The Honorable Max Baucus
Chair, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member, Senate Finance Committee
135 Hart Senate Office Building
Washington, DC 20510

May 22, 2009

Dear Chairman Baucus and Senator Grassley:

The Partnership to Fight Chronic Disease (PFCD) strongly supports your – and the Senate Finance Committee's – efforts to enact meaningful health care reform in this Congress, and we thank you for the opportunity to comment on your recent paper, "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans" (hereafter referred to as the "coverage policy options paper").

PFCD is a national and state-based coalition of hundreds of partner organizations committed to reforming the health care system to better prevent, detect, and manage the nation's number one cause of death, disability and rising health care costs: chronic illness.

We believe that the only sustainable way to address health care costs is by improving health in America and reducing the toll of chronic disease. By inspiring a culture of wellness, we can improve our health, strengthen the financial stability of our health care system, and grow our economy.

PFCD commends you for your focus on improving access to high quality, affordable health care coverage for all Americans. The fact that chronic diseases consume 75 percent of what we spend on health care establishes how critical enhanced prevention and better chronic disease management are to improving health care affordability. Preventing and managing chronic diseases effectively depends upon people engaging in healthy lifestyles and having access to preventive health care services, diagnostic services that detect chronic disease early, and coordinated care to help us manage chronic illness once detected.

Coverage, while a critical ingredient to reform, by itself will not address the growing burden of chronic disease. More comprehensive health reform is needed to effectively address the prevention and control of chronic disease directly.

The coverage policy options paper covers a great range of suggested policy changes. Many , though of particular interest to our individual partner organizations, are outside the scope of PFCD's shared areas of interest. Accordingly, our comments provided below are limited to these shared areas of interest particularly those related to access to preventive services raised in Section VI and addressing health disparities raised in Section VIII.

The following comments are intended to strengthen the ideas brought forward in that paper. We begin by sharing our more general comments, and then offer more detailed recommendations of potential improvements. These comments reflect our general principles of shared understanding, and not final opinions on specific legislative language that may be developed.

Reducing the toll of chronic diseases requires a focus on prevention across the continuum of health status and settings that influence health.

We must do a better job helping people to prevent, to manage, and to slow the progression of disease – so that more costly problems are delayed or, ideally, wholly avoided. To that end, much more must be done to help promote prevention across the continuum of health status:

- Primary prevention – which entails avoiding the development of disease – is a necessity, as it will help the entire population move toward better health. (Examples include weight management, physical fitness, stress management, and smoking cessation)
- Secondary prevention – which is aimed at early disease detection to increase opportunities for interventions to prevent the progression of disease and emergence of symptoms – is also critically important. (Examples include cholesterol screening, vision screenings and eye exams, mammograms, and colonoscopy)
- Finally, tertiary prevention – which attempts to reduce the negative impact of an already established disease by restoring function and reducing disease-related complications – must also be a priority. (Examples include foot exams and diabetes education for diabetics and blood pressure management for hypertension)

Access to quality health care coverage and medical treatment are important contributors to improving health status, but good health extends well beyond these factors. Individual behaviors, including tobacco use, sedentary lifestyles, and poor nutritional choices, are large contributors to an individual's health status. Improving coverage to evidence-based, clinical preventive care involving primary, secondary, and tertiary prevention is a major step forward.

Having coverage, however, does not mean having access. We also need public policies that build bench strength in our primary care and public health workforces that both support greater emphasis on primary, secondary, and tertiary prevention and improve people's access to these important services. Supporting safety net providers is also important as, in addition to providing care to underserved populations, they will play a key role in assisting uninsured patients as they evaluate, and enroll in, coverage options.

As good health is more than a result of good medical care, we must support improvements in primary, secondary, and tertiary prevention in settings outside the medical system – at home, at work, at school, and in the community –as an integral part of health care reform. Public policy can have a substantial

impact on creating supportive environments for individuals, family caregivers, businesses, schools, and community organizations working with individuals and groups of individuals to reduce the burden of chronic diseases.

For example, school-age children are often prime targets for public health interventions carried out by school and after-school health and wellness professionals, including school nurses. Between 10 to 20 percent of school-age children suffer from chronic disease and depend upon supportive school environments to help them manage their health. Currently, however, school health professionals often are not funded by the health care system, but instead must compete with instructional needs for finite school resources. Supporting health professionals within school settings would allow for a greater health improvement focus within the schools and support for children already dealing with chronic conditions. Helping children establish lifelong healthy habits is also an important aspect of chronic disease prevention and efforts should include a renewed emphasis on physical, nutrition, and health education in school curriculums.

