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

**Compiled by the HHS Interagency Workgroup on
Multiple Chronic Conditions**



**Department of Health and Human Services
Office of the Secretary
Office of the Assistant Secretary for Health**

SEPTEMBER 2011

Suggested Citation:

U.S. Department of Health and Human Services. U.S. Department of Health and Human Services (HHS) Inventory of Programs, Activities and Initiatives Focused on Improving the Health of Individuals with Multiple Chronic Conditions (MCC). Compiled by the *HHS Interagency Workgroup on Multiple Chronic Conditions* under the direction of Anand Parekh, MD, MPH, Deputy Assistant Secretary for Health (Science and Medicine), Office of the Assistant Secretary for Health. September 2011

DISCLAIMER

This publication does not constitute medical advice; individuals seeking health care advice should consult their personal physicians. The purpose of this inventory is to provide basic information about existing (as of September 2011) HHS programs for researchers, providers, and organizations concerned about improving the care of individuals with multiple chronic conditions (MCC). This inventory consists of information self-reported by HHS agencies and includes programs that are primarily focused on the MCC population. Because other HHS programs that serve individuals with MCC may not have been included, this inventory should not be considered as an exhaustive compilation of Federal activities for persons with MCC.

Table of Contents

I. FOREWORD..... 5

II. INTRODUCTION 7

III. PROGRAMS, ACTIVITIES, AND INITIATIVES BY HHS MCC FRAMEWORK OBJECTIVES 8

GOAL 1: FOSTER HEALTH CARE AND PUBLIC HEALTH SYSTEM CHANGES TO IMPROVE THE HEALTH OF INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS..... 14

GOAL 2: MAXIMIZE THE USE OF PROVEN SELF-CARE MANAGEMENT AND OTHER SERVICES BY INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS..... 42

GOAL 3: PROVIDE BETTER TOOLS AND INFORMATION TO HEALTH CARE, PUBLIC HEALTH, AND SOCIAL SERVICES WORKERS WHO DELIVER CARE TO INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS 53

GOAL 4: FACILITATE RESEARCH TO FILL KNOWLEDGE GAPS ABOUT, AND INTERVENTIONS AND SYSTEMS TO BENEFIT, INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS. 62

IV. APPENDIX: PROGRAMS, ACTIVITIES, AND INITIATIVES BY AGENCY 97

I. Foreword

In December 2010, the U.S. Department of Health and Human Services (HHS) released the document, *Multiple Chronic Conditions: A Strategic Framework* (HHS MCC Strategic Framework), to guide the HHS in coordinating its efforts internally and collaborating with stakeholders externally in improving the health status of individuals with multiple chronic conditions (MCC).¹

An important aim for this framework has been to help catalyze major change in addressing chronic illnesses in the United States—from a focus on individual chronic diseases to one that uses a MCC approach. It is this culture change, or paradigm shift, and the subsequent implementation of framework strategies that provide a foundation for realizing the vision of optimum health and quality of life for individuals with MCC.

In 2008, the HHS Assistant Secretary for Health first convened the Interagency Workgroup on Multiple Chronic Conditions under the direction of the Deputy Assistant Secretary for Health (Science and Medicine). This Workgroup includes representatives from the following divisions of HHS:

- Administration for Children and Families (ACF)
- Administration on Aging (AoA)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Services (IHS)
- National Institute of Health (NIH)
- Office of the Assistant Secretary for Health
- Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Office of the National Coordinator for Health Information Technology (ONC)
- Office on Disability (OD)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

The Workgroup produced this compilation – the *U.S. Department of Health and Human Services Inventory of Programs, Activities, and Initiatives Focused on Improving the Health of Individuals with Multiple Chronic Conditions (HHS Inventory)* – to catalog HHS activities, programs, and initiatives in support of the goals and objectives of the HHS MCC Strategic Framework. The inventory aims to provide basic information about existing (as of September 2011) HHS programs for researchers, providers, and organizations concerned about improving the care of

¹ US Department of Health and Human Services, *Multiple Chronic Conditions: A Strategic Framework*, <http://www.hhs.gov/ash/initiatives/mcc/>

individuals with multiple chronic conditions. The information has been self-reported by HHS agencies and includes programs that are primarily focused on the MCC population. Because other HHS programs that serve individuals with MCC may not have been included, this inventory should not be considered as an exhaustive compilation of Federal activities for people with MCC.

This inventory is intended to assist HHS by creating linkages and synergies between existing programs in the Department, as well as by delineating the gaps that exist in supporting the implementation of the goals and objectives outlined in the HHS MCC Framework.

II. Introduction

The HHS MCC Framework comprises four major, overarching goals that support the Department's vision for optimum health and quality of life for individuals with multiple chronic conditions. These goals are to:

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

Each of these goals includes several key objectives and strategies that HHS—in conjunction with stakeholders and those who have or who provide care for individuals with MCC—can use to guide efforts to address MCC.

The HHS Inventory is a compilation of major activities, initiatives, and programs at the Federal level across the divisions of HHS. The HHS Inventory has been organized around the Framework's four major goals and sixteen objectives. Each entry has been catalogued under a primary goal and objective, although more than one goal and/or objective may apply to a particular entry. In addition, the appendix organizes the inventory entries according to HHS Divisions.

Programs, activities, and initiatives selected to be part of this inventory are directed toward improving the care of individuals with MCC. MCC are defined as at least two or more conditions that last at least one year or more and require ongoing medical attention. These include physical conditions (e.g., arthritis, asthma, chronic respiratory conditions, diabetes, heart disease, HIV infection, hypertension), behavioral health conditions (e.g., mental disorders, substance use and addiction disorders, dementia), and intellectual/developmental disabilities.

For each of the 111 entries listed, the inventory includes a brief description of the program's scope and current status, associated web links and/or publications, information about collaborating HHS agencies, and contact information. In addition, each entry describes the related HHS MCC Framework goals, objectives, and strategies that it supports in implementing.

III. Programs, Activities, and Initiatives by HHS MCC Framework Objectives

GOAL 1: FOSTER HEALTH CARE AND PUBLIC HEALTH SYSTEM CHANGES TO IMPROVE THE HEALTH OF INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS.....	14
---	-----------

OBJECTIVE A: IDENTIFY EVIDENCE-SUPPORTED MODELS FOR PERSONS WITH MULTIPLE CHRONIC CONDITIONS TO IMPROVE CARE COORDINATION	14
CDC: JAIL-BASED INTEGRATION OF HIV/SEXUALLY TRANSMITTED INFECTION (STI)/HEPATITIS SCREENING, HEPATITIS B VACCINATION, AND LINKAGE TO CARE AND TREATMENT	14
CMS: MEDICARE COORDINATED-CARE DEMONSTRATION	15
CMS/CMMI: CARE MANAGEMENT FOR HIGH-COST BENEFICIARIES DEMONSTRATION	15
CMS/CMMI: INDEPENDENCE AT HOME DEMONSTRATION	16
HRSA: IMPROVING THE INTEGRATION OF BEHAVIORAL HEALTH CARE AND PRIMARY CARE DELIVERY.....	17
HRSA/BHPR: THE PATIENT NAVIGATOR OUTREACH AND CHRONIC DISEASE PREVENTION DEMONSTRATION PROGRAM	17
IHS: IMPROVING PATIENT CARE PROGRAM	18
NIH/NIMH: A RANDOMIZED TRIAL IN LIAISON PSYCHIATRY IN PRIMARY CARE.....	19
SAMHSA: PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION GRANT PROGRAM	20
OBJECTIVE B: DEFINE APPROPRIATE HEALTH CARE OUTCOMES FOR INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS	21
CMS/CMMI/REG: ADVERSE EVENTS AMONG CHRONICALLY ILL BENEFICIARIES	21
CMS/CMMI/REG: MONITORING CHRONIC DISEASE CARE AND OUTCOMES AMONG ELDERLY MEDICARE BENEFICIARIES WITH MULTIPLE CHRONIC DISEASES.....	21
OBJECTIVE C: DEVELOP PAYMENT REFORM AND INCENTIVES	22
CMS/CMMI/REG: CHRONICALLY CRITICALLY ILL POPULATION PAYMENT REFORM	22
CMS/CMMI/REG: DETERMINING MEDICAL NECESSITY AND APPROPRIATENESS OF CARE AT MEDICARE LONG TERM CARE HOSPITALS.....	23
CMS/CMMI/REG: GROUPING OF CLINICAL EPISODES AND MEASURING PHYSICIAN RESOURCE USE IN MEDICARE	24
CMS/CMMI/MEDICARE DEMONSTRATION PROGRAM GROUP: AFFORDABLE CARE ACT SECTION 4108 – MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES.....	24
CMS/CMMI/REG: POST ACUTE CARE PAYMENT REFORM DEMONSTRATION FOR MEDICARE	25
OBJECTIVE D: IMPLEMENT AND EFFECTIVELY USE HEALTH INFORMATION TECHNOLOGY	26

AHRQ: AMBULATORY SAFETY AND QUALITY PROGRAM: IMPROVING MANAGEMENT OF INDIVIDUALS WITH COMPLEX HEALTHCARE NEEDS THROUGH HEALTH IT.....	26
CDC: USING DISTANCE TECHNOLOGY FOR TREATING DEPRESSION IN PEOPLE WITH EPILEPSY: PROJECT UPLIFT: USING PRACTICE AND LEARNING TO INCREASE FAVORABLE THOUGHTS	27
CMS/CSP: CMS CHRONIC CONDITIONS DATA WAREHOUSE	27
NIH/NINR: TELEHEALTH NURSING INTERVENTION FOR CHILDREN WITH COMPLEX HEALTH CARE NEEDS.....	28
OBJECTIVE E. PROMOTE EFFORTS TO PREVENT THE OCCURRENCE OF NEW CHRONIC CONDITIONS AND TO MITIGATE THE CONSEQUENCES OF EXISTING CONDITIONS	29
CDC: NATIONAL NETWORK OF TOBACCO CESSATION QUITLINES, 1-800 QUIT NOW	29
CDC: NATIONAL TOBACCO CONTROL PROGRAM	29
CDC: IOM STUDY ON LIVING WELL WITH CHRONIC DISEASE: PUBLIC HEALTH ACTION TO REDUCE DISABILITY AND IMPROVE FUNCTIONING AND QUALITY OF LIFE	30
CDC: NATIONAL COMPREHENSIVE CANCER CONTROL PROGRAM.....	30
CDC: REDUCE DISPARITIES IN OBESITY AND OTHER HEALTH INDICATORS IN CHILDREN, YOUTH, AND ADULTS WITH DISABILITIES.....	31
CDC: VISION HEALTH INITIATIVE.....	31
IHS: HEALTHY HEART PREVENTION INITIATIVE.....	32
NIH/NCI: CANCERSPACE (CANCER – SIMULATING PRACTICE AND COLLABORATIVE EDUCATION)	33
SAMHSA: SUBSTANCE ABUSE AND HIV PREVENTION READY-TO-RESPOND INITIATIVE IN COMMUNITIES HIGHLY IMPACTED BY SUBSTANCE USE AND HIV INFECTION DESCRIPTION.....	34
SAMHSA: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT: HIV/AIDS SET-ASIDE.....	34
SAMHSA: THE 10X10 WELLNESS CAMPAIGN	35
SAMHSA: TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE TREATMENT AND HIV/AIDS SERVICES	35
OBJECTIVE F. PERFORM PURPOSEFUL EVALUATION OF MODELS OF CARE, INCENTIVES, AND OTHER HEALTH SYSTEM INTERVENTIONS	36
ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY PROGRAM TITLE: ANALYSIS OF THE 2010 NATIONAL SURVEY OF RESIDENTIAL CARE FACILITIES (NSRCF)	36
ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CHRONIC HOMELESSNESS PERMANENT SUPPORTIVE HOUSING PROGRAMS EVALUATION	37
ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF NEW DEVELOPMENTS IN HOUSING WITH SERVICES TO ENHANCE AGING IN PLACE FOR OLDER ADULTS.....	37

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF THE MEDICAID STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.....	38
CDC: ENHANCED COMPREHENSIVE HIV PREVENTION PLANNING AND IMPLEMENTATION FOR METROPOLITAN STATISTICAL AREAS MOST AFFECTED BY HIV/AIDS: PHASE II	39
CMS: SENIOR RISK REDUCTION DEMONSTRATION (SRRD)	39
HRSA/BPHC: HEALTH CENTERS	40

GOAL 2: MAXIMIZE THE USE OF PROVEN SELF-CARE MANAGEMENT AND OTHER SERVICES BY INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS.....	42
--	-----------

OBJECTIVE A: FACILITATE SELF-CARE MANAGEMENT.....	42
AOA: CHRONIC DISEASE SELF-MANAGEMENT PROGRAM	42
CDC: ADDRESSING ARTHRITIS IN THE CONTEXT OF CO-MORBID CONDITIONS.....	42
CDC: WISEWOMAN	43
CMS/CMMI/REG: EVALUATION OF COMMUNITY BASED WELLNESS AND PREVENTION PROGRAM IN THE UNITED STATES	44
OBJECTIVE B: FACILITATE HOME AND COMMUNITY-BASED SERVICES	45
ACF/ADD: STATE COUNCILS ON DEVELOPMENTAL DISABILITIES	45
ACF/ADD: STATE PROTECTION AND ADVOCACY AGENCIES	45
AOA: ALZHEIMER’S DISEASE SUPPORTIVE SERVICE PROGRAM	46
AOA: COMMUNITY BASED CARE TRANSITIONS.....	46
ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CAREGIVER SUPPLEMENT TO THE NATIONAL HEALTH AND AGING TRENDS SURVEY	47
CDC: PEARL DEPRESSION TREATMENT FOR ADULTS WITH EPILEPSY	48
HRSA/MCHB: CHILDREN WITH SPECIAL HEALTH CARE NEEDS.....	48
HRSA/MCHB: FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS (F2F HICS)	49
IHS: ELDER CARE INITIATIVE LONG TERM CARE GRANTS	50
OBJECTIVE C: PROVIDE TOOLS FOR MEDICATION MANAGEMENT.....	51
AHRQ: TOOL FOR IMPROVED MEDICATION FOR ELDERLY VIA REVIEW (TIMER)	51
HRSA/HSB: PATIENT SAFETY AND CLINICAL PHARMACY SERVICES COLLABORATIVE.....	51
NIH/NINR: ADHERENCE & HRQOL: TRANSLATION OF INTERVENTIONS.....	52

GOAL 3: PROVIDE BETTER TOOLS AND INFORMATION TO HEALTH CARE, PUBLIC HEALTH, AND SOCIAL SERVICES WORKERS WHO DELIVER CARE TO INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS.....	53
--	-----------

OBJECTIVE A: IDENTIFY BEST PRACTICES AND TOOLS	53
---	-----------

AHRQ: COMPARATIVE EFFECTIVENESS REVIEW ON EFFECTIVENESS OF INTERVENTIONS ADDRESSING CONCOMITANT MENTAL HEALTH AND CHRONIC MEDICAL CONDITIONS IN THE PRIMARY CARE SETTING.....	53
AHRQ: MEASURES FOR THE MEDICAID HOME AND COMMUNITY-BASED SERVICES POPULATION	53
ASPE/HEALTH POLICY: CONSENSUS DEVELOPMENT PROCESS FOR MEASURE ENDORSEMENT: ESTABLISHING A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS	54
HRSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS	55
OASH/OFFICE OF WOMEN’S HEALTH: PROVIDING BETTER TOOLS AND INFORMATION FOR HEALTH CARE WORKERS DELIVERING CARE TO WOMEN WITH MULTIPLE CHRONIC CONDITIONS CARDIOVASCULAR DISEASE, DEPRESSION, AND OTHER CO-MORBIDITIES.....	56
SAMHSA: SHARED DECISION MAKING	56
SAMHSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS.....	57
OBJECTIVE B: ENHANCE HEALTH PROFESSIONALS TRAINING	58
ACF/ADD: UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES (UCEDD) IN EDUCATION, RESEARCH AND SERVICES	58
NIH/NINR: MULTIPLE MORBIDITIES IN VULNERABLE POPULATIONS: NURSE SCIENTIST TRAINING	58
SAMHSA: RECOVERY-TO-PRACTICE	59
OBJECTIVE C: ADDRESS MULTIPLE CHRONIC CONDITIONS IN GUIDELINES	60
CDC: US MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2010	60
HRSA/HAB: QUALITY CARE – PATIENTS WITH HIV/AIDS.....	60
IHS: INJURY PREVENTION PROGRAM INITIATIVE TO PREVENT FALL-RELATED INJURY IN OLDER AMERICAN INDIANS AND ALASKA NATIVES LIVING IN THE COMMUNITY.....	61
GOAL 4: FACILITATE RESEARCH TO FILL KNOWLEDGE GAPS ABOUT, AND INTERVENTIONS AND SYSTEMS TO BENEFIT, INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS.	62
OBJECTIVE A: INCREASE THE EXTERNAL VALIDITY OF TRIALS	62
FDA: INVENTORY OF CLINICAL TRIALS TO SUPPORT HHS MULTIPLE CHRONIC CONDITIONS INITIATIVE.....	62
NIH/NCI: CTEP INITIATIVES TO INCLUDE INDIVIDUALS WITH HIV AND CANCER ONTO NCI-SPONSORED CANCER CLINICAL TRIALS	62
OBJECTIVE B: UNDERSTAND THE EPIDEMIOLOGY OF MULTIPLE CHRONIC CONDITIONS	63
CDC: EXAMINING PREVALENCE AND IMPLICATIONS OF ARTHRITIS FOR ADULTS WITH CO-MORBID CHRONIC CONDITIONS	63
CMS/CSP: REPORT ON CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES	64

NIH/NIMH: CENTRAL NERVOUS SYSTEM HIV ANTI-RETROVIRAL THERAPY EFFECTS RESEARCH (CHARTER).....	65
OBJECTIVE C: INCREASE CLINICAL, COMMUNITY, AND PATIENT-CENTERED HEALTH RESEARCH.....	66
AHRQ: COMPARATIVE EFFECTIVENESS RESEARCH TO OPTIMIZE PREVENTION AND HEALTHCARE MANAGEMENT FOR THE COMPLEX PATIENT.....	66
AHRQ: EXPANSION OF RESEARCH CAPABILITY TO STUDY COMPARATIVE EFFECTIVENESS IN COMPLEX PATIENTS.....	67
ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: INDIVIDUALS LIVING IN THE COMMUNITY WITH CHRONIC CONDITIONS AND FUNCTIONAL LIMITATIONS: A CLOSER LOOK...	67
CDC: EXAMINING THE IMPACT OF COGNITIVE IMPAIRMENT ON CO-OCCURRING CHRONIC CONDITIONS AND GERIATRIC SYNDROMES.....	68
NIH/NCI: AIDS MALIGNANCY CLINICAL TRIALS CONSORTIUM (AMC)	68
NIH/NCI: COMMUNITY-ENGAGED RESEARCH ON HIV/AIDS-RELATED CANCERS AMONG UNDERSERVED POPULATIONS.....	69
NIH/NCI: NCI ORGAN DYSFUNCTION WORKING GROUP	70
NIH/NEI: LOW VISION AND CLINICAL DEPRESSION	71
NIH/NHLBI: REDUCING CARDIOVASCULAR DISEASE RISK THROUGH TREATMENT OF OBSTRUCTIVE SLEEP APNEA.....	72
NIH/NIA: DEVELOPING INTERVENTIONS FOR MULTIMORBIDITIES.....	73
NIH/NIAAA: INTERVENTIONS FOR ALCOHOL USE DISORDERS AND HIV/AIDS: REDUCING ACQUISITION, PROGRESSION, TRANSMISSION OVER THE LIFESPAN.....	74
NIH/NIAAA: TREATMENT OF CO-OCCURRING ALCOHOL USE DISORDERS AND DEPRESSION/ANXIETY DISORDERS.....	75
NIH/NICHD: OBESITY RESEARCH	77
NIH/NIDA: CO-OCCURRING DRUG ABUSE AND HIV	78
NIH/NIDA: CO-OCCURRING DRUG ABUSE/ADDICTION AND CHRONIC PAIN.....	78
NIH/NIDA: CO-OCCURRING SUBSTANCE ABUSE/ADDICTION AND OTHER MENTAL HEALTH DISORDERS.....	79
NIH/NIDCR: DIABETES AND PERIODONTITIS RESEARCH PROGRAM	80
NIH/NIDDK: DEPRESSION AND DIABETES.....	81
NIH/NIDDK: ENHANCING TREATMENT ADHERENCE IN PATIENTS WITH MULTIPLE CHRONIC CONDITIONS.....	82
NIH/NIMH: ADDRESSING DEPRESSION AND ANTI-RETROVIRAL THERAPY ADHERENCE IN HIV-POSITIVE ADULTS ON THE US-MEXICO BORDER.....	83
NIH/NIMH: DEPRESSION-DIABETES CARE DISPARITIES, ADVERSE OUTCOMES.....	83

NIH/NIMH: DEPRESSION, ESTROGEN REPLACEMENT, AND CARDIOVASCULAR HEALTH IN PERIMENOPAUSE.....	85
NIH/NIMH: EFFICACY OF COGNITIVE BEHAVIOURAL THERAPY FOR TREATMENT ADHERENCE AND DEPRESSION IN HIV CARE SETTINGS	85
NIH/NIMH: LINKAGE AND RETENTION: A RANDOMIZED TRIAL TO OPTIMIZE HIV/TB CARE IN SOUTH AFRICA	86
NIH/NIMH: PREVENTION OF POST-STROKE DEPRESSION AND MORTALITY.....	87
NIH/NIMH: STEPPED CARE FOR DEPRESSION AND MUSCULOSKELETAL PAIN	87
NIH/NIMH: THE SAFETY AND EFFICACY OF USING SERTRALINE FOR TREATING DEPRESSION IN PATIENTS WITH CONGESTIVE HEART FAILURE	88
NIH/NINDS: RESEARCH ON COMORBID CONDITIONS OF EPILEPSY	89
NIH/NINR: CHRONIC CO-MORBID CONDITIONS IN HIV+ U.S. ADULTS ON HIGHLY EFFECTIVE ANTI-RETROVIRAL THERAPY	90
NIH/NINR: CHRONIC ILLNESS SELF-MANAGEMENT IN CHILDREN AND ADOLESCENTS.....	90
NIH/NINR: COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA IN STABLE HEART FAILURE.....	91
NIH/NINR: COST EFFECTIVENESS AND QUALITY OF LIFE IN HEART FAILURE PATIENTS WITH DIABETES	92
NIH/NINR: INTERACTIONS AMONG DEPRESSIVE SYMPTOMS AND GENETIC INFLUENCES ON CARDIAC OUTCOMES.....	92
NIH/NINR: PROMOTING PHYSICAL ACTIVITY IN OLDER ADULTS WITH COMORBIDITY	93
OBJECTIVE D: ADDRESS DISPARITIES IN MULTIPLE CHRONIC CONDITIONS POPULATIONS.....	94
NIH/NCI: PARTNERSHIPS TO REDUCE CANCER HEALTH DISPARITIES	94
NIH/NINR: DETERMINANTS OF MEDICATION ADHERENCE IN HIV-INFECTED ADULTS WITH HYPERTENSION.....	95
NIH/NINR: NURSING IMPACT ON CARE OUTCOMES FOR CHRONICALLY ILL AND MINORITY PATIENTS	95
SAMHSA: CAPACITY BUILDING INITIATIVE FOR SUBSTANCE ABUSE (SA) AND HIV PREVENTION SERVICES FOR AT-RISK RACIAL/ETHNIC MINORITY YOUNG ADULTS.....	96

Goal 1: Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions

Objective A: Identify Evidence-supported Models for Persons with Multiple Chronic Conditions to Improve Care Coordination

CDC: JAIL-BASED INTEGRATION OF HIV/SEXUALLY TRANSMITTED INFECTION (STI)/HEPATITIS SCREENING, HEPATITIS B VACCINATION, AND LINKAGE TO CARE AND TREATMENT

Description: The purpose of this program is to support the development and programmatic evaluation of a comprehensive, routine, opt-out HIV rapid testing, STI screening, and Hepatitis B vaccination initiative within a county jail facility. All persons detained in the jail and who undergo a medical evaluation during their intake process are routinely provided an HIV screening test. The program incorporates HIV screening into medical services that are routinely provided to all new detainees at the jail.

