June 22, 2015

The Honorable Orrin Hatch
United States Senate
Washington, DC 20515

The Honorable Ron Wyden
United States Senate
Washington, DC 20515

The Honorable Johnny Isakson
United States Senate
Washington, DC 20515

The Honorable Mark Warner
United States Senate
Washington, DC 20515

Sent via email to: chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Thank you for bringing attention to the challenges and opportunities of chronic care in America and for highlighting eight key areas in need of new and creative solutions:

1. Medicare Advantage plan approaches
2. Incentives for patient outcome improvements
3. Incentives for care coordination
4. Coordination specific to prescription drugs
5. Opportunities for tele-health solutions
6. Special challenges in rural and frontier areas
7. **Options to empower Medicare patients in care management**
8. Innovative approaches for primary care to improve chronic care patient outcomes

In this letter we will focus primarily on #7. The greatest untapped resource for managing chronic care lies in helping patients with chronic conditions to do more for themselves, to learn to ask for the care they need, and to say "no" to care that does not advance their own health goals. While our focus is on #7, the solutions proposed help to advance improvements in the other seven priorities as well.

Healthwise is a nonprofit whose mission is to help people make better health decisions. Since our founding 40 years ago, people have turned to Healthwise information to make a decision or change behavior more than 1.6 billion times. Perhaps more importantly, 25% of U.S. physicians can now prescribe Healthwise information and tools to their patients through their electronic health record (EHR) systems.

Last year, Healthwise merged with the Informed Medical Decisions Foundation, a research and advocacy non-profit, to form the nation's leading organization dedicated to helping people make better health decisions. The merger has further strengthened our expertise and focus on patient engagement, care self-management, population health, and shared decision making.

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX **208.345.1897**
www.healthwise.org

The key areas of concern outlined in your letter can be addressed by supporting the patient in decision making and self-care, supporting the provider in care coordination, and encouraging all stakeholders, including the payer, patients, and their support networks, to collaborate on care.

Health IT is a critical tool to help achieve many of the goals your letter cites, including:

- increasing care coordination across care settings and among individual providers who are treating patients with chronic disease,
- facilitating the delivery of high-quality care,
- improving transitions,
- producing stronger patient outcomes,
- increasing efficiency, and
- reducing growth in spending.

General Comments

Advances in the treatment of chronic conditions over time have resulted in patients living longer with these diseases. Managing multiple chronic conditions is often the norm. Increased care coordination and collaboration can address this "new normal" for Medicare patients. In order for the many participants in each patient's care to provide the needed care and no unnecessary care, health information exchange is essential, along with access for all stakeholders, including patients, family members, providers, payers, and caregivers. Patient education is paramount as patients—as active members of their care team—try to manage advice, care plans, medications, and other therapies from multiple providers.

The starting point for bending the cost curve for this population must be focused on disease prevention and early detection along with care collaboration and supporting systems. Patients must be able to be as self-sufficient as possible, get appropriate needed care, be able to knowledgeably decline unnecessary care, and have the support systems in place to improve their health, remain stable, or manage decline. Patients should help design a care plan that reflects their individual goals.

Our comments below focus specifically on the role of health IT in enabling improved chronic care through supporting increased patient engagement and improved continuity of care, support, collaboration, and value. Mobile health technology is critical to provide patients with the tools for self-care, preventive care, and real-time interactions with their providers through phone, text, and video.

Patient Engagement

Improving chronic care starts with patients' readiness to learn, engage, and have support in health prevention and wellness. Patient engagement contributes to improved health and health outcomes and lower costs. Health IT can support engagement through innovative technologies focused on the following:

Health Management	Supports functions that include patient engagement,	Examples: • Portals, secure messaging, video

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX 208.345.1897
www.healthwise.org

	patient/provider family communication, shared decision making, care planning, etc.	• Shared decision making tools, patient education functionality, patient access to records, patient-generated data • Standards-based access to individual clinical and financial data • Interoperable EHRs that include or link to many of these functions
Social & Behavioral	Supports functions that include patients' ability to share their record via social media; patient-reported outcomes from daily living, adherence, and self-care; providers' ability to prescribe self-help tools. Supports functions like readiness to learn, behavior change, engagement, and sustaining health.	Examples: • Texting, health gaming, information therapy • Wearables and mobile health technology • Interoperable EHRs with patient-facing apps linked to EHRs and other health IT • Patient readiness
Home Health	Supports functions that include the patient's ability to share information from home monitoring devices	Examples: • Tele-health, remote patient monitoring, and smart homes • Patient education resources
Financial Health	Supports functions that include managing insurance and expenses, transparency and consumerism, patient onboarding, and financial options. Supports shared decision making efforts by providing cost information to the patient and the provider.	Examples: • Patient and provider secure access to a portal with information on cost projections for actual or proposed care • Shared decision making tools

