



University of Pittsburgh



The Stern Center for Evidence-Based Policy



Addressing the Health Needs of an Aging America

New Opportunities for Evidence-Based Policy Solutions



The Stern Center for Evidence-Based Policy

The Stern Center for Evidence-Based Policy (“Stern Center”) fosters, supports, and leads rigorous scientific research initiatives that generate actionable, evidence-based health policy recommendations. By leveraging significant advances in evidence-based research methods and collaborating with key stakeholders, the Stern Center aims to empower policymakers with the best research information available. The goal of the Center is to improve the health of the U.S. population by increasing the use of evidence in the policymaking process.

Housed in the University of Pittsburgh’s Health Policy Institute, the Stern Center brings together experts from across the health sciences, including medicine, public health, pharmacy, nursing, dentistry and the rehabilitation sciences, to collaborate on applied policy research. Subject matter experts are supported by a team of political scientists, health economists, biostatisticians, information scientists and regulatory experts who provide the methodological and analytical backbone for the Center’s projects. The Center partners with other academic institutions, research organizations, associations, stakeholder groups and governmental entities to enrich our work and disseminate findings.

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Table of Contents

Executive Summary	4
Introduction	7
The Challenges of Caring for an Aging America	8
Identifying Opportunities for Evidence-Based Policy Solutions	10
Where Evidence and Policy Meet	13
Evidence Searching for Policy Levers	24
Policy Recommendations Searching for an Evidence Base	26
Conclusion	32
Appendix A: Research Methodology	33
Appendix B: Results	35

Executive Summary

The U.S. population is rapidly aging. And its healthcare needs are changing.

By 2050, adults over the age of 65 will make up 20 percent of the U.S. population. The budgetary and policy implications of this demographic shift represent two of the greatest challenges faced by federal and state governments today. An aging population will place intense stress on our healthcare system, its funding sources, and American families. Lack of personal savings for long term-care and a fragmented and institutionally-dependent delivery system will pose significant risks to the health and quality-of-life of aging Americans. Our healthcare workforce will need to be re-tooled to manage the multiple chronic conditions prevalent in this vulnerable population. Addressing the needs of the elderly will be a top priority of policymakers at every level.

Evidence-based policymaking can improve the cost and quality of care for the aging.

Meeting the health needs of an aging America requires policy proposals based on the best-available research evidence about how to improve access, affordability and the quality of health services. Today, for many reasons, health policymaking often fails to fully consider scientific research evidence. With aging Americans and their loved ones at risk, policymakers have a responsibility to inform their decisions with rigorous, objective evidence. At the same time, health policy researchers must find a way to present scientific results in a manner that is relevant to and applicable by policymakers. This study is the first in a series of efforts to connect research evidence to the set of policy recommendations being made to address the health needs of older adults in the United States.

This study is the first to systematically map health policy recommendations for the aging to the body of research evidence

In an unprecedented effort to map evidence to health policies, a multidisciplinary team of researchers conducted a two-phase study to identify opportunities for policymakers seeking to improve the cost and quality of healthcare for the aging. Results of a broad literature search of medical research evidence were matched and compared to policy recommendations from multiple, cross-cutting healthcare stakeholder groups. From an initial search return of over four hundred thousand literature citations and over 493 health stakeholder organizations, researchers conducted a scoping study and policy scan to identify unique stakeholder policy recommendations and studies related to the health of the aging population. An expert panel used these results to organize the information into 10 usable policy categories (further divided for easy reference into 75 subtopic areas), which combine to present a comprehensive and unbiased view of the best-available evidence and policy activity around healthcare for older adults. The study intends to inform future policymaking in this critical area with an easily applied index of evidence-based policy research mapped to the full range of policy options.

Matching these results allows policy makers and the stakeholder community to identify potential areas of interest:

- 1) Where there is significant policy interest and evidence to support proposed changes;
- 2) Where policy topics have a strong evidence base but are receiving little attention; and
- 3) Where there is policy activity but a lack of scientific evidence.

Where Evidence and Policy Meet

The study revealed three areas in which a rich base of research evidence and a high level of demand for policy change exist:

Prevention and Wellness interventions lower the cost of care and improve health outcomes by preventing the onset of disease entirely, detecting the early onset of disease through screening, and slowing or stopping the progression of disease. Within this broad category, the study revealed specific focus areas where evidence and policy demand strongly converge: **screening and early detection; nutrition and diet; and patient education, empowerment, and physical activity.**

The Healthcare and Informal Caregiver Workforce reforms seek to address a significant shortage in the number of professionals who have the necessary skills to treat complex geriatric patients. Policy interventions could support the use of new models of care to expand the role of **family caregivers**, leverage the unique skills of **nurses** and other advanced practice providers, train the workforce in **geriatric competencies, coordinate interprofessional teams** to manage care, and identify opportunities for engaging **community health workers.**

Coordinated Care interventions encourage healthcare payers and providers to move toward a more accountable system, where a greater portion of reimbursement is tied to patient health outcomes. The study revealed significant evidence and policy activity on interventions related to **care pathways and bundles, disease management programs, specialized units, discharge coordination and patient navigation, and coordinated delivery of primary and long-term care.**

Evidence That Deserves Greater Attention From Policymakers

The following topics had an extensive, rigorously conducted evidence base but received limited attention in the policy arena.

Patient Self-Care and Self-Management initiatives encourage patients to work with their providers to preserve their health status and minimize avoidable complications. These initiatives utilize strategies such as patient education to encourage healthy decisions and behaviors as well as technology enabled self-care. Better management of chronic disease can help patients with complex, co-morbid conditions avoid unnecessary interactions with the healthcare system, such as costly trips to the emergency room.

Palliative and End-of-Life Care refer to approaches that focus on relieving symptoms for patients with pain and terminal illnesses and providing support and resources for their family members. Approximately one-third of Medicare dollars are spent on patients in their last two years of life; these initiatives seek to reduce the suffering of patients at the end-of-life while creating considerable opportunities for healthcare cost reduction. Such initiatives hope to improve patient and caregiver satisfaction.

Policy Recommendations That Demand an Evidence Base

Two topics were notable for a large number of policy recommendations within the sampled stakeholder organizations, but a lack of research evidence to support these recommendations.

Medical Malpractice: A cost-effective, high-value healthcare system would ideally eliminate wasteful and unnecessary care associated with the practice of defensive medicine. Yet the study found considerable gaps in the evidence base on the potential consequences of malpractice reform on the costs and quality of care for the aging population

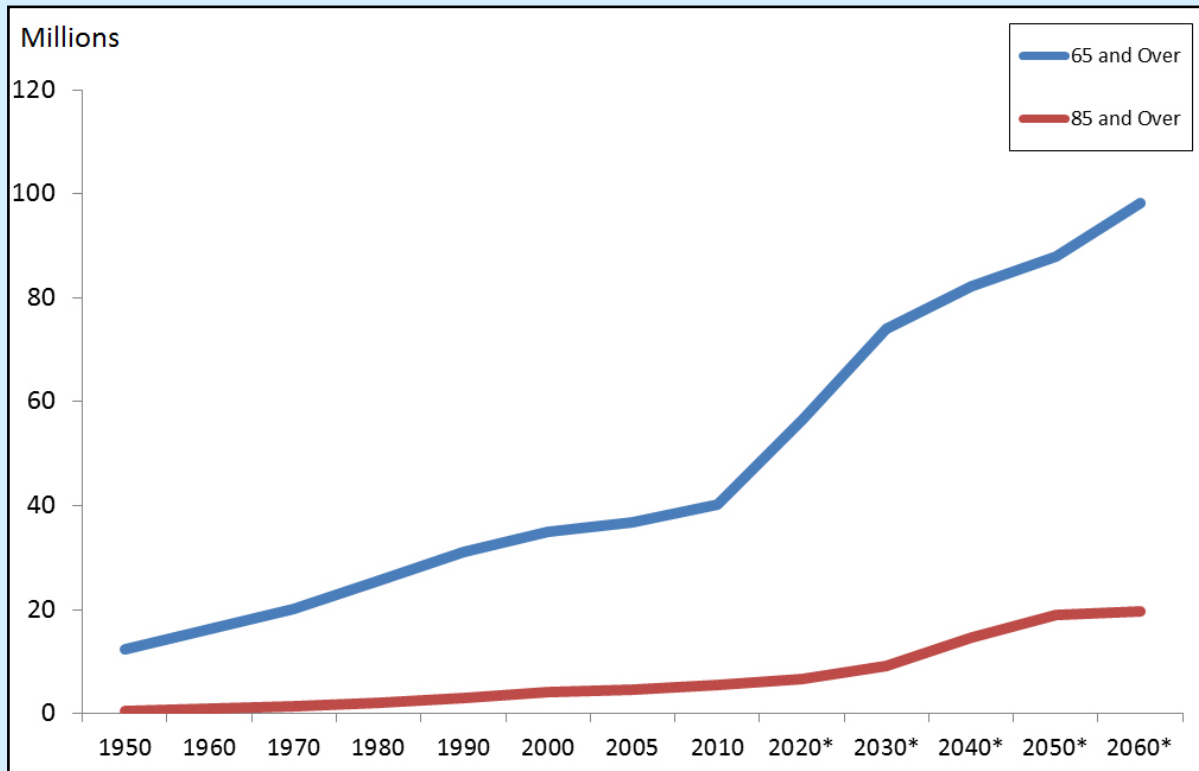
Long-Term Care: While reforming the current long-term care system is a major policy priority for many stakeholder organizations in the study, the evidence base on the effects of proposals to reform the system for financing and delivering long-term care is limited, particularly at the federal level. A great deal of policy activity in long term care is happening at the state level, as state leaders use policy levers such as Medicaid waivers to deliver long-term services and supports in innovative ways. However, many significant gaps remain and additional evaluation and research are needed to provide an evidence-base for these policies.



Introduction

The U.S. population is rapidly aging. By 2050, older adults, age 65 and older, will make up 20 percent of the total U.S. population, up from 12 percent in 2000 and just 8 percent in 1950. The number of people age 85 or older will grow the fastest over the next few decades, constituting 4 percent of the population by 2050, or 10 times its share in 1950 (see Figure 1).

Figure 1. Growth in U.S. Aging Population, 1950-2060 (Projected)



Source: U.S. Census Bureau

Note: * indicates projection 2014 Population Projections

The budgetary and policy implications of this demographic shift represent the greatest challenges faced by the government and the U.S. health system today. While the U.S. population of adults aged 65 and older currently account for only 13 percent of the population, this cohort consumes more than 34 percent of national health expenditures. On average, the older adult population spends \$18,424 annually per person, with more than one-third of those expenditures occurring after the age of 85. The Medicaid program accounted for more than 40 percent of overall U.S. nursing home costs in 2012, and 65 percent of these costs in graying states like Pennsylvania. Together with Medicare, these programs comprise more than 31 percent of all U.S. health expenditures.¹

¹G. Burtless, Trends in the Well-Being of the Aged and Their Prospects through 2030, Brookings Institution Report, June 2015, available from: <http://www.brookings.edu/~media/Research/Files/Papers/2015/06/04-medicare-2030-paper-series/060215BurtlessWellBeingSeniors.pdf?la=en>; U.S. Senate, Commission on Long-Term Care, Report to Congress, September 2013, available from: <http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>.

What policy solutions have been advanced to address the challenges of reducing healthcare costs and improving health outcomes in the elderly population, and are these solutions supported by rigorous scientific evidence? Over the last year, a multidisciplinary team at the Stern Center for Evidence-Based Policy conducted an unprecedented study that answers these questions.

Researchers systematically analyzed scientific evidence related to the cost and quality of care for the aging population from across the entire domain of published biomedical literature, as well as health policy recommendations from a sampled set of stakeholder organizations (advocacy, membership, and trade organizations) in the United States.

The results of this study provide policymakers with essential insights into the current state of evidence-based health policy in the United States. The findings will thus drive the future work of the Stern Center in this politically, economically, and socially critical area of health policy research.

The Challenges of Caring for an Aging America

Meeting the health needs of an aging America requires sizable changes to our existing approach to treatment and service delivery. Unless policymakers take action now, aging Americans and their loved ones will soon experience unsustainably high costs for healthcare coverage as well as significant declines in the access to and quality of care.

Care needs among the U.S. aging population are changing rapidly. An aging America will experience increasingly severe and complex health conditions. Almost half of the U.S. population is expected to have at least one chronic disease by 2020. By 2030, over 40 percent of the 65+ population is likely to have diabetes; nearly 80 percent will experience hypertension. The number of aging individuals with three or more chronic conditions has also increased significantly within the last ten years, and this is expected to grow to 40 percent among the 65 and over population by 2030. Complicating the task of treating multiple chronic conditions is the rising prevalence of age-related functional impairments. This will dramatically expand the number of individuals requiring assistance to perform daily activities to maintain quality of life and independence. By 2050, the number of Americans needing long-term services and supports (LTSS) will more than double to 27 million.²

The fragmented U.S. healthcare system is ill-suited to address an expanding aging population's complex needs. While multiple chronic conditions can be effectively managed through coordinated approaches to treatment, providers rarely coordinate with one another and often lack appropriate incentives for improving the overall health of the patient. This places individuals with multiple chronic conditions at a significantly higher risk for adverse drug reactions and preventable hospitalizations. Fragmented service delivery also makes it more difficult for aging individuals to navigate their health choices.³

²Id.

³R. Gijzen, N. Hoeymans, F.G. Schellevis, et al., Causes and consequences of comorbidity: a review, *Journal of Clinical Epidemiology* 2001;54(7):661-674.

Gaps in the caregiver workforce will place an increasing number of older adults at risk of losing their health and independence. Less than 3 percent of medical students enroll in geriatrics electives, while less than 1 percent of nurses and pharmacists have gerontological certifications. Training requirements for direct care workers, which vary from state to state, are often inadequate. Across health services professions, certification programs fail to emphasize competencies related to caring for older adults. Finally, surveys of family caregivers also reveal that they have little access to necessary training and skills. These workforce gaps will make it increasingly difficult to provide high-quality care to aging Americans and will limit access to home or community-based long-term care, which the vast majority of Americans prefer to nursing homes.⁴

Though an increasing number of Americans will need long-term care, few will have the capacity to finance that care, shifting the burden to taxpayer-funded programs. Less than 1/3 of Americans 50 and older have begun saving for long-term care. Without such savings and with a diminishing long-term care insurance market, most individuals will be forced to spend down their savings in order to qualify for Medicaid-provided Long-Term Services and Supports (LTSS). The rise in demand for LTSS will place a significant burden on Medicaid spending, which is expected to increase by 68 percent between 2015 and 2025, reaching to \$576 billion dollars.⁵ If these present trends continue, the federal government and the states may be forced to roll back support for other taxpayer priorities, such as raising school performance, solving the housing crisis, and fixing our decaying transportation infrastructure.⁶

Our approach to caring for the aging is fiscally unsustainable for taxpayers and consumers alike. Absent changes to a fragmented system of care delivery which rewards high-cost rather than high-quality care, the burden of healthcare spending for the aging population will soon become unsustainable for taxpayer-funded programs like Medicare and Medicaid, as well as individual consumers paying out-of-pocket. Between 2015 and 2025, annual Medicare spending is projected to double to \$1.2 trillion dollars. The median annual out-of-pocket costs for Americans age 65 will rise to \$6,200, nearly double what it was in 2010.⁷

The Patient Protection and Affordable Care Act (ACA) alone cannot address these challenges. While the ACA represents the most significant advance in health reform in half a century, its advances in addressing the challenges of an aging population have been comparatively modest, limited to several, albeit promising, demonstration programs. As Medicare and the Older Americans Act reach their fiftieth anniversaries continue to improve aging America's access to affordable, high-quality care, it will be necessary to identify, evaluate, and scale-up policy interventions that work.⁸

⁴ Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, 2008 Report, available from: <http://www.iom.edu/Reports/2008/Retooling-for-an-aging-America-Building-the-Health-Care-Workforce.aspx>

⁵ Updated Budget Projections: 2015 to 2025, Congressional Budget Office, March 2015, available from: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf>

⁶ U.S. Senate, Commission on Long-Term Care, Report to Congress.

⁷ Centers for Medicare and Medicaid Services, *National Health Expenditure Projections, 2013-2023, Forecast Summary*, available from: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf>

⁸ H. Goldbach, *The Affordable Care Act and Older Americans*, Stanford Aging Institute, December 8, 2013, available from: <https://aging.stanford.edu/2013/12/affordable-care-act-older-americans/>

Identifying Opportunities for Evidence-Based Policy Solutions

Addressing the health needs of an aging America will require actionable insights based on the best-available research evidence about how to improve the affordability and quality of care for this rapidly expanding demographic. **Policy choices are often made without adequate insights from the full range of available effectiveness research, and all too often, policy research treats health problems narrowly, ignoring evidence that reveals effective interventions.**

With aging Americans and their loved ones at risk, policymakers have a responsibility to base their decisions on rigorous, objective analysis about which policy proposals work and which do not. **Evidence-based health policy should examine the widest array of available research and information to identify actionable recommendations that improve the cost and quality of care. It also seeks to highlight policy proposals on which additional effectiveness research is necessary.**⁹

To target opportunities for evidence-based policymaking, researchers at the Stern Center undertook a systematic two-phase study to map the full landscape of research evidence and policy ideas. In the first phase, as **Figure 2** shows, a multidisciplinary team conducted a **Scoping Study**, systematically sampling the entire domain of biomedical literature on the cost and quality of care for the aging (over 24 million citations) to identify areas in which there exists a wide base of up-to-date research literature. To ensure the search captured the broadest range of current literature, researchers identified systematic reviews, and rigorous, highly cited individual studies published between 2010 and 2014 that were relevant to older adults and included data on either cost or clinical outcomes. This resulted in an inventory of 1196 citations, which included 333 systematic reviews and 836 individual studies.

In the second phase, the team conducted a Policy Scan in order to map the universe of existing policy recommendations related to aging and health in the United States. As **Figure 3** shows, researchers used major databases U.S. organizations to identify 493 health stakeholder groups whose central purpose is to advocate, research, or lobby in the area of health care, health outcomes, or physical wellness of older adults. They then targeted all groups producing actionable policy recommendations and identified 98 health policy organizations from a database. From these organizations, researchers extracted more than 600 policy proposals.

To identify areas where a significant level of evidence and policy demand existed, researchers categorized all policy recommendations and citations into 10 valid categories and 75 subtopic areas. They then ranked topics based on the strength of the evidence base and policy demand from multiple, cross-cutting stakeholder groups.

> See **Appendix A** for a full description of the methodology.

⁹See, among others, Pew-MacArthur Results First Initiative, Evidence-Based Policymaking: A Guide for Effective Government, November 2014, p. 2, available from:

<http://www.pewtrusts.org/~media/Assets/2014/11/EvidenceBasedPolicymakingAGuideforEffectiveGovernment.pdf>

The results of this study provide an inventory of areas in which actionable, evidence-based policy is possible. The study intends to provide a useful inventory of topics on which there exists sufficient research evidence, along with policy recommendations put forth by multiple stakeholders, thus improving prospects for meaningful evidence-based reform. Second, the study illustrates evidence-based interventions that deserve more serious attention from policymakers. Finally, the study highlights areas where policy recommendations require a more substantial evidence base.

> See **Appendix B** for a full list of the results.

Figure 2. Scoping Study Diagram

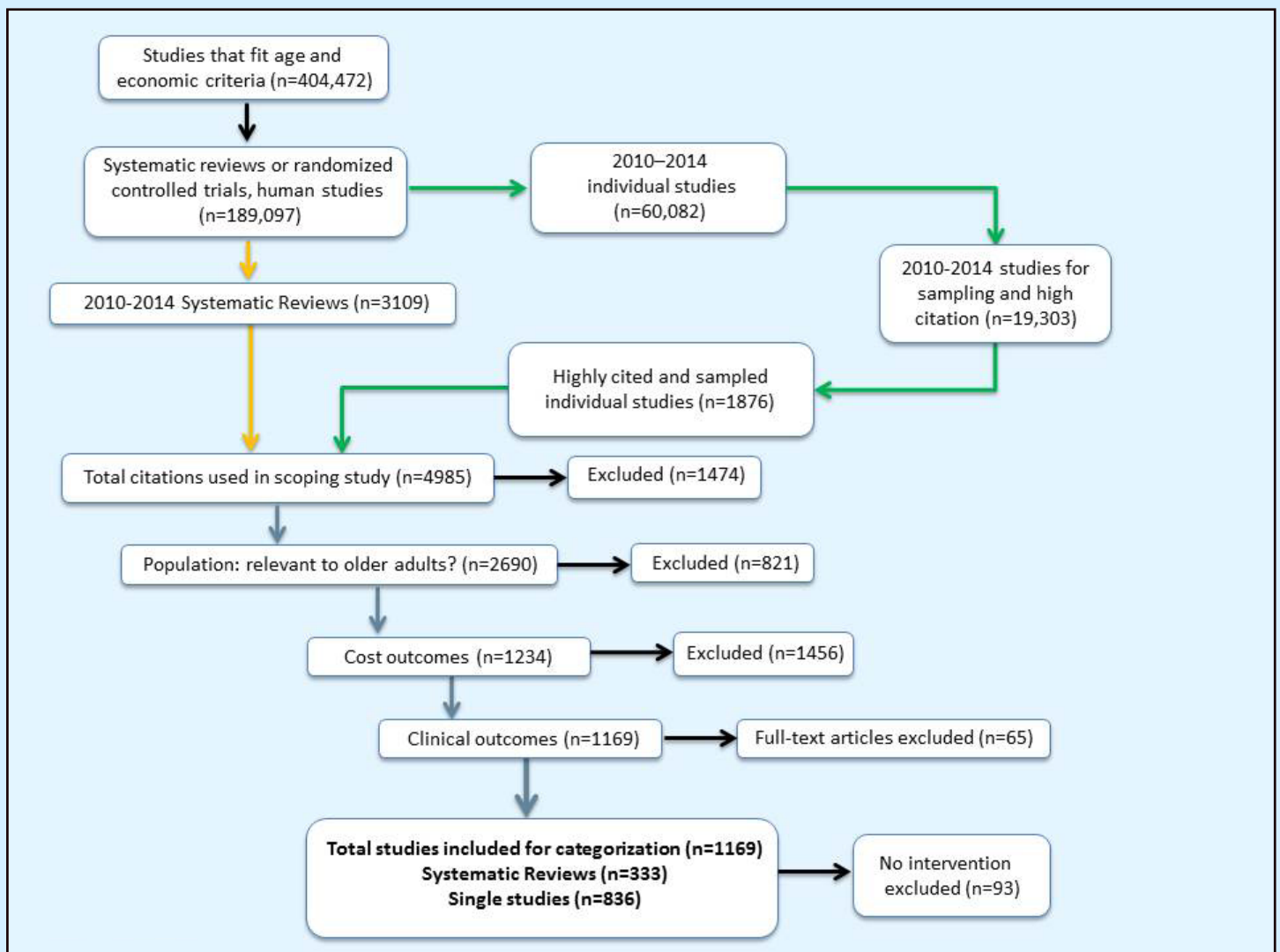
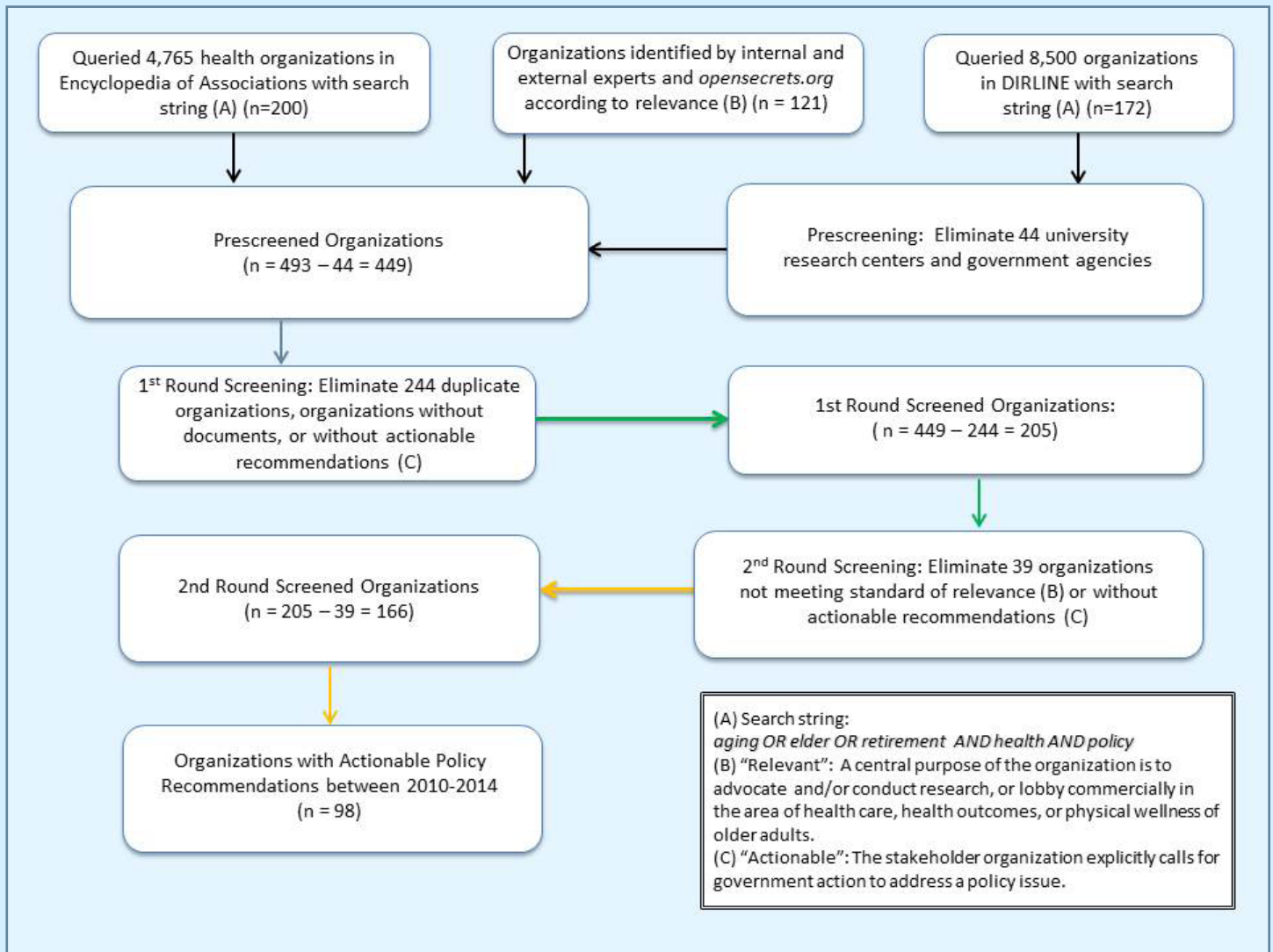


