

Aging

Futures

**. . . older adults living well
as they define it.**

Chronic Disease Management Workgroup Report

2003

A Community Partnership for Older Adults Project

A National Program of The Robert Wood Johnson Foundation

Aging Futures Partnership
Broome County, New York

Our Mission

*Creating and strengthening community systems,
thus enabling persons age 60 and over to maintain
the highest quality of life.*

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About the Partnership

“The beauty of collaboration is the acknowledgement that each organization has a special function, a power that it brings to the joint effort. At the same time, each organization provides valuable services or products critical to the health of its community.” (Winer Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey, 1994)

Since 1989 Broome County has benefited from a dedicated Partnership of consumers, educational institutions, public and private and not-for-profit agencies and faith communities dedicated to enhancing the quality of life for seniors in Broome County. Aging Futures demonstrates their commitment to strengthening Broome County’s long term care system by:

- Engaging seniors, listening to their needs and including them in planning processes
- Promoting the independence of seniors
- Building and supporting a responsive long term care system

Broome County was one of 13 communities nationwide to receive a planning grant from The Robert Wood Johnson Foundation, as part of their Community Partnership for Older Adults initiative. The grant, awarded in August 2002, supported our local Partnership in coordinating a planning process to meet the needs of vulnerable elders and their caregivers in Broome County.

Aging Futures Partnership goals:

- Strengthen a long standing and diverse Partnership focused on long term care services and supports
- Understand local needs, prioritize action steps and act collectively to address them
- Develop strategies that will bring about change in both practice and policy
- Secure funding and evaluate our efforts
- Support and coordinate community education about senior issues

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Aging Futures

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Chronic Disease Management Workgroup Report

I. INTRODUCTION

A. Overall Goals of Aging Futures

The Aging Futures Partnership is dedicated to enhancing the quality of life for all people over the age of 60 in Broome County. The Aging Futures planning initiative began in 1989 and continues to support the work of all agencies in Broome County serving seniors. The Aging Futures Partnership offers seniors the opportunity to be involved in problem solving and recognizes that to foster change in our community and our long term care system, we need to collaborate. Aging Futures builds on the strengths of our community and works towards innovative approaches that address unmet needs.

The Aging Future Partnership is committed to:

1. Sustaining a strong and diverse partnership committed to strengthening long term care.
2. Developing strategies to foster needed changes in both practice and policy.
3. Securing resources and funding needed to enhance community services.
4. Providing community leadership and education on issues impacting seniors.

B. Workgroup Charge

The Chronic Disease Management Workgroup met five times in the spring of 2003 to assess local needs, identify strengths and shortcomings in current services, and to identify strategies that would be particularly meaningful to vulnerable seniors. The workgroup was charged with developing and recommending two or three fully developed implementation strategies that would prevent functional decline among Broome County seniors diagnosed with chronic disease and support seniors in remaining independent and capable of continuing in their preferred living environment.

C. Desired Outcome

Create and sustain community supports that promote well being, maximize independence and minimize functional decline.

D. Rationale for Selection of Chronic Diseases

The journal of the American College of Physicians, Effective Clinical Practice, notes: "Meeting the complex needs of patients with chronic illness or impairment is the single

greatest challenge facing organized medical practice. Usual care is not doing the job; dozens of surveys and audits have revealed that sizable proportions of chronically ill patients are not receiving effective therapy, have poor disease control and are unhappy with their care.” The economic and societal costs of chronic disease are high as well. Health and Human Services Secretary Tommy Thompson noted, “Chronic diseases and conditions, including heart disease, consume more than 75% of our nation’s health care dollars, yet they are largely preventable.”

Over the course of five meetings, the Chronic Disease Management Workgroup reviewed prevalence data on a number of chronic conditions including diabetes, cardiovascular disease, arthritis and dementia. The workgroup reviewed best practice literature on chronic disease management in the senior population and discussed how the community could enhance services. Additionally, the workgroup heard from local leaders on initiatives that are addressing chronic conditions. After extensive review and discussion of the relevant information, the workgroup felt that two conditions stood out as having unmet needs that we had the ability to address: stroke prevention through hypertension detection and treatment; and depression detection and treatment.

Stroke Prevention

Stroke is the third leading cause of death in the nation and in our region. It is the most common cause of severe chronic disability in the elderly, and a common cause of admission to the nursing home. Nearly three times more elderly die of stroke than diabetes (National Center for Health Statistics, March 2003). It disproportionately affects African Americans and older adults, with an occurrence doubling each decade after age 55. Although the age-specific incidence of stroke has declined in recent decades, thought primarily due to treatment of hypertension (HTN), the number of strokes is increasing because of our aging population.

