

June 22, 2015  
Senate Finance Committee Chronic Care Workgroup  
US Senate  
Washington, D.C.

Dear Senators Hatch, Wyden, Isakson and Warner,  
Chronic diseases are the leading causes of death and disability in the U.S. and account for 75% of the nation's health care spending. Older adults are disproportionately affected; 80% have at least one chronic health condition, and more than half have multiple chronic conditions, which are especially difficult and costly to manage. With an aging population and unprecedented obesity rates (a risk factor for many chronic conditions), the burden of chronic disease is rapidly increasing and causing extraordinary challenges for the U.S. health care system.

Older adults with chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include 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."

#### The Importance of Chronic Disease Self-Management Education

Health care policymakers and practitioners have expressed continuing concern about inadequate chronic care management and treatment with the consensus that changes in primary, secondary, and tertiary care are needed to better serve this population and that health care providers should place a priority on slowing the progression of chronic disease.<sup>1[1]</sup> Many strategies to improve care have been advanced, including better coordination of care and care transition among multiple care sites and providers, as well as innovative models of patient- and family-centered care. Among the strategies advanced is greater attention to the dissemination of models of chronic disease self-management education (CDSME) to more Americans through both in-person and online programs. Despite evidence that motivated and informed patients are more likely to have better health care outcomes,<sup>2[2]</sup> the health care delivery system is more oriented toward acute care than helping people to better manage the effects of chronic disease. Clinicians tend to see patients for very short periods of time, limiting their ability to discuss how lifestyles may affect their health or ways to self-manage chronic conditions. According to the CDC, many people suffer from health risk behaviors that people themselves can change, such as improved physical activity and nutrition, decreased use of tobacco and alcohol, and control of high blood pressure and cholesterol.<sup>3[3]</sup> Many experts believe that all of these issues could be addressed by helping individuals manage their symptoms. Self-management has been identified by health care experts to be one of six models that successfully improve the lives of chronically ill persons and that integrate medical and community-based care.<sup>4[4]</sup> Some payers and insurance plans have incorporated self-management into patient care protocols, but adoption is not widespread.

The Chronic Care Model (CCM), developed in the mid-1990s and refined in 1997, is a widely accepted conceptual model for treatment and management of chronic disease that identifies the essential elements of a high quality health care system. These elements include not only the organization and delivery design of the health system itself, but also components that involve the

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1[1] Gerard Anderson, "Chronic Conditions: Making the Case of Ongoing Care."