The goal of the program is to demonstrate that HIV screening can be routinely provided to, and accepted by, the majority of new jail detainees when they are screened for other medical conditions, such as hepatitis, sexually transmitted infections, tuberculosis and other chronic conditions. This is consistent with the CDC recommendations where HIV screening should be routinely provided during a medical examination in the same voluntary manner as other medical screening tests. This demonstration project was funded in September 2010 and will continue through August 2011.

Web link: None

Collaborating HHS Agencies: None

Point of Contact: Robin MacGowan, rim3@cdc.gov

Related MCC Framework Provisions:
Goal 1/Objective A/ Strategy 2

CMS: MEDICARE COORDINATED-CARE DEMONSTRATION

Description:

Authorized by section 4016 of the Balanced Budget Act of 1997, the Medicare Coordinated Care Demonstration is testing whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions can yield improved patient outcomes without increasing program costs. The demonstration was implemented in 2002 in 15 sites with various delivery models and targeting a variety of conditions. However, after 8 years, only one of the original sites, Health Quality Partners (HQP) of Doylestown, Pennsylvania is in operation. While HQP did not achieve budget neutrality for its population overall, it has realized a savings and a statistically significant decline in mortality for a subset of its population, beneficiaries with coronary artery disease and those with congestive heart failure, diabetes, and chronic obstructive pulmonary disease and at least one hospitalization in the prior 12 months. The HQP program has been extended through June 2013 for beneficiaries in the identified subgroup. The plan is currently providing services for approximately 500 beneficiaries and is actively working to expand its enrollment.

Web Link:

[http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,keyword&filterValue=Medicare Coordinate Care&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1198864&intNumPerPage=10](http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,keyword&filterValue=Medicare%20Coordinate%20Care&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1198864&intNumPerPage=10)

Collaborating HHS Agencies: None

Point of Contact: Cynthia Mason, Cynthia.Mason@cms.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective A, C, F

Goal 2/Objective A, B, C

CMS/CMMI: CARE MANAGEMENT FOR HIGH-COST BENEFICIARIES DEMONSTRATION

Description:

The Care Management for High Cost Beneficiaries (CMHCB) Demonstration was initially approved for a three-year demonstration period in 2005 to provide disease management services for thousands of beneficiaries by awarding six organizations with populations in sizes from 1,800 to 15,000. The demonstration tests provider-based intensive care management services as a way to improve quality of care and reduce costs for fee-for-service beneficiaries who have one or more chronic diseases and generally incur high Medicare costs. The sites were chosen in different areas of the country, with the primary focus on disease states of congestive heart failure (CHF), diabetes, and/or chronic kidney disease (CKD).

Program services are intended to increase adherence to physician prescribed care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating complications. There are three remaining sites in the demonstration, which have been granted extensions of the demonstration for 3 additional years subject to monthly operational monitoring and quarterly financial evaluations of performance.

Web Link:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=3&sortOrder=descending&itemID=CMS1198967&intNumPerPage=10>

Collaborating HHS Agencies: None

Point of Contact:

Linda Colantino

T:410-786-3343

Linda.Colantino@cms.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objectives A, B, C

Goal 2/Objective A

CMS/CMMI: INDEPENDENCE AT HOME DEMONSTRATION

Description:

The Independence at Home Demonstration (IAH), authorized by Section 3024 of the Affordable Care Act (ACA), tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries including beneficiaries with two or more chronic illnesses. The demonstration will be accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinate health care across all treatment settings. All providers and practitioners affiliated with a practice as described above may share in any potential savings under the demonstration program. The demonstration is to begin January 1, 2012, and will run for a 3-year period.

Web Link:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=3&sortOrder=descending&itemID=CMS1240082&intNumPerPage=10>

Collaborating HHS Agencies: None

Point of Contact:

Linda Colantino
T: 410-786-3343
Linda.Colantino@cms.hhs.gov

Related MCC Strategic Framework Provisions:

- Goal 1/Objectives A, B, C, D and F;
- Goal 2/Objectives A, B, C
- Goal 3/Objective A
- Goal 4/Objective C

HRSA: IMPROVING THE INTEGRATION OF BEHAVIORAL HEALTH CARE AND PRIMARY CARE DELIVERY

Description:

In the fall of 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) initiated a unique partnership as a component of Co-Occurring Disorders Integration and Innovation (CODI) contract. The purpose of the partnership was to test an innovative technical assistance model to improve the integration of primary health care and co-occurring behavioral health services within Federally Qualified Health Centers (FQHCs). Additionally, the study included development and refinement of an assessment tool to assist sites in assessing their capability to serve individuals with co-occurring disorders. This pilot study was completed on July 2011.

Web Link: <http://www.samhsa.gov/>

Collaborating HHS Agencies: SAMHSA

Point of Contact: Lynette Araki, HRSA 301.443.6204, LAraki@hrsa.gov

Related MCC Strategic Framework Provisions:

- Goal 1/Objective A
- Goal 1/Objective B
- Goal 1/Objective E
- Goal 1/Objective F
- Goal 2/Objective A

HRSA/BHPR: THE PATIENT NAVIGATOR OUTREACH AND CHRONIC DISEASE PREVENTION DEMONSTRATION PROGRAM

Description:

The Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program (PNDP) strives to improve health care outcomes for individuals with cancer and/or other

chronic diseases, with a specific emphasis on health disparity populations. Demonstration grants are made to organizations such as health centers, hospitals, and non-profit groups for the development and operation of patient navigator services.

Specifically, funds are used to recruit, train and employ patient navigators, who can be nurses, social workers, community health workers or anyone with firsthand knowledge of the communities they serve. The grants focus on improving health outcomes through the coordination of comprehensive health services for patients in need of chronic disease prevention, care, and management. Patient navigators carry out a range of activities including: coordinating health care services, facilitating involvement of community organizations, notifying individuals about clinical trials, overcoming barriers to quality health services, coordinating with health insurance programs, and conducting outreach to health disparity populations.

Web Link: <http://bhpr.hrsa.gov/grants/patient.htm>

Collaborating HHS Agencies: None

Point of Contact:

Kyle Peplinski

T: 301-443-7758

kpeplinski@hrsa.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective A

Goal 3/Objectives A

IHS: IMPROVING PATIENT CARE PROGRAM

Description:

American Indians and Alaska Natives are disproportionately affected by multiple chronic conditions (MCC). To assist in improving the quality of health care for American Indians and Alaska Natives living with MCC, the Indian Health Service (IHS) operates its recently expanded Improving Patient Care (IPC) Program in 90 sites across the IHS, tribal and urban Indian health system. The IPC Program works to implement the patient-centered medical home model by training care teams, redesigning the health system, promoting self-care management, integrating behavioral health care into primary care, improving the use of health information technology, and other innovations. This effort is aligned with specific objectives in the MCC framework that encourage implementing care coordination models, facilitating self-care management, and providing better tools and information to care teams, patients, and caregivers for improved health outcomes for persons with MCC. The IPC Program works in partnership with IHS, and with Tribal and Urban Indian health programs to improve prevention

and treatment of chronic diseases. The IPC Program began in 2006 with 14 sites and will expand to 170 sites by 2013.

Web Link: <http://www.ihs.gov/ipc/>

Collaborating HHS Agencies: AHRQ

Point of Contact: Lyle Ignace, M.D., lyle.ignace@ihs.gov

Related MCC Framework Provisions:

Goal 1/Objective A

NIH/NIMH: A RANDOMIZED TRIAL IN LIAISON PSYCHIATRY IN PRIMARY CARE

Description:

The National Institute of Mental Health's Division of Services and Intervention Research has a significant portfolio of studies that test the effectiveness and implementation of interventions to improve outcomes for people with mental illness and co-occurring medical illnesses, including diabetes, cardiovascular disease, substance abuse, and cancer. This research focuses on models that improve coordination of care within primary care, specialty mental health, public health and specialty medical settings, as well as trials to utilize self-management and health promotion interventions for people with serious mental illness, and studies to implement and sustain evidence-based interventions.

One notable achievement in this area is the recently completed project, A Randomized Trial in Liaison Psychiatry in Primary Care, which showed that collaborative care for depression, diabetes, and cardiovascular disease was more effective in improving outcomes across the three conditions compared to usual care. This intervention, TEAMCARE, employs a case manager to coordinate care for people with multiple chronic conditions and is one of the first examples of a treatment model with broad effects across diseases. The research findings related to this priority area will build evidence on optimal ways to manage the care of patients with multiple chronic conditions and demonstrate improved physical and mental health outcomes.

Web Link:

<http://www.teamcarehealth.org/>

<http://www.nimh.nih.gov/science-news/2010/case-managed-care-improves-outcomes-for-depressed-patients-with-multiple-medical-conditions.shtml>

Publication Link:

[**Katon W et al. Collaborative care for patients with depression and chronic illnesses. N Engl J Med. 2010; 363\(27\):2611-20.**](#)

Collaborating HHS Agencies: None

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 2

Goal 1/Objective B/Strategy 2

Goal 1/Objective C/Strategy 2

Goal 4/Objective C/Strategy 1

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

SAMHSA: PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION GRANT PROGRAM

Description:

The purpose of this program is to improve the physical health status of people with serious mental illnesses (SMI) by supporting communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. By building the necessary partnerships and infrastructure to support this goal, the expected outcome is for grantees to enter into partnerships to develop or expand their offering of primary healthcare services for people with SMI, resulting in improved health status. The population of focus for this grant program is individuals with serious mental illness served in the public mental health system.

It is projected that better coordination and integration of primary and behavioral health care should lead to outcomes such as improved access to primary care services; improved prevention, early identification and intervention to avoid serious health issues including chronic diseases; enhanced capacity to holistically serve those with mental and/or substance use disorders; and better overall health status of clients.

Web Link: http://www.samhsa.gov/Grants/2009/sm_09_011.aspx

Collaborating HHS Agencies: N/A

Point of Contact: Trina Dutta, trina.dutta@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective A, Strategies 1 and 2

Goal 1, Objective E, Strategy 1

Goal 4, Objective D, Strategy 1

Objective B: Define Appropriate Health Care Outcomes for Individuals With Multiple Chronic Conditions

CMS/CMMI/REG: ADVERSE EVENTS AMONG CHRONICALLY ILL BENEFICIARIES

Description:

Two papers have been produced under this project. They include, *Event Analysis of All-Cause and Ambulatory Care Sensitive Hospitalization of Long-Stay Nursing Home Residents* explores effects of measures of care -- including staffing, upon time to any hospitalization, while adjusting for individual beneficiary characteristics, particularly health and disability status -- on the time to acute hospitalization. The second paper *Time to Readmission among Chronically Ill Community-Resident Beneficiaries* explores the impact of proxy measures for care continuity by providers, upon risk of hospital readmission, adjusting for demographic and health risk factors among a cohort of community dwelling, chronically ill beneficiaries.

Web Link:

http://www.cms.gov/Reports/Downloads/Bishop_NHAdverseEventsChronIllness_Final_2010.pdf

http://www.cms.gov/Reports/Downloads/Perloff_CommDwellers_AdverseEventsChronIllness_2010.pdf

Collaborating HHS Agencies: None

Point of Contact: Bill Clark, William.Clark@cms.hhs.gov

Related MCC Framework Provisions

Goal 1/Objective A/Strategy 1

Goal 1/Objective B/Strategy 1

CMS/CMMI/REG: MONITORING CHRONIC DISEASE CARE AND OUTCOMES AMONG ELDERLY MEDICARE BENEFICIARIES WITH MULTIPLE CHRONIC DISEASES

Description

This research project has resulted in two reports. The first study reports the rates of appropriate/recommended care for diabetes, and Medicare reimbursed preventive services among elderly Medicare beneficiaries with one, two or three specific chronic diseases: diabetes, diabetes + depression, diabetes + chronic obstructive pulmonary disease (COPD), or diabetes + depression + COPD.

In the second paper, the authors report mortality rates and costs to Medicare among elderly Medicare beneficiaries with one, two or three of these diseases: diabetes, diabetes + chronic obstructive pulmonary disease (COPD), diabetes + major depression, or diabetes + COPD + major depression. Age-adjusted mortality rate was the lowest among persons with diabetes only (13.8 per 100). It was 1.7 times greater for those with diabetes + depression (24.0 per 100); 2.2 times greater for those with diabetes + COPD (30.3 per 100); and 3.0 times greater for those with all three diseases (40.8 per 100), $p < 0.05$ for all comparisons. The mean per beneficiary cost to Medicare in 2003 varied almost 3-fold between the cohort with diabetes only (\$9,052) and the cohort with all three diseases (\$26,707). The most salient finding was the progressively decreasing odds of dying and of lower costs as the number of diabetes care services received increased.

Web Link:

<http://www.cms.gov/reports/downloads/MCDC A1 McBean 2010.pdf>
<http://www.cms.gov/Reports/Downloads/MCDC A2 McBean 2010.pdf>

Collaborating HHS Agencies:

Point of Contact: Pauline KariKari-Martin, Pauline.Karikarimartin@cms.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective B/Strategy 1
Goal 4/Objective B/Strategy1

Objective C: Develop Payment Reform and Incentives

CMS/CMMI/REG: CHRONICALLY CRITICALLY ILL POPULATION PAYMENT REFORM

Description:

The purpose of this project is to better understand and develop payment reform recommendations for providers treating medically complex, chronically critically ill patients requiring hospital-level care for an extended period of time. The payment reform recommendations developed under this project are expected to cross multiple provider settings with a focus on general acute care hospitals and long-term care hospitals. In addition to claims and other secondary data sources, this project uses data collected under CMS's Post Acute Care Payment Reform Demonstration, including CARE assessment data and cost and resource use logs.

Web Link: None

Collaborating HHS Agencies

Point of Contact:

Shannon Flood

Shannon.Flood@cms.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective C/ Strategy 1

CMS/CMMI/REG: DETERMINING MEDICAL NECESSITY AND APPROPRIATENESS OF CARE AT MEDICARE LONG TERM CARE HOSPITALS

Description:

The purpose of this project, mandated under Section 114 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173), is to study the establishment of national long-term care hospital (LTCH) and patient criteria for determining medical necessity, appropriateness of admission, and continued stay and discharge from long-term care hospitals. Research covers Medicare policy areas such as facility classification/conditions of participation, payment systems (including patient classification issues and "bundled" models across individual payment systems), quality of care and other related topics. Data analyses (performed in project years 2 and 3) will address: (1) whether facility/patient criteria can be used to uniquely define LTCHs and patients that are appropriate for care in LTCHs; (2) whether facility criteria are needed to ensure appropriate provision of care in LTCHs; (3) whether criteria are needed to determine appropriateness of admissions, discharges, and treatment modalities, medical complexity, quality of care and improvement potential for patients commonly treated in LTCHs; and (4) what criteria/reforms are needed to ensure parity in Medicare payments, access to care and quality of care between patients treated in LTCHs and patients with similar conditions treated in other settings.

Web Link:

Report to Congress is in the process of being posted to the web. (Signed by the Secretary on March 9, 2011)

Collaborating HHS Agencies: None

Point of Contact:

Bill Buczko

William.Buczko@cms.hhs.gov

Related MCC Strategic Framework Provisions

CMS/CMMI/REG: GROUPING OF CLINICAL EPISODES AND MEASURING PHYSICIAN RESOURCE USE IN MEDICARE

Description:

CMS has a series of activities addressing approaches to measuring physician resource use and grouping clinical episodes of care. Some projects have assessed the application of existing products to the Medicare population, while others focus on refinement of existing software or development of new approaches. Projects have addressed topics such as using physician profiles generated from claims data to identify those responsible for higher care costs; testing the stability of physician efficiency measures; and exploring alternative approaches to measuring physician resource use, both from an episode of care framework that begins with care in an inpatient hospital setting and a beneficiary-level, rather than episode-level, approach. Other work examines the challenges and issues encountered in risk adjusting the costs of episodes built by two commercial groupers, risk adjusting episode costs controlling for beneficiary demographics, specialties of attributed physicians, and beneficiary health conditions.

Web link and/or publication link

http://www.cms.gov/reports/downloads/Knutson_2010.pdf

<http://www.cms.gov/Reports/Downloads/MaCurdy ERA 2010.pdf>

<http://www.cms.gov/reports/downloads/Knutson MN 2nd InterimReport AltApproaches 2010.pdf>

<http://www.cms.gov/Reports/Downloads/StabilityinPhysicianScores 2010.pdf>

Collaborating HHS Agencies: AHRQ

Point of Contact: Curt Mueller, Curt.Mueller@cms.hhs.gov

Related MCC Strategic Framework Provisions

Goal 1/Objective B/Strategy 1

Goal 1/Objective C/ Strategy 1

CMS/CMMI/MEDICARE DEMONSTRATION PROGRAM GROUP: AFFORDABLE CARE ACT SECTION 4108 – MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES

Description:

CMS is conducting a nationwide program to test and evaluate the effectiveness of a program to provide financial and non-financial incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives or programs are to be

“comprehensive, evidence-based, widely available, and easily accessible.” The programs must use relevant evidence-based research and resources, including: the Guide to Community Preventive Services; the Guide to Clinical Preventive Services; and the National Registry of Evidence-Based Programs.

The purpose of the program is to test and evaluate the effect of the initiative on the use of health care services by Medicaid beneficiaries participating in the program; the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and the administrative costs incurred by State agencies that are responsible for administration of the program.

Collaborating HHS Agencies: OASH, ONC, CDC

Point of Contact:

Ed Hutton, Ph.D.

Edward.Hutton@CMS.HHS.GOV

410-786-6616

Related MCC Framework Provisions:

Goal 1/Objective C

Goal 1/Objective F

CMS/CMMI/REG: POST ACUTE CARE PAYMENT REFORM DEMONSTRATION FOR MEDICARE

Description:

The purpose of this project is to examine acute care hospitals and four types of post acute care providers: Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). This project addresses implementation and analysis of the demonstration and is broken into two phases: (1) tasks relating to the development of the demonstration including creating analysis plans, determining how cost and resource use shall be collected, recruitment of facilities, and a limited roll out of the demonstration in one referral network; (2) data collection using the newly developed instruments, analysis of the data and report writing. Analysis topics include payment reform recommendation, predicting resource utilization, predicting discharge placement, and predicting outcomes.

