Hitting the "Bulls-eye" in Health Reform:
Controlling Chronic Disease Improves Quality and Lowers Costs

PARTNERSHIP TO FIGHT
CHRONIC DISEASE

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- While everyone agrees that making health coverage affordable is the key to providing health care to all, **no Congressional proposal has yet put forth a plan for how we deliver, administer and pay for health care that is bold enough to make this goal attainable and sustainable while being comprehensive enough to improve health.** Why? Because they do not do enough to target the underlying cost increases – namely the unchecked rise in rates of chronic illness – and the many serious and costly care failures that fuel that growth.
- The Partnership to Fight Chronic Disease believes **the only way our nation will be able to improve health, and solve our long-term cost problems is to pass comprehensive health reform that fundamentally changes how our health system helps Americans prevent, treat, and manage chronic disease.**
- Rising rates of chronic disease are the greatest factor driving health care spending, accounting for 75 percent of every dollar spent on health care – and 83 percent in Medicaid and 99 percent in Medicare. The doubling of obesity rates since the mid-1980s alone is responsible for nearly 1/3 of the growth in health spending.

> "In the legislation that has been reported we do not see the sort of fundamental changes that would be necessary to reduce the trajectory of federal health spending by a significant amount."
>
> Congressional Budget Office Director
> Doug Elmendorf, July 16, 2009

The PFCD believes Congressional proposals could get much closer to hitting the health reform "bulls-eye" by doing the following five things:

- **Rollout evidence-based models for coordination of care nationwide in Medicare within the next three years**
- **Immediately expand the types of treatments in Medicare that would be paid on a "value" not "volume" basis**
- **Aggressively promote chronic disease prevention in the traditional health care system and beyond**
- **Remove barriers that would reduce patients' ability to avert the development and progression of chronic illness**
- **Move from a paper-based system to a high-tech system that helps to coordinate care**

Consistent with the PFCD's "Ideas for Change," meaningful health reform must:

- **Advance sustainable "next generation" chronic disease prevention, early intervention, and management models throughout the health care system and public health infrastructure**
- **Promote healthy lifestyles and disease prevention and management in every community**
- **Encourage and reward continuous advances in clinical practice and research that improve the quality of care for those with costly chronic diseases**
- **Accelerate improvements in the quality and availability of health information technology (HIT) throughout the health care system**
- **Reduce health disparities by focusing on barriers to good health**

The following pages present summaries of how well the current Congressional health reform bills address each of these priorities.

Advance sustainable "next generation" chronic disease prevention, early intervention, and management models throughout the health care system and public health infrastructure

As counterintuitive as it sounds, health is not always the highest priority in the current health care system. More often than not, delivery and payment is built around treating illness and responding to health problems only when they have become acute. Promotion of health and physical and mental wellbeing is not routinely practiced because it is not routinely rewarded. Yet, prevention and management of chronic disease are integral to the financial sustainability of our health care system, not to mention the quality of patients' care, health and lives.

Where Current Proposals Hit the Mark:

The current health legislation contains several provisions in this area, including policies to improve care coordination, support patients and self-management, lower out-of-pocket costs for chronic disease preventive care and management, and improve access to preventive and chronic care services.

Where They Miss:

Current proposals stop well short of the level of reform needed to move the system to one that actively promotes health and links payment to quality of care. This is a major missed opportunity from a cost and value perspective. Evidence-based, well-coordinated care can help Americans can stay in good health, catch and treat disease in its earliest stages, and prevent costly complications and disease progression. Those are the reforms needed to bend the cost curve in the long term.

PFCD PRINCIPLE Advance sustainable "next generation" chronic disease prevention, early intervention, and management models throughout the health care system and public health infrastructure	
Examples of policies that address this principle include:	**Suggested Improvements**
Implements transitional and care coordination programs such as: • Readmission reduction efforts • Medical homes pilots • Grants for medication management programs (**HELP** - Sec. 212; **Tri-Committee** - Sec. 1722, 1302, 1302) (**HELP** - Sec. 142, adding Sec. 3101(m); **Tri-Committee** - Sec. 1732) (**HELP** - Sec. 213, adding Sec. 935)	• Build out evidence-based care coordination models into Medicare nationwide within 3 years • Incorporate evidence-based care transitions models into care coordination for Medicare and Medicaid • Provide support for patients and family caregivers to improve adherence to treatment recommendations in quality improvement and care coordination efforts
Improves access by eliminating or lowering patient out-of-pocket costs, e.g., limits on cost-sharing on preventative services (**HELP** - Sec. 101, amending Sec. 2708; **Tri-Committee** - Sec. 1202, 3131, 3132, 3121)	• Support efforts to improve adherence to chronic care recommendations that prevent disease development and progression • Avoid policies that raise access barriers for patients (e.g., lowering limits on pre-tax savings accounts for out-of-pocket medical expenses)
Mechanisms to strengthen the primary care and public workforce (**HELP** - Sec. 174; **Tri-Committee** - Sec. 1303, 2212, 2213, 2214, and 2215)	• Improve access to care in needed professions and in communities experiencing shortages of providers, including investments in telehealth • Encourage the educational pursuit of underrepresented specialties in areas where specific unmet needs exist, including preventive medicine, geriatrics, pediatrics, and disease-specific areas such as juvenile arthritis • Support training at all levels of the health care workforce that emphasizes the prevention and management of chronic diseases

