



The Honorable George Miller
Chair, House Education and Labor Committee
2205 Rayburn House Office Building
Washington, DC 20515

The Honorable Howard McKeon
Ranking Member, House Education and Labor Committee
2184 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Chair, House Energy and Commerce Committee
2204 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Barton
Ranking Member, House Energy and Commerce Committee
2109 Rayburn House Office Building
Washington, DC 20515

The Honorable Charles B. Rangel
Chair, House Ways and Means Committee
2354 Rayburn House Office Building
Washington, DC 20515

The Honorable Dave Camp
Ranking Member, House Ways and Means Committee
341 Cannon House Office Building
Washington, DC 20515

June 29, 2009

Dear Chairmen Miller, Rangel, and Waxman and Congressmen Barton, Camp, and McKeon:

The Partnership to Fight Chronic Disease (PFCD) strongly supports your – and your Committee's – efforts to enact meaningful health care reform in this Congress, and we thank you for sharing the draft legislative language of Health Reform that the Tri-Committee leadership is working to develop (“hereafter referred to as “legislative draft”). As you move to build upon the legislative draft, we look forward to working with you and to serving as a resource on the critical issue of addressing chronic disease.



PFCD is a national and state-based coalition of hundreds of partner organizations committed to reforming the health care system to better prevent, detect, and manage the nation's number one cause of death, disability and rising health care costs: chronic illness.

We believe that the only sustainable way to address health care costs is to improve health in America by reducing the toll of chronic disease. By inspiring a culture of wellness, we can improve our health, strengthen the financial stability of our health care system, and grow our economy.

PFCD commends you for including Prevention and Wellness as a pillar of reform in the legislative draft. The fact that chronic diseases consume 75 percent of what we spend on health care establishes how critical enhanced prevention and better chronic disease management are to improving health care affordability. Preventing and managing chronic diseases effectively depends upon people engaging in healthy lifestyles and having access to preventive health care services, diagnostic services that detect chronic disease early, and coordinated care to help us manage chronic illness once detected.

Coverage, while a critical ingredient to reform, by itself will not address the growing burden of chronic disease. More comprehensive health reform is needed to effectively address the prevention and control of chronic disease directly. There are additional opportunities to enhance reforms within the legislation based upon proven, evidence-based programs, as we described below.

The legislative draft covers many areas for suggested policy changes. Many, though of particular interest to our individual partner organizations, are outside the scope of PFCD's shared areas of interest. Accordingly, our comments provided below are limited to these shared areas of interest particularly those related to improving the health status of Americans through a focus on prevention, wellness, and chronic disease management.

The following comments are intended to strengthen the ideas raised in the legislative draft. We followed the organization of the legislative draft summary and offered suggestions for each. These comments reflect our general principles of shared understanding, and not final opinions on specific legislative language that may be developed.

Affordability

Improving Access to Quality Health Care

The financial decisions people face must be designed to lower barriers to patient compliance with preventive care and prescribed care recommended by their health care providers to prevent, detect, and manage chronic disease. Patients should not face high financial barriers to following prescribed care regimens that help them avoid more serious illness. Likewise, providing incentives to improve health by encouraging healthy behavior and following preventive and prescribed care recommendations can provide the motivation needed to make the necessary changes.

To that end, we recommend no, or very low, copays on services that are important not only to detecting disease – like recommended screenings – and avoiding acute illnesses – like influenza vaccinations, but



also to maintaining health and managing disease to prevent costly complications. Evidence from private-sector programs shows that ones that lower patient financial barriers and improve access to recommended treatment generate higher levels of compliance with prescribed treatment regimens related to lifestyle change, diet modification, and medication use.

For instance, in a diabetes management program known as the Asheville Project, public and private employers in Asheville, NC provided free screenings, diabetes self-testing supplies, and any diabetes medicines prescribed to participants who met regularly with their pharmacist coach. In addition, participants had access to diabetes educators, dietitians, and other support to help make lifestyle changes and receive clinically recommended preventive care to prevent disease progression and complications. Under the program, participants brought their blood sugar under control within a year on average and had about half as many absences from work. The program resulted in an average net decrease of 34 percent in health care costs for each participating employee.

The elimination of cost-sharing for clinically recommended preventive services as described in the draft legislation is a good step forward. We encourage you to also consider using cost-sharing reductions, particularly among Medicare and Medicaid beneficiaries, to encourage greater compliance with treatment recommended by their health care providers to prevent the progression of chronic disease.

Translating Knowledge into Action

One of our biggest challenges is making better use of existing knowledge to improve health and lower costs by better preventing and managing chronic disease. Unfortunately, the gap between what we know and what we currently do is great. Health care reform has tremendous potential to help narrow this gap and improve health in America.

Learning from evidence-based health improvement efforts and facilitating their wider adoption are important tactics in meaningful health care reform. The draft legislation includes many quality improvement efforts that, if done properly, can help to facilitate greater learning and adoption of evidence-based care that improves health outcomes.