Web Link: None

Collaborating HHS Agencies: ASPE

Point of Contact: Shannon Flood, Shannon.Flood@cms.hhs.gov

Related MCC Strategic Framework Provisions

Goal 1/Objective C/ Strategy 1

Objective D: Implement and Effectively Use Health Information Technology

AHRQ: AMBULATORY SAFETY AND QUALITY PROGRAM: IMPROVING MANAGEMENT OF INDIVIDUALS WITH COMPLEX HEALTHCARE NEEDS THROUGH HEALTH IT

Description:

In 2008, AHRQ published a one-time federal funding announcement seeking research grant proposals to support the development of health information technology (health IT) that assists clinicians, physician practices, health care delivery systems, and patients and families in improving the quality and safety of health care for individuals with complex healthcare needs (e.g. multiple chronic conditions). The grant announcement targeted novel methods and evaluation of existing strategies for both clinician and patient/family use of health IT in ambulatory settings to improve outcomes through more effective decision support or care delivery for patients with complex healthcare needs and those in high risk care transitions. Applicants were encouraged to demonstrate the ability of EHRs and/or PHRs to effectively move evidence-based information to the point of care, including the development and utilization of machine actionable, evidence-based clinical information, and participation of both providers and patients/families in health information exchanges. AHRQ awarded 12 three-year grants under this initiative that began in September 2008 and which will run at least through September 2011.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-08-002.html>

http://gold.ahrq.gov/projectsearch/grant_search_result.jsp?PA=HS08-002

Collaborating HHS Agencies: None

Point of Contact: Angela Lavanderos

Angela.Lavanderos@ahrq.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective D/ Strategy 1

CDC: USING DISTANCE TECHNOLOGY FOR TREATING DEPRESSION IN PEOPLE WITH EPILEPSY: PROJECT UPLIFT: USING PRACTICE AND LEARNING TO INCREASE FAVORABLE THOUGHTS

Description:

Depressive disorders, the most common co-morbidity with epilepsy, affect between 30-50% of people with epilepsy. The suicide rate in people with epilepsy is between 5-25 times higher than in the general population. Project UPLIFT, based on mindfulness-based cognitive therapy is an 8-session, weekly intervention designed for group delivery via the Internet and telephone to people with epilepsy and comorbid depression. Project UPLIFT was found to be effective in reducing symptoms of depression, whether by Internet or telephone delivery. A modified version of Project UPLIFT, for preventing depression, is currently undergoing evaluation in a multi-site study across the CDC Managing Epilepsy Well Network.

Web Link:

UPLIFT for Treatment:

http://www.sph.emory.edu/ManagingEpilepsyWell/research/eprc_uplift.php

UPLIFT for Prevention:

http://www.sph.emory.edu/ManagingEpilepsyWell/research/nih_uplift.php

Collaborating HHS Agencies: None

Point of Contact: Rosemarie Kobau, RMK4@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective D, Strategy 2

CMS/CSP: CMS CHRONIC CONDITIONS DATA WAREHOUSE

Description

The CMS Chronic Condition Data Warehouse (CCW) contains a vast amount of Medicare data including fee-for-service institutional and non-institutional claims, enrollment/eligibility information, MCBS Survey data, and assessment data. All data within the CCW are linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze Medicare beneficiaries across the continuum of care. Prior to the availability of the CCW, researchers involved in projects utilizing Medicare data were required to expend extensive resources related to beneficiary matching, de-duplication, and merging of files in preparation for their analysis. With data from the CCW, this linkage is already accomplished allowing researchers to focus on their projects and eliminating data discrepancies resulting from different linkage methodologies.

To facilitate research on Medicare beneficiaries with chronic conditions, the CCW offers 21 predefined chronic condition cohorts. The availability of predefined chronic condition cohorts makes data extraction from the CCW very efficient, allowing for data requests that utilize these predefined chronic conditions to be fulfilled in a timely and cost efficient manner.

Web link: <http://www.ccwdata.org>

Collaborating HHS Agencies: None

Point of Contact:

Tom Reilly, Director
Data Development and Services Group
Center for Strategic Planning
Centers for Medicare and Medicaid Services
(410) 786-0631
thomas.reilly2@cms.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective A/ Strategy 1
Goal 1/Objective D/ Strategy 3

NIH/NINR: TELEHEALTH NURSING INTERVENTION FOR CHILDREN WITH COMPLEX HEALTH CARE NEEDS

Description:

This NINR-supported research program examines the impact on health and quality of life of children with complex special health care needs and their families through implementation of: 1) care coordination and case management, and, 2) home telehealth. The lack of interdisciplinary research into the effectiveness of coordination and management interventions by advanced practice nurses represents a significant gap in the current knowledge of providing optimal care for children with complex special health care needs, while the lack of research into the efficacy of home-based telehealth in this population represents a significant gap in the current knowledge of pediatric telehealth. The NINR is supporting a randomized controlled trial that will address both of these issues, with the goal of developing and testing advanced practice nurse-based care coordination and case management programs with increased reliance on home telehealth technology to accomplish this objective.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7944034&icde=7397622

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Karen Huss (NIH/NINR);
hussk@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1
Goal 1/Objective D/Strategy 2

Objective E. Promote Efforts to Prevent The Occurrence Of New Chronic Conditions And To Mitigate The Consequences Of Existing Conditions

CDC: NATIONAL NETWORK OF TOBACCO CESSATION QUITLINES, 1-800 QUIT NOW

Description:

In 2004, HHS announced a new toll-free access number to all state-based quitlines—1-800-QUIT-NOW—a key component in the Secretary’s previously announced initiative to establish a National Network of Tobacco Cessation Quitlines. CDC/OSH and the National Cancer Institute (NCI) joined forces with other national partners to form the North American Quitline Consortium (NAQC) to promote quitlines and standard evaluation methods. As of December 2009, 2,460,323 calls were made to the quitline in efforts to help more than 45 million U.S. adult smokers quit. Telephone quitlines remain a cost effective system for delivering science based cessation treatments across different geographic, socioeconomic and racial and ethnic groups.

Web Link: <http://www.smokefree.gov>

Collaborating HHS Agencies: National Institutes of Health/National Cancer Institute

Point of Contact: Sherrill Brady SBrady@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E, Strategy 2

CDC: NATIONAL TOBACCO CONTROL PROGRAM

Description:

CDC’s Office on Smoking and Health (OSH) created the National Tobacco Control Program (NTCP) in 1999 to encourage coordinated, national efforts to reduce tobacco-related diseases and deaths. The program provides funding and technical support to state and territorial health departments. NTCP funds all 50 states; the District of Columbia; eight U.S.

territories/jurisdictions; six national networks; and eight tribal support centers. The goals of NTCP are to: 1) Eliminate exposure to secondhand smoke; 2) Promote quitting among adults and youth; 3) Prevent initiation among youth; and 4) Identify and eliminate disparities among population groups. The four components of NTCP are population-based community interventions; counter-marketing; program policy/regulation; and surveillance and evaluation.

Web Link: <http://www.cdc.gov/tobacco>

Collaborating HHS Agencies: none

Point of Contact: Sherrill Brady SBrady@cdc.gov

Related MCC Strategic Framework Provisions:
Goal 1, Objective E, Strategy 1 and Strategy 2

CDC: IOM STUDY ON LIVING WELL WITH CHRONIC DISEASE: PUBLIC HEALTH ACTION TO REDUCE DISABILITY AND IMPROVE FUNCTIONING AND QUALITY OF LIFE

Description:

The Institute of Medicine has established a committee to examine the non-fatal burden of chronic disease and the implications for population-based public health action. Questions are being considered for persons with single as well as multiple chronic diseases. The approximate start date for the project is September 1, 2010, and a report will be issued at the end of the project in approximately 15 months.

Web Link: <http://www.iom.edu/Activities/PublicHealth/HealthChronicDisease.aspx>

Collaborating HHS Agencies: none

Point of Contact: Charles Helmick, CHelmick@cdc.gov

Related MCC Strategic Framework Provisions:
Goal 1, Objective E, Strategy 1
Goal 4, Objective C, Strategy 3

CDC: NATIONAL COMPREHENSIVE CANCER CONTROL PROGRAM

Description:

CDC's National Comprehensive Cancer Control Program (NCCCP) funds all 50 states, DC, 7 tribes and tribal organizations, one territory, and 6 U.S. Affiliated Pacific Islands to develop and implement policy, systems-level or environmental changes aimed at preventing cancer, detecting cancers early when they are more treatable, increasing access to treatment, and

improving the quality of life of cancer survivors. Funding is used by grantees to foster strong coalitions of key public and private partners and experts to develop and implement specific cancer plans designed to reduce the burden of cancer. Many of the primary prevention activities funded by NCCCP also work to prevent other chronic conditions, such as diabetes and heart disease, by promoting healthy lifestyles and reducing obesity.

Web Link: <http://www.cdc.gov/cancer/ncccp/>

Collaborating HHS Agencies: None

Point of Contact: Laura Seeff, lvs3@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E

CDC: REDUCE DISPARITIES IN OBESITY AND OTHER HEALTH INDICATORS IN CHILDREN, YOUTH, AND ADULTS WITH DISABILITIES

Description:

The growing body of research on the link between obesity and disability indicates that, for both children and adults, those at greatest risk for obesity have mobility limitations, intellectual/learning disabilities, or both. CDC is implementing a public health approach to reducing the obesity disparity in children, youth, and adults with disabilities. This includes promoting the inclusion of people with disabilities in general obesity-reduction campaigns, identifying effective disability-specific interventions, developing relevant communications campaigns, supporting health promotion through our network of state disability and health programs, and providing support for research and information sharing.

Web Link: <http://www.cdc.gov/ncbddd/disabilityandhealth/obesity.html>

Collaborating HHS Agencies: NA

Point of Contact: Pam Costa, pic9@cdc.gov

Related MCC Framework Provisions:

Goal 1/Objective B, E

Goal 3/ Objective A

Goal 4/Objective B

CDC: VISION HEALTH INITIATIVE

Description:

CDC's Vision Health Initiative (VHI) promotes vision health and quality of life for all populations, through all life stages, by preventing and controlling eye diseases, eye injury, and vision loss resulting in disability. VHI, in a cooperative agreement with Prevent Blindness America, is supporting two state level collaboratives to embed vision health into existing state health promotion programs addressing smoking, diabetes education for rural Hispanics, and education components on vision and multiple chronic conditions for professional preparation programs and continuing education programs. Moreover, VHI research has focused on the prevalence of vision and chronic condition dyads as well as the effects of these dyads.

Web Link:

<http://www.cdc.gov/visionhealth/>
<http://www.cdc.gov/visionhealth/publications/index.htm>

Points of contact:

Jinan B. Saaddine
JSaaddine@cdc.gov
John E. Crews
JCrews@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E
Goal 3, Objective B
Goal 4, Objective B

IHS: HEALTHY HEART PREVENTION INITIATIVE

Description:

The Indian Health Service Healthy Heart Initiative was launched in 2010 following the successful demonstration of the Healthy Heart prevention project as effective in reducing cardiovascular risk in American Indians and Alaska Natives who live with diabetes. The Healthy Heart prevention program uses an intensive clinical, team-based case management approach to treat risk factors for cardiovascular disease, which is the number one killer of American Indian and Alaska Native adults. The Healthy Heart program encourages the use of culturally appropriate strategies to support the case management efforts.

Web Link:

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=programsSDPIDemonstrationProjects>

Collaborating HHS Agencies: None

Point of Contact: S. Lorraine Valdez, RN, s.lorraine.valdez@ihs.gov

Related MCC Framework Provisions:

Goal 1/Objective E

NIH/NCI: CANCERSPACE (CANCER – SIMULATING PRACTICE AND COLLABORATIVE EDUCATION)

Description:

CancerSPACE is an interactive, Web-based learning application for health professionals' education. CancerSPACE incorporates aspects of e-learning, adult learning theory, and behaviorism to advance learning, promote knowledge retention, and encourage behavior change. In an online simulation format, it facilitates self-directed learning by presenting users with real world situations similar to those they face in clinics, asking them to make choices, and providing feedback on consequences. The current version promotes strategies clinicians can enact to overcome barriers and facilitate cancer screening. Included in the development stage are several scenarios focusing on using chronic care visits as opportunities to recommend or perform cancer screening.

In addition to the cancer screening version, the CancerSPACE platform is a model, and could alternatively be filled with content pertaining to other diseases. In 2010, CancerSPACE was evaluated for its educational aims. In 2011, CancerSPACE demonstrations and discussions were held with HRSA and the HHS ACA Prevention Workgroup. As a proof of concept, CancerSPACE seemed to align with HHS's healthy weight and smoking cessation initiatives. Re-conceptualized as PreventionSPACE, discussions have focused on how the game could help providers overcome barriers to primary prevention.

Web Link: <http://www.cancer.gov/cancertopics/cancerlibrary/cancerspace>

[Note: The most recent version of CancerSPACE is housed on a contractor's development site. A demonstration CD can be obtained from OCE's Office of Partnerships and Dissemination Initiatives (Linda Parreco, 301.594.9066)]

Collaborating HHS Agencies: None

Point of Contact:

Madeline La Porta
Associate Director
Office of Communication and Education (OCE), NCI-OD
6116 Executive Blvd., Room 4127
Bethesda, MD 20892
T: 301.594.8025;
F: 301.496.7063

laportam@mail.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective E/Strategy 1

Goal 3/Objective A/Strategy 1

**SAMHSA: SUBSTANCE ABUSE AND HIV PREVENTION READY-TO-RESPOND INITIATIVE
IN COMMUNITIES HIGHLY IMPACTED BY SUBSTANCE USE AND HIV INFECTION
DESCRIPTION**

Description:

The Ready-To-Respond Initiative (RTR) is the ninth cohort of SAMHSA's Minority AIDS Initiative (MAI) programs. The RTR program builds on previous accomplishments of MAI grantees in providing evidence-based prevention services by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for these populations. This initiative will develop a comprehensive strategy for creating best practices in combining SA/HIV prevention practices.

Web Link: <http://www.samhsa.gov/Grants/2010/SP-10-003.aspx>

Collaborating HHS Agencies: CDC

Point of Contact:

Kirk E. James, Kirk.James@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective A, Strategies 1 and 2

Goal 1, Objective E, Strategies 1 and 2

**SAMHSA: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT:
HIV/AIDS SET-ASIDE**

Description:

The Substance Abuse Prevention and Treatment Block Grant distributes funds to 60 eligible states, territories, the District of Columbia and the Red Lake Indian Tribe of Minnesota to support substance abuse treatment and recovery support services for individuals, families, and communities impacted by substance abuse and substance use disorders. Under this program, the statute authorized 5% of the amount of the state grant award can be set-aside to support HIV/AIDS intervention programs for substance abusers in treatment for states reporting AIDS case rates of 10/100,000 population or greater. Currently, nineteen states are eligible to set-aside funds.

Web Link: http://www.samhsa.gov/Grants/2008/ti_08_006.aspx

Collaborating HHS Agencies: N/A

Point of Contact: Alejandro Arias, alejandros.arias@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E, Strategy 2

Goal 4, Objective D, Strategies 1 and 2

SAMHSA: THE 10X10 WELLNESS CAMPAIGN

Description:

The major goal of this effort is to reduce early mortality by conducting outreach, educating and mobilizing multiple stakeholders to address this aim. SAMHSA, in partnership with the FDA, launched the 10x10 Wellness Campaign in 2010 to promote the importance of addressing all parts of a person's life in hopes of increasing life expectancy for persons with behavioral health problems by 10 years over the next 10 years.

More than [2,000 organizations and individuals](#) have expressed their commitment to promoting wellness and reducing the disproportionate impact of preventable co-morbidity and mortality on people with behavioral health problems by signing the [Pledge for Wellness](#). The Campaign is guided by a multidisciplinary [steering committee](#) representing consumers, providers, and researchers.

Web Link: <http://www.10x10.samhsa.gov>

Collaborating HHS Agencies: FDA, CDC

Point of Contact: Wilma Townsend, wilma.townsend@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E, Strategies 1 and 2

SAMHSA: TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE TREATMENT AND HIV/AIDS SERVICES

Description:

The Minority AIDS Initiative TCE-HIV program is designed to provide funding to enhance or expand substance abuse treatment and/or outreach and pretreatment services and integrate HIV/AIDS services. The target populations for these funds are African American, Latino/Hispanic, and/or other racial and ethnic minority populations highly impacted by

HIV/AIDS. The goal of this program is reduce the risk of HIV infection and transmission through a structured program emphasis on outreach, rapid HIV testing, substance abuse treatment and case management referral to HIV treatment for those who are determined to be HIV positive.

Web Link: http://www.samhsa.gov/Grants/2008/ti_08_006.aspx

Collaborating HHS Agencies: N/A

Point of Contact: David Thompson, david.thompson@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective E, Strategy 2

Objective F. Perform Purposeful Evaluation of Models Of Care, Incentives, And Other Health System Interventions

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY PROGRAM TITLE: ANALYSIS OF THE 2010 NATIONAL SURVEY OF RESIDENTIAL CARE FACILITIES (NSRCF)

Description:

Residential care facilities differ significantly from nursing homes in both their financing and regulation. Unlike nursing home care, the vast majority of residential care residents are private pay. Additionally, unlike nursing homes and Medicare home health care, residential care and assisted living is not regulated at the federal level. State approaches to licensing and regulation of residential care vary significantly. As residential care has grown in importance, providers, states, and consumers have increasingly turned to Medicaid to pay for long-term care services in residential care settings. Previous reports estimated that approximately 10% of residents in residential care are receiving Medicaid sponsored services. To gain a greater understanding of residential care, ASPE and NHCS recently completed fielding the first National Survey of Residential Care Facilities (NSRCF). This project will analyze data from the NSRCF, examining the health conditions and functional status of residents of facilities in the NCSRF, document the services provided, and identify the characteristics of facilities serving Medicaid beneficiaries.

Web Link: <http://www.cdc.gov/nchs/nsrcf.htm>

Collaborating HHS Agencies: NCHS

Point of Contact: Emily Rosenoff, Emily.Rosenoff@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective F/Strategy 1

Goal 2/Objective B/Strategy 2

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CHRONIC HOMELESSNESS PERMANENT SUPPORTIVE HOUSING PROGRAMS EVALUATION

Description:

The purpose of this project is to evaluate programs that integrate housing with health care services to create permanent supportive housing for chronically homeless persons, thereby enhancing housing stability and improvements in health outcomes for this population. HHS will work with HUD to identify five sites that use HUD funds to provide housing for Medicaid enrollees that typically have mental illness, substance abuse, and major chronic conditions. This project will produce a report that synthesizes findings from the case studies on how Medicaid can be used to provide services to chronically homeless individuals, including a description of all the various legal authorities a state can use to provide such services (e.g. 1915c, 1915i). This project is expected to be completed by December, 2012.

Web Link: N/A

Collaborating HHS Agencies: CMS, SAMHSA

Point of Contact:

Emily Rosenoff, Emily.Rosenoff@hhs.gov

Gavin Kennedy, Gavin.Kennedy@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective F/Strategy 1

Goal 2/Objective B/Strategy 2

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF NEW DEVELOPMENTS IN HOUSING WITH SERVICES TO ENHANCE AGING IN PLACE FOR OLDER ADULTS

Description:

The purpose of this project is to evaluate existing housing with services programs that combine housing, health, and long-term services and supports, thereby enhancing housing stability and improvements in health outcomes for this population. Approximately 1.8 million older adults live in subsidized housing-- more than the number living in nursing homes or assisted living facilities. Most of these people are single women in their mid-seventies to early eighties, who typically have high health care needs. Older adults in subsidized housing are twice as likely to be disabled as those who are homeowners. They report being in poorer health, have more chronic conditions, and a higher number of ADL impairments than renters in unsubsidized housing.

HHS will work with HUD to identify sites that use HUD funds to provide housing to older adults. This project will produce a report that describes how housing might be coupled with targeted, coordinated health and long-term services and supports to help certain older adults age better and longer in the community, while promoting efficient service delivery. This project is expected to be completed by May 2013.

Web Link: N/A

Collaborating HHS Agencies: CMS, AOA

Point of Contact:

Emily Rosenoff, Emily.Rosenoff@hhs.gov

Gavin Kennedy, Gavin.Kennedy@hhs.gov

Related MCC Strategic Framework Provisions

Goal 1/Objective F/Strategy 1

Goal 2/Objective B/Strategy 2

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF THE MEDICAID STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS

Description:

The Affordable Care Act (ACA) provides a new optional benefit in Medicaid to encourage states to provide care coordination and care management services to enrollees who have two or more chronic conditions, one chronic condition and at risk of another, or a serious mental health disorder. The ACA provides a 90 percent federal match for the first eight quarters as incentive for the states to develop the necessary program infrastructure.

The purpose of this project is to evaluate the effect on cost and quality of care of providing health homes services including comprehensive care management, care coordination, transitional services and linkages to support services to Medicaid enrollees with multiple chronic conditions. In particular, the evaluation will estimate the effect of health homes on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

The report from this project is expected to be completed by September 2016.

Web Link: N/A

Collaborating HHS Agencies: CMS, SAMHSA

Point of Contact: Kirsten Beronio, Kirsten.Beronio@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective F/Strategy 1

Goal 2/Objective B/Strategy 2

CDC: ENHANCED COMPREHENSIVE HIV PREVENTION PLANNING AND IMPLEMENTATION FOR METROPOLITAN STATISTICAL AREAS MOST AFFECTED BY HIV/AIDS: PHASE II

Description:

Phase I of this program (CDC-RFA-PS10-10181) supported the development and initial implementation of Enhanced Comprehensive HIV Prevention Plans (ECHPPs) for Metropolitan Statistical Areas (MSAs) most affected by the HIV epidemic in order to reduce HIV risk and incidence in those areas. Phase II (CDC-RFA-PS11-1117) will provide funding for jurisdictions to further support coordination and implementation of their ECHPPs over a two-year project period. Plans address the continuum of HIV prevention activities (including substance abuse and mental health treatment), medical care including antiretroviral treatment, and integration of diagnostic and prevention services for the Human Immunodeficiency Virus (HIV), hepatitis C virus (HCV), hepatitis B virus (HBV), sexually transmitted diseases (STD); and tuberculosis (TB).

