



State of Utah

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Senate Committee on Finance Chronic Care Working Group
US Senate
Washington, D.C.

Dear Senators Hatch, Wyden, Isakson, and Warner,

Thank you for addressing policy reforms to improve the health of Medicare beneficiaries with chronic conditions. The Utah Department of Health supports the following nationally recognized, evidence-based programs: the **Chronic Disease Self-Management Program**, **National Diabetes Prevention Program**, **EnhanceFitness**, and **Stepping On Falls Prevention Program**. These programs empower participants to play a greater role in managing their health and meaningfully engage with their health care providers.

Research has shown these programs both improve the health of participants and decrease healthcare costs. The National Diabetes Prevention Program helps people with prediabetes and/or at risk for type 2 diabetes cut their risk of developing type 2 diabetes by 58%.¹ The Chronic Disease Self Management Program results in significant, measurable improvements in patient outcomes and quality of life. The Self Management Program also saves enough through reductions in healthcare expenditures to pay for itself within the first year.² The presence of multiple comorbidities is a risk factor for falls. Therefore, falls prevention should be included as part of chronic disease management programs. Evidence-based falls prevention programs have a return on investment of between 64% and 500%.³

Although chronic disease management and falls prevention programs are often part of patient care plans, the programs are not a covered service by Medicare or Medicare Advantage plans. Funding for evidence-based community health programs in Utah relies on government and private sources that are time-limited and inconsistent. This lack of sustainable funding hinders program development and expansion, especially in rural and frontier areas, whose populations are generally older, in poorer health, and most likely to be unequally impacted.



Chronic diseases and falls represent some of the most costly occurrences to hospitals and patients. Therefore, early detection and management of risk factors is essential. Evidence-based chronic disease management and falls prevention programs decrease the burden on primary care providers, improve the health of older Americans with chronic conditions, and reduce healthcare costs. Current funding of these programs is unsustainable and will not meet the future needs of Medicare beneficiaries. As part of health care reform, we urge you to provide evidence-based community disease management and falls prevention programs as a Medicare benefit.

Several programs at the Utah Department of Health address medication management: the chronic disease management and falls prevention programs encourage participants to review medications with their pharmacist or primary care provider; the medication synchronization process (i.e. refilling all of a patient's medications on the same day) improves medication adherence and reduces the negative drug interactions; and the Utah Prescription Drug Monitoring Program combats prescription drug abuse and misuse. Expanding the role of pharmacists within healthcare will improve medication management, promote the effective use of prescription medication, and reduce prescribing errors. Medicare should reimburse pharmacists for the time they spend counseling patients and for their participation in disease management programs.

The Utah Department of Health, similar to other State Health Departments, has developed strong relationships with agencies that provide care in rural and frontier areas, i.e., Local Health Departments, Area Agencies on Aging, Centers for Independent Living, Tribal communities, Health care organizations, Faith-based organizations, and Community Based Organizations. These organizations know whom best to work with in their areas to increase chronic care coordination. In addition to encouraging multi-sectorial partnerships, we suggest the following strategies to increase chronic care coordination in rural and frontier areas:

- Encourage the expansion and support of existing **Alternative Payment Models**, which aim to improve coordination of care for older adults with chronic diseases, while reducing overall healthcare costs.
- Deliver health information and health-related services using **telehealth**.
- Promote the use of **Community Health Workers** within care coordination teams.
- Continue to improve and expand **Health Information Technology** in order to coordinate care, organize patient health information, and reduce errors and duplication of services.

The population of Americans age 65 and older between 2010 and 2030 will increase from 39.7 million to 67.0 million.⁴ During the same time period, the share of Medicare beneficiaries with three or more chronic conditions is expected to increase from 26% to 40%.⁴ Research has validated chronic disease management and falls prevention programs in the Medicare population. What is lacking is adequate and consistent funding, and strong linkages between community programs and clinical care to assure effective coordination.

The Utah Department of Health encourages the Senate Chronic Care Solutions Workgroup to recommend evidence-based community chronic disease management and falls prevention program as a covered benefit for Medicare beneficiaries.

Thank you for your consideration.

Sincerely,



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Executive Director



Robert T. Rolfs, MD, MPH
Deputy Director

¹ Source: www.cdc.gov/diabetes/prevention/about.htm

² Lorig, KR., et al. "Chronic disease self-management program: 2-year health status and health care utilization outcomes." *Medical care* 39.11 (2001): 1217-1223.

³ Carande-Kulis V., et al., A cost-benefit analysis of three older adult fall prevention interventions, *Journal of Safety Research* (2015), <http://dx.doi.org/10.1016/j.jsr.2014.12.007>

⁴Gaudette E., et al., Health and health care of Medicare beneficiaries in 2030, The Brookings Institution and the USC Schaeffer Center, June 4, 2015

http://www.brookings.edu/~media/Research/Files/Papers/2015/06/04-medicare-2030-paper-series/Chartbook2030_Final.pdf?la=en