



The Honorable Edward M. Kennedy
Chair, Senate Health, Education, Labor and Pensions Committee
317 Russell Senate Building
Washington D.C. 20510

The Honorable Michael B. Enzi
Ranking Member, Senate Health, Education, Labor and Pensions Committee
379A Senate Russell Office Building
Washington, D.C. 20510

July 15, 2009

Dear Senators Kennedy and Enzi:

The Partnership to Fight Chronic Disease (PFCD) commends the Senate Health, Education, Labor and Pensions Committee for its efforts on health care reform, particularly on its continuing work on several key provisions in the "Affordable Health Choices Act" that address the key cost driver in health care: chronic disease. We support your efforts to improve health in America by proposing important investments to help Americans better prevent, detect, and manage chronic illnesses. We submit these comments to build upon this important work.

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 costs: chronic disease. Chronic diseases affect almost 1 in 2 Americans; the annual economic impact on the U.S. of just the seven most common chronic diseases is estimated to be \$1.3 trillion.

Preventing and managing chronic diseases effectively depends upon people engaging in healthy behaviors and having access to preventive health care services, diagnostic services that detect chronic disease early, and coordinated care to manage chronic illness once detected. PFCD commends you for your focus not only on improving access to high quality, affordable health care coverage for all Americans, but also on seeking reforms that address the prevention and control of chronic disease directly.

The Affordable Health Choices Act covers a great range of proposed policy changes. Many, though of particular interest to our individual partner organizations, are outside the scope of PFCD's shared areas of interest. Accordingly, we have limited our comments to these shared areas of interest and do not express any opinion as to any other provisions in the Act. These comments reflect our general principles of shared understanding, and not final opinions on specific legislative language that may be developed.

Assuring the long-term financial viability of the health care system requires a focus on improving health in America by addressing the burden of chronic disease. Reducing the toll of chronic disease requires policies that empower people to engage in healthy behaviors and to seek, access, and follow through on recommended care.

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.

We also recognize that most of the work in preventing and treating chronic disease occurs outside the medical system. Individual success, and ultimately success overall, depends upon people understanding and following recommendations in terms of adopting healthy behaviors, seeking recommended preventive care, and following through on prescribed treatment.

There are several provisions in the Affordable Health Choices Act we comment on below which can help achieve better health by both encouraging and supporting people in their efforts to live healthier lives. We commend your efforts on these provisions, and offer the following comments for enhancing them:

Building Bench Strength in our Primary Care and Public Health Workforces: Having health care coverage does not equate to having access to care. We need to build our primary care and public health workforces to fulfill the need for a greater emphasis on primary, secondary, and tertiary prevention and to improve people's access to these important services. We support investments that will help to expand the primary care and public health workforces.

In addition, we support greater investments to improve workforce diversity and improve access to care in needed professions and in communities experiencing shortages of providers. In these efforts, we 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, addiction medicine, 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, better managing transitions between care settings, and elder care, to reduce the risks of chronic disease development and progression and the likelihood of acute health crises.

Reducing Patient Financial Barriers to Health Improvement: There are far too many "missed opportunities" for improving beneficiaries' health in the current Medicare program. While rates of screening among the Medicare population have increased over time, data also show that few beneficiaries receive comprehensive screening for multiple conditions. For instance, according to a General Accounting Office (GAO) study, only 10 percent of female Medicare beneficiaries are screened for cervical, breast, and colon cancer and are immunized against influenza and pneumonia. As for male beneficiaries, just 27 percent receive colorectal screening and are immunized against influenza and pneumonia. Moreover, research has shown that chronically ill patients receive the clinically recommended preventive care less than 60 percent of the time.

Patients should not face high financial barriers to seeking preventive care or following prescribed care regimens that help them avoid more serious illness. To that end, we recommend assuring that

patient cost sharing is not a barrier to access to services that are important to maintaining health and managing disease. Evidence from private sector programs shows that lower patient financial barriers generate higher levels of compliance with prescribed treatment regimens related to lifestyle change, diet modification, and medication use.

Supporting Patient Follow Through on Recommended Treatment: In addition to financial barriers, many patients and family caregivers face informational barriers to following through on treatment recommendations. Given that almost three out of four Medicare beneficiaries has more than one chronic illness, helping these patients and their family caregivers understand their health needs and how recommended treatment addresses them can help improve adherence to those recommendations and enhance health outcomes.

For example, research shows that patients who take their medications as prescribed for the duration recommended have much better outcomes than those who do not. Unfortunately, only about half of chronically ill patients take medications as prescribed. For these reasons, the proposed Medication Therapy Management pilot for Medicare provides a good opportunity to engage pharmacy and help Medicare patients taking multiple medications to improve their adherence rates, and, more importantly, enjoy better health.