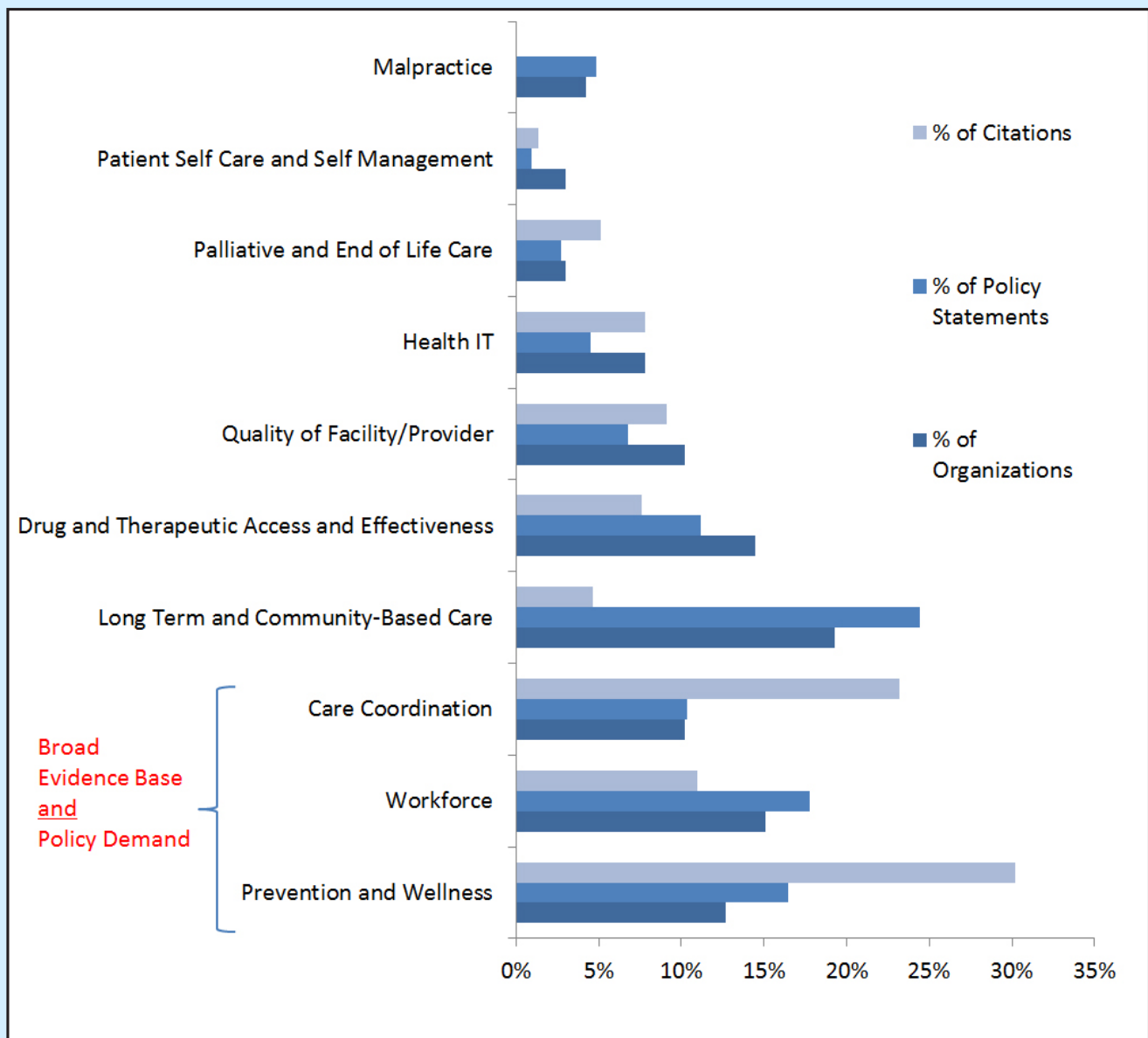
Figure 3. Policy Scan Diagram



Where Evidence and Policy Meet

Numerous opportunities exist for evidence-based policymaking that will improve the quality and affordability of care for the older adult population in the United States. In particular, the study found a sizable basis of both research evidence and policy demand on interventions related to **prevention and wellness**, the healthcare and informal **caregiver workforce**, and **care coordination** (results are summarized in **Figure 4**). Within each of these major topics, the study also identified focus areas where policymakers and researchers should invest the greatest amount of time and energy in developing actionable evidence-based policy proposals.

Figure 4. Results of Scoping Study and Policy Scan, by Major Topic



Realizing the Value of Prevention and Wellness Services

Prevention activities seek to avoid the onset of disease entirely, detect the onset of disease early through screening, and stop disease from progressing or worsening. In addition to healthcare services such as cancer screening and vaccinations, patient education to promote nutrition and physical activity can help prevent the onset or worsening of disease. Within prevention and wellness, the study revealed three focus areas where there exists an especially strong evidence base and high policy demand: **screening and early detection; nutrition and diet; as well as patient education, empowerment, and physical activity.**

Focus Area: Screening and early detection

Screening and early detection refer to a broad range of instruments—including exams, tests, and clinical guidelines—used to identify a disease in individuals who do not have symptoms. While not all screenings have proven effective, employing evidence-based detection techniques has the potential to improve health outcomes and lower the cost of treatment by detecting and mitigating the progression of numerous diseases associated with aging, including multiple forms of cancer, cardiovascular disease, chronic kidney disease, diabetes, hepatitis, as well as Alzheimer's, dementia, depression, and alcohol abuse.

Examples of Policy Levers:

- Ensuring that national clinical guidelines adequately include evidence-based screening procedures for age-related diseases
- Expanding public awareness campaigns to drive early detection
- Eliminating Medicare beneficiary copays for preventive screening procedures
- Expanding community health programs that provide access to screening in low-income communities

Active Organizations:

American Association of Retired Persons (AARP), Colorectal Cancer Coalition; American Urological Association; Association of Asian Pacific Community Health Organizations; American Society of Nephrologists; Association of Jewish Aging Services of North America; Alzheimer's Foundation of America

[<See Full Results>](#)

Focus Area: Nutrition and diet

Research on nutrition and diet has revealed a significant linkage between dietary components and health risks associated with aging. Randomized controlled trials have shown, for instance, that reducing sodium intake by 3 grams per day is projected to reduce the annual number of new cases of Coronary Heart Disease by 60,000 to 120,000, stroke by 32,000 to 66,000, and myocardial infarction by 54,000 to 99,000. Other studies illustrate dietary components, such as fiber and Vitamin D, which reduce age-related health risks and the costs of healthcare. Interventions using oral nutritional supplements (ONS) have also led to significant reductions in hospital admissions and readmissions, particularly in older patient groups. Finally, nutritional education or advice about diet has been shown to contribute to affect physical function and eating habits within the aging population.

Examples of Policy Levers:

- Updating FDA Nutrition Facts Panel to list essential vitamins and minerals of public health significance, shift daily values (DVs) for sodium, and revise serving sizes
- Updating Dietary Guidelines Advisory Committee (DGAC) recommendations on consumption of cholesterol, milk products, red and processed meats
- Providing practical advice to consumers on how to follow DGAC recommendations when eating at restaurants
- Removing federal five-year bar for lawfully present immigrants from Medicaid, the Supplemental Nutritional Assistance Program, Medicare, and Insurance Exchanges
- Directing additional resources to senior nutrition programs for congregate and home-delivered meals
- Expanding Commodity Supplemental Food Program (CSFP) to reach seniors in all fifty states
- Supporting programs to encourage purchase of fruits and vegetables
- Incentivizing SNAP use at farmers' markets

Active Organizations:

Trust for America's Health, Partnership for Prevention, National Association of Nutrition and Aging Services Programs, Generations United, Association of Asian Pacific Community Health Organizations

[<See Full Results>](#)

Focus Area: Patient Education, Empowerment and Physical Activity

Engaging older adults and their peers to monitor and improve their own health has been shown to reduce adverse health events in a variety of settings. Randomized controlled trials of peer coaching for low-income patients with diabetes show substantial improvement in glycemic control. Community-based risk assessment and education sessions provide evidence of significant declines in hospital admission for events such as acute myocardial infarction, stroke, and congestive heart failure, among others. Self-monitoring interventions such as the Cardiovascular Health Awareness Program (CHAP) has been shown to reduce cardiovascular morbidity at the population level.

Examples of Policy Levers:

- Providing Medicare coverage for patient and caregiver education
- Expanding support for evidence-based intervention campaigns

Active Organizations:

American Society of Clinical Oncology, Association of Jewish Aging Services of North America, American Public Health Association

[<See Full Results>](#)

Adapting the Caregiver Workforce for an Aging Population

Labor accounts for approximately 60 percent of healthcare costs in the United States, making an efficient and effective workforce a critical policy priority, particularly for complex geriatric patients. Policy interventions that could affect the use of new models of care include: **expanding the role of family caregivers; leveraging the unique skills of the nursing profession; training the workforce in geriatric competencies; coordinating interprofessional teams to manage care; and identifying opportunities for engaging community health workers.**

Focus Area: Family Caregivers

A significant body of research indicates that informal caregivers – people who spend a great deal of unpaid time assisting a parent, spouse, or child with personal care and other routine needs – can play an important role in improving the quality of their loved one’s healthcare and minimizing the need for costly institutional care. Yet studies have shown that caregiver effectiveness can be measurably improved with structured training programs, palliative care interventions, and support groups. Educational and behavioral interventions can also help to address knowledge gaps and can also mitigate caregiver-specific health risks, including higher levels of stress, chronic physical health disease, depression, and anxiety, which increase the risk of hospitalization, emergency department use, and other unplanned care that contributes to unnecessary healthcare costs.

Examples of Policy Levers:

- Providing Medicare reimbursement to cover survivorship services
- Expanding eligibility for programs such as family and medical leave, which enable intergenerational caregiving
- Expanding implementation of programs like the Resources for Enhancing Alzheimer's Caregiver Health (REACH)
- Developing publicly funded programs that allow participants to hire family members as caregivers
- Establishing a program to train and compensate family caregivers

Active Organizations:

AARP, Generations United, American Society of Clinical Oncology, national Association of Nutrition and Aging Services Programs, Alzheimer's Foundation of America, Eldercare Workforce Alliance, Paraprofessional Healthcare Institute, American Academy of Physician Assistants

<See Full Results>

Focus Area: Nursing

Nurses bring a unique set of skills to bear in caring for the aged. There exist an array of interventions that leverage and support nursing practice to improve the affordability and quality of healthcare. Clinical effectiveness research has shown that home-based, nurse-led health promotion can significantly reduce the cost of care as well as the risk of adverse health events. Nurse-delivered collaborative care provides effective treatment across a range of long term behavioral and physical health conditions. Nurses with specialized skills, training, and scope of practice can help to reduce hospital visits and improve outcomes related to chronic conditions like diabetes and coronary artery disease. Finally, appropriate staffing levels and work environment have been shown to reduce rates of heart failure.

Examples of Policy Levers:

- Permitting non-physician practitioners (NPPs) to practice to the full extent of their training
- Amending the Nurse Reinvestment Act to include educational and financial assistance, establish a national nursing database, and enhance number of nurse educators
- Expand the public Health Service Act's Title VIII Geriatrics Nursing Workforce Development Programs

Active Organizations:

American Association of Nurse Life Care Planners, American Holistic Nurses Association, American Healthcare Association, American Hospital Association, Eldercare Workforce Alliance, Center for Bioethics

[<See Full Results>](#)

Focus Area: Geriatric Competency

The increasing demand for geriatric competencies is well established. Barriers to geriatric training within the medical field place the supply of trained specialists well behind the demand. Nevertheless, models of effective geriatric training exist. For instance, since their inception in 1975, the Department of Veterans Affairs (VA)'s Geriatric Research, Education, and Clinical Centers have advanced geriatric training and clinical care. Elsewhere, programs such as Dementia for Medical Students offer an inexpensive and ready-to-implement training that has been shown to improve performance on AD patient-case simulations.

Examples of Policy Levers:

- Congressional and state legislative investigations into the adequacy and appropriateness of geriatric workforce training and education on content and modalities of delivery
- Modifying standards of state licensing boards to require professional competence or training in caring for older adults
- Supporting and expanding education and training programs at federal and state level to develop gerontological workforce, including Titles VII and VIII of the Health Resources and Services Act.
- Developing CMS requirements for geriatric competencies and dementia training for primary care clinicians and staff to improve detection, treatment, and care for individuals with Alzheimer's disease
- Funding geriatric training programs for physicians, dentists, and behavioral and mental health professions

Active Organizations:

American Association for Geriatric Psychiatry, Alzheimer's Foundation of America, American Public Health Association, Eldercare Workforce Alliance

[<See Full Results>](#)

Focus Area: Interprofessional Teams

A diverse range of interprofessional care models bring multiple specialists together to provide services, manage patient health, and share accountability for patient outcomes. Systematic reviews of the interdisciplinary Acute Care for Elders (ACE) model have shown significant reduction in functional decline, hospital stay, nursing-home discharges, and costs. Outside unit-based interventions, models in which guided-care nurses work in partnership with patients' primary care physicians have also been effective at reducing episodes of home healthcare. Remote physician-pharmacist team-based care has also proven effective at improving cholesterol levels in diabetes patients. Workforce reforms that support such interdisciplinary approaches to care show are especially promising for improving specific health outcomes in patients with multimorbidity.

Examples of Policy Levers:

- Requiring the Secretary of Health and Human Services to make grants to the states to support the establishment and maintenance of interdisciplinary geriatric mental health outreach teams in community settings where older adults reside or receive social services.
- Requiring training programs certified by state licensure boards to place a greater emphasis on communication and interpersonal problem-solving skills in order to strengthen caregiving relationships
- Incentivizing workforce training focused on unique social, physical, and mental healthcare needs of older adults.

Active Organizations:

American Holistic Nurses' Association, Society for Post-Acute and Long-Term Care Medicine, Elder-care Workforce Alliance, Paraprofessional Healthcare Institute

[<See Full Results>](#)



Focus Area: Community Health Workers

In a fragmented health system, older adults—especially those with multiple, complex conditions—could benefit substantially from the support of community health workers who serve as “system navigators.” Navigator roles for aging and chronically ill patients have developed relatively recently, yet they show promise in helping to patients to manage their health, from serving as peer health coaches and assisting with transitions across care settings. Randomized controlled trials have also shown significant reductions in glycemic control for low-income patients with diabetes.

Examples of Policy Levers:

- Ensure seniors have adequate access to community-based supports and services that keep enable aging-in-place
- Using authority of public health agencies to make evidence-based musculoskeletal programs and resources available to public health and healthcare workers

Active Organizations:

American Association of Service Coordinators, American Public Health Association

[<See Full Results>](#)

Coordinating Care to Improve Age-Related Health Outcomes

Fragmentation in the healthcare system between settings and even between professional groups has been proven as an indicator for poor quality, higher costs, and lower health outcomes. Lack of coordination can result in the failure to deliver necessary services and overtreatment that exposes patients to unnecessary risks and costly hospital readmissions. Care coordination, in its most basic form, involves deliberately integrating the activities of two or more participants involved in a patient’s care to provide appropriate and timely care. Typically, care coordination activities fall within the clinical domain, but there are many policy levers that can influence how clinicians provide services to improve the patients’ value of care.

The study revealed several strong opportunities for evidence-based policy related to care pathways and bundles, disease management programs, specialized units, discharge coordination and patient navigation, and coordinated delivery of primary care. Learning from the evidence base what interventions improve care coordination, including the results of ongoing demonstration programs, will inform which policy levers could be most effective.

Focus Area: Care Pathways and Bundles

Care pathways are detailed, evidence-based, multidisciplinary plans for the treatment of a particular patient over time and in multiple settings towards an anticipated outcome. For geriatric patients, these pathways often emerge from the results of a comprehensive geriatric assessment and can treat a variety of conditions, such as stroke, colorectal surgeries, hip fractures, and ventilator associated pneumonia. One example is the enhanced recovery after surgery (ERAS) pathway, which has been proven a cost effective strategy for treating patients with major colorectal surgeries. Related to care pathways are bundled payments, which define an “episode of care” and provide a global payment to cover the costs for the episode. This transfers the risk of care from the payer to the healthcare provider to provide the highest quality care at the lowest cost. The payments can include one setting or span across multiple healthcare settings, which are jointly at risk for the care. These bundles have often been developed around identifiable episodes, such as congestive heart failure or knee replacements.

Examples of Policy Levers:

- Expanding effective demonstration programs nationally that employ bundled payments, such as the Acute Care Episode (ACE) bundled payment demonstration.
- Phasing in alternatives to fee for service payment, such as bundled payments, within Medicare and Medicaid.
- Exploring new opportunities for demonstration programs to incentivize adoption of evidence-based care pathways.

Active Organizations:

American Association of Kidney Patients, National Academy of Social Insurance, America’s Health Insurance Plans

[<See Full Results>](#)

Focus Area: Disease Management Programs

Disease management programs focus on coordinating treatments for one or multiple chronic conditions, such as cancer, COPD, and heart failure in which patient self-care is central for success. Models such as integrated disease management (IDM) establish an integrated care program of self-management, exercise, and nutrition in which multiple healthcare providers collaborate to provide care. These programs require both interventions with patients as well as organizational changes to be effective. When applied to COPD, IDM interventions were proven to significantly improve quality of life and reduce respiratory-related hospital admission and stay. Disease management programs are typically implemented through managed health plans or government payers. Policy levers to create or incentivize effective disease management programs have the potential to improve patient health outcomes and decrease healthcare spending.

Examples of Policy Levers:

- Providing coverage for cancer care planning and coordination under Medicare.
- Development and implementation of national standards for treatment summary and care plan templates.
- Coordinating and integrating health and long-term services and supports for individuals living with Alzheimer's Disease.
- Incentivizing the development of chronic-care system interventions such as Money Follows the Person that promote patient-centered care.

Active Organizations:

American Society of Clinical Oncology, Alzheimer's Foundation of America, American Association for Geriatric Psychiatry

<See Full Results>

Focus Area: Primary Care Coordination

Improving access to comprehensive primary care has been identified as a model for improving quality and safety outcomes in the aging population. The research literature suggests that the targeted use of medical homes for several chronic conditions, including congestive heart failure, major depression, and diabetes mellitus can be effective for improving health outcomes for the elderly. Collaborative care management, which is a nurse-delivered model that coordinates physical and mental healthcare for depression and other multi-morbid conditions, has been proven as another cost-effective approach to coordinate care.

Examples of Policy Levers:

- Expanding access to patient-centered medical homes in public and private health coverage.
- Aligning requirements for Medicare Shared Savings Program ACOs with current requirements for medical homes or collaborative care models.

Active Organizations:

America's Health Insurance Plans, Association of Asian Pacific Community Health Organizations

<See Full Results>

Focus Area: Care Transitions and Patient Navigation

Moving patients from one healthcare setting to another or back into the community is a high risk situation with great potential for poor quality and outcomes. Care transition programs, including discharge planning, as well as patient navigation programs are designed to help at-risk patients transfer between levels and settings of care and navigate the complex healthcare system. Randomized controlled trials of transition-oriented interventions have been shown to reduce readmissions for complex chronic conditions. Particularly successful interventions involve assigning nurses as clinical managers and providing in-person home visits to discharged patients. Among others, transitional care programs designed for individuals with heart failure improve quality of life and decrease the number of readmissions and the overall cost of care.

Examples of Policy Levers:

- Expand or fund the use of evidence-based care-transition models through demonstration programs.
- Setting targeted readmission reduction goal for skilled nursing facilities.
- Eliminating Medicare's three-day prior hospitalization requirement for coverage of post-acute skilled nursing facility care.
- Counting all days in the hospital including those spent in observation status towards the Medicare three-day requirement.

Active Organizations:

American Healthcare Association, Center for Medicare Advocacy, American Medical Association

<See Full Results>



Evidence Searching for Policy Levers

Since 2010, biomedical and health services research has produced a wealth of potentially effective policy interventions that have received less attention from stakeholders and policy-makers. In many cases, the staggering number of research studies, researchers' ineffective dissemination of findings to policymakers, and policymakers' limited capacity to routinely scan the evidence base, have combined to make it difficult to scale these interventions into actionable policy recommendations. The Stern Center research team found this pattern to be particularly evident in the fields of **patient self-care, as well as palliative and end-of-life care.** In these areas especially, researchers, stakeholders, and policymakers should **collaborate to identify ways that public policy can better apply the insights of effective interventions.**

Supporting Palliative and End-of-Life Care

Palliative care is a holistic approach to care that focuses on relieving symptoms and easing stress for patients with serious illness. Hospice care is similar to palliative medicine, in that it focuses on managing the symptoms and reducing the suffering of a patient at the end-of-life. Hospice care can take place either in an individual's home or in an institutional setting. About 70 percent of Americans would prefer to die at home,¹⁰ but only about 25 percent actually die at home.¹¹ Approximately one-third of Medicare spending is on patients in their last two years of life. Conversations about preferences for end-of-life care are difficult and many Americans do not have an advanced directive expressing their preferences for care at the end-of-life. As a result, many patients at the end-of-life receive costly and painful healthcare interventions that do not truly respond to individual needs or wishes.

Focus Area: Palliative Care

A few studies have revealed that integrating palliative care into usual care settings can result in improved health outcomes, patient satisfaction, and cost. One pilot study of integrating on-site palliative care advanced practice nurses in the community oncology setting found significant decreases in hospitalization and mortality. A nationwide study also revealed that hospice-provided palliative care results in lower costs for terminal geriatric hepatocellular carcinoma patients. There is a small but emerging evidence-base for the effective deployment of palliative care programs in nursing home and community settings.

