January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20515

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20515

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

On behalf of Insignia Health, I am writing to support the efforts of the Chronic Care Working Group to develop bipartisan legislative solutions to improve care for millions of Americans managing chronic disease. Insignia Health believes that individuals become more engaged in preventing disease and managing a chronic condition when they receive support and education based on a clear understanding of what they are realistically capable of taking on. We commend the efforts of the Chronic Care Working Group, and appreciate the opportunity to provide feedback on the Working Group's Policy Options released in December 2015.

As you examine policy options, I urge you to incorporate a validated patient-centered assessment of health activation, which will benefit not only beneficiaries, but also taxpayers and the Medicare program. More than 150 leading healthcare organizations, including Medicare Advantage plans, state and local Medicaid programs, CMS-directed quality improvement organizations (QIOs), accountable care organizations (ACOs), integrated hospital and health systems, life sciences/pharma companies, and health insurance companies, are successfully using these tools to improve outcomes and reduce costs for patients managing chronic disease. Recognizing the relationship of patient activation to chronic disease self-management capability will enhance the effectiveness of care provided to these patients. Applying the proven predictive qualities of accurately measuring patient activation will achieve precise use of finite program resources, so patients in most need of targeted chronic disease management support receive it.

About Insignia Health and the Patient Activation Measure® (PAM®)

Insignia Health, based in Portland, Oregon, is dedicated to helping patients develop their self-management abilities in order to become more activated and engaged in their health care. Insignia Health provides support to a wide variety of healthcare organizations by assessing a patient's level of activation, and then developing strategies *targeted to that patient's level of activation* to help patients become more successful managers of their health and healthcare. Insignia Health applies its proprietary family of health activation assessments to measure each individual's self-management competencies.

The Patient Activation Measure® (PAM®), which anchors this effort, was developed by health researchers at the University of Oregon and has been validated by more than 240 third-party, peer reviewed, published studies over the past twelve years. PAM® is a brief 10- or 13-item survey that assesses an individual's knowledge, skills, and confidence for managing their health and health care. The measure has strong psychometric properties and is being used in clinical settings around the globe (with translations in 23 languages).

The results of the PAM® assessment segment patients along an empirically derived 100-point continuum, which in turn indicates one of four levels of activation:

Research consistently shows that patients with low-activation (levels 1 and 2) are poor health self-managers. They are more likely to struggle with making care transitions, understanding health-related instructions, keeping scheduled medical appointments, and adhering to medication protocols. They have higher use of emergency room services and are more frequently readmitted to the hospital within 30 days after discharge, resulting in significantly higher health system costs[i]. Low-activated individuals represent 45-50% of the Medicare population, but account for a much greater percentage of healthcare utilization. Engaging these individuals in their health is essential to improved health and control over healthcare spending.

When a patient's level of activation is known, health care providers can proactively tailor communication, information, goals, and action steps to the abilities of the patient. This leads to more effective approaches to increasing the patient's knowledge, skills and confidence to self-manage their health and the patient ultimately realizing the importance of things such as appropriate use of preventive care services and medication adherence. As the patient becomes aware and confident in their self-management capabilities, health-related behaviors change, health outcomes improve and there is reduction in avoidable medical spending.

A 2011 study from researchers at Cornell Medical College found that among hypertensive patients over 65, higher activation was associated with higher self-ratings of health, health literacy, and receipt of patient-centered care, shorter lengths of hospital stay, and lower depression and hearing impairment levels.[ii] And a 2015 study from the University of Massachusetts Medical School concluded that chronically ill patients reporting low stages of patient activation are at an increased risk for hospitalization and ER utilization.[iii]

In order to improve patient outcomes and enhance quality of care, leading health plans, health systems, hospitals and clinics in over 40 states and Medicaid programs in 6 states, as well as NHS England and its regional Clinical Commissioning Groups, are already measuring patients' activation level independently and using that information to guide patient-provider and patient-plan interaction and communication.[iv]

Insignia Comments on the Working Group Policy Options

Insignia's experience, which is supported by both peer reviewed studies and data from clinical use of PAM®, supports the Working Group's assertion that beneficiary access to timely, accurate information is linked to the empowerment of Medicare beneficiaries to better manage their chronic conditions and lower overall costs. However, access to information is only the starting point.

