Prevention in the Context of Frailty: The Role of Evidence based Programs

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Speaker Disclosures

Dr. Schreiber has disclosed that he has no relevant financial relationship(s).

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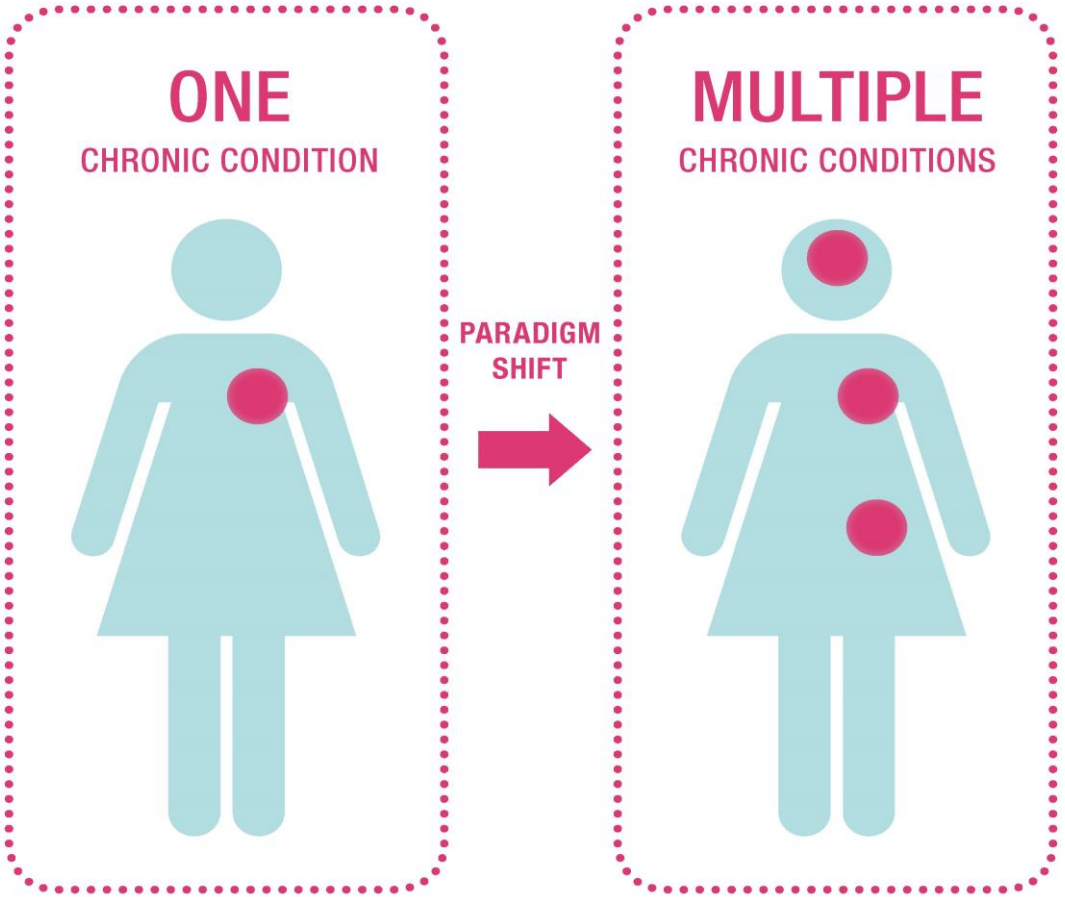
Objectives

1. Discuss the evidence base for self management and the important role it has in enhancing health outcomes in frail older adults and those with multiple morbidities
2. Discuss how the Chronic Care Model integrated the use of self management programs as an integral part of the model of managing chronic disease
3. Discuss the different type of evidence based programs and how they can be useful tools for your health care system
4. Discuss the value proposition of community-based organizations in multiple chronic condition (MCC) population management and self management

“The most common chronic condition experienced by adults is multimorbidity, the coexistence of multiple chronic diseases or conditions.”

Tinetti et al, JAMA, 2012



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U.S. Multiple Chronic Conditions Challenge

Prevalence

- 26% of adults have MCC
- 66% of fee-for-service Medicare beneficiaries have MCC
- 67% of Medicaid beneficiaries w/ disabilities have 3 or more conditions

Access

- 16% of the uninsured have MCC

Outcomes

- As the number of conditions increase, so does the frequency of mortality, poor functional status, hospitalizations, readmissions, and adverse drug events

Costs

- 71% of US health care costs are for individuals with MCC
- 93% of Medicare expenditures are for individuals with MCC

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Sources: Anderson, RWJF, 2010; Kronick, CHCS, 2009; Lee, JGIM, 2007; Machlin, AHRQ, 2011; Vogeli, JGIM, 2007; Ward, PCD, 2(Generation, 2006; Wolff , Arch Intern Med, 2002; http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Maps_Charts.html; http://www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

“Treating an Illness Is One Thing. What About a Frail Patient With Many?”

New York Times, March 31, 2009

Image: Brendan Smialowski for the New York Times

- Disease in isolation is exception, not rule
- Variability in conditions and how they affect people’s function
- Cumulative approach of care is not evidence-based, can be overwhelming and is often harmful

Attaining care that focuses on what people with multiple chronic conditions, and their loved ones, want requires:

- respect diverse decision-making preferences,
- minimize harms and focus on what matters to the person, and
- support the context in which people manage their health
- appropriately use evidence from studies to inform, not dictate, care

Approach to the Evaluation and Management of Older Adults with Multimorbidity: Guiding Principles

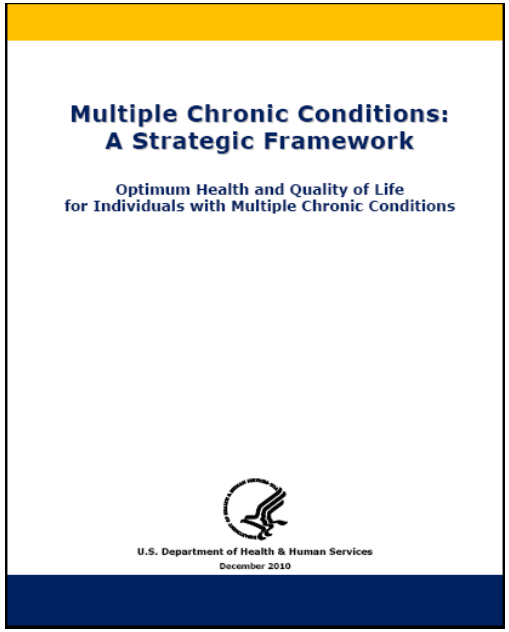
- Patient Preferences
- Interpreting the Evidence
- Prognosis
- Treatment Complexity and Feasibility
- Optimizing Therapies and Care Plans

http://www.americangeriatrics.org/health_care_professionals/clinical_practice/multimorbidity

What Do Clinicians Need to Do to Best Care for People Living with Multiple Chronic Conditions and/or Frailty?

