

**2015  
WHITE HOUSE  
CONFERENCE ON AGING  
WEBINAR**

**21<sup>ST</sup> Century  
Challenge for Healthy Aging:  
Balancing Living Well With the Reality of  
Multiple Chronic Conditions**

Thursday, December 12, 2014

1                   **INTRODUCTION:** Hello everyone, and  
2 welcome today's webinar, 21<sup>st</sup> Century Challenge for  
3 Healthy Aging; Balancing Living Well with the Reality  
4 of Multiple Chronic Conditions.

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

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

19                  Please note that a recording of today's  
20 presentation will be made available to you on December  
21 the 18<sup>th</sup>. At this time, I will turn the presentation  
22 over to Nora Super.

23                  **MS. SUPER:** Good afternoon, everyone.  
24 This is Nora Super and I'm the Executive Director of

1 the White House Conference on Aging. And I'm  
2 delighted to welcome you to our webinar today on the  
3 topic of Balancing Living Well with the Reality of  
4 Multiple Chronic Conditions.

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

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

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

24 Through this position, he's developed

1 and implemented national initiatives focused on  
2 prevention and wellness and on care-management for  
3 individuals with multiple chronic conditions.

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

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

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

24 He also serves on the faculty at

1 Harvard Medical School and is a Senior Leader of the  
2 Practice Change Leaders Program which mentors  
3 physicians, nurses and social workers to improve the  
4 care of older adults and their health systems.

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

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

16 Dr. Boyd's main interest includes the  
17 clinical care of comorbid chronically ill and frail  
18 older adult both chronically and during acute illness,  
19 such as hospitalization. Currently, she's working on  
20 projects such as Treatment Burdens Among Older Adults  
21 with Multi-Morbidity, and that means, for those lay  
22 people, those who have multiple chronic conditions,  
23 and also working on diabetes and other competing risks  
24 for improving care of the elderly.

1                   So with that, I'd like to turn it over  
2 to our speakers and beginning with Dr. Parekh.

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

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

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

23                   Specially, the challenge for this  
24 country, vis-à-vis, multiple chronic conditions from a

1 prevalent standpoint is over one in four adults in  
2 this country have multiple chronic conditions. And  
3 two in three Medicare beneficiaries and Medicaid  
4 beneficiaries with disabilities have multiple chronic  
5 conditions. In terms of access, one in six who are  
6 uninsured have multiple chronic conditions, which  
7 makes the Affordable Care Act that much more important  
8 to help this population gain access to care and remain  
9 healthy.

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

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

24 Individuals with multiple chronic

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

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

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

24 For example, for goal one, starting in



1 2015, the Centers for Medicare and Medicaid Services,  
2 or CMS, will begin for the first time to pay providers  
3 separately for the non-face-to-face chronic care  
4 management of patients with multiple chronic  
5 conditions. CMS is also testing new care models  
6 through the Independence-at-Home demonstration, for  
7 example. Eight thousand frail Medicare beneficiaries  
8 with multiple chronic conditions and functional  
9 limitations are receiving home-based primary care.

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

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

22 For goal three, HHS is expanding  
23 professional education and training in conjunction  
24 with our office and health resources and services

1 administration. An interprofessional curriculum for  
2 multiple chronic condition education and training is  
3 being developed and will be disseminated to providers.

4 And finally, for goal four, the Food  
5 and Drug Administration has recently announced a  
6 policy to more closely examine populations included in  
7 clinical trials of new drug applications to discourage  
8 unnecessary exclusion and encourage inclusion of  
9 individuals with multiple chronic conditions.

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

19 In conclusion, living well with chronic  
20 diseases increasingly means living well with multiple  
21 chronic diseases. With the complexity of the American  
22 elderly population increasing, it's that much more  
23 important to better understand the wishes and goals of  
24 these individuals so that care choices can be

1 optimized for them.

2 And now, as Nora mentioned, we'll move  
3 to two speakers who are leaders in the field helping  
4 to implement the goals of this strategic framework.

5 Dr. Schreiber will discuss how community-based  
6 organizations help individuals with multiple chronic  
7 conditions age healthier, and then Dr. Boyd will then  
8 discuss how patient-centered outcomes research can  
9 help individuals with multiple chronic conditions age  
10 healthier. First, we'll turn it over to Dr.  
11 Schreiber.

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

20 The Health and Human Services strategic  
21 framework helps promote community-based organizations  
22 to develop partnerships with medical care providers  
23 with the mutual goal of promoting health aging and  
24 preventing the development of frailty, disability and

1 functional limitations. Approaches to help this  
2 particular population stay healthier and safer while  
3 decreasing their cost of care will be the focus of  
4 this presentation.

