The Affordable Care Act Lays The Groundwork For A National Diabetes Prevention And Treatment Strategy
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The Affordable Care Act Lays The Groundwork For A National Diabetes Prevention And Treatment Strategy

ABSTRACT The Affordable Care Act includes several provisions that could create a comprehensive approach to preventing and treating diabetes and other chronic health conditions. The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. This article presents a three-part proposal: expand the Diabetes Prevention Program nationally; build care coordination through health teams into the traditional Medicare program; and use these teams to connect public health, prevention, and treatment. Enrollment in evidence-based lifestyle modification programs—specifically, those focused on excess weight—should be added as a covered benefit under Medicare with no cost sharing. Funding for the Medicare component could be provided through the budget of the Center for Medicare and Medicaid Innovation. The proposal in its totality has the potential for improving health outcomes and reducing costs.

The Affordable Care Act of 2010 included several provisions designed to reduce the incidence, increase the detection, and provide more effective medical management of diabetes and other chronic conditions. However, there are several overlapping provisions in the legislation. Depending on how they are implemented, they could actually result in further fragmentation of our health care system. Only if an integrated strategy is developed and effectively implemented will these new initiatives be coordinated.

This article presents a national framework for integrating several provisions in the Affordable Care Act into a coherent national strategy for preventing and managing chronic diseases such as diabetes.

The Challenge
Since 1980 the prevalence of diagnosed diabetes has more than doubled, rising from 2.8 percent of the US population to 8.3 percent in 2010.1 Diabetes prevalence is particularly high among people age sixty-five and older, and it doubled among Medicare beneficiaries between 1987 and 2008, rising from 11.3 percent to 22.6 percent.2-5 Should these trends persist, nearly a third of all US adults born in 2000 will have diabetes by 2050. Furthermore, the number of diagnosed cases of diabetes in the United States will increase by 165 percent, from eleven million (4.0 percent prevalence) in 2000 to twenty-nine million (7.1 percent) by 2050.6 These statistics underestimate the growing challenge of diabetes. Today approximately 27 percent of total diabetes cases, some seven million, are undiagnosed and therefore not treated.1 The ratio of diagnosed to total cases of diabetes has
improved only modestly over the past forty years. Adults with prediabetes are another important indicator of the scope of the problem. According to estimates from the Centers for Disease Control and Prevention, 79 million adults have prediabetes, and approximately 105 million have either prediabetes or diabetes.

The rising prevalence of diabetes is a major contributor to increased health care costs overall, and to Medicare costs in particular. Among all medical conditions, diabetes has accounted for the largest share—nearly 8 percent—of growth in Medicare costs over the past decade.

The impact of rising diabetes prevalence on Medicare spending is likely to persist. The number of people age sixty-five and older who are diagnosed with diabetes in the United States is expected to increase by eight million in just ten years, from thirteen million in 2010 to twenty-one million in 2020.

The following sections present a proposal for using the Affordable Care Act to create a national program on diabetes. The program would reduce the current trends in rising diabetes prevalence; improve the quality of care provided to people with the disease; and, in so doing, reduce health care spending.

A National Framework For Implementation

The Affordable Care Act contains several provisions that could increase the national capacity to prevent and treat diabetes. These provisions include those related to the National Diabetes Prevention Program (section 10501), the Prevention and Public Health Fund (section 4002), and the creation of community health teams (section 3502).

There are several additional components of the act that could work in conjunction with the proposals outlined below. These include the state Medicaid option to create health homes for chronically ill patients (section 2703) and other incentives for states to prevent chronic illnesses among Medicaid beneficiaries (section 4108).

I outline three proposals below that combine several elements of reforms in the Affordable Care Act addressing diabetes and other chronic diseases. These proposals, if adopted, would create a national approach for preventing, detecting, and treating diabetes. Although the focus here is on diabetes, the proposals would also reduce other obesity-related chronic conditions such as hypertension and hyperlipidemia.

A National Community-Based Diabetes Prevention Program

Slowing the growth in obesity and related chronic illnesses is a major US health policy goal. Meeting this objective will require a multipart strategy.

Expand the Current Program

A first step would take the community-based Diabetes Prevention Program currently administered locally by YMCAs and expand it nationwide. The prevention program is an intensive lifestyle intervention designed to achieve and maintain at least a 7 percent reduction in body weight among overweight adults who do not yet have diabetes. This intervention has been evaluated through randomized controlled trials at both the individual and community levels. Both levels have produced weight loss of 4.2–7 percent overall and even greater loss among people age sixty and older.

Weight loss in the original Diabetes Prevention Program trial generated a 58 percent reduction in diabetes incidence (relative to a placebo), as well as reductions in high blood pressure and metabolic syndrome. A ten-year follow-up of the original Diabetes Prevention Program demonstrated that the reductions in diabetes incidence persisted even after a decade: The cumulative incidence of diabetes over a ten-year period was 34 percent lower among those in the intensive lifestyle intervention, compared to the placebo group.