Remaining policy challenges include misaligned payment incentives and a lack of insurer coverage and reimbursement for palliative care, the failure of major quality metrics to include palliative care, financial barriers to third party payments for such care, and state-level policies that create barriers to essential pain medications in end-of-life settings.

[<See Full Results>](#)

⁹ J. Cloud, A Kinder, Gentler Death, Time, September 18, 2000, available from: <http://content.time.com/time/magazine/article/0,9171,997968,00.html>

¹⁰ National Center for Health Statistics, Health, United States, 2010, With Special Feature on Death and Dying, available from: <http://www.cdc.gov/nchs/data/hus/hus10.pdf>

Focus Area: Advance Care Planning

Patients often lose their capacity or ability to communicate their preferences on end-of-life care goals. Systematic reviews have suggested that written directives or non-resuscitate orders hold promise for addressing this problem and improving the quality of end-of-life care. Policies that support patients' preferences, however, will likely encompass more than written directives alone, however, and further research is required to evaluate the effectiveness of interventions that promote shared decision-making.

To date, the Physicians' Orders for Life Sustaining Treatment (POLST) paradigm has attempted to address these concerns, yet faces legal and political barriers to implementation in many states.¹²

[<See Full Results>](#)

Incentivizing Patient Self-Care and Self-Management

Patients with chronic disease account for a huge portion of healthcare spending in the US. Among older adults, 80 percent have at least one chronic condition.¹³ 99 percent of Medicare spending is attributable to individuals with at least one chronic condition, and 79 percent is attributable to individuals with 5 or more chronic conditions.¹⁴ Better management of chronic disease could help patients with complex, co-morbid conditions avoid unnecessary interactions with the healthcare system, such as costly trips to the emergency room. Patient self-care and self-management initiatives encourage patients to work with their providers to maintain their health status and minimize avoidable complications. These initiatives utilize strategies, such as patient education, to encourage healthy decisions and behaviors.

Patient Self-Care and Self-Management Interventions

Behavioral Adherence Contracts:

Behavioral contracts are often used to achieve patient adherence to medications or treatment plans by identifying motivations or positive reinforcements, problems and barriers that interfere with adherence, social supports to assist in adherence, reminder strategies, and identification of the consequences for non-adherence. These contracts have been effective in improving adherence among renal transplant recipients undergoing immunosuppressant therapy.

¹² National POLST Paradigm Task Force, POLST Legislative Guide, Approved February 28, 2014, available from: <http://www.polst.org/wp-content/uploads/2014/02/2014-02-20-POLST-Legislative-Guide-FINAL.pdf>

¹³ Centers for Disease Control, Chronic Disease Overview, available from: <http://www.cdc.gov/chronicdisease/overview/>

¹⁴ G. Anderson, Chronic Care: Making the Case for Ongoing Care, Robert Wood Johnson Foundation and Johns Hopkins University Bloomberg School of Public Health Report, 2010, available from: <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583>

Supported Self-Management:

Whereas traditional self-management is not typically effective for severe chronic conditions, such as COPD, supported self-management interventions combine traditional self-management activities with training, led by a nurse or a facilitator. These techniques have been shown to improve quality of life in patients managing multimorbidity.

E-Patient Communication Tools:

Participatory interventions using Web 2.0 applications can enable older adults to share disease management information and receive interactive health advice. While additional randomized controlled trials are necessary, recent studies have suggested that such communication tools hold promise for managing some chronic diseases.

[<See Full Results>](#)

Policy Recommendations Searching for an Evidence Base

Numerous policy proposals related to the health of the aging lack a foundation in rigorous evidence. For a variety of reasons, including the difficulty of systematically evaluating or modeling age-related health policies, policymakers will continue to face obstacles to evidence-based decision-making. Researchers of this study found this to be particularly true for proposals related to **malpractice and the financing of long-term care.** In these areas, researchers and policymakers alike **should support efforts to conduct systematic research and rigorous evaluation of pilot interventions at the local, state, and federal levels.**

Malpractice Reform: Can It Safely Eliminate the Costs of Defensive Medicine?

Defensive medicine – a practice in which physicians order excessive or unnecessary tests and treatments out of fear of a potential lawsuit – leads to somewhere between \$45.6 to \$650 billion per year in healthcare system spending. Proposals to reform malpractice often focus on creating evidence-based standards of care that would limit the liability of doctors who adhere to these standards.¹⁵

A cost effective, high-value healthcare system would ideally eliminate wasteful and unnecessary care associated with the practice of defensive medicine. **However, there are considerable gaps in the evidence base on the potential consequences of malpractice reform on the costs and quality of care.** To address this problem, some organizations have suggested expanding demonstration and incentive programs to test alternative medical liability systems following the Patient Protection and Affordable Care Act authorization of \$50 million for this purpose. However, the \$50 million has yet to be appropriated. As part of the funding for demonstration projects, the Agency for Healthcare Research and Quality (AHRQ) has awarded \$25 million for pilot programs to improve patient safety and reduce the number of medical liability lawsuits filed. The results of at least four of these programs are showing initial potential, but comprehensive analysis has yet to be conducted.¹⁶

¹⁵ Bipartisan Policy Center, What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth, 2012 Report, available from: <http://bipartisanpolicy.org/library/what-driving-us-health-care-spending-americas-unsustainable-health-care-cost-growth/>

¹⁶ Agency for Healthcare Research and Quality, Patient Safety and Medical Liability Initiative, Summary of Findings, June 2014, available from: http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/liability_initiative.html



Malpractice Reform Proposals In Need of Rigorous Evaluation

Pre-Dispute Arbitration Agreements: Anecdotal evidence indicates that group-practice physicians have responded to rising malpractice premiums by increasing the volume and unit-price of services they perform.¹⁷ To address these concerns, several policy recommendations support the use of written contracts in which healthcare providers and patients agree to use less-costly arbitration procedures rather than litigation to settle claims. Yet it remains difficult to identify studies that illustrate a clear relationship between the usage of arbitration and costs or health outcomes.

Evidence-Based Standards and Liability Exemptions: Another policy option the study identified was to grant physicians a legal presumption that they have acted appropriately if their actions adhere to evidence-based clinical standards. Maine's Medical Liability Demonstration Project, for instance, adopted 20 practice guidelines in four specialties and provided physicians adhering to these guidelines an affirmative defense against malpractice claims. Studies of the project, however, did not show significant reductions in defensive medicine practice or malpractice claims.¹⁸

Health Courts and Neutral Medical Experts: Initially introduced in the 1970s, no-fault health courts are already in place in Sweden, Denmark, and New Zealand. These courts employ neutral experts in medicine and epidemiology to review claims before an administrative law judge. Some models for health courts include a centralized database of past decisions to improve efficiency. More incremental reform proposals would incentivize courts to retain their own neutral medical experts at trial. Evidence on the effectiveness of alternatives to the adversarial system of adjudicating malpractice claims exist in states like Virginia and Florida, but evidence on the effectiveness of these systems is limited.¹⁹

[<See Full Results>](#)

¹⁷ M. Mello, A. Chandra, A. Gawande et al., National Costs of the Medical Liability System, *Health Affairs* 2010; 29(9):1569-1577

¹⁸ T. Mackey and B. Liang, The Role of Practice Guidelines in Medical Malpractice Litigation, *AMA Journal of Ethics* 2011; 13(1):36-41.

¹⁹ L.A. Miller, Health Courts: an Alternative to Traditional Tort Law, *Journal of Perinatal and Neonatal Nursing* 2011; 25(2):99-102.

Financing Long-Term Care: Is There an Evidence-Based Paradigm for Reform?

Long-term services and supports (LTSS) encompass a range of services needed by individuals with cognitive and functional limitations. As the population ages, the number of Americans who need LTSS will more than double in the coming decades, rising from 12 to 27 million by 2050.²⁰ **The impact of this increase for aging individuals and their loved ones will be profound.** LTSS care is often delivered in an institutional setting, which is very costly for patients and families – nursing home care costs approximately \$90,000 annually, and home health aide services cost \$21,000 annually.²¹ Though many individuals in need of LTSS receive care at home from family caregivers, these individuals are often unpaid and untrained.

Taxpayer-funded programs that support LTSS will also experience strain. Currently, Medicaid is the largest payer for LTSS in the United States. In 2012, the US spent \$220 billion on LTSS, approximately 61 percent of which was paid by the Medicaid program.²² Yet whereas Medicaid spending on LTSS grew by 1 percent per year between 2002 and 2012, the Congressional Budget Office estimates a growth rate of 5.5 percent per year between 2013 and 2023.²³

Access to long-term care insurance remains limited. Few individuals have access to the kind of insurance products that would allow them to pay for the kind of LTSS they are likely to need. Currently, Medicare covers only short-term skilled nursing for 100 days and home healthcare needs after an acute care episode. Medicaid pays for a majority of long term care in the US and provides a safety net for those who are impoverished by the cost of long term care. Because of this financing structure, a great deal of policy activity in long term care is happening at the state level, as state leaders use policy levers such as Medicaid waivers to deliver LTSS in innovative ways. However, many significant gaps remain. Few resources are directed toward supports for family caregivers. In the private marketplace, the combination of financial risks and adverse-selection problems has made premiums for long-term care insurance prohibitively high. Moreover, the poor performance of the short-lived Community Living Assistance Services and Supports (CLASS) program suggests major challenges for achieving comprehensive long-term care reform at the federal level. Finally, the existence of Medicaid as a “second payer” for long-term care services has contributed to the crowding out of demand for long-term care insurance.²⁴

While meaningful LTSS reform is a major policy priority for many organizations in the study, the evidence base on the effects of proposals to reform the system for insuring long-term care is limited particularly at the federal level. All states are engaged in some effort to rebalance their long term care systems to care for beneficiaries at home rather than in an institutional setting.

²⁰ U.S. Senate, Commission on Long-Term Care, Report to Congress.

²¹ E. Reaves and M. Musumeci, Medicaid and Long-Term Services and Supports: A Primer, Kaiser Family Foundation, May 2015 Report, available from: <http://files.kff.org/attachment/report-medicare-and-long-term-services-and-supports-a-primer>

²² Id.

²³ Congressional Budget Office, Rising Demand for Long-Term Services and Supports for Elderly People, June 2013 Report, p. 25, available from: <http://www.cbo.gov/publication/44363>

²⁴ W. Yin, Strengthening Risk Protection Through Private Long-Term Care Insurance, Hamilton Project Discussion Paper, June 2015, available from: http://www.brookings.edu/~media/research/files/papers/2015/06/thp-retirement-series/yin_private_long_term_care_insurance.pdf

In 2012, close to half of all Medicaid LTSS spending was for home and community based services (HCBS).²⁵ A number of states are using managed care as a strategy to promote greater integration and efficiency in Medicaid LTSS delivery systems, but evidence on the effectiveness of these programs is limited. Fewer than 10 states have had a managed Medicaid LTSS program in place for over a decade. Studies of long running, well-established MLTSS program have shown mixed results on indicators such as cost savings, utilization and quality, though some programs have demonstrated modest improvements in preventable hospitalizations and emergency room visits.²⁶ To date, over 20 states have implemented or are considering implementation of a Medicaid MLTSS program. Some evidence indicates that states with a long-running, extensive HCBS programs are able to slow Medicaid long term care spending growth more effectively than states which rely predominantly on institutional services.²⁷

Numerous proposals exist for expanding the availability of long-term care insurance. Yet further research is needed to determine the costs and benefits of each. In particular, studies should evaluate the following aspects of each proposal:

- **Affordability for Consumers and Taxpayers:** How likely is each proposal to generate affordable coverage for those who require long-term care while reducing the expanding burden of public spending on long-term care?
- **Eligibility:** How will each proposal ensure that those who need long-term care can access it? How many activities of daily living (ADL) should trigger eligibility for tax credits or social insurance? How long must an individual require assistance prior to eligibility? What should the standards be for determining individuals' likely needs for future assistance? How should mental health status inform eligibility decisions?
- **Coverage:** How likely is each proposal to ensure that insurance covers an adequate mix of LTSS? LTSS could include skilled nursing facility care; home health care; personal care attendants; care management and coordination; adult day centers; and respite options for family and volunteer caregivers.
- **Quality:** How will the proposal affect the quality of LTSS delivery? How likely is each proposal to incentivize coordinated, patient-centered care?

²⁵S. Eiken et al., Medicaid Expenditures for Long-Term Services and Supports in FFY 2012, CMS and Truven Analytics, April 2014, available from:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf>

²⁶ R.L. Kane et al. Patterns of utilization for the Minnesota senior health options program. *J Am. Geriatr. Soc.* 2004; 52(12):2039–2044; R.L. Kane et al. The quality of care under a managed-care program for dual eligibles. *Gerontologist* 2005; 45(4):496–504; R.L. Kane, Outcomes of managed care of dually eligible older persons. *Gerontologist* 2003; 43(2): 165–174; W.G. Weissert et al. Cost savings from home and community based services: Arizona's capitated Medicaid long-term care program. *J. Health Polit. Policy Law* 1997; 22(6):1329–1357.

²⁷ H.S. Kaye et al. Do noninstitutional long-term care services reduce Medicaid Spending?, *Health Affairs* 2009; 28(1):262–272.

Long-Term Care Insurance Proposals

Federal Policy Levers

Medicare Part A Expansion: This option, financed through the Medicare payroll tax and new premiums, would create a comprehensive LTSS benefit that would be triggered when physicians certify that individuals meet eligibility criteria. One proposal advanced by the Senate Commission on Long-Term Care would provide benefits to individuals who require assistance with at least two activities of daily living, have needed assistance for 90 days, and are likely to continue to need services. These benefits would be financed through the Medicare payroll tax and new premiums and would include “skilled nursing facility care or daily skilled care; home healthcare without the need for a skilled service; personal care attendant services; care management and coordination; adult day center services, respite care options to support family or other volunteer caregiver; outpatient therapies; and other reasonable and necessary services.”²⁸

Catastrophic Coverage: This option would create a Medicare Part A benefit that covers out-of-pocket expenses after a lengthy waiting period defined either in time (beneficiary has paid for three years of home care services) or expenditures (beneficiary has paid for \$50,000 in home care services). One study found that it took 6.8 years, on average, for LTSS users to spend down their assets and become Medicaid eligible.²⁹

Medicare Advantage Coverage: Incorporating LTSS coverage as a supplemental benefit in Medicare Advantage (MA) plans would highlight new methods of organizing care and emphasize the potential benefits of care integration. An example of an integrated program is the Program of All-Inclusive Care for the Elderly (PACE), which integrates acute and long term care for enrollees and is financed through capitated payments from Medicare and Medicaid. PACE initially demonstrated positive results³⁰ but was slow to expand and remains small, due to factors such as low awareness about the program and its services, a lack of financing alternatives to Medicaid, and competition from other service providers.³¹

Market Reforms: Complementary proposals for reforms aim to empower consumers of long-term care insurance marketplace by standardizing policies, creating electronic marketplaces, and developing consumer protections and appeals processes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required some standardization of LTC insurance plan eligibility triggers as a condition of preferred tax treatment.³²

²⁸ U.S. Senate, Commission on Long-Term Care, Report to Congress, September 2013, pp. 66-67.

²⁹ J. Wiener et al., Medicaid Spend Down: New Estimates and Implications for Long-Term Services and Supports Financing Reform, Prepared for the SCAN Foundation by RTI International, March 2013, available from: <http://www.thescanfoundation.org/rti-international-medicaid-spend-down-new-estimates-and-implications-long-term-services-and-supports>

³⁰ C. Eng et al., Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing, *Journal of the American Geriatric Society* 1997 Feb; 45(2):223-32.

³¹ G.L. Gross et al., The Growing Pains of Integrated Health Care for the Elderly: Lessons from the Expansion of PACE, *Milbank Quarterly* 2004 Jun; 82(2): 257-282.

³² M. Cohen et al., The Historical Development of Benefit Eligibility Triggers Underlying the CLASS Plan. The SCAN Foundation, Spring 2011, available from:

http://www.thescanfoundation.org/sites/default/files/TSF_CLASS_TA_No2_History_Benefit_Eligibility_FINAL.pdf

State Policy Levers

Tax Credits for Long-Term Care Policies: Organizations like America’s Health Insurance Plans (AHIP) recommend subsidizing the purchase of long-term care through refundable tax credits in order to enhance access to private long-term insurance. These credits could guarantee that assistance is available to individuals, regardless of whether or not they owe federal taxes. Savings in Medicaid costs could also be used to finance the tax credits. According to one AHIP study, 75 percent of Americans do not believe that it is “the government’s responsibility to pay for the long-term care needs of everyone,” and about half of respondents over 50 supported tax incentives to purchase LTC insurance.³³ Nearly half of states offer some form of tax deduction or credit to purchase LTC insurance, which results in an average reduction in cost of 5 percent and an estimated increase of 2.7 percent in the purchase of private LTC plans. However, most of this increase is attributed to individuals at the upper end of the income distribution who have a minimal risk of spending down into Medicaid.³⁵

Long-Term Care Partnership Programs: These programs allow individuals to purchase long-term care insurance and protect some of their assets if they exhaust their insurance coverage and spend down into Medicaid eligibility. Over 40 states currently participate in the Partnership Program, but less than 10 percent of active LTC insurance policies are partnership plans.³⁶ It is unknown whether the Partnership Program has increased the purchase of private LTC.³⁷ Connecticut was one of the first four states to implement that partnership program in the 1990s. Over the first nearly 20 years of the program in Connecticut, out of 53,064 purchased policies, only 95 claimants used up their private benefits and spent down into Medicaid.³⁸

Medicaid Carve Out: This approach would give individuals the opportunity to use their expected Medicaid benefits as a subsidy to purchase permanent long-term care insurance in exchange for the right to future Medicaid LTSS.

[<See Full Results>](#)

³³ America’s Health Insurance Plans, *Who Buys Long-Term Care Insurance in 2010–2011? A Twenty Year Study of Buyers and Non-Buyers (In the Individual Market)*, March 2012, available from: <https://www.ahip.org/WhoBuysLTCInsurance2010-2011/>

³⁵ Id.
³⁶ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Long-Term Care Insurance*, ASPE Research Brief, June 2012, available from: <http://aspe.hhs.gov/daltcp/reports/2012/ltcinsRB.pdf>

³⁷ Id.

³⁸ Id.

Conclusion

Unless policymakers take action soon, changes in the care needs of the aging population will likely push our current healthcare system to its breaking point—with significant and negative consequences for older adults and their families.

This study identifies immediate and medium-term opportunities to adapt to this generational and demographic shift with actionable, evidence-based reforms to:

- **Expand prevention and wellness efforts;**
- **Address gaps in the caregiver workforce; and**
- **Improve care coordination.**

Further collaboration between policymakers and researchers in these focus areas is likely to yield success in improving the health of our aging population.

There are also **opportunities for more long-term investment in policy development and analysis.** In focus areas such as patient self-management and palliative care, policymakers and researchers alike can work together to generate policy solutions by using and expanding the existing evidence base. Finally, policy recommendations on subjects like malpractice reform and long-term care reform may require more rigorous analysis prior to implementation.

Building on the results of this study, future research at the Stern Center of Evidence-Based Policy will focus on:

- **Policy-focused systematic reviews** to identify timely interventions that effectively improve the cost and quality of healthcare.
- **Pilot Studies** of cutting-edge interventions that are likely to reduce healthcare utilization costs and improve health outcomes;
- **Modeling of policy options to demonstrate** the effects of evidence-based policy choices on long-term socioeconomic trends affecting providers and patients; and
- **Dissemination of** policy recommendations based on rigorous evidence to a broad range of policy stakeholders at multiple levels of government.

Appendix A: Research Methodology

This study resulted from a two-year combined effort of a multidisciplinary research team to identify, without bias, the universe of scientific evidence and policy recommendations that may reduce health-care costs and maintain or improve health outcomes in the target older adult population.

Scoping Study

The objective of the scoping study was to use existing systematic review techniques to scan research articles from across the entire domain of published biomedical and health services literature in order to capture all possible healthcare interventions that are relevant to older adults and aim to reduce costs while maintaining or improving quality of care. Our study was comprised of three phases.

1. Researchers used PubMed to identify systematic reviews and individual studies that were published following passage of the Affordable Care Act (2010-2014). From an initial database of studies that met age and economic criteria (n=404,472), researchers identified all systematic reviews (n=3,109) and individual studies (n=60,082). All individual studies in the top 5% of highly cited articles as well as a random sample of 5% of articles added to PubMed in their publication year were then identified (n=1,876).

2. All studies that were relevant to older adults, included cost and clinical outcomes, and contained interventions were included for review (n=1169).

Policy Scan

Building on major studies by the Patient-Centered Outcomes Research Institute (PCORI) and the Institute of Medicine (IOM) and parallel work by McCabe et al. (2007), the Policy Scan identified actionable policy recommendations relevant to the healthcare of older adults in the United States from a diverse set of relevant organizations.³⁹ We defined relevant organizations as those whose central purpose is to advocate and/or conduct research, or lobby commercially, in the area of healthcare, health outcomes, or physical wellness of older adults. This included advocacy organizations (e.g. American Association of Retired Persons), industry groups (e.g. America's Health Insurance Plans), professional associations (e.g. American Medical Association) and think tanks or non-government policy organizations (e.g. Bipartisan Policy Center). Actionable recommendations were those in which organizations explicitly called for government action to achieve goals of efficiency, effectiveness, equity, and responsiveness. Our study was comprised of four phases.

1. Researchers queried organizations indexed by the Encyclopedia of Associations, DIRLINE, and OpenSecrets.Org, as well as organizations identified by internal experts, to identify a unique set of relevant organizations making actionable policy recommendations. An initial analysis of 493 organizations identified by searching databases of the Encyclopedia of

³⁹O.L. McCabe, A.K. Page, A.S. Daniels, Improving health care for mental and substance use conditions: A framework for bridging the quality chasm, *International Journal of Mental Health* 2007; 36(2): 65-79.

Associations, Opensecrets.org, and DIRLINE was supplemented by data provided by internal experts. After applying inclusion and exclusion criteria, the research team arrived at a final list of 98 organizations with documented policy recommendations.

2. The sources of documented policy recommendations included publicly available documents included in downloadable files, webpages, and other written statements made by the organizations. Saved files were classified by organization and received a document number. A total of more than 400 documents were placed in a data repository and profiled with basic descriptive statistics.

3. Policy recommendations were extracted from documents by coders and entered individually into Excel spreadsheets, which were later exported into IBM SPSS 21 for statistical analysis. To be included, policy recommendations had to be actionable, relevant to an older adult population, and health-related. This yielded more than 600 recommendations that were sorted into different policy categories and subcategories by three independent coders. Recommendations were then matched with studies identified in the scoping study.

Developing Policy Categories

Because most biomedical and health services studies are not typically conducted with the policy process in mind, it was necessary to develop broad policy categories in order to sort and match research studies and policy positions. By developing a method to assign biomedical articles and policy recommendations to the same categories of health policy, it is possible to identify areas where policy demand is high and the evidence base is broad. For this study, broadly applicable categories were developed as follows:

1. Researchers used existing research literature to identify 42 potential major topic categories.
2. An expert panel of 3 researchers then iteratively condensed this list of categories to 10 major topics.
3. Within each of the 10 major topics, this procedure was repeated to generate 75 subcategories, which are presented as focus areas in the analysis.
4. On the basis of the scoping study and policy scan the research team developed the set of focus areas detailed in Appendix B.

Section 1. Health Information Technology

Description: Information technology is taking on a larger role in healthcare both in healthcare facilities and in the homes of patients and caregivers. Policies around HIT include funding for IT capital investment, such as the HITECH Act, reimbursement for services via telehealth by government payers, and inclusion of IT strategy, particularly EHRs, within demonstration programs, such as the Patient Centered Medical Home (PCMH).

