AGS Geriatrics Healthcare Professionals

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The Honorable Lamar Alexander
Chairman, Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Alexander:

The American Geriatrics Society ("AGS") appreciates the opportunity to provide input on the Senate Committee on Health, Education, Labor, and Pensions ("HELP") efforts to address America's rising healthcare costs. The AGS is a national not-for-profit health professions organization comprised of over 6,000 physician and non-physician practitioners and researchers who are devoted to improving the health, independence, and quality of life of all older people. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy.

Older persons with chronic illnesses and geriatric conditions frequently do not receive optimal care and account for a disproportionate share of healthcare expenditures. Improved care for patients with multiple chronic conditions has been identified as one approach that has high potential for cost savings by reducing preventable hospitalizations as well as helping older adults with multiple chronic conditions have a higher quality of life and age in place. We believe there are changes that Congress can make now that would not only improve the quality of care that these individuals receive, but will increase beneficiary satisfaction and reduce the growth in Medicare spending.

We urge Congress to consider the following recommendations and look forward to working with the HELP Committee on this important effort.

- The AGS urges Congress to direct the Centers for Medicare and Medicaid Services ("CMS") to develop a process to encourage and incentivize beneficiaries to designate a primary care provider ("PCP") and to educate beneficiaries about the benefits of primary care.
- The AGS urges Congress to restore the primary care bonus payment indefinitely, which would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses, and physician assistants to enter and stay in primary care, including geriatrics.
- The AGS urges Congress to direct CMS to develop a payment code for a comprehensive geriatric assessment ("CGA"), a service that is more involved and comprehensive than the standard medical exam and which has demonstrated improved care for older adults with complex conditions.
- The AGS asks Congress to direct CMS to develop programs that utilize Community Health Teams ("CHTs")—groups of community-based coaches and facilitators under the supervision of a healthcare professional—to treat patients who are at risk to be negatively affected by social determinants of health.

- The AGS urges Congress to consider statutory changes to the graduate medical education ("GME") program that would create geriatrics curricula requirements for all appropriate trainees and require that all health professionals who treat older adults be trained in geriatrics competencies upon completion of post-graduate training.
- The AGS urges Congress to support and advance the Geriatrics Workforce Improvement Act (S. 299), legislation that authorizes key geriatrics workforce training programs to address the shortage of health professionals expertly trained to care for older people.
- The AGS urges Congress to enact legislation that supports the market expansion of geriatrics models of care into Medicare Part B, including Independence at Home ("IAH"), Programs for All-inclusive Care for the Elderly ("PACE"), Comprehensive Primary Care Plus ("CPC+"), and Hospital at Home ("HaH").
- The AGS asks Congress to encourage use of the advance care planning codes and to educate patients about the importance of discussing care preferences before the onset of a serious illness or medical crisis. Further education for providers about how to utilize the codes is equally important and necessary.
- The AGS asks Congress to support person-centered care and active beneficiary participation by expanding and facilitating the use of programs such as Patient Priorities Care ("PPC").
- The AGS urges Congress to enact legislation to allow pharmacists to have Part B provider status when working as part of a team of other Part B providers. Pharmacists play a key role related to adherence to medications, medication reconciliation, polypharmacy, and identification of drug interactions.
- The AGS urges Congress to enact legislation establishing a national Medicare drug registry to improve safety, cost containment, and quality of care.
- The AGS supports efforts to enhance EHR interoperability and address inclusion of assessment tools and templates specific to care of older adults. The AGS asks that Congress require the Office of the National Coordinator ("ONC") to assess EHR content and structure for geriatric care by convening an expert panel.
- The AGS supports efforts to make EHRs accessible to beneficiaries/surrogates for patient safety, engagement and empowerment.
- The AGS urges Congress to reduce the geographic restrictions on telehealth and to add new originating sites to the telehealth benefit. Telehealth has the potential to improve outcomes for chronically ill, multi-morbid patients, including homebound older adults and those living in underserved areas.

We provide further detail on our recommendations below.