The Diabetes Prevention Program could be expanded nationwide by building on the current structure created by the YMCA of the USA, the Centers for Disease Control and Prevention, and UnitedHealth Group. As of 2011 there were nearly 2,700 YMCAs nationally, and nearly sixty million Americans lived within three miles of a YMCA (Kathleen Adamson, director of health partnerships and policy, YMCA of the USA, personal communication, February 15, 2011). Other not-for-profit groups such as local health departments and community health centers could also be certified to deliver the program.

The Centers for Disease Control and Prevention has established the Diabetes Training and Technical Assistance Center to train lifestyle coaches. The YMCA of the USA also has established its own training program for interested YMCA centers.

Expanding the program nationwide through the YMCAs would cost about $80 million per year (Jonathan Lever, national director of Activate America, YMCA of the USA, personal communication, December 10, 2010). Expanding the program to the 100 largest Metropolitan Statistical Areas would provide access for fifty million of the estimated fifty-seven million US adults who have...
Taking the program nationwide could be achieved through funding from either of two sections in the Affordable Care Act. First, the act established the National Diabetes Prevention Program, which provides grants to eligible entities to deliver community-based diabetes prevention. And second, the Prevention and Public Health Fund will make $1 billion in funds available to support programs like the Diabetes Prevention Program in fiscal year 2012, increasing to $2 billion per year from 2015 through 2019.

**Increase Screening of Adults**
A second step in the strategy to slow the growth of obesity and related chronic illnesses is to increase screening rates for adults at risk for cardiovascular disease and diabetes. Employers could include such screening as part of any workplace wellness programs or health risk appraisals that they establish.

Medicare could also increase screening rates by making sure that new beneficiaries are up to date with glucose tests and other screens through the federal government’s "welcome to Medicare" preventive visit. Those not up to date could receive the tests through Medicare’s diabetes screening benefit for those with risk factors such as hypertension, hyperlipidemia, obesity, and a history of high glucose levels.

To maximize referrals and participation among Medicare beneficiaries, enrollment in evidence-based lifestyle modification programs—specifically, those focused on excess weight—should be added as a covered benefit with no cost sharing. Funding for the Medicare component could be provided through the budget of the Center for Medicare and Medicaid Innovation.

Moreover, employers could use the new flexibility outlined for them in the Affordable Care Act (section 4303, title IV) to provide financial incentives for eligible workers to participate in workplace wellness programs that could be linked to the Diabetes Prevention Program. Grant funding for small employers—those that have fewer than 100 workers—is available from 2011 through 2015 to establish workplace programs that could also be linked to the community-based Diabetes Prevention Program.

**National Community Health Care Coordination Teams**
Despite the high rate of chronic disease among people age sixty-five and older, the traditional fee-for-service Medicare program does not provide any team-based care coordination, other than for homebound patients. As a result, health care use is high among Medicare beneficiaries. For instance, care coordination could prevent more than 50 percent of readmissions to a hospital within thirty days of discharge for Medicare patients. These potentially preventable readmissions will cost the Medicare program approximately $250 billion between 2012 and 2021.

The Affordable Care Act contains several provisions aimed at increasing the use of team-based care coordination in both public and private health plans. For instance, the act created the Center for Medicare and Medicaid Innovation, mentioned above, to test and evaluate alternative payment structures and care coordination models. It also contains a provision that promotes community health teams that work closely with provider practices to coordinate care. However, Congress has yet to appropriate funds for many of the programs established in the Affordable Care Act, including the health teams concept.

The act’s major care coordination provisions envision the testing of various pilot projects to measure their impact on quality and health care spending. But a voluminous body of research from randomized trials compiled over several years already demonstrates the effectiveness of a wide range of care coordination activities. These evidence-based care coordination activities are outlined in section 3502 of the Affordable Care Act, concerning community health teams.

Community health teams consist of primary care providers such as nurses, nurse practitioners, social and mental health workers, nutritionists, pharmacists, public health workers, and community outreach workers. Working closely with provider practices, clinics, and community health centers, the teams help execute care plans for patients developed by the primary care provider. The teams also provide health coaching and education to improve patients’ self-management skills and support transitional care for patients entering a hospital, nursing home, or other institutional setting.

In addition, the teams refer patients to com-
munity-based primary prevention resources such as smoking cessation, diet, and exercise and nutrition programs like the Diabetes Prevention Program. Finally, the teams can support medication management, reconciliation, and adherence.

The community health teams are based on successful models already in operation in Vermont and North Carolina. The structure of the teams is based on evidence from randomized trials showing that the functions of the teams described above can effectively lower health care spending and improve quality and outcomes.

For instance, several randomized trials have demonstrated that transitional care programs can reduce preventable readmissions by up to 56 percent. That alone could reduce Medicare spending by more than $125 billion between 2012 and 2021. Other randomized trials have demonstrated that health coaching to improve patient self-management skills also reduces health care spending. The most recent evidence from a randomized trial enrolling more than 174,000 participants is that health coaching alone reduced health care spending by more than 3 percent after one year. There are also several years of data available from North Carolina’s community care networks that showed major savings—nearly $1.5 billion between 2007 and 2009.