We encourage building improved adherence to treatment recommendations into the Medication Therapy Management pilot as well, care coordination, care transitions, and other quality of care improvement efforts. Providing such support can enable those who are chronically ill and their family caregivers to better manage their health to prevent costly complications, reduce disability, and ultimately lower costs.

Improving Care Coordination: Determining how to integrate care coordination into traditional Medicare is one of the most important tasks we face in health care reform. The Community Health Team approach as proposed in the Affordable Health Choices Act would help small provider groups to take advantage of the care coordination tools larger, integrated practices, including Marshfield Clinic, Cleveland Clinic, and Geisinger, have successfully used to improve the quality of care and reduce costs by avoiding preventable hospital admissions and readmissions, ER and clinical visits.

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 can help build the networks and infrastructure 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 patients and family caregivers.

The advantage of these teams is that they emphasize management of health (as opposed to just treatment of disease). 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.

We also suggest that the value of “remote” services, such as health information technology, remote monitoring and telephonic interventions be recognized and incorporated as part of the solution for providing care coordination, patient coaching and monitoring, and other evidence-based patient supports that improve follow through on recommended treatment and health outcomes.

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.

Investing in Community-focused Health Promotion and Wellness: As good health is more than a result of good medical care, improvements in primary, secondary, and tertiary prevention in settings outside the medical system – at home, at work, at school, and in the community – must be an integral part of health care reform. Grant funding 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 and reducing the impact of health disparities. The investments made in the Affordable Health Choices Act in Community Transformation Grants and within the Health and Wellness Trust will provide much needed funds to spur the replication of evidence-based health programs to reduce the incidence and impact of chronic disease in communities across America.

We support the provision of federal grants to help communities build these programs and to collect and disseminate best practices to facilitate replication in other communities.

Reducing and Eliminating Health Disparities: Not every American has an equal likelihood of living a long and healthy life. Health status varies by geographic location, gender, race/ethnicity, education and income, and disability, among other factors. Disparities are common, and among Americans with chronic diseases, minorities are more likely to suffer poor health outcomes. To improve health overall, we must focus on eliminating health disparities. We support efforts to improve data collection on the extent of disparities, and to build upon those efforts by funding measurement of the causes of and solutions to health disparities.

Encouraging Workplace Wellness: Chronic diseases cost American businesses billions and threaten their competitiveness. Businesses are burdened not only with medical costs, but also losses in productivity caused by chronic illnesses. Recognizing the true bottom line impact of these losses, some employers are addressing these issues by providing workplace wellness programs to improve the health of their employees. Policies that support these efforts and encourage adoption by additional employers would help to increase the reach of these efforts. For example, facilitating the analysis and sharing of best practices among employers of all sizes would help to build the evidence base for workplaces wanting to build successful wellness programs.

We commend your efforts to address the chronic disease crisis as a cornerstone of health care reform, and urge your continued support to see these investments preserved if not enhanced as health care reform moves from the HELP Committee to the full Senate for consideration.

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

Sincerely, the undersigned PFCD partners:

AHEAD

Alliance for Aging Research

Alzheimer's Foundation of America

American Academy of Nurse Practitioners

American Academy of Nursing

American College of Preventive Medicine

American Dietetic Association

American Osteopathic Association

American Sleep Apnea Association

American Society of Addiction Medicine

American Society of Health-System Pharmacists

America's Agenda: Healthcare for All

Arthritis Foundation

Association of Maternal and Child Health Programs

Asthma and Allergy Foundation of America

Biotechnology Industry Organization

Canyon Ranch Institute

Cleveland Clinic

The COSHAR Foundation

Dialysis Patient Citizens

DMAA: The Care Continuum Alliance

Easter Seals

GlaxoSmithKline

Healthcare Leadership Council

Health Dialog

Healthways

The International Health, Racquet and Sportsclub Association
Kerr Drug
The Leapfrog Group
Marshfield Clinic
Medical Fitness Association
Mental Health America
Milken Institute
National Alliance for Caregiving
National Association of Chronic Disease Directors
National Association of Manufacturers
National Business Coalition on Health
National Family Caregivers Association
National Health Foundation
National Patient Advocate Foundation
Partnership for Prevention
Pharmaceutical Research and Manufacturers of America
Pharos Innovations
PILMA
US Preventive Medicine
WomenHeart: The National Coalition for Women with Heart Disease
XLHealth
YMCA of the USA