Building supportive environments in the community is also an important part of improving health and promoting wellness. The provision of grants to states or communities to implement innovative, evidence-based prevention and wellness programs at the community level, as described in Senator Baucus' white paper draft from November 2008 is noticeably absent from the coverage policy options paper. Existing grant programs, including CDC's Healthier Communities Program and REACH initiative, provide seed funding that have helped local governments, employers, schools, health systems, and community organizations work together to achieve sustainable health improvement efforts with measurable results.

Federal funding has helped to support Pioneering Healthier Communities grants allowing school, business, and community leaders to address local health challenges and to make changes to improve health. Though initially local in nature, successful efforts lead to replication and a broader impact. For example, working in partnership with local YMCA's, grant funding in Clearwater, Florida helped to pass a state law requiring 30 minutes of physical education 5 days a week in elementary schools, and led to county licensing changes requiring at least 150 minutes of physical activity per week in all after-school programs.

We support the provision of federal grants to help communities build these programs and to collect and disseminate best practices to facilitate replication in other communities.

Financial decisions people face must be designed to lower barriers to patient compliance with recommended preventive care and prescribed care to prevent, detect, and manage chronic disease.

Patients should not face high financial barriers to following prescribed care regimens that help them avoid more serious illness. Likewise, providing incentives to improve health by making healthy lifestyle choices and following preventive and prescribed care recommendations can provide the motivation needed to make the necessary changes.

To that end, we recommend no, or very low, copays on services that are important not only to detecting disease – like recommended screenings – and avoiding acute illnesses – like influenza vaccinations, but also to maintaining health and managing disease to prevent costly complications. Evidence shows that programs that lower patient financial barriers generate higher levels of compliance with prescribed treatment regimens related to lifestyle change, diet modification, and medication use.

For instance, in a diabetes management program known as the Asheville Project, public and private employers in Asheville, NC provided free screenings, diabetes self-testing supplies, and diabetes medicines to all participants who met regularly with their pharmacist coach. In addition, participants had access to diabetes educators, dietitians, and received support to help make lifestyle changes and receive clinically recommended preventive care to prevent disease progression and complications. Under the program, participants brought their blood sugar under control within a year on average and had about half as many absences from work. The program resulted in an average net decrease of 34 percent in health care costs for each participating employee.

Section VI of the coverage options policy paper provides several policy options, which support these principles.

Promoting Prevention and Wellness in Medicare and Medicaid: We believe that removing barriers and providing incentives to promote prevention and wellness within the Medicare and Medicaid programs will help to reduce the significant toll avoidable chronic disease exacts on these programs and the people they serve. Improving not only access to needed recommended care and screenings, but also the utilization of these benefits holds tremendous promise to improve health status and quality of life and to reduce avoidable health care costs. Enhancing access and providing incentives for behavior change should reflect opportunities for primary, secondary, and tertiary prevention for beneficiaries at risk for developing or experiencing chronic diseases.

Right Choices Grants: Improving access to evidence-based preventive care services for uninsured adults and children is a laudable goal. The Right Choices grant program represents an important step forward to achieving better access. We encourage that such a grant program, if established, be sufficiently funded to allow all eligible uninsured to participate, and to include not only recommended screenings for chronic diseases, but also coverage for evidence-based, recommended care for any chronic diseases detected.

Prevention and Wellness Grants: Coordination, continuity of care, and care management are of paramount importance as they help to facilitate the U.S. health system's transition to one that is more focused on preventing or delaying disease onset and progression. Embracing care coordination arrangements has the potential to improve both the delivery and outcomes of care, to drive down errors and avoidable spending, and to reduce disparities.

One of the most important tasks we face in health care reform is how to integrate care coordination into the traditional Medicare program. Traditional fee-for-service Medicare is expected to spend about $395 Billion in FY 2010. It has high rates of preventable hospital admissions, clinic and ER visits. Moreover, 20 percent of patients are readmitted within 30 days. Much of the high utilization reflects the fact that the program has no care coordination at all! A modest investment in care coordination using the tools successfully applied by Geisinger, Intermountain Healthcare and other integrated group practices nationally is one approach. The problem is such plans are not easily replicated or scalable.