Successful health self-management is accomplished by providing information and direction that is appropriate to each person's ability as determined by his or her level of health activation. Patients are routinely buried in accurate information for achieving guideline behaviors from doctors, health coaches, therapists, health media, and websites. But it is often not actionable given their knowledge, skills and confidence to accurately use that information. This is the equivalent of providing a non-swimmer with pamphlets, videos and verbal direction on how to swim, then throwing him into the deep end of the pool and expecting success. Access to information was the starting point. Providing level-appropriate instruction toward progressive behavioral goals that match the person's abilities at particular intervals is the key to lasting success.

> **Encouraging Beneficiary Use of Chronic Care Management Services**: The CCWG recommendation to waive the beneficiary co-payment for the existing chronic care management code will simplify this benefit for both patients and providers. Waiving cost sharing will impact patients in different ways depending on their level of activation. This policy recommendation could be enhanced by including an assessment of patient activation.
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> Waiving cost-sharing would incentivize beneficiaries with higher activation (Level 3 or 4) to seek and embrace these services. These individuals are characterized as information-hungry problem solvers that are eager to adopt new best practice behaviors because they understand the link between steps they take day-to-day to self-manage their condition and an improvement in their health. For lower activated beneficiaries (Level 1 or 2), waiving the beneficiary co-payment may be insufficient for these beneficiaries to seek these services. These patients lack confidence in their self-management capabilities and feel that their health is largely out of their control. They

do not recognize the connection between their actions and their health; they do not have confidence to take on self-management behaviors.

Assessing a patient's level of activation identifies a patient's self-management capabilities, and enables a provider to tailor education to the patient's activation level in *conjunction* with pre-existing conditions, rather than simply determining care based on a typical course of action. This assessment is essential *prior* to providing care in order to tailor the care plan to meet the patient's knowledge, skills and confidence with respect to self-management responsibilities.

Typical chronic care management strategies and patient education programs provide large volumes of information and instruction – brochures, websites, and support group details – that can be overwhelming to low-activated patients. In order to translate these services into patient gains in disease self-management skill, the services must be tailored to support a patients' level of knowledge and skill. Starting a disease/condition management education program at the point where the patient can effectively take action builds motivation, confidence and ultimately, successful self-management.

PAM®-use identifies the segment of chronic disease patients with lower activation who require tailored education and coaching in order to gain the knowledge, skills and confidence necessary to successfully adopt behavioral changes and lifestyle modifications. Similarly, PAM® scores enable health care teams to recognize with certainty beneficiaries that are more highly activated and already possess the knowledge, skills and confidence to self-manage a chronic condition with some guidance and limited coaching (Level 3 and 4 patients).[v] Tailoring disease management support to a patient's self-management competency is key. Chronic disease management education without this insight will fail the low-activated and be wasted on the high-activated. Tailoring care and education to activation levels increases the efficiency and efficacy of support programs.

Allocating more time or more resources to lower-activated beneficiaries gives practitioners the opportunity to address knowledge gaps and confusion, and to craft more appropriate care plans that place patients on a path to achieve successful self-management of chronic conditions. Conversely, patients with high activation tend to proactively seek out information and will succeed with nominal support. Using PAM® scores can help prevent ineffective, one-size-fits all approaches to chronic disease management from being applied, and instead encourages accurate resource allocation.

Expanding Access to Digital Coaching: Insignia supports the Working Group's recommendation to require CMS to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health. Insignia recommends the inclusion of appropriate digital coaching to significantly enhance chronic disease management while also improving a patient's level of activation. Digital coaching conversations should use a patient's PAM® levels to guide condition-specific goals and action steps that are realistic and achievable to improve health outcomes and lower healthcare costs.

Insignia Health's Flourish® online health management program is the first and only e-health education solution that incorporates the individual's activation level. It is available to users 24

hours a day, seven days a week. Flourish uses the patient's PAM® level, biometric measures and self-reported health data to customize the digital health coaching experience toward attaining guideline behaviors. The curriculum is tailored to each of the four levels of activation, as revealed by PAM® score. Flourish combines the benefits of dynamic online information with the more personalized attributes of one-on-one coaching to help individuals become more active and successful in managing their health. Users learn at their own pace and at the right intensity through a series of interactive challenges and engaging level-appropriate content.

Flourish was offered to diabetes patients through Fairview, a health system (7 hospitals, 40+ primary care clinics) in Minnesota. 1,250 patients enrolled in one of four program cohorts – Flourish only, Flourish + telehealth, Flourish + in-person coaching, and a control group (care as usual). Telephone and in-person coaching used Insignia's PAM® based Coaching for Activation® model.