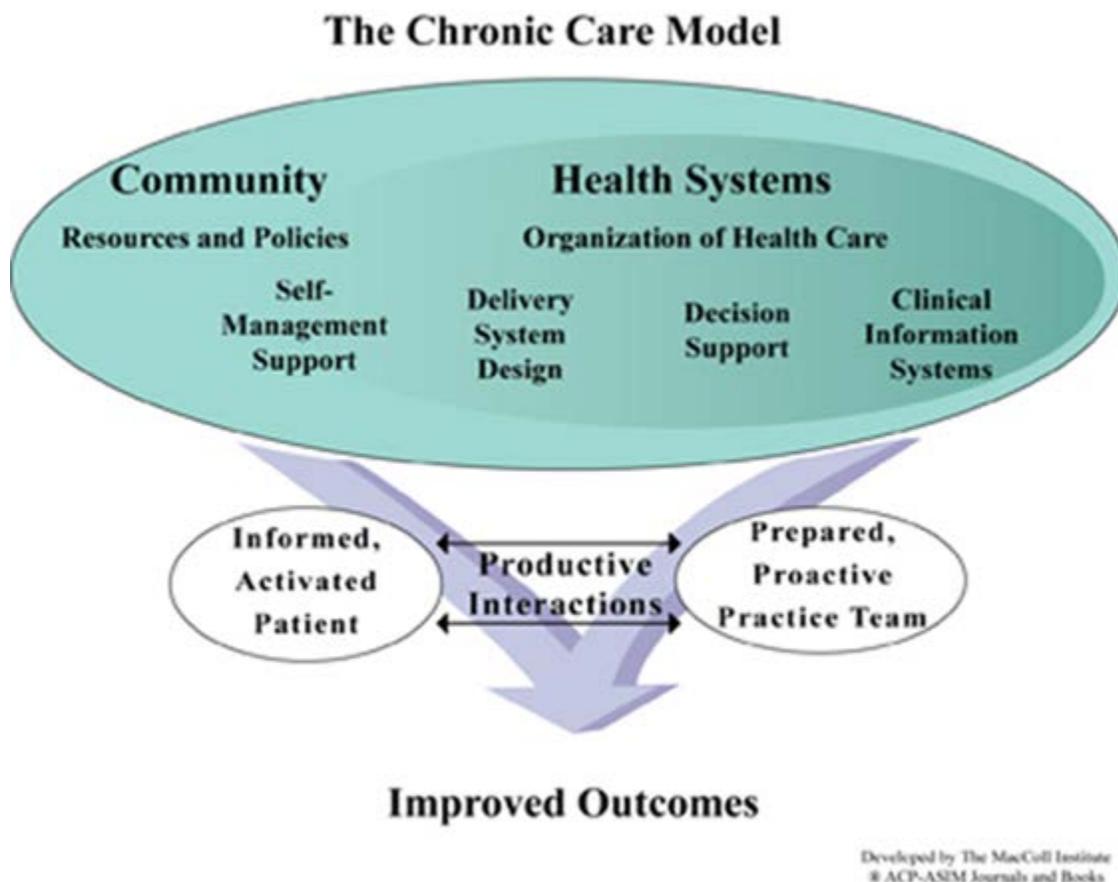
2[2] David M. Mosen *et al.*, "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management*, 30, no. 1 (2007): pp. 21–29; and Thomas Bodenheimer, Kate MacGregor, and Claire Sharifi, "Helping Patients Manage Their Chronic Conditions," prepared for the California HealthCare Foundation, June 2005, available at [www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf](http://www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf)

3[3] CDC, "Chronic Disease and Health Promotion." <http://www.cdc.gov/chronicdisease/overview/index.htm#sec3>

4[4] Chad Boulton and Erin K. Murphy, "New Models of Comprehensive Health, Care for People with Chronic Conditions," in Institute of Medicine. *Living Well with Chronic Illness: A Call for Public Health Action*, January 31, 2012. The other models were: transitional care, caregiver education and support, interdisciplinary primary care. Care management, and geriatric evaluation and management. <http://www.iom.edu/Reports/2012/Living-Well-with-Chronic-Illness.aspx>

community and self-management support.<sup>5[5]</sup> A key feature of the CCM is its explicit attention to the need to empower and prepare patients to improve health outcomes through the use of community resources and self-management support, existing outside of the clinical setting both in-person and online. See Figure 1.

Figure 1



Another helpful framework is an adapted version of Frieden’s pyramid of public health impact<sup>6[6]</sup>, tailored to reflect self-management support<sup>7[7]</sup>. This pyramid highlights the various domains that are collectively needed for self-management to have an impact at a population health level. These domains include media, policy, community, health systems, and the individual. These domains are organized on the pyramid by the contrast of population health impact with the level of individual effort needed. See Figure 2.

Figure 2

5[5] Chronic Care Model. [http://improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

6[6] Frieden TR. A framework for public health action: the health impact pyramid. *Am J Public Health* 2010;100(4):590–5.

7[7] Ruiz S, Brady TJ, Glasgow RE, Birkel R, Spafford M. Chronic Condition Self-Management Surveillance: What Is and What Should Be Measured? *Prev Chronic Dis* 2014;11:130328.



The Stanford Chronic Disease Self-Management Program (CDSMP), one of the most well-known and researched evidence-based programs, is a good model for people with multiple chronic conditions (MCCs), as research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, and symptom management.

Major published studies have found that CDSME results in significant, measurable improvements in the health of people with chronic conditions, as well as cost savings:

- A 2013 national study supported by the Administration on Aging of 1,170 CDSMP enrollees found annual \$364 per capita savings in reduced emergency room visits and hospital utilization, with potential savings of \$6.6 billion if 10% of those with one or more chronic conditions participated in the program.<sup>8[8]</sup>
- A study published in *Medical Care* found a 2.5 visit reduction in ER and outpatient visits per participant over two years, and a 0.49 day reduction in hospitalizations in the first six months.
- Another study published in *Effective Clinical Practice* of CDSMP participants found that, over a one-year period, participants had a mean 0.97 day reduction in hospitalization and averaged 0.2 fewer ER visits. This suggests an estimated savings of about \$1,000 per participant in the first year.

