Administration on Aging (AoA)

Agency Highlight:
AoA is committed to furthering the implementation of the HHS MCC Framework with its various programs and activities, which encourage the facilitation of home and community-based services, emphasize prevention outreach, and focus on the implementation of care coordination models that lead to improved health outcomes. Towards this end, AoA has awarded grants to 45 states, Puerto Rico and the District of Columbia to deliver evidence-based chronic disease self-management programs to older adults with chronic diseases. The purpose of these grant awards is also to build statewide distribution and delivery systems to increase the availability of these programs and provide a distribution channel for other evidence based programs that may be delivered by community based organizations. Thus far, grantees in 46 states and the District of Columbia have hosted 3,142 workshops which have reached 34,173 participants, of whom 25,220 have completed four of six sessions (retention rate of 74%). 58.5% of participants indicate having more than one chronic condition.

To learn more:
http://www.aoa.gov/AoARoot/AoA_Programs/HPW/ARRA/index.aspx

Centers for Medicare and Medicaid Services (CMS)

Agency Highlight:
Through the Medicaid program, CMS supports its state partners in providing technical assistance for quality home and community-based services, innovative service delivery models, and person-centered programs and practices. CMS has provided recent guidance to state Medicaid directors on a new optional benefit available January 1, 2011, through the Affordable Care Act, that will provide health homes to enrollees who have at least two chronic conditions, as well as to those who have one chronic condition, but are deemed to be at risk for another. CMS is presently providing technical assistance to States that have expressed an interest in this benefit. Three states have submitted state plan amendments (SPAs) to include the state health home option. Many other states have expressed their interest.

CMS is also working with its state partners to develop new delivery system and payment models for dual eligibles (individuals eligible for both Medicare and Medicaid coverage), a population with large numbers of individuals with MCC. 15 states have been selected to design new approaches to better coordinate care for dual eligible individuals. CMS will provide funding and technical assistance to these States to develop person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for this population. CMS will also allow states access to Medicare data for dual eligible beneficiaries. Through access to and an informed use of

data across the individual's health care experience, States can better coordinate care to improve quality, costs and the beneficiary's experience.

To learn more:
(1) http://www.cms.gov/smdl/downloads/SMD10024.pdf
(2) http://www.cms.gov/DualEligible/01_Overview.asp - TopOfPage

The Partnership for Patients: Better Care, Lower Costs

Description:
The Partnership for Patients: Better Care, Lower Costs is a new public-private partnership that will help improve the quality, safety and affordability of health care for all Americans. The two goals of this new partnership are to:

> **(1) Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
>
> **(2) Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Because a substantial proportion of preventable hospital readmissions occur among individuals with MCC, the Partnership for Prevention's second goal is especially related to key elements of the HHS Strategic Framework on Multiple Chronic Conditions.

Using as much as $1 billion in new funding provided by the Affordable Care Act and leveraging a number of ongoing programs, the Department of Health and Human Services (HHS) will work with a wide variety of public and private partners to achieve the two core goals of this partnership. We encourage you to learn more about this Initiative and join hundreds of organizations across the country to partner together in improving patient safety, quality, and the affordability of health care for all.

To join, visit:
http://www.healthcare.gov/center/programs/partnership/join/index.html