Web link: None

Collaborating HHS Agencies: HRSA

Point of Contact:

Steven Flores, sif2@cdc.gov

David Purcell, dhp8@cdc.gov

Related MCC Framework Provisions:

Goal 1/Objective E

CMS: SENIOR RISK REDUCTION DEMONSTRATION (SRRD)

Description:

The SRRD tests whether health promotion and health management programs that have been developed and tested in the private sector can also be tailored to and work well with Medicare beneficiaries to improve their health and reduce avoidable health care utilization. These programs begin by assessing self-identified risk factors as well as factors determining whether an individual is ready to change their health behaviors. Initially, CMS conducted two pilot programs with six vendors, which resulted in two of the vendors participating in the three-year

demonstration. The target population is original fee-for-service Medicare beneficiaries, ages 67-74 years of age who became eligible for Medicare due to age rather than disability status. A random national sample of 20,000 individuals who met the criteria have been selected to participate in the demonstration. The demonstration started May 1, 2009 and will end April 30, 2012.

Web Link:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1190654&intNumPerPage=10>

Collaborating HHS Agencies: None

Point of Contact:

Kathleen Connors de Laguna

(410) 786-2256

Kathleen.Connorsdelaguna@cms.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective F/Strategies 1 and 2

HRSA/BPHC: HEALTH CENTERS

Description:

Health centers are community-based and patient-directed organizations that serve populations with limited access to health care. Health center patients, including the poor, racial and ethnic minorities, and the uninsured, experience higher rates than average of MCCs.

To evaluate and track the quality of care in health centers, the Health Center Program has established a core set of clinical performance measures. These clinical performance measures, which are reported annually, are aligned with those of national quality measurement organizations and are consistent with the overarching goals of Healthy People 2020. Currently reported measures include childhood immunizations, entry to prenatal care, low birth weight infants, hypertensive control, diabetic control and adherence to Pap smear guidelines. Calendar year 2011 will add asthma pharmacotherapy, tobacco use status, childhood and adult BMI assessments. Data are reported along with ethnographic information in order to evaluate progress in disparities reduction.

Further, HRSA is encouraging all of its health centers to become Patient Centered Medical Homes (PCMH), a concept of care delivery that emphasizes coordinated, patient centric care in which primary care teams utilize data to track and maximize patient outcomes while using this information to create clinical strategies that also promote population health improvement. HRSA is also encouraging health centers to achieve Meaningful Use (MU) status. MU promotes the inclusion of evidence-based clinical decision support, easy transfer of patient data to avoid

harmful or wasteful duplications and redundancies, prescription reconciliation and data reporting that will quickly identify errors, potential harms and allows for clinical self feedback for quality improvement purposes.

Web Link: <http://bphc.hrsa.gov/>

Collaborating HHS Agencies: CMS, CDC, ONC, SAMHSA, IHS

Point of Contact:

Jim Macrae

JMacrae@hrsa.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective A

Goal 1/Objective B

Goal 1/Objective D

Goal 1/Objective E

Goal 1/Objective F

Goal 2/Objective A

Goal 2/Objective B

Goal 2/Objective C

Goal 3/Objective A

Goal 3/Objective B

Goal 2: Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions.

Objective A: Facilitate Self-Care Management

AOA: CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

Description:

Funding support to states under the Evidence-Based Disease and Disability Prevention programs has been provided by AoA to empower older adults to take control of their health. In these programs, seniors learn to maintain a healthy lifestyle through increased self-efficacy and self-management behaviors. The program is operational in 48 states/territories and made available through ARRA.

Web Link: <http://www.healthyagingprograms.org/>

Collaborating HHS Agencies: None

Point of Contact: Mimi Toomey, Mimi.Toomey@aoa.hhs.gov

Related MCC Framework Provisions:

- Goal 1/Objective A/Strategy 1.
- Goal 2/Objective A/Strategy 2.
- Goal 2/Objective B./Strategy 1 and 3
- Goal 2/Objective C/Strategy 2

CDC: ADDRESSING ARTHRITIS IN THE CONTEXT OF CO-MORBID CONDITIONS

Description:

The CDC Arthritis Program is using two different approaches to address the needs of people with arthritis as well as another chronic condition. The CDC is working with 12 state arthritis programs to extend effective, evidence-based interventions to reach more people with arthritis within these states. Also, there is collaboration with the National Association of Chronic Disease Directors to work with 9 state health departments to integrate self-management education or physical activity guidance into the activities of other state programs. In this project, CDC awards arthritis funds to state arthritis, diabetes, and aging programs to disseminate CDSMP and/or EnhanceFitness to constituents with MCC.

Web link: http://www.cdc.gov/arthritis/state_programs/index.htm

Collaborating HHS Agencies: none

Point of Contact: Teresa Brady, TBrady@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 2, Objective A, Strategy 1 and 2

CDC: WISEWOMAN

Description:

The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program helps uninsured and underinsured, 40- to 64-year-old women reduce their risks for heart disease, stroke, and other chronic diseases. The women are screened for cardiovascular risk factors including high blood pressure, high blood cholesterol, and diabetes. WISEWOMAN participants receive risk reduction counseling based upon their screening results and are able participate in lifestyle intervention programs tailored to address their identified risk factors. Local programs also partner with community-based organizations to help expand the reach of their services and coordinate patient health care referrals. CDC funds WISEWOMAN programs in nineteen states and two tribal organizations. While offerings vary from program to program, all funded programs are expected to partner with their state or tribal Breast and Cervical Cancer Early Detection Program, Tobacco Control Program, and Heart Disease and Stroke Prevention Program. Other partnerships are also encouraged, as WISEWOMAN's ultimate goal is to promote lasting, healthy lifestyle changes among women.

Web Link:

<http://www.cdc.gov/wisewoman/index.htm>

http://www.cdc.gov/wisewoman/pdf/health_promotion_interventions.pdf

Collaborating HHS Agencies: none

Point of Contact: Deborah Borbely, dborbely@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 2, Objective A

CMS/CMMI/REG: EVALUATION OF COMMUNITY BASED WELLNESS AND PREVENTION PROGRAM IN THE UNITED STATES

Description:

This project will evaluate community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. Due to the large number of existing programs and scope of some of the individual programs, CMS is implementing a two-phase approach to evaluating their impacts on Medicare beneficiaries. The first phase of the evaluation effort consists of an environmental scan of existing programs and a report on the evidence surrounding them. Evaluation design recommendations that will provide guidance on which programs and sites are best suited for subsequent evaluation, on relevant research questions to examine specific to each intervention program, and on how to best interface with programs and intervention sites during the actual evaluation. The second phase of the evaluation will consist of implementing the various program evaluations will begin in late 2011.

Web Link: None

Collaborating HHS Agencies: AoA, CDC, SAMSHA, ASPE

Point of Contact: Benjamin Howell , Benjamin.Howell@cms.hhs.gov

Related MCC Strategic Framework Provisions

Goal 2/Objective A/Strategy 1 and 3

Objective B: Facilitate Home and Community-based Services

ACF/ADD: STATE COUNCILS ON DEVELOPMENTAL DISABILITIES

Description:

The State DD Councils are located in every State and Territory and engage in advocacy (e.g., educating policy makers about unmet needs of individuals with developmental disabilities), capacity building (e.g., working with state service agencies to provide training and benefits to direct care workers) and systemic change activities (e.g., the way human service agencies do business so that individuals with developmental disabilities and their families have better or expanded services). Councils work to promote the independence, self-determination, productivity, integration, and inclusion of people with developmental disabilities and promote systems change that will eliminate obvious inequities in areas such as education, access to healthcare and employment.

Web Link: <http://www.acf.hhs.gov/programs/add/states/ddcs.html>

Point of Contact:

Jamie Kendall, Deputy Commissioner,
T: 202-690-5911
Jamie.Kendall@acf.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective A
Goal 1/Objective C
Goal 2/Objective A
Goal 2/Objective B

ACF/ADD: STATE PROTECTION AND ADVOCACY AGENCIES

Description:

The State Protection and Advocacy Agencies (P&As) are required to pursue legal, administrative and other appropriate remedies under all applicable federal and state laws to protect and advocate for the rights of individuals with developmental disabilities. Collectively, the P&A network is the largest provider of legally based advocacy services to people with disabilities in the United States. The federally mandated P&As provide multiple services to individuals with developmental disabilities such as protecting and advocating for individual legal and human rights; information and referral; investigation of complaints of violation of rights of individuals with developmental disabilities; working to resolve complaints through mediation, alternative dispute resolution and litigation.

Web Link: <http://www.acf.hhs.gov/programs/add/states/ucedds.html>

Point of Contact:

Jamie Kendall, Deputy Commissioner

T: 202-690-5911

Jamie.Kendall@acf.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective A

Goal 1/Objective E

Goal 2/Objective C

AOA: ALZHEIMER’S DISEASE SUPPORTIVE SERVICE PROGRAM

Description:

The Alzheimer’s Disease Supportive Services Program (ADSSP) supports state efforts to expand the availability of community-level supportive services for persons with Alzheimer’s Disease and Related Disorders (ADRD) and their caregivers. The AoA Alzheimer’s Disease Supportive Services Program delivers supportive services (both for ADRD and MCC) and facilitates informal support for persons with ADRD and their family caregivers using proven models and innovative practices. It also translates evidence-based models that have proven beneficial for persons with ADRD and their family caregivers into community-level practice and advances state initiatives toward coordinated systems of home and community-based care – linking public, private, and non-profit entities that develop and deliver supportive services for individuals with ADRD and their family caregivers. The program is currently in 34 states/territories.

Web Link: http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/index.aspx

Collaborating HHS Agencies: None

Point of Contact: Mimi Toomey, Mimi.Toomey@aoa.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 1

Goal 2/Objective A/Strategy 1

Goal 2/Objective B/Strategy 1-2

AOA: COMMUNITY BASED CARE TRANSITIONS

Description:

In most care transition interventions, participants are first engaged while in an acute care settings and then followed intensively after discharge to the community. The basic goals of a care transitions program are to ensure that patients/residents and their caregivers understand how to adhere to post-discharge instructions for medication and self-care; recognize symptoms that signify potential complications requiring immediate attention; and make and keep follow-up appointments with their primary care physicians.

AoA is actively involved in supporting community-based care transition programs for patients with MCCs. AoA has funded 16 states to coordinate Community-Base Care Transition programs in September 2010. Of those initially funded, five were awarded additional funds to include technology as part of the program.

Web Link: http://www.aoa.gov/AoARoot/Aging_Statistics/Health_care_reform.aspx

Collaborating HHS Agencies: CMS

Point of Contact: Mimi Toomey, Mimi.Toomey@aoa.hhs.gov

Related MCC Framework Provisions:

- Goal 2/Objective A/Strategy 1 and 3
- Goal 2/Objective B/Strategy 1-3
- Goal 2/Objective C/Strategy 1-2

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CAREGIVER SUPPLEMENT TO THE NATIONAL HEALTH AND AGING TRENDS SURVEY

Description:

The purpose of this project is to field the caregiver supplement to the new National Health and Aging Trends Survey (NHATS) that the National Institute on Aging (NIA) is funding to examine the social and economic consequences of late-life disability for individuals, families, and society. NHATS will measure outcomes of disabling conditions, living and care arrangements, medical and long-term care expenditures, and other aspects of economic well-being and quality of life. In-person interviews will be conducted with a sample of Medicare enrollees age 65 and older, who will be resurveyed annually. The caregiver supplement will be the only nationally-representative data on caregivers linked to care recipients, and will be used to answer important policy questions such as:

- What policy and programmatic changes can be made to enable caregivers to continue to provide care and keep the care recipient in the community?
- Which interventions are most effective for preserving the health and well being of caregivers themselves?
- What is the financial value of elder caregiving?
- What types of services do informal caregivers provide and how does this compare to services provided by paid workers in home and institutional settings?
- Does publicly funded respite care make a difference in supporting caregivers and keeping elders at home longer?

This project is expected to be completed by December 31, 2012.

Web Link: N/A

Collaborating HHS Agencies: NIA

Point of Contact:

Helen Lamont, Helen.Lamont@hhs.gov

Hakan Aykan, Hakan.Aykan@hhs.gov

Pam Doty, Pam.Doty@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective F/Strategy 1

Goal 2/Objective B/Strategy 2

CDC: PEARL DEPRESSION TREATMENT FOR ADULTS WITH EPILEPSY

Description:

The University of Washington's Prevention Research Center developed and evaluated a home-based collaborative care intervention called Program to Encourage Active, Rewarding Lives (PEARL). PEARL consists of problem solving treatment, behavioral activation, pleasant events scheduling, and psychiatric consultation.—PEARLS was found to effectively reduce depressive symptoms in adults with epilepsy and comorbid depression, with effects maintained for 18 months.

Web Link: http://www.sph.emory.edu/ManagingEpilepsyWell/research/wash_pearls.php

Collaborating HHS Agencies: None

Point of Contact: Rosemarie Kobau, RMK4@cdc.gov.

Related MCC Strategic Framework Provisions:

Goal 2/Objective B/Strategy 1-2

HRSA/MCHB: CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Description:

HRSA has legislative authority: (1) to provide rehabilitation services for blind and disabled individuals under the age of 16 years receiving benefits under Title XVI ' (the Social Security Act), to the extent medical assistance for such services is not provided under Title XIX (Medicaid); (2) to provide and promote family-centered, community-based, coordinated care for children with special health care needs; and, (3) to facilitate the development of community-based services for such children and their families. HRSA accomplishes this mission through multiple programs:

The Title V Block Grant Program for Children with Special Health Care Needs (CSHN), which targets 30 percent of the State Maternal and Child Health Block Grants to support care for CSHCN, a large percentage of whom have multiple chronic conditions; and, the Discretionary Grant Program, which provides funding to support services and infrastructure for individuals with specific diagnoses (e.g., Traumatic Brain Injury program, hemophilia) and the general population of individuals with special health care needs, many of whom have multiple chronic conditions.

Web link: <http://mchb.hrsa.gov/>

Collaborating HHS Agencies: None

Point of Contact:

Bonnie Strickland, Ph.D.

Health Resources and Services Administration

Maternal and Child Health Bureau

Division of Services for Children with Special Health Needs (DSCSHN)

5600 Fishers Ln. Rm. 18A-27

Rockville, Maryland 20857

T:301.443.9331

bstrickland@hrsa.gov

Related MCC Framework Provisions:

Goal 2/Objective B

Goal 3/ Objective A

HRSA/MCHB: FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS (F2F HICS)

Description:

Family-to-Family Health Information Centers (F2F HICs) Program were established by the Family Opportunity Act of 2005 (FOA) as a part of the Deficit Reduction Act of 2005 (P.L. 109-171), to provide information to parents of children with disabilities and special health needs, many of whom have multiple chronic conditions. These family-staffed/run Centers assist families in making informed decisions about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children. F2F HICs also assist in assuring that families of children with special health care needs (CSHCN) will partner in decision-making at all levels.

The law requires that these Centers will: 1) assist families of CSHCN to make informed choices about health care in order to promote good treatment decisions, cost effectiveness and improved health outcomes; 2) provide information regarding the health care needs of and resources available for CSHCN; 3) identify successful health delivery models for CSHCN; 4)

develop with representatives of health care providers, managed care organization, health care purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals; 5) provide training and guidance regarding the care of CSHCN; 6) conduct outreach activities to families of CSHCN, health professionals, schools and other appropriate entities; and 7) be staffed by such families who have expertise in federal and state public and private health care systems; and by health providers.

Web Link: <http://www.familyvoices.org>

Collaborative HHS Agencies: None

Point of Contact:

LaQuanta Person Smalley
301 443-2372
LPerson@hrsa.gov

Related MCC Framework Provisions:

Goal 1/Objective A
Goal 1/Objective F
Goal 2/Objective B

IHS: ELDER CARE INITIATIVE LONG TERM CARE GRANTS

Description:

The IHS Elder Care Initiative Long Term Care Grants Program, last awarded in FY 2010, provided 2-year funding to support assessment and planning or implementation of home and community-based services by Tribes, Tribal organizations, and Urban Indian Health programs. There is a recognized deficit in long term services and supports on Tribal lands, limiting access to home and community-based care for individuals with disability resulting from multiple chronic conditions. This grant program aids Tribes in the development of these services, supporting independence and community integration for individuals who need support in activities of daily living.

Point of Contact: Bruce Finke bruce.finke@ihs.gov

Related MCC Strategic Framework Provisions:

Goal 2/Objective B/Strategy 2

Objective C: Provide Tools for Medication Management

AHRQ: TOOL FOR IMPROVED MEDICATION FOR ELDERLY VIA REVIEW (TIMER)

Description:

The CERT (Centers for the Evaluation and Research on Therapeutics) is developing and disseminating a decision aid, Tool for Improved Medication for Elderly via Review (TIMER), for medication reviews for seniors. This decision aid will be a useful tool for pharmacists and other health professionals to focus medication reviews on the Top 25 medication problems among older adults with a goal to increase the likelihood of identifying clinically important medication-related problems. The decision aid has been disseminated at health professional meetings and in the scientific literature accessible to geriatricians, family physicians, pharmacists,, and nurses. In partnerships with a drug plan (Outcomes, Inc.) and a pharmacy chain (Kerr Drug), the CERT will test TIMER's usefulness and pharmacists' acceptance.

Web Link: None

Collaborating HHS Agencies: None

Point of Contact:

Chunliu Zhan

Chunliu.zhan@ahrq.hhs.gov

Web Link:

<http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1099&context=publichealthresources&seiredir=1#search=%22TIMER%20Iowa%20medication%22;>

<http://www.public-health.uiowa.edu/cert/education/TIMER.pdf>

Related MCC Framework Provisions:

Goal 2/Objective C/Strategy 2

HRSA/HSB: PATIENT SAFETY AND CLINICAL PHARMACY SERVICES COLLABORATIVE

Description:

In May 2008, HRSA launched the Patient Safety and Clinical Pharmacy Services (PSPC) Collaborative. The Collaborative focuses on reducing medication errors and improving health outcomes by integrating clinical pharmacy services into primary care. In its efforts to protect patient safety, the collaborative targets one area of significant risk: "the experience of high-risk patients (such as individuals with MCCs) "as they encounter multiple providers and different medication practices¹.

The PSpC is designed to spread leading practices proven to improve patient safety and health outcomes. During the 18-month process of the PSpC, learning sessions, action periods, web training, and list serves have been used to measure, report, and track improvement. Expert faculty has also been on hand to help teams adapt, test, and implement successful practices.

Web Link: <http://www.hrsa.gov/patientsafety/default.htm>

Publication Link:

¹ Health Resources and Services Administration (HRSA). "The Patient Safety & Clinical Pharmacy Services Collaborative (PSpC) Overview" @ [fip://fip.hrsa.gov/patientsafety/PSpCoverview.pdf](http://fip.hrsa.gov/patientsafety/PSpCoverview.pdf). Accessed on 1/8/2009.

Collaborating HHS Agencies: FDA

Point of Contact: Krista Pedley, kpedley@hrsa.gov.

Related MCC Strategic Framework provisions:

Goal 2/Objective C

NIH/NINR: ADHERENCE & HRQOL: TRANSLATION OF INTERVENTIONS

Description:

One of the components of this NINR-supported P01 Center is evaluating the effectiveness of a single-modality treatment adherence intervention based on Concordance Therapy. The intervention is delivered by primary care nurses in a racially diverse sample of primary care patients with unipolar depression and comorbid diabetes mellitus or hypertension. This study is also assessing whether improvement in adherence to antidepressant therapy is associated with improvement in adherence to oral medications for diabetes or hypertension. The study is scheduled to be completed by July 31, 2013.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7922652&icde=7397685

Collaborating HHS Agencies: None

Point of Contact:

Dr. Karen Huss (NIH/NINR)

hussk@mail.nih.gov

Related MCC Framework Provisions:

Goal 2/Objective C/Strategy 1

Goal 2/Objective C/Strategy 3

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

Objective A: Identify Best Practices and Tools

AHRQ: COMPARATIVE EFFECTIVENESS REVIEW ON EFFECTIVENESS OF INTERVENTIONS ADDRESSING CONCOMITANT MENTAL HEALTH AND CHRONIC MEDICAL CONDITIONS IN THE PRIMARY CARE SETTING.

Description:

The field of mental health and primary care is moving from consideration of single conditions and their outcomes to more real-world complex-care paradigms. To date, there has not been a synthesis of the evidence in a way that accounts for the patient with multiple chronic conditions and examines both mental health and chronic medical outcomes. This evidence report will focus on a population of adults treated in primary care settings who have one or more chronic medical conditions and concomitant depression and/or anxiety. The report will review the effectiveness of practice-based interventions available in primary care settings that target the care processes within a system of care and are aimed at improving the mental health condition or both the mental health and chronic medical conditions. The review will examine the effects on the mental health and the chronic medical condition outcomes, as well as on general health outcomes and harms.

Web Link:

<http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displaytopic&topicid=297&search=>

Collaborating HHS Agencies: None

Point of Contact:

Sonia Tyutyulkova; Sonia.Tyutyulkova@ahrq.hhs.gov

Related MCC Framework Provisions:

Goal 3/Objective A/Strategy 1

AHRQ: MEASURES FOR THE MEDICAID HOME AND COMMUNITY-BASED SERVICES POPULATION

Description:

Nationwide, state Medicaid programs fund home and community-based services (HCBS) for both adults (including seniors) and children who have diverse disabilities and impairments. These disabilities may be cognitive—such as mental retardation and related conditions, developmental disabilities, acquired brain injuries, and dementia—or physical—such as paraplegia and quadriplegia, age-related frailty, multiple chronic conditions, and HIV/AIDS. The Deficit Reduction Act of 2005 directed the Agency for Healthcare Research and Quality (AHRQ) to develop quality indicators for the Medicaid Title XIX home and community-based services (HCBS) population and to use the indicators to describe the health and welfare outcomes of this population.