We found one especially promising approach that we would encourage you to expand and make available nationally—the use of community health teams. Such teams include the key design features that have reduced admissions and readmissions (i.e. formal transitional care program, close integration of care coordination and the primary care physicians' office) in the larger group practices. The facilitation of community health teams through Prevention and Wellness Innovation grants can help build the networks needed to improve care coordination. These teams can include care coordinators, nurses, nurse practitioners, social and mental health workers, dietitians, pharmacists, patient education specialists, community-based health and wellbeing specialists, and community outreach workers that work with smaller practices to provide prevention and care coordination for all patients and family caregivers.

The advantage of these teams is that they emphasize management of health (as opposed to just treatment of disease). They greatly enhance communication between providers and patients, and offer the ability to focus on disease prevention and early detection. They also support patient self-management by helping patients and family caregivers understand and follow treatment recommendations for making behavior changes, taking their medications, monitoring their health, and following up when needed. We strongly encourage you to make a modest federal investment to enable the development of community health teams, encourage the management of health, and improve health care outcomes – all achievable we believe at lower Medicare and Medicaid costs.

Several states have already created community health teams, including Vermont, North Carolina, and Rhode Island. Published empirical research on these models from North Carolina and other settings show these approaches improve clinical outcomes and reduce health care spending. The data indicate that well-designed community health teams could save 3 to 7 percent in overall Medicare spending for a 0.6 percent investment.

A complementary addition would be to establish a Medicare transitional care benefit designed to support beneficiaries as they transition from in-patient hospital care to home or another care setting. Such a benefit would facilitate care coordination among providers, provide patient and family caregiver education and support, ensure greater compliance with treatment plans and medication management, and make referrals to community resources. In clinical studies targeting individuals at high risk for readmissions, nurse-led interdisciplinary teams working with

patients and family caregivers before hospital or nursing home discharge have led to reduced readmissions and lower costs.

Employer Wellness Credits: Chronic diseases cost American businesses billions and threaten their competitiveness. Businesses are burdened not only with medical costs, but also losses in productivity caused by chronic illnesses. Some employers are addressing these issues by providing workplace wellness programs to improve the health of their employees. Providing tax credits to help offset some of the costs of qualified wellness programs would encourage more employers to provide these benefits. Designing the credit to recognize the challenges faced by small businesses and specifying that the tax credit would apply to both on-site and off-site qualified wellness programs would go far to encourage greater participation.

Improvements to the health system should work to reduce health disparities.

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.

Section VIII of the coverage policy options paper describes several options for improving health disparities. We support those efforts and encourage more to be done. Specifically, we support efforts not only to improve data collection on the extent of disparities as described in the coverage policy options paper, but also to fund measurement of the causes of and solutions to health disparities. We also suggest consideration of policy changes that:

Embrace models of care coordination and management shown to improve health among Americans of all backgrounds and situations;

Improve "cultural competency" in the provision of care and facilitate better communication that enhances self-management, including seeking appropriate care, making behavioral changes, taking medications as prescribed, monitoring health status, and following up as needed; and

Support employment of "community-based" approaches to addressing health disparities. Community-based approaches have demonstrated success in helping to eliminate disparities, both in broader community-wide settings, and in targeted settings, such as schools and workplaces. The CDC's Healthier Communities Program and REACH (Racial and Ethnic Approaches to Community Health) initiative are great examples of community-based efforts addressing disparities through culturally competent health promotion activities and by overcoming wellness barriers including the lack of access to healthy foods, safe neighborhoods, and safe places to be physically active.

In conclusion, we would again like to thank you for the opportunity to share our comments. We look forward to working with you to pass meaningful health reform during this Congress.