Encourage and reward continuous advances in clinical practice and research that improve the quality of care for those with prevalent and costly chronic diseases

Reform must recognize that America does a lot well with health care, particularly with advancing medical knowledge and innovation, and build reform efforts around preserving what works and changing what doesn't. For example, we need to do a better job of translating advances in medical knowledge into medical practice and daily living. Learning from evidence-based health improvement efforts and facilitating their wider adoption are critical to meaningful health care reform.

Where Proposals Hit the Mark:

The current health reform legislation contains several provisions in this area, including recognizing and establishing measures for quality improvement and developing national standards of quality improvement. The bills also support enhancements in medical education that promote primary care and public health workforce development and address health disparities.

Where They Miss:

There are significant opportunities to promote population health improvements by setting national quality standards and benchmarks that evaluate how policies and practices are working to reduce the prevalence, morbidity, and mortality of chronic diseases and encourage improvements in those areas. In addition, policies that build upon existing, successful models for quality improvements in clinical practice resulting in better health outcomes for patients (e.g., the Medicare Physician Group Practice demonstration, Bridges-to-Excellence program, APN Transitional care model, and the VA telehealth program) are not sufficiently reflected in the legislative proposals to date.

PFCD PRINCIPLE Encourage and reward continuous advances in clinical practice and research that improve the quality of care for those with prevalent and costly chronic diseases	
Examples of policies that address this principle include:	**Suggested Improvements**
Establishes a National Strategy in Quality Improvement, supports the development and endorsement of quality measures, and establishes a process to develop national priorities for population health improvement (**HELP** – Title II; **Tri-Committee** – Secs. 1441 - 1445)	• Ensure that the national quality strategy includes measurable goals for reducing the number of patients with undiagnosed, untreated, and uncontrolled chronic conditions and a process for regular public reporting on progress towards those goals • Support quality measures that evaluate and improve clinical health outcomes, including promoting adherence to treatment recommendations • Incentivize improvements in the quality of care and health outcomes through reimbursement that encourages chronic disease prevention and management and care coordination • Avoid policies which discourage use of evidence-based wellness and disease management programs in public and private sector programs (e.g., private plan "admin costs" include funding for these programs & limits on costs would discourage programs)

Promote healthy lifestyles and disease prevention and management in every community

Good health is more than a result of good medical care. So much depends on empowering and motivating Americans to be physically active and otherwise "do the right thing" for their health in their day-to-day lives. As such, promoting improvements in prevention – averting disease development and progression – in settings outside the medical system – at home, at work, at school, and in the community – must be an integral part of health care reform.

Where Proposals Hit the Mark:

The current health legislation contains several provisions in this area, including grants for community-based wellness programs, grants to facilitate community health teams and care coordination within Medicare, and supports for public health infrastructure enhancements.

Where They Miss:

While these provisions are good first steps, they do not do enough to support and encourage a cultural shift toward wellness that is needed to bend the cost-curve long-term. Prevention – avoiding the development and progression of chronic disease – must be given greater emphasis. For instance, while SCHIP has helped children in the U.S. access much needed medical care, it has done nothing to stem the rise in childhood obesity and prevent related conditions. We also need to enhance the public health infrastructure to allow response to acute crises as well as building and sustaining chronic disease prevention and management efforts.