5 The expanded chronic care model seen  
6 here represents a conceptual framework for improving  
7 the health of populations with chronic illness. A key  
8 component of this model involves prepare proactive  
9 community partners integrating with prepared proactive  
10 practice teams working with an informed and activated  
11 patient. Community-based organizations traditionally  
12 focus on providing individuals with long-termed  
13 service support as well as helping them improve self-  
14 management skills.

15 Due to the changing healthcare  
16 environment, area agencies on aging are now starting  
17 to mirror changes employed by healthcare systems  
18 through the use of decision support, information  
19 systems and self-management strategies leading to  
20 redesign of care delivery. Improved and sustainable  
21 outcomes can be achieved if partnerships develop and  
22 work in an integrated and coordinated fashion which  
23 promotes the activation of individuals with multiple  
24 chronic conditions.

1                   This shift in care delivery is  
2                   illustrated in this slide. On top, the healthcare  
3                   system has been incentivized to care for acute illness  
4                   and treat chronic disease exacerbation rather than  
5                   preventing illness and promoting wellness. This  
6                   reactive medical care approach has resulted in  
7                   medicalization of healthcare and has often been siloed  
8                   from community-based organizations who often deal with  
9                   populations having other challenges including  
10                  substance abuse, mental illness, dementia and  
11                  development disabilities.

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

20                  In particular, area agencies on aging  
21                  can serve as boundary spanners providing a bridge for  
22                  the individual to connect with healthcare providers,  
23                  social service and community-based organizations  
24                  resulting in improved health while maintaining the

1 individual's independence in the community. This need  
2 was highlighted by a 2011 Robert Wood Johnson  
3 Foundation Survey of a thousand primary care  
4 physicians.

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

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

18           The traditional scope of community-  
19 based organizations have been on long-term service  
20 supports, shown on the left side of this slide, which  
21 assist individuals to live independently in their  
22 community. New approaches for integration of these  
23 organizations and to healthcare have been facilitated  
24 by the Administration on Community Living and state

1 aging and disability agencies. These include the  
2 following four areas highlighted.

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

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

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

24 At baseline, the average for 30-day

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

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

18 Another model approach on how  
19 community-based organizations can partner with  
20 healthcare systems is through disseminating evidence-  
21 based programs. The Healthy Living Center of  
22 Excellence is a partnership between Elder Services of  
23 Merrimack Valley and Hebrew SeniorLife, a healthcare  
24 provider in Boston. It promotes the integration of



1 evidence-based self-management programs within the  
2 healthcare delivery system through system-wide  
3 collaborations, including community-based partners,  
4 healthcare providers, insurance plans, government  
5 agencies, foundations and for-profit organizations.

6 Key features of this model include a  
7 state-wide disease management coalition involving over  
8 60 community-based organizations, utilizing a website  
9 and universal license which allows for scalability.  
10 There is a centralized referral and technical  
11 assistance system that provides quality assurance.

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

18 Elder Services of the Merrimack Valley  
19 has other measures and outcomes which have promoted  
20 healthier and safer aging in the community, and I will  
21 highlight just a few. Similar outcomes are being  
22 achieved by many other community-based organizations  
23 across the country. In care transitions, there has  
24 been a 25 percent increase in referrals to visiting

1 nursing agencies due to recognition of significant  
2 medical needs that were not addressed on hospital  
3 discharge.

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

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

16 The agency staff's ability to manage  
17 chronic disease has been enhanced, and they are now  
18 practicing at the top of their license through quality  
19 improvement processes and programs. These include  
20 trans-disciplinary learning sessions with medical  
21 providers in attendance and decision support from care  
22 transition teams. The Care-At-Hand tool now allows a  
23 care transitions nurse to manage at least twice the  
24 number of patients with better outcomes.

1 Long-term service supports are being  
2 enhanced by building and leveraging supportive housing  
3 models. This has resulted in decreased admissions for  
4 at-risk individuals through community care  
5 coordination that is culturally competent and  
6 individually centered and directed.

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

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

20 **DR. BOYD:** Thank you. I'm very pleased  
21 to participate today and to tell you about improving  
22 health and healthcare for people living with multiple  
23 chronic conditions through patient-centered outcomes  
24 research.

1                   As we've heard earlier today, it is  
2                   very important that we consider not just how to treat  
3                   one illness, but that we think about the person living  
4                   with many conditions. Disease in isolation is the  
5                   exception and not the rule.

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

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

20                  Guidelines are designed to be based on  
21                  a rigorous evaluation of the quality of evidence from  
22                  clinical trials and other studies and are intended to  
23                  inform but not dictate the care that doctors and other  
24                  clinicians provide.

1                   On the next slide, I'm going to show  
2                   you the treatment regimen that may result from using  
3                   single disease-focused guidelines to inform care for  
4                   an older woman in her late seventies with five common  
5                   chronic conditions including arthritis, high-blood  
6                   pressure, diabetes, osteoporosis and chronic  
7                   obstructive pulmonary disease.