Sincerely, the undersigned PFCD partners:

National PFCD Partners and other interested organizations

Alliance for Aging Research
Alliance for Health, Education, and Development (AHEAD)
Alzheimer's Foundation of America
American Academy of Nursing
American College of Physicians
American College of Preventive Medicine
American Dietetic Association
American Osteopathic Association
American Pharmacists Association
American Society of Health-Systems Pharmacists
America's Agenda: Health Care for All
Arthritis Foundation
Association of Maternal and Child Health Programs
Asthma and Allergy Foundation of America
Boston Public Health Commission (REACH Center of Excellence in the Elimination of Health Disparities)
Brooklyn Perinatal Network, BACHE Project
CommonHealth ACTION
Community Health Charities of America
Community Health Councils
The COSHAR Foundation
DMAA: The Care Continuum Alliance
Easter Seals
Epilepsy Foundation
Delta Dental
GlaxoSmithKline
Health Dialog
International Health, Racquet & Sportsclub Association
Kerr Drug
Khmer Health Advocates, Inc.
Marshfield Clinic
Medical Fitness Association
National Alliance for Caregiving
National Association of Chronic Disease Directors

National Association on Mental Illness
National Business Coalition on Health
National Coalition for Promoting Physical Activity
National Council for Community and Behavioral Healthcare
National Health Foundation
National Hispanic Medical Association
National Kidney Foundation
National Latina Health Network
National Medical Association
National Patient Advocate Foundation
National REACH Coalition for the Elimination of Health Disparities
Novo Nordisk
Partnership for Prevention
Pharmaceutical Research and Manufacturers of America
Pharos Innovations
PILMA
Prevent Blindness America
Self chec, Inc.
SEIU
Society for Public Health Education
US Preventive Medicine
XLHealth
YMCA of the USA

PFCD Arkansas

Arkansas Association of Charitable Clinics
Arkansas Respiratory Health Association
Coalition for a Tobacco Free Arkansas
Harmony Health Clinic
Lupus Foundation of America, Arkansas Chapter, Inc.

PFCD Colorado

American Cancer Society
Alliance of Health Disparities
Colorado Gerontological Society
Mission Medical Clinic
NAMI
National Multiple Sclerosis Society
National Association of Hispanic Nurses
SEIU

PFCD Connecticut

Advocacy for Patients with Chronic Illness, Inc.
American Cancer Society CT Chapter
Commission on Substance Abuse Policy and Prevention
Connecticut Dietetic Association
Connecticut Society of Physical Medicine and Rehabilitation
Epilepsy Foundation of Connecticut
Lower Fairfield County Regional Action Council
National Kidney Foundation, Connecticut Chapter
Ovation Benefits Group

PFCD Delaware

Delaware Ecumenical Council on Children and Families (DECCF)
H&S Enterprise
Integrated Social Solutions
NAMI – DE
William "Hicks" Anderson Community Center

PFCD Indiana

Indiana Black Expo, Inc.
Indiana Minority Health Coalition
Indiana Dietetic Association
Indiana General Assembly, Chair
Public Health Committee
Arthritis Foundation – Indiana
Indianapolis Urban League
Indiana Latino Institute
Indiana University School of Nursing

PFCD Illinois

Alzheimer's Association – Greater Illinois Chapter
Chicagoland Chamber of Commerce
Epilepsy Foundation of Greater Chicago
Epilepsy Resource Center/ Division of Sparc
Illinois Chamber of Commerce

Illinois Pharmacists Association
LULAC Metropolitan Chicago
Lupus Foundation of America, Illinois Chapter
Mental Health Summit
National Alliance on Mental Illness – Greater Chicago
YMCA of Metropolitan Chicago

PFCD Iowa

Community Health Charities of Iowa
Des Moines WomenHeart
Epilepsy Foundation North/Central Illinois, Iowa, Nebraska
Iowa Biotechnology Association
Iowa Nurses Association
Iowa Pharmacy Association
Leukemia & Lymphoma Society Iowa Chapter
Lupus Foundation, Iowa Chapter
NAMI Iowa
National Multiple Sclerosis Society, North Central States Chapter

PFCD Maryland

The COSHAR Foundation
Health Resource Solutions, Inc.
Maryland Academy of Family Physicians
Maryland Pharmacists Association
Maryland Society of Health-System Pharmacists
National Multiple Sclerosis Society – Maryland Chapter
NAMI- MD
Sudden Cardiac Arrest Association
XLHealth

PFCD New Hampshire

AIDS Services for the Monadnock Region
Advanced Laser Therapy
Council for Children and Adolescents with Chronic Health Conditions
National Alliance on Mental Illness New Hampshire
New Hampshire Fitness Professionals Association