IMPROVE PRIMARY CARE

Develop a process to encourage and incentivize beneficiaries to designate a primary care physician, and to educate beneficiaries about the benefits of primary care

Primary care is a key feature of all high-performing healthcare systems. Primary care involves providing and/or coordinating substantially all medical care for a patient and plays an especially important role in the care of older adults with complex and chronic health conditions who often have multiple providers across multiple settings. Our members provide primary care to the sickest and most complex Medicare beneficiaries, a population characterized by the presence of multiple, co-existing chronic conditions and a high prevalence of frailty. Patients with multiple chronic diseases cannot be treated as though these conditions exist independently of one another. A "whole patient" orientation is a core principle of

geriatric primary care, indeed of all primary care. We treat patients, not diseases. Geriatric primary care takes into account the complexity of multiple diseases, medications, and symptoms, as well as the patient's values and preferences.

The AGS urges Congress to direct the Centers for Medicare and Medicaid Services ("CMS") to develop a plan to encourage beneficiaries to designate a primary care provider ("PCP"). We recommend that CMS educate its beneficiaries that having a regular source of primary care is an important part of care, and that for most people high quality health care starts with having a relationship with a trusted PCP. Congress and CMS should also consider incentivizing beneficiaries to choose a PCP by offering, for example, to not apply the Part B deductible or any coinsurance amount when a patient sees his/her designated PCP (or other PCP in the same group practice). Such a policy would create a significant incentive for beneficiaries to see their primary care physician early in a disease's progression and hopefully reduce the number of avoidable hospitalizations or visits to the emergency department. This is a common sense extension of already enacted legislative provisions that do not require beneficiary cost-sharing for annual wellness visits and certain other preventive services.

Restore the primary care bonus payment

As part of the Affordable Care Act ("ACA"), Medicare implemented a 10 percent bonus payment for primary care physicians for five years. The bonus payment expired at the end of 2015. The AGS urges Congress to restore the payment indefinitely, which would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses, and physician assistants to enter and stay in primary care, including geriatrics.

Research shows that healthcare outcomes and costs in the U.S. are strongly linked to the availability of primary care physicians. According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care, studies have found that patients with access to a regular primary care physician have lower overall healthcare costs than those without one, and health outcomes improve.[1] Another study revealed that a higher proportion of PCPs in an area is associated with a lower level of spending. Specifically, states with a greater proportion of general practitioners had lower spending per Medicare beneficiary compared with other states.[2] Most recently new research by Sanjay Basu et al. shows that greater PCP supply was associated with improved mortality.[3]

However, in the U.S. there is a workforce crisis, with a disappearing supply of primary care physicians, including geriatricians. According to the Health Resources and Services Administration ("HRSA"), there will only be 6,230 geriatricians by 2025, or approximately one for every 3,000 older adults that require geriatric care, leaving thousands without access to these services.[4] This trend must be reversed if we are

[1] Health Resources and Services Administration. Advancing Primary Care: Council on Graduate Medical Education Twentieth Report. https://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf. Published December 2010. Accessed February 28, 2019.

[2] Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Aff*. 2004;23:184 –197.

[3] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med*. Published online February 18, 2019. doi:10.1001/jamainternmed.2018.7624

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025. Rockville, Maryland; 2017.

to provide older Americans – whose numbers are projected to increase dramatically in the coming years – with the quality care they need and deserve.[5]

In large part, this shortage is the result of under-funding of primary care, which has made careers in primary care medicine unattractive to graduating physicians because of the relatively low incomes they generate compared to other medical fields. Primary care also has greater levels of responsibility between visits, in quality reporting, and in dealing with the shortcomings of electronic health records ("EHRs"). Further, the work of primary care is not adequately recognized in the current fee-for-service payment system. The mismatch between payment and responsibility is as negative an incentive as the payment level itself.

Develop a payment code for a comprehensive geriatric assessment

Caring for older adults with multiple chronic conditions is atypically time intensive and requires an assessment that is often more involved and comprehensive than the standard medical exam. The AGS believes Medicare should provide payment coverage for a comprehensive geriatric assessment ("CGA") code. When conducting a geriatric assessment, a healthcare provider will ask about a person's health "history" – about health problems he/she has had over the course of his/her life and how they may have changed with time. CGA is a team-based service requiring a comprehensive assessment and a care plan. In addition to the standard history and examination, a CGA includes functional, cognitive, mobility, and psychosocial assessments. These assessments involve the entire care team including social workers, physical/occupational therapists, nurses, and registered dieticians. Of note, home geriatric assessment has been shown to be effective in improving functional status, preventing institutionalization, and reducing mortality. CGA performed in the hospital, especially in dedicated units, also has benefit on survival.[6] Many geriatrics health professionals typically provide CGA to their patients but it is not described by current coding and it is not appropriately reimbursed.