#### The Importance of Elder Falls Prevention

One in three Americans aged 65 and over falls each year. In 2013, 2.5 million nonfatal fall injuries among older adults were treated in emergency rooms with more than 734,000 of these hospitalized. Among older adults, falls are the leading cause of injury death. In 2013, \$34 billion in direct medical costs was spent treating older adults for the effects of falls, with 78% of these costs

<sup>8[8]</sup> <http://www.ncoa.org/assets/files/pdf/center-for-healthy-aging/National-Study-Brief-FINAL.pdf>

reimbursed by Medicare. If we cannot stem the rate of increase in falls, it is projected that the cost in 2020 will be \$67.7 billion, including Medicare costs estimated at about \$48 billion.

A number of evidence-based programs are now available which have been shown to reduce falls and save money. When compared with controls, the Tai Ji Quan: Moving for Better Balance intervention reduced falls by 55%; the Stepping On program reduced falls by 30%; and the Otago Exercise Program reduced falls by 35% when delivered to adults 80 years of age and older. A *Journal of Safety Research* special report from the CDC titled: "A cost-benefit analysis of three older adult fall prevention interventions" found that:

- The Otago Exercise Program had an average cost per participant of \$339.15, an average expected benefit of \$768.33 for participants over age 80, and a return-on-investment (ROI) of 127% for each dollar invested for this group.
- Tai Ji Quan: Moving for Better Balance had an average cost per participant of \$104.02, an average expected benefit of \$633.90, and an ROI of 509% for each dollar invested.
- Stepping On had an average cost per participant of \$211.38, an average expected benefit of \$345.75, and an ROI of 64% for each dollar invested.

In addition, in the November 2013 CMS Evaluation of Community-based Wellness and Prevention Programs analysis found that participation in the A Matter of Balance (MOB) falls prevention program was associated with a \$938 decrease in total medical costs per year. This finding was driven by a \$517 reduction in unplanned hospitalization costs, a \$234 reduction in skilled nursing facility costs, and an \$81 reduction in home health costs.

### **NCOA Recommendations**

In December 2010, the Department of Health and Human Services released Multiple Chronic Conditions: A Strategic Framework Optimum Health and Quality of Life.<sup>9[9]</sup> Goal 2 of the framework is to "Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions." Many of our suggestions below are closely aligned with and responsive to this goal, particularly Objective A on facilitating self-care management. Specific strategies from the framework in this area include:

- Strategy 2.A.1. Continually improve and bring to scale evidence-based, self-care management activities and programs, and develop systems to promote models that address common risk factors and challenges that are associated with many chronic conditions.
- Strategy 2.A.2. Enhance sustainability of evidence-based, self-management activities and programs.
- Strategy 2.A.3. Improve the efficiency, quality, and cost-effectiveness of evidence-based, self-care management activities and programs.

The following are NCOA recommendations to reduce costs and improve care for Medicare beneficiaries with multiple chronic conditions:

1. **Expand the Patient-Centered Medical Home (PCMH) self-management quality standards to other delivery models for Medicare**

With respect to self-management, diabetes self-management training (DMST) and chronic disease self-management education programs have demonstrated success in improving

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<sup>9[9]</sup> [http://www.hhs.gov/ash/initiatives/mcc/mcc\\_framework.pdf](http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf)

health outcomes, promoting more appropriate health care utilization, and reducing health care costs for people with chronic conditions. The American Medical Association Physician Consortium for Performance Improvement-National Committee for Quality Assurance (NCQA) recommendations contain outcome and process measures to improve health status. Specifically, they include initiation of a DSMT program within 12 months of new diagnosis, and initiation of a DSMT program within six months before or six months after the start of insulin therapy. In addition, aspects of self-management are included in patient experience metrics on discharge (National Quality Metrics Clearinghouse [NQMC]: 005475), for behavioral health services (NQMC: 000850), and for disease-specific treatment plans.