Based upon testing, 13 outcome indicators were developed and judged to be of sufficient validity and reliability; these include short-term complications of diabetes, asthma or chronic obstructive pulmonary disease, congestive heart failure, composite: ambulatory care sensitive condition (ACSC) chronic conditions, pressure ulcer, injurious falls, and three acute conditions and associated composites. Currently in preparation is a methods report on the measures development process and a findings report that uses the outcome measures to assess the health and welfare of the Medicaid HCBS population.

Web Link:

<http://www.ahrq.gov/research/ltc/hcbs.htm>
<http://www.ahrq.gov/research/ltc/hcbsrepor/>

Collaborating HHS Agencies:

CMS, Medicaid and Disabled and Elderly Health Programs Group

Point of Contact:

D.E.B. Potter, M.S.
AHRQ,
T: 301-472-1564
d.e.b.potter@ahrq.hhs.gov

Related MCC Framework Provisions:

Goal 1/Objective B/Strategy 1
Goal 3/Objective A/Strategy 2
Goal 4/Objective B/Strategy 3

**ASPE/HEALTH POLICY: CONSENSUS DEVELOPMENT PROCESS FOR MEASURE
ENDORSEMENT: ESTABLISHING A MEASUREMENT FRAMEWORK FOR MULTIPLE
CHRONIC CONDITIONS****Description:**

The core objective of the proposed 14-month project is to develop and endorse, through NQF's Consensus Development Process, an MCC Measurement Framework. The Framework will

establish the definitions, domains, and guiding principles that are instrumental for measuring and reporting the efficiency—quality and cost—of care for patients with MCCs. Subsequent work guided by the Framework (but not encompassed by this proposal) would be endorsement of performance measures and best practices addressing MCCs. The project will result in a report that encompasses the NQF-endorsed MCC Measurement Framework, including definitions, domains, and guiding principles. In addition, a commissioned paper will be included as an appendix to the report.

Web Link:

http://www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework_k.aspx

Collaborating HHS Agencies: CMS, AHRQ, HRSA, SAMHSA, ONC, CDC

Point of Contact: Kate Goodrich, MD MHS, Kate.Goodrich@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objective B/Strategy 1

Goal 4/Objective C/Strategy 2

HRSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS

Description:

The purpose of this program, which is jointly funded by SAMHSA and HRSA, is to serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care across the health care delivery system and related workforce development. As a national resource, the CIHS will provide technical assistance to grantees in SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders, including individuals seen in Health Centers funded under Section 330 of the Public Health Service Act.

Web Link: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions

Collaborating HHS Agencies: SAMHSA

Point of Contacts:

Trina Dutta

SAMHSA

Trina.Dutta@SAMHSA.hhs.gov

Alex Ross

HRSA

ARoss@hrsa.gov

Related MCC Strategic Framework Provisions:

- Goal 1, Objective A, Strategies 1 and 2
- Goal 1, Objective D, Strategy 1
- Goal 3, Objective A, Strategy 1

OASH/OFFICE OF WOMEN’S HEALTH: PROVIDING BETTER TOOLS AND INFORMATION FOR HEALTH CARE WORKERS DELIVERING CARE TO WOMEN WITH MULTIPLE CHRONIC CONDITIONS CARDIOVASCULAR DISEASE, DEPRESSION, AND OTHER CO-MORBIDITIES.

Description:

The goal of this three-year initiative is to improve the interface of primary care, cardiology, and mental health services for women. This initiative creates a collaboration of primary care providers (such as physicians, nurse practitioners and physician assistants), mental health specialists (such as psychiatrists, psychologists and psychiatric-mental health nurses), and other providers (such as social workers and nurses) to improve the effectiveness of their engagement with MCC clients in the management of co-morbidities. This multi-component initiative will include provider feedback, case management, provision of information on treatment guidelines/protocols to providers, and use of information technology to make systematic changes in the care of these patients.

In addition, this initiative will develop (Year 1), pilot test (year 2), and disseminate (year 3) appropriate curriculum for professional training and CME programs to address multiple chronic conditions in an integrated fashion.

Web Link: <http://www.womenshealth.gov/hearttruth>

Collaborating HHS Agencies: CMS, NHLBI, HRSA, AOA

Point of Contact:

Suzanne G. Haynes, Ph.D.
DHHS Office on Women’s Health
T:202-205-2623,
Suzanne.Haynes@hhs.gov

Related MCC Strategic Framework Provisions:

- Goal 3/Objective A/Strategy 1, 3, and 4
- Goal 3/Objective B/Strategy 1, 2

SAMHSA: SHARED DECISION MAKING

Description:

The purpose of this effort is to increase consumer participation in healthcare by the development and dissemination of models of shared decision making for individuals with behavioral health disorders. This will enable consumers/peers to make informed treatment decisions with their providers.

An on-line decision aid is being developed on the topic of anti-psychotic medications enabling an individual to consider the benefits and costs of various options – including examining the impact of side effects that may impact the development of MCCs (e.g., obesity, diabetes). Other decision aids will address other behavioral health issues such as medication-assisted treatment for substance use disorders.

Web Link: <http://www.samhsa.gov/ConsumerSurvivor/shared.asp>

Collaborating HHS Agencies: N/A

Point of Contact: Paolo del Vecchio, paolo.delvecchio@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 3, Objective A, Strategies 3 and 4

SAMHSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS

Description:

The purpose of this program, which is jointly funded by SAMHSA and HRSA, is to serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care across the health care delivery system and related workforce development. As a national resource, the CIHS will provide technical assistance to grantees in SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders, including individuals seen in Health Centers funded under Section 330 of the Public Health Service Act.

Web Link: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions

Collaborating HHS Agencies: HRSA

Point of Contact: Trina Dutta, trina.dutta@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective A, Strategies 1 and 2

Goal 1, Objective D, Strategy 1

Goal 3, Objective A, Strategy 1

Objective B: Enhance Health Professionals Training

ACF/ADD: UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES (UCEDD) IN EDUCATION, RESEARCH AND SERVICES

Description:

The DD Act authorizes core funds to 68 UCEDDs, at least one in every State and Territory, that are components of a university system or are public or not for profit entities associated with universities. UCEDDs provide interdisciplinary training to students and professionals, engage in cutting edge research, provide technical assistance, and direct services and support to people with disabilities of all ages and their families. Funds are distributed through five year competitive grants.

UCEDDs share information and research findings, as well as support activities that address various issues from prevention to early intervention to supported employment. They represent a broad range of disabilities. Additional grants may be awarded to UCEDDs to carry out national training and other initiatives. Currently, a training emphasis is on enhancing self-determination skills.

Web Link: <http://www.acf.hhs.gov/programs/add/states/ucedds.html>

Point of Contact:

Jamie Kendall, Deputy Commissioner

T: 202-690-5911

Jamie.Kendall@acf.hhs.gov

Related MCC Framework Provisions:

Goal 3/Objective A

Goal 3/Objective B

Goal 4/Objective C

NIH/NINR: MULTIPLE MORBIDITIES IN VULNERABLE POPULATIONS: NURSE SCIENTIST TRAINING

Description:

This NINR-supported pre-doctoral and post-doctoral training program provides research training for nurses pursuing research careers focused on vulnerable populations with multiple morbidities. The coexistence of multiple conditions is more common in vulnerable populations and it confers a compounding burden on overall health status, functional ability, and quality of life. Scientists need to be equipped with the knowledge and skills required to tackle the study of the complex phenomena associated with research with persons with multiple morbidities. The

translation of conceptual models and methods from several fields of study is needed as well as the integration of multiple interdisciplinary perspectives, methodologies, and levels of analyses.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7826829&icde=7398141

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Lois Tully (NIH/NINR); tullyla@mail.nih.gov

Related MCC Framework Provisions:

Goal 3/Objective B/Strategy 1

SAMHSA: RECOVERY-TO-PRACTICE

Description:

This effort is designed to re-tool the behavioral health workforce to increase their knowledge, skills and abilities in person-centered, recovery-based practices. This includes the need to address a whole health perspective to address the somatic health issues – including MCCs – that people with behavioral health disorders experience.

The Recovery-To-Practice has partnered with major behavioral health professional organizations - including the American Psychiatric Association, the American Psychological Association, the American Psychiatric Nurses Association, the National Association of Peer Specialists, and the Council on Social Work Education – to develop and implement training programs to educate their members. A series of other tools and training events are also being developed to help improve provider practices.

Web Link: <http://dsgdev2.dsgonline.com/rtp/>

Collaborating HHS Agencies: N/A

Point of Contact: Wilma Townsend, wilma.townsend@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 3/Objective B

Objective C: Address Multiple Chronic Conditions in Guidelines

CDC: US MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2010

Description:

Half of all pregnancies in the United States were unintended in 2006, a percentage unchanged since 1994. Women with unintended pregnancies have greater risks of poor pregnancy outcomes; these risks may be further increased among women with chronic medical conditions. Strategies to reduce unintended pregnancies include helping women and couples who do not wish to become pregnant to correctly and consistently use effective methods of contraception. However, many women with chronic medical conditions, especially those with multiple chronic conditions, and their providers are concerned about the safety of contraceptive method use, given their medical conditions.

CDC's Safe Motherhood Program has been a key contributor to the development of evidence-based guidance on contraceptive practice by the World Health Organization (WHO). CDC has recently adapted the WHO guidance for use by US health care providers. This guidance, *US Medical Eligibility Criteria for Contraceptive Use, 2010*, provides recommendations for safe use of contraceptive methods for women with chronic medical conditions and other characteristics. This guidance addresses over 160 medical conditions and other characteristics. CDC is working closely with partners, such as the Office of Population Affairs and other service and professional organizations, to disseminate, implement, and evaluate this guidance.

Web Link:

<http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm>
<http://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf>

Collaborating HHS Agencies: Office of Population Affairs, HHS; NICHD; FDA

Point of Contact: Kate Curtis Kmc6@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 1/Objectives A & B
Goal 3/Objective A, B, D

HRSA/HAB: QUALITY CARE – PATIENTS WITH HIV/AIDS

Description:

The care and treatment of persons living with HIV/AIDS must also take into account three types of additional chronic conditions: (1) Other infectious diseases such as hepatitis C and hepatitis B, (2) Physical conditions such as diabetes and heart disease and (3) behavioral health conditions, such as substance use, addiction, and depression. The Department of Health and Human Services HIV Guidelines provide updated guidelines to screen patients for these additional chronic conditions and deliver the care they need.

From these guidelines, the HIV/AIDS Bureau (HAB) develops and maintains performance measures for care and treatment. These ensure funded providers focus on the multiple chronic conditions in this population. HRSA/HAB will pursue adoption of these measures as part of meaningful use for Electronic Health Records.

Collaborating HHS Agencies: NIH (OAR, NIAID, NICHD); CMS; AHRQ

Web Link:

<http://www.aidsinfo.nih.gov/>
<http://hab.hrsa.gov/special/habmeasures.htm>

Point of Contact:

Tracy Matthews
T:301-443-7804
tmatthews@hrsa.gov

Related MCC Framework Provisions:

Goal 1/Objective D/ Strategy 1
Goal 3/Objective A/Strategy 1- 2

IHS: INJURY PREVENTION PROGRAM INITIATIVE TO PREVENT FALL-RELATED INJURY IN OLDER AMERICAN INDIANS AND ALASKA NATIVES LIVING IN THE COMMUNITY

Description:

The IHS, in collaboration with the CDC Injury Prevention and Healthy Aging Programs, is developing guidance for the prevention of fall-related injury in frail elders which integrates evidence-based clinical guidelines with guidance in the development of community-based programs. The elderly carry a high burden of multiple chronic conditions and are at increased risk of fall, injury, and resultant loss of function. The goal of the initiative is to support the development of comprehensive, integrated efforts to reduce fall-related injury and loss of function in this older population with high rates of multiple chronic conditions.

Point of Contact: Nancy Bill nancy.bill@ihs.gov

Collaborating HHS Agencies: CDC

Related MCC Strategic Framework Provisions:

Goal 2/Objective B/Strategies 2 and 3.
Goal 3/Objective C/Strategies 1 and 2

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

Objective A: Increase the External Validity Of Trials

FDA: INVENTORY OF CLINICAL TRIALS TO SUPPORT HHS MULTIPLE CHRONIC CONDITIONS INITIATIVE

Description:

The project will examine the extent to which individuals with MCCs are included in clinical trials submitted to FDA to support recent new drug applications. This effort is aligned with specific objectives in the MCC framework to ensure that individuals with MCCs are not unnecessarily excluded from clinical trials, particularly those trials that are used as the regulatory basis for ensuring that drugs are safe and effective in their intended populations and for their intended uses.”

Web Link: None

Collaborating Agencies: None

Point of Contact:

Theresa Mullin

Theresa.Mullin@fda.hhs.gov

Related MCC Framework Provisions:

Goal 4/Objective A

NIH/NCI: CTEP INITIATIVES TO INCLUDE INDIVIDUALS WITH HIV AND CANCER ONTO NCI-SPONSORED CANCER CLINICAL TRIALS

Description:

The Cancer Therapy Evaluation Program (CTEP) of the National Cancer Institute has initiated a new research program to improve the approach to cancer therapy in individuals with HIV infection and cancer. CTEP has three new initiatives to enhance access to cancer clinical trials for those with HIV, including studying potential drug interactions and defining safe and effective use of anti-HIV therapy and anti-cancer therapy, increasing the participation of HIV+ patients in clinical trials of potentially curative therapy such as bone-marrow transplantation,

ensuring that other phase II and III cancer clinical trials will also be made available to those with HIV, and conducting a prospective sero-epidemiologic survey to assess the burden of HIV disease in cancer patients.

Web Link:

<http://ctep.cancer.gov/>
<http://pham.cancer.gov/health/trials>

Collaborating HHS Agencies:

N/A

Point of Contact:

Rich Little, MD
Head, Head- Hematologic and HIV-Related Cancer Therapeutics and Stem Cell Therapeutics
6130 Executive Blvd., Room 7025
Bethesda, MD 20892
T: 301.435.9193
F: 301.402.0557
little@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective A/Strategy 1
Goal 4/Objective A/Strategy 2

Objective B: Understand the Epidemiology Of Multiple Chronic Conditions

CDC: EXAMINING PREVALENCE AND IMPLICATIONS OF ARTHRITIS FOR ADULTS WITH CO-MORBID CHRONIC CONDITIONS

Description:

CDC's Arthritis Program is conducting epidemiologic analysis to characterize the co-occurrence of arthritis with other chronic conditions. To date, CDC has found that arthritis is common among adults with diabetes, heart disease, and obesity.

Web Link: <http://www.cdc.gov/arthritis/>

Collaborating HHS Agencies: None

Point of Contact: Charles Helmick, CHelmick@cdc.gov

Related MCC Strategic Framework Provisions:

CMS/CSP: REPORT ON CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES

Description

The report “Chronic Conditions among Medicare Beneficiaries” defines chronic conditions among Medicare fee-for-service (FFS) beneficiaries by examining the type and distribution of chronic conditions as well as multiple chronic conditions (MCC). The report examines 15 specific chronic conditions and the number of chronic conditions in terms of prevalence, service utilization, and cost. The report also examines specific clusters of conditions that are common among the Medicare population. The report is based upon data from CMS’s Chronic Condition Data Warehouse (CCW) for the year 2008. The CCW contains 100 percent of Medicare claims for beneficiaries who are enrolled in the FFS program and was designed as a database to support research on beneficiaries with chronic conditions. The 15 chronic conditions included in this report were developed in collaboration with members of the HHS Interagency Workgroup on MCC. The chronic condition definitions take into account clinical criteria (e.g. diagnoses codes), the type and number of claims (e.g. inpatient hospitalization versus office visit) and the dates of service.

The information available from this report is intended to provide internal and external policymakers a better understanding of the MCC burden among the Medicare FFS population and provide preliminary insights into the targeting of prevention and management strategies that will improve care and reduce costs for those with multiple chronic conditions. The report will be presented in a series of charts and will be made available to the public on the CMS website.

Web Link: TBD

Collaborating HHS Agencies:

OS/OASH

CDC National Center for Chronic Disease Prevention and Health Promotion

Point of Contact:

Christine Cox

Group Director

Center for Strategic Planning

Centers for Medicare and Medicaid Services

T: (410)786-6540

Related MCC Framework Provisions:

Goal 1/Objective/Strategy 1

Goal 4/Objective B/Strategy 1 and 2

NIH/NIMH: CENTRAL NERVOUS SYSTEM HIV ANTI-RETROVIRAL THERAPY EFFECTS RESEARCH (CHARTER)

Description:

The Central Nervous System HIV Anti-Retroviral Effects Research (CHARTER) program at the National Institute of Mental Health was established in 2002 to understand the impact of anti-retroviral therapy on the neurological (brain functioning) and neurocognitive (thinking and memory) complications for people living with HIV/AIDS. There are several categories of HIV-Associated Neurocognitive Disorders (HAND), including Asymptomatic Neurocognitive Impairment, Mild Neurocognitive Disorder (MND), and HIV-Associated Dementia. MND is the most prevalent form of HAND; yet even mild neurocognitive deficits can interfere with activities of daily living and reduce the quality of life in long-standing HIV-positive patients who are aviremic (lacking virus in blood plasma). The prevalence of HAND remains high for patients with HIV/AIDS despite wide spread use of highly active anti-retroviral therapy (HAART).

To increase understanding of the neurological and neurocognitive complications for individuals with HIV/AIDS, CHARTER recently completed a large epidemiologic study, which examined 1,574 participants cross-sectionally (at a particular point in time) and 657 participants longitudinally (over an extended period of time). CHARTER reported a HAND prevalence rate of greater than 50% in HIV-infected individuals in the United States. The CHARTER program will continue to follow a subset of the longitudinal cohort in an effort to further define predictors of neurocognitive decline. In addition, CHARTER will provide research resources—datasets and clinical samples—to research investigators focused on determining how HIV affects the central nervous system to give rise to HAND.

Web Link:

<https://www.charterresource.ucsd.edu>

Collaborating HHS Agencies:

NINDS

Related MCC Framework Provisions:

Goal 4/Objective B/Strategy 1

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

Objective C: Increase Clinical, Community, and Patient-Centered Health Research

AHRQ: COMPARATIVE EFFECTIVENESS RESEARCH TO OPTIMIZE PREVENTION AND HEALTHCARE MANAGEMENT FOR THE COMPLEX PATIENT

Description:

This AHRQ FOA invites Exploratory/Developmental grant (R21) applications from organizations that aim to understand the comparative value of different strategies in the prevention and management of chronic illness in persons with specific constellations of co-morbid conditions. Exploratory research studies will contribute evidence to help guide the appropriate integration (i.e., prioritization, timing, provision and coordination) of therapeutic and preventive services in individuals with multiple chronic conditions. This work should improve our understanding of the comparative value of interventions to patients with multiple conditions, how the safety and effectiveness of specific interventions may be affected by co-morbid conditions, and how interventions may need to be modified for specific patient populations with multiple conditions. This information should help clinicians better integrate care provided to such individuals, help patients make informed decisions about health care choices, and help policymakers identify better ways to measure and promote quality care for complex patients.

AHRQ funded fourteen two-year grants under this initiative in 2010 that will run until September of 2012.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-009.html>

http://gold.ahrq.gov/projectsearch/grant_search_result.jsp?PA=HS10-009

Collaborating HHS Agencies: None

Point of Contact:

Mary Barton, MD, MPP
AHRQ
T:301-427-1638,
mary.barton@ahrq.hhs.gov

Related MCC Framework Provisions:

Goal 4, Objective C, Strategy 1
Goal 1/Objective F/Strategy 1

AHRQ: EXPANSION OF RESEARCH CAPABILITY TO STUDY COMPARATIVE EFFECTIVENESS IN COMPLEX PATIENTS

Description:

This one-time funding opportunity announcement (FOA) issued by the Agency for Healthcare Research and Quality (AHRQ) solicited Infrastructure Development grant applications from applicant organizations that propose to build or enhance partnerships, datasets and methodologies that will improve the capacity to study, and the quality of studies, of patients with multiple chronic illnesses.

AHRQ awarded thirteen two-year grants under this initiative to begin in September 2010 and last until September 2012, with budgets up to \$1,000,000 over two years.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-001.html>

http://gold.ahrq.gov/projectsearch/grant_search_result.jsp?PA=HS10-001

Collaborating HHS Agencies: None

Point of Contact:

Mary Barton, MD, MPP
AHRQ
T:301-427-1638,
mary.barton@ahrq.hhs.gov

Related MCC Framework Provisions:

Goal 4/Objective C/ Strategy 2

ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: INDIVIDUALS LIVING IN THE COMMUNITY WITH CHRONIC CONDITIONS AND FUNCTIONAL LIMITATIONS: A CLOSER LOOK

Description:

This report provides an analysis of 2006 Medical Expenditure Panel Survey data that describe how individuals with chronic conditions compare to other elderly and non-elderly individuals living in the community, in terms of their health care service use and expenditures. Within the group that has chronic conditions, those with functional limitations have the greatest service use and expense. Programs that support the needs of these individuals may have the potential to reduce the use of certain services, e.g., hospitalization, as well as reduce expenditures.

A similar analysis of Medicare Current Beneficiary Survey data will enable comparisons between elderly individuals living in the community and those living in institutions. It will also estimate

transitions to institutions, and the factors that place people at risk of entering institutions. The report is expected to be completed by December 31, 2011.