Consideration of social determinants of health

Conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health. Examples include socioeconomic status, race, educational attainment, neighborhood and environment, public safety, and food security. Healthy People 2020 highlights the importance of addressing social determinants of health by including "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[7]

Healthcare professionals across disciplines play key roles in helping to reduce negative health outcomes related to social determinants. Good primary care experiences, including accessibility and continuity of care, are associated with better self-reported health and can reduce the adverse association between income inequality and general health.[8]

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[5] Colby SL, Ortman JM. U.S. Census Bureau. Projections of the Size and Composition of the U.S. Population: 2014 to 2060, Current Population Reports, P25–1143, Washington, DC; 2014.

[6] Ward KT, Reuben DB. Comprehensive geriatric assessment. UpToDate website. https://www.uptodate.com/contents/comprehensive-geriatric-assessment/print. Accessed on March 1, 2019.

[7] Social Determinants of Health. HealthyPeople.gov website. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Accessed on February 28, 2019.

[8] Shi L, Starfield B, Politzer R, Regan J. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37:529–550.

The AGS asks Congress to direct CMS to develop programs that utilize Community Health Teams ("CHTs") — groups of community-based coaches and facilitators under the supervision of a healthcare professional—to treat patients who are at risk to be negatively affected by social determinants of health. We also ask Congress to define CHTs as covered provider types and the Secretary to develop criteria for qualification as a CHT and the criteria for beneficiary eligibility. We do not believe these programs should be limited to the dual-eligible beneficiary, even if this is the most common beneficiary subtype in need.

BUILD THE HEALTHCARE WORKFORCE

Improve geriatrics education and training for healthcare professionals across all disciplines

Medicare graduate medical education ("GME") is the hands-on training phase of physician education that is mandatory in order for doctors to obtain a license for independent practice. However, funding for GME, while supported by the Medicare program, does not require that hospitals and other sites provide training that leads to a health professional workforce that is able to care for frail older adults with multiple illnesses. According to a 2009 Medicare Payment Advisory Commission ("MedPAC") report, Medicare has never used these payments to affect medical education or the composition of the workforce.[9] In a 2010 report, MedPAC stated that institutions using Medicare dollars to support GME should be providing training to enable health professionals to develop competency in the care of older adults.[10] Furthermore, the Institute of Medicine ("IOM") has said that a geriatrics competent workforce will contribute to higher quality, safer, and more cost effective care for patients.[11]

The AGS advocates for improvements to the GME program that would require that all health professionals who treat older adults to be trained in geriatrics competencies upon completion of post-graduate training. Further, we urge Congress to consider statutory changes to the program that would create geriatrics curricula requirements for all appropriate trainees. The overall goal should be to produce health professionals who are prepared to care for complex patients with multiple comorbidities. AGS has participated in efforts to define the core competencies that all physicians should have[12] as well as in specialty-specific efforts including emergency medicine, surgery, and psychiatry[13,14,15,16]. Additionally, AGS led an effort to define the core competencies that family and internal medicine residents should possess at the end of residency.[17]

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[9] Medicare Payment Advisory Commission. 2009. Report to Congress: Improving Incentives in the Medicare Program. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/reports/Jun09_EntireReport.pdf

[10] Medicare Payment Advisory Commission. 2010. Report to Congress: Aligning Incentives in Medicare. Washington, DC: MedPAC. https://www.aacom.org/docs/default-source/grad-medical-education/jun10_entirereport.pdf?sfvrsn=2

[11] Institute of Medicine. 2008. *Retooling for an Aging America: Building the Health Care Workforce.* Washington, DC: The National Academies Press. https://doi.org/10.17226/12089

[12] Minimum Geriatric Competencies for Medical Students. American Geriatrics Society website. https://www.americangeriatrics.org/sites/default/files/inline-files/Minimum-Geriatric-Competencies-Medical-Students.pdf. Updated June 30, 2010. Accessed March 1, 2019.

[13] Minimum Geriatric Competencies for Emergency Medicine Residents. POGOe website. https://www.pogoe.org/EM_Competencies. Updated March 2010. Accessed March 1, 2019.