Decision support

- **American Hospital Association:** AHA must advocate for a significant national investment in developing methods to quickly and effectively translate standards and guidelines and changes as they emerge into the decision support tools embedded in the electronic health record (EHR).
- J. Avery, S. Rodgers, J. A. Cantrill, et al. (2012). A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. *Lancet*, 379(9823), 1310-9
- B. Clyne, M. C. Bradley, C. Hughes, et al. (2012). Electronic prescribing and other forms of technology to reduce inappropriate medication use and polypharmacy in older people: a review of current evidence. *Clinics in geriatric medicine*, 28(2), 301-22
- M. N. Walsh, N. M. Albert, A. B. Curtis, et al. (2012). Lack of association between electronic health record systems and improvement in use of evidence-based heart failure therapies in outpatient cardiology practices. *Clinical cardiology*, 35(3), 187-96
- J. Kryworuchko, E. Hill, M. A. Murray, et al. (2013). Interventions for shared decision-making about life support in the intensive care unit: a systematic review. *Worldviews on evidence-based nursing / Sigma Theta Tau International, Honor Society of Nursing*, 10(1), 3-16

Electronic health records

Development incentives for post-acute settings

- **Association of Jewish Aging Services of North America (AJAS):** FMAP provisions that were part of the American Recovery & Reinvestment Act (ARRA PL. 111- 5), included funding to hospitals and independent physician practice associations for improved health information technology services such as the introduction of electronic health records (EHRs) into respective health providers. However, several health disciplines, such as aging service providers, were not eligible to receive grants. AJAS will vigorously support efforts that will lead to the eligibility of providers of long-term services and supports.

- **American Healthcare Association:** To provide HIT funding to long term & post-acute settings comparable to the support acute & ambulatory care settings receive, plus direct the HHS Secretary to use discretionary funding to promote HIT adoption by long term & post-acute care providers.
- **American Healthcare Association:** AHCA/NCAL applauds the provisions in the Health Information Technology for Economic & Clinical Health (HITECH) Act included in the American Recovery & Reinvestment Act of 2009 (ARRA, now Public Law 111-5), which promote HIT adoption. Unfortunately, the HITECH Act leaves out long term and post-acute care providers. AHCA/NCAL urges Congress to remedy this oversight by providing comparable support for HIT adoption by long term and post-acute care as was ordered to providers in acute and ambulatory care settings. In the meantime, the Secretary of Health & Human Services (HHS) should use discretionary funding, perhaps from the Center for Medicare & Medicaid Innovation (CMI), to promote HIT in long term and post-acute care settings.
- **LeadingAge:** We support the Fostering Independence Through Technology (FITT) Act (S. 596) to promote Medicare savings through home health agencies' use of technology.
- Vedel, S. Akhlaghpour, I. Vaghefi, et al. (2013). Health information technologies in geriatrics and gerontology: a mixed systematic review. *Journal of the American Medical Informatics Association*, 20(6), 1109-19

Development incentives for providers

- **American Hospital Association:** The limited exception to the Stark law and the anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire Dec. 31, 2013. These regulatory provisions should be extended beyond the current expiration date.
- **American Academy of Physician Assistants:** The American Academy of Physician Assistants recommends that section 4201(a)(3)(B) of the Health Information Technology for Economic and Clinical Health (HITECH) Act be amended to extend the EHR Medicaid incentive payment to all physician assistants whose patient volume includes at least 30 percent Medicaid recipients.
- **Bipartisan Policy Center:** Assure health IT investments support electronic information sharing to meet the needs of new delivery and payment models- HHS should provide implementation support for such information sharing, with a particular focus on the needs of small physician practices and community hospitals.

Meaningful use

- **Association of Asian Pacific Community Health Organizations:** Include explicit alignment with HITECH meaningful use requirements. The HITECH Act provides incentives for hospitals and physicians to achieve "meaningful use of certified electronic health records." There is great potential for health information technology to improve communication and quality for underserved populations. Accordingly, we support the explicit alignment of the requirements for Medicare Shared Savings Program ACOs with the meaningful use requirements.
- **American Hospital Association:** The Stage 2 final rules also assess penalties for those who do not meet the meaningful use standards. By law, penalties begin in FY 2015; how-

ever, CMS will instead base penalties on whether hospitals met the meaningful use requirements two years earlier, or 15 months earlier for those attesting to meaningful use for the first time. The AHA strongly believes this unfairly accelerates the timeframe under which hospitals must meet meaningful use to avoid penalties.

- **American Hospital Association:** AHA believes that Stage 2 of meaningful use should not start until at least 75 percent of hospitals and physicians have successfully achieved Stage 1.
- **American Hospital Association:** Eligibility for Other Care Settings. The law establishing EHR incentive programs limited them to hospitals and physicians. As we move toward a more integrated healthcare system, additional settings of care also should receive support for transitioning to EHRs.
- **American Hospital Association:** AHA's ongoing advocacy efforts to ensure that the meaningful use and certification standards are within reach for the majority of hospitals and physicians.
- **American Academy of Physician Assistants:** Recommends that section 4201(a)(3)(B) of the Health Information Technology for Economic and Clinical Health (HITECH) Act be amended to extend the EHR Medicaid incentive payment to all physician assistants whose patient volume includes at least 30 percent Medicaid recipients.
- **American Hospital Association:** AHA's ongoing advocacy efforts to ensure that the meaningful use and certification standards are within reach for the majority of hospitals and physicians.

Privacy

- **American Hospital Association:** the code of conduct should discourage vendors from including in their contracts indemnity clauses or non-disclosure language that limit the ability of users to identify and raise safety concerns.
- **American Association for Geriatric Psychiatry:** Assurance of confidentiality is at the foundation of an effective relationship between doctor and patient, and AAGP urges that privacy and security of individually identifiable health information—particularly with regard to mental health, substance abuse, and other sensitive patient information—be a critical core element on any national HIT system.
- **American Hospital Association:** The AHA supports the development of a voluntary code of conduct for EHR vendors with specific commitments to ensuring and promoting safety. The code of conduct should make clear that vendors are responsible for safe design and product development and will support safe use of their products.

Standardization

- **American Hospital Association:** AHA must advocate for a significant national investment in developing methods to quickly and effectively translate standards and guidelines and changes as they emerge into the decision support tools embedded in the electronic health record (EHR).

- **American Medical Association:** Chief among the safeguards outlined in AMA policy is the need to ensure that these technologies (HIT) are covered to enhance care coordination and information-sharing between those who provide virtual care and in-person care.
- **American Hospital Association:** EHRs hold the promise of providing clinicians and patients with real-time access to medical information, which can improve medical decision-making, quality and patient safety. We need to standardize these technologies and achieve interoperability. Insurers, government and vendors should implement interoperability standards that allow providers to share health information.

Electronic prescribing

- **Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine (AMDA) work with legislators, regulatory agencies, and pharmacy organizations to promulgate secure, regulatory-compliant electronic means of prescribing controlled substances to ensure ready patient access to needed medications in the post-acute and long-term care (PA/LTC) setting.

Patient portals

- **National Alliance for Caregiving:** we encourage CMS to continue to identify ways to leverage Health Information Technology (“HIT”) as a tool that family caregivers can use to help patients. The Dept. of Veterans Affairs has found new ways to help families access patient information, through its Blue Button program and the Family Caregiver Pilot which equips caregivers with iPads to help manage care. We would urge CMS to look towards these VA programs as an example of how to transform clinical practice to better support patients and their caregivers and reduce overall health system costs.

Population health informatics

- **American Hospital Association:** The AHA and hospitals must advocate for the development of datasets that allow providers to understand the full picture of care delivery.
- S. J. Crane, E. E. Tung, G. J. Hanson, et al. (2010). Use of an electronic administrative database to identify older community dwelling adults at high-risk for hospitalization or emergency department visits: the elders risk assessment index. *BMC health services research*, 10, 338
- S. J. Atlas, R. W. Grant, W. T. Lester, et al. (2011). A cluster-randomized trial of a primary care informatics-based system for breast cancer screening. *Journal of general internal medicine*, 26(2), 154-61
- Bajorek, P. Magin, S. Hilmer, I. Krass (2014). A cluster-randomized controlled trial of a computerized antithrombotic risk assessment tool to optimize stroke prevention in general practice: a study protocol. *BMC health services research*, 14, 55
- P. Colais, N. Agabiti, D. Fusco, et al. (2013). Inequality in 30-day mortality and the wait for surgery after hip fracture: the impact of the regional healthcare evaluation program in Lazio (Italy). *International journal for quality in healthcare*, 25(3), 239-47

- Willis, M. Davies, T. Yates, K. Khunti (2012). Primary prevention of cardiovascular disease using validated risk scores: a systematic review. *Journal of the Royal Society of Medicine*, 105(8), 348-56

Standards, uniformity, and connectivity

- **Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine investigate the current availability of and work with appropriate stakeholders to help develop ideal bidirectional electronic message and document exchanges (i.e., communicating electronically among nursing homes and other community healthcare providers) for use in post-acute and long-term care (PALTC) settings;
- **American Hospital Association:** Create data-sharing mechanisms among the Medicare and Medicaid programs, health plans, providers and other government programs to collect, analyze and report data in a timely manner to support care
- **American Urological Association:** Oppose or defer implementation of ICD-10
- **AHIP:** Develop and implement a national roadmap for HIT that ultimately would lead to adoption of uniform national standards that allow for interoperable electronic communication across the healthcare system.
- **AHIP:** Prioritize the development and adoption of uniform measures and advance electronic data collection to support reporting.
- **AHIP:** States should take advantage of the “qualified entities” under the Availability of Medicare Data for Performance Measurement program to link Medicare, Medicaid, and commercial claims data ...We recommend developing mechanisms for providing this information in a way that avoids adding unnecessary costs to the healthcare system, protects patient privacy, enables consistent analytic results, and allows for the data aggregation to evolve with changes in payment models and methodologies
- **American Hospital Association:** The regulation also should include additional flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software.
- **American Hospital Association:** Require in contracts with vendors that they become CORE-certified.
- **Bipartisan Policy Center:** support of electronic capture of data for measurement through the use of common standards
- **American Hospital Association:** the AHA continues to press for a resolution and recommends the creation of a national unique identifier system to connect records and ensure that hospitals and physicians have the best information available when providing care for each patient.
- **American Hospital Association:** The AHA supports HIEs and will work with state hospital associations to ensure that federal efforts do not unintentionally result in state-level systems that cannot be connected.
- **American Hospital Association:** The AHA continues to advocate for a uniform system of identification in order to streamline supply chain efficiencies, reduce costs and improve patient safety.

- **National Medical Association:** To ensure that HIT does not become a blunt instrument in the hands of untrained healthcare providers and regulators, NMA recommends: Discussions on standards, certification, and interoperability must be as robust as possible.
- M. Hustey, R. M. Palmer (2010). An internet-based communication network for information transfer during patient transitions from skilled nursing facility to the emergency department. *Journal of the American Geriatrics Society*, 58(6), 1148-52

Telehealth and remote telemonitoring

General

- **American Medical Association:** Identifying technical solutions and requirements. Telemedicine technology also must facilitate easy information sharing and comply with Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements. The AMA is working with telemedicine stakeholders to identify solutions and establish technical standards.
- **American Medical Association:** Both bills would allow telemedicine to be practiced across state lines by changing medical licensure laws. Under these bills, licensure would be based on the state in which the patient is located rather than on the state in which the physician is licensed to practice.
- **American Medical Association:** To ensure proper diagnoses and follow-up care, the principles specify that a valid patient-physician relationship should exist before using telemedicine or the physician should meet the standard of care and other safeguards outlined in the AMA policy for establishing this relationship using appropriate telecommunication technologies.
- **Association of Asian Pacific Community Health Organizations:** Telemedicine and Telehealth Communications We also recommend that organizations or agencies using an automated telephonic system be required to use dedicated language lines or, at a minimum, add voice prompts in multiple languages. Further, HHS should ensure that the staff providing information is trained to respond appropriately to LEP callers and know how to access bilingual staff or interpreters.
- P. Y. Takahashi, J. L. Pecina, B. Upatising, et al. (2012). A randomized controlled trial of telemonitoring in older adults with multiple health issues to prevent hospitalizations and emergency department visits. *Archives of internal medicine*, 172(10), 773-9
- Steventon, M. Bardsley, J. Billings, et al. (2012). Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial. *BMJ (Clinical research ed.)*, 344, e3874
- N. van den Berg, M. Schumann, K. Kraft, W. Hoffmann (2012). Telemedicine and telecare for older patients--a systematic review. *Maturitas*, 73(2), 94-114

Heart failure

- S. C. Inglis, R. A. Clark, F. A. McAlister, et al. (2010). Structured telephone support or telemonitoring programmes for patients with chronic heart failure. *The Cochrane database of*

systematic reviews, (8), CD007228

- S. I. Chaudhry, J. A. Mattera, J. P. Curtis, et al. (2010). Telemonitoring in patients with heart failure. *The New England journal of medicine*, 363(24), 2301-9
- Anker, S.D., Koehler, F., Abraham, W.T. (2011) Telemedicine and remote management of patients with heart failure. *The Lancet*, 378 (9792), pp. 731-739.
- F. Koehler, S. Winkler, M. Schieber, et al. (2011). Impact of remote telemedical management on mortality and hospitalizations in ambulatory patients with chronic heart failure: the telemedical interventional monitoring in heart failure study. *Circulation*, 123(17), 1873-80
- G. H. Crossley, A. Boyle, H. Vitense, et al. (2011). The CONNECT (Clinical Evaluation of Remote Notification to Reduce Time to Clinical Decision) trial: the value of wireless remote monitoring with automatic clinician alerts. *Journal of the American College of Cardiology*, 57(10), 1181-9
- V. M. Conraads, L. Tavazzi, M. Santini, et al. (2011). Sensitivity and positive predictive value of implantable intrathoracic impedance monitoring as a predictor of heart failure hospitalizations: the SENSE-HF trial. *European heart journal*, 32(18), 2266-73
- Clarke, M., Shah, A., Sharma, U. (2011). Systematic review of studies on telemonitoring of patients with congestive heart failure: A meta-analysis. *Journal of Telemedicine and Telecare*, 17(1), 7-14.
- P. Mabo, F. Victor, P. Bazin, et al. (2012). A randomized trial of long-term remote monitoring of pacemaker recipients (the COMPAS trial). *European heart journal*, 33(9), 1105-11
- E. Seto, K. J. Leonard, J. A. Cafazzo, et al.(2012). Mobile phone-based telemonitoring for heart failure management: a randomized controlled trial. *Journal of medical Internet research*, 14(1), e31
- Landolina, M., Perego, G. B., Lunati, M., et al. (2012). Remote monitoring reduces health-care use and improves quality of care in heart failure patients with implantable defibrillators: The evolution of management strategies of heart failure patients with implantable defibrillators (EVOLVO) study. *Circulation*, 125(24), 2985-2992.
- U. Augustin, C. Henschke (2012). [Does telemonitoring lead to health and economic benefits in patients with chronic heart failure? - a systematic review]. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany))*, 74(12), e114-21
- R. Xiang, L. Li, S. X. Liu (2013). Meta-analysis and meta-regression of telehealth programmes for patients with chronic heart failure. *Journal of telemedicine and telecare*, 19(5), 249-59
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- S. C. Inglis, A. Conway, J. G. Cleland, R. A. Clark (2014). Is age a factor in the success or failure of remote monitoring in heart failure? Telemonitoring and structured telephone support in elderly heart failure patients. *European journal of cardiovascular nursing*

COPD

- J. Polisena, K. Tran, K. Cimon, et al. (2010). Home telehealth for chronic obstructive pulmonary disease: a systematic review and meta-analysis. *Journal of telemedicine and telecare*, 16(3), 120-7
- K. E. Lewis, J. A. Annandale, D. L. Warm, et al. (2010). Does home telemonitoring after pulmonary rehabilitation reduce healthcare use in optimized COPD? A pilot randomized trial. *Copd*, 7(1), 44-50
- O. Karg, M. Weber, C. Bubulj, et al. (2012). [Acceptance of a telemonitoring device in patients with chronic obstructive pulmonary disease]. *Deutsche medizinische Wochenschrift (1946)*, 137(12), 574-9
- H. Ding, M. Karunanithi, Y. Kanagasingam, et al. (2014). A pilot study of a mobile-phone-based home monitoring system to assist in remote interventions in cases of acute exacerbation of COPD. *Journal of telemedicine and telecare*, 20(3), 128-34

Stroke

- M. Demaerschalk, R. Raman, K. Ernstrom, B. C. Meyer (2012). Efficacy of telemedicine for stroke: pooled analysis of the Stroke Team Remote Evaluation Using a Digital Observation Camera (STRoKE DOC) and STRoKE DOC Arizona telestroke trials. *Telemedicine journal and e-health*, 18(3), 230-7
- B. M. Demaerschalk, H. M. Hwang, G. Leung (2010). Cost analysis review of stroke centers, telestroke, and rt-PA. *The American journal of managed care*, 16(7), 537-44

Physical therapy

- J. C. Jackson, E. W. Ely, M. C. Morey, et al. (2012). Cognitive and physical rehabilitation of intensive care unit survivors: results of the RETURN randomized controlled pilot investigation. *Critical care medicine*, 40(4), 1088-97
- Salisbury, N. E. Foster, C. Hopper, et al. (2013). A pragmatic randomised controlled trial of the effectiveness and cost-effectiveness of 'PhysioDirect' telephone assessment and advice services for physiotherapy. *Health technology assessment (Winchester, England)*, 17(2), 1-157, v-vi

Other

- C. M. Lilly, S. Cody, H. Zhao, et al. (2011). Hospital mortality, length of stay, and preventable complications among critically ill patients before and after tele-ICU reengineering of critical care processes. *JAMA*, 305(21), 2175-83
- H. Solomon, M. D. Iversen, J. Avorn, et al. (2012). Osteoporosis telephonic intervention to improve medication regimen adherence: a large, pragmatic, randomized controlled trial. *Archives of internal medicine*, 172(6), 477-83
- S. Gentry, M. H. van-Velthoven, L. Tudor Car, J. Car (2013). Telephone delivered interven-

tions for reducing morbidity and mortality in people with HIV infection. The Cochrane database of systematic reviews, 5, CD009189

- S. Edirippulige, M. Martin-Khan, E. Beattie, et al. (2013). A systematic review of telemedicine services for residents in long term care facilities. *Journal of telemedicine and telecare*
- Foster, J. Richards, M. Thorogood, M. Hillsdon (2013). Remote and web 2.0 interventions for promoting physical activity. *The Cochrane database of systematic reviews*, 9, CD010395
- M. Stellefson, B. Chaney, A. E. Barry, et al. (2013). Web 2.0 chronic disease self-management for older adults: a systematic review. *Journal of medical Internet research*, 15(2), e35

General and Other

- **Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine advocate with Congress and appropriate Federal agencies to establish incentives and appropriate reimbursement levels for PA/LTC physicians and facilities in order to adopt these technologies.
- A. Dyer, D. Kansagara, D. K. McInnes, et al. (2012). Mobile Applications and Internet-based Approaches for Supporting Non-professional Caregivers: A Systematic Review.
- K. L. Lapane, R. E. Goldman, B. J. Quilliam, et al. (2012). Tailored DVDs: a novel strategy for educating racially and ethnically diverse older adults about their medicines. *International journal of medical informatics*, 81(12), 852-60
- J. Joe, G. Demiris (2013). Older adults and mobile phones for health: a review. *Journal of biomedical informatics*, 46(5), 947-54
- K. M. Godwin, W. L. Mills, J. A. Anderson, M. E. Kunik (2013). Technology-driven interventions for caregivers of persons with dementia: a systematic review. *American journal of Alzheimer's disease and other dementias*, 28(3), 216-22
- N. M. Kosse, K. Brands, J. M. Bauer, et al. (2013). Sensor technologies aiming at fall prevention in institutionalized old adults: a synthesis of current knowledge. *International journal of medical informatics*, 82(9), 743-52

Section 2. Workforce: New Models of Care and Regulatory Issues

Description: Labor accounts for approximately 60 percent of healthcare costs in the United States, making an efficient and effective workforce a critical policy priority, particularly for complex geriatric patients. Care coordination models and many other interventions rely on clinicians and non-clinicians taking on new roles and working together in new ways. Policies that affect the use of new models of care include training the workforce in geriatric competencies, reimbursement, funding for demonstration programs, and licensing.

Caregivers

- **Generations United:** Generations United supports public policies that assist family caregivers of all types in caring for family members. Family-friendly national policies will require eliminating barriers to eligibility in current programs, expanding programs to allow greater access, and creating new programs to address the continuing growth in intergenerational caregiving. Policies should place special emphasis on assisting families with low to moderate incomes and limited assets, in addition to other vulnerable populations.
- **American Society of Clinical Oncology:** ASCO will advocate for adequate Medicare reimbursement to cover survivorship services provided by MDs, NPs and PAs survivorship services.
- **American Society of Clinical Oncology:** Supports legislation like the Comprehensive Cancer Care Improvement Act ; which aims to improve survivorship care throughout the cancer care continuum by supporting coverage of comprehensive cancer care planning, establishing grant programs to increase provider education of palliative care and symptom management.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports additional funding for the supportive services and family caregiver programs as proposed in the Administration's FY 2012 budget
- **Alzheimer's Foundation of America:** AFA identified certain action steps in the national plan that could advance the delivery of care for people with Alzheimer's disease and their family caregivers- and that are vital to advancing this strategic plan. The analysis suggests that implementation of these provisions will eliminate costly medical interventions and will work to make significant improvements in the quality of life for diagnosed individuals.
- **Alzheimer's Foundation of America:** Support caregivers through call centers (3.B.7)
- **Alzheimer's Foundation of America:** Expand and Promote Family Caregiver Training and Support Across the Continuum of Care
- **Alzheimer's Foundation of America:** REACH is now implemented at all facilities operated by the U.S. Department of Veterans Affairs, and it should also be implemented system-wide for Medicare and Medicaid beneficiaries by CMS through the Center for Medicare and Medicaid Innovation, known as the Innovation Center. AFA urges CMS to expand and promote the Resources for Enhancing Alzheimer's Caregiver Health (REACH program) systemwide for Medicare and Medicaid beneficiaries through CMS' Innovation Center.
- **Alzheimer's Foundation of America:** AFA urges CMS and the Administration on Aging (AoA) to develop new ideas for supporting younger family members who may be helping with care, such as teens and young adults.
- **Alzheimer's Foundation of America:** Educate and support people with AD and their families upon diagnosis ...Providing support services, education and training upon diagnosis is vital to ensuring that families can adequately plan for the responsibilities and life changes that occur after a loved one is diagnosed with Alzheimer's disease.

- **Alzheimer’s Foundation of America:** Urging adoption of family-friendly workplace policies, with federal incentives to carry them out. Examples of family-friendly workplace policies include: flextime; work-at-home options; job-sharing; counseling; dependent care accounts; information and referral to community services; and employer-paid services of a care manager.
- **Alzheimer’s Foundation of America:** The national plan must call for further expansion of publicly-funded “participant-directed” (aka “consumer-directed,” “cash and counseling,” “self-directed care”) programs that allow participants to hire family members—including spouses, adult children and even teens—as caregivers.
- **Eldercare Workforce Alliance:** EWA also strongly supports the recommendation for adequate training and compensation for paraprofessional caregivers, as well as your sustained and increased emphasis on funding, supports, and resources for family caregivers. Family Caregiver Support Services: EWA requests \$154.5 million.
- **Paraprofessional Healthcare Institute:** Training programs, information and tools for caregivers—both paid and unpaid—who are providing and coordinating care
- **Paraprofessional Healthcare Institute:** Align government payment policies in order to expand the availability of quality home and community-based services by establishing parity in the reimbursement of training costs for all direct care workers.
- **Eldercare Workforce Alliance:** We request that DOL take timely action to issue a revised interpretation of the exemption that will extend greater federal minimum wage and overtime protection under FLSA to the more than 1,500,000 paid home and community-based care workers who provide essential services to our nation’s older adults and people with disabilities.
- **Paraprofessional Healthcare Institute:** Providing decent paying jobs for direct-care workers is the key to ensuring quality of life and quality of care for millions of Americans with disabilities and chronic illnesses.
- **Paraprofessional Healthcare Institute:** Revise the companionship exemption to the Fair Labor Standards Act to extend federal minimum wage and overtime protections to home care aides.
- **Paraprofessional Healthcare Institute:** Increase government payment for long-term care services and supports to promote parity between the compensation received by certified nursing assistants and direct-care workers who provide similar supports in home and community-based settings.
- **Paraprofessional Healthcare Institute:** Encourage states to establish minimum standards for wages and benefits paid to direct-care workers under public programs, including requiring states to demonstrate that reimbursement rates are based on market analyses of wages and benefits of comparable occupations and are adequate to attract a workforce sufficient to meeting demand for long-term care services and supports.
- **Paraprofessional Healthcare Institute:** Encourage states to target payment policies, ensuring that state and federal funds directly improve wages and benefits for direct-care workers through such measures as: wage floors; minimum percentages of service rates allocated to direct-care labor costs; incentive payments for superior performance with respect to staffing adequacy, stability, and care quality; procurement/contracting standards; and wage pass-throughs.
- **Paraprofessional Healthcare Institute:** Enhance the content of entry-level and advanced training for direct-care workers, by identifying the competencies required for workers to provide quality services to long-term care consumers in any setting.
- **Paraprofessional Healthcare Institute:** Develop consensus competencies for personal and

home care aides (for whom there are currently no federal training requirements) by building on ongoing efforts to identify core competencies, skills and knowledge to provide quality, person-centered care.