- Think beyond diseases
- Recognize heterogeneity
- Be cognizant of the challenges of the evidence base for this population
- Maximize use of therapies likely to benefit
- Minimize use of therapies unlikely to benefit or likely to harm
- Incorporate patient preferences and values regarding burdens, risks, and benefits

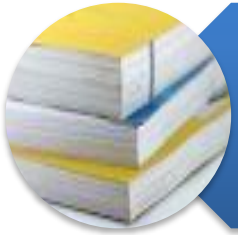
Goals of the Strategic Framework on Multiple Chronic Conditions



http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf
http://www.hhs.gov/ash/initiatives/mcc

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

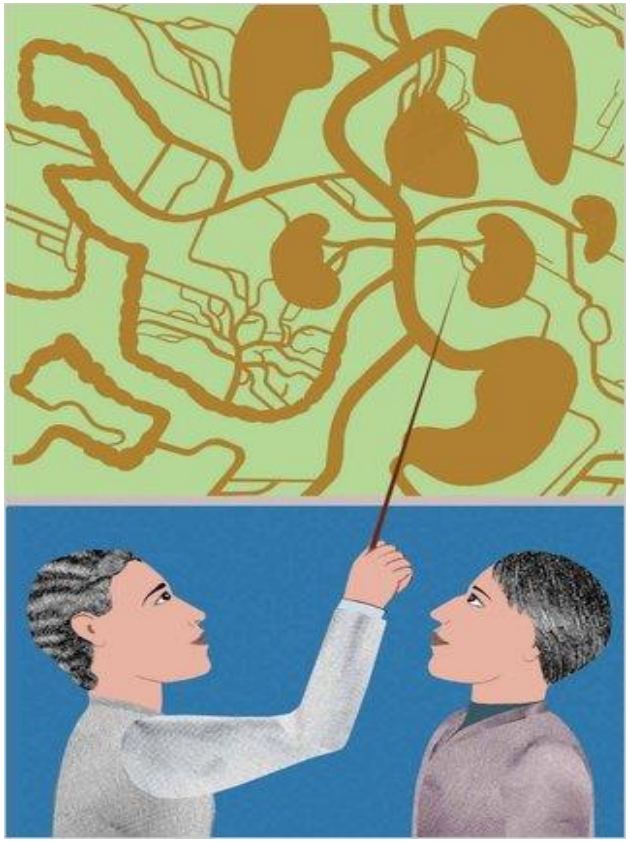


3. Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions

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

Photos: http://www.sxc.hu

Living well with chronic diseases increasingly means, living well with multiple chronic diseases



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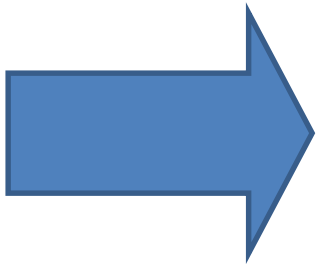
Why Now??

5%  50%

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Healthcare Payment Change
Putting Providers at Risk for Population Health

- Health care transformation from Volume based to Value based payment system
- US Department of Health and Human Services
  - Goal of tying 30% of Fee for service Medicare payments to quality or value to alternative models of care by 2016
  - Tying 50% of Medicare payments to these models by 2018
- Several of nations largest healthcare systems and payers, joined by purchasers and patient stakeholders, have committed to 75% of their business into value based arrangement by 2020

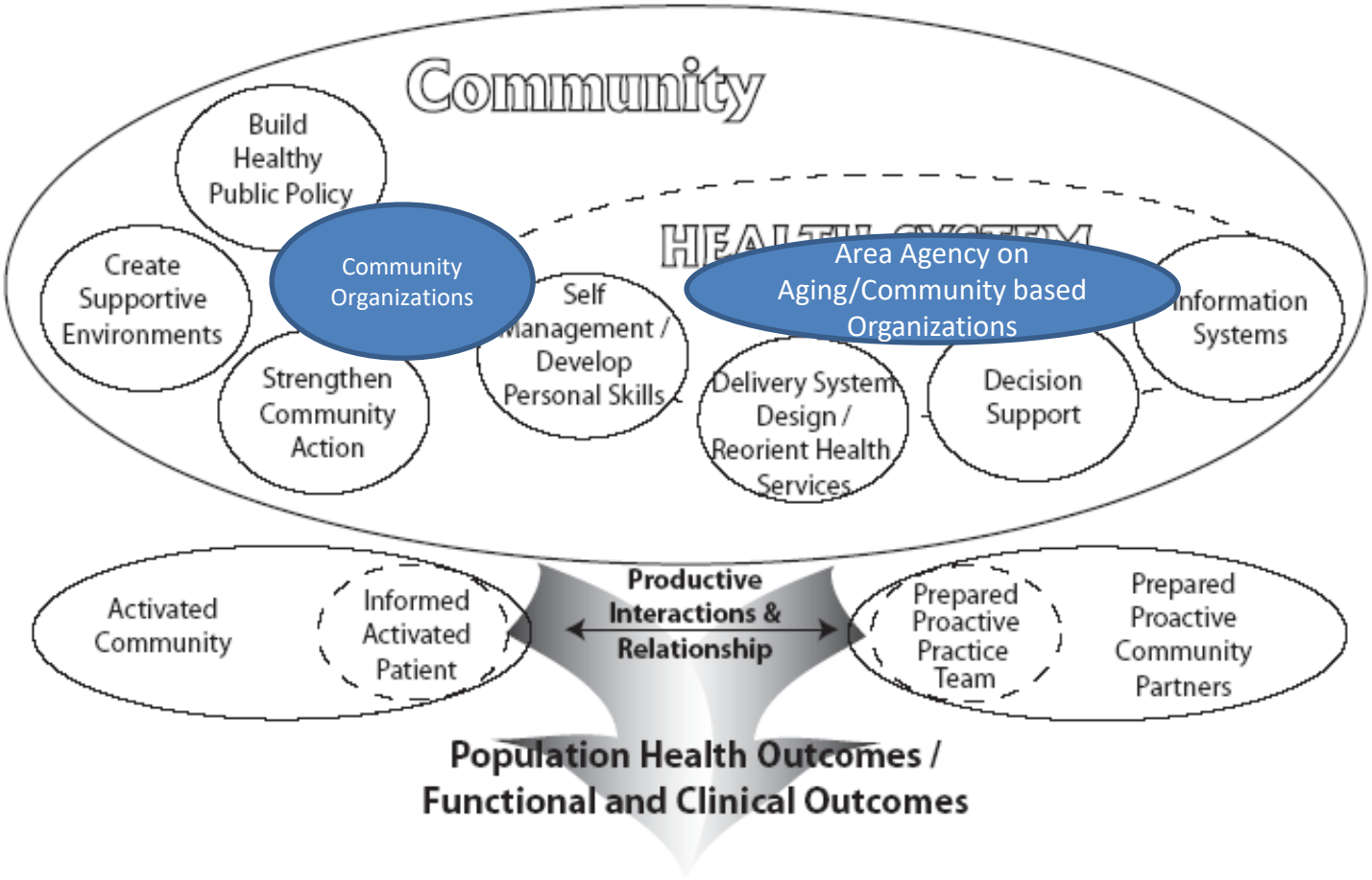
Triple Ai m

- Improving the U.S. health care system requires simultaneous pursuit of three aims