[14] Bell RH Jr, Drach GW, Rosenthal RA. Proposed competencies in geriatric patient care for use in assessment for initial and continued board certification of surgical specialists. *J Am Coll Surg*. 2011;213(5):683–90.

[15] Geriatric Core Competencies. American Association for Geriatric Psychiatry website. https://www.aagponline.org/index.php?src=gendocs&ref=GeriatricCoreCompetencies&category=Education&link=GeriatricCoreCompetencies. Accessed March 1, 2019.

Reauthorize the geriatrics workforce programs at HRSA
To address the care needs of Medicare beneficiaries, especially those with complex and chronic conditions, it is imperative that sufficient federal resources be dedicated to increasing the number of physicians, including geriatricians, and other health professionals with the knowledge and skills to meet the unique care needs of older adults.

In January, Senators Susan Collins (R-ME) and Bob Casey (R-PA) introduced the Geriatrics Workforce Improvement Act (S. 299)—legislation that would authorize the Geriatrics Workforce Enhancement Program ("GWEP") and the Geriatrics Academic Career Awards ("GACAs") administered by HRSA. Together, these programs aim to address the shortage of health professionals expertly trained to care for older people, and also advance supports for older adults, caregivers, and the interprofessional teams responsible for their care. Sustained and enhanced federal investments in these initiatives are essential to delivering high quality, better coordinated, and more cost effective care to older Americans, whose numbers are projected to increase dramatically in the coming years. We urge the HELP Committee to support this important legislative proposal and help move the bill through the legislative process.

SUPPORT FURTHER EXPANSION AND ADOPTION OF GERIATRIC MODELS OF CARE

Studies have shown that models providing coordinated and interdisciplinary geriatrics team-based care can make a critical difference, especially for persons with multiple chronic conditions, by preventing complications and enhancing the quality and efficiency of care provided across the healthcare continuum. Models, for example, that reinforce the patient-provider relationship might prove superior to usual care and other new financial models that are potentially cumbersome for and confusing to older adults, their family caregivers, and their medical providers. Below we identify four such models.

We urge Congress to identify and enact legislation that supports the market expansion of these models into Medicare Part B as all have been shown to improve care.

The Independence at Home ("IAH") Demonstration model provides home-based primary medical care to older adults with severe chronic illness and disability. An interdisciplinary team coordinates all medical and social services, providing better clinical care and patient experience. Each IAH practice delivers 24/7 service to improve care and to help avoid preventable emergency room visits and hospitalizations. The demonstration began in 2012 as part of the ACA and was originally authorized for three years. It has been extended two times—first for two years by the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015, and second as further extended and amended by Section 50301 of the Bipartisan Budget Act of 2018 ("BBA") for an additional two years, beginning January 2019 which extends the demonstration through December 31, 2020.

CMS recently published the Summary of Results from Performance Year 3. In the third performance year of the demonstration, CMS found that the IAH practices saved approximately 4.7 percent, equating to

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[16] Proposed Geriatric Psychiatry Core Competencies. American Association for Geriatric Psychiatry website. https://www.aagponline.org/index.php?src=gendocs&ref=CurriculumforGeriatricPsychiatryCoreComp&category=Education&link=CurriculumforGeriatricPsychiatryCoreComp. Accessed March 1, 2019.
[17] Minimum Geriatric Competencies for IM-FM Residents. American Geriatrics Society website. https://www.americangeriatrics.org/sites/default/files/inline-files/Min_Geriatric_Competencies_IM-FM_Residents.pdf. Updated September 2010. Accessed March 1, 2019.

$16.3 million, an average of $1,431 per beneficiary. This brings the first three year savings of the IAH demonstration to $51 million dollars. This savings is all the more powerful in that it was achieved on the treatment of approximately 12,000 beneficiaries per year. This also indicates that IAH is by far the most successful Medicare demonstration in terms of per beneficiary savings. At the same time, IAH practices have consistently reflected quality improvement and for the third performance year, 14 out of the 15 IAH practices improved on at least one quality measure from the second performance year. Further, five of the practices met the performance thresholds for all six quality measures.