- **Paraprofessional Healthcare Institute:** Create career pathways that allow workers to advance from entry-level through higher levels of mastery by identifying core competencies necessary for all direct-care workers, additional competencies needed by nursing assistants and home health aides, and advanced competencies to serve in enhanced roles as key members of care teams in integrated and coordinated care models.
- **Paraprofessional Healthcare Institute:** Fund train-the-trainer programs to support nurse educators and others in using adult learner-centered methods in delivering direct-care worker training.
- **Paraprofessional Healthcare Institute:** Encourage state and local workforce investment boards to support the expansion of training for direct-care workers, particularly through the Workforce Investment Act (WIA) public workforce investment system.
- **Paraprofessional Healthcare Institute:** Establish a national joint venture of the Centers for Medicare and Medicaid Services and the Department of Labor to identify and promote best practices in direct-care worker training and training system design, to support state efforts and sponsor large- scale state demonstrations based on an apprenticeship training model.
- **Paraprofessional Healthcare Institute:** Make workforce an explicit part of CMS's review processes by including greater oversight and guidance to states about the adequacy and quality of their direct-care workforce in Home and Community-Based Services waiver applications/renewals and Medicaid State Plan Amendments.
- **Alzheimer's Foundation of America:** Supports passage of S. 1095, the Caring for an Aging America Act.
- **American Academy of Physician Assistants:** the American Academy of Physician Assistants urges Congress to approve the Home Health Planning and Improvement Act (HR 2504/S 1332) in the 113th Congress.
- R. T. Woods, E. Bruce, R. T. Edwards, *et al.* (2012). REMCARE: reminiscence groups for people with dementia and their family caregivers - effectiveness and cost-effectiveness pragmatic multicentre randomised trial. *Health technology assessment (Winchester, England)*, 16(48), v-xv, 1-116
- K. M. Godwin, W. L. Mills, *et al.*(2013). Technology-driven interventions for caregivers of persons with dementia: a systematic review. *American journal of Alzheimer's disease and other dementias*, 28(3), 216-22
- A. Forster, J. Dickerson, J. Young, *et al.*(2013). A cluster randomised controlled trial and economic evaluation of a structured training programme for caregivers of inpatients after stroke: the TRACS trial. *Health technology assessment (Winchester, England)*, 17(46), 1-216
- E. Wittenberg, L. A. Prosser (2013). Disutility of illness for caregivers and families: a systematic review of the literature. *Pharmacoeconomics*, 31(6), 489-500
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- C. M. Marim, V. Silva, M. Taminato, D. A. Barbosa (2013). Effectiveness of educational programs on reducing the burden of caregivers of elderly individuals with dementia: a systematic review. *Revista latino-americana de enfermagem*, 21 Spec No, 267-75
- C. Gardiner, L. Brereton, R. Frey, *et al.* (2014). Exploring the financial impact of caring for family members receiving palliative and end-of-life care: a systematic review of the literature. *Palliative medicine*, 28(5), 375-90

Community health workers

- **American Association of Service Coordinators:** Service coordinators working with low-income seniors save taxpayer dollars by providing access to community-based supports and services that keep them aging-in-place in their own apartments instead of having to move to more costly institutional settings such as a nursing home
- **American Public Health Association:** Calls on public health agencies to make available evidence-based musculoskeletal programs and resources to public health and healthcare workers. These are offered through organizations such as the Arthritis Foundation and Bone and Joint Decade/Initiative.
- D. Margolius, T. Bodenheimer, H. Bennett, *et al.* (2012). Health coaching to improve hypertension treatment in a low-income, minority population. *Annals of family medicine*, 10(3), 199-205
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Cultural sensitivity

- **Alzheimer's Foundation of America:** Ensure receipt of culturally sensitive education, training, and support materials.
- **American Public Health Association:** With the stipulation that such training (gerontological) should incorporate alternative views based on religious and cultural beliefs and values as well as guidance on cultural competency for all health workers
- **Eldercare Workforce Alliance:** Ensure that the workforce is trained to provide culturally-competent care that addresses the variety of languages, ethnicities, cultures, and health beliefs of older adults and is effectively able to serve all older adults regardless of their race, sexual orientation, gender identity, disability status, and geographical location.

Geriatric competency

- **American Association for Geriatric Psychiatry:** Chronic care systems must encourage and provide **reimbursement for staff training by geriatric specialists** in residential and other healthcare delivery sites, such as nursing homes, assisted living, home care, and community health centers.
- **Alzheimer's Foundation of America:** An integrated national plan to overcome Alzheimer's disease must include... how healthcare professionals should screen, diagnose and treat cognitive problems
- **Alzheimer's Foundation of America:** AFA urges CMS to **require geriatric competencies and dementia training** for primary care clinicians and staff to improve detection, treatment and care for people with Alzheimer's disease.
- **American Public Health Association:** Federal and state governments are urged to make funding available to: support education and training to **develop a public health, gerontological, and generalist-level palliative care workforce** (including physicians, nurses, social workers, and other health professionals and direct care workers)
- **Eldercare Workforce Alliance: Geriatric Training Program** for Physicians, Dentists, (GTPD) and Behavioral and Mental Health Professions: EWA requests \$8.9 million.
- **Eldercare Workforce Alliance:** Ensure that the training and education (content and modalities of delivery) are adequate and appropriate for preparing and sustaining a **quality eldercare workforce**.
- **Eldercare Workforce Alliance:** The Eldercare Workforce Alliance supports the U.S. Department of Labor's (DOL) final rule (RIN) 1235-AA05 that would narrow the current "companionship" exemption under the Fair Labor Standards Act (FLSA) and strongly urges DOL to maintain the current implementation date of January 1, 2015.
- **Eldercare Workforce Alliance:** Organizations and state licensing boards should modify their standards to **require professional competence or training in caring for older adults**, including geriatric mental health, for those professionals who provide such care.
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Interprofessional teams

- **American Holistic Nurses' Association:** Identifying the need for CAM interventions. Assisting clients in locating providers of CAM interventions Facilitating the use of CAM interventions

through education, counseling, coaching, and other forms of assistance Coordinating the use of CAM among various healthcare providers involved in clients' care

- **Society for Post-Acute and Long-Term Care Medicine:** AMDA further recommends that nurse practitioners and other non-physician practitioners work collaboratively with attending physicians and medical directors to maximize the value of all members of the interdisciplinary care team, and that physicians commit to fostering and strengthening this collaboration.
 - **Eldercare Workforce Alliance:** Infuse the concepts related to the care and support of older adults and their families into all trainings such as supporting collaboration and team work and pain and symptom management, and create incentives for work- force training specifically focused on the unique social, physical and mental healthcare needs of older adults.
 - **Eldercare Workforce Alliance:** EWA supports the Positive Aging Act, which is designed to make mental health services for older adults an integral part of primary care services by supporting interdisciplinary team care.
 - **Eldercare Workforce Alliance:** Be consumer-centered and committed to a team-based approach and the organizational redesign required to support it, with the consumer, and/or his/ her family caregivers at the center of the care team.
 - **Paraprofessional Healthcare Institute:** Require training programs to place a greater emphasis on communication and interpersonal problem-solving skills in order to strengthen caregiving relationships, ensure delivery of person-centered services, and coordinate with family caregivers.
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Mental health

- **American Association for Geriatric Psychiatry:** Reimbursement for Geriatric Services: Congress and CMS should act to address aspects of the Medicare payment system that both discourage entry into geriatric mental health specialties and discourage continuation of practice in this area, including the unacceptably low reimbursement rates for psychiatric services combined with inadequate reimbursement for geriatric specialists who generally treat the frailest of Medicare patients. AAGP urges consideration of bonus payments under Medicare to clinicians in geriatric specialties, a recommendation included in the 2008 IOM study on the geriatric workforce.
- **Eldercare Workforce Alliance:** The Alliance asks that you consider expanding funding for and inclusion of geriatric programs, including mental health training, in programs authorized under Titles VII and VIII of the Public Health Service Act in addition to expanding federal coordination and research focused on mental health.
- **Eldercare Workforce Alliance:** Sec. 761(b) of the Public Service Health Act - National Center for Health Workforce Analysis: Broaden the scope of this funding to include the development of information describing and analyzing the mental health workforce and the geriatrics workforce in addition to the traditional healthcare workforce.
- **Eldercare Workforce Alliance:** Medicare should also expand the list of mental health professionals that can be reimbursed under Medicare to cover all providers who are fully licensed by their state for independent practice.

Nursing

- **American Association of Nurse Life Care Planners:** Nurse life care planners function within their individual professional scope of practice and, when applicable, incorporate opinions arrived upon collaboratively with various health professionals. The nurse life care plan is considered a flexible document and is evaluated and updated as needed. (AANLCP®, 2008)
- **American Holistic Nurses' Association:** AHNA believes that inherent in the nursing role is the ability to touch the client's/patient's body, and to assess, plan, intervene, evaluate, and perform preventive, supportive, and restorative functions of the physical, emotional, mental, and spiritual domains. Therefore, it is expected that the nurse may draw upon and utilize principles and techniques of both conventional and CAM therapies, and that these would be within the scope of nursing practice.
- **American Holistic Nurses' Association:** Each client should be treated as an active participant in his or her healthcare and should be included in all nursing care planning decisions.
- **American Healthcare Association:** To amend the Nurse Reinvestment Act to include educational, financial assistance for caregivers in all healthcare settings; establish a national nursing database; & enhance the number of nurse educators.
- **American Hospital Association:** Permit non-physician practitioners (NPPs) to practice to the full extent of their training.
- **Eldercare Workforce Alliance:** Title VIII Geriatrics Nursing Workforce Development Programs Appropriations Request: \$5million
- **Center for Bioethics:** The federal government should consider offering a financial incentive to states that enact the following reforms: NCSBN Advanced Practice Registered Nurse Consensus Model Act.

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- J. Moore, M. McQuestion (2012). The clinical nurse specialist in chronic diseases. *Clinical nurse specialist CNS*, 26(3), 149-63
- P. Tappenden, F. Campbell, A. Rawdin, *et al.* (2012). The clinical effectiveness and cost-effectiveness of home-based, nurse-led health promotion for older people: a systematic review. *Health technology assessment (Winchester, England)*, 16(20), 1-72
- E. A. Barley, M. Haddad, R. Simmonds, *et al.* (2012). The UPBEAT depression and coronary heart disease programme: using the UK Medical Research Council framework to design a nurse-led complex intervention for use in primary care. *BMC family practice*, 13, 119
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- M. D. McHugh, C. Ma (2013). Hospital nursing and 30-day readmissions among Medicare patients with heart failure, acute myocardial infarction, and pneumonia. *Medical care*, 51(1), 52-9
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- S. Clark, R. Parker, B. Prosser, R. Davey (2013). Aged care nurse practitioners in Australia: evidence for the development of their role. *Australian health review*, 37(5), 594-601
- T. J. Roberts, K. A. Nolet, B. J. Bowers (2013). Consistent Assignment of Nursing Staff to Residents in Nursing Homes: A Critical Review of Conceptual and Methodological Issues. *The Gerontologist*
- E. A. Capezuti, B. Bricoli, M. P. Boltz (2013). Nurses Improving the Care of Healthsystem Elders: creating a sustainable business model to improve care of hospitalized older adults. *Journal of the American Geriatrics Society*, 61(8), 1387-93
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- I. M. Abumaria, M. Hastings-Tolsma, T. J. Sakranda (2014). Levine's Conservation Model: A Framework for Advanced Gerontology Nursing Practice. *Nursing forum*

- G. Arendts, C. Etherton-Ber, K. Howard, *et al.* (2014). Nurse led care coordination: trial protocol and development of a best practice resource guide for a cluster controlled clinical trial in Australian aged care facilities. *Archives of gerontology and geriatrics*, 58(1), 15-9
- E. A. Barley, M. Haddad, R. Simmonds, *et al.* (2012). The UPBEAT depression and coronary heart disease programme: using the UK Medical Research Council framework to design a nurse-led complex intervention for use in primary care. *BMC family practice*, 13, 119
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Pharmacy

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- K. L. Lapane, C. M. Hughes, J. B. Christian, *et al.* (2011). Evaluation of the fleetwood model of long-term care pharmacy. *Journal of the American Medical Directors Association*, 12(5), 355-63
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- J. K. Lee, M. K. Slack, J. Martin, *et al.* (2013). Geriatric patient care by U.S. pharmacists in healthcare teams: systematic review and meta-analyses. *Journal of the American Geriatrics Society*, 61(7), 1119-27
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Physicians and residents

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- H. L. Wald, J. J. Glasheen, J. Guerrasio, *et al.* (2011). Evaluation of a hospitalist-run acute care for the elderly service. *Journal of hospital medicine*, 6(6), 313-21
- L. Z. Silverman, L. M. Hoesel, A. Desai, *et al.* (2011). It takes an intensivist. *American journal of surgery*, 201(3), 320-3; discussion 323
- J. M. Stolker, D. S. Allen, D. J. Cohen, *et al.* (2014). Comparison of procedural complications with versus without interventional cardiology fellows-in-training during contemporary percutaneous coronary intervention. *The American journal of cardiology*, 113(1), 44-8

Rehabilitation

- C. Jesudason, K. Stiller, M. McInnes, T. Sullivan (2012). A physiotherapy service to an emergency extended care unit does not decrease admission rates to hospital: a randomised trial. *Emergency medicine journal*, 29(8), 664-9
- S. Voigt-Radloff, G. Ruf, A. Vogel, *et al.* (2013). Occupational therapy for elderly: Evidence mapping of randomised controlled trials from 2004-2012. *Zeitschrift fur Gerontologie und Geriatrie*

Social work

- M. Galati, H. J. Wong, D. Morra, R. C. Wu (2011). An evidence-based case for the value of social workers in efficient hospital discharge. *The healthcare manager*, 30(3), 242-6

Workforce shortage

- **American Healthcare Association:** AHCA/NCAL believes that new immigration laws should serve the needs of the U.S. economy and that policy remedies to address immediate needs should be pursued. Given the current nurse shortage nationwide, AHCA/ NCAL recommends that the federal government consider allowing employers access to previously unused H-1B temporary worker visas.
- **American Healthcare Association:** In terms of the broader policy issues around immigration, AHCA/NCAL would support the following approach: if a U.S. employer is offering a job that American citizens are not available to take, we should welcome into our country a person who will fill that job – especially a critical job that has the capacity to improve the health and well-being of America’s seniors and people with disabilities.

- **American Urological Association:** Address workforce shortages in all urologic practice environments, preserve access to timely and appropriate care
- **American Association for Geriatric Psychiatry:** As the baby boom generation swells Medicare enrollment, policy ideals are not enough: funding must be dedicated to reverse the trend toward declining numbers of healthcare providers equipped to serve older adults and to increase their numbers substantially.
- **American Geriatrics Society:** Loan forgiveness program will provide the incentives needed to bring more providers into the field of geriatrics
- **Alzheimer's Foundation of America:** AFA believes that adequate education of and reimbursement for primary care clinicians and staff are essential to improving earlier detection, treatment and care for people with Alzheimer's disease—as well as supporting family caregivers.
- **Alzheimer's Foundation of America:** AFA urges the Administration to ensure that direct-care workers are able to provide the highest-quality care to all long-term care consumers by requiring employers to offer comprehensive training, certification and career advancement opportunities; livable, family-sustaining wages; affordable health insurance and other benefits; full-time hours, if desired; and balanced workloads.
- **Alzheimer's Foundation of America:** AFA urges the Administration and Congress to support full funding for Title VII Geriatrics Health Professions Programs and Title VIII Geriatrics Nursing Workforce Development Programs.
- **Alzheimer's Foundation of America:** AFA urges the Administration to implement the National Healthcare Workforce Commission to formulate a national strategy for bolstering the healthcare workforce in order to meet the needs of the escalating number of older Americans.
- **American Hospital Association:** The AHA will continue to oppose reductions in Medicare funding for IME and direct graduate medical education and also advocate for maintaining existing funding for graduate medical education conducted in children's hospitals.
- **American Hospital Association:** The AHA continues to recommend that the 1996 cap on residency slots be lifted.
- **Eldercare Workforce Alliance:** We hope you will support a total of \$44.7 million in funding for geriatrics programs in Title VII and Title VIII of the Public Health Service Act and \$173.9 million in funding for programs administered by the Administration for Community Living.
- **Eldercare Workforce Alliance:** Geriatric Academic Career Awards (GACA): EWA requests \$5.5 million.
- **Eldercare Workforce Alliance:** Geriatric Education Centers (GEC): EWA requests \$20 million.
- **Eldercare Workforce Alliance:** Urges you to provide the largest possible 302(b) allocations to the Labor, Health and Human Services, Education and Related Agencies (Labor-HHS) Appropriations Subcommittee. The Labor-HHS bill funds the Health Resources and Services Administration (HRSA)'s essential geriatrics health professions training programs authorized under Titles VII and VIII of the Public Health Service Act.
- **Eldercare Workforce Alliance:** EWA strongly encourages you to explicitly support the development of an eldercare workforce through recruitment, training, retention and compensation for healthcare professionals, including direct care workers, and through supports and resources for family caregivers.
- **Eldercare Workforce Alliance:** We now urge DOL to revise the companionship exemption, and improve quality care by facilitating the recruitment and retention of a quality workforce, in part by expanding federal wage and hour protection.

- **Center for Advocacy for the Rights and Interests of the Elderly (CARIE):** The State Health Insurance Program (SHIP) should be enhanced to support the addition of more professionals to the program to work along with volunteers in assisting eligible seniors apply for multiple benefit programs.
- **Center for Bioethics:** Repurpose 50 percent of the proposed reduction in IME funds for performance-based incentive payments. Restructure Medicare's investment to require that all recipients of IME funding be held accountable for reaching specified educational goals and outcomes. Only institutions that meet these standards should be eligible for the performance-based payments.
- **Center for Bioethics:** Increase residency slots to meet anticipated demand. Repurpose the remaining 50 percent of savings from IME payment reduction to additional residency slots, one-third of which should be made available to teaching hospitals that are training above their cap. Half of the additional slots should be allocated to programs that train primary care physicians and other providers for which there are identified specialty shortages.
- **Center for Bioethics:** Reduce variation in DGME payments. Limit the PRA to 120 percent of the locality-adjusted national average PRA when calculating direct graduate medical education payments.
- **American Healthcare Association:** Amending the Nurse Reinvestment Act (NRA), which was enacted in 2002 with portions updated in 2010 by the Patient Protection & Affordable Care Act, may provide a mechanism for addressing our nation's nursing shortage. By further revising provisions in the NRA regarding nursing education loan repayment programs, loan repayment programs for nurses practicing in facilities that have a critical shortage of nurses or facilities that care for the underserved or high-risk groups like the elderly, and career advancement for all levels of nursing personnel, AHCA/NCAL believes that we will better serve America's seniors today and into the future.
- **American Medical Association:** AMA recommendations included ensuring adequate payments for services and treatment and removing provisions that would create unnecessary administrative burdens for participating physicians.

Workforce regulation

Licensing and certification

- **American Medical Association:** AMA policy supports state-based medical licensure because it protects the interests of patients and the ability of states to enforce state medical practice laws. The approach in these bills threatens to undermine state medical practice laws and would leave state boards helpless to protect their citizens in an adverse medical event. The AMA and the Federation of State Medical Boards (FSMB) have been holding meetings on Capitol Hill in opposition to both pieces of legislation.
- **Cato Institute:** State governments should: eliminate licensing of medical professionals or, as a preliminary step, recognize licenses issued by other states.
- **Cato Institute:** Congress should: eliminate states' ability to use licensing laws as a barrier to entry by medical professionals licensed by other states.
- **Paraprofessional Healthcare Institute:** Revise federal and state training requirements to align with competencies and to set consistent standards across occupations requiring similar skills.
- **Paraprofessional Healthcare Institute:** Update federal training requirements for certified nursing assistants and home health aides to align with the competencies identified as necessary for providing quality long-term care.

- **Paraprofessional Healthcare Institute:** Establish federal requirements for competency and training standards for personal and home care aides based on consensus competencies.

Scope of practice

- **Bipartisan Policy Center:** Eliminate outdated statutory or regulatory requirements in Medicare and Medicaid that interfere with states' abilities to regulate and determine scopes of practice. For example, Congress should strike language from the Medicare statute that requires physician collaboration as a condition of direct nurse practitioner reimbursement.
- **American Association of Nurse Life Care Planners:** The American Nurses Association (ANA) recognizes that "all nursing practice, regardless of specialty, role, or setting, is fundamentally independent practice" (ANA Scope and Standards, 2010, p.24).
- **American Healthcare Association:** Controlled Substances Act (CSA) explicitly permits a practitioner to rely on an "agent" to prepare and transmit prescription drug orders, the DEA currently does not recognize any "agency" relationship between a practitioner and a long term care nurse. As a practical matter, this means that practitioners cannot rely on nurses in these care environments to document their orders and transmit those orders to the pharmacy. update the controlled substances act of 1970 (CSA) to recognize the long term care nurse act as "an agent of the prescriber" in documenting, transmitting & communicating orders for controlled substances to the pharmacy.
- **American Medical Association:** We strongly believe that in order to ensure safe, high-quality healthcare, all health professionals must be held to the highest standard of care under scope of practice policies that appropriately match education and experience levels to particular procedures, services and other aspects of patient care," the letter states. "Section 2706(a) has been invoked, improperly, to support expansion of scope of practice beyond current state policies.
- **AHIP:** Federal policymakers should remove federal-level regulatory barriers that prevent states from making optimal use of non-physician providers in care teams.
- **American Academy of Physician Assistants:** The American Academy of Physician Assistants recommends that sections 1861(dd)(3)(B) and 1814(a)(7)(A)(i)(I) of the Social Security Act be amended to permit physician assistants (PAs) to provide hospice care to their patients who elect Medicare's hospice benefit.
- **Eldercare Workforce Alliance:** Make certain that interdisciplinary care team members are allowed and encouraged to practice to the full extent of their knowledge, training, and skills and work together to provide well-coordinated care, as each team member plays a valuable role in providing quality care.
- **American Association of Nurse Practitioners:** Pass the Home Healthcare Planning Improvement Act (H.R. 2504/S. 1332) - NPs can provide face-to-face assessments of the patient's needs, yet current law requires that a physician document that the encounter has taken place, even if the physician is not involved.
- **American Association of Nurse Practitioners:** Authorize NPs to Document Evaluations for Durable Medical Equipment (DME)
- **American Association of Nurse Practitioners:** AANP calls on Members of Congress to urge the VHA to move forward with their plan of recognizing Nurse Practitioners and other Advanced Practice Registered Nurses to practice to their full scope throughout the VA system.
- **American Association of Nurse Practitioners:** Authorize NPs to Certify Medicare Patients for Hospice Care

- **American Association of Nurse Practitioners:** Enact legislation amending the Medicare conditions of participation for skilled nursing facilities to authorize nurse practitioners to perform admitting examinations and to provide monthly patient assessments.
- **American Association of Nurse Practitioners:** Ensure that NPs in all states are able to fully participate as providers in the qualified health plans made available to uninsured individuals in all insurance programs participating in the Insurance Exchange (Marketplace).
- **Healthcare Leadership Council:** Nonphysician health professionals, including pharmacists and nurse practitioners, can make the current healthcare workforce more productive and efficient and should be allowed to practice to the top of their licenses and be reimbursed for such services provided in collaboration with health teams.