Rather than continue to field pilot projects of limited scope, we should expand the community health teams nationwide, starting with the traditional Medicare program. States should also be encouraged to rely on the teams to manage Medicaid patients that are outlined in section 2703 of the Affordable Care Act. States that use the teams, with approval from Medicaid through a state plan amendment, should receive a two-year, 90 percent federal match on the costs associated with developing the teams for Medicaid patients.

To expand the care teams nationwide, the Department of Health and Human Services could contract with providers such as home health agencies, hospitals, and community health centers to provide prevention and establish care teams. Medicare already contracts for administrative claims processing services with fiscal intermediaries in fifteen different jurisdictions. The department could choose a contractor in each of those jurisdictions to provide care coordination services.

Expanding community health teams nationwide will require new federal funding. Based on the staffing models used in North Carolina to manage Medicaid patients and in Vermont to manage all patients, providing such teams nation-wide will cost about $40 billion between 2012 and 2021. However, the expenditure has the potential to create 40,000 new jobs and improve the quality of care provided for patients at a lower cost.

**Linking Care Coordination Teams To Population And Public Health Programs**

A third step in the strategy to slow the growth of obesity and related chronic illnesses is linking population and public health services with clinical treatment in the medical care system. Prevention resources such as local health departments, community health centers, behavioral health centers, public health nurses, and diabetes educators are already in place in communities throughout the United States. Local health departments, for instance, provide a wide range of community prevention and educational services. These include cancer screening (available at 42 percent of departments nationwide), immunizations (88 percent), smoking cessation programs (70 percent), and primary prevention activities directed at chronic disease and physical activity (53 percent).

Coordinating the services provided by these community resources with the community health teams and the community-based diabetes prevention programs will be important. In essence, these community resources should become part of the overall community health team. Each jurisdiction with a team should ascertain how best to leverage these existing public health resources.

For instance, local health departments might sponsor and deliver diabetes prevention programs. They could also provide evidence-based smoking cessation programs to patients referred from the health teams. Thus, the health teams could serve as the interface between community prevention services, lifestyle modification programs, and care coordination of people with chronic diseases such as diabetes.
Conclusion
The proposal outlined above would create a national public health and treatment system that targeted diabetes prevention and improved detection and treatment of the disease. National adoption of the community-based Diabetes Prevention Program has the potential to generate billions of dollars in health care savings and a substantial reduction in diabetes incidence. As noted, simply providing national access to transitional care has the potential to save $125 billion between 2012 and 2021 in the Medicare program alone.

The proposal would also seamlessly integrate community-based prevention, more-targeted individual prevention services such as the Diabetes Prevention Program, disease detection, and treatment.

There is at least one caveat, however. Although a substantial body of research indicates that the key functions performed by the teams—including transitional care, care coordination, health coaching, and medication therapy management—have reduced costs in randomized trials and in North Carolina, it is not clear that similar results could be reproduced on a national scale. However, the scope of the diabetes epidemic is such that it is surely worth investing in an innovative and effective prevention and treatment program focused on diabetes and other chronic health conditions. The Affordable Care Act provides the necessary statutory language to accomplish this. We just need the political will and vision to implement it.

NOTES
16 Author’s calculations using data from Notes 15 and 17.
LIFESTYLE INTERVENTIONS

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In this month’s Health Affairs, Kenneth Thorpe writes that the Affordable Care Act offers opportunities to create a comprehensive approach to diabetes prevention and treatment—in stark contrast to the current silo-based approach that leads to reduced effectiveness and higher costs. He offers a three-prong proposal that expands the Diabetes Prevention Program nationally; builds care coordination through health teams into the traditional Medicare program; and uses these teams to connect public health, prevention, and treatment. He also urges that enrollment in evidence-based lifestyle modification programs—specifically, those focused on excess weight—should be a covered benefit under Medicare with no cost sharing.

Thorpe, who is the Robert W. Woodruff Professor and chair of the Department of Health Policy and Management at Emory University’s Rollins School of Public Health, says that his goal in writing the article was “to provide a road map for policy makers to combine population health, prevention, and treatment in one system.”

The funds already authorized under the Affordable Care Act are enough to modernize delivery of care and prevention of diabetes relatively quickly, he adds: “Now we just need the political vision to do so.”

Thorpe, a former deputy assistant secretary at the Department of Health and Human Services, is also executive director of the Partnership to Fight Chronic Disease and executive director of Emory’s Center for Entitlement Reform. He has served as a consultant, developing statewide approaches to health reform and universal health insurance in California, Kansas, Massachusetts, New York, South Carolina, and West Virginia, among other states. He is a member of the Health Affairs editorial board.

Thorpe holds a doctorate in public policy from the RAND Graduate Institute and a master’s degree in public policy from Duke University.