Programs for All-inclusive Care for the Elderly ("PACE") is a managed-care program that was developed to enable individuals to live independently in the community, rather than a nursing home, with a high quality of life. Several evaluations of the program have shown PACE to be effective in creating cost savings and improving quality of life for frail older adults. The PACE model uses an interdisciplinary team of healthcare professionals to provide and manage care in the community, and serves more than 45,000 enrollees, about 95 percent of which remain in this setting. Research has shown that PACE provides better health outcomes when compared to traditional services for seniors with chronic care needs.[18]While beneficiaries with Medicare and/or Medicaid can join PACE, which is currently available in 31 states (126 programs in total), current policy has kept these programs siloed and has made adoption challenging. Barriers include the considerable time and monetary investment required of prospective PACE organizations. Also, developing a PACE program requires the active support of state Medicaid agencies which can be difficult in times of severe budget and resource constraints.[19]

Further, there is an opportunity to move forward without delay on innovative PACE-like models that could address the needs of medically complex Medicare and/or Medicaid beneficiaries who are at-risk of needing nursing home ("NH") level of care.

Comprehensive Primary Care Plus ("CPC+") is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. This program not only strengthens primary care for all beneficiaries, but is also designed to meet the specific needs of the chronically ill patient. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care patients in the U.S. The AGS recommends expanding the CPC+ concept because currently, participation is limited to certain geographic regions (18) and not all practices that hoped to participate were selected. In addition, Congress should add funding to integrate appropriately trained pharmacists in CPC+ healthcare teams. Pharmacists have been proven to be very effective in managing transitions from the hospital to the home by seeing patients in clinics, office practices, and in the home for post-discharge and/or post-acute care. These interventions help avoid the use of potentially inappropriate medications among Medicare patients who are frequently on multiple medications.

Hospital at Home ("HaH") offers patients who need to be hospitalized the option of receiving hospital-level care at home for conditions that can be safely treated there. Patients often are more comfortable receiving care in a familiar home environment. For the frail and elderly in particular, hospital stays can pose a variety of health threats, including delirium, infections, and falls. While, HaH may be available to Medicare Advantage beneficiaries and through commercial insurance, it is not covered by traditional

[18] Leavitt M. 2009. Interim Report to Congress: The Quality and Cost of the Program of All-Inclusive Care for the Elderly.
[19] Bloom S, Sulick S, Hansen JC. Picking Up the PACE: The Affordable Care Act Can Grow and Expand a Proven Model of Care. *Generations*. 2011;35(1):53–55.

Medicare. A study published August 2018 that spanned almost three years (November 2014 — August 2017) found that HaH care provides a shorter length of stay; reductions in hospital readmissions, emergency department visits, and transfers to skilled nursing facilities; and improved patient experience versus traditional inpatient care.[20]

EMPOWER PATIENTS TO PLAY A GREATER ROLE IN MANAGING THEIR HEALTH

Encourage advance care planning

Advance care planning ("ACP") is a critical tool for helping individuals articulate and document their care values and preferences as they age, to ensure that the care they receive matches their wishes, particularly near the end of life. ACP involves early and ongoing discussions among healthcare professionals, family members, friends, caregivers, or other designated decision-makers. ACP conversations that document care preferences using advance directives have been shown to result in care that reflects personal preferences.[21] Also, research has shown that ACP improves care and quality of life, while increasing satisfaction with the healthcare system and reducing stress, anxiety, and depression for older adults, family caregivers, and other relatives.[22,23] Finally, emerging data shows that ACP reduces the cost of end-of-life care without increasing mortality.[24] In fact, in one prospective randomized, controlled clinical trial, relative to patients receiving usual care, patients receiving palliative care in addition to usual care were shown to have a 25 percent longer survival.[25]

In 2016, Medicare began payment for billing codes that cover ACP services. This was an important first step but more is needed to educate patients about the importance of having these conversations. National and state policies should encourage older adults and those who care for them to have confidential, voluntary ACP discussions before the onset of a serious illness or medical crisis. These discussions play a vital role in developing legal advance directives and appointing surrogate decision-makers before older people are no longer able to make their care preferences known. Additionally, as the codes for ACP have been covered by Medicare for only a few years, further education for providers is equally important and necessary.