Credentialing

- **Society for Post-Acute and Long-Term Care Medicine:** Physicians and advanced healthcare professionals practicing at the LTC facility must meet uniform specified written criteria for appointment to the facility. This would include those employed by the corporate entity as well as non-employed providers. i. Credentialing criteria must be reasonable and pertinent to the mission and goals of the facility. ii. Credentialing criteria must be evenly applied to all providers seeking privileges.
- **AHIP:** Streamline the credentialing process by promoting the use of a single system for provider credentialing across both public and private payers.
- **American Hospital Association:** Standardize provider credentialing requirements.

Other

- **Society for Post-Acute and Long-Term Care Medicine:** Given that healthcare providers specializing in geriatric medicine and LTC practice are a recognized minority force, facilities should not be allowed to require or include any form of restrictive covenant on employed physicians. Such practice could jeopardize adequate access to healthcare for LTC residents in the community, would reduce competition among providers, and foster the development of healthcare monopolies.
- **Society for Post-Acute and Long-Term Care Medicine:** Support and work with appropriate parties towards creating an exemption for physicians prescribing pain medication in nursing home facilities from controlled substance prescribing requirements such as the Florida Statute 456.44, subsection 3.
- **Cato Institute:** Eliminate “corporate-practice-of-medicine” laws.
- **Cato Institute:** Eliminate “certificate-of-need” laws.

Section 3. Care Coordination

Description: Fragmented care is a serious problem in the healthcare system. Poor communication between different settings of care, especially when the patient is transitioning between settings, can result in the failure to deliver necessary services, overtreatment that exposes patients to unnecessary risks, and poor health outcomes. For the elderly, these failures in coordination can lead to costly hospital readmissions. Under traditional fee for service (FFS) reimbursement, healthcare providers are paid for the volume of services provided to the patient, rather than the value each service provides to patient health. The delivery of unnecessary treatments and services drives up costs in the healthcare system without improving patient health and quality of life. On a systemic level, proposals to move away from FFS payment encourage healthcare payers and providers to move toward a more accountable system, where at least some reimbursement is tied to patient health outcomes, such as Accountable Care Organizations (ACOs). Many care coordination efforts utilize integrated, multi-disciplinary teams of healthcare professionals.

Care pathways and bundles

Geriatric assessment

- Kristjansson, S. R., Nesbakken, A., Jordhøy, M. S., *et al.* (2010). Comprehensive geriatric assessment can predict complications in elderly patients after elective surgery for colorectal cancer: A prospective observational cohort study. *Critical Reviews in oncology/hematology*, 76(3), 208-217.
- E. Graf, D. Zekry, S. Giannelli, *et al.* (2011). Efficiency and applicability of comprehensive geriatric assessment in the emergency department: a systematic review. *Aging clinical and experimental research*, 23(4), 244-54
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Payment bundling

- **American Association of Kidney Patients:** The new law modernizes the Medicare reimbursement system for ESRD by moving to a bundled payment by 2011. Under a bundled payment system, the dialysis provider will receive one payment for both the dialysis and related drugs and lab services. This reform has been a longstanding recommendation of both the Medicare Payment Advisory Commission and the Government Accountability Office.
- **National Academy of Social Insurance:** We strongly urge Congress to wait to evaluate the findings of current bundling demonstrations, pilots and research before proposing new, or expanding existing, bundling authority.
- **AHIP:** Expanding bundled payment initiatives by expanding the Acute Care Episode (ACE) bundled payment demonstration nationally and expanding the number of inpatient procedures subject to bundled payments.
- **AHIP:** Gradually phasing-in alternatives to fee-for-service in public programs—such as bundled payments—so that at least 75 percent of Medicare and Medicaid payments are based on alternatives to FFS.

Stroke

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- A. Collinge, K. McWilliam-Ross, M. J. Beltran, T. Weaver (2013). Measures of clinical outcome before, during, and after implementation of a comprehensive geriatric hip fracture program: is there a learning curve? *Journal of orthopaedic trauma*, 27(12), 672-6

Ventilator

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- J. Rello, E. Afonso, T. Lisboa, *et al.* (2013). A care bundle approach for prevention of ventilator-associated pneumonia. *Clinical microbiology and infection*, 19(4), 363-9

Other

- F. Irani, N. Herial, W. R. Colyer (2012). Impact of an acute coronary syndrome pathway in achieving target heart rate and utilization of evidence-based doses of beta-blockers. *American journal of therapeutics*, 19(6), 397-402
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Care plans and contracts

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Care transitions and patient navigation

- **American Healthcare Association:** The American Healthcare Association/National Center for Assisted Living (AHCA/NCAL) is concerned that Medicare beneficiaries' access to SNF care is being constrained by the increased use of extended hospital stays in observation status. There is bipartisan support in both the House and Senate to fix this problem. Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA) have introduced the Improving Access to Medicare Coverage Act of 2013 (H.R. 1179) to address these situations. Senator Sherrod Brown (D-OH) has introduced a companion bill, S. 569, cosponsored by Senator Susan Collins (R-ME).

- **American Healthcare Association:** Ensure observation stays count toward the required three-day stay by co-sponsoring the Improving Access to Medicare Coverage Act of 2013 (H.R. 1179/S. 569). The American Healthcare Association/National Center for Assisted Living (AHCA/NCAL) strongly supports the use of arbitration as a reasonable, intelligent option for patients, residents, and providers seeking resolution of legal disputes.
- **American Healthcare Association:** After establishing a baseline for the SNF 30-day readmission rate and calculating costs associated with those readmissions, the Secretary would then set a targeted readmissions reduction goal for SNFs necessary to achieve \$2 billion in savings from 2015-2022.
- **Center for Medicare Advocacy, Inc.:** Congress can fix the major problem that outpatient status and observation status create for Medicare patients – the loss of Medicare coverage of their post-hospital care in the SNF – by enacting H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013. The identical bipartisan bills, in essentially a single sentence, count all time in the hospital for purposes of satisfying the three-midnight rule.
- **Center for Medicare Advocacy, Inc.:** Eliminate the three day prior hospitalization requirement for coverage of post-acute skilled nursing facility (SNF) care. At a minimum, count all days in the hospital – including those spent in “observation status” – towards the three day requirement.
- **American Medical Association:** The AMA submitted a statement for the record, outlining its opposition to Medicare’s two-midnight policy and noting support of the Centers for Medicare & Medicaid Services’ decision to adopt AMA recommendations for short inpatient stays. The statement also highlighted the AMA’s formal recommendations submitted last year for improving the RAC statement of work, such as penalties for RACs that have a high error rate or that fail to meet administrative deadlines.
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- M. D. Naylor, L. H. Aiken, E. T. Kurtzman, *et al.* (2011). The care span: The importance of transitional care in achieving health reform. *Health affairs (Project Hope)*, 30(4), 746-54
- D. Stauffer, C. Fullerton, N. Fleming, *et al.* (2011). Effectiveness and cost of a transitional care program for heart failure: a prospective study with concurrent controls. *Archives of internal medicine*, 171(14), 1238-43
- B. Manderson, J. McMurray, E. Piraino, P. Stolee (2012). Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature. *Health and social care in the community*, 20(2), 113-27
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- J. Brock, J. Mitchell, K. Irby, *et al.* (2013). Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. *JAMA*, 309(4), 381-91

Case management

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- C. You, D. R. Dunt, C. Doyle (2013). Case managed community aged care: what is the evidence for effects on service use and costs? *Journal of aging and health*, 25(7), 1204-42
- L. Huntley, R. Thomas, M. Mann, *et al.* (2013). Is case management effective in reducing the risk of unplanned hospital admissions for older people? A systematic review and meta-analysis. *Family practice*, 30(3), 266-75

Discharge coordination

- **Center for Medicare Advocacy, Inc.:** Incentivize Discharge Planning. We encourage Congress to include support for discharge planning in any legislative package addressing post-acute care and in particular to provide rigorous oversight and monitoring of discharge planning as a condition of participation in the Medicare program.
- **Center for Medicare Advocacy, Inc.:** Hospitals receiving a bundled payment that includes post-hospital care for 30 days following discharge should be motivated to conduct good discharge planning and to identify the appropriate setting.
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- M. T. Fox, M. Persaud, I. Maimets, *et al.* (2013). Effectiveness of early discharge planning in acutely ill or injured hospitalized older adults: a systematic review and meta-analysis. *BMC geriatrics*, 13, 70
- S. Shepperd, N. A. Lannin, L. M. Clemson, *et al.* (2013). Discharge planning from hospital to home. *The Cochrane database of systematic reviews*, 1, CD000313

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Disease management programs

Cancer

- **American Society of Clinical Oncology:** SCO strongly supports the Planning Actively for Cancer Treatment (PACT) Act, H.R. 2477...to improve cancer care by providing coverage for cancer care planning and coordination under the Medicare program.
- **American Society of Clinical Oncology:** ASCO strongly supports coordinating care between oncologists and other care providers in a number of ways. We have created templates for treatment summaries and care plans and encourage providers to create them for each patient and share the finished document with their patient and the patient's other providers.
- **American Society of Clinical Oncology:** Planning Actively for Cancer Treatment Act of 2013 (H.R.2477) - Medicare coverage for cancer planning services.
- **Alzheimer's Foundation of America:** Advance coordinated and integrated health and long-term services and supports for individuals living with Alzheimer's Disease.

Chronic care

- **American Association for Geriatric Psychiatry:** Chronic care systems for the frail elderly in outpatient, hospital, and long-term care settings should be developed under the direction and coordination of geriatric specialists, including geriatric psychiatrists.
- **American Association for Geriatric Psychiatry:** Chronic Care Systems- Systems of care targeted towards persons with chronic illness can be especially helpful. However, such systems must include an integrated, comprehensive range of healthcare providers and services. Mental health and substance use treatment must not be separated into a different provider and payment system. Appropriate care of these most vulnerable patients requires knowledge and skills that are intrinsic to geriatric medicine and geriatric psychiatry. AAGP supports design and promotion of systems of patient-centered care that follow the patient across the boundaries of service types and locations.
- **American Geriatrics Society:** Ensure that appropriate care coordination services are available to older adults with complex chronic conditions regardless of their coverage option
- U. Thiem, T. Hinrichs, C. A. Muller, *et al.*(2011). [Prerequisites for a new healthcare model for elderly people with multiple morbidities: results and conclusions from 3 years of research in the PRISCUS consortium]. *Zeitschrift fur Gerontologie und Geriatrie*, 44 Suppl 2, 101-12
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- J. Wigg, R. McCormick, R. Wundke, R. J. Woodman (2013). Efficacy of a chronic disease management model for patients with chronic liver failure. *Clinical gastroenterology and hepatology*, 11(7), 850-8 e1-4

COPD

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- V. S. Fan, J. M. Gaziano, R. Lew, *et al.*(2012). A comprehensive care management program to prevent chronic obstructive pulmonary disease hospitalizations: a randomized, controlled trial. *Annals of internal medicine*, 156(10), 673-83
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- M. R. Boland, A. Tsiachristas, A. L. Kruis, *et al.*(2013). The health economic impact of disease management programs for COPD: a **systematic literature review and meta-analysis**. *BMC pulmonary medicine*, 13, 40
- V. Prieto-Centurion, M. A. Markos, N. I. Ramey, *et al.*(2014). Interventions to reduce rehospitalizations after chronic obstructive pulmonary disease exacerbations. **A systematic review**. *Annals of the American Thoracic Society*, 11(3), 417-24
- L. Kruis, N. Smidt, W. J. Assendelft, *et al.*(2014). Cochrane corner: is integrated disease management for patients with COPD effective? *Thorax*

Heart failure

- L. Young, L. Zimmerman, B. Pozehl, *et al.*(2012). Cost-effectiveness of a symptom management intervention: improving physical activity in older women following coronary artery bypass surgery. *Nursing economic\$,* 30(2), 94-103
- J. Wakefield, S. A. Boren, P. S. Groves, V. S. Conn (2013). Heart failure care management programs: a review of study interventions and meta-analysis of outcomes. *The Journal of cardiovascular nursing*, 28(1), 8-19

Orthopedics

- M. Martinez-Reig, L. Ahmad, G. Duque (2012). The orthogeriatrics model of care: systematic review of predictors of institutionalization and mortality in post-hip fracture patients and evidence for interventions. *Journal of the American Medical Directors Association*, 13(9), 770-7
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- K. V. Grigoryan, H. Javedan, J. L. Rudolph (2014). Orthogeriatric care models and outcomes in hip fracture patients: a systematic review and meta-analysis. *Journal of orthopaedic trauma*, 28(3), e49-55

Other

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- N. McCall, J. Cromwell (2011). Results of the Medicare Health Support disease-management pilot program. *The New England journal of medicine*, 365(18), 1704-12
- H. Ihle-Hansen, B. Thommessen, M. W. Fagerland, *et al.*(2012). Multifactorial vascular risk factor intervention to prevent cognitive impairment after stroke and TIA: a 12-month randomized controlled trial. *International journal of stroke*
- J. Chodosh, M. L. Pearson, K. I. Connor, *et al.*(2012). A dementia care management intervention: which components improve quality? *The American journal of managed care*, 18(2), 85-94

- M. G. Jaffe, G. A. Lee, J. D. Young, *et al.*(2013). Improved blood pressure control associated with a large-scale hypertension program. *JAMA* , 310(7), 699-705
- H. Bergquist, L. Agreus, L. Tillander, *et al.*(2013). Structured diagnostic and treatment approach versus the usual primary care approach in patients with gastroesophageal reflux disease: a cluster-randomized multicenter study. *Journal of clinical gastroenterology*, 47(7), e65-73

Global payment programs

Accountable care organizations

- **American Medical Association:** Move to a system that would permit most specialists to participate in multiple ACOs. Under current rules, CMS attributed patients to a particular ACO through a two-step process that effectively has made it impossible for most physicians—including specialists—to participate in more than one ACO.
- **American Medical Association:** Replace the many process-based ACO quality measures with a small set of population-based outcome measures
- **American Medical Association:** Give ACOs the flexibility to waive certain Medicare requirements, including the three-day hospital stay that now is a condition of Medicare coverage for care in a skilled nursing facility
- **Association of Asian Pacific Community Health Organizations:** Interpret the Patient Protection and Affordable Care Act to allow full participation of Federally Qualified Health Centers, including aligning its Medicare fee-for-service beneficiaries, in Medicare Shared Savings Program Accountable Care Organizations. We endorse and support the comments submitted by the National Association of Community Health Centers (NACHC) on this issue, including the use of alternate cost benchmarking methods for Medicare fee-for-service beneficiaries served by FQHCs.
- **Association of Asian Pacific Community Health Organizations:** In the final rule, the Centers for Medicare and Medicaid Services (CMS) should require that applications from Medicare Shared Savings Program ACOs include a demographic profile of the proposed service area (using data from the U.S. Census, American Community Survey, Medically Underserved Area and Medically Underserved Populations designations, and other readily available sources), accompanied by a specific action plan to address that beneficiary diversity in all the activities of the ACO.
- **Association of Asian Pacific Community Health Organizations:** Add an explicit requirement for all Medicare Shared Savings Program ACOs to identify and address disparities in healthcare as part of its quality improvement interventions. The final rule should include an explicit requirement that the Medicare Shared Savings Program ACOs identify and address disparities in healthcare as part of its quality improvement interventions.
- **Association of Asian Pacific Community Health Organizations:** Medicare Shared Saving Program ACOs could use frameworks and measures such as the U.S. Department of Health and Human Services Office of Minority Health’s Culturally and Linguistically Appropriate Services Standards, the National Quality Forum’s “disparities-sensitive” measures for ambulatory healthcare quality and framework and preferred practices for cultural competency, or the National Committee for Quality Assurance (NCQA) Multicultural Healthcare distinction program, to meet such a requirement. At a minimum, the ACOs should collect race, ethnicity, language, disability and other relevant demographic data from beneficiaries served, stratify quality data by those demographics, and develop and implement specific interventions to reduce any identified disparities. This may be done using retrospective population level data, including any data shared with the ACO by CMS.

- **Association of Asian Pacific Community Health Organizations:** Add an explicit requirement that all Medicare Shared Savings Program ACOs must comply with Title VI and the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. The final rule should include an explicit requirement that all Medicare Shared Savings Program ACOs comply with Title VI and the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.
- **Association of Asian Pacific Community Health Organizations:** Add enabling services, including interpretation and translation, case management, health education, and transportation services, as required services for all Medicare Shared Savings Program ACOs. Community health centers have documented the importance of enabling services to meet the needs of diverse and underserved patients. These enabling services should be specifically listed as the types of services to be provided by the Medicare Shared Savings Program ACO through its participating providers to ensure quality improvement and quality outcomes for the ACO's aligned beneficiaries.
- **Association of Asian Pacific Community Health Organizations:** While we support the requirement of consumer representation on the governing board of the ACO, we note that FQHCs have the requirement that a majority of its board members be consumers. In order for there to be meaningful representation, we urge that the requirement of consumer representation on the governing board be increased beyond a single seat.
- **Association of Asian Pacific Community Health Organizations:** In addition, we urge that the applications from Medicare Shared Savings Program ACOs include the applicant's plan for beneficiary engagement, and for community engagement and partnerships, to ensure the achievement of the population health improvements.
- **Association of Asian Pacific Community Health Organizations:** Support the exemption from the minimum savings rate when Federally Qualified Health Centers participate in a Medicare Shared Savings Program ACO. The proposed rule would allow "first dollar" shared savings when Federally Qualified Health Centers or Rural Health Centers participate in a Medicare Shared Savings Program ACO, without having to surpass a minimum savings rate of 2 percent-3.9 percent.
- **Association of Asian Pacific Community Health Organizations:** Interpret the Patient Protection and Affordable Care Act to allow full participation of Federally Qualified Health Centers, including aligning its Medicare fee-for-service beneficiaries, in Medicare Shared Savings Program Accountable Care Organizations.
- **Association of Asian Pacific Community Health Organizations:** In the final rule, the Centers for Medicare and Medicaid Services (CMS) should require that applications from Medicare Shared Savings Program ACOs include a demographic profile of the proposed service area (using data from the U.S. Census, American Community Survey, Medically Underserved Area and Medically Underserved Populations designations, and other readily available sources), accompanied by a specific action plan to address that beneficiary diversity in all the activities of the ACO.
- **Association of Asian Pacific Community Health Organizations:** Support the increased shared savings for both the Track 1 One-Sided and the Track 2 Two-Sided Medicare Shared Savings Program ACOs when Federally Qualified Health Centers participate in such ACOs. The proposed rule would increase the shared savings available when Federally Qualified Health Centers or Rural Health Centers participate in a Medicare Shared Savings Program ACO by up to 2.5 percent in one-sided ACOs and by up to 5 percent in two-sided ACOs. This financial incentive to include FQHCs in Medicare Shared Savings Program ACOs should be included in the final rule.

- **Association of Asian Pacific Community Health Organizations:** Include explicit alignment with HITECH meaningful use requirements. The HITECH Act provides incentives for hospitals and physicians to achieve “meaningful use of certified electronic health records.” There is great potential for health information technology to improve communication and quality for underserved populations. Accordingly, we support the explicit alignment of the requirements for Medicare Shared Savings Program ACOs with the meaningful use requirements
- **AHIP:** As HHS implements the Medicare Shared Savings Program, it should encourage a range of different delivery models that have preliminarily demonstrated effectiveness and efficiency and build on existing collaborations and innovation.
- **American Hospital Association:** Payment systems need to move away from fee-for-service toward integrated and innovative delivery models, such as medical homes, bundled payments and accountable care organizations (ACOs).
- **American Hospital Association:** Align the Federal Employees Health Benefits Program (FEHBP) with Medicare to require plans to use alternative payment methods, such as ACO arrangements or value-based purchasing.
- **AHIP:** Allow Medicare Advantage plans to use tools that promote quality and value, such as using VBID incentives to induce beneficiaries to choose high-performing networks, or varying their cost-sharing based on the clinical effectiveness and value of services. Additional cost-sharing flexibility should also be applied to the Medicare Shared Savings Program and the Pioneer ACO Initiative to enable them to tier cost-sharing based on quality performance and the clinical effectiveness of services.

Gain sharing

- **American Hospital Association:** Permit, encourage and simplify broad-scale hospital-physician “gain sharing.”
- **AHIP:** Incentivize States to Partner with Public and Private Stakeholders to Transform the Healthcare System. For states that bring stakeholders together to develop innovative reforms that lower the growth of total healthcare spending throughout the public and private sectors, we propose a gain-sharing system that would enable those states to receive fiscal rewards for successfully meeting cost- and quality-related goals
- **AHIP:** Establish a gain-sharing program for states to innovate to control healthcare costs.

Other

- **AHIP:** Medicare should adopt site-neutral payment proposals for physician and other ambulatory services performed at the facility level—thereby reducing costs and improving payment efficiency and equity for Medicare-covered services.
- **AHIP:** Regulators should encourage alternative approaches that may be effective when providers are not equipped to assume high levels of risk. One possibility is a model that utilizes the following combination of structures/payment arrangements to promote shared accountability and improve outcomes: (1) low intensity, longitudinal care could be managed through a Patient Centered Medical Home (PCMH) 7 with payment for services on a monthly basis; (2) episodic or emergency response services could be paid on a fee-for-service basis, with cost sharing for patients; and (3) clinical interventions involving hospitalizations and outpatient services could be paid using a global payment.
- **American Hospital Association:** Assume under Medicare the full financial responsibility and coverage of Medicare premiums and cost sharing for the dually eligible to treat Medicare beneficiaries equally and to reduce administrative complexity.

- **American Hospital Association:** Change both Medicare and Medicaid to overcome care and coverage coordination issues and conflicting administrative requirements and financial incentives to increase administrative efficiency in caring for the dually eligible.
- **Bipartisan Policy Center:** Streamline and clarify the application of existing federal legal and regulatory guidance for private-sector entities seeking to form integrated, coordinated systems of care delivery.
- **AHIP:** Real transformation of payment and delivery across payers and settings of care will require reforming how Medicare pays physicians and other healthcare providers who are paid under the Medicare physician fee schedule

Long term care coordination

- **American Association for Geriatric Psychiatry:** Chronic care systems for the frail elderly in outpatient, hospital, and long-term care settings should be developed under the direction and coordination of geriatric specialists, including geriatric psychiatrists.
- **Society for Post-Acute and Long-Term Care Medicine Support:** Allow medical providers in long term care and Medical Directors of nursing facilities to participate in multiple ACOs.
- **National Academy of Social Insurance: Site-Neutral Payment Proposal:** This proposal would equalize payment rates for certain patients who, depending on the severity of their condition, are treated in both rehab hospitals and Skilled Nursing Facilities. We oppose this proposal and urge Congress to reject it.
- **Alzheimer's Foundation of America:** AFA is proposing that CMS adopt new care delivery models that recognize the benefit of care coordination integrated with access to home care services.
- **LeadingAge Home Health:** We support provisions of the Affordable Care Act (ACA) that require development of a system of value-based purchasing for home health agencies under the Medicare program. This system will base reimbursement on quality of care delivered instead of on the number of episodes or therapy visits.
- **National Academy of Social Insurance:** Oppose Copayments for Medicare Home Health Services and expand delivery reforms such as the Independence at Home Program and Care Transitions Program
- **National Academy of Social Insurance:** We recommend fully implementing and expanding, where appropriate, design reforms which focus on treating beneficiaries with costly chronic conditions in their homes and communities, thus avoiding unnecessary hospitalizations— design reforms such as the Independence at Home Program and the Care Transitions Program.
- **Alzheimer's Foundation of America:** AFA urges CMS to implement systemwide proven pilot and demonstration programs such as Independence at Home (IAH) and other care coordination models.
- **American Hospital Association:** Provide payment incentives for reducing preventable readmissions, infections and complications.
- **Consortium for Citizens with Disability:** Rather than cutting funding, CCD recommends testing and implementing strategies for better care coordination within the post-acute care rehabilitation world, such as the Continuing Care Hospital demonstration authorized under the Affordable Care Act.
- J. G. Ouslander, G. Lamb, R. Tappen, *et al.* (2011). Interventions to reduce hospitalizations from nursing homes: evaluation of the INTERACT II collaborative quality improvement project.