Shared Decision Making

Shared decision making (SDM) between patients and their clinicians is a well-tested strategy for helping people make better health decisions. Shared decision making can be made practical with the use of patient decision aids, which can help communicate the medical options open to a patient along with the risks and benefits of those options, and help people clarify their values related to the decision they face. A systematic review article summarizes the evidence of the effect of patient decision aids from 115 randomized controlled trials with 34,444 participants. It provides strong support for the benefits of patient decision aids. The review finds that when patients use decision aids, they:

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX 208.345.1897
www.healthwise.org

a) Improve their knowledge,
b) Have more accurate risk perceptions,
c) More often choose an option consistent with their values,
d) Have lower decisional conflict,
e) Participate more in decision making, and
f) Are less often undecided about what to do.

In 15 trials of decision aids for major surgeries, there was a 21% reduction in surgery rates among participants who used a decision aid. (Stacey D, Legare F, Col NF, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2014; Issue 1. Art No.: CD001431.).

Shared decision making is not only for major, one-time decisions but can also help with the many daily decisions that are part of chronic condition management, where patient self-management is critical. Using asthma in adults as an example, one study randomized 612 adults with poorly controlled asthma to usual care (asthma education in person and by phone) or an SDM intervention where a non-physician clinician negotiated a treatment regimen with the patient that accommodated patient goals and preferences. Patients assigned to the SDM intervention had significantly better adherence with their controller medication, a higher cumulative controller medicine dose, better lung function, fewer asthma-related health care visits, and improved asthma quality of life. (Wilson SR, Strub P, Buist S, et al. Shared decision making improves adherence and outcomes in poorly controlled asthma. *Am J Resp Crit Care Med* 2010; 181: 566-577.)

When people have multiple chronic conditions, as is so often the case, SDM can prioritize interventions for common coexisting conditions, like diabetes, high cholesterol, and high blood pressure, to achieve the best outcome. For example, the most frequent and morbid complications of diabetes include heart attacks and strokes, which are more preventable through lowering cholesterol and blood pressure than through lowering glucose. In a pilot study funded by our Foundation, decision support programs motivated self-management of chronic conditions in two Los Angeles County senior centers and provided insight into how engagement affects outcomes. Participants at one site were encouraged with a gift card incentive to participate in the group video screenings. Seniors who attended three or more video screenings reported greater activation, more physical activity, and better health-related quality of life. (Frosch DL, Rincon D, Ochoa S, Mangione CM. Activating seniors to improve chronic disease care: Results from a pilot intervention study. *J Am Geriatr Soc* 2010; 58: 1496-1503.)

Specific recommendations to support shared decision making (SDM):

Action	Reference	Enabling Body
Fee schedule for shared decision making	http://www.iom.edu/global/perspectives/2014/sdmforbestcare.aspx	CMS
Secure Messaging for Patients/providers	www.Directtrust.org	ONC
HIT certification	http://files.himss.org/FileDownloads/HIMSS%20PGHD%20Industry%20Briefing.pdf	ONC

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX **208.345.1897**
www.healthwise.org

includes acceptance of patient-generated data		
Shared decision making defined and best practices supported within existing provisions of the ACA. Shared Decision Making promoted by payment for providers who engage in Shared Decision Making. CMS urged to adopt regulations supporting Shared Decision Making.	Affordable Care Act Sections 3506 and 3021 For definitions and conditions for Shared Decision Making, see Wyden S 1133.	Congress/OME
Certification of Decision Aids	http://www.iom.edu/global/perspectives/2014/sdmforbestcare.aspx	ONC

Continuity of Care

Continuity of care broadly can be described as coordinated and collaborative care for an individual patient as that patient's health issue is diagnosed, treated, and managed by the healthcare establishment. The focus on both coordination and collaboration across multiple care settings and providers is particularly important in the context of patients with chronic conditions.

Health IT enables better continuity of care for patients with chronic conditions, ensuring that the right information follows the patient and their caregivers to inform better care decisions. Health IT provides a means for patients and caregivers to have access to information and participate as active members of the care team. Health IT provides an opportunity for the patient to tell their story, outlining their goals and wishes, to ensure every member of the patient's care team is informed. A personal care plan can inform the provider about the patient's goals, wishes, and needs in order to provide a more holistic and preference-driven care path.