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

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

23                  Attaining person-centered care requires  
24                  that we respect the diverse decision-making

1 preferences that older adults and often their loved-  
2 ones have, that we minimize harms and focus on what  
3 matters to the person, that we support the context in  
4 which people manage their health. And we  
5 appropriately use evidence from studies to inform, not  
6 dictate care.

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

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

21           In 2012, the American Geriatric Society  
22 developed a roadmap describing guiding principles to  
23 approach the care of older adults with multiple  
24 chronic conditions. These were that we want to elicit

1 and incorporate patient preferences into medical  
2 decision-making for older adults with multiple chronic  
3 conditions, recognizing that family and social support  
4 play a vital role in both the day-to-day management of  
5 health conditions and in decision-making.

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

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

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

1 very large population of people with multiple chronic  
2 conditions.

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

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

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

23           For the last several years, a large  
24 group of people have been working hard on how we can



1 translate research from clinical studies into practice  
2 for people with multiple chronic conditions. How do  
3 we need to transform this process of translation in  
4 light of the population of people with multiple  
5 chronic conditions?

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

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

20 Best guidance is necessary in order to  
21 inform clinical decisions for individuals like the  
22 patient pictured here so that we can make the  
23 decisions that are best for her. This will also need  
24 to inform the way we integrate care across multiple

1 providers who often care for people with multiple  
2 chronic conditions, and the way that we integrate care  
3 for the person so that we choose those possibly  
4 recommended things that we choose those that are  
5 actually most important for that person.

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

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

17 We will synthesize the evidence-base to  
18 support the development of clinical practice  
19 guidelines that can better inform patient-centered  
20 care for people with multiple chronic conditions. And  
21 we will finally develop method guidance for others for  
22 how to do this to help other organizations who conduct  
23 systematic reviews and who develop clinical practice  
24 guidelines.

1                   Such patient-centered research for  
2 older adults with multiple chronic conditions is  
3 important to ensure that individuals with multiple  
4 chronic conditions age healthier and get the best  
5 possible healthcare. I thank you for your attention  
6 and I look forward to the questions.

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

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

23                   The first question I wanted to address  
24 that many of you sent in is wanting to know if you'll

1 be able to get the slides. So I'll just say right now  
2 that yes, we will have the slides available, as well  
3 as a recording of the webinar because we know some  
4 folks have wanted to get in and our registration was  
5 full. Those will be sent to everyone who's registered  
6 next week, so a week from today, on Thursday, the  
7 17<sup>th</sup>.

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

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

20 So one of our offices here at Health  
21 and Human Services are Assistant Secretary for  
22 Planning and Evaluations Office, or ASPE, has recently  
23 published results of a project that's identified data  
24 and methods and topics for research on exactly this,

1 on health disparities and multiple chronic condition  
2 populations. And it is also assessing the potential  
3 utility of existing data systems and datasets so we  
4 can really get at multiple chronic condition  
5 disparities research.

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

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

15 **DR. SCHREIBER:** Thank, Nora, for that  
16 question, a very good one. So there are a multitude  
17 of preventive measures, and a lot of them do focus on  
18 the role of the individual becoming much more engaged  
19 and activated in their care. Oftentimes, one of the  
20 key determinants of what makes a difference is what  
21 matters most to the individual. By giving people the  
22 opportunity to deal with the challenges that they face  
23 and the tools that they need to be able to problem  
24 solve, they oftentimes can direct their own care and

1 work with their care team to develop a plan that's  
2 effective in managing their issues.

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

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

21 And lastly, I would say that the other  
22 piece that's really important is people actually take  
23 charge, they become the captains of their healthcare  
24 ship. And they become much more compliant and also

1 much more engaged with their medical providers in  
2 terms of communicating more effectively.

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

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

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

23 So while certainly there are age-  
24 related changes as we get older, many times the

1 symptoms and the issues that our patients are raising  
2 are not attributable just to the aging process, that  
3 they are either related to a specific disease or that  
4 they are rising for multifactorial reasons, that the  
5 person is experiencing something as a result of  
6 impairments or changes across multiple organ systems.

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

17           **MS. SUPER:** Thank you. Dr. Schreiber,  
18 I am combining a couple of different questions. You  
19 talked about the importance of community-based  
20 organizations and how they help to deliver critical  
21 support services. We have a question. We do have  
22 three medical doctors on the line, which we're happy  
23 to have, but there are some non-medical care providers  
24 who are asking how they can provide support to adults



1 with regard to multiple chronic conditions.