Journal of the American Geriatrics Society, 59(4), 745-53

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- G. Arendts, C. Etherton-Ber, K. Howard, *et al.*(2014). Nurse led care coordination: trial protocol and development of a best practice resource guide for a cluster controlled clinical trial in Australian aged care facilities. Archives of gerontology and geriatrics, 58(1), 15-9

Medication coordination

Medication adherence

- W. F. Gellad, J. L. Grenard, Z. A. Marcum (2011). A systematic review of barriers to medication adherence in the elderly: looking beyond cost and regimen complexity. The American journal of geriatric pharmacotherapy, 9(1), 11-23
- G. L. Kreps, M. M. Villagran, X. Zhao, *et al.*(2011). Development and validation of motivational messages to improve prescription medication adherence for patients with chronic health problems. Patient education and counseling, 83(3), 375-81
- K. Ito, W. H. Shrank, J. Avorn, *et al.*(2012). Comparative cost-effectiveness of interventions to improve medication adherence after myocardial infarction. Health services research, 47(6), 2097-117
- T. L. Laba, J. Bleasel, J. A. Brien, *et al.*(2013). Strategies to improve adherence to medications for cardiovascular diseases in socioeconomically disadvantaged populations: a systematic review. International journal of cardiology, 167(6), 2430-40
- McGinnis, Y. Kauffman, K. L. Olson, *et al.*(2014). Interventions aimed at improving performance on medication adherence metrics. International journal of clinical pharmacy, 36(1), 20-5

Medication reconciliation

- L. M. Hellstrom, A. Bondesson, P. Hoglund, *et al.*(2011). Impact of the Lund Integrated Medicines Management (LIMM) model on medication appropriateness and drug-related hospital revisits. European journal of clinical pharmacology, 67(7), 741-52
- O. Ghatnekar, A. Bondesson, U. Persson, T. Eriksson (2013). Health economic evaluation of the Lund Integrated Medicines Management Model (LIMM) in elderly patients admitted to hospital. BMJ open, 3(1)
- M. Kilcup, D. Schultz, J. Carlson, B. Wilson (2013). Postdischarge pharmacist medication reconciliation: impact on readmission rates and financial savings. Journal of the American Pharmacists Association, 53(1), 78-84

Medication therapy management

- D. Ramalho de Oliveira, A. R. Brummel, D. B. Miller (2010). Medication therapy management: 10 years of experience in a large integrated healthcare system. Journal of managed care pharmacy, 16(3), 185-95
- D. M. Scott, M. W. Dewey, T. A. Johnson, *et al.*(2010). Preliminary evaluation of medication therapy management services in assisted living facilities in rural Minnesota. The Consultant pharmacist , 25(5), 305-19
- S. J. Shoemaker, A. Hassol (2011). Understanding the landscape of MTM programs for Medicare. Part D: Results from a study for the Centers for Medicare and Medicaid services. Journal of the American Pharmacists Association , 51(4), 520-6

Other

- Z. A. Marcum, S. M. Handler, R. Wright, J. T. Hanlon (2010). Interventions to improve suboptimal prescribing in nursing homes: A narrative review. *The American journal of geriatric pharmacotherapy*, 8(3), 183-200
- H. M. Smeets, N. J. de Wit, N. P. Zuithoff, *et al.*(2010). A health insurance company-initiated multifaceted intervention for optimizing acid-suppressing drug prescriptions in primary care: a randomized controlled trial. *Archives of internal medicine*, 170(14), 1264-8
- E. Topinkova, J. P. Baeyens, J. P. Michel, P. O. Lang (2012). Evidence-based strategies for the optimization of pharmacotherapy in older people. *Drugs and aging*, 29(6), 477-94
- S. M. Patterson, C. Hughes, N. Kerse, *et al.*(2012). Interventions to improve the appropriate use of polypharmacy for older people. *The Cochrane database of systematic reviews*, 5, CD008165
- K. Tamura, C. L. Bell, M. Inaba, K. H. Masaki (2012). Factors associated with polypharmacy in nursing home residents. *Clinics in geriatric medicine*, 28(2), 199-216
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- J. K. Lee, M. K. Slack, J. Martin, *et al.*(2013). Geriatric patient care by U.S. pharmacists in healthcare teams: systematic review and meta-analyses. *Journal of the American Geriatrics Society*, 61(7), 1119-27
- J. Tjia, S. J. Velten, C. Parsons, *et al.*(2013). Studies to reduce unnecessary medication use in frail older adults: a systematic review. *Drugs and aging*, 30(5), 285-307
- L. Chenoweth, J. Sheriff, L. McAnally, F. Tait (2013). Impact of the Parkinson's disease medication protocol program on nurses' knowledge and management of Parkinson's disease medicines in acute and aged care settings. *Nurse education today*, 33(5), 458-64

Primary care coordination

Collaborative care

- E. A. Barley, M. Haddad, R. Simmonds, *et al.*(2012). The UPBEAT depression and coronary heart disease programme: using the UK Medical Research Council framework to design a nurse-led complex intervention for use in primary care. *BMC family practice*, 13, 119
- D. A. Richards, J. J. Hill, L. Gask, *et al.*(2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ (Clinical research ed.)*, 347, f4913
- D. Ekers, R. Murphy, J. Archer, *et al.*(2013). Nurse-delivered collaborative care for depression and long-term physical conditions: a systematic review and meta-analysis. *Journal of affective disorders*, 149(1-3), 14-22

Medical homes

- **AHIP:** Expand the use of patient-centered medical homes—in public and private health coverage.
- **Association of Asian Pacific Community Health Organizations:** Include explicit adoption of/alignment with patient-centered medical home standards. Similarly, patient-centered medical homes have the potential for improving quality of care for underserved populations.²¹

Accordingly, we support the explicit alignment of the requirements for Medicare Shared Savings Program ACOs with current requirements for medical homes

- R. J. Gilfillan, J. Tomcavage, M. B. Rosenthal, *et al.* (2010). Value and the medical home: effects of transformed primary care. *The American journal of managed care*, 16(8), 607-14
- R. L. Fuller, S. Clinton, N. I. Goldfield, W. P. Kelly (2010). Building the affordable medical home. *The Journal of ambulatory care management*, 33(1), 71-80
- K. Moran, R. Burson, J. Critchett, P. Olla (2011). Exploring the cost and clinical outcomes of integrating the registered nurse-certified diabetes educator into the patient-centered medical home. *The Diabetes educator*, 37(6), 780-93
- S. Erickson, J. Hambleton (2011). A pharmacy's journey toward the patient-centered medical home. *Journal of the American Pharmacists Association*, 51(2), 156-60
- J. W. Williams, G. L. Jackson, B. J. Powers, *et al.* (2012). Closing the quality gap: revisiting the state of the science (vol. 2: the patient-centered medical home). *Evidence report/technology assessment*, (208.2), 1-210
- M. J. DePuccio, T. J. Hoff (2013). Medical home interventions and quality outcomes for older adults: a systematic review. *Quality management in healthcare*, 22(4), 327-40

Other

- T. Koch, S. Iliffe (2010). Rapid appraisal of barriers to the diagnosis and management of patients with dementia in primary care: a systematic review. *BMC family practice*, 11, 52
- S. M. Smith, H. Soubhi, M. Fortin, *et al.* (2012). Managing patients with multimorbidity: systematic review of interventions in primary care and community settings. *BMJ (Clinical research ed.)*, 345, e5205
- S. M. Smith, H. Soubhi, M. Fortin, *et al.* (2012). Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *The Cochrane database of systematic reviews*, 4, CD006560
- M. D. Howell, L. Ngo, P. Folcarelli, *et al.* (2012). Sustained effectiveness of a primary-team-based rapid response system. *Critical care medicine*, 40(9), 2562-8
- (2013). Specialized nursing practice for chronic disease management in the primary care setting: an evidence-based analysis. *Ontario health technology assessment series*, 13(10), 1-66
- H. Leleu, E. Minvielle (2013). Relationship between longitudinal continuity of primary care and likelihood of death: analysis of national insurance data. *PloS one*, 8(8), e71669

Regionalization and integrated care

- J. Chen, H. M. Krumholz, Y. Wang, *et al.* (2010). Differences in patient survival after acute myocardial infarction by hospital capability of performing percutaneous coronary intervention: implications for regionalization. *Archives of internal medicine*, 170(5), 433-9
- E. De Maria, S. Ricci, S. Cappelli, *et al.* (2010). Feasibility of transradial approach in a hub and spoke cath lab network. *Minerva cardioangiologica*, 58(1), 11-5
- S. R. Markar, A. Karthikesalingam, S. Thrumurthy, D. E. Low (2012). Volume-outcome relationship in surgery for esophageal malignancy: systematic review and meta-analysis 2000-2011. *Journal of gastrointestinal surgery*, 16(5), 1055-63
- N. Curry, M. Harris, L. H. Gunn, *et al.* (2013). Integrated care pilot in north-west London: a

mixed methods evaluation. *International journal of integrated care*, 13, e027

- Philp, K. A. Mills, B. Thanvi, *et al.*(2013). Reducing hospital bed use by frail older people: results from a systematic review of the literature. *International journal of integrated care*, 13, e048

Risk stratification

- H. Smith, E. S. Johnson, M. L. Thorp, *et al.*(2010). Integrating clinical trial findings into practice through risk stratification: the case of heart failure management. *Population health management*, 13(3), 123-9
- J. C. Hill, D. G. Whitehurst, M. Lewis, *et al.*(2011). Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. *Lancet*, 378(9802), 1560-71
- H. Miller, P. E. Pepe, R. Peshock, *et al.*(2011). Is coronary computed tomography angiography a resource sparing strategy in the risk stratification and evaluation of acute chest pain? Results of a randomized controlled trial. *Academic emergency medicine*, 18(5), 458-67

Specialized units

Geriatric

- J. J. Baztan, F. M. Suarez-Garcia, J. Lopez-Arrieta, L. Rodriguez-Manas (2011). [Efficiency of acute geriatric units: a meta-analysis of controlled studies]. *Revista espanola de geriatria y gerontologia*, 46(4), 186-92
- M. T. Fox, M. Persaud, I. Maimets, *et al.*(2012). Effectiveness of acute geriatric unit care using acute care for elders components: a systematic review and meta-analysis. *Journal of the American Geriatrics Society*, 60(12), 2237-45
- M. S. Chong, E. F. Empensando, Y. Y. Ding, T. L. Tan (2012). A subacute model of geriatric care for frail older persons: the Tan Tock Seng Hospital experience. *Annals of the Academy of Medicine, Singapore*, 41(8), 354-61
- Bonnet-Zamponi, L. d'Arailh, C. Konrat, *et al.*(2013). Drug-related readmissions to medical units of older adults discharged from acute geriatric units: results of the Optimization of Medication in AGEd multicenter randomized controlled trial. *Journal of the American Geriatrics Society*, 61(1), 113-21

Stroke

- Y. Sun, D. Paulus, M. Eyssen, *et al.*(2013). A systematic review and meta-analysis of acute stroke unit care: what's beyond the statistical significance? *BMC medical research methodology*, 13, 132
- Tamm, M. Siddiqui, A. Shuaib, *et al.*(2014). Impact of stroke care unit on patient outcomes in a community hospital. *Stroke; a journal of cerebral circulation*, 45(1), 211-6

Other and General

- **American Urological Association:** Preserve the use of the in-office ancillary services exception (IOASE) to the Stark Law when appropriate.
- **AHIP:** Pay for Care that Is Proven to Work. To the extent that we continue paying for specific health services under a fee-for-service payment structure, public programs and the private sector should reduce payments for services that prove to be less effective and to have less value than alternative therapies.

- **American Hospital Association:** Ensure continued funding for the Center for Medicare and Medicaid Innovation.
- **American Hospital Association:** Establish financial incentives for providers and patients to participate in models that move away from fee-for-service reimbursement and reward value.
- Kammerlander, T. Roth, S. M. Friedman, *et al.*(2010). Ortho-geriatric service--a literature review comparing different models. *Osteoporosis international*, 21(Suppl 4), S637-46
- L. O. Hansen, R. S. Young, K. Hinami, *et al.*(2011). Interventions to reduce 30-day rehospitalization: a systematic review. *Annals of internal medicine*, 155(8), 520-8
- P. Y. Wai, T. O'Hern, D. O. Andersen, *et al.*(2012). Impact of business infrastructure on financial metrics in departments of surgery. *Surgery*, 152(4), 729-34; discussion 734-7
- R. S. Brown, D. Peikes, G. Peterson, *et al.*(2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health affairs (Project Hope)*, 31(6), 1156-66
- M. Parsons, H. E. Senior, N. Kerse, *et al.*(2012). The Assessment of Services Promoting Independence and Recovery in Elders Trial (ASPIRE): a pre-planned meta-analysis of three independent randomised controlled trial evaluations of ageing in place initiatives in New Zealand. *Age and ageing*, 41(6), 722-8
- H. Wiese, C. P. Schepp, I. Bergmann, *et al.*(2012). [Age rationing: means of resource allocation in healthcare systems]. *Der Anaesthetist*, 61(4), 354-62
- W. T. Koelewijn, M. L. Ehrenhard, A. J. Groen, W. H. van Harten (2012). Intra-organizational dynamics as drivers of entrepreneurship among physicians and managers in hospitals of western countries. *Social science and medicine* (1982), 75(5), 795-800
- P. S. Hussey, A. W. Mulcahy, C. Schnyer, E. C. Schneider (2012). Closing the quality gap: revisiting the state of the science (vol. 1: bundled payment: effects on healthcare spending and quality). *Evidence report/technology assessment*, (208.1), 1-155
- L. L. Berry, B. L. Rock, B. Smith Houskamp, *et al.*(2013). Care coordination for patients with complex health profiles in inpatient and outpatient settings. *Mayo Clinic proceedings*, 88(2), 184-94
- C. J. Murray, M. A. Richards, J. N. Newton, *et al.*(2013). UK health performance: findings of the Global Burden of Disease Study 2010. *Lancet*, 381(9871), 997-1020
- H. Dickinson, J. Glasby, A. Nicholds, H. Sullivan (2013). Making sense of joint commissioning: three discourses of prevention, empowerment and efficiency. *BMC health services research*, 13 Suppl 1, S6
- R. Dalton, E. P. Vamos, M. J. Harris, *et al.*(2014). Impact of universal health insurance coverage on hypertension management: a cross-national study in the United States and England. *PloS one*, 9(1), e83705
- N. Degani (2013). Impact of advanced (open) access scheduling on patients with chronic diseases: an evidence-based analysis. *Ontario health technology assessment series*, 13(7), 1-48

Section 4. Quality of Facility/Provider

Description: A healthcare system that is focused on the value rather than the volume of services delivered will offer cost effective, high quality services. Health providers engaged in Quality Improvement (QI) programs focus on redesigning processes of care to continuously improve patient outcomes, safety, and satisfaction. Payment reforms in the Affordable Care Act reward providers who have low rates of Healthcare Associated Infections (HAIs), underscoring the importance of efforts to improve patient safety and care quality. Elderly patients may be particularly vulnerable to contracting HAIs, and approximately 75,000 acute care hospital patients with HAIs die annually in the US.⁴⁰

Many different quality metrics and methodologies are currently employed by payers and accrediting institutions. This lack of uniformity, coupled with a lack of transparency about the price of healthcare services, makes it difficult for patients to use quality information to make informed decisions about

Patient safety

Falls prevention

- S. Church, T. N. Robinson, E. M. Angles, *et al.*(2011). Postoperative falls in the acute hospital setting: characteristics, risk factors, and outcomes in males. *American journal of surgery*, 201(2), 197-202
- K. E. Covinsky, E. Pierluissi, C. B. Johnston (2011). Hospitalization-associated disability: “She was probably able to ambulate, but I’m not sure”. *JAMA*, 306(16), 1782-93
- N. Tescher, M. E. Branda, T. J. Byrne, J. M. Naessens (2012). All at-risk patients are not created equal: analysis of Braden pressure ulcer risk scores to identify specific risks. *Journal of wound, ostomy, and continence nursing*, 39(3), 282-91

Hospital acquired infections prevention

- C. Morris, A. W. Hay, D. G. Swann, *et al.*(2011). Reducing ventilator-associated pneumonia in intensive care: impact of implementing a care bundle. *Critical care medicine*, 39(10), 2218-24
- Seron-Arbeloa, J. Puzo-Foncillas, T. Garces-Gimenez, *et al.*(2011). A retrospective study about the influence of early nutritional support on mortality and nosocomial infection in the critical care setting. *Clinical nutrition (Edinburgh, Scotland)*, 30(3), 346-50
- P. E. Grgurich, J. Hudcova, Y. Lei, *et al.*(2012). Management and prevention of ventilator-associated pneumonia caused by multidrug-resistant pathogens. *Expert review of respiratory medicine*, 6(5), 533-55
- R. Pickard, T. Lam, G. Maclennan, K. Starr, *et al.*(2012). Types of urethral catheter for reducing symptomatic urinary tract infections in hospitalised adults requiring short-term catheterisation: multicentre randomised controlled trial and economic evaluation of antimicrobial- and antiseptic-impregnated urethral catheters (the CATHETER trial). *Health technology assessment*, 16(47), 1-197
- V. D. Rosenthal, C. Rodrigues, C. Alvarez-Moreno, *et al.*(2012). Effectiveness of a multidimensional approach for prevention of ventilator-associated pneumonia in adult intensive care units from 14 developing countries of four continents: findings of the International Nosocomial Infection Control Consortium. *Critical care medicine*, 40(12), 3121-8
- K. E. VerLee, J. L. Finks, M. J. Wilkins, E. V. Wells (2012). Michigan *Clostridium difficile*

⁴⁰<http://www.cdc.gov/HAI/surveillance/index.html>

hospital discharges: frequency, mortality, and charges, 2002-2008. Public health reports, 127(1), 62-71

- D. Salgado, K. A. Sepkowitz, J. F. John, et al.(2013). Copper surfaces reduce the rate of healthcare-acquired infections in the intensive care unit. *Infection control and hospital epidemiology*, 34(5), 479-86
- S. J. Allen, K. Wareham, D. Wang, et al.(2013). A high-dose preparation of lactobacilli and bifidobacteria in the prevention of antibiotic-associated and *Clostridium difficile* diarrhoea in older people admitted to hospital: a multicentre, randomised, double-blind, placebo-controlled, parallel arm trial (PLACIDE). *Health technology assessment (Winchester, England)*, 17(57), 1-140
- P. A. Pintar (2013). An entrepreneurial innovative role: integration of the clinical nurse specialist and infection prevention professional. *Clinical nurse specialist CNS*, 27(3), 123-7

Patient education

- D. G. Vreeland, R. E. Rea, L. L. Montgomery (2011). A review of the literature on heart failure and discharge education. *Critical care nursing quarterly*, 34(3), 235-45
- T. P. Haines, A. M. Hill, K. D. Hill, et al.(2011). Patient education to prevent falls among older hospital inpatients: a randomized controlled trial. *Archives of internal medicine*, 171(6), 516-24

Pressure ulcer prevention

- E. McInnes, A. Jammali-Blasi, S. E. Bell-Syer, et al.(2011). Support surfaces for pressure ulcer prevention. *The Cochrane database of systematic reviews*, (4), CD001735
- Z. E. Moore, J. Webster (2013). Dressings and topical agents for preventing pressure ulcers. *The Cochrane database of systematic reviews*, 8, CD009362

Other and general

- L. L. Pyszka, T. M. Seys Ranola, S. M. Milhans (2010). Identification of inappropriate prescribing in geriatrics at a Veterans Affairs hospital using STOPP/START screening tools. *The Consultant pharmacist*, 25(6), 365-73
- Benning, M. Ghaleb, A. Suokas, M. Dixon-Woods, et al.(2011). Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation. *BMJ (Clinical research ed.)*, 342, d195
- S. J. Long, K. F. Brown, D. Ames, C. Vincent (2013). What is known about adverse events in older medical hospital inpatients? A systematic review of the literature. *International journal for quality in healthcare*, 25(5), 542-54

Perceptions of quality among providers and patients

- **Paraprofessional Healthcare Institute:** Make workforce an explicit part of CMS's review processes by including greater oversight and guidance to states about the adequacy and quality of their direct-care workforce in Home and Community-Based Services waiver applications/renewals and Medicaid State Plan Amendments.
- **American Society of Clinical Oncology:** Achieve national recognition for QOPI by assuring that the implementation of legislative language on specialty registries allows QOPI participation to fulfill federal quality requirements.
- **Consortium for Citizens with Disability:** A requirement that CMS work with independent, third party non-profit organizations familiar with consumers with disabilities and chronic

illnesses who require the long term use of complex rehabilitation technology to develop, modify and implement: a continuous survey of the Medicare beneficiary experience with the DMEPOS benefit, including functional outcome measures; and o a continuous quality control 'secret shopper' survey over time of contract suppliers.

- N. A. Bickell, J. Neuman, K. Fei, *et al.*(2012). Quality of breast cancer care: perception versus practice. *Journal of clinical oncology*, 30(15), 1791-5
- D. D. Cline, V. V. Dickson, C. Kovner, *et al.*(2013). Factors Influencing RNs' Perceptions of Quality Geriatric Care in Rural Hospitals. *Western journal of nursing research*, 36(6), 748-768
- H. Lyu, E. C. Wick, M. Housman, *et al.*(2013). Patient satisfaction as a possible indicator of quality surgical care. *JAMA surgery*, 148(4), 362-7

Provider incentives and pay for performance

- **AHIP:** Apply a value-based pricing model for new services covered under Medicare so that higher reimbursement is awarded only upon evidence of superior effectiveness.
- **AHIP:** VBID should support both a reduction in the use of low-value services and an increase in the use of high-value services, should take into consideration the needs of vulnerable populations by including targeted support for those populations, as well as for individuals with multiple co-morbid conditions.
- **AHIP:** Allow Medicare Advantage plans to use tools that promote quality and value, such as using VBID incentives to induce beneficiaries to choose high-performing networks, or varying their cost-sharing based on the clinical effectiveness and value of services. Additional cost-sharing flexibility should also be applied to the Medicare Shared Savings Program and the Pioneer ACO Initiative to enable them to tier cost-sharing based on quality performance and the clinical effectiveness of services.
- **Center for Medicare Advocacy, Inc.:** Bonus payments to Medicare Advantage for quality improvement should not serve as a model for payment reforms to incentivize improvement in quality of care. According to a recent Government Accountability Office report, the Medicare demonstration providing bonus payments to Medicare Advantage plans mainly benefits plans whose performance is no more than average. Congress should ensure that payment reforms intended to incentivize quality of care reward more than average performance.
- **American Association of Kidney Patients:** To ensure proper care for Medicare beneficiaries with more complex needs, the law puts in place protections to ensure every patient will get the ESAs necessary to manage their anemia. First, the bill requires case mix adjustment, which adjusts payments upwards for more complex patients with higher costs of care. Second, the bill requires additional reimbursement to help providers cover the expense of high-cost outlier patients. Third, the legislation requires providers of ESRD services to meet a certain standard for quality of care, and cuts payments for providers who don't.
- **American Healthcare Association:** If the \$250 million savings targeted for each year is not achieved, then the bottom 40 percent of skilled nursing care centers would pay a penalty to reach the targeted amount.
- **American Hospital Association:** Limit provider payment penalties related to readmissions, infections and complications only to those that are truly preventable.
- **American Hospital Association:** Provide incentives, such as discounts, for those individuals who choose high-value plans or providers.
- **American Hospital Association:** Align value-based purchasing initiatives across all providers to ensure they are working toward the same goals.

