

FRIENDS OF THE FUTURE

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Senate Finance Committee Chronic Care Workgroup
US Senate
Washington, D.C.

Aloha Senators Hatch, Wyden, Isakson and Warner:

As you have noted in your stakeholder letter dated May 22, 2015, there are increasing numbers of people in the United States with chronic disease. I'm sure you are well aware it is the leading causes of death and disability in the U.S. and account for over 79% of the nation's health care spending. In fact, the most common chronic disease experienced by adults is multimorbidity, the coexistence of multiple chronic diseases. As has been noted by the Senate Finance Chronic Care Workgroup, we need to find ways to provide high quality care at lower cost without adding to the deficit.

Self-management is heralded as a key component in the improvement of health outcomes associated with chronic disease. According to the Institute of Medicine, self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions". There has been very little focus by health plans, including Medicare and Medicaid, on the role of the individual in proactively managing their health conditions and taking more responsibility for improving their personal behaviors that will result in improved health outcomes and lower costs.

I urge the Chronic Care workgroup to support Medicare beneficiaries' access to evidence based self-management programs for chronic disease, pain management, fall prevention and physical activity which will result in improved quality of care, improved disease management and lower per capita costs. In particular, I ask you to support Medicare funding for evidence based programs such as the Stanford Chronic Disease Self-Management Program (CDSMP). CDSMP is one of the most well-known and researched evidence-based programs, is a good model for people with multiple chronic conditions, as research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, and symptom management as well as reducing per capita costs of health care with an approximate 2:1 return on investment in the first year as noted in a national study published in 2013. **This equates to a potential net savings of \$364 per participant, and potential national savings of 3.3 billion if just 5% of adults with a chronic disease were positively influenced by CDSMP.** These programs should be a patient covered benefit provided to patients and integrated with care traditionally given by health care providers.

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CDSMP and other evidence-based programs can address a number of the areas you have asked for input on in the stakeholder letter. These programs will improve the health and quality of life for Medicare beneficiaries with multiple chronic conditions. For example, individuals are more likely to effectively use of their prescription drugs and understand their importance. There is an on-line version of the CDSMP which would allow use of technology to spread self-management strategies with broader reach. In addition, there is a mailed tool kit for CDSMP for those living in rural and frontier areas that do not have access to the internet or community programs. Each one of these options has been shown to be effective in improving self-management skills. These programs are the best option for empowering Medicare patient to play a greater role in managing their health and meaningfully engaging with their health care providers. This will meet the goals of primary care providers and care coordination teams to maximize the health care outcomes for Medicare patients living with chronic conditions.

Having a policy that allows for any person with chronic illness to attend a CDSMP program will be transformative for the state of healthcare.

Best Regards,

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Friends of the Future
Resource Development Leader

and

CDSMP
Community Volunteer.