By far the most important prevention of stroke is the detection and treatment of high blood pressure. Uncontrolled HTN also increases the risk of congestive heart failure, coronary heart disease, and kidney failure. Persons with diabetes mellitus are particularly prone to complications of HTN. Hypertension is one of the two most common health conditions among seniors. In Broome County, 40.3% of seniors age 65 or older have been identified as having hypertension. But HTN detection and treatment lag far behind the need. A recent study found that nearly one-third of older Americans whose systolic blood pressure was 140 mm Hg or higher, did not think they had high blood pressure. Their limited awareness of the dangers of systolic hypertension was a greater barrier to BP control than medication costs. The recent report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC7) notes that “Current control rates...though improved, are still far below the Healthy People 2010 goal of 50%,” and “HTN occurs in more than two thirds of individuals after age 65. This is also the population with the lowest rates of BP control.” Generally, only about half of identified hypertensives have blood pressures in the target range.

While many seniors appear unconcerned with high blood pressure, their fear of stroke is palpable. Recognizing this factor, the strategy adopted by the workgroup is to market a

“stroke prevention” model that includes attention to reducing and managing hypertension. Adequately prescribed and taken, medications almost always can control HTN. Poor control comes mainly from inadequate treatment or poor compliance with medication regimens. “The most effective therapy prescribed by the most careful clinician will control hypertension only if patients are motivated.” (JNC7) We believe part of the reason people are not more motivated in BP control is lack of awareness of its importance in stroke prevention. Stroke is a highly feared event, and enhancing people’s knowledge that HTN control can prevent it may significantly motivate elders. Physicians also would benefit from education regarding the importance of stroke prevention through HTN treatment and methods of treating geriatric HTN.

The workgroup recommends a broad collaborative community approach to reduce stroke through improved HTN recognition and control. This can be done by increasing community awareness of stroke and HTN, BP screenings, education of physicians and patients, initiating quality improvement efforts in primary care offices, and enhancing elders’ ability to self monitor BP. Broadcast and print messages will expand community awareness of stroke and its prevention.

To improve blood pressure control among older Americans, clinicians and health educators need to increase awareness and understanding about the dangers of hypertension. Also, health care workers need to use a more holistic approach to managing high blood pressure (HBP), according to the researchers funded by the Agency for Healthcare Research and Quality (HS1087). Recent public education efforts regarding hypertension have been absent from the mainstream media and public eye. Community efforts that combine media messages, proclamations by the legislature (Stroke Awareness Month), and partnerships between providers and community organizations in states such as South Carolina and Georgia have proven effective in raising awareness regarding the relationship between hypertension, stroke, heart attack and disability. Broome County will review these best practice models to embark on a similar public education efforts. These new guidelines can complicate matters when attempting to educate older adults on the importance of controlling their blood pressure. Not only does the public need education on the new acceptable range of blood pressure measures, practical everyday ways to control blood pressure are not routinely expressed or understood by elders. The *RWJF Data Portrait: Chronic Illness in America*, notes as a key finding “of those with high blood pressure, 46 percent say they were never advised to increase their exercise. Research suggests that regular exercise can lower blood pressure and reduce the risk of heart disease and stroke.”

Depression

According to the National Academy on Aging Society, 25 –33% of persons with other chronic conditions such as cardiovascular disease, diabetes and arthritis are considered depressed. Depression is a serious problem associated with functional decline among frail elders. The U. S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up. The Task Force has evidence that screening improves the accurate identification of depressed patients in primary care settings and

that treatment of depressed adults identified in primary care settings decreases clinical morbidity.

The Merck Institute of Aging and Health and the Gerontological Society of America released a report titled “The State of Aging and Health in America”. The report included an excellent summary titled “Older Americans’ Use of Mental Health Services”.

- Older Americans account for only 7% of all inpatient mental health services, 6% of community-based mental health services, and 9% of private psychiatric care (Persky, 1998).
- It is estimated that only half of older adults who acknowledge mental health problems actually receive treatment from any health care provider, and fewer than 3% of those receive outpatient mental health treatment by specialty mental health providers, a rate that is lower than for any other adult age group (Lebowitz et al., 1997).