Web Link: <http://aspe.hhs.gov/daltcp/reports/2010/closerlook.pdf>

Collaborating HHS Agencies: None

Point of Contact: John Drabek, John.Drabek@hhs.gov

Related MCC Strategic Framework Provisions:

Goal 4/Objective B/Strategy 2

Goal 4/Objective C/Strategy 3

CDC: EXAMINING THE IMPACT OF COGNITIVE IMPAIRMENT ON CO-OCCURRING CHRONIC CONDITIONS AND GERIATRIC SYNDROMES

Description:

Increasing age is a risk factor for developing cognitive impairment along with chronic diseases and geriatric syndromes (e.g., falling, functional impairments, urinary incontinence, or polypharmacy). The current project is designed to examine the effects of multiple chronic conditions (dementia plus other chronic illness or geriatric syndromes) on various health outcomes such as functioning, quality of life, or mortality. The project will also examine how dementia specifically impacts other co-occurring chronic illness or geriatric syndromes, such as chronic disease management or morbidity.

Web Link:

<http://www.cdc.gov/aging/healthybrain/research.htm>

<http://www.prc-han.org/cognitive-health>

Collaborating HHS Agencies: National Institutes of Health

Agency contact: Lynda Anderson, PhD, Laa0@cdc.gov

Related MCC Strategic Framework Provisions:

Goal 4/Objective B/Strategy 2

Goal 4/Objective C/Strategy 3

NIH/NCI: AIDS MALIGNANCY CLINICAL TRIALS CONSORTIUM (AMC)

Description:

This clinical trials consortium was established in 1995 to evaluate clinical trials interventions for the treatment and prevention of malignancies in HIV. The consortium conducts multi-site

clinical trials in medical centers across the United States and in selected sites in Africa, India and Brazil. The AMC facilitates the rapid evaluation of hypothesis-driven Phase I, II, and III clinical trials.

Despite dramatic declines in HIV mortality rates due to the success of highly active antiretroviral therapy (HAART), cancer is the leading cause of death among HIV-infected patients. An increase in non-AIDS defining cancers is now becoming evident in this population, as well as the late occurrence of Kaposi's sarcoma and other AIDS-related cancers.

The AMC has recently identified four new sites (Kenya, South Africa, Uganda and Zimbabwe) that will serve as "Core" clinical trials sites in Africa. The AMC plans to develop treatment strategies and clinical trials for HIV-associated malignancies that are appropriate for resource limited countries. It is hoped that these treatment strategies will significantly increase the standard of care for HIV-associated malignancies in these countries.

Web Link:

<http://pub.emmes.com/study/amc/public/index.htm>

Collaborating HHS Agencies:

N/A

Point of Contact:

Rebecca Liddell Huppi, Ph.D.

Program Director

AIDS Cancer Clinical Program; Office of HIV and AIDS Malignancy, NCI

31 Center Drive, Room 3A33

Bethesda, MD 20892

T: 301.496.4995

F: 301.480.4137

liddellr@exchange.nih.gov

Related MCC Framework Provisions:

Goal 3/Objective A/Strategy 1

Goal 4/Objective A/Strategy 1

NIH/NCI: COMMUNITY-ENGAGED RESEARCH ON HIV/AIDS-RELATED CANCERS AMONG UNDERSERVED POPULATIONS

Description:

In 2009 and 2010, CRCHD provided administrative supplemental funding to grantees conducting community-engaged cancer health disparities research in order to target an additional disparate population - the HIV-affected from underserved populations (e.g., diverse racial/ethnic groups, rural, poor, uninsured). The timeline for the program is one to two years

per project. CRCHD plans to continue the program through 2013 with support through the Office of HIV/AIDS Malignancy (OHAM).

The overall purpose of this program is two-fold: (1) to prepare projects for sustainable investigator-initiated funding on research concerning HIV/AIDS as a contributing factor to cancer health disparities, and (2) to identify and train a cadre of emerging community engaged researchers focused on cancer health disparities. Studies must be conducted using community-based participatory research (CBPR) principles through a collaboration comprised of a cancer health disparities research project (the grantee), a federally funded HIV/AIDS research project, and community-based partners. Examples of projects include: evidence-based smoking cessation research among people living with HIV (PLWH), adaptation of patient navigation for women dually affected with HIV and HPV, feasibility testing of different methods for screening for anal neoplasia among PLWH, and feasibility testing of IPod delivered messages concerning early detection of cancer for PLWH.

Web Link:

<http://crchd.cancer.gov/>

Collaborating HHS Agencies:

N/A

Point of Contact:

Martha L. Hare, PhD, RN
Program Director
NCI Center to Reduce Health Disparities
6116 Executive Blvd., Room 6073
Bethesda, MD 20892
T: 301.594.1908
F: 301.435.9225
Martha.Hare@nih.gov

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1
Goal 4/Objective D/Strategy 1

NIH/NCI: NCI ORGAN DYSFUNCTION WORKING GROUP

Description:

Cancer patients who present with renal or hepatic organ dysfunction may require dose reductions or modifications. Gathering organ dysfunction data has traditionally been a post-marketing function. No information has been available concerning use of the newest, potentially most effective investigational therapies or chemotherapies for these patients, and clinicians tend to make dose adjustments for these and the tried-and-true standard therapies

empirically. The National Cancer Institute's Organ Dysfunction Working Group, the Southwest Oncology Group Early Therapeutics Committee, and the Cancer and Leukemia Group B (CALGB) were formed to address the paucity of information for patient with organ dysfunction, and to accrue patients efficiently. The investigators associated with these Groups enroll cancer patients in organ dysfunction studies of new agents that are under investigation at CTEP. This is an on-going program of clinical trials/studies enrolling appropriate patient populations of about 25 to 100 patients per study over a 15 month period for an individual study.

In addition, the Organ Dysfunction Working Group is collaborating with the NCI-Sponsored AIDS-Malignancy Consortium to define pharmacokinetic interactions and safe combination dosing of novel anti-cancer agents and major classes of antiretroviral therapies for HIV-infected persons. This new, important component to the program has almost completed its first trial in one year's time and three new trials are being planned.

Web Link:

http://ctep.cancer.gov/MajorInitiatives/Organ_Dysfunction_Studies.htm

Collaborating HHS Agencies: None

Point of Contact for Primary Program:

Percy Ivy, MD
Associate Branch Chief
Investigational Drug Branch, CTEP, DCTD, NCI
6130 Executive Blvd., Room 7131
Bethesda, MD 20892
T: 301.496.1196
301.402.0428
ivyp@mail.nih.gov

Additional Contact for Component of Program for HIV+ Patients:

Rich Little, MD
Head, Head-Hematologic and HIV-Related Cancer Therapeutics and Stem Cell Therapeutics;
6130 Executive Blvd., Room 7025
Bethesda, MD 20892
T: 301.435.9193
F: 301.402.0557
little@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective A/Strategy 4

NIH/NEI: LOW VISION AND CLINICAL DEPRESSION

Description:

Diseases that cause reduction or loss of vision are a major source of disability, while lowering quality of life by preventing people from driving, reading, and living independently. Younger patients with blinding diseases like retinitis pigmentosa or older patients with age related macular degeneration (AMD), diabetic retinopathy, or glaucoma often become clinically depressed, further complicating the complexity of their disease and the cost of treatment. The Low Vision Depression Prevention Trial for AMD tests the efficacy of a collaborative care intervention that pairs occupational therapists with optometrists who specialize in low vision. The aims are to reduce depression and improve quality of life in AMD patients. NEI is also supporting career training to mental health professionals conducting clinical trials for patients with low vision.

Web Link: <http://clinicaltrials.gov/ct2/show/NCT00769015>

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Steven Oversby
Clinical Studies
Division of Extramural Research
National Eye Institute, NIH
5635 Fishers Lane, Suite 1300
Rockville, MD 20892
soversby@mail.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 2
Goal 4/Objective C/Strategy 1

NIH/NHLBI: REDUCING CARDIOVASCULAR DISEASE RISK THROUGH TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Description:

Scientific evidence suggests that obstructive sleep apnea (OSA) is a significant risk factor for myocardial infarction (MI), hypertension, sudden death, and stroke, and for exacerbating the progression of cardiovascular disease (CVD). However, no population-based studies in the U.S. have assessed the effect of treatment of OSA on any CVD outcome or CVD risk factors.

The program supports pilot studies that will inform the design of a Phase III clinical trial to test whether positive airway pressure (PAP) treatment of OSA reduces cardiovascular events. The program is expected to provide information regarding the feasibility of long-term PAP treatment in OSA patients at risk of CVD. It also is expected to provide data regarding the effects of PAP on surrogate or intermediate markers of CVD risk. The program focuses on

individuals with established OSA who are at high risk for CVD and who have no prior history of PAP treatment. The NHLBI is supporting two 3-year awards.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-10-023.html>

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Carl A. Roth Ph.D., LL.M.

301.496.6331

rothc@nhlbi.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1 and 2

NIH/NIA: DEVELOPING INTERVENTIONS FOR MULTIMORBIDITIES

Description:

The National Institute on Aging (NIA) supports research projects that provide information needed to design clinical trials of interventions to improve health outcomes related to interactions of multiple co-occurring conditions in elderly patients. Specific projects include: Patient-Centered Care Management for Seniors with Multiple Morbidities, Walking Activity and the Burden of Multiple Morbidities, Nursing Home Co-morbid Depression Care Management, Osteoporosis in Women with Rheumatoid Arthritis, Tailored Clinical Trials for Hypertension and Fall Risk, and Improving Medication Therapy for Older Patients with Common Co-morbidities.

In addition, other NIA-supported clinical trials are addressing important issues related to MCC. An NIA trial in older men (with joint support from NINDS, NICHD, and NHLBI) is examining the efficacy of testosterone therapy for physical disability, sexual dysfunction, and loss of vitality, including potential differences in effects in men who have two or more of these conditions compared with men who have only one. Investigators with the NIA Lifestyle Interventions and Independence for Elders (LIFE) trial, with joint support from NHLBI, are testing the effectiveness of a physical activity intervention in preventing mobility disability in at-risk older adults with several chronic diseases in various combinations.

Web Link:

None

Collaborating HHS Agencies:

None

Point of Contact:

Kathie Reed, OPAAE, NIA

Related MCC Framework Provisions:

Goal 4/Objective A/Strategy 1

Goal 4/Objective C/Strategy 2

**NIH/NIAAA: INTERVENTIONS FOR ALCOHOL USE DISORDERS AND HIV/AIDS:
REDUCING ACQUISITION, PROGRESSION, TRANSMISSION OVER THE LIFESPAN.****Description:**

NIAAA has supported three primary programs of research to improve survival and quality of life among people living with HIV/AIDS: 1) The Veteran's Aging Cohort Study (VACS); 2) alcohol pharmacotherapies in people living with HIV/AIDS; and 3) behavioral interventions for alcohol misuse in people at risk for and living with HIV/AIDS.

VACS is a large multi-site study of the effects of alcohol use on HIV outcomes over the life span in individuals aging with HIV. Records of treatment actions and treatment outcomes are maintained for each participating veteran, integrated with careful assessments for alcohol misuse and psychiatric comorbidities.

The program of research on alcohol pharmacotherapies in people living with HIV/AIDS is examining the use of combined behavioral and pharmacotherapies (e.g., oral and injectable naltrexone) in individuals with co-occurring HIV infection, heavy drinking, alcohol abuse, and alcohol dependence.

The third key area of interest, behavioral interventions for alcohol misuse in people at risk for and living with HIV/AIDS, focuses on the further development of emerging basic behavioral approaches for co-occurring HIV infection and problem drinking to increase adherence to medications and reduce HIV risk behavior. This program of research places special emphasis on mechanisms of behavior change (e.g. behavioral economics); the integration of effective behavioral interventions for alcohol misuse in HIV treatment settings; the integration of effective HIV risk reduction interventions in alcohol treatment settings; and the adoption of effective integrated behavioral treatments for alcohol and HIV in a variety of general medical settings, such as primary care practices and STD clinics. Among other priorities, future research on alcohol and HIV will emphasize interdisciplinary approaches to the design and conduct of multilevel intervention trials that integrate strategies at the individual, family, and community levels to reduce the impact of alcohol on HIV transmission and disease progression.

Web Link:

<http://grants.nih.gov/grants/guide/pa-files/PA-10-103>

<http://grants.nih.gov/grants/guide/pa-files/PA-10-104>

<http://grants.nih.gov/grants/guide/pa-files/PA-10-105>

<http://medicine.yale.edu/intmed/vacs/index.aspx>

Collaborating HHS Agencies: VA, NIA, NIAID, NHLBI

Point of Contact:

Kendall J. Bryant, Ph.D.
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Director of HIV/AIDS Research
Office of the Director
Rm. 2069
5635 Fishers Lane, MSC 9304
Bethesda, MD 20892-9304
T: 301.402.9534
kbryant@mail.nih.gov

Deidra Roach, M.D.
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Division of Treatment and Recovery Research
Rm. 2039
5635 Fishers Lane, MSC 9304
Bethesda, MD 20892-9304
T: 301.443.5820
droach@mail.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective B/Strategy 1
Goal 1/Objective E/Strategy 1
Goal 4/Objective D/Strategy 1

NIH/NIAAA: TREATMENT OF CO-OCCURRING ALCOHOL USE DISORDERS AND DEPRESSION/ANXIETY DISORDERS

Description:

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH) is expanding and strengthening a program of research to identify effective treatments for individuals with co-occurring alcohol use disorders and depression/anxiety.

The scope of NIAAA's recent research initiative on co-occurring alcohol use disorders and depression/anxiety includes innovative pharmacological and behavioral treatments based on biological, psychological, behavioral, and social/cultural models of the etiology and treatment of comorbid alcohol use disorders and depression/anxiety. A particular area of emphasis is comparative effectiveness research, which will compare the effectiveness of two or more existing treatments in various populations with comorbid alcohol use disorders and

depression/anxiety, and, in cases where treatments vary in effectiveness, attempt to explain why these differences occur. A second area of emphasis is pharmacogenetic research to examine the influence of certain genetic polymorphisms on the response to various medications used for the treatment of alcohol dependence and depression/anxiety disorders. As this line of research advances, it is expected to lead to the identification of medications that are increasingly tailored to the needs of specific subsets of patients within the existing broad categories of patients with comorbid alcohol and mood disorders.

Other key objectives of this initiative include establishing interdisciplinary partnerships to integrate biological, behavioral, psychological, and social/cultural research to develop and test novel treatments; developing and testing theoretical models that underlie these particular comorbidities; and addressing the many unique methodological issues and challenges before the field, including but not limited to assuring the safety of research participants; determining optimal study design; improving recruitment/retention and adherence; and identifying improved approaches to assessment and outcome measurement.

Web Link:

<http://grants.nih.gov/grants/guide/pa-files/PAS-10-251.html>

Collaborating HHS Agencies:

None

Point of Contact:

Raye Z. Litten, Ph.D.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Division of Treatment and Recovery Research

Rm. 2041

5635 Fishers Lane, MSC 9304

Bethesda, MD 20892-9304

T: 301.443.0636

rlitten@mail.nih.gov

Deidra Roach, M.D.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Division of Treatment and Recovery Research

Rm. 2039

5635 Fishers Lane, MSC 9304

Bethesda, MD 20892-9304

T: 301.443.5820

droach@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1 and 2

NIH/NICHD: OBESITY RESEARCH

Description:

The NICHD supports research on childhood obesity and the effect of obesity on pregnancy outcomes. Research activities include, for example, examining gestational diabetes and examining the links among polycystic ovary syndrome (PCOS), infertility, and controlling weight. A recent NICHD study showed that the more obese a woman is when she becomes pregnant, the greater the likelihood that she will give birth to an infant with a congenital heart defect. In addition, the Institute is encouraging research on home and family based approaches that prevention or manage overweight or obesity in young children, on diet composition and energy balance, and on the economics of diet, activity, and energy balance. In addition, NICHD researchers are conducting studies on approaches to manage diabetes in children and their families. Plus, NICHD is supporting research to investigate the potential use of glucose monitoring technology and its impact on the management of type 1 diabetes in children. The Institute brought together a scientifically diverse group to discuss research gaps in the area of obesity in children and adolescents with physical or intellectual disabilities. A meeting publication is forthcoming.

Web Link:

<http://www.nichd.nih.gov/womenshealth/research/disorders/infertility.cfm#polycystic>
<http://www.nih.gov/news/health/apr2010/nichd-07.htm>
http://www.nichd.nih.gov/funding/foa/foa.cfm?org_term=HNT3D
<http://www.nichd.nih.gov/about/org/despr/studies/chrondis/index.cfm>
<http://direcnet.jaeb.org/ViewPage.aspx?PageName=Home>
<http://www.nichd.nih.gov/about/org/od/orsc/>
<http://www.nichd.nih.gov/about/meetings/2010/071510-obesity-children.cfm>

Collaborating Agencies: None

Point of Contact:

Layla Esposito, PhD
Health Scientist Administrator
Center for Research for Mothers and Children
Eunice Kennedy Shriver National Institute of Child Health and Human Development
National Institute of Health
6100 Executive Blvd., Room 4B05F
Rockville, MD 20852
(301) 435-6888
espositl@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1-3

NIH/NIDA: CO-OCCURRING DRUG ABUSE AND HIV

Description:

The National Institute on Drug Abuse (NIDA) supports research to learn more about how drug abuse and HIV interrelate and to further promising primary and secondary prevention and treatment for co-occurring drug abuse and HIV infection. For example, research is demonstrating that increasing HIV testing and reducing viral load among HIV positive individuals through HAART therapy can be effective in reducing the HIV transmission at a population level. However, substance abusers and individuals with mental illness often face barriers to care due to factors such as stigma, social marginality, or economic, cultural or structural factors that lead to high rates of HIV and poor health outcomes. NIDA is therefore investing in developing and testing seek, test, treat, and retain strategies for settings that are typically outside the traditional health care system, such as social service settings, needle exchange programs, drug treatment programs, mental health centers, or other community settings where these vulnerable populations receive care.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-11-001.html>

Collaborating HHS Agencies:

NIH/NIMH

Point of Contact:

Susan Weiss
301.443.6071
sweiss@nida.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective E/Strategy 2
Goal 4/Objective D/Strategy 1
Goal 4/Objective D/Strategy 2

NIH/NIDA: CO-OCCURRING DRUG ABUSE/ADDICTION AND CHRONIC PAIN

Description:

The National Institute on Drug Abuse (NIDA) has embarked on a research program to examine the intersection of pain treatment with abuse of and addiction to opioid medications. Major goals are to develop alternative pain medications with reduced addiction potential, and to elucidate risk or protective factors related to opioid abuse and addiction. Studies that provide a better understanding of the shared cellular networks and mechanisms involved in chronic pain and drug addiction, for example, could lead to pain medications with less abuse potential and to better treatments for drug addiction. Another effort that NIDA has undertaken in this area is the first-ever large-scale national study conducted through NIDA's National Drug Abuse

Treatment Clinical Trials Network evaluating a treatment for addiction to prescription opioid analgesics such as Vicodin and OxyContin in patients with and without chronic pain. Further, because of the integral role physicians can play in treating pain and preventing, recognizing, and treating drug addiction, NIDA is working to enhance physician training in recognizing and treating substance abuse in the context of chronic pain through our Centers of Excellence for Physician Information (CoEs).

Web Link:

<http://www.drugabuse.gov/ctn/ProtocolSelected.php?id=%2017;>

[http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-09-017.html;](http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-09-017.html)

<http://www.drugabuse.gov/coe/topic.htm#pda>

Collaborating HHS Agencies:

NINDS

Point of Contact:

Susan Weiss

301.443.6071

sweiss@nida.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective E/Strategy 1

Goal 3/Objective B/Strategy 1

NIH/NIDA: CO-OCCURRING SUBSTANCE ABUSE/ADDICTION AND OTHER MENTAL HEALTH DISORDERS

Description:

People diagnosed with substance use disorders (SUDs) are roughly twice as likely to suffer also from mood and anxiety disorders—with the reverse also true. NIDA therefore funds research grants to study comorbid drug abuse and mental illness with the general goal of finding better prevention and treatment strategies for both. These include studies to elucidate epidemiology and etiology of these co-occurring conditions and the effects of various treatment strategies in comorbid populations. For example, to better understand the causal factors and how best to prevent and treat the interconnected problems of substance abuse and mental illness being faced by returning veterans and their families, NIDA has joined with NIAAA, NCI, and the Department of Veterans Affairs (VA) in a joint call for research. As a result, NIDA has funded studies on how to optimally integrate treatment for interrelated post-traumatic stress syndrome (PTSD), depression, anxiety, sleep disturbances, and substance abuse. NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) is also studying these issues, working in regional VA hospitals and research centers to explore possible collaborations to develop and test effective interventions for comorbid PTSD and SUD in active duty service personnel and war veterans.

Web Link

<http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-10-001.html>

Collaborating HHS Agencies:

NIAAA, NCI

Point of Contact:

Susan Weiss

301.443.6071

sweiss@nida.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective E/Strategy 1

NIH/NIDCR: DIABETES AND PERIODONTITIS RESEARCH PROGRAM**Description:**

The Diabetes and Periodontitis Research Program currently includes 4 major studies that address questions to help improve the care of persons with MCC.

(1)The Diabetes and Periodontics Therapy Trial, a multi-center, randomized, controlled single-masked Phase III clinical trial designed to evaluate whether non-surgical treatment of chronic periodontitis will help improve diabetes control. Having periodontal (gum) disease may make it more difficult to control blood sugar levels for people with Type 2 diabetes. This study will test whether non-surgical periodontal disease treatment leads to improved blood sugar control. Improving the way people manage their blood sugar is key to preventing diabetes complications and reducing health care costs. The study results have the potential to provide a scientific basis for an improvement in the standard of care for patients with diabetes.