PFCD PRINCIPLE Promote healthy lifestyles and disease prevention and management in every community	
Examples of policies that address this principle include:	**Suggested Improvements**
Recognizes the significance of wellness programs through: • Grants for community-based wellness programs • Effort to evaluate and share best practices in employment-based wellness programs (**HELP** – Sec. 302; **Tri-Committee** – Sec. 3142)	• Ensure that funding goes to evidence-based programs • Efforts to include fighting chronic disease and eliminating health disparities as areas of focus for grant funding • Support incentives that encourage workplaces of all sizes to encourage healthy behaviors, with safeguards for personal privacy
Supports community-focused care coordination within Medicare through funding of community health teams	• Adequately fund community health teams and other evidence-based care coordination approaches within Medicare and other public programs to allow for nationwide implementation • Support evidence-based transitional care models, particularly for the frail elderly
Funds state, local, tribal and territorial public health departments and programs Funds community health centers (including school-based centers) (**HELP** – Sec. 212; **Tri-Committee** – Sec. 1894A)	• Provide sufficient funding to enhance the public health infrastructure to facilitate state and local efforts to support healthier communities • Facilitate access to chronic disease prevention and wellness by providing incentives and funding support for programs within schools, workplaces, and other community settings

Accelerate improvements in the quality and availability of health information technology (HIT) throughout the health care system

With a growing population of chronically ill Americans, many of whom see numerous providers, health information technology provides a sound economic approach to facilitating care coordination, tracking progress and follow up, and achieving overall health improvements. Unfortunately, the health system is not yet routinely using HIT to improve Americans' care quality and infrastructure needs are great. Few U.S. patients have computerized health records and the potential of disease and other health registries isn't being realized.

Where Proposals Hit the Mark:

The current health legislation contains several provisions in this area representing a modest investment in using technology largely to enroll individuals in health plans and to achieve cost savings through simplifying administrative claims processing and payment standards.

Where They Miss:

Proposals should facilitate the use of HIT to better coordinate care and support patients and family caregivers in terms of understanding and following treatment recommendations, receiving test results, follow-up notices, and refill reminders, and tracking their progress. We also suggest that the value of "remote" services, such as remote monitoring, telephonic interventions, and personalized health records (PHRs) be incorporated as part of the solution for providing care coordination, patient coaching and monitoring, and other evidence-based patient supports that improve follow through on recommended treatment and resulting health outcomes.

PFCD PRINCIPLE Accelerate improvements in the quality and availability of health information technology (HIT) throughout the health care system	
Examples of policies that address this principle include:	**Suggested Improvements**
HIT Standards and Quality • Uses HIT to assist in identifying and enrolling individuals in health plans and for affordability credits (**HELP** – Sec. 142, 185) • Requires the use of HIT in efforts to develop reimbursement structures that provide incentives for high quality care. Requires an expedited approval process for administrative standards relating to claims and eligibility. (**HELP** – Sec. 2707)	• Coordinate Medicare incentive payments for meaningful use of HIT with incentives to promote improvements in patient outcomes and align with national quality improvement goals to reduce the prevalence and burden of chronic disease
Telehealth • Adds renal dialysis facilities as eligible telehealth sites under Medicare (**Tri-Committee** – Sec. 1191) • Establishes a Telehealth Advisory Committee to make recommendations to the Secretary regarding Medicare covered telehealth services (**Tri-Committee** – Sec. 1191)	• Expand Medicare telehealth services to all health shortage areas, small population counties, or to specific HHS grantees like the Indian Health Service and community health centers • Encourage remote monitoring, telephonic interventions, and self-management coaching through infrastructure support and appropriate reimbursement
Improves access to data for research, including Medicare data & publically available data on key health indicators (**Tri-Committee** – Sec. 2402)	• Support development and use of disease and other health registries for use in population health improvement initiatives and to improve projection modeling of chronic disease prevalence and cost trends

Reduce health disparities by focusing on barriers to good health

Not every American has an equal likelihood of living a long and healthy life. Health status varies by geographic location, gender, race/ethnicity, education and income, and disability, among other factors. Disparities are common, and among Americans with chronic diseases, minorities are more likely to suffer poor health outcomes. To improve health overall, we must focus on eliminating health disparities. We support efforts to close the gap and encourage more to be done.

Where Proposals Hit the Mark:

The current health legislation contains several provisions in this area, including more funding on education and training and the improvement of data collection to document health disparities.

Where They Miss:

We must do more, not only to understand the extent of disparities, but more importantly to understand the causes of and better ways to address health disparities.

PFCD PRINCIPLE Reduce health disparities by focusing on barriers to good health	
Examples of policies that address this principle include:	**Suggested Improvements**
Improves data collection efforts to manage, collect, collate, and report on health information, especially for minority and underserved populations (**HELP** – Sec. 201, 203, 332; **Tri-Committee** – Sec. 1222)	• Also fund the measurement of the causes of and solutions to health disparities • Evaluate existing health disparities efforts to develop and disseminate information on successful programs and encourage replication
Incorporates training on health disparities into medical education to improve culturally competent care (**HELP** – Sec. 937; **Tri-Committee** – Sec. 1221)	• Include health literacy training as a part of medical education to facilitate provider-patient communication and improve understanding of and follow through on treatment recommendations • Support community-focused solutions, including care coordination among safety net providers