PFCD New Jersey

Action CF
Caregivers of New Jersey
Elevator Constructors Local 5
Epilepsy Foundation of New Jersey
Heat and Frost Insulators Local 14
Heat and Frost Insulators Local 32
Heat and Frost Insulators Local 42
Heat and Frost Insulators Local 89
HealthCare Institute of New Jersey
IBEW Local 102
IBEW Local 164
IBEW Local 269
IBEW Local 351
IBEW Local 400
IBEW Local 456
Juvenile Diabetes Awareness Coalition
Lung Cancer Circle of Hope
Mechanical and Allied Crafts Council of New Jersey
New Jersey Alliance for Action
New Jersey Health Care Payers Coalition
New Jersey Health Care Quality Institute
New Jersey Primary Care Association
New Jersey Carpenters Fund
New Jersey State Association of Pipe Trades
New Jersey State Chamber of Commerce
New Jersey State League of Municipalities
Pipefitters Local 274
Plumbers Local 14
Plumbers Local 24
Plumbers and Pipefitters Local 9
Plumbers and Pipefitters Local 322
Public Utility Construction/Gas Appliance Local 855
Road Sprinkler Fitters 669
Sheet Metal Workers Local 19
Sheet Metal Workers Local 22
Sheet Metal Workers Local 25
Sheet Metal Workers Local 27
Sheet Metal Workers Local 137
Sprinkler Fitters Local 692

Sprinkler Fitters Local 696
Steamfitters Local 475
Women's Heart Foundation

PFCD North Carolina

Arc of North Carolina
Alliance of Disability Advocates
American Cancer Society North Carolina
American Lung Association of the Atlantic Coast
The Autism Society of North Carolina
Governor's Institute on Alcohol and Substance Abuse-NC
Mental Health Association-North Carolina
NASW-NC
National MS Society, NC Chapters
NC Psychological Association
Old North State Medical Society
Old North State Medical Society, Fayetteville Chapter-Dr. Johnny Williams
Old North State Medical Society, Jacksonville Chapter-Dr. Beverly A. Davis
Partnership For A Drug Free NC
State Employees Association of NC (SEANC)
UCP/Easter Seals

PFCD Ohio

Cleveland Medical Association
National Kidney Foundation Serving Ohio
Ohio Dietetic Association
Ohio Osteopathic Association
Ohio Pharmacists Association
Prevent Blindness Ohio
Summa Health System
Summit County Health District

PFCD Pennsylvania

American Liver Foundation – Mid Atlantic Division
American Liver Foundation – Western PA/West Virginia Chapter
Delaware Valley Chapter of National Hemophilia Foundation
Western PA Chapter of National Hemophilia Foundation

PFCD Minnesota

Community Health Charities of Minnesota
Epilepsy Foundation of Minnesota
LifeScience Alley
Minnesota Pharmacists Association
Native American Community Clinic, Minneapolis
United Cerebral Palsy of Minnesota

PFCD South Carolina

Ambassador Diabetic Supplies & Services, LLC
Bethel Baptist Church
Bethel Senior Daycare Center
Care Improvement Plus
Chi Eta Phi Sorority, Inc.
Columbia Hospital Alumni Association
Diabetes Today Advisory Council
Dianne's Call
Eau Claire Cooperative Health Centers, Inc.
Educational Therapy LLC.
Faith Christian Center
Family Outreach Word and Worship Center
Georgetown Diabetes CORE Group
Madison Alexander, LLC
Midlands Diabetes Coalition
Mother of Pearl, Inc.
Mt. Zion Baptist Church
Palmetto Center for Advocacy
Quality of Life Wellness Programs
REACH SEA-CEED
Ridge Branch Baptist Church
South Carolina Academy of Physician Assistants
South Carolina Asthma Alliance
South Carolina Pharmacy Association
South Carolina Public Health Institute
The Greater Charleston Central Labor Council
Tri-County Black Nurses Association
United Way Association of South Carolina
Vista Smiles
Walterboro Christian Center

PFCD Wisconsin

AIDS Resource Center of WI
Community Health Charities of Wisconsin
Epilepsy Foundation of Central and Northeast Wisconsin
Epilepsy Foundation Southeast Wisconsin
Epilepsy Foundation, Southern Wisconsin
Epilepsy Foundation of Western Wisconsin
Metropolitan Milwaukee Association of Commerce
Prevent Blindness Wisconsin
Wisconsin Academy of Family Physicians
Wisconsin Dietetic Association
Wisconsin Manufacturers and Commerce