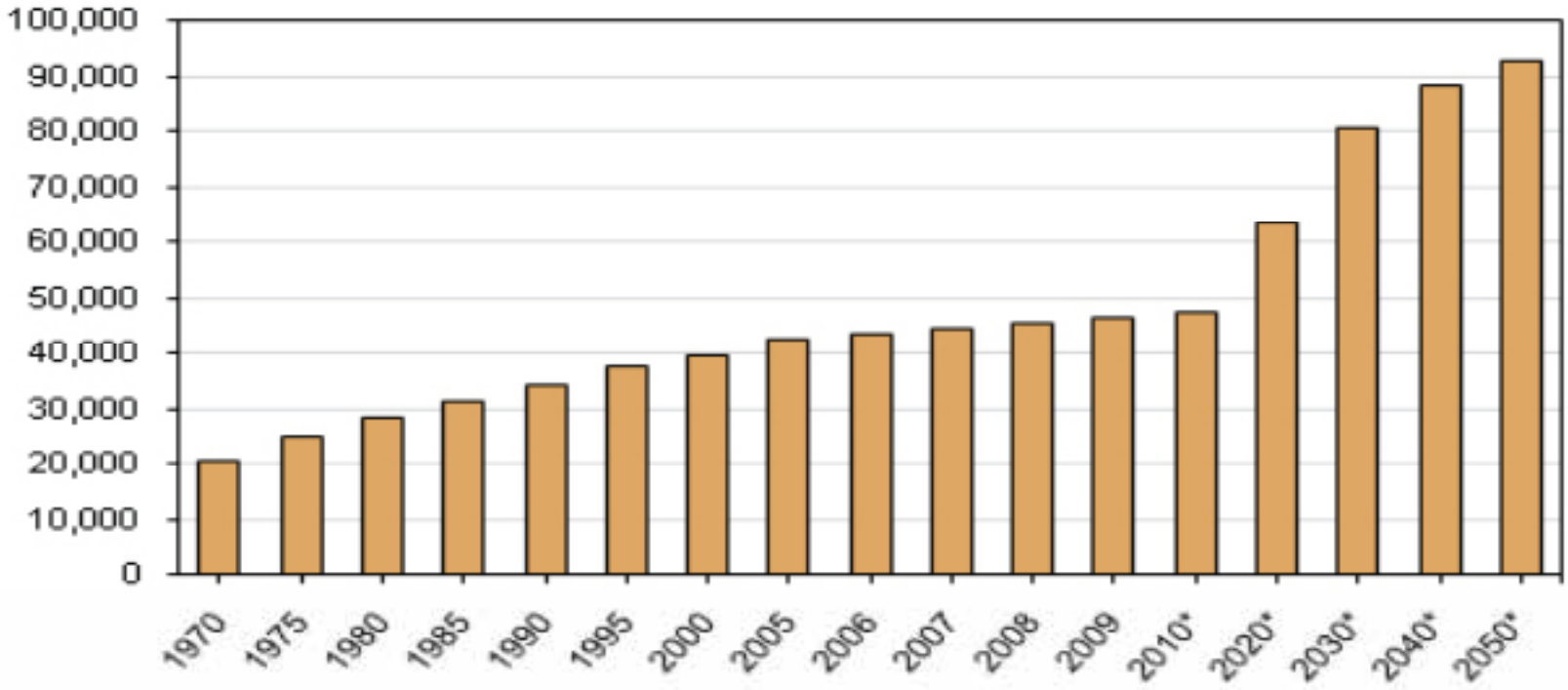
CHRONIC DISEASE TRAJECTORY



ESCALATING MEDICARE BENEFICIARIES

Growing number of Medicare beneficiaries

Past and projected enrollment in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI), in thousands, 1970–2050



Source: "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," August 2010, Centers for Medicare and Medicaid Services

AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act of 2010

111TH CONGRESS
2d Session
COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010
PREPARED BY THE
Office of the Legislative Counsel
FOR THE USE OF THE U.S. HOUSE OF REPRESENTATIVES