The Fairview study found that PAM® scores changed based on program cohorts. All three Flourish cohorts outperformed the control group. PAM® score improvements for patients offered Flourish increased between 2.5 and 9.4 points, while PAM® scores declined for the control group on average 2.6 points. Additionally, the Fairview study found improved diabetes outcomes -- controlling blood pressure, cholesterol and A1c/blood glucose levels -- for all three Flourish cohorts, and all three cohorts outperformed the control group. A 1-point increase in a patient's PAM® score is associated with, on average, about a 2% reduction in ER use and hospital admits. Similarly, each 1-point improvement is also associated with a 2% boost in medication adherence and improvement in A1c.[vi]

A digital coaching experience should do much more than provide beneficiaries with access to health information. It should be guided by a validated assessment of self-management capabilities that will significantly and progressively increase activation level time. Higher activation across a population indicates higher levels of health self-management ability, which results in lower hospital readmissions, reduced ER use, and increased medication adherence, leading to lower overall costs and better chronic condition management.

Other Uses of PAM® in Chronic Care Management

As mentioned above, in addition to enhancing chronic disease management, PAM® is a powerful predictive tool to determine a patient's medication adherence behaviors.

Prescription Medication Adherence: Prescription drug therapies are an element of many chronic disease management regimens, and effective disease management requires strict medication adherence. Peer reviewed studies have revealed that medication adherence is more directly tied to a patient's level of activation than to their health condition.[vii] Therefore, knowing a patient's level of activation is essential to successful medication adherence.

As poor managers of self-health, patients in the lower two levels of activation are challenged by medication adherence. The Kaiser Center for Health Research found that low activated patients with some of the most common chronic diseases missed one or more doses of medications per week. Specifically, 31.2% of Level 1 patients with hypertension missed one or more doses of

medication per week compared to only 16.7% of Level 4 patients. Similarly, 31.5% of Level 1 patients with congestive heart failure (CHF) missed one or more doses of medication per week compared to 13.6% of Level 4 CHF patients.[viii] Comparable results were seen with other prevalent conditions like diabetes, COPD, chronic heart failure, coronary artery disease, arthritis, and even cancer, indicating a similar mindset for patients at Level 1 regardless of the perceived severity of the condition.

During the past 7 days, including last weekend, on how many days have you missed any of your doses?

Percent Reporting one or more days

Condition	Level 1	Level 2	Level 3	Level 4	P
Arthritis (1611)	31.1	28.5	21.1	20.1	.001
CAD (992)	34.0	23.2	20.7	16.0	.002
Cancer (322)	32.1	22.1	15.6	17.6	.190
CHF (733)	31.5	23.8	16.2	13.6	.001
Chronic Pain (1126)	29.5	27.2	22.2	14.1	<.001
COPD (276)	30.4	23.4	20.9	18.0	.050
Depression (717)	30.7	28.6	21.0	20.3	.093
Diabetes (1528)	29.7	28.7	21.0	19.2	.001
Hypertension(2290)	31.2	26.5	20.2	16.7	<.001

Source: Kaiser Center for Health Research 2006

Knowing the activation level of beneficiaries with a chronic disease would boost the effectiveness of medication adherence efforts offered through disease management education programs. Once activation level is measured, members of a patient's health care team, from the physician to the nurse to the pharmacist, can tailor medication adherence instructions to the self-management abilities of the patient, insuring instructions are provided in a manner that enables the patient to both comprehend and act upon them. Providing a beneficiary with guidance that is informed by his level of activation results in patients grasping the role they have in their own health outcomes and them becoming more knowledgeable and confident in how and why to be adherent to their medication.[ix]

The potential savings associated with improved medication adherence is substantial. The New England Healthcare Institute (NEHI) has estimated that non-adherence along with other related prescription drug factors could result in $290 billion of avoidable medical spending annually. NEHI found that non-adherence alone has been shown to result in $100 billion each year in excess hospitalizations. Incorporating validated methods to increase medication adherence, such as measurement of patient activation and subsequent tailored coaching will achieve better overall condition management, lower utilization of high-cost emergency department services, lower overall hospitalizations and readmissions, and lower expenditures on unneeded services by individuals, institutions and tax-payer financed programs.

Chronic condition management programs that recognize patient activation consistently demonstrate that patients low in activation are not intractable, and in fact, they show the greatest gains in activation

and self-management ability. These gains result in improved health, lower utilization and reduced economic burden. Expanding systematic assessment to capture a patient's level of health activation will strengthen the patient-centeredness of care plans and improve resource allocation, while providing a validated measure of performance.