In addition, the NCQA measures associated with patient-centered medical home (PCMH) certification include criteria for evaluating self-management skill-building within medical practice. Consideration should be given to taking current PCMH self-management quality metrics and applying many of them to the Physician Quality Reporting System (PQRS), Accountable Care Organizations (ACOs), Chronic Special Need Plans (SNPs), and Medicare Advantage Star Ratings. Specifically, NCQA's PCMH Standard on Care Management and Support (Standard Four) measures include 4B: Care Planning and Self-Care Support and 4E: Support Self-Care and Shared Decision-Making. These measures capture critical elements of care that support self-management for people coping with chronic illness.<sup>10</sup>[10]

NCOA recommends that these Chronic Disease Self-Management quality metrics be included in standards for other Medicare providers, such as Medicare Advantage plans and ACOs.

## **2. Strengthen the Annual Medicare Wellness Visit to Better Promote Healthy Aging**

Section 4103 of the Affordable Care Act provided Medicare coverage for annual wellness visits, which include a personalized prevention plan. NCOA recommends that this provision be strengthened to better address the needs of older adults with multiple chronic conditions, specifically:

- Improve requirements for screenings and referrals to CDSME and falls prevention interventions, including specific protocols, recommended best processes and practices, and use of CDC's STEADI tool;
- Develop billing codes for falls risk assessments and for patient activation assessments;
- Develop standards for post-visit follow-up to better ensure compliance with the personalized prevention plan and referrals;
- Broaden the permissible circumstances under which visits can be conducted in a beneficiary's home.

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<sup>10</sup>[10] <http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PCMH2014Standards.aspx>

Electronic health records vendors are incorporating assessment tools into their software. For example, Epic, an electronic health records software system for medical groups, hospitals, and integrated health care systems, will release an update of their tool that will include CDC's STEADI algorithm for falls risk assessment. This electronic tool will provide a more streamlined approach for health care providers to integrate falls risk assessment into patient care.

**1. Conduct a new CMMI demonstration on Integrated Self-Care Planning (ISP)**

Self-management education and support in health systems and the community are highly fragmented, and neither sector has a practical process for integrating services at the patient/consumer level. To fill this gap, the Center for Medicare and Medicaid Innovation (CMMI) should be directed to develop and test Integrated Self-Care Planning (ISP), in which primary care and community service providers collaborate and integrate support to help older adults and their caregivers reach personal goals for aging well. This new process would bring together older adults, caregivers, primary care providers, and aging network providers so they have a shared pathway to managing each person's chronic conditions. Practical protocols for team-based care planning would be developed that center on older adults' goals and results in individualized service integration.

Using the ISP process, a primary care provider and trained community coordinator from an aging network provider would help older adults and caregivers set and track personal goals and outcomes. This care team would draw on health system and community resources to guide the coordinated delivery of self-care education, programs and services from both sources. Periodic team meetings, supplemented with technology-based communications, would assess progress and then update the goals, plan and service mix. The ISP model would directly respond to the call from health systems, payers, and consumer advocates for integrating clinical and community-based support for self-care.

**2. Include CDSME in new Medicare billing codes for complex chronic care**

NCOA recommends that Medicare billing codes for Chronic Care Management (CCM) services include the provision of CDSME. Considering that the vast majority of chronic condition management takes place outside of the health care setting, providers should be able to bill for those patients who attend a CDSME workshop either in-person or online. These workshops are available throughout the country, with more than 256,000 participants to date.

### 3. **Fund a Medicare Demonstration Modeled after the Medicaid Incentives for Prevention of Chronic Diseases Program**

Section 4108 of the ACA created the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program for States to develop and implement evidence-based chronic disease prevention approaches to demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives must be comprehensive, evidence-based, widely available, and easily accessible. Ten states were awarded grants test the use of incentives addressing at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or when there is a diagnosis of diabetes, improving the management of the condition.

NCOA recommends that a similar Medicare demonstration program be designed and funded targeting high risk beneficiaries, including dual-eligibles. Properly constructed based on recent learnings, evidence-based interventions and incentives to promote healthy aging and behavior change for this population has great potential to reduce Medicare spending and improve lives.