MAY 2010

ACA TITLE IV

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Affordable Care Act. 2010

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FEDERAL INITIATIVES PROMOTING CHANGE IN CHRONIC DISEASE

AHRQ

CENTERS FOR DISEASE CONTROL AND PREVENTION
CDC

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA ·

Agency On Aging

NQF
National Quality Forum

CMS

FEDERAL TRADE COMMISSION
INTO OUR 2ND CENTURY

pcori

NCOA
NATIONAL COUNCIL ON AGING

NATIONAL INSTITUTES OF HEALTH

MOST FREQUENT USE OF HEALTHCARE RESOURCES

CHRONIC EXACERBATIONS

Congestive Heart failure

Chronic Obstructive Pulmonary Disease

POORLY MANAGED DISEASE and SYMPTOMS

CMS, 2010, IOM, 2010, US Department of HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

MCC are concurrent chronic conditions (>2) that affect a person at the same time

Americans 65 and older, 3 out of 4 have MCC with increased risk for morbidity and mortality

MCC are associated with substantial health care costs – 66% of total health care spending is associated with care for over one in 4 Americans with MCC

IOM, 2012; US Dept of HHS, 2013

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US DEPT OF HEALTH & HUMAN SERVICES

U.S. Dept of HHS in 2010 commissioned a task force to recommend and produce a strategic framework to improve the health status of Americans living with concurrent MCC.

US Dept HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions

provides the *federal strategic framework* for *Multiple Chronic Conditions initiatives.*

US Dept of HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

US Dept of HHS Goals for MCC:

- Foster health care and public health system changes
- Maximize the use of proven *SELF-MANAGEMENT*
- Provide better tools and information to health care professionals who deliver care
- Facilitate research to fill knowledge gaps

CMS, 2010; US Dept. of HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

Goal 2, addresses self-management and suggests that clinicians….

"Maximize the use of proven self-management and other services for individuals with multiple chronic conditions"

CMS, 2010; US Dept. of HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

The framework defines self management as…

"the tasks that individuals must undertake to live well with chronic conditions, such as having the confidence to deal with medical management, role management, and emotional management – as a critical part of chronic condition care"

CMS, 2010; US Dept. of HHS, 2010

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MULTIPLE CHRONIC CONDITIONS

- Primary objective of this initiative is to enhance health professionals training in chronic disease.
- Citing that healthcare and social service professionals are dependent on and influenced by training programs that prepare them for the environments in which they practice.

US Dept of HHS, 2010

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CHRONIC CONDITIONS CMS BENEFICIARIES

CMS selected 15 common chronic conditions used to define MCC for the US Dept of HHS Strategic Framework on Multiple Chronic Conditions.

Chronic conditions were examined for approximately 31 million Medicare beneficiaries, who were continuously enrolled in the Medicare fee for service (FFS) program in 2008.