1. Improving the experience of care
2. Improving the health of populations
3. Reducing per capita costs of health care

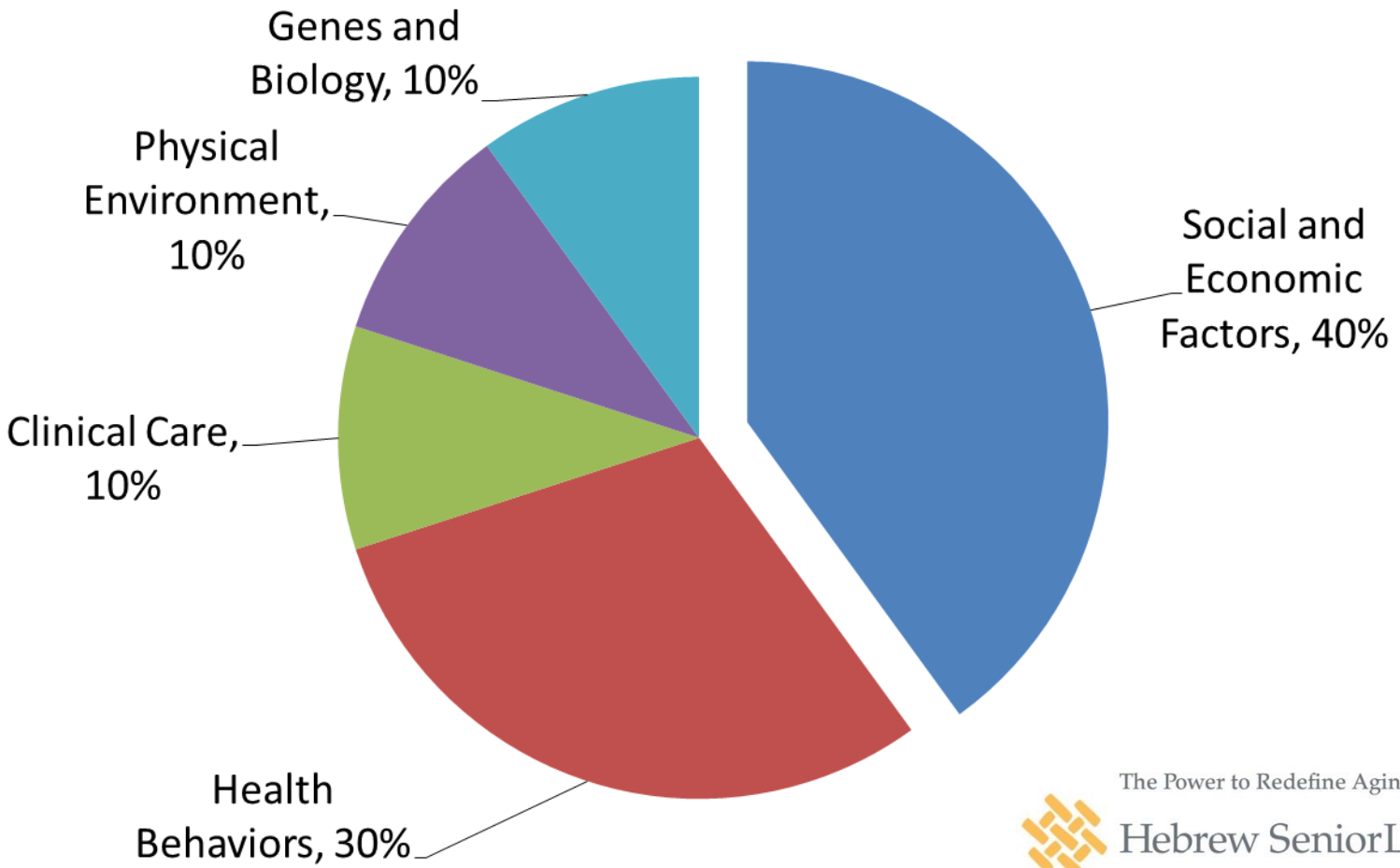
Don Berwick et al, Health Affairs, 27, no. 3 (2008): 759-769

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION



The Expanded Chronic Care Model, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

Public Policy Framework for Improving Population Health



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Tarlov AR. Public policy frameworks for improving population health. *Ann N Y Acad Sci* 1999; 896: 281-93.

U.S Preventive Services Task Forces Principal Findings

- Most effective interventions address personal health practices: smoking, diet, safety, physical activity, substance abuse
- Counseling and patient education are most important criteria than certain diagnostic tests
- **Patients need to assume greater responsibility for their health**

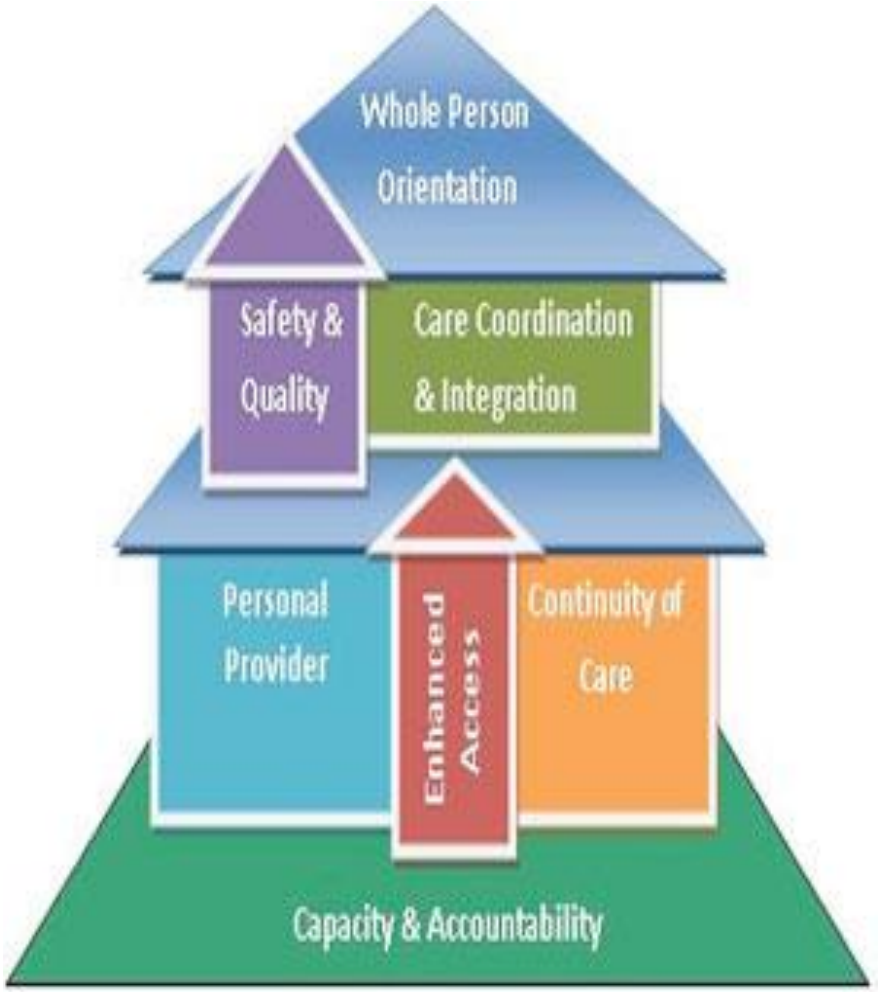
Importance of Patient Engagement/Activation