(2) Another NIDCR-supported study is establishing and following a cohort of overweight and obese individuals free of diabetes from the San Juan municipality. This Hispanic population has high levels of periodontal disease and insulin resistance. The long-term goals will be to assess whether periodontal disease is a risk factor for the incidence of Type 2 diabetes among participants with glucose intolerance and/or insulin resistance.

(3) A separate NIDCR study is investigating the microbiome associated with periodontal disease and diabetes in a high- risk Hispanic population. This study will define the microbial community and metagenomic signatures that distinguish the oral microbiome of periodontal health and disease in Type 2 diabetics from that of non-diabetic subjects, and may lead to further studies for the development of innovative clinical approaches to diagnosing, preventing and managing the disease in diabetics.

(4) The American Academy of Periodontology (AAP) has proposed clinical use of statins in the treatment of periodontal disease as one of its clinical initiatives over the next five-to-ten years. Periodontal disease is a chronic disease of the supporting structures of the teeth, characterized by tissue inflammation and destruction that eventually lead to tooth loss – conditions exacerbated in diabetic patients. A current NIDCR-supported research project seeks to clarify the role of the anti-inflammatory effects of statin use on periodontal disease and tissue inflammation in both nondiabetic and diabetic patients.

Web Link: none

Collaborating HHS Agencies: None

Point of Contact:

Amy B. Adams

adamsamy@mail.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective E/Strategy 1

Goal 4/Objective C/Strategy 1, 2

Goal 4/Objective B/Strategy 3

Goal 4/Objective D/Strategy 1

NIH/NIDDK: DEPRESSION AND DIABETES

Description:

It has been estimated that depressed individuals are 60 percent more likely than non-depressed individuals to develop type 2 diabetes, and those with schizophrenia and bipolar disorder have similar or even higher risk. Increased risk is most likely mediated primarily by increased rates of obesity, smoking, and inactivity in these populations, as well as limitations in quality and access to general medical care.

NIDDK supports a diverse portfolio of investigator-initiated projects related to diabetes and depression. Examples of ongoing research programs include studies to understand the biological, behavioral, and environmental mechanisms between diabetes and depression as well as research that focuses on the prevention and treatment of these co-morbid conditions with a focus on reduced complications, improved diabetes outcomes, increased quality of life, and better adherence to treatment recommendations.

Web Link:

<http://www2.niddk.nih.gov/AboutNIDDK/ReportsAndStrategicPlanning/DiabetesPlan/Background>

Collaborating HHS Agencies:

N/A

Point of Contact:

Richard Farishian, Ph.D.
Director
Office of Scientific Program and Policy Analysis
T: 301.496.6623
FarishianR@niddk.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 1

NIH/NIDDK: ENHANCING TREATMENT ADHERENCE IN PATIENTS WITH MULTIPLE CHRONIC CONDITIONS

Description:

A key NIDDK research priority is to identify strategies to improve adherence in patients with multiple chronic conditions. The Institute hosted a workshop in September 2008 on “Non-Adherence in Adolescents with Chronic Illness.” In 2010, NIDDK issued an RFA for R01 grants related to “Adherence Studies in Adolescents with Chronic Kidney or Urologic Diseases, or Diabetes.” Awards are expected to be made by April 1, 2011.

In addition to these research efforts, the Institute supports education programs to help patients better self-manage their treatment. The National Diabetes Education Program (NDEP) seeks to reduce the burden of diabetes and pre-diabetes by facilitating the adoption of proven approaches to prevent or delay the onset of diabetes and its complications. The National Kidney Disease Education Program aims to raise awareness of the seriousness of kidney disease, the importance of testing those at high risk (those with diabetes, high blood pressure, or a family history of kidney failure), and the availability of treatment to prevent or slow kidney failure.

Web Link:

<http://www3.niddk.nih.gov/fund/other/nonadherence/>
<http://grants.nih.gov/grants/guide/rfa-files/RFA-DK-10-004.html>
<http://www.ndep.nih.gov/>
<http://www.nkdep.nih.gov/>

Collaborating HHS Agencies:

NDEP: CDC

Point of Contact:

Richard Farishian, Ph.D.
Director

Office of Scientific Program and Policy Analysis
301.496.6623
FarishianR@niddk.nih.gov

Related MCC Framework Provisions:

Goal 2/Objective A/Strategy 2
Goal 2/Objective C/Strategy 1
Goal 3/Objective A/Strategy 1
Goal 4/Objective C/Strategy 2

NIH/NIMH: ADDRESSING DEPRESSION AND ANTI-RETROVIRAL THERAPY ADHERENCE IN HIV-POSITIVE ADULTS ON THE US-MEXICO BORDER

[Index](#)

Description:

Patients living with HIV/AIDS are more likely to have depression and mood disorders than the general population. Research indicates that depression can compromise adherence to HIV medications and treatment, and there is a dearth of culturally tailored strategies to address these problems among Hispanic populations. This study will test a culturally tailored counseling program to treat depression and improve HIV medication adherence among Latino adults. In this small randomized trial, 60 HIV-positive Latino adults will be randomly assigned to receive either a counseling program to improve treatment adherence; a pillbox with dosage reminder alarms; both the counseling program and the pillbox; or standard clinical care. The investigators will examine the cultural acceptability of these interventions, hypothesizing that individuals who receive both the counseling intervention and the pillbox will show improved medication adherence and amelioration of depression symptoms.

Web Link:

None

Collaborating HHS Agencies:

None

Related MCC Framework Provisions:

Goal 2/Objective B/Strategy 1
Goal 4/Objective B/Strategy 3

Point of Contact:

Liza Bundesen, Ph.D.
lbundese@mail.nih.gov

NIH/NIMH: DEPRESSION-DIABETES CARE DISPARITIES, ADVERSE OUTCOMES

Description:

Research has shown that depression is commonly associated with diabetes. People who have both diabetes and depression tend to have more severe symptoms of both diseases, higher rates of work disability, and use more medical services than those who only have diabetes alone. This study examined the association between type 2 diabetes and depression among 4,623 adult patients enrolled in Group Health, a health plan serving residents of Washington State. The researchers first interviewed participants from 2000-2002, and conducted follow-up interviews from 2005-2007. The investigators tracked participants' rates of microvascular complications (e.g., blindness, end-stage kidney disease, amputations, and kidney failure deaths) and macrovascular complications (e.g., heart attack, stroke, cardiovascular procedures, and deaths). The findings from the study indicate that individuals with co-occurring type 2 diabetes and major depression are more likely to experience life-threatening complications than those without comorbid major depression.

Web Link:

<http://www.nlm.nih.gov/science-news/2010/diabetes-and-depression-associated-with-higher-risk-for-major-complications.shtml>

Publication Link:

Lin EH, Rutter CM, Katon W, Heckbert SR, Ciechanowski P, Oliver MM, Ludman EJ, Young BA, Williams LH, McCulloch DK, Von Korff M. [Depression and advanced complications of diabetes: a prospective cohort study](#). Diabetes Care. 2010 Feb;33(2):264-9. Epub 2009 Nov 23.

Collaborating HHS Agencies:

NIDDK and NHLBI

Related MCC Framework Provisions:

Goal 4/Objective B/Strategy 3

Goal 4/Objective C/Strategy 2

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

NIH/NIMH: DEPRESSION, ESTROGEN REPLACEMENT, AND CARDIOVASCULAR HEALTH IN PERIMENOPAUSE

Description:

Cardiovascular disease (CVD) is a leading cause of death in women in the U.S. due to higher cardiovascular risk after menopause. Research indicates that depression, as well as estrogen withdrawal, increases risk for CVD in women. Understanding the link between depression and CVD has particular relevance for women since women are 70% more likely than men to experience depression during their lifetime.

This study will examine potential biological risk factors that are common to both CVD and depression, such as inflammation and metabolic disturbances, within the context of estrogen withdrawal during perimenopause. It is hoped that the study will provide information about the predictors (e.g., history of recurrent depression) and moderators (e.g., lifetime trauma exposure) of cardiovascular risk progression in untreated perimenopausal women and the potential beneficial effects of estrogen treatment on depression and cardiovascular risk.

Web Link:

None

Collaborating HHS Agencies:

NHLBI

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 2

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

NIH/NIMH: EFFICACY OF COGNITIVE BEHAVIOURAL THERAPY FOR TREATMENT ADHERENCE AND DEPRESSION IN HIV CARE SETTINGS

Description:

Patients living with HIV/AIDS are more likely to have depression and mood disorders than the general population, and research indicates that depression can compromise adherence to HIV medications and treatment. This clinical trial will study the efficacy of a cognitive-behavioral counseling program designed to treat depression and improve HIV medication adherence among HIV patients who are depressed. In this randomized trial, 240 patients with HIV infection who have been clinically diagnosed with major depression will receive either the combined depression/adherence counseling program, a comparison psychotherapy program, or standard clinical care. The investigators hypothesize that the combined

depression/adherence counseling intervention will reduce depression severity and improve HIV medication adherence, HIV treatment outcomes (viral load and CD4 white blood cell counts), and quality of life. In addition, the investigators will test the cost-effectiveness of the counseling intervention program.

Web Link:

<http://clinicaltrials.gov/ct2/show/NCT00951028>

Collaborating HHS Agencies:

None

Related MCC Framework Provisions:

Goal 2/Objective B/Strategy 1

Goal 4/Objective B/Strategy 3

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

NIH/NIMH: LINKAGE AND RETENTION: A RANDOMIZED TRIAL TO OPTIMIZE HIV/TB CARE IN SOUTH AFRICA

Description:

HIV and tuberculosis (TB) epidemics are largely co-occurring and combine to produce high mortality worldwide. Few evidence-based approaches exist for quickly referring individuals with HIV infection to primary care and optimizing diagnosis of co-occurring TB infection. This clinical trial will examine the efficacy of a “peer navigator” program to rapidly link individuals diagnosed with HIV to primary medical care and TB screening services. In this randomized trial, approximately 1,000 individuals in South Africa who are diagnosed with HIV infection will receive either standard clinical care or will interact with a peer who helps them navigate HIV care engagement and TB screening. The investigators hypothesize that the peer navigator program will improve HIV medical care entry, TB diagnosis rates, and treatment outcomes. Additionally, the investigators will test the cost-effectiveness of the peer navigator program in achieving these ends.

Web Link:

None

Collaborating HHS Agencies:

None

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 2

Goal 4/Objective B/Strategy 1

Point of Contact:

Liza Bundesen, Ph.D.

lbundese@mail.nih.gov

NIH/NIMH: PREVENTION OF POST-STROKE DEPRESSION AND MORTALITY

Description:

Numerous studies have demonstrated an increased death rate associated with post-stroke depression. An important research question is whether prophylactic antidepressants are an effective way of preventing mortality associated with post-stroke depression. In this study, National Institute of Mental Health (NIMH) researchers are conducted a follow-up assessment of patients who received 12 months of antidepressant treatment compared to placebo or to problem solving therapy following a stroke.

The aim of the follow-up study was to determine whether those who received the antidepressant treatment had significantly different measures of cardiac physiology compared to the placebo group. This study has helped with expanding the research on the utility of the antidepressant medication in reducing long-term mortality as well as potential cardiac-related mechanisms, which may be producing this increased mortality.

Web Link: None

Publication Link:

Jorge RE, Acion L, Moser D, Adams HP Jr, Robinson RG. [Escitalopram and enhancement of cognitive recovery following stroke](#). Arch Gen Psychiatry. 2010 Feb;67(2):187-96.

Collaborating HHS Agencies:

None

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1

Point of Contact:

Liza Bundesen

lbundese@mail.nih.gov

NIH/NIMH: STEPPED CARE FOR DEPRESSION AND MUSCULOSKELETAL PAIN

Description:

Comorbid pain and depression have reciprocal adverse effects on both symptom-specific outcomes (reduction of pain and depression) as well as health-related quality of life (HRQL) outcomes. To establish whether treatment strategies shown to improve outcomes for depression in primary care are effective in patients with co-morbid pain and depression, the National Institute of Mental Health (NIMH) developed the Stepped Care for Affective disorders and Musculoskeletal Pain (SCAMP) study. In the study, stepped care strategies accounted for variability between patients by assigning different levels of treatment based on personal characteristics. The study tested whether stepped care is more effective than usual care in improving the outcomes of depression and pain. In addition, the study tested the intervention's impact on HRQL, pain beliefs and behaviors, and health care costs. Finally, longitudinal assessment of the non-depressed cohort will establish the frequency and risk factors for incident depression.

Web Link: None

Publication Link:

Ang DC, Bair MJ, Damush TM, Wu J, Tu W, Kroenke K. [Predictors of pain outcomes in patients with chronic musculoskeletal pain co-morbid with depression: results from a randomized controlled trial](#). Pain Med. 2010 Apr;11(4):482-91. Epub 2009 Dec 9.

Collaborating HHS Agencies:

NIAMS

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1

Point of Contact:

Liza Bundesen

lbundese@mail.nih.gov

NIH/NIMH: THE SAFETY AND EFFICACY OF USING SERTRALINE FOR TREATING DEPRESSION IN PATIENTS WITH CONGESTIVE HEART FAILURE

Description:

Patients who suffer from chronic illnesses including vascular disease (cerebrovascular and coronary artery disease) are more likely to suffer from mood disorders compared to the normal population. In patients with vascular disease, depression also is associated with increases in inpatient hospitalizations, healthcare costs, morbidity, and mortality. Despite this knowledge, little is known about the association between congestive heart failure (CHF) and depression. The rate of depression may be high in the CHF population, but studies have not specifically addressed the impact of treating depression on morbidity and mortality in CHF patients.

Therefore, the National Institute of Mental Health (NIMH) supported a clinical trial to study the safety and efficacy of using sertraline (Zoloft) to treat depression in patients with CHF, in addition to reducing the rates of mortality and re-hospitalization and improving daily functioning and quality of life.

Web Link: None

Publication Link:

Steffens DC, Wei Jiang, Krishnan KR, Karoly ED, Mitchell MW, O'Connor CM, Kaddurah-Daouk R. [Metabolomic differences in heart failure patients with and without major depression](#). J Geriatr Psychiatry Neurol. 2010 Jun;23(2):138-46. Epub 2010 Jan 25.

Collaborating HHS Agencies:

None

Related MCC Framework Provisions:

Goal 4/Objective C/Strategy 1

Point of Contact:

Liza Bundesen

lbundese@mail.nih.gov

NIH/NINDS: RESEARCH ON COMORBID CONDITIONS OF EPILEPSY

Description:

Compared to those without epilepsy, people with epilepsy are more likely to develop or report certain neuropsychiatric conditions, including depression, anxiety, sleep disturbances, cognitive impairment, and psychosis, as well as poor physical health outcomes, such as pain and arthritis, heart disease, and even sudden unexpected death. In 2007, NINDS facilitated the expansion of a set research goals developed by and for the epilepsy research community to include a major emphasis on better understanding and treating or preventing such comorbid conditions of epilepsy.

These goals have helped to promote more research in this area, including several studies supported by NINDS on cognitive deficits, depression, and other epilepsy comorbidities. For example, clinical research and studies in animal models focus on depression in epilepsy and on psychological and cognitive consequences of epileptic brain activity and recurrent childhood seizures. Other recent or ongoing studies focus on adverse effects of epilepsy medications, such as neurodevelopmental outcomes and the potential for some anticonvulsants to increase the risk of heart attack or stroke.

Web Link: http://www.ninds.nih.gov/research/epilepsyweb/2007_benchmarks.htm

Collaborating HHS Agencies:

NIH Institutes--NICHD, NIMH, NHLBI, NINR, and NIMHD.

Point of Contact:

Brandy Fureman, PhD

NINDS program director for epilepsy

furemanb@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective B/Strategy 3

NIH/NINR: CHRONIC CO-MORBID CONDITIONS IN HIV+ U.S. ADULTS ON HIGHLY EFFECTIVE ANTI-RETROVIRAL THERAPY

Description:

The National Institute of Nursing Research, National Institutes of Health, solicited research project grant applications from institutions/organizations proposing mechanistic projects or interventions designed to understand or intervene in chronic co-morbid conditions common to HIV+ adults living in the U.S. who are treated with anti-retroviral therapy. The objectives of this initiative are to gain mechanistic knowledge of and/or demonstrate effective interventions for either prevention or management of chronic co-morbid conditions in HIV+ adults living in the U.S. who are treated with anti-retroviral therapy.

Web Link:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-NR-10-001.html>

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Jeanette Hosseini

jeanetteh@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective B/Strategy 1 and 3

NIH/NINR: CHRONIC ILLNESS SELF-MANAGEMENT IN CHILDREN AND ADOLESCENTS

Description:

The goal of this NINR-led research program is to encourage research to improve self-management and quality of life in children and adolescents with chronic illnesses. Children diagnosed with a chronic illness and their families have a life-long responsibility for self-

management, to maintain and promote health and prevent complications. This program is open to supporting research identifying strategies for self-management and promotion of personal health among children and adolescents with chronic illness or disability including routine health promotion and monitoring and attention to co-morbid conditions.

Web Link:

<http://grants.nih.gov/grants/guide/pa-files/PA-11-070.html>

Collaborating HHS Agencies:

NIH Institutes—

National Heart, Lung, and Blood Institute;

National Institute of Arthritis and Musculoskeletal and Skin Diseases;

National Institute of Child Health and Human Development;

National Institute of Diabetes and Digestive and Kidney Diseases

Point of Contact:

Dr. Linda Weglicki

weglickils@mail.nih.gov

Related MCC Framework Provisions:

Goal 2/Objective A

Goal 4/Objective D

NIH/NINR: COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA IN STABLE HEART FAILURE

Description:

Heart Failure (HF) affects over 5 million Americans and is associated with poor functioning, negative symptoms, and poor quality of life. Insomnia, a disorder of initiating and maintaining sleep, is common in persons with HF and contributes to daytime symptoms and functioning. Cognitive behavioral therapy for insomnia (CBT-I) is an effective treatment for insomnia comorbid with several medical and psychiatric disorders, but has not been tested in HF. NINR is supporting an exploratory developmental research program to test the feasibility, acceptability, and size of the effects of CBT-I on subjective and objective characteristics of sleep, insomnia, and, functional performance in patients with stable HF.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7914365&icde=7397879

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Karen Huss
hussk@mail.nih.gov

Related MCC Framework Provisions:
Goal 4/Objective B/Strategy 3

NIH/NINR: COST EFFECTIVENESS AND QUALITY OF LIFE IN HEART FAILURE PATIENTS WITH DIABETES

Description:

This NINR-supported research program addresses the problems of poor patient outcomes documented by reduced quality of life and high health resource use in heart failure (HF) patients with comorbid diabetes mellitus (DM). The study goals are twofold: 1) to develop and test an integrated self care intervention for HF patients with DM for its effects on patient outcomes including health related quality of life (HRQOL), physical function and health resource utilization, and, 2) to assess the costs and cost effectiveness of the intervention.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7942037&icde=7397844

Collaborating HHS Agencies:
N/A

Point of Contact:

Dr. Karen Huss
hussk@mail.nih.gov

Related MCC Framework Provisions:
Goal 1/Objective A/Strategy 2
Goal 4/Objective C/Strategy 1

NIH/NINR: INTERACTIONS AMONG DEPRESSIVE SYMPTOMS AND GENETIC INFLUENCES ON CARDIAC OUTCOMES

Description:

Patients with acute coronary syndromes (ACS) who are diagnosed with major depression are at greater risk for subsequent major adverse coronary events (MACE). In this NINR-supported study, researchers expect to identify a well-defined, high-risk subgroup of ACS patients in which the interaction of depression and the genetic polymorphisms identified increases risk of subsequent MACE (myocardial infarctions, revascularization procedures, strokes, and death) more than does either of these factors alone, in part because of their combined effect of increasing inflammatory proteins. The discovery of a relationship among depression, genetics,

inflammatory protein levels, and subsequent MACE in an ACS subgroup would provide a rationale for studying environmental triggers of depression and the effects of depression interventions (different medications, psychotherapies, combinations of treatment, and self-management techniques such as exercise) on inflammatory protein levels for their effects on future MACE.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7849579&icde=7398036

Point of Contact: Dr. Karen Huss, husk@mail.nih.gov

Collaborating HHS Agencies:

N/A

Related MCC Framework Provisions:

Goal 4/Objective B/Strategy 3

NIH/NINR: PROMOTING PHYSICAL ACTIVITY IN OLDER ADULTS WITH COMORBIDITY

Description:

At least half of those with osteoarthritis (OA) of the knee are diagnosed with hypertension or high blood pressure (HBP), one of the most prevalent risk factors for cardiovascular disease. Many other individuals with OA of the knee unknowingly have HBP and remain untreated. Persons with OA of the knee experience reductions in BP when they participate in a regular regimen of physical activity. This NINR-supported study examines the modified Staying Active with Arthritis (STAR) program to improve leg exercise, fitness walking, and clinical outcomes (function, blood pressure, leg strength, pain, and health-related quality of life) in older Americans with OA of the knee and high blood pressure. The modified STAR program addresses the barriers to physical activity from (OA) of the knee as well as high blood pressure related physical activity concerns.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7888561&icde=7397733

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Noreen Aziz
azizn@mail.nih.gov

Related MCC Framework Provisions:

Goal 2/Objective A/Strategy 1
Goal 4/Objective C/Strategy 3

Objective D: Address Disparities in Multiple Chronic Conditions Populations

NIH/NCI: PARTNERSHIPS TO REDUCE CANCER HEALTH DISPARITIES

Description:

The Comprehensive Partnerships to Reduce Cancer Health Disparities program establishes equal partnerships between research intensive institutions such as the NCI-designated Cancer Center (CC) and institutions in racial/ethnic and/or underserved communities (MSI) with cancer health disparities. The Partnership program supports research projects addressing issues related to co-morbid conditions of cancer patients generally associated with MCC; specifically focusing on obesity, impairment of cognitive functions and HIV-AIDS. The program awarded the first partnerships in 2001. There are currently 12 U54 partnerships addressing cancer health disparities issues (research, training, community outreach and education) in African Americans, Hispanic, Native Americans, Asian, Pacific Islanders, and Low Socioeconomic groups.