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

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

18 A lot of the important work that has to  
19 be done has to happen in the community. And non-  
20 medical care providers actually understand much more  
21 effectively what are the challenges individuals face  
22 and are able to actually leverage resources; whether  
23 it's coming up with problem-solving on transportation  
24 issues, nutritional issues, economic issues, safety

1 issues in the environment, how can they make certain  
2 that people are safe, and also dealing with other  
3 issues involving family members.

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

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

22           And so they really are poised to help  
23 deal with the majority of issues that people are  
24 really challenged with, and they can't really deal

1 with those medical issues unless some of these non-  
2 medical situations are dealt with first.

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

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

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

21 And I think, as we have heard about in  
22 today's webinar, people with multiple chronic  
23 conditions have multiple conditions, they have  
24 multiple providers and multiple medications. What is

1 really needed is care coordination, care management,  
2 integrated care. And that's really what bundled  
3 payments try to do. They try to incentivize providers  
4 so providers can better collaborate in caring for  
5 individuals who are complex, who have many conditions.

6 So I think this will continue to be a  
7 growing trend, these alternative payment models, and I  
8 think they can really benefit this population.

9 Already for Medicare -- ACOs, for example -- there are  
10 several hundred Medicare ACOs serving several millions  
11 of Medicare beneficiaries.

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

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

23 This listener talks about how people  
24 are driven from one to another without much

1 coordination. What can we do to improve that?

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

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

20 And so, I think in order to get to the  
21 next level, we need to have all providers, not just  
22 primary care physicians or not just geriatricians, but  
23 really all providers really begin to think about  
24 patients with multiple chronic conditions and their

1 role as part of that larger holistic fear.

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

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

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

24 **MS. SUPER:** Thank you, Dr. Boyd. I

1 appreciate that answer. And we have a couple of  
2 questions that I'll ask Dr. Schreiber to first  
3 address, and then either of the other doctors if  
4 they'd like to add.

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

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

23 So people with physical disabilities  
24 and spinal cord injuries, yes that would be a chronic

1 condition. There are some that are more significant  
2 than others, and it depends on the individual as well.  
3 You can have an individual with diabetes, heart  
4 failure, as well as kidney disease and be running and  
5 very active. And then you can have others that are  
6 near a dialysis and are very inactive. So it really  
7 depends on the individual and other factors, as well.

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

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

19 **DR. PAREKH:** Great. Thanks so much.  
20 So I think, in general, it's important to know for  
21 Health and Human Services Initiative focused on this  
22 population. As Dr. Schreiber mentioned, we look at  
23 chronic conditions very inclusively. So a standard  
24 definition of chronic condition is essentially a



1 condition that lasts a year or longer and requires  
2 either ongoing care or causes limitations in  
3 activities of daily living.

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

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

19 Several of our agencies here at HHS,  
20 including SAMHSA, or Substance Abuse and Mental Health  
21 Services Administration, for example, have started new  
22 programs in the communities to better integrate  
23 primary and behavioral health. So that one-stop  
24 shopping, if you will, at the same visit, both

1 physical health conditions as well as behavioral  
2 health conditions can be addressed. And these models  
3 have been shown to be quite promising.

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

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

18 You talked a bit about decision  
19 support, but we have a question from Mikhail asking  
20 how can technology such as social media and blogs  
21 assist in raising awareness about multiple chronic  
22 conditions, helping people have behavioral  
23 modification or help with their management of their  
24 disease. Can you address that question?

1                   **DR. BOYD:** That's a great question.  
2                   And I feel like there were actually a couple of  
3                   questions imbedded in there. So one of the things  
4                   about multiple chronic conditions actually is, is that  
5                   I think it has in the media and in the larger world  
6                   sort of lacked in voice, lacked in advocacy groups  
7                   because, by definition, there's a great degree of  
8                   heterogeneity in terms of what the conditions are.

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

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

24                  Just as an example, how do people with

1 multiple chronic conditions identify? What words  
2 would they use when they wrote about it in a blog or  
3 social media? I think that starting to hear those  
4 voices will help us figure out the really true  
5 patient-centered and person-centered ways to be  
6 talking about people with multiple chronic conditions.

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

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

21 **MS. SUPER:** Great. Thank you. And I  
22 know we have many questions. We are closing in on the  
23 end of time, so I'm going to give one more question to  
24 Dr. Schreiber and one more to Dr. Parekh and then

1 close up. But we appreciate all the questions that  
2 people have sent and we will do our best to respond.

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

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

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

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

1 environments. They have the wisdom. They have the  
2 knowledge. They have the experience.

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

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

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

24 **MS. SUPER:** Great. Thank you. That

1 ties in so much to what we're hearing across the  
2 country about healthy aging and how people want to  
3 really choose how to live their lives and have meaning  
4 and purpose.

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

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

24 Hundreds of thousands of individuals

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

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

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

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



1 need it.

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

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

14 \* \* \* \*