The report notes that the mistaken belief that depression is a natural part of aging is a barrier to older adults getting care for depression and mental illness. Older adults also tend to emphasize their physical complaints when visiting their physicians, even when depression is a major cause of their discomfort. There remains a stigma to mental illness among the elder population, who often believe that you just “tough it out.” The article notes that primary care physicians should be the first line of defense for identifying depression in the elderly, yet they may remain as uninformed about the condition and how to detect it. One study found a sad fact, that 70 percent of elders who had committed suicide in the study had visited their primary care physician within one month of the suicide.

An article posted on the Medscape website entitled “Measuring Depression in the Elderly: Which Scale is Best?” identified the Geriatric Depression Scale as being the most useful scale for measuring depression in the elderly and that depression in the elderly is often undiagnosed or untreated. It has been estimated that only 10% of depressed elderly receive treatment. Thus, accurate assessment of depression in the elderly poses a challenge because they may deny that they are depressed despite having classic symptoms of depression. Moderate to severe cognitive impairment can also complicate diagnosing depression in the elderly. While the Geriatric Depression Scale has been validated as being the most useful scale for measuring depression in the elderly, little research has been conducted as to useful measures of detecting depression in the cognitively impaired.

One policy barrier to good depression management is the fact that Medicare coverage rules require seniors to pay 50% co-pay for outpatient mental health services compared to 20% for general medical services. Not only does this preclude the elder from seeking care from a psychiatrist, it discourages psychiatrists from accepting Medicare patients. This disparity makes it more crucial for primary care physicians to identify and treat depression in their elderly patients.

Population to be Served

The workgroup targeted vulnerable seniors defined as any senior at home who is over age 75 or someone age 60 or older with 1 Activity of Daily Living (ADL) limitation or 2 Instrumental Activities of Daily Living (IADL) limitations.

F. Rationale for Selection of Initiatives

The health care system is based on acute care models of service delivery, yet caring for those with chronic conditions now dominate most medical practices. Providers need support in caring for those with chronic disease and there is evidence that people with chronic disease have better outcomes if they actively participate in their care management. As noted by the American College of Physicians, “Patients and families struggling with chronic illness have different needs, and these needs are unlikely to be met by an acute care organization and culture. They required planned, regular interactions with their caregivers, with a focus on function and prevention of exacerbations and complications. This interaction includes systematic assessments, attention to treatment guidelines, and behaviorally sophisticated support for the patient’s role as self-manager.”

Systems change in medical care delivery will be incremental as we begin to move from an acute care model of medical care to a chronic care model. Community based human service agencies may find themselves in new partnerships with primary care providers as the system moves to one that is driven by partnerships, patient self-management and a holistic approach to overall health maintenance.

The Chronic Care Model

The Chronic Disease Management Workgroup reviewed the essential elements of a chronic disease management system as outlined by the Improving Chronic Illness Care (ICIC), a national program of The Robert Wood Johnson Foundation. Using information from the literature and input from national experts, the ICIC developed the Chronic Care Model.

The Chronic Care Model identifies the essential elements of a system that encourages high quality chronic disease management: community; health care systems; self-management support; delivery system design; decision support; and clinical information systems. The RWJF Improving Chronic Care web site notes that by creating effective self-management supports providers and patients working together to define problems, set priorities, establish goals and create treatment plans can positively impact health outcomes. Patients benefit from information on best practices related to minimizing complications, symptoms and disability.

Our community has longstanding formal and informal partnerships between health care providers and human service networks addressing a variety of issues. Building on this strength, the Chronic Disease Workgroup focused primarily on two of the essential elements, those that support community resources and self-management support. The

group recognizes the importance of all elements, but felt that our sphere of influence could most effectively be applied to the development of enhancements in these areas.

Community Resources and Self-Management

The Senior Wellness Program (SWP) in Bothel, Washington has adopted the Chronic Disease Self-Management Program, developed by Kate Lorig at Stanford University, as the foundation for their program model. This community-based program uses volunteers and consumers themselves to take the lead in three program components: health enhancement; fitness and chronic disease self-management. The SWP has demonstrated that patient self-management can be promoted and supported by partnering health, education and human service agencies in the community, thus leading to significant cost benefit to insurers and better health outcomes for patients.

The John A Hartford Foundation funded a local initiative from 1992 to 1996. System Case Management was a primary care-based coordination service offered to patients over 60 years of age who needed assistance in achieving their maximum wellness potential and/or negotiating local health and social service resources. Advanced practice nurses worked with primary care physicians at United Medical Associates to act as an advocate and advisor to at-risk patients over age 60 and their care providers. As noted by one of the advance practice nurses who participated in the study and was a member of this workgroup, “We found that elders who actively participated in their care management had better outcomes than those who were passive and who sat back and ‘let you do it’.”

