

Dear Members of the Senate Finance Committee:

On behalf of the Virginia Commonwealth University (VCU) Health System in Richmond, Virginia, I am writing to submit comments to support the work of your committee in the development of legislation to improve the coordination of care for Medicare patients. The following ideas have been compiled by the providers and staff of the VCU Health System, who respectfully submit them for your consideration as you work to improve the quality of care and reduce costs for the Medicare population:

- It is recommended that incentives for physicians and care teams be introduced to provide quality advance care planning for those with chronic diseases, terminal illnesses who are elderly and frail. Trained care plan facilitators acting on behalf of physicians should be allowed to help patients and their health care decision-making agents to develop these advance care plans with oversight by the provider. There are a number of models and programs for training care plan facilitators (nurses, social workers, chaplains, etc.) including the "Respecting Choices" model which is evidence-based and provides quality training and certification for health care workers to assist patients and their families/agents in the advance care planning process.
- To support the widespread adoption of education regarding advance directives, it is recommended that financial incentives be provided for providers that partner with Medicare and other payer partners to introduce basic advance directives concepts to all patient populations served. These care plans are helpful for those who are otherwise healthy but may experience an unexpected catastrophic illness or injury such as a result of an auto accident or other event. This planning is best suited for the primary care setting.
- In order to address one of the barriers to successful advance care planning, initiatives are needed to make the plans authentically portable and easily accessed by providers wherever and whenever necessary. The mechanisms for the storage, access, and retrieval of the plans is a problem currently faced by providers in the implementation of advance care planning. Enhancements are needed to connect the electronic medical records systems of divergent health care institutions and in the creation of electronic registries for advance care plans that can be easily accessed by providers.
- Introduce a benefits structure that creates incentives for patients (and their family/caregivers) to be actively engaged in their care. This program will need to make accommodations for those beneficiaries who are not cognitively able to engage.
- To support beneficiaries with a long list of medications, it is recommended that programs be developed that enhance the level of medication compliance. This includes exploring the introduction of teams of Pharmacy Technicians or Community Health Workers under the supervision/guidance of a Pharmacist to work collaboratively with Primary Care Providers and Specialty physicians. The primary goal would be to address the health literacy, education, and support needs of poly-pharmacy patients.
- Develop an incentive or reimbursement structure that supports creating higher levels of coordination for transitions of care for very complex and/or frail, elderly patients. This would include development of a common incentive pool that could be shared by acute care facilities and nursing homes that partner to control the re-admissions for populations they collectively serve.

- Ensure new regulations highlight the importance of person-centered primary care that is appropriately resourced to manage routine to complex patient subsets. This should include supporting opportunities for the coordination between medical care, behavioral health care, and social services providers. Inherent in this model should be an expectation that adequate access to a comprehensive care continuum with multiple points of access, including specialty care, is available. The model will require enhancements in the transportation services offered to ensure coordination of visits to providers with additional services that may be needed such as diagnostic and ancillary services, as well as visits to a pharmacy. Finally, it is recommended that consideration be given to optimizing patient access through the provision of home-based services (short or long term), remote home monitoring, and Telehealth programs. Future reimbursement programs should include adequate funding to support these types of services.

- In an effort to minimize administrative burdens for providers, it is recommended that Medicare establish a standard set of core benchmarking, evaluation, and continuous care improvement metrics that can be adopted by regional payers and reported in a central database. This should be based upon provider-developed, evidence-based care guidelines and protocols that emphasize one standard of care, regardless of where patients are treated. This process should be supported by a commitment from providers and payers to include standards focused on quality of services, patient/family satisfaction, and patient engagement.

- It is recommended that a reimbursement structure be developed to support the coordination of patient services that is needed between provider visits. This includes services provided by diverse members of the health care team including health coaches, patient navigators, community health workers, and care coordinators. To facilitate the sharing of information, it is also recommended that incentives be provided for the implementation of information systems that enhance communications and information flow across the entire continuum of care to allow health care providers to access information from the diverse points where patients receive services.

Sincerely,

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