Support person-centered care and active beneficiary participation

Person-centered care puts personal values and preferences at the forefront of decision-making. Though critically important to the quality of care, eliciting and documenting personal values remains uncommon in routine older adult care, particularly for people with multiple health concerns that complicate pinpointing broader health priorities.[26] Making person-centered care a reality for older adults with

[20] Federman AD, Soones T, DeCherrie LV, Leff B, Siu AL. Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences. *JAMA Intern Med.*2018;178(8):1033–1040.
[21] Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med*. 2010;362(13),1211–1218.
[22] Detering KM, Hancock AD, Reade MC, Silvester W. The impact of Advance Care Planning on end of life care in elderly patients: Randomised controlled trial. *BMJ*. 2010;340, c1345.
[23] Schwartz CE, Wheeler HB, Hammes B, et al. Early intervention in planning end-of-life care with ambulatory geriatric patients: Results of a pilot trial. *Arch Intern Med*. 2002;162(14):1611–1618.
[24] *See* Zhang B, Wright AA, Huskamp HA, et al. Health care costs in the last week of life: associations with end-of-life conversations. *Arch Intern Med*. 2009;169(5):480–488.
[25] Temel JS, Greer JA, Muzikanski A, et al. Early palliative care for patients with metastatic non-small lung cancer. *N Engl J Med*. 2010;363(8):733–742.
[26] American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A Definition and Essential Elements. *J Am Geriatr Soc*. 2016;64(1):15-18.

complex care needs will take time and effort. However, there are programs that are currently paving the way for person-centered care and we have highlighted one such approach here.

Patient Priorities Care ("PPC") (formerly known as CaRe-Align Implementation) is a new approach to health care which helps patients and clinicians focus decision-making on patients' health priorities, defined as both their health outcome goals—what they want from their healthcare, and their healthcare preferences—and the healthcare activities they are able and willing to do. Over the past five years, Mary Tinetti, MD of Yale University and Caroline Blaum, MD, MS of New York University have led a broad group of stakeholders to design and pilot PPC. A new feasibility study that took place at a primary care and cardiology practice in central Connecticut found that PPC can be integrated into a real-world clinical practice.[27] This work is funded by The John A. Hartford Foundation, Robert Wood Johnson Foundation, and the Gordon and Betty Moore Foundation; and through a Patient-Centered Outcomes Research Institute ("PCORI") Eugene Washington PCORI Engagement Award. In comparison to similar patients receiving usual care, patients who received care aligned with their specific health priorities had more unwanted medication stopped and unwanted (and unhelpful) diagnostic testing, and procedures avoided; they also reported a reduction in the treatment burden of their care. PPC is a patient-centered approach to reducing costs.

In order to expand on and facilitate the use of PPC and other similar programs and approaches, the AGS recommends that Congress encourage development and deployment of quality metrics related to patient goals and treatment burden and eliminate disease specific quality metrics for Medicare beneficiaries with multiple chronic diseases; provide coverage of the patient priorities identification and decision-making process – including coverage for payment codes specifically focused on patient priorities aligned care; and require Medicare Advantage programs to identify and align care with patients' health priorities.

ENSURING MEDICATION SAFETY AND ACCESS

Increase pharmacy support across the continuum of care

Medication errors are a large contributor to poor outcomes, complications, and hospitalizations (and readmissions). Limited pharmacy support in real-time in the office setting complicates this issue, although appropriate reviews of total medication lists should be required in all care settings – with particular attention to care transitions. Pharmacy support may include, for example, an assessment of appropriate dose and duration of treatment as well as medications of particular risk for older adults (e.g., medications listed in the *American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults*).[28]

Congress should enact legislation allowing pharmacists to enroll as Medicare Part B providers. Specifically, they should have Part B provider status when working as part of a team of other Part B providers (i.e., in a physician practice or hospital outpatient) where Medicare will reimburse pharmacists for consultations related to adherence to medications, medication reconciliation, polypharmacy, and identification of drug interactions. This includes community pharmacists who also play a key role in

[27] Blaum CS, Rosen J, Naik AD, et al. Feasibility of Implementing Patient Priorities Care for Older Adults with Multiple Chronic Conditions. *J Am Geriatr Soc*. 2018;66(10):2009–2016.

[28] American Geriatrics Society 2019 Beers Criteria Update Expert Panel. American Geriatrics Society Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc.* 2019; doi: 10.1111/jgs.15767

raising potential red flags and reconciling medications to avoid duplications. The judicious use of appropriately trained pharmacists in healthcare teams has the potential to be one of the largest innovations in care.