By focusing on community resources and self-management programs, activities will be developed for frail elders that are user friendly and that address the management of hypertension and depression in our community. To ensure continuity of care, efforts will be made to coordinate community based chronic disease supports with medical services. For example, patients will be provided with records and tools to make it easier for them to record their daily blood pressure readings and share this information with their numerous medical providers. Physicians will be made aware that patients are keeping track of BP and be encouraged to reinforce that effort by discussing with their patients the importance of “taking charge” of that responsibility. Physicians will also be encouraged to relate to the patients how much easier it makes their job to work in partnership with their patients when managing chronic conditions such as hypertension.

II. SPECIFIC IMPLEMENTATION STRATEGIES PROPOSED

A. Hypertension/Stroke Prevention Initiative

1. Outcome

Outcomes that will be achieved as part of personalized goals and action plans include, lower blood pressure and weight loss combined with an emphasis on diet and exercise. Outcomes will be tracked through the outpatient clinical information systems of each health system and their affiliated physician practices.

2. Output

This strategy will lead to increased detection and self-management of hypertension. Physicians will be given information on best practices in geriatric hypertension management and made aware of the patient self-management model. Physician practices will be provided with literature and tools on using a collaborative approach with patients who are diagnosed with high blood pressure. Patients taking part in the self-management program will be offered support group sessions and be assigned a peer mentor who will assist them over the course of twelve months.

3. Activities

Community Component of Chronic Care Model

- Develop and implement community awareness/media campaign regarding new blood pressure guidelines and local supports. Media will include billboards and PSAs and will link to an Aging Futures campaign promoting the theme of “Stay Connected Stay Well”.
- Develop and implement a marketing plan to expand availability of community based hypertension screenings at grocery stores, faith communities, and other community sites frequented by seniors.
- Purchase necessary equipment for individuals and programs supporting hypertension management (i.e. large cuffs for Parish Nurses, easy to use blood pressure monitors to be shared among seniors residing in high rise centers, emergency squad volunteers, meals on wheels volunteers and Broome County Council of Churches Interfaith Volunteers who frequently interact with frail seniors frequently).
- Partner with participating provider practices to reinforce and monitor blood pressure status of participants identified by the providers. Participants will be offered personalized health management tools that include information and charting opportunities for blood pressure information and support behavior change and communication about blood pressure status with providers.

- Participants will be matched with a peer mentor to assist them in using the management tools and developing good self-management practices.

Self Management Support of Chronic Care Model

A Request for Proposals will be issued to identify a subcontractor to coordinate a self-management program. The subcontractor will:

- Recruit, train, and support volunteers Volunteers will be recruited from a variety of communities with efforts to match volunteers with participants from those communities.
- Create new hypertension self-management program Participants will define their goals and personalized health action plans in collaboration with their provider. Volunteers will work with participants over a twelve-month period of time by conducting support groups and serving as peer mentors, either in person or over the phone, to those who are managing hypertension.
- Create hypertension self-management protocol for physician practices Participating physician groups will be provided with information and tools on working with patients to control their hypertension. Primary care provider education will focus on management of geriatric hypertension. It is often difficult for primary care providers to keep up with the latest medical information in any one disease group. Our initiative will compile the most recent and proven data in the field of hypertension management and organize that for the providers. We will pay particular attention to studies that denote the effects of self-management on positive outcomes.

Additional Activities That Will Enable Us to Work Toward Full Implementation of ICIC Model

- Develop an RFP to support the Quality Initiative. The focus will be on medical office education to increase primary care provider awareness in screening and working with patients with hypertension as part of every office visit. Our education with the office staff will include a discussion of how they incorporate hypertension screening and discussion in the course of routine exams. We will provide staff with information on best practices and brainstorm ways to measure compliance.
- Determine feasibility of linkages to outpatient clinical information systems within the health systems and affiliated physician practices so that providers can efficiently track outcomes and coordinate referrals.

4. Assumptions for Outcomes, Outputs and Activities

- Seniors need education, support and motivation to better manage hypertension.
- Providers need support and tools to systematize how hypertension is managed in a primary care setting.
- Community supports can reinforce good self-management between primary care visits.
- Supports and services must be relevant and accessible to seniors or provided in an in-home setting.
- Coordination between volunteer, community based and clinical settings will enhance the delivery of care.
- Criteria for selection of lead agency will include experience and success in implementing similar initiatives, capacity, commitment, credibility in community, knowledge, commitment to a community-wide project involving multiple sectors and providers.