- Active involvement in health and health care leads to better health outcomes with some evidence suggesting lower cost
- Patients with the lowest activation scores—having the least skills and confidence to actively engage in their own health care—incurred **increased medical costs** up to 21 percent higher than patients with the highest activation levels

Hibbard Health Affairs 2/13/13

What Does Patient Engagement Look Like?

Patient Centered Medical Homes



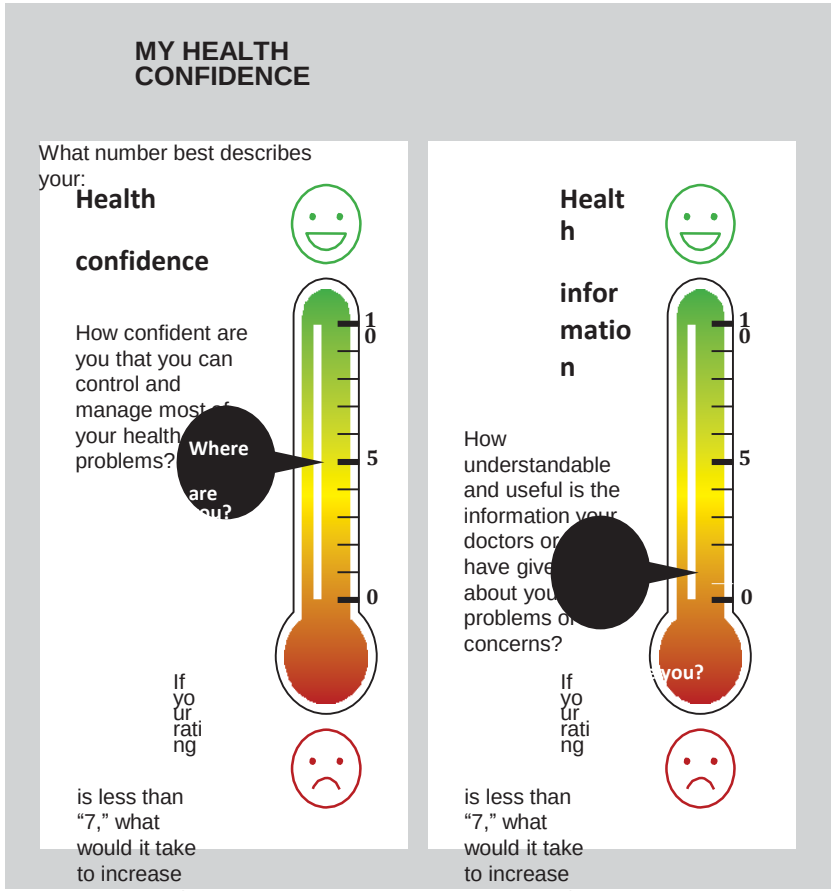
- Model of Care strengthens physician-patient relationship
- Team based care with collective responsibility
- Goal is more personalized, coordinated, effective and efficient care
- Support patient self management and shared decision making