Although there are many examples of health IT being used to facilitate coordinated, collaborative care, challenges remain. These challenges include a lack of widespread information sharing across settings; lack of patient access to or information about the purpose and outcome of the care in each setting; and the lack of a shared medical record, with a way for the patient to have input into the medical record or to track performance across settings. Silos of healthcare information result in siloes of healthcare delivery that lead to inefficiencies, redundant services, higher cost, and lower value.

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX 208.345.1897
www.healthwise.org

The costs of this lack of coordination, beyond the system issues mentioned above, are the quality of life and quality of end-of-life for patients. Each of us should be able to make informed decisions that help direct the care that we want or care that we do not want. Advanced care planning documents record the patient's instructions, yet these instructions are largely unknown to most of the patient's care providers. ONC and CMS should include care plans generated by the patient to be integrated into the medical record, with the first use case selected for regulatory improvements to be end-of-life care.

Specific recommendations for continuity of care

Action	Reference	Enabling Body
HIT certification required for long term post-acute care, rehab, ambulatory care, and others not currently engaging in the EMR incentive program	http://www.ltpachealthit.org/	ONC
Secure messaging for patients/providers	www.Directtrust.org	ONC
Paid family caregiver support to provide many of the basic clinical services needed by people with chronic conditions and post-operative patients	Planetree	CMS
HIT certification includes acceptance of patient-generated data	http://files.himss.org/FileDownloads/HIMSS%20PGHD%20Industry%20Briefing.pdf	ONC
Care plan certification to include providers, patients, and payers	http://wiki.hl7.org/index.php?title=Care_Plan	ONC
Advance care plans integrated into the EMR	ONC HIT certification	ONC

Digital Encounters

Healthwise believes that better patient-facing technology is vital to improving care and value for patients with chronic conditions. This patient population, in particular, requires active monitoring and regular touch points with providers. Digital encounters go beyond Tele-health. Tele-health today is often considered a real-time encounter using technology to replace the face-to-face visit. Digital encounters can be this and more: a text message from the provider, a secure email, a video sent to the mobile device to help patients with self-care, a shared decision aid, coaching, exercise support, apps, and more.

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX 208.345.1897
www.healthwise.org

A provider can prescribe these tools and send them to a patient, who can use them for self-care. The tools themselves can communicate the patient's response back to the provider's record. This kind of digital encounter, with the patient response updating to the record via patient-generated data, begins to give the provider information needed for care and for the patient's moral and care support. Providers will need to use all available tools to manage patients, support them in care, and coach them in wellness.

CMS needs to remove all barriers to digital encounters. We encourage CMS to provide a fee schedule for digital encounters that support chronic care management, and a certification mechanism for tools that CMS knows are evidence-based, are free of commercial bias, and include the patient's response.

Action	Reference	Enabling Body
HIT certification	http://www.healthit.gov/FACAS/sites/faca/files/HITPC120413CECT_WG_Recommendations_0.pdf	ONC
Secure messaging for patients	www.Directtrust.org	ONC
HIT certification that includes acceptance of patient-generated data	http://www.iom.edu/global/perspectives/2014/sdmforbestcare.aspx	ONC
HIT certification open application interface to enable patients' ability to attach apps to the electronic health record	http://www.hl7.org/fhir/	ONC
Fee schedule for digital encounters to include the use of digital tools	HIMSS mHealth, HIMSS Center for Patient and Family Connectedness	ONC

Chronic care, wellness, prevention, and acute care all benefit when the patient is ready to learn, adheres to care plans they help create, can act on health priorities they set, and share in decisions. While the focus of this letter has been primarily on the working group's seventh area of concern (Options to empower Medicare patients in care management), the chart below reveals how well these recommendations would advance each of the other areas of interest:

1. Medicare Advantage	Every recommendation made above would improve Medicare Advantage plan performance.
2. Incentives for outcomes	Each recommendation creates incentives for both provider/plan and patient/person incentives.
3. Incentives for coordination	The personal care plan and goals become the coordination hub.

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX **208.345.1897**
www.healthwise.org

4. Prescription drug coordination	Shared decision making is key to getting the right drug to the right person at the right time without contra-indicators.
5. Tele-health solutions	Digital care and support take tele-health into the mainstream
6. Rural and frontier areas	Shared decision making aids, digital care management programs, and other patient interactive tools have no geographic limits.
7. Primary care	All of this is best delivered within a primary care-focused, patient-centered medical home.

Infrastructure that Meaningful Use mandates has provided many opportunities for patients to engage in care. These recommendations build upon these successes.

Sincerely,

Leslie Kelly Hall
Senior Vice President, Policy
Healthwise, Inc.

Healthwise
2601 N. Bogus Basin Rd.
Boise, Idaho 83702
208.345.1161
800.706.9646
FAX **208.345.1897**
www.healthwise.org