CMS, 2011

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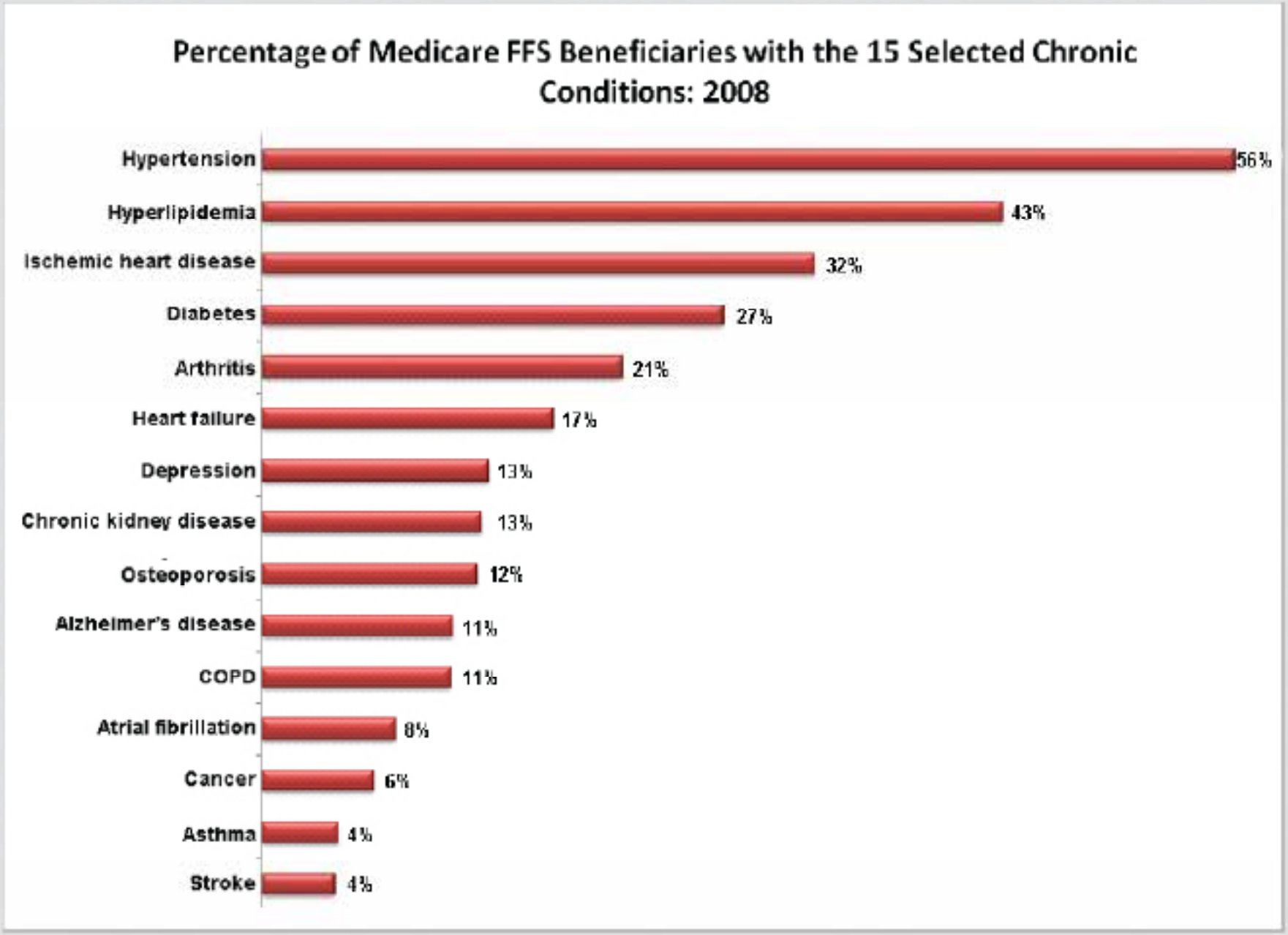