The legislative draft also recognizes the importance of conducting additional research to close knowledge gaps and improve care quality, and would create a new federal program for comparative effectiveness research. We are concerned that, as structured, comparative effectiveness will not achieve its full potential of fighting chronic disease and improving health care quality and, ultimately, providing value. To achieve this, the CER program must encompass preventive interventions and delivery system interventions, which play major roles in the effective management and prevention of chronic disease, and must provide greater focus on the information needs of patients and providers.

Broadening the scope of research to include delivery system interventions would make the legislative draft more consistent with the definition of comparative effectiveness research drafted by the HHS Federal Coordinating Council on CER, and ensure that CER address evidence gaps related to organization, management and delivery of care that have a substantial impact on the care of patients with chronic diseases and conditions.



Specifically, we encourage greater emphasis on developing a research agenda that is in step with diverse patient populations and provider needs, and provides for wide dissemination of timely, relevant information to patients and providers, rather than developing coverage recommendations for public and private payers that could restrict access. We also support greater clarity to assure transparency in decision-making and the inclusion of broad stakeholder participation, input, and feedback in the process.

Effective management of chronic conditions requires consideration of patient comorbidities, needs, and preferences, which should occur in the context of the patient-care provider relationship. As President Obama stated in his speech to the American Medical Association, "learning what works" through CER is "about providing patients and doctors with the information they need to make the best medical decisions."

In addition, it is important for CER to help reduce, rather than worsen, disparities in care among at risk, underserved, disabled, and chronically ill patients and support greater care coordination. We appreciate inclusion of provisions that recognize the need to consider these and other subpopulations in clinical trials. We recommend that these provisions be further strengthened by ensuring patient differences are represented in the decision-making process and recognized in communication of results. We also urge that strong patient safeguards be included to protect patient and provider flexibility in tailoring care to the needs of the individual.

In addition, we suggest including greater clarity around the transparency of decision-making and the inclusion of broad stakeholder participation, input, and feedback in the process. This will be important to ensure patient, provider, and other perspectives all are given appropriate consideration. As health care reform legislation moves forward, we look forward to working with you to ensure appropriate representation of all patient populations and to guarantee applicability of data to emerging populations.

Prevention and Wellness:

As good health is more than a result of good medical care, we must also support improvements in primary, secondary, and tertiary prevention in settings outside the medical system – at home, at work, at school, and in the community – as an integral part of health care reform. Public policy can have a substantial impact on creating supportive environments for individuals, family caregivers, businesses, schools, and community organizations working to reduce the burden of chronic diseases.

The legislative draft includes grant funding for community-based prevention and wellness research and services. We support increasing funding for evidence-based chronic disease prevention and care programs at the community level that improve population health and reduce the impact of health disparities.

The legislative draft, however, does not specifically list the problem of chronic disease as a leading driver of cost, disability, and death in America among the priorities for consideration in the development of a



National Strategy. We urge you to make this critical inclusion in the National Strategy, as preventing and better managing chronic disease holds the greatest promise to improving population health and lowering costs.

Existing community level chronic disease prevention programs have made significant strides in the communities they serve. For example, federally funded grant programs, including CDC's Healthier Communities Program and REACH initiative, provide seed funding that have helped local governments, employers, schools, health systems, and community organizations work together to achieve sustainable health improvement efforts with measurable results, including the reduction of health disparities.

Federal funding has also helped to support Pioneering Healthier Communities grants allowing school, business, and community leaders to address local health challenges and to make changes to improve health. Though initially local in nature, successful efforts lead to replication and a broader impact. For example, working in partnership with local YMCA's, grant funding in Clearwater, Florida helped to pass a state law requiring 30 minutes of physical education 5 days a week in elementary schools, and led to county licensing changes requiring at least 150 minutes of physical activity per week in all after-school programs.

Community-focused programs offer significant opportunities through a variety of interventions, including face-to-face support and coaching, remote patient monitoring, and telephonic and telehealth coaching, to reduce the toll of chronic disease in communities across America. We support funding for these programs and research on community level efforts strengthened by legislative language recognizing the need to address chronic disease among the priorities for development of the National Strategy.

Workforce Investments:

As the legislative draft recognizes, having health care coverage does not equate to having access to care. We also need public policies that build bench strength in our primary care and public health workforces that both support greater emphasis on primary, secondary, and tertiary prevention and improve people's access to these important services.

Specifically, we must do a better job helping people to prevent, to manage, and to slow the progression of disease – so that more costly problems are delayed or, ideally, wholly avoided. We support investments that will help to expand the primary care and public health workforces and applaud your efforts to improve workforce diversity and training to help eliminate health disparities.

We support greater investments to improve workforce diversity and improve access to care in needed professions and in communities experiencing shortages of providers. We also need to encourage the educational pursuit of underrepresented specialties in areas of primary and chronic care where specific unmet needs exist, including preventive medicine, geriatrics, pediatrics, and disease-specific areas such as juvenile arthritis.



We also support training at all levels of the health care workforce that emphasize the prevention and management of chronic diseases, including managing comorbidities, coordinating care, and elder care, to reduce the risks of chronic disease development and progression and improve health outcomes.