Congress should also enact legislation establishing a national Medicare drug registry to improve safety, cost containment, and quality of care. While hospitals are also expected to reconcile medications, there needs to be a more accurate and robust effort that supports reconciliation for community-based care given that most older adults see one or more specialists in addition to their primary care provider. State-based controlled substance monitoring programs have demonstrated the feasibility of internet-accessible registries listing drugs that patients have filled at their pharmacy. On a national scale, an internet-accessible registry listing all drugs that a patient has filled would help greatly in monitoring medication adherence and prevent inadvertent drug interactions among patients seeing multiple prescribers. This registry must seamlessly interface with the EHR so that clinicians can readily access the information as part of the routine workflow. This requires standards for electronic records, reporting to the registry and registry structure. The current systems provide fill histories that are incomplete and/or out of date which reduces the chance clinicians will routinely access them.

Overall, these interventions will help avoid the use of potentially inappropriate medications among Medicare patients who are frequently on multiple medications. They will also help avoid the polypharmacy cycle (or prescribing cascade) where new medications are used to treat the side effects of currently prescribed medications, thereby saving costs on pharmaceuticals, reducing pill burden and its associated complications.

IMPROVING ELECTRONIC HEALTH RECORDS AND EXPANDING TELEHEALTH

Improve interoperability between health systems

The AGS supports efforts to enhance EHR interoperability among multiple providers and across different settings so that care coordination is more efficient, effective, and accurate. We also encourage innovations in health information technology (e.g., assessment tools and templates) that are specific to older adult care. EHRs have the potential to improve care of frail, older adults with multiple chronic conditions. To fulfill that potential, EHRs must have the capacity to capture key issues that affect care and well-being of older adults with chronic conditions, including, but not limited to, function, cognition and patient's goals of care over time. This will aid providers in focusing on issues that address the overall goals of the patient, including function and maintaining independence. We ask that Congress require the Office of the National Coordinator ("ONC") to assess EHR content and structure for geriatric care by convening an expert panel.

Redesign the electronic record

Electronic record designs have greatly added to the burden in all practices, but especially primary care. Vendors and designers seem to have completely neglected assessment of human factors, realistic safety improvements and practical workflow. Care has to be redesigned around the record rather than the record supporting good care. The record system costs are now a staggering budget item for large health systems as well as small practices. Changing systems loses patient information and reduces productivity for a significant period of time and therefore is avoided whenever possible, also stifling improvements. Congress needs to recognize the public utility nature of the record and promote standards that address usability at the point of care and cost. The record continues to have great potential and many positives have resulted, but it is time to revisit the processes and costs associated with these technologies.

Make the record accessible to the beneficiary/surrogate
We believe a beneficiary and/or authorized caregiver must have access to their records. This is a safety, engagement, and empowerment issue. Additionally, it would allow patients to share information with other providers in those cases where information has not otherwise been shared. We ask that this be a standard for electronic record systems and value-based payment criteria, with appropriate exceptions.

Expand telehealth
Geriatrics health professionals are not available to everyone based on geography and other barriers – thus greater flexibility is needed with telehealth and other waivers for innovative ways to extend the reach of specialized medical care. Telehealth has the potential to improve outcomes for chronically ill, multi-morbid patients, including homebound older adults and those living in underserved areas. Patients often have to travel long distances to reach a provider and this can be especially challenging for older adults who may have multiple medical appointments and difficulty traveling. Web-based consultations using telehealth, or shared audio and imaging between rural primary care providers, geriatricians, and specialists not in practice within the patient's catchment area, for example, would help ensure that the 62 million Americans living in these communities receive the best care possible. Telehealth support has also shown to improve care for patients in SNFs and assisted living facilities by decreasing emergency department utilization and hospitalization. The AGS urges Congress to reduce the geographic restrictions on telehealth and to add new originating sites to the telehealth benefit. For example, Congress should allow telehealth visits to originate from the patient's home under certain circumstances, including from assisted living facilities or nursing homes. In addition, Congress should allow telehealth services to be performed across the entire country without requiring that the beneficiary be in a rural location.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein at agoldstein@americangeriatrics.org.

Sincerely,

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