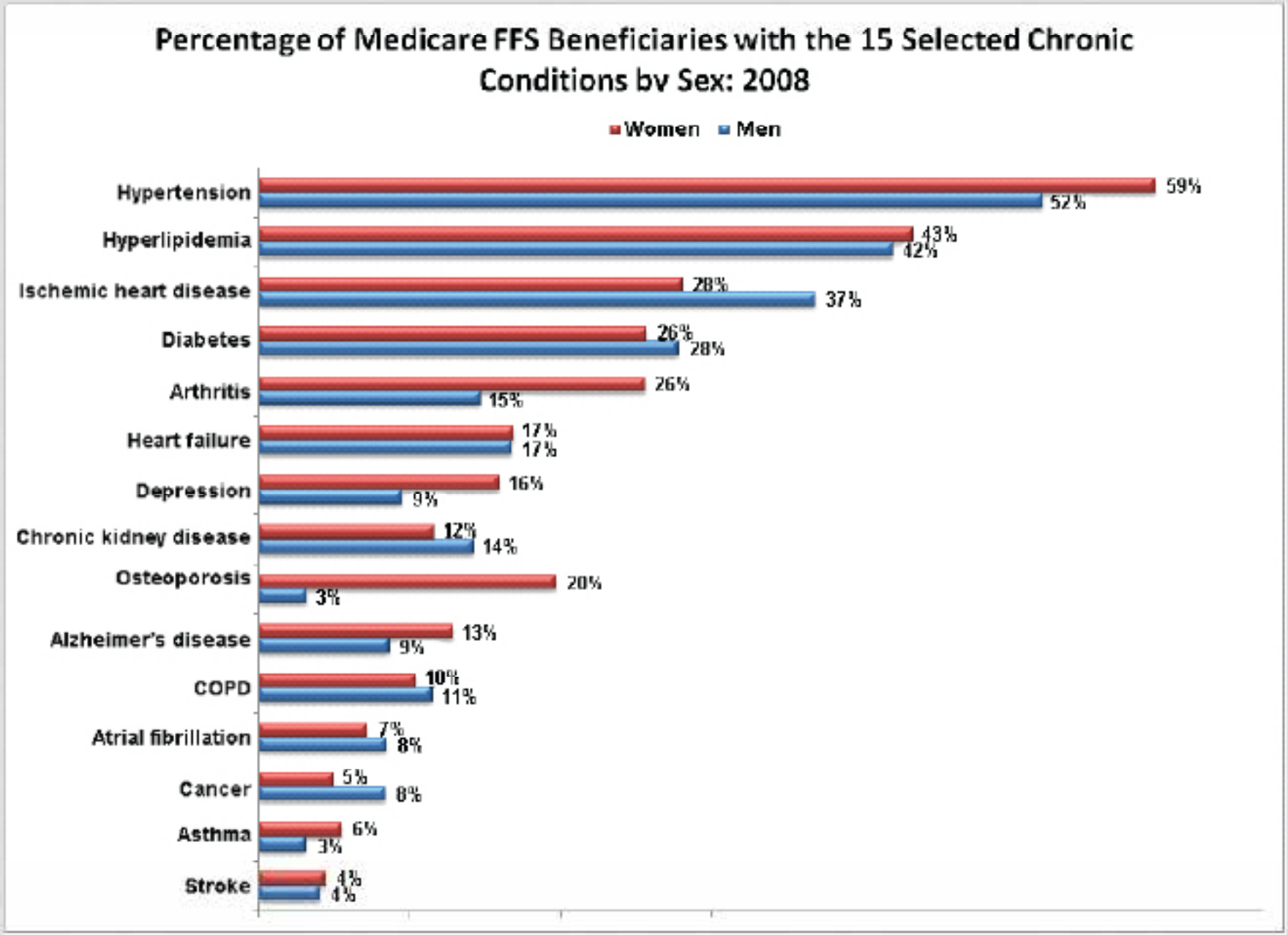
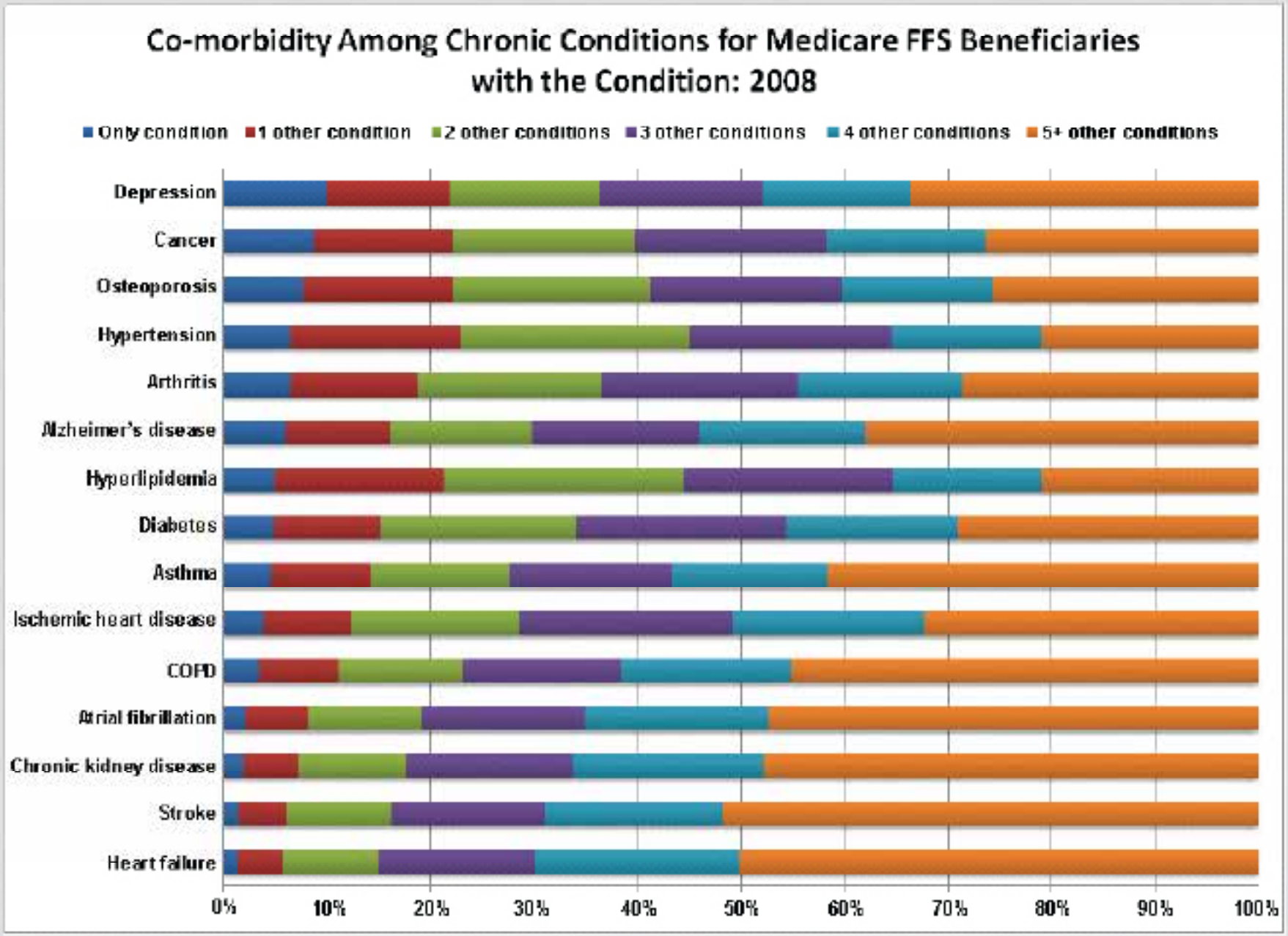