A relevant legislative proposal worth examining is the *Medicare Better Health Rewards Program Act of 2013* (S. 1228), introduced by Senators Wyden and Isakson. The demonstration would establish a point system to enable participant beneficiaries to receive up to \$400 per year if they comply with the protocols developed by the Cleveland Clinic, including those for: (1) an annual wellness visit, (2) tobacco cessation, (3) Body Mass Index (BMI), (4) a diabetes screening test, (5) cardiovascular disease screening, (6) cholesterol level screening, and (7) screening tests and specified vaccinations. Consideration should be given to adding protocols related to chronic disease self-management.

### 4. **Add Second Falls as a Hospital Readmissions Reduction Program Measure**

The Hospital Readmissions Reduction Program, mandated by the ACA, requires CMS to reduce Medicare payments to inpatient prospective payment system hospitals with excess readmissions. This program went into effect on October 1, 2012. This is a penalty program that reduces the base diagnosis related group (DRG) payments for discharges as result of performance on specific readmission measures. Such measures currently include unplanned 30-day readmissions for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective total hip arthroplasty and total knee arthroplasty. In 2017, CMS will add a measure for 30-day unplanned readmissions for coronary artery bypass graft surgery. NCOA recommends that a measure be added for

readmissions due to a second fall and could include fractures, brain injuries, and other injuries resulting from a fall.

**5. Provide assistance to states on how to incorporate evidence-based healthy aging programs within their Medicaid programs**

Several states have successfully incorporated evidence-based healthy aging programs within Medicaid. Some states have included CDSME in 1915(c) Home and Community-Based Services (HCBS) waiver programs. Others have sought to include evidence-based healthy aging programs within Medicaid managed care and duals integration demonstrations. States have a great deal of flexibility to incorporate evidence-based programs and related supports for participation (e.g. transportation) through various Medicaid HCBS authorities and programs, such as the 1915(c) HCBS waiver programs, 1915(i) State Plan Option, Health Homes, and Money Follows the Person Demonstrations.

Some of these options could provide an enhanced federal match. For example, the Medicaid Health Home benefit allows states to receive an enhanced federal match to implement Health Homes to support an integrative, whole-person approach to care for individuals with two or more chronic conditions, those with one who are at risk for a second, and those with a serious and persistent mental health condition. Services can include care management and coordination, health promotion, transitional care follow-up, and referrals to community and social support services. States could better utilize this option to provide evidence-based healthy aging programs. NCOA recommends that CMS be directed to provide technical assistance and guidance to states on incorporating evidence-based healthy aging programs within Medicaid. The Medicaid Innovation Accelerator Program could provide a platform to deliver technical assistance on these issues to states.

**6. Enhance Access to CDSME and Family Caregiver Support Programs for Veterans and Federal Employees**

Building Better Caregivers is an online workshop aimed to equip caregivers with knowledge, skills, and peer support to boost confidence, reduce feelings of burden and stress, and improve overall mental and physical health. The program is currently available to family caregivers through the Department of Veterans Affairs. Since 2012, over 1,400 caregivers have participated in workshops. However, recruitment efforts to date have primarily focused on caregivers of younger, post-9/11 veterans with traumatic brain injury and post-traumatic stress disorder. In partnership with the aging services network, additional outreach and recruitment should be undertaken to reach family caregivers of older veterans with disabilities who could also benefit from this program.

As the country ages, increasing numbers of workers are juggling work and family caregiving responsibilities. Businesses lose up to \$33.6 billion annually in work productivity and absenteeism due to caregiving responsibilities of full-time employees. In addition, businesses face approximately 8% higher health care costs of employees with eldercare responsibilities, potentially costing an estimated \$13.4 billion per year.

The average age of the federal workforce is also increasing. Many workers are living with multiple chronic conditions which are costly in terms of absenteeism, loss of productivity, and health care claims. Furthermore, chronic diseases have a negative effect on quality of life for the employee and can lead to disability and premature death if not appropriately managed. The DHHS has invested in evidence-based programs and supports national dissemination of proven healthy aging programs, such as the suite of CDSME online and community-based programs.

The federal government should be a model employer by promoting the availability evidence-based health programs to federal workers. As such, NCOA recommends that the Office of Personnel Management provide federal employees with access to CDSME and family caregiver support programs for federal employees. Access for federal contractors should also be considered.