Building Health Confidence in PCMH

Geriatric Friendly PCMH

HARTFORD Change AGEnts

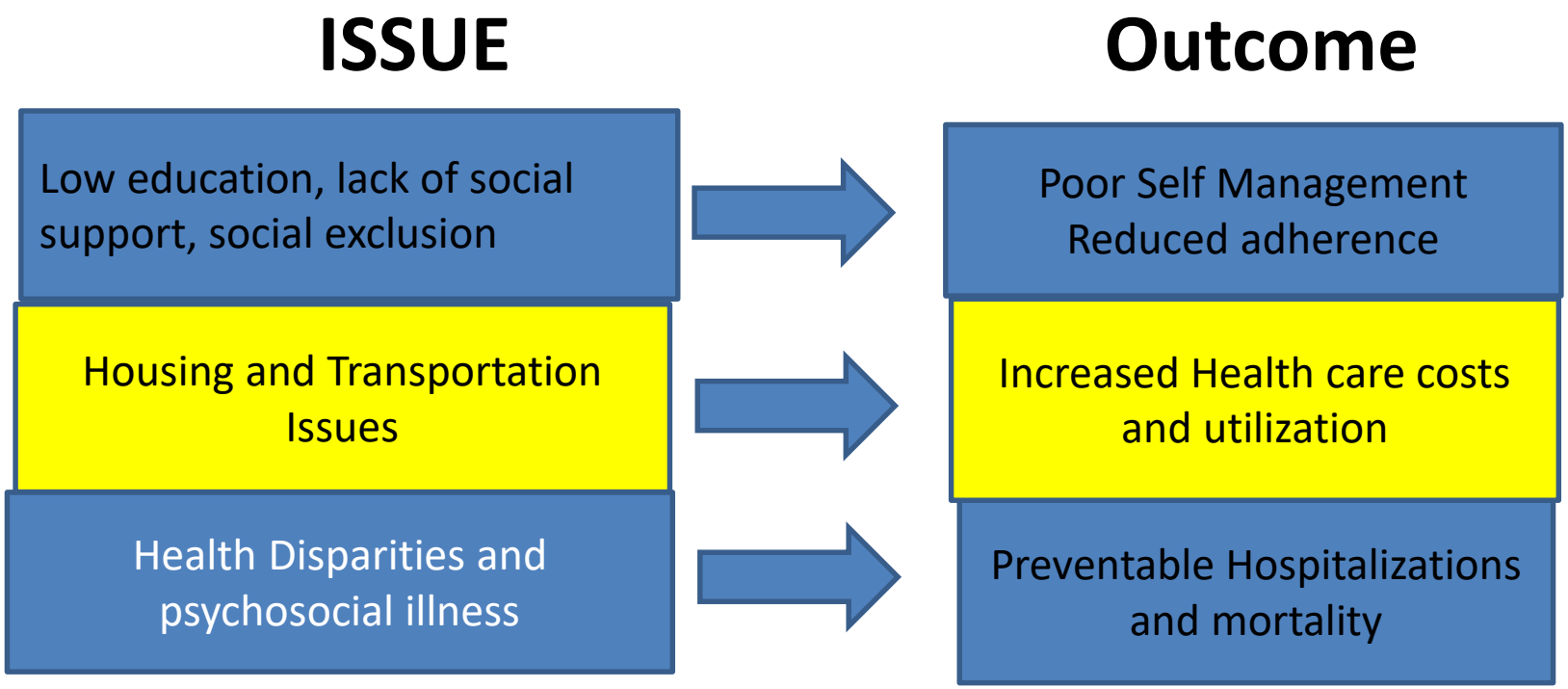
Wasson's Health Confidence Measure



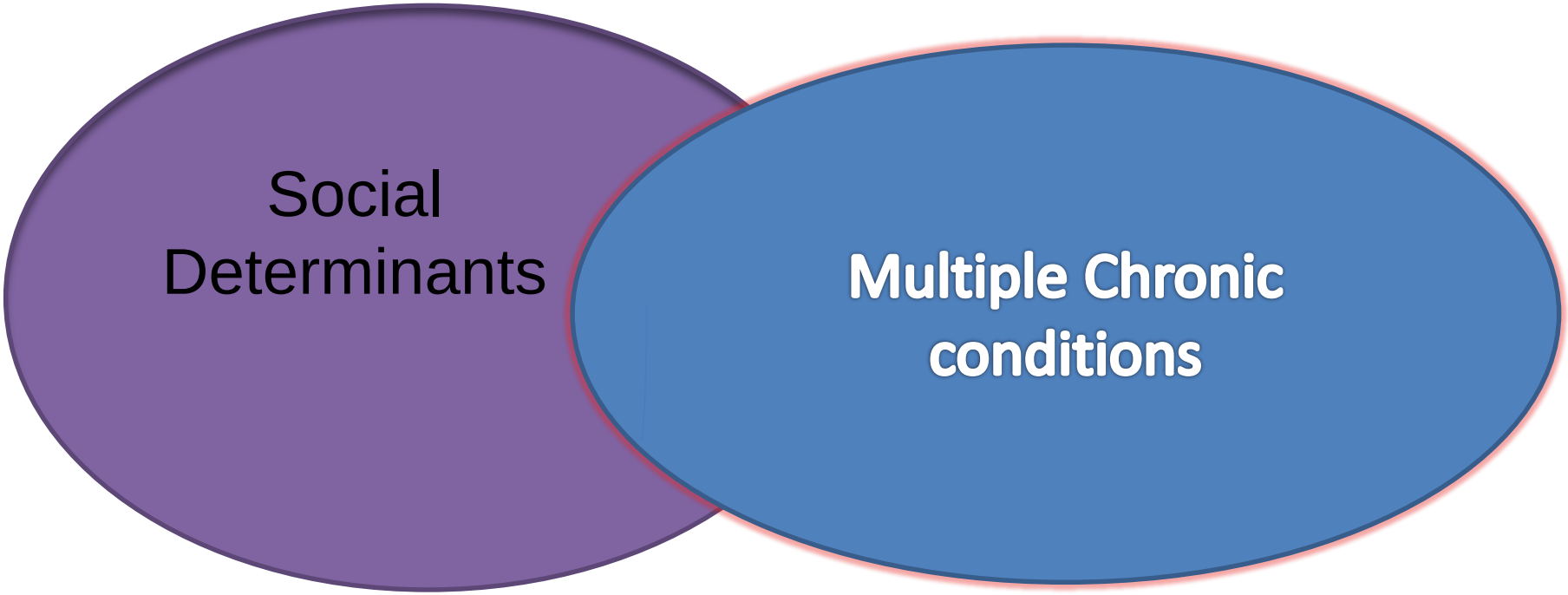
Healthcare's Blind Side

- 2011 RWJF survey of 1,000 **primary care physicians**
  - 85%: Social needs directly contribute to poor health
  - 4 out of 5 not confident can meet social needs, hurting their ability to quality care
  - **85% of physicians say patients' social needs are as important to address as their medical conditions**
    - 95% of physicians serving patients in low income, urban
    - 76% wish the health system would cover the costs associated with connecting patients to services that met their social needs
  - **1 in 7 prescriptions would be for social needs**
  - Psychosocial issues treated as physical concerns

Social Determinants



Patients with Frailty and/or MCC have Social Determinant Needs



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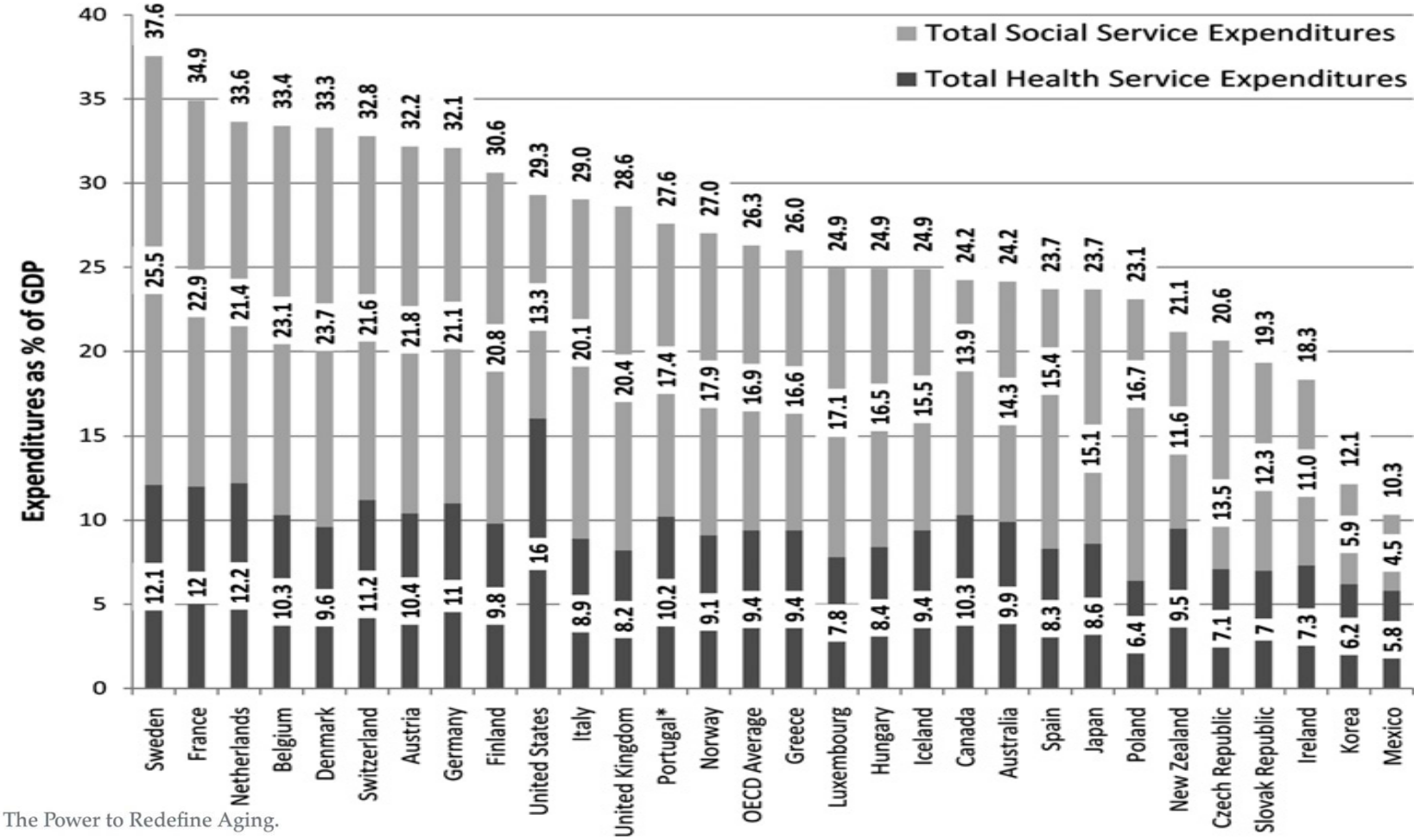
Fragmentation of Care