Source: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book. Baltimore, MD. 2011.



Source: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book. Baltimore, MD. 2011.



Source: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book. Baltimore, MD. 2011.

SELF-MANAGEMENT

Self-management has increased in prominence as a broader concept in patient education:

- ***Governments in many developed countries manage the escalating costs of chronic disease in the aging population – by shifting care responsibilities to patients and families***

- ***Empowering patients suggests that a patient makes his or her own care choices from available options***

Redman, 2012

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PATIENT SELF-MANAGEMENT

Optimal health outcomes can occur in the face of:

- **Collaborative partnership's that exist between the health care team and the patient**
- **Patients who are informed, motivated, and involved as partners in their own care**

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PATIENT SELF-MANAGEMENT

Patient self-management can reduce risk factors, promote adherence to medication, increase physical activity and reduced hospital re-admission rates

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INSTITUTES OF MEDICINE

Living Well with Chronic Illness: A Call for Public Health Action, 2012

Supports the importance and value of including the concept of patient self-management in the national directives for chronic disease and MCC.

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INSTITUTES OF MEDICINE

IOM identify diet, level of physical activity, and suitable living environment as influencing factors that may adversely affect patients' ability to self-manage MCCs - significantly diminishing patients' quality of life.

Institutes of Medicine, 2012

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INSTITUTES OF MEDICINE

IOM suggests that providers preform ongoing assessment of patient progress and problems, and offer goal setting and problem-solving support.

