Salem Health

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Public Comments submitted to the
United States Senate Committee on Finance regarding
"A Pathway to Improving Care for Medicare Patients with Chronic Conditions"
May 14, 2015

Salem Health supports the United States Senate Committee on Finance's effort to develop and implement policies that will improve care for patients with chronic diseases.

Salem Health is a not-for-profit regional medical center located in Salem, Oregon, serving patients in Marion, Polk, Benton, Lincoln and Yamhill counties. It includes: 454-bed Salem Hospital (founded in 1896), with a Level II Trauma Center, the busiest between Seattle and Los Angeles; West Valley Hospital, a small Critical Access Hospital, in Dallas, Oregon; Regional Rehabilitation Center; Willamette Health Partners medical clinics spread throughout the mid-Willamette Valley; and 673 physicians on the active medical staff at Salem Hospital and 76 at West Valley Hospital.

Improving the health and well-being of patients with chronic conditions is a multifaceted mission. The prevalence of chronic conditions in Medicare beneficiaries is high, with 68.4% having two or more chronic conditions and 36.4% with four or more chronic conditions. The resulting impact to the care delivery system is significant with 93% of Medicare spending attributed to beneficiaries with two or more chronic conditions, and almost 75% of Medicare spending attributed to beneficiaries with four or more chronic conditions.[1]

Our specific recommendations are as follows:

- **Give nurse practitioners (NP) full practice authority and compensation**

  Nurse practitioners play an essential role in the delivery of healthcare services. Studies have shown nurse practitioners provide high quality, cost-effective care at the same level or better than physicians. All providers who perform the same work and bill the same codes, should receive equal pay.

  Although nurse practitioners are considered providers under Medicare, they are still unable to order home health and hospice services resulting in rework and delays in care. Giving nurse practitioners full practice authority ensures Medicare patients with chronic conditions receive exceptional, efficient care.

- **Expand coverage to include services provided by more healthcare professionals**

  The successful management of patients with chronic conditions requires a team approach. All healthcare providers play an important role in patient care, including dieticians,

[1] CDC Report. Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010. Available at: http://www.cdc.gov/pcd/issues/2013/12_0137.htm. Accessed June 16, 2015.

pharmacists, physical therapists, nurses, licensed social workers, and others. To meet the needs of increasingly complex patients, physicians and other practitioners should be practicing to the full extent of their skills and training and utilizing specialty healthcare professionals to deliver other necessary elements of care.

For example, approximately 50% of patients with chronic illnesses do not take medications as prescribed.[2] There is a risk for declining health resulting in readmissions to the hospital and a decrease in life expectancy, impacting the overall cost of care delivery, when patients with chronic diseases do not follow therapy recommendations. Studies have shown the provision of post-discharge pharmacy services either in an outpatient clinic or a home-based intervention have a positive impact on patient outcomes.

- **Increase payment for chronic care management services**

  As a participant in the Comprehensive Primary Care (CPC) initiative, a multi-payer Centers for Medicare & Medicaid Services' (CMS) innovation model to provide comprehensive primary care services, we are encouraged by the overall support for primary care. Practitioners in our primary care setting have come to rely on the chronic care management services embedded in outpatient clinics to help coordinate care, address barriers to care, provide patient education and self-management support, and engage patients and their families in care planning. These patient-centered services are able to rapidly intervene if needed and prevent future periods of instability. The sustainability of chronic care management services is dependent on a robust payment system that encourages providers to effectively manage care, including significant payment for non-face-to-face services.

- **Expand the criteria for patients to qualify for home health services**

  Clinicians who visit patients with chronic diseases in their home can assess problems that are either yet to be addressed or are awaiting acknowledgement from the patient and/or provider, resulting in a more successful plan of care. Home health services, for all patients with chronic conditions, not just those that are home bound, like chronic care management, patient and caregiver education, resolution of therapy discrepancies, and communication and follow-up with the rest of the patient's care team, can be more convenient, less expensive, and more effective.

- **Provide coverage for non-traditional care items and services**

  For patients with a poorly controlled chronic disease, different care delivery approaches

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[2] World Health Organization. Adherence to long-term therapies: evidence for action. January 2003. Available at: http://www.who.int/chp/knowledge/publications/adherence_report/en/. Accessed June 15, 2015.

may be needed. A patient-centered initiative to pay for transportation to and from healthcare visits for patients covered by Willamette Valley Community Health (WVCH), the Coordinated Care Organization (CCO) health plan (Medicaid) in our local area, has been very successful. The most effective intervention to help avoid adverse outcomes may be non-traditional care items and services like transportation support, air conditioning for a heart failure patient, or housekeeping services for a patient with asthma. In order to improve the health of patients with chronic conditions, it is essential to deliver and receive payment for whatever interventions are necessary.

- **Provide financial incentives for patients to participate in chronic care management programs**

  Chronic care management programs require patients to commit to improving their health. Financial incentives for chronically ill patients to participate in chronic disease management programs like decreased premiums or lower coinsurance amounts are needed to encourage both enrollment and compliance.

Thank you for the opportunity to provide the United States Senate Committee on Finance comments on chronic care reform.