- Siloed health care and social service systems
- Person and family-centered , coordinated care is rare in models of care
  - Lack of mental health
  - Not bilingual and bicultural

Total Health-Service and Social-Services for Organization for Economic Cooperation and Development Countries 2005



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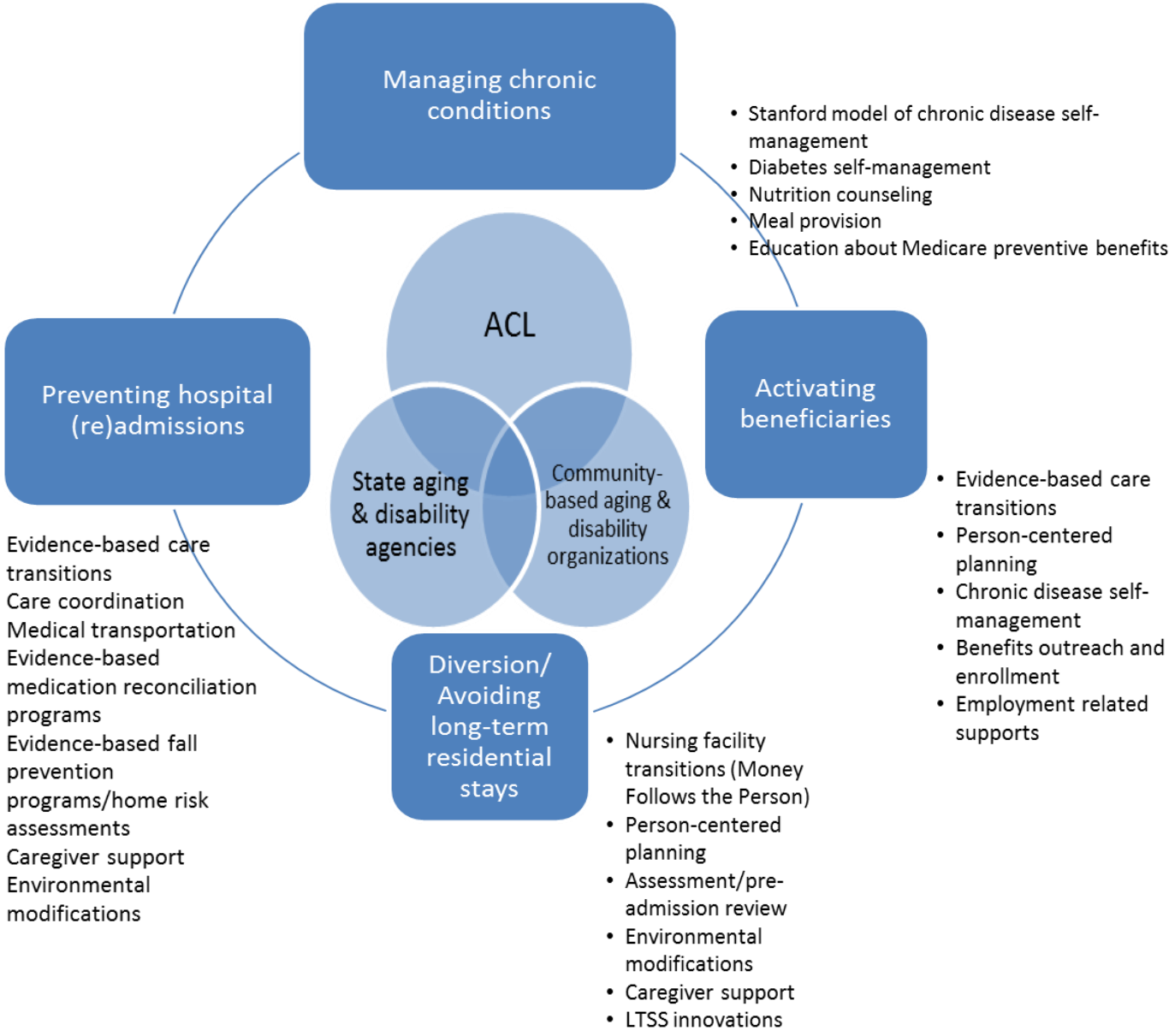
Integration of *Community Based Organizations* into Healthcare: Optimizing Health Outcomes

Traditional <u>Scope of Long Term Services & Supports</u>

- *Home-delivered/ congregate meals*
- *Transportation*
- *Medication review*
- *Respite/Caregiver support*
- *Falls/Home risk assessments*
- *Information and assistance*
- *Personal care*
- *Employment-related supports*
- *Housing*
- *Homemaker*
- *Shopping*
- *Money management*



Slide from ACL

The Community Organization Bridge to Improving Health of Individuals with Multiple Chronic Conditions and Frailty

What are Evidence-based Programs?

- An evidence-based program has been demonstrated to be effective in basic research that involved the same target audience

- Then it has been demonstrated to be effective in dissemination in the “real world.”

- There are clear protocols for the training and conducting of the program so that community programs can maintain fidelity and be successful.