Centers for Disease Control, 2014

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NATIONAL QUALITY FORUM: MEASUREMENT FRAMEWORK

- The National Quality Forum announced a project to seek and achieve consensus through NQF's Consensus Development Process on a measurement framework for assessing the efficiency of patient care.
- These measurements are used to define quality and cost of care provided to patients who are living with MCCs .
- The scope of this initiative is to provide input to the U.S. Dept. of HHS that can be used to guide and align programmatic initiatives targeting patients with MCCs

National Quality Forum, 2012

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NATIONAL QUALITY FORUM: MEASUREMENT FRAMEWORK

NQF has identified six key areas for establishing measurement criteria :

The *person-and-family-centered care* measurement includes the concept of self-management in MCC's

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NATIONAL QUALITY FORUM: MEASUREMENT FRAMEWORK

The value of self-management as an indicator for preventative healthcare in the management of MCCs - a significant measurement!

This initiative will be used promote standardized accountability

National Quality Forum, 2012

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CENTERS FOR MEDICARE AND MEDICAID

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act).

Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care" for those individuals who receive Medicare and Medicaid…

US Department of HHS, 2014

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CENTERS FOR MEDICARE AND MEDICAID

Innovation Center is currently focused on the following priorities:

- **Testing new payment and service delivery models**
- **Evaluating results and advancing best practices**
- **Engaging a broad range of stakeholders to develop additional models for testing**

US Department of HHS, 2014

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MEDICAID INCENTIVES FOR THE PREVENTION OF CHRONIC DISEASE

The Medicaid Incentives for the Prevention of Chronic Disease grant program, provided a total of $85 million over five years –

Testing the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs, and change their health risks and outcomes by adopting healthy behaviors.

Centers for Medicare and Medicaid, 2014

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NATIONAL INSTITUTES OF HEALTH

3 new research awards totaling 19.4 million over 5yrs address the growing US population with MCCs

NIH, Health Care System Research Collaboratory engages health systems as research partners to align with the HHS initiatives.

Collaboratory Center at Duke University

IOM, 2014

MEDICAID INCENTIVES FOR THE PREVENTION OF CHRONIC DISEASE

Awards are for a 5-year period and subject to annual renewal of funding. Grants must address at least one of the following prevention goals:

tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition.

Centers for Medicare and Medicaid, 2014

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MEDICAID INCENTIVES FOR THE PREVENTION OF CHRONIC DISEASE

Participating States:	*Self Management Areas*
California	Smoking, nicotine
Connecticut	Smoking, physical activity
Hawaii	T2DM
Minnesota	Increased physical activity
Montana	Chronic disease prevention
New Hampshire	Physical activity, obesity
New York	Smoking, HTN, T2DM
Nevada	Obesity
Texas	MCCs and mental illness
Wisconsin	Smoking cessation

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U.S. DEPT OF HHS INTERAGENCY WORKGROUP: MCC

U.S. Department of Health and Human Services Inventory of Programs, Activities, and Initiatives Focused on Improving the Health of Individuals with Multiple Chronic Conditions, 2011

Provides a list of federal initiatives on Self-Management.

US Dept of HHS, 2011

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NATIONAL COUNCIL ON AGING

The *Communities Putting Prevention to Work: Chronic Disease Self-Management Program*,

funded by the American Recovery and Reinvestment Act of 2009, is an initiative led by the U.S. Administration on Aging, in collaboration with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS).

Administration on Aging, 2012

NATIONAL COUNCIL ON AGING CENTERS FOR DISEASE CONTROL

Communities are using and institutionalizing the *Stamford Chronic Disease Self-Management Program*. It has been rolled out in 48 states and has reached well-over 150,000 people

This is the largest federal project used to spread self-management programs throughout the US.

National Council on Aging, 2012

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STAMFORD CHRONIC DISEASE SELF MANAGEMENT PROGRAM

Subjects covered in this program include:

1. Techniques to deal with problems such as frustration, fatigue, pain and isolation,
2. Appropriate exercise for maintaining and improving strength, flexibility, and endurance,
3. Appropriate use of medications,
4. Communicating effectively with family, friends, and health professionals,
5. Nutrition,
6. Decision making, and,
7. How to evaluate new treatments.

