June 16, 2015

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

Dear 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. 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 of care at greater value and lower cost without adding to the deficit.

There have been little or no significant improvements demonstrated in studies when disease management or care coordination services have been provided for traditional Medicare fee for service beneficiaries. Although successful Medicare Advantage plans have incentives for doing disease management and care coordination, these approaches often do not result in members of the plan having sustained improvement in health status, self-efficacy skills or improved confidence in managing their health conditions and care. Older adults with chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include the lack of social support, low skill levels for symptom management, and low confidence in their abilities to manage their conditions (self-efficacy). 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 am urging the Chronic Care workgroup support for Medicare beneficiaries to have 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 am asking you to support Medicare funding the Stanford Chronic Disease Self-Management Program (CDSMP), for older adults with chronic disease. 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 a national savings of $3.3 billion if 5% of adults with one or more chronic conditions are reached. These programs should be a patient covered benefit provided to patients and integrated with care traditionally given by health care providers.

The Administration for Community Living and the Centers for Disease Control and Prevention have provided funding to support state and community-based organizations in expanding chronic disease self-management education and infrastructure to support the dissemination of these programs. State-level and community-based organizations are making great strides with sustaining programs by embedding them in health care systems and these programs exist in almost states. The past three Surgeon Generals have supported these programs and the 2011 Health and Human Services Strategic Framework for Multiple Chronic Conditions endorses chronic disease self-management as one of the critical factors.

The uncertainty of future funding provides challenges to continuing this forward momentum. Funding is critical to continue the gains that have been made toward improving the quality of life for millions of older adults and lessening the burden of an aging population on our nation's scarce health care resources.

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 and the Chronic Care Workgroup can recommend that all Medicare Advantage Programs, ACO Programs, CMS piloted alternate payment models (APMs) and Patient Centered Medical Homes make these programs available to their population with chronic disease. I urge the Chronic Care Workgroup to recommend CDSMP be provided by community-based organizations to all health care providers, organization and systems as the fundamental self-management approach for Medicare beneficiaries with one or more chronic diseases. These programs will allow individuals to live with the dignity and independence they want to have, having their health care needs met reliably and well, and with the costs being sustainable for our country.

Sincerely,

Jennifer Ann Schachner

Jennifer Schachner

San Jose State University

Silicon Valley Healthy Aging Partnership