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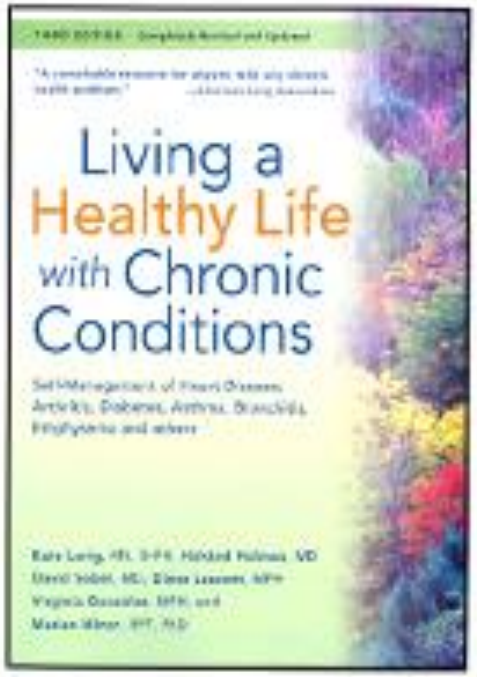
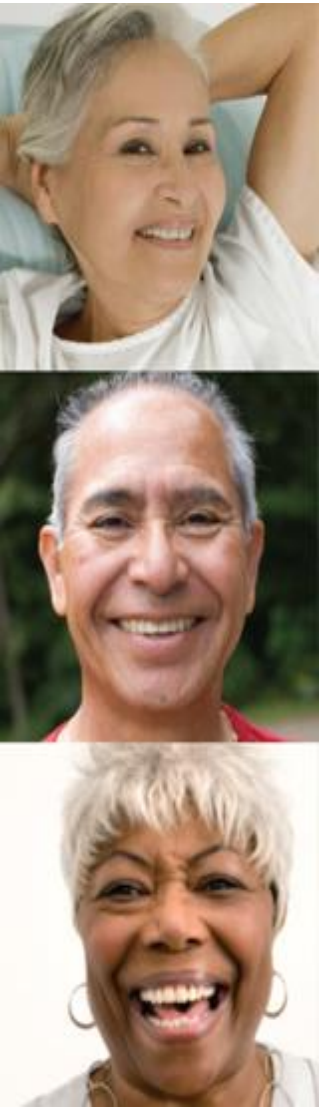
Select Programs

Stanford University's Self-Management Education Programs:

- Tomando Control de su Salud
- Programa de Manejo Personal de la Diabetes
- Pain Self-Management Program
- Cancer Thriving and Surviving
- Positive Self-Management
- Healthy Eating for Successful Living

Endorsed by CDC, AHRQ, HHS, Administration on Community Living and the Surgeon General





Tomando du : The Stanford Model

- CDSMP is a 6 week workshop offered to adults living with the challenges of 1 or more persistent health conditions.
- Ages 18 and over
- Participants meet for 2 ½ hours once a week.
- Each workshop is lead by 2 certified Lay Leaders.
- Workshops use a mutually supportive model that encourages:
  - Discussion
  - Problem solving

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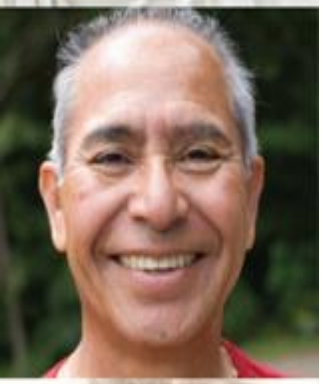

Take Control of My Health: The Stanford Model

Workshops cover different topics each week

- Dealing with difficult emotions
- Physical activity and exercise
- Power of the mind
- Muscle relaxation and guided imagery
- Pain and fatigue management
- Healthy eating
- Communication skills
- Medication usage
- Making informed treatment decisions

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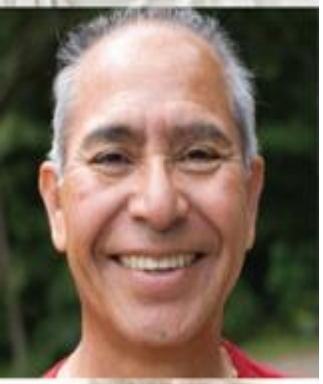

Take Control of Your Health: The Stanford Model

ACTION PLAN FORM

In writing your action plan, be sure it includes

1. what you are going to do,
2. how much you are going to do,
3. when you are going to do it, and
4. how many days a week you are going to do it.

For example: This week, I will walk (*what*) around the block (*how much*) before lunch (*when*) three times (*how many*).

This week I will _____(what)

_____(how much)

_____(when)

_____(how many)

How confident are you? (0 = not at all confident; 10 = totally confident) _____
[*Just a note: You may want to make copies of this form.*]

	Check Off	Comments
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Participants Learn How To Create <u>Action Plans</u>

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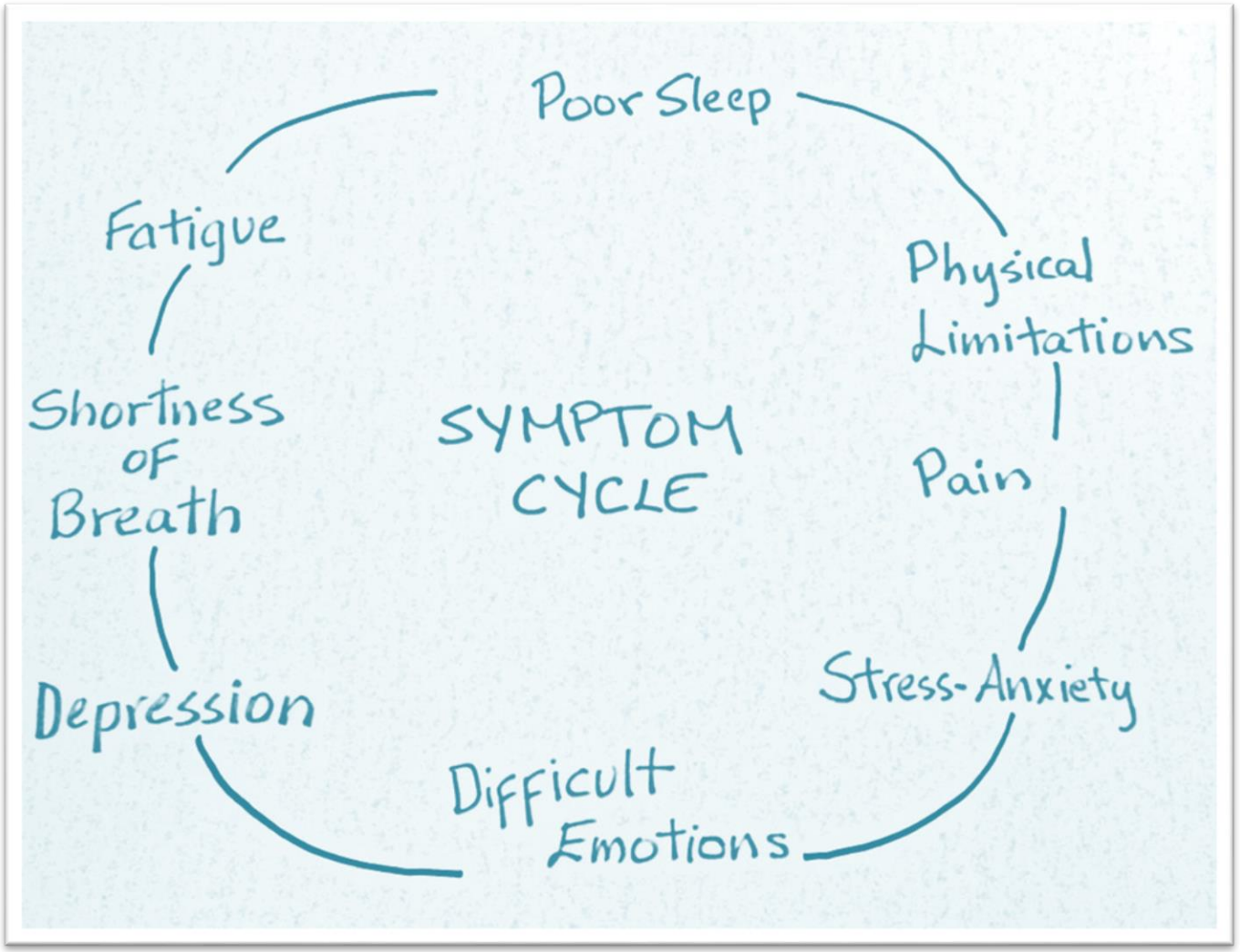
The Symptom Cycle