Stamford School of Medicine, 2012

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SELF MANAGEMENT ALLIANCE

In partnership with the National Council on Aging – promote strategic collaboration among government, corporate, nonprofit organizations to help turn the US Dept. of HHS, MCC Framework Goal 2 into a reality…

National Council on Aging, 2014

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SELF MANAGEMENT ALLIANCE

The Mission **is to coordinate the accelerated development and implementation of self-management interventions, practices, payment systems and policies to achieve the goal of making self-management an integral part of health care by 2020.**

National Council on Aging, 2014

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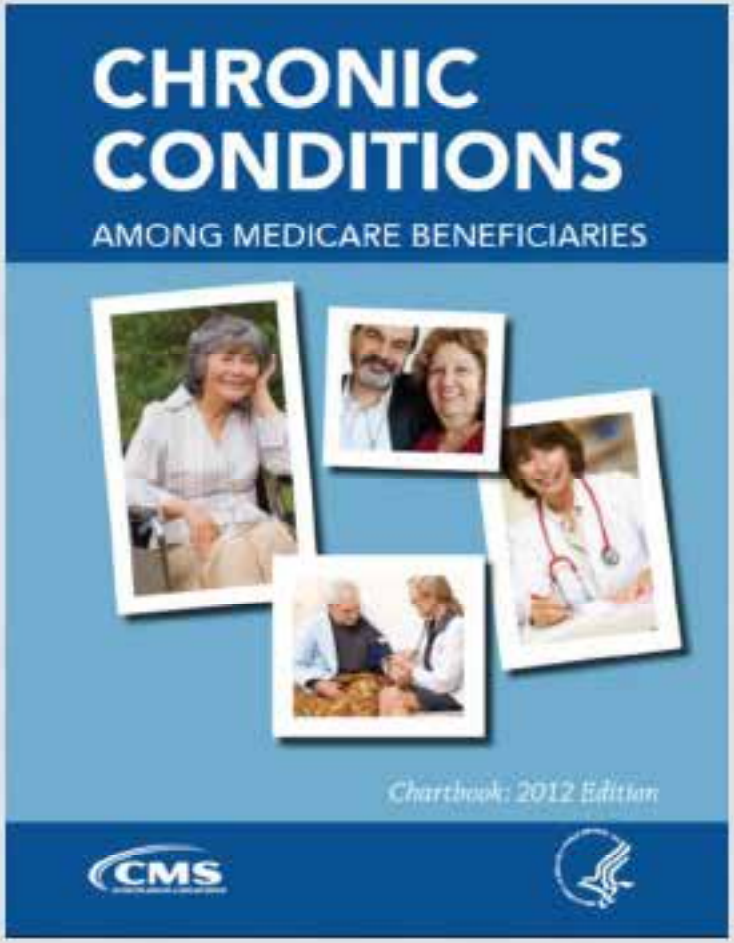
US DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID



- Updated chart-book 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

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AGENCY FOR HEALTH CARE RESEARCH AND QUALITY

According to the *Agency for Healthcare Research and Quality (AHRQ)*, primary care practices should:

- **Providing empathic, patient-centered care.**
- **Involve the whole care team in planning, carrying out, and following up on a patient visit.**
- **Planning patient visits that focus on prevention and care management, rather than on acute care.**

Agency for Healthcare Research and Quality, 2013

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AGENCY FOR HEALTH CARE RESEARCH AND QUALITY

- Involve the patient in goal setting.
- Provide tailored education and skills training using materials appropriate for different cultures and health literacy levels.
- Make referrals to community-based resources, such as programs that help patients quit smoking or follow an exercise plan.
- Regular follow-up with patients via e-mail, phone, text messages, and mailings to support their efforts to maintain healthy behaviors.

Agency for Health Care Research and Quality, 2013

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IOM AND HHS

May, 2012 meeting – HHS through the strategic MCC framework – made a call for the development of MCCs evidence based practice guidelines – in partnership with the IOM.