B. Initiative for Feeling Better and Getting Out of Depression

1. Outcomes

Outcomes that will be achieved through personalized goals and action plans include improved functional status as a result of improved emotional health and well being of patients. Potential tools to assist in measuring these outcomes are functional health status surveys that are done pre and post intervention, and the use of the Rand SF-36 survey or similar tool. Measures will also be developed and tracked through outpatient clinical information systems of each health system and their affiliated physician practices.

2. Outputs

Outputs to be achieved will include: increased detection of depression among vulnerable seniors with other chronic conditions or functional limitations; improved intervention due to support from primary providers who are aware of best practices in management of geriatric depression; increased community awareness of depression among the elderly; and increase in self-referral for assistance.

3. Activities

Community Component of Chronic Care Model

Community programs enhance a health care system's ability to care for chronically ill patients.

- Media campaign to increase community awareness, reduce stigma of depression and to encourage seniors to take a participatory role in their health care and to seek help from their primary provider.
- Education on existing services and interventions for elders with depression will be provided to hospital discharge planning staff and provider office staff to support elders in their efforts to manage their depression. For instance, a person may be experiencing anxiety and depression due to financial concerns; these concerns may be addressed via existing programs such as consumer credit counseling or the senior health insurance counseling program. Appropriate referrals to existing programs that address management of chronic conditions such as diabetes or social circumstances such as dealing with the death of a loved one may go along way to address underlying problems.
- Increase use of simple, effective, easy to administer depression screening tool at the following sites in year three:
 - a. Selected inpatient medical/surgical units of participating hospitals
 - b. Interested primary care physician practices affiliated with each health system
 - c. Independent family practices
 - d. Depression screening and follow-up referral for caregivers involved in the Aging Futures Caregiver Support Initiative
- Increase use of depression screening tool to sub-specialists in year 4:
 - a. Interested specialty physician practices
 - b. Specialty offices
 - c. Physical therapy settings

Self-Management Component of Chronic Care Model

- Increase use of depression screening tools by making them widely available at community sites and on-line via the Elder Services Guide. The Geriatric Depression Scale was developed to be a self-administered test and could be made available via a wide array of community venues.

- After self-assessment, ensure that information on obtaining assistance is readily available in a variety of formats.
- Educate providers on geriatric depression management and how to discuss and work in partnership with patients on managing the condition.
- Partner with local physical fitness programs to emphasize the connection between staying active and managing depression.

Additional Activities That Will Enable Us to Work Toward Full Implementation of Improving Chronic Illness Care (ICIC)

- Determine feasibility of linkages to outpatient clinical information systems within the health system and affiliated physician practices so that providers can efficiently track progress, outcomes and coordinate referrals and follow-up.

4. Assumptions for Outcomes, Outputs and Activities

- Depression is a difficult topic to approach with seniors.
- By decentralizing screenings and supports, seniors are more likely to receive services.
- Community supports will be utilized more readily if trusted physicians make referrals.
- The stigma of depression among the elderly will be reduced if the community responds in a coordinated and integrated manner.
- Depression strategies need to include the clear message that it is possible to manage depression and recover from it.
- Criteria for selection of lead agency will include experience and success in implementing similar initiatives, capacity, commitment, credibility in community, knowledge, commitment to a community-wide project involving multiple sectors and providers.

Conclusion

The strategies identified for both hypertension and depression involve building on existing capacity, yet they also involve a strong self-management component that partners the elder with their provider. The self-management component is not only consistent with the Improving Chronic Illness Care model but has been endorsed by the American College of Physicians who are encouraging physicians to work with their patients in developing “self-management support that gives priority to increasing patient’s confidence and skills so that they can be the ultimate manager of their illness.” Elders need to be empowered to recognize the impact they can have on managing their chronic conditions when they take control of their circumstances. With the support of their physician, they are more likely to be successful if they believe their physician takes an interest in their success and works with them on a plan.

The Aging Futures Partnership has secured the commitment of the organizations and provider networks that will assist us in successfully implementing these strategies. The chairs of the Chronic Disease Management Workgroup thank those who enthusiastically gave their time and talent to formulating these strategies and look forward to working with the community to see that our vision for a healthier, functional and independent old age is achieved.