The objectives of the partnership are to: 1) increase participation of MSIs in the nation's cancer research and research training enterprise; 2) increase competitive grant funding of minority scientists; 3) increase competitive research capacity at MSIs; 4) increase involvement and effectiveness of CCs in research and training related to underserved populations; 5) develop more effective research, outreach, and education programs that will have a direct impact on public health as well as the health of ethnic minority and underserved populations; and 6) enhance collaborative research in cancer health disparities (CHD) at CCs. The program is in its 10th year and will continue as Program Announcement with annual evaluations of accomplishments.

Web Link: <http://crchd.cancer.gov/research/cprchd-current-partnerships.html>

Collaborating HHS Agencies: N/A

Point of Contact:

H. Nelson Aguila, D.V.M.

Program Director

T: 301.496.7344

F: 301.435.9225

Aguilah@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective D/Strategy 1

NIH/NINR: DETERMINANTS OF MEDICATION ADHERENCE IN HIV-INFECTED ADULTS WITH HYPERTENSION

Description:

Hypertension (HTN) is one of the most prevalent comorbid conditions in persons with HIV-infection and cardiovascular disease now ranks as a major cause of death in this population. This NINR-supported study is investigating the determinants of adherence to the treatment of HTN in HIV-infected persons with the goal of developing interventions to decrease the risk for cardiovascular disease among HIV- positive adults on highly-effective anti retroviral (ARV) therapy. The study objectives are to: 1) Determine the relationship between disease-specific adherence factors (illness representation and beliefs about the necessity of medication and concerns about potential adverse effects) and adherence to antihypertensive and ARV medication in HIV-positive subjects with comorbid HTN; (2) Explore differences in HIV and HTN illness representation and medication beliefs among the three most prevalent racial/ethnic patient groups (blacks, Hispanics, non-Hispanic whites), controlling for stage of disease.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=8070092&icde=7397919

Collaborating HHS Agencies:

N/A

Point of Contact:

Dr. Jeanette Hosseini

jeanetteh@mail.nih.gov

Related MCC Framework Provisions:

Goal 4/Objective D/Strategy 1

NIH/NINR: NURSING IMPACT ON CARE OUTCOMES FOR CHRONICALLY ILL AND MINORITY PATIENTS

Description:

Changes in population health, including sharp increases in chronic conditions, contribute to the complexity of hospital care and increase the risk for poor outcomes. Disparities in hospital outcomes by race and ethnicity persist. NINR is supporting research examining whether improving nursing resources in hospitals would be an effective strategy to improve outcomes in overlapping populations. Among other components under study, the researchers are examining racial and ethnic disparities in hospital outcomes to test whether poorer outcomes for minorities are explained by a combination of multiple underlying chronic health conditions, the concentration of minorities in hospitals with poor nurse staffing and education, and, less satisfactory care environments.

Web Link:

http://projectreporter.nih.gov/project_info_description.cfm?aid=7983708&icde=7397989

Collaborating HHS Agencies: N/A

Point of Contact:

Dr. Karen Huss

hussk@mail.nih.gov

Related MCC Framework Provisions:

Goal 1/Objective A/Strategy 2

SAMHSA: CAPACITY BUILDING INITIATIVE FOR SUBSTANCE ABUSE (SA) AND HIV PREVENTION SERVICES FOR AT-RISK RACIAL/ETHNIC MINORITY YOUNG ADULTS

Description:

The Capacity Building Initiative (CBI) is the tenth cohort of SAMHSA's Minority AIDS Initiative (MAI) programs. The CBI will support an array of activities to assist grantees in building a solid foundation for delivering and sustaining quality and accessible state of the science substance abuse and HIV prevention services. Specifically, the program aims to engage colleges, universities, and community-level domestic public and private non-profit entities to prevent and reduce the onset of SA and transmission of HIV/AIDS among at-risk racial/ethnic minority young adults, ages 18-24, including minority college students.

Web Link: <http://www.samhsa.gov/Grants/2010/SP-10-004.aspx>

Collaborating HHS Agencies: CDC

Point of Contact: Kirk E. James, Kirk.James@samhsa.hhs.gov

Related MCC Strategic Framework Provisions:

Goal 1, Objective A, Strategies 1 and 2

Goal 1, Objective E, Strategies 1 and 2

IV. APPENDIX: Programs, Activities, and Initiatives by Agency

Administration for Children and Families (ACF)

<u>ACF/ADD: STATE COUNCILS ON DEVELOPMENTAL DISABILITIES</u>	45
<u>ACF/ADD: STATE PROTECTION AND ADVOCACY AGENCIES</u>	45
<u>ACF/ADD: UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES (UCEDD) IN EDUCATION, RESEARCH AND SERVICES</u>	58

Agency for Healthcare Research and Quality (AHRQ)

<u>AHRQ: AMBULATORY SAFETY AND QUALITY PROGRAM: IMPROVING MANAGEMENT OF INDIVIDUALS WITH COMPLEX HEALTHCARE NEEDS THROUGH HEALTH IT</u>	26
<u>AHRQ: TOOL FOR IMPROVED MEDICATION FOR ELDERLY VIA REVIEW (TIMER)</u>	51
<u>AHRQ: MEASURES FOR THE MEDICAID HOME AND COMMUNITY-BASED SERVICES POPULATION</u>	53
<u>AHRQ: COMPARATIVE EFFECTIVENESS REVIEW ON EFFECTIVENESS OF INTERVENTIONS ADDRESSING CONCOMITANT MENTAL HEALTH AND CHRONIC MEDICAL CONDITIONS IN THE PRIMARY CARE SETTING.</u>	53
<u>AHRQ: COMPARATIVE EFFECTIVENESS RESEARCH TO OPTIMIZE PREVENTION AND HEALTHCARE MANAGEMENT FOR THE COMPLEX PATIENT</u>	66
<u>AHRQ: EXPANSION OF RESEARCH CAPABILITY TO STUDY COMPARATIVE EFFECTIVENESS IN COMPLEX PATIENTS</u>	67

Administration on Aging (AoA)

<u>AOA: CHRONIC DISEASE SELF-MANAGEMENT PROGRAM</u>	42
<u>AOA: ALZHEIMER’S DISEASE SUPPORTIVE SERVICE PROGRAM</u>	46
<u>AOA: COMMUNITY BASED CARE TRANSITIONS</u>	46

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY PROGRAM TITLE: ANALYSIS OF THE 2010 NATIONAL SURVEY OF RESIDENTIAL CARE FACILITIES (NSRCF)</u>	36
--	----

<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CHRONIC HOMELESSNESS PERMANENT SUPPORTIVE HOUSING PROGRAMS EVALUATION</u>	37
<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF NEW DEVELOPMENTS IN HOUSING WITH SERVICES TO ENHANCE AGING IN PLACE FOR OLDER ADULTS</u>	37
<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: EVALUATION OF THE MEDICAID STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS</u> .	38
<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: CAREGIVER SUPPLEMENT TO THE NATIONAL HEALTH AND AGING TRENDS SURVEY</u>	47
<u>ASPE/HEALTH POLICY: CONSENSUS DEVELOPMENT PROCESS FOR MEASURE ENDORSEMENT: ESTABLISHING A MEASUREMENT FRAMEWORK FOR MULTIPLE CHRONIC CONDITIONS</u>	54
<u>ASPE/DISABILITY, AGING, AND LONG-TERM CARE POLICY: INDIVIDUALS LIVING IN THE COMMUNITY WITH CHRONIC CONDITIONS AND FUNCTIONAL LIMITATIONS: A CLOSER LOOK</u>	67

Centers for Disease Control and Prevention (CDC)

<u>CDC: JAIL-BASED INTEGRATION OF HIV/SEXUALLY TRANSMITTED INFECTION (STI)/HEPATITIS SCREENING, HEPATITIS B VACCINATION, AND LINKAGE TO CARE AND TREATMENT</u>	14
<u>CDC: USING DISTANCE TECHNOLOGY FOR TREATING DEPRESSION IN PEOPLE WITH EPILEPSY: PROJECT UPLIFT: USING PRACTICE AND LEARNING TO INCREASE FAVORABLE THOUGHTS</u>	27
<u>CDC: NATIONAL NETWORK OF TOBACCO CESSATION QUITLINES, 1-800 QUIT NOW</u>	29
<u>CDC: NATIONAL TOBACCO CONTROL PROGRAM</u>	29
<u>CDC: IOM STUDY ON LIVING WELL WITH CHRONIC DISEASE: PUBLIC HEALTH ACTION TO REDUCE DISABILITY AND IMPROVE FUNCTIONING AND QUALITY OF LIFE</u>	30
<u>CDC: NATIONAL COMPREHENSIVE CANCER CONTROL PROGRAM</u>	30
<u>CDC: REDUCE DISPARITIES IN OBESITY AND OTHER HEALTH INDICATORS IN CHILDREN, YOUTH, AND ADULTS WITH DISABILITIES</u>	31
<u>CDC: VISION HEALTH INITIATIVE</u>	31
<u>CDC: ENHANCED COMPREHENSIVE HIV PREVENTION PLANNING AND IMPLEMENTATION FOR METROPOLITAN STATISTICAL AREAS MOST AFFECTED BY HIV/AIDS: PHASE II</u>	39
<u>CDC: ADDRESSING ARTHRITIS IN THE CONTEXT OF CO-MORBID CONDITIONS</u>	42
<u>CDC: WISEWOMAN</u>	43

<u>CDC: PEARL INTERVENTION TO REDUCE DEPRESSION AMONG ADULTS WITH EPILEPSY</u>	48
<u>CDC: US MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2010</u>	60
<u>CDC: EXAMINING PREVALENCE AND IMPLICATIONS OF ARTHRITIS FOR ADULTS WITH CO-MORBID CHRONIC CONDITIONS</u>	63
<u>CDC: EXAMINING THE IMPACT OF COGNITIVE IMPAIRMENT ON CO-OCCURRING CHRONIC CONDITIONS AND GERIATRIC SYNDROMES</u>	68
<u>Centers for Medicare and Medicaid Services (CMS)</u>	
<u>CMS: MEDICARE COORDINATED-CARE DEMONSTRATION</u>	15
<u>CMS/CMMI: CARE MANAGEMENT FOR HIGH-COST BENEFICIARIES DEMONSTRATION</u>	15
<u>CMS/CMMI: INDEPENDENCE AT HOME DEMONSTRATION</u>	16
<u>CMS/CMMI/REG: ADVERSE EVENTS AMONG CHRONICALLY ILL BENEFICIARIES</u>	21
<u>CMS/CMMI/REG: MONITORING CHRONIC DISEASE CARE AND OUTCOMES AMONG ELDERLY MEDICARE BENEFICIARIES WITH MULTIPLE CHRONIC DISEASES</u>	21
<u>CMS/CMMI/REG: CHRONICALLY CRITICALLY ILL POPULATION PAYMENT REFORM</u>	22
<u>CMS/CMMI/REG: DETERMINING MEDICAL NECESSITY AND APPROPRIATENESS OF CARE AT MEDICARE LONG TERM CARE HOSPITALS</u>	23
<u>CMS/CMMI/MEDICARE DEMONSTRATION PROGRAM GROUP: AFFORDABLE CARE ACT SECTION 4108 – MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES</u>	24
<u>CMS/CMMI/REG: GROUPING OF CLINICAL EPISODES AND MEASURING PHYSICIAN RESOURCE USE IN MEDICARE</u>	24
<u>CMS/CMMI/REG: POST ACUTE CARE PAYMENT REFORM DEMONSTRATION FOR MEDICARE</u>	25
<u>CMS/CSP: CMS CHRONIC CONDITIONS DATA WAREHOUSE</u>	27
<u>CMS: SENIOR RISK REDUCTION DEMONSTRATION (SRRD)</u>	39
<u>CMS/CMMI/REG: EVALUATION OF COMMUNITY BASED WELLNESS AND PREVENTION PROGRAM IN THE UNITED STATES</u>	44
<u>CMS/CSP: REPORT ON CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES</u>	64

Food and Drug Administration (FDA)

FDA: INVENTORY OF CLINICAL TRIALS TO SUPPORT HHS MULTIPLE CHRONIC CONDITIONS INITIATIVE 62

Health Resources and Services Administration (HRSA)

HRSA: IMPROVING THE INTEGRATION OF BEHAVIORAL HEALTH CARE AND PRIMARY CARE DELIVERY..... 17

HRSA/BHPR: THE PATIENT NAVIGATOR OUTREACH AND CHRONIC DISEASE PREVENTION DEMONSTRATION PROGRAM 17

HRSA/BPHC: HEALTH CENTERS 39

HRSA/MCHB: CHILDREN WITH SPECIAL HEALTH CARE NEEDS..... 48

HRSA/MCHB: FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS (F2F HICS) 49

HRSA/HSB: PATIENT SAFETY AND CLINICAL PHARMACY SERVICES COLLABORATIVE 51

HRSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS..... 55

HRSA/HAB: QUALITY CARE – PATIENTS WITH HIV/AIDS 60

Indian Health Services (IHS)

IHS: IMPROVING PATIENT CARE PROGRAM.....18

IHS: HEALTHY HEART PREVENTION INITIATIVE.....32

IHS: ELDER CARE INITIATIVE LONG TERM CARE GRANTS..... 50

IHS: INJURY PREVENTION PROGRAM INITIATIVE TO PREVENT FALL-RELATED INJURY IN OLDER AMERICAN INDIANS AND ALASKA NATIVES LIVING IN THE COMMUNITY.....61

National Institute of Health (NIH)

NIH/NIMH: A RANDOMIZED TRIAL IN LIAISON PSYCHIATRY IN PRIMARY CARE.....19

NIH/NINR: TELEHEALTH NURSING INTERVENTION FOR CHILDREN WITH COMPLEX HEALTH CARE NEEDS 28

NIH/NCI: CANCERSPACE (CANCER – SIMULATING PRACTICE AND COLLABORATIVE EDUCATION)..... 32

NIH/NINR: ADHERENCE & HRQOL: TRANSLATION OF INTERVENTIONS 52

<u>NIH/NINR: MULTIPLE MORBIDITIES IN VULNERABLE POPULATIONS: NURSE SCIENTIST TRAINING</u>	58
<u>NIH/NCI: CTEP INITIATIVES TO INCLUDE INDIVIDUALS WITH HIV AND CANCER ONTO NCI-SPONSORED CANCER CLINICAL TRIALS</u>	62
<u>NIH/NIMH: CENTRAL NERVOUS SYSTEM HIV ANTI-RETROVIRAL THERAPY EFFECTS RESEARCH (CHARTER)</u>	65
<u>NIH/NCI: AIDS MALIGNANCY CLINICAL TRIALS CONSORTIUM (AMC)</u>	68
<u>NIH/NCI: COMMUNITY-ENGAGED RESEARCH ON HIV/AIDS-RELATED CANCERS AMONG UNDERSERVED POPULATIONS</u>	69
<u>NIH/NCI: NCI ORGAN DYSFUNCTION WORKING GROUP</u>	70
<u>NIH/NEI: LOW VISION AND CLINICAL DEPRESSION</u>	71
<u>NIH/NHLBI: REDUCING CARDIOVASCULAR DISEASE RISK THROUGH TREATMENT OF OBSTRUCTIVE SLEEP APNEA</u>	72
<u>NIH/NIA: DEVELOPING INTERVENTIONS FOR MULTIMORBIDITIES</u>	73
<u>NIH/NIAAA: INTERVENTIONS FOR ALCOHOL USE DISORDERS AND HIV/AIDS: REDUCING ACQUISITION, PROGRESSION, TRANSMISSION OVER THE LIFESPAN.</u>	74
<u>NIH/NIAAA: TREATMENT OF CO-OCCURRING ALCOHOL USE DISORDERS AND DEPRESSION/ANXIETY DISORDERS</u>	75
<u>NIH/NICHD: OBESITY RESEARCH</u>	77
<u>NIH/NIDA: CO-OCCURRING DRUG ABUSE AND HIV</u>	78
<u>NIH/NIDA: CO-OCCURRING DRUG ABUSE/ADDICTION AND CHRONIC PAIN</u>	78
<u>NIH/NIDA: CO-OCCURRING SUBSTANCE ABUSE/ADDICTION AND OTHER MENTAL HEALTH DISORDERS</u>	79
<u>NIH/NIDCR: DIABETES AND PERIODONTITIS RESEARCH PROGRAM</u>	80
<u>NIH/NIDDK: DEPRESSION AND DIABETES</u>	81
<u>NIH/NIDDK: ENHANCING TREATMENT ADHERENCE IN PATIENTS WITH MULTIPLE CHRONIC CONDITIONS</u>	82
<u>NIH/NIMH: ADDRESSING DEPRESSION AND ANTI-RETROVIRAL THERAPY ADHERENCE IN HIV-POSITIVE ADULTS ON THE US-MEXICO BORDER</u>	83
<u>NIH/NIMH: DEPRESSION-DIABETES CARE DISPARITIES, ADVERSE OUTCOMES</u>	83

<u>NIH/NIMH: DEPRESSION, ESTROGEN REPLACEMENT, AND CARDIOVASCULAR HEALTH IN PERIMENOPAUSE</u>	85
<u>NIH/NIMH: EFFICACY OF COGNITIVE BEHAVIOURAL THERAPY FOR TREATMENT ADHERENCE AND DEPRESSION IN HIV CARE SETTINGS</u>	85
<u>NIH/NIMH: LINKAGE AND RETENTION: A RANDOMIZED TRIAL TO OPTIMIZE HIV/TB CARE IN SOUTH AFRICA</u>	86
<u>NIH/NIMH: PREVENTION OF POST-STROKE DEPRESSION AND MORTALITY</u>	87
<u>NIH/NIMH: STEPPED CARE FOR DEPRESSION AND MUSCULOSKELETAL PAIN</u>	87
<u>NIH/NIMH: THE SAFETY AND EFFICACY OF USING SERTRALINE FOR TREATING DEPRESSION IN PATIENTS WITH CONGESTIVE HEART FAILURE</u>	88
<u>NIH/NINDS: RESEARCH ON COMORBID CONDITIONS OF EPILEPSY</u>	89
<u>NIH/NINR: CHRONIC CO-MORBID CONDITIONS IN HIV+ U.S. ADULTS ON HIGHLY EFFECTIVE ANTI-RETROVIRAL THERAPY</u>	90
<u>NIH/NINR: CHRONIC ILLNESS SELF-MANAGEMENT IN CHILDREN AND ADOLESCENTS</u>	90
<u>NIH/NINR: COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA IN STABLE HEART FAILURE</u> ...	91
<u>NIH/NINR: COST EFFECTIVENESS AND QUALITY OF LIFE IN HEART FAILURE PATIENTS WITH DIABETES</u>	92
<u>NIH/NINR: INTERACTIONS AMONG DEPRESSIVE SYMPTOMS AND GENETIC INFLUENCES ON CARDIAC OUTCOMES</u>	92
<u>NIH/NINR: PROMOTING PHYSICAL ACTIVITY IN OLDER ADULTS WITH COMORBIDITY</u>	93
<u>NIH/NCI: PARTNERSHIPS TO REDUCE CANCER HEALTH DISPARITIES</u>	94
<u>NIH/NINR: DETERMINANTS OF MEDICATION ADHERENCE IN HIV-INFECTED ADULTS WITH HYPERTENSION</u>	95
<u>NIH/NINR: NURSING IMPACT ON CARE OUTCOMES FOR CHRONICALLY ILL AND MINORITY PATIENTS</u>	95

Office for the Assistant Secretary of Health (OASH)

<u>OASH/OFFICE OF WOMEN’S HEALTH: PROVIDING BETTER TOOLS AND INFORMATION FOR HEALTH CARE WORKERS DELIVERING CARE TO WOMEN WITH MULTIPLE CHRONIC CONDITIONS CARDIOVASCULAR DISEASE, DEPRESSION, AND OTHER CO-MORBIDITIES.</u>	56
--	----

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA: PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION GRANT PROGRAM 20

SAMHSA: SUBSTANCE ABUSE AND HIV PREVENTION READY-TO-RESPOND INITIATIVE IN COMMUNITIES HIGHLY IMPACTED BY SUBSTANCE USE AND HIV INFECTION DESCRIPTION... 34

SAMHSA: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT: HIV/AIDS SET-ASIDE 34

SAMHSA: THE 10X10 WELLNESS CAMPAIGN..... 35

SAMHSA: TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE TREATMENT AND HIV/AIDS SERVICES..... 35

SAMHSA: SHARED DECISION MAKING..... 56

SAMHSA: CENTER FOR INTEGRATED HEALTH SOLUTIONS..... 57

SAMHSA: RECOVERY-TO-PRACTICE 59

SAMHSA: CAPACITY BUILDING INITIATIVE FOR SUBSTANCE ABUSE (SA) AND HIV PREVENTION SERVICES FOR AT-RISK RACIAL/ETHNIC MINORITY YOUNG ADULTS..... 96