Goodman et al., 2014 Annuals of Family Medicine

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CENTERS FOR DISEASE CONTROL

Chronic Condition Self-Management Surveillance: What is and What Should be Measured

Plan to test measures for comprehension, variability, sensitivity to change, reliability and content validity with relevance to policy makers, patient groups and practitioners.

Ruiz et al., 2014 CDC

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FEDERAL REGISTER

July 2013: CMS 2015 reimbursement plan – focused on the role of the APRN with heavy reimbursement direction on the coordinated and comprehensive care of patients with chronic disease a year prior to death…

Federal Register, 2013

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INSTITUTES OF MEDICINE

The Future of Nursing, Leading Change, Advancing Health, Report Recommendations: Advising the Nation/Improving Health

Institutes of Medicine, 2010

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IOM NURSING REPORT

- Nurses should be full partners with physicians and other health care professionals in redesigning health care in the US;
- Effective workforce planning and policy making require better data collection and improved information infrastructure.

IOM, 2010

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FEDERAL TRADE COMMISSION

Policy Perspectives

Competition and the Regulation of Advanced Practice Nurses

Federal Trade Commission, 2014

FEDERAL TRADE COMMISSION

Numerous expert health policy organizations have concluded that expanded APRN scope of practice should be a key component of our nation's strategy to deliver effective health care efficiently and to fill gaps in primary care access.

Federal Trade Commission, 2014

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PRIMARY CARE MEDICAL SHORTAGE

It is predicted that over 52,00 more Primary care Physicians are needed by 2025 to meet the countries health care utilization needs.

NIH, 2010

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ADVANCED PRACTICE NURSES

Currently, 19 states allow APRNs full independent practice authority

IOM and Federal Trade Commission support the standardization of APRN practice nationally

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NURSING EDUCATION FINDINGS

Kuebler, K. (2012). Implications for palliative care nursing education. *Clinical Scholars Review, 5*(12), 86-90.

Kuebler, K. et al., (2014). A Systematic Review: A Collaborative Partnership on Evaluating Graduate Nursing Education in Chronic Symptomatic Disease. *Clinical Scholars Review*

Kuebler, K. et al., (in review) National Graduate Nursing Survey on Chronic Disease, Symptoms and Self Management

THE GOOD SAMARITAN SELF-MANAGEMENT

URE

Light of the Coastal Empire | Sunday, March 9, 2014

Photos by Richard Burkhart/Savannah

uebler, an associate professor at South University College of Health Professic students on ways to improve health outcomes for patients at the Good Samari en City.

th then provide a "self- gement" approach of

have graduated in the pro- gram since summer and each will be followed for a year by

both English an part of the conv

STUDENT DRIVEN COMMUNITY BASED SELF-MANAGEMENT

- Indigent Patients/Hispanic and English speaking
- Interdisciplinary students developed educational content (physical activity, diet, adherence to treatment, motivation, denial, literacy, goal setting)
- Three consecutive 1.5 hr. classes
- Students meet one-on-one with each patient
- Individualize realistic goals
- Track bio-markers in the medical record
- Ongoing follow-up, one month, three month, six month and one year

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STUDENT DRIVEN COMMUNITY BASED SELF-MANAGEMENT

To-date enrolled 53 patients (6 withdrew):

Total weight loss 624 lbs.
Reduction in Hemoglobin A1C
Normalized BMIs
Reduction in blood pressure
Reduction in LDLs
Reduction in disease exacerbation
Patients feel supported and actively participate
Student awareness of patient changes

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THE DOCTOR OF NURSING PRACTICE

Federal initiatives and evidence based interventions direct and regulate patient care and promote the use of self-management and the collection of measureable outcomes

The DNP can empower patients living with symptomatic MCC to be responsible for their own health care and quality of life.

DOCTOR OF NURSING PRACTICE

There is a role for every healthcare discipline to become accountable stewards in the costly management of chronic disease.

The Advanced Practice Nurse or the Doctor of Nursing Practice are ideal providers who can initially identify the need for patient self care management in all therapeutic areas.

National Practice and Policy Conference

Please Join Us

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