Self-Management Tools Help Break the Symptom Cycle

My Life, My Health:
Stanford University's
Chronic Disease Self-Management Program

http://www.ncoa.org/improve-health/chronic-conditions/healthier-lives-a.html

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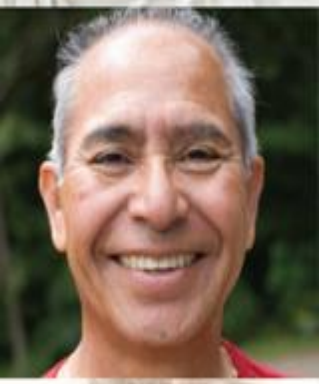

My Life, My Health: Better Health

- Decreased depression symptomatology
  - **21% improvement p<0.01**
- Significant improvements in self-assessed health, quality of life, fatigue, and sleep problems
- Significant Improvements in pain and shortness of breath
- Increased odds of participating in moderate physical activity (*p* <0.001)
- Feel healthier: 5% improvement in self-reported health

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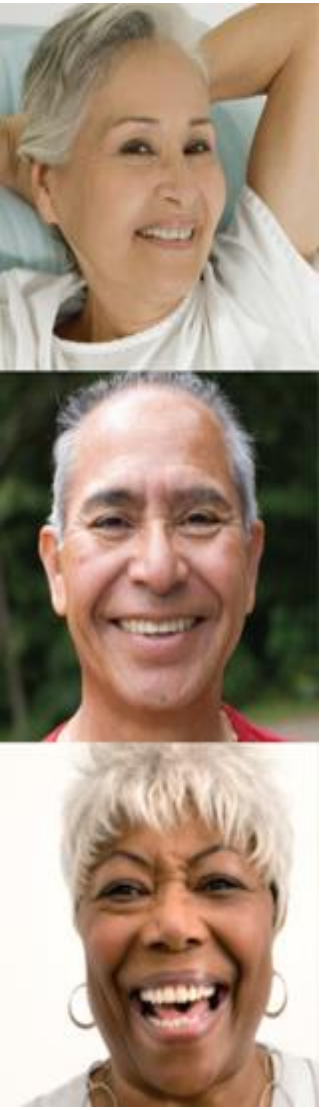
Ahn, S., et al.. (2013). The impact of chronic disease self-management programs: healthcare savings through a community-based intervention. BMC Public Health, 13:1141



My Life, MyHealth: Better Healthcare

- Improved communication with physicians ($p<0.001$)
- Medication compliance: 12% improvement
- Health Literacy: 4% improvement in confidence of filling out medical forms.

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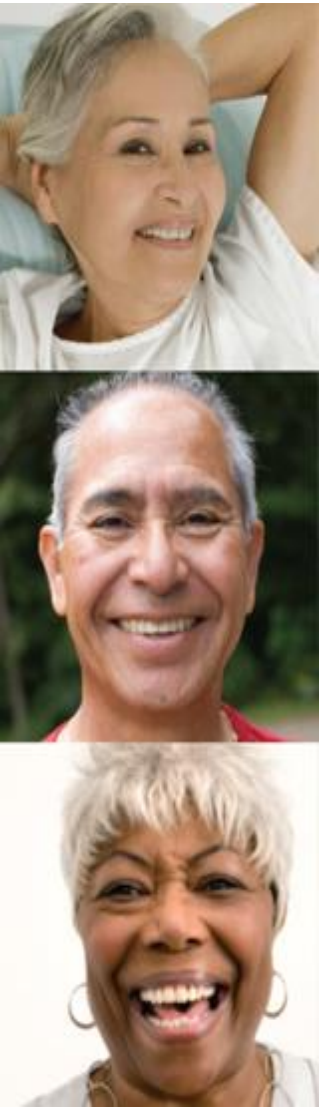
My Life, MyHealth: Lower Cost



Better Value and Lower Cost per patient/year

- Significantly reduced risks of ER visits, from 18-13% ($p<.007$)
- Significantly lower odds of hospitalization in 6 months from 14-11% ($p<.03$)
- Potential estimated cost savings of $713.80 per patient (net savings after costs of $364)

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A Matter of Balance:
Managing Concerns About Falls

- Direct Medical costs of falls is $30 billion
- In older community dwellers, fall related injury is one of the 20 most expensive medical conditions
- CDC Steadi Toolkit
- http://www.ocagingservicescollaborative.org/wp-content/uploads/2014/07/STEADI-toolkit-contents-and-link.pdf

Outcomes

- Ninety-seven percent of participants are more comfortable talking about fear of falling.
- Ninety-seven percent feel comfortable increasing activity.
- Ninety-nine percent plan to continue exercising.
- Ninety-eight percent would recommend A Matter of Balance.

Value Proposition to Patients and Caregivers

- Unique position of EBPs to afford patients activation
- **Can not achieve best outcomes in individuals with multiple chronic conditions without activation**
- Make it part of all their care plans and make this part of a patient education benefit package especially individuals with MCC and frailty

Value Proposition to Patient Centered Medical Home

- Self Management is a criteria for PCMH
- P4P for outcomes-diabetes, hypertension
- Improve patient satisfaction with providers/practice
- Improve PCP satisfaction
- Increase referrals to practice

Summary

- Self management is an integral component for improved health outcomes, lower cost and better healthcare and has impact on frailty
- The HHS Strategic Framework on Multiple Chronic Conditions is a guide for health care providers with an emphasis on self management
- Community based organizations have a key role in ensuring individuals with multiple chronic conditions age or frailty age healthier through the provision of evidenced based self management programs


Questions