Thank you for the opportunity to share our thoughts, and to encourage the measurement of patient activation. As the drafting process continues, Insignia Health wishes to remain a resource for you and your staff. Should you have any questions or want to discuss patient activation further, please contact JD Derderian of the Stanton Park Group at 202-470-4904 or jderderian@stantonparkgroup.com.

Respectfully,

Chris Delaney
Chief Executive Officer, Insignia Health

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[i] Hibbard JH, et.al. "Patients With Lower Activation Associated With Higher Costs; Delivery Systems Should Know Their Patients' Scores." Health Affairs Feb. 2013. Know Their Patients' Scores." Health Affairs Feb. 2013
Mitchell S, et. al. "Patient Activation and 30-day Post-discharge Hospital Utilization." Journal of General Internal Medicine. October 2013

[ii] Gerber L, Barron Y, Mongoven J, McDonald M, Henriquez E, Andreopoulos MA, Feldman P. "Activation Among Chronically Ill Older Adults with Complex Medical Needs: Challenges to Supporting Effective Self-Management." Journal of Ambulatory Care Management. Vol. 34, No 3: 292-303. July 2011. http://www.ncbi.nlm.nih.gov/pubmed/21673530

[iii] Kinney RL, Lemon SC, Person SD, Pagoto SL, Saczynski JS. "The association between patient activation and medication adherence, hospitalization and emergency room utilization in patients with chronic illness: A systematic review." Patient Education and Counseling. 98:545-52. May 2015. http://www.pec-journal.com/article/S0738-3991(15)00074-9/abstract

[iv] Health plans that currently measure patient activation include Anthem/Wellpoint, United Health Group, Coventry Health Plan, Kaiser, Permanente, Rocky Mountain Health Plans, Priority Health, Providence Health Plans, and Tufts Health Plan. Medicaid programs that measure patient activation include Colorado, New York, Oregon, South Carolina, and Washington.

[v] Hibbard JH, Greene J, Tusler M. "Improving the Outcomes of Disease-Management by Tailoring Care to the Patient's Level of Activation." *American Journal of Managed Care* Vol. 15 No 6:353-360. June 2009. http://www.ajmc.com/publications/issue/2009/2009-06-vol15-n6/AJMC_09Jun_Hibbard_353to360/

[vi] "Is Patient Activation Associated With Outcomes Of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management* Volume 30 No 1; 21---29: 2007.

[vii] "Patients with high PAM scores were significantly more likely to perform self-management behaviors, use self-management services, and report high medication adherence, compared to patients with the lowest PAM scores." From: Mosen D, Schmittdiel J, Hibbard JH, Sobel D, Remmers C, Bellows J. "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" Journal of Ambulatory Care Management Volume 30 No 1; 21-29: 2007. http://www.ncbi.nlm.nih.gov/pubmed/17170635

"Participatory decision making during primary care encounters by patients with type 2 diabetes resulted in improvements in hemoglobin A1c levels and LDL cholesterol values by improving patient activation, which in turn improved medication adherence."
From: Parchman ML, Zeber JE, and Palmer RF. "Participatory Decision-Making, Patient Activation, Medication Adherence, and Intermediate Clinical Outcomes in Type 2 Diabetes: A STARNet Study." Annals of Family Medicine 8:410-417. 2010. http://www.annfammed.org/content/8/5/410.long

"Higher patient activation was most strongly associated with positive recovery attitudes, higher levels of hope, and fewer emotional discomfort symptoms. Patient activation was significantly related to a broad measure of illness self-management, providing evidence for the construct validity of the patient activation measure. Our findings emphasize the importance of recovery-based mental health services that recognize level of patient activation as a potential factor in consumer outcomes."
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[viii] Mosen D, Schmittdiel J, Hibbard JH, Sobel D, Remmers C, Bellows J. "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management* Volume 30 No 1; 21-29: 2007. http://www.ncbi.nlm.nih.gov/pubmed/17170635

[ix] "What's more, patient activation was a significant predictor of cost even after adjustment for a commonly used 'risk score' specifically designed to predict future costs. As health care delivery systems move toward assuming greater accountability for costs and outcomes for defined patient populations, knowing patients' ability and willingness to manage their health will be a relevant piece of information integral to health care providers' ability to improve outcomes and lower costs."
From: Hibbard JH, Greene J, Overton V. "Patients With Lower Activation Associated With Higher Costs; Delivery Systems Should Know Their Patients' Scores." Health Affairs Feb. 2013.
http://www.ncbi.nlm.nih.gov/pubmed/23381513