Access to quality health care coverage and medical treatment are important contributors to improving health status, but good health extends well beyond these factors. Individual behaviors, including tobacco use, sedentary lifestyles, and poor nutritional choices, are large contributors to an individual's health status. Improving both coverage for and access to evidence-based, clinical preventive care involving primary, secondary, and tertiary prevention is a major step forward.

Controlling Costs:

We share your support for reforms that promote care coordination, reward high quality, effective care, and reduce health disparities. Coordination, continuity of care, and care management are of paramount importance as they help to facilitate the U.S. health system's transition to one that is more focused on preventing or delaying disease onset and progression. Addressing chronic diseases as a driver of costs is a major step forward to delivering greater value from our finite health care resources and controlling costs in the long term.

One of the most important tasks we face in health care reform is how to integrate care coordination into the traditional Medicare program. The draft legislation includes pilot programs and innovation grants aimed at improving care coordination. Through existing models and pilots, including the Medicare Physician Group Practice demonstration, the Community Cares of North Carolina Medicaid program, and the Vermont model, we have gained a great deal of evidence about what works well in care coordination to both improve outcomes and reduce costs. We encourage you to consider a broader approach beyond the additional pilot programs the current draft legislation proposes.

Traditional fee-for-service Medicare is expected to spend about \$395 Billion in FY2010. A modest investment in care coordination using the tools successfully applied by Geisinger, Intermountain Healthcare and other integrated group practices nationally is one approach to reducing preventable hospital admissions and readmissions, ER visits, and other medical care. The problem is such plans are not easily replicated or scalable.

We found one especially promising approach that we would encourage you to expand and make available nationally—the use of community health teams. Such teams include the key design features that have reduced admissions and readmissions (i.e. formal transitional care program, close integration of care coordination and the primary care providers' office) in the larger group practices. The facilitation of community health teams through grants can help build the networks needed to improve care coordination. In addition to physicians, these teams can include care coordinators, nurses, nurse practitioners, social and mental health workers, dietitians, pharmacists, patient education specialists, community-based health and wellbeing specialists, and community outreach workers that work with smaller practices to provide prevention and care coordination for all patients and family caregivers.



The advantage of these teams is that they emphasize management of health (as opposed to just treatment of disease). They greatly enhance communication between providers and patients, and offer the ability to focus on disease prevention and early detection. They also support patient self-management by helping patients and family caregivers understand and follow treatment recommendations for making behavior changes, taking their medications, monitoring their health, and following up when needed. We strongly encourage you to make a modest federal investment to enable the development of community health teams, encourage the management of health, and improve health care outcomes – all achievable we believe at lower Medicare and Medicaid costs.

Published empirical research on these models from North Carolina and other settings show these approaches improve clinical outcomes and reduce health care spending. The data indicate that well-designed community health teams could save 3 to 7 percent in overall Medicare spending for a 0.6 percent investment.

A complementary addition would be to establish a Medicare transitional care benefit designed to support beneficiaries as they transition from in-patient hospital care to home or another care setting. Such a benefit would facilitate care coordination among providers, provide patient and family caregiver education and support, ensure greater compliance with treatment plans and medication management, and make referrals to community resources. In clinical studies targeting individuals at high risk for readmissions, nurse-led interdisciplinary teams working with patients and family caregivers before hospital or nursing home discharge have led to reduced readmissions and lower costs.

We appreciate your efforts and fully grasp the complexity of the issues which comprehensive health care reform presents. You may depend upon us as a resource for your efforts.

We look forward to working with you to pass meaningful health reform during this Congress.

Sincerely, the undersigned PFCD partners and other interested organizations:

Alliance for Aging Research
Alzheimer's Foundation of America
American Academy of Nurse Practitioners
American Academy of Nursing
American Association of Colleges of Pharmacy
American Cancer Society Cancer Action Network
American College of Nurse Practitioners
American College of Preventive Medicine
American Pharmacists Association
American Osteopathic Association
American Sleep Apnea Association



American Society of Addiction Medicine
American Society of Health-System Pharmacists
Arthritis Foundation
Association of Maternal and Child Health Programs
Asthma and Allergy Foundation of America
Biotechnology Industry Organization
Canyon Ranch Institute
Center for Integrated Behavioral Health Policy, George Washington University Medical Center
Community Health Charities
The COSHAR Foundation
Dialysis Patient Citizens
DMAA: The Care Continuum Alliance
Easter Seals
GlaxoSmithKline
Health Dialog
Healthways
International Health, Racquet and Sportsclub Association
Kerr Drug
Lance Armstrong Foundation
Marshfield Clinic
Medical Fitness Association
Men's Health Network
Mental Health America
National Alliance on Mental Illness
National Association of Chronic Disease Directors
National Black Nurses Association
National Business Coalition on Health
National Family Caregivers Association
National Latina Health Foundation
National Recreation and Park Association
Partnership for Prevention
Pharmaceutical Research and Manufacturers of America
Pharos Innovations
PILMA
SEIU
Self chec
US Preventive Medicine
WomenHeart: The National Coalition for Women with Heart Disease
XLHealth
YMCA of the USA