- **American Association of Kidney Patients:** To ensure proper care for Medicare beneficiaries with more complex needs, the law puts in place protections to ensure every patient will get the ESAs necessary to manage their anemia. First, the bill requires case mix adjustment, which adjusts payments upwards for more complex patients with higher costs of care. Second, the bill requires additional reimbursement to help providers cover the expense of high-cost outlier patients. Third, the legislation requires providers of ESRD services to meet a certain standard for quality of care, and cuts payments for providers who don't.
- **AHIP:** The current Medicare payment formula (SGR) for physicians is broken and needs to be replaced by transitioning toward a value-based payment model.
- **Center for Medicare Advocacy, Inc.:** Ensure beneficiaries are held harmless from payment adjustments. Because beneficiary premiums and cost sharing are based on overall Medicare expenditures, provider payment adjustments should not lead to increased Medicare spending. Instead, innovative reimbursement and delivery models should be implemented, which reduce Medicare expenditures by incentivizing quality and value, rather than quantity and volume.
- **American Geriatrics Society:** Ensure that value-based purchasing and other quality initiatives take into account the unique healthcare needs of all older patients
- B. Serumaga, D. Ross-Degnan, A. J. Avery, *et al.*(2011). Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study. *BMJ (Clinical research ed.)*, 342, d108
- R. M. Werner, J. T. Kolstad, E. A. Stuart, D. Polsky (2011). The effect of pay-for-performance in hospitals: lessons for quality improvement. *Health affairs (Project Hope)*, 30(4), 690-8
- P. Boeckxstaens, D. D. Smedt, J. D. Maeseneer, *et al.*(2011). The equity dimension in evaluations of the quality and outcomes framework: a systematic review. *BMC health services research*, 11, 209
- L. A. Petersen, K. Simpson, K. Pietz, *et al.*(2013). Effects of individual physician-level and practice-level financial incentives on hypertension care: a randomized trial. *JAMA*, 310(10), 1042-50
- T. Esse, O. Serna, A. Chitnis, *et al.*(2013). Quality compensation programs: are they worth all the hype? A comparison of outcomes within a Medicare advantage heart failure population. *Journal of managed care pharmacy*, 19(4), 317-24

Quality improvement: evidence-based interventions

Community based

- C. Tricco, N. M. Ivers, J. M. Grimshaw, *et al.*(2012). Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis. *Lancet*, 379(9833), 2252-61
- M. E. Dellefield, A. Kelly, J. F. Schnelle (2013). Quality assurance and performance improvement in nursing homes: using evidence-based protocols to observe nursing care processes in real time. *Journal of nursing care quality*, 28(1), 43-51

Hospital based

- **American Hospital Association:** The AHA must advocate for a concerted national effort to develop and disseminate best practices to help hospitals, physicians and other clinicians, and other providers effectively and efficiently identify and address sources of inappropriate variation.

- R. C. Hendel, M. Cerqueira, P. S. Douglas, *et al.*(2010). A multicenter assessment of the use of single-photon emission computed tomography myocardial perfusion imaging with appropriateness criteria. *Journal of the American College of Cardiology*, 55(2), 156-62
- L. O. Hansen, R. S. Young, K. Hinami, *et al.*(2011). Interventions to reduce 30-day rehospitalization: a systematic review. *Annals of internal medicine*, 155(8), 520-8
- T. B. Cumming, A. G. Thrift, J. M. Collier, *et al.*(2011). Very early mobilization after stroke fast-tracks return to walking: further results from the phase II AVERT randomized controlled trial. *Stroke; a journal of cerebral circulation*, 42(1), 153-8
- F. Krummenauer, K. P. Guenther, S. Kirschner (2011). Cost effectiveness of total knee arthroplasty from a healthcare providers' perspective before and after introduction of an interdisciplinary clinical pathway--is investment always improvement? *BMC health services research*, 11, 338
- J. R. Curtis, E. L. Nielsen, P. D. Treece, *et al.* (2011). Effect of a quality-improvement intervention on end-of-life care in the intensive care unit: a randomized trial. *American journal of respiratory and critical care medicine*, 183(3), 348-55
- S. Middleton, P. McElduff, J. Ward, *et al.* (2011). Implementation of evidence-based treatment protocols to manage fever, hyperglycaemia, and swallowing dysfunction in acute stroke (QASC): a cluster randomised controlled trial. *Lancet*, 378(9804), 1699-706
- S. Garcia-Botello, R. Canovas de Lucas, C. Tornero, *et al.* (2011). [Implementation of a perioperative multimodal rehabilitation protocol in elective colorectal surgery. A prospective randomised controlled study]. *Cirugia espanola*, 89(3), 159-66
- T. A. Holt, T. D. Hunter, C. Gunnarsson, *et al.*(2012). Risk of stroke and oral anticoagulant use in atrial fibrillation: a cross-sectional--survey. *The British journal of general practice*, 62(603), e710-7
- J. Turagava, T. Sammour, F. Al-Herz, *et al.* (2012). Short-term outcomes of laparoscopic resection for colon cancer in a provincial New Zealand hospital. *The New Zealand medical journal*, 125(1356), 17-26
- W. D. Reid, C. Yamabayashi, D. Goodridge, *et al.* (2012). Exercise prescription for hospitalized people with chronic obstructive pulmonary disease and comorbidities: a synthesis of systematic reviews. *International journal of chronic obstructive pulmonary disease*, 7, 297-320
- F. Irani, N. Herial, W. R. Colyer (2012). Impact of an acute coronary syndrome pathway in achieving target heart rate and utilization of evidence-based doses of beta-blockers. *American journal of therapeutics*, 19(6), 397-402
- M. Theilla (2013). Nutrition support for wound healing in the intensive care unit patient. *World review of nutrition and dietetics*, 105, 179-89
- N. M. Kosse, A. L. Dutmer, L. Dasenbrock, *et al.* (2013). Effectiveness and feasibility of early physical rehabilitation programs for geriatric hospitalized patients: a systematic review. *BMC geriatrics*, 13, 107
- E. A. Nutescu, A. K. Wittkowsky, A. Burnett, *et al.* (2013). Delivery of optimized inpatient anticoagulation therapy: consensus statement from the anticoagulation forum. *The Annals of pharmacotherapy*, 47(5), 714-24

Long term care

- **Society for Post-Acute and Long-Term Care Medicine:** Help the facility establish systems and methods for reviewing the quality and appropriateness of clinical care and other health-related services and provide appropriate feedback; Participate in the facility's quality improvement process; and help the facility provide a safe and caring environment.

- **Society for Post-Acute and Long-Term Care Medicine:** AMDA policy on Performance Review supports performance review conducted under the auspices of the Quality Assessment & Assurance process for all attending physicians caring for residents in long-term care facilities, including performance review of the medical director when the medical director is also serving as attending physician.
- **Society for Post-Acute and Long-Term Care Medicine:** AMDA recommends that the medical director should be a part of the Quality Assurance, Infection Control, and Pharmacy Committees.
- Roe, L. Flanagan, B. Jack, *et al.*(2011). Systematic review of the management of incontinence and promotion of continence in older people in care homes: descriptive studies with urinary incontinence as primary focus. *Journal of advanced nursing*, 67(2), 228-50
- K. Charlton, C. Nichols, S. Bowden, *et al.*(2012). Poor nutritional status of older subacute patients predicts clinical outcomes and mortality at 18 months of follow-up. *European journal of clinical nutrition*, 66(11), 1224-8
- Pileggi, B. Manuti, R. Costantino, *et al.*(2014). Quality of care in one Italian nursing home measured by ACOVE process indicators. *PloS one*, 9(3), e93064

National evidence base

- **National Association of Nutrition and Aging Services Programs:** NANASP supports the repeal of Independent Payment Advisory Board (IPAB) on the basis that it provides too much power in the hands of unelected individuals to determine future issues with Medicare spending. NANASP urges Congress to adopt legislation to either modify IPAB by limiting its authority and making it more advisory in nature and subject to normal Congressional review and action or repeal it.
- **AHIP:** One proposed solution is the creation of a single, national entity to assess the clinical and cost- effectiveness of new and existing drugs, devices, procedures, and healthcare services to determine whether they provide superior patient benefit, or value, compared to existing alternatives. Such a system would provide a much needed venue to evaluate new treatments and technologies at least as quickly as they come to market.
- **AHIP:** Creation of a national clearinghouse for the collection of best practices and dissemination of information among employers, government and local communities to accelerate the adoption of evidence-based strategies for care coordination.
- **American Hospital Association:** AHA must advocate for money to be allocated to support National Institutes of Health and professional society work in this area and to AHRQ to disseminate best practice approaches to reducing variation.

Provider education

- J. J. Sclafani, J. My, L. L. Zacher, R. E. Eckart (2010). Intensive education on evidence-based evaluation of syncope increases sudden death risk stratification but fails to reduce use of neuroimaging. *Archives of internal medicine*, 170(13), 1150-4
- J. J. Diaz, P. R. Norris, R. S. Miller, *et al.*(2010). Acute care surgery program: mentoring fellows and patient outcomes. *The Journal of surgical research*, 160(2), 202-7

Quality improvement: screening interventions

- M. L. Gaubert-Dahan, A. Cougnaud-Petit, L. De Decker, *et al.*(2011). [Beyond to pattern of risk factors in elderly subjects]. *Geriatric et psychologie neuropsychiatrie du vieillissement*, 9(3),

- S. H. Brown, K. Flint, A. Storey, A. H. Abdelhafiz (2012). Routinely assessed biochemical markers tested on admission as predictors of adverse outcomes in hospitalized elderly patients. *Hospital practice* (1995), 40(1), 193-201
- C. F. Ski, K. Page, D. R. Thompson, *et al.*(2012). Clinical outcomes associated with screening and referral for depression in an acute cardiac ward. *Journal of clinical nursing*, 21(15-16), 2228-34
- L. Keay, K. Lindsley, J. Tielsch, *et al.*(2012). Routine preoperative medical testing for cataract surgery. *The Cochrane database of systematic reviews*, 3, CD007293
- M. Young, S. Kidston, M. D. Banks, *et al.*(2013). Malnutrition screening tools: comparison against two validated nutrition assessment methods in older medical inpatients. *Nutrition* (Burbank, Los Angeles County, Calif.), 29(1), 101-6
- D. K. Nishijima, M. Sena, J. M. Galante, *et al.*(2014). Derivation of a clinical decision instrument to identify adult patients with mild traumatic intracranial hemorrhage at low risk for requiring ICU admission. *Annals of emergency medicine*, 63(4), 448-56 e2

Transparency and reporting

- **AHIP:** A new entity to compare the clinical effectiveness and value of new treatments and services to existing ones would provide Americans with a trusted source from which to obtain up-to-date, objective, and credible information on which healthcare services are most effective and provide the best value.
- **AHIP:** An effort initiated by the federal government to measure and report on physician and hospital performance within public programs similar to initiative already undertaken in the private sector.
- **AHIP:** Congress should change the statutory language on Medicare pricing to a system in which first-time prices for new treatments are set in conjunction with a determination of their effectiveness compared to services currently covered by Medicare.
- **American Hospital Association:** Require that information about insured enrollees' expected out-of-pocket costs is available to them through their insurance company or public program.
- **American Medical Association:** Replace the many process-based ACO quality measures with a small set of population-based outcome measures
- **American Medical Association:** In addition, the AMA is urging CMS to develop and refine a more selective data set that could actually help patients and physicians make more informed care decisions. The data set released in April does not include crucial metrics that should be part of information intended for patients, including quality, outcomes and a full picture of the physician's practice.
- **Families USA (The Voice for Healthcare Consumers):** States can play a pivotal role in improving price transparency. Moving forward, states should consider taking steps to improve consumer access to meaningful price and quality information.
- **AHIP:** We recommend that the federal government and private-sector stakeholders identify a parsimonious set of meaningful and useful performance measures, focused on high-priority health conditions where performance varies widely, building on the work begun by the National Quality Forum and expanding the scope to include all major public programs and commercial populations
- **American Hospital Association:** Align quality measurement and reporting across all public and private payers.

- **Eldercare Workforce Alliance:** Include quality metrics for practitioners and providers that promote quality care and recognize the complexity of caring for older adults with multiple chronic conditions, including those who are cognitively impaired, and support the need to work collaboratively with family caregivers.
- **Families USA (The Voice for Healthcare Consumers):** It is also critical that these programs be designed so that consumers can easily obtain care from providers who charge within the reference price and not simply become a tool to shift costs to consumers.
- **Leadership Council of Aging Organizations:** LCAO supports adoption of quality metrics and comparable measurement tools to allow Medicare beneficiaries to make decisions based on quality of care.
- **Partnership for Prevention:** Financing mechanisms should support the development of system performance standards related to prevention and the subsequent evaluation of performance.
- **Families USA (The Voice for Healthcare Consumers):** Reference pricing programs must be built on a foundation of price transparency and must be limited to shoppable healthcare services that have wide price variation.
- **Leadership Council of Aging Organizations:** measuring plan improvements through star ratings metrics; and we support standardizing the reporting of negotiated drug prices by a network pharmacy and a prescription drug.
- **National Committee to Preserve Social Security & Medicare:** The National Committee supports revising and improving the Experimental Consumer Price Index for the Elderly (CPI)
- **Society for Post-Acute and Long-Term Care Medicine:** (AMDA) work with the Centers for Medicare & Medicaid Services (CMS) and other stakeholders to address the issue of appropriate use of Quality Indicators in the post-acute and long-term care population in quality programs such as the Physician Quality Reporting System (PQRS).
- **Society for Post-Acute and Long-Term Care Medicine:** AMDA work with organizations such as the Centers for Medicare & Medicaid Services, National Quality Forum (NQF) and the American Medical Association convened Physician Consortium for Performance Improvement (PCPI) in order to establish appropriate, evidence based quality measures for the post-acute and long-term care population.
- **Society for Post-Acute and Long-Term Care Medicine:** AMDA recommends that medical directors be familiar with the facility process of gathering MDS (minimum data set) data and reviewing the quality indicators/quality measures at least quarterly as a part of ongoing quality assurance activities.
- K. E. Joynt, D. M. Blumenthal, E. J. Orav, *et al.*(2012). Association of public reporting for percutaneous coronary intervention with utilization and outcomes among Medicare beneficiaries with acute myocardial infarction. *JAMA* , 308(14), 1460-8

Section 5. Patient Self Care and Self Management

Description: Patients with chronic disease account for a huge portion of healthcare spending in the US. Among older adults, 80 percent have at least one chronic condition.⁴¹ 99 percent of Medicare spending is attributable to individuals with at least one chronic condition, and 79 percent is attributable to individuals with 5 or more chronic conditions.⁴² Better management of chronic disease can help patients with complex, co-morbid conditions avoid unnecessary interactions with the healthcare system, such as costly trips to the Emergency Room. Patient self care and self management initiatives encourage patients work with their providers to preserve their health status and minimize avoidable complications. These initiatives utilize strategies such as patient education to encourage healthy decisions and behaviors.

- **American Association of Kidney Patients:** The law also creates a new education benefit for pre-ESRD patients. This is the first time ever such activities will be covered by Medicare. The goal here is that hopefully patients can delay onset of the need for dialysis. And when they do need dialysis, they will be better informed about their options between home and in-center dialysis, as well as the importance of getting a fistula.
- **American Hospital Association:** Insurers and employers should offer insurance products with lower premiums for patients who receive recommended preventive services or who improve their health.
- **American Hospital Association:** Offer incentives to Medicare and Medicaid enrollees to engage in their care planning and self-management of chronic conditions.
- **National Academy of Social Insurance:** It is time to develop a multi-pronged strategy that focuses on the consistent promotion of a patient's right to informed consent and self-determination in all major services settings, while at the same time identifying and preventing unwanted medical treatment.
- **National Coalition on Healthcare:** Implement a Medicare Health Rewards program that provides small monetary incentives for Medicare beneficiaries to set and achieve health goals.
- **Consortium for Citizens with Disability:** AAHD commends the interim report pages 5-6 identification of the need for new and improved measures to address the "high priority measure gaps." Each of these is of significant importance to persons with disabilities: (a) goal directed, person-centered care planning and implementation; (b) shared decision-making; (c) systems to coordinate healthcare with nonmedical community resources and service providers; (d) beneficiary sense of control, autonomy, self-determination; (e) psychosocial needs; (f) community integration, inclusion, and participation; and (g) optimal functioning.
- C. Clar, K. Barnard, E. Cummins, *et al.* (2010). Self-monitoring of blood glucose in type 2 diabetes: systematic review. *Health technology assessment (Winchester, England)*, 14(12), 1-140
- D. K. Remler, J. A. Teresi, R. S. Weinstock, *et al.* (2011). Healthcare utilization and self-care behaviors of Medicare beneficiaries with diabetes: comparison of national and ethnically diverse underserved populations. *Population health management*, 14(1), 11-20
- D. E. Holland, P. Mistiaen, K. H. Bowles (2011). Problems and unmet needs of patients discharged "home to self-care". *Professional case management*, 16(5), 240-50; quiz 251-2

⁴¹<http://www.cdc.gov/chronicdisease/resources/publications/aag/aging.htm>

⁴²<http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583>

- C. E. Bucknall, G. Miller, S. M. Lloyd, *et al.*(2012). Glasgow supported self-management trial (GSuST) for patients with moderate to severe COPD: randomised controlled trial. *BMJ*, 344, e1060
- S. B. Bentsen, E. Langeland, A. L. Holm (2012). Evaluation of self-management interventions for chronic obstructive pulmonary disease. *Journal of nursing management*, 20(6), 802-13
- M. A. Chisholm-Burns, C. A. Spivey, J. Graff Zivin, *et al.*(2013). Improving outcomes of renal transplant recipients with behavioral adherence contracts: a randomized controlled trial. *American journal of transplantation*, 13(9), 2364-73
- M. Stellefson, B. Chaney, A. E. Barry, *et al.*(2013). Web 2.0 chronic disease self-management for older adults: a systematic review. *Journal of medical Internet research*, 15(2), e35
- C. L. Brandt (2013). Study of older adults' use of self-regulation for COPD self-management informs an evidence-based patient teaching plan. *Rehabilitation nursing*, 38(1), 11-23

Section 6. Palliative and End-of-life Care

Description: Palliative care is a holistic approach to care that focuses on relieving symptoms and easing stress for patients with serious illness. Hospice care is similar to palliative medicine, in that it focuses on managing the symptoms and relieving the suffering of a patient at the end-of-life. Hospice care can take place either in an individual's home or in an institutional setting. About 70 percent of Americans would prefer to die at home,⁴³ but only about 25 percent of Americans actually die at home.⁴⁴ Approximately one-third of Medicare spending is on patients in their last two years of life. Conversations about preferences for end-of-life care are difficult and many Americans do not have an advanced directive expressing their preferences for care at the end-of-life. As a result, many patients at the end-of-life receive costly and painful healthcare interventions that they do not want or need.

Advanced care planning

- **Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine and its state chapters promote the Physician's Orders for Life-Sustaining Treatment (POLST) Paradigm by supporting education about, dissemination and appropriate use of, and resident access to the POLST Paradigm and other advance care planning materials.
- **American Hospital Association:** Lead a multi-stakeholder effort to promote the development of advanced care directives.
- **American Hospital Association:** Require all Medicare and adult Medicaid patients to have an advance directive.
- T. T. Levin, B. Moreno, W. Silvester, D. W. Kissane (2010). End-of-life communication in the intensive care unit. *General hospital psychiatry*, 32(4), 433-42
- K. S. Lau, D. M. Tse, T. W. Tsan Chen, *et al.*(2010). Comparing noncancer and cancer deaths in Hong Kong: a retrospective review. *Journal of pain and symptom management*, 40(5), 704-14
- E. L. Sampson, L. Jones, I. C. Thune-Boyle, *et al.*(2011). Palliative assessment and advance care planning in severe dementia: an exploratory randomized controlled trial of a complex intervention. *Palliative medicine*, 25(3), 197-209
- D. S. Finnell, Y. W. Wu, M. A. Jezewski, *et al.*(2011). Applying the transtheoretical model to healthcare proxy completion. *Medical decision making*, 31(2), 254-9
- L. Robinson, C. Dickinson, N. Rousseau, *et al.*(2012). A systematic review of the effectiveness of advance care planning interventions for people with cognitive impairment and dementia. *Age and ageing*, 41(2), 263-9
- N. Evans, C. Bausewein, A. Menaca, *et al.*(2012). A critical review of advance directives in Germany: attitudes, use and healthcare professionals' compliance. *Patient education and counseling*, 87(3), 277-88
- M. A. Brown, E. L. Sampson, L. Jones, A. M. Barron (2013). Prognostic indicators of 6-month mortality in elderly people with advanced dementia: a systematic review. *Palliative medicine*, 27(5), 389-400
- J. Kryworuchko, E. Hill, M. A. Murray, *et al.*(2013). Interventions for shared decision-making about life support in the intensive care unit: a systematic review. *Worldviews on evidence-based nursing / Sigma Theta Tau International, Honor Society of Nursing*, 10(1), 3-16

⁴³<http://content.time.com/time/magazine/article/0,9171,997968,00.html>

⁴⁴<http://www.cdc.gov/nchs/data/hus/hus10.pdf>

- Brinkman-Stoppelenburg, J. A. Rietjens, A. van der Heide (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative medicine*, 28(8), 1000-1025
- Q. R. Razlighi, E. Stallard, J. Brandt, *et al.* (2014). A new algorithm for predicting time to disease endpoints in Alzheimer's disease patients. *Journal of Alzheimer's disease*, 38(3), 661-8
- C. Araw, A. M. Araw, R. Pekmezaris, *et al.* (2014). Medical orders for life-sustaining treatment: is it time yet? *Palliative & supportive care*, 12(2), 101-5

End-of-life care providers

- **American Academy of Physician Assistants:** The American Academy of Physician Assistants recommends that sections 1861(dd)(3)(B) and 1814(a)(7)(A)(i)(I) of the Social Security Act be amended to permit physician assistants (PAs) to provide hospice care to their patients who elect Medicare's hospice benefit.
- **American Hospital Association:** Reimburse providers for discussing a patient's goals/wishes.
- **American Public Health Association:** Improved coordination across the continuum of care to reduce unnecessary and harmful care transitions that result in adverse outcomes for seriously ill patients.
- M. Prince-Paul, C. J. Burant, J. N. Saltzman, *et al.* (2010). The effects of integrating an advanced practice palliative care nurse in a community oncology center: a pilot study. *The journal of supportive oncology*, 8(1), 21-7
- N. N. Ahmed, M. Farnie, C. B. Dyer (2011). The effect of geriatric and palliative medicine education on the knowledge and attitudes of internal medicine residents. *Journal of the American Geriatrics Society*, 59(1), 143-7
- C. Gardiner, L. Brereton, R. Frey, L. Wilkinson-Meyers, M. Gott (2014). Exploring the financial impact of caring for family members receiving palliative and end-of-life care: a systematic review of the literature. *Palliative medicine*, 28(5), 375-90

Palliative care

- **American Hospital Association:** Insurers should expand coverage and reimbursement of hospice and palliative care.
- **American Public Health Association:** Eliminate financial barriers to third-party payments for early and comprehensive hospice and palliative care
- **American Public Health Association:** State and local health departments are encouraged to take an active public health role in addressing palliative and end-of-life issues and unmet needs among seriously ill individuals, including advocating for patient rights and honoring patients' full participation in shared informed decision making, as well as developing public health agency accreditation processes that demonstrate competencies in these areas.
- **American Public Health Association:** State governments and state health departments are urged to promote effective pain care and pain management in the case of serious illnesses and at the end-of-life through the development of policies that remove barriers to use of essential pain medications including opioid analgesics.
- **American Public Health Association:** The establishment of clinical guidance for the appropriate medical use of opioid and non-opioid analgesics in diverse patient populations, and evaluations of policy responses to alleviate intolerable and intractable forms of suffering, with appropriate safeguards to protect against diversion and abuse.

- **American Public Health Association:** Promotion of the use of hospice care and palliative care through education about their availability and benefits among healthcare providers, public health professionals, and government entities
- **American Public Health Association:** Ensure that health reform initiatives at the federal and state levels are fully implemented through innovations in palliative care delivery (e.g., in medical and health homes), helping to eliminate health disparities among the sickest and most vulnerable patients and frail elderly individuals.
- **American Public Health Association:** Federal and state governments are urged to consider making palliative care an essential health benefit and a condition of payment to hospitals and providers by Medicare, private insurers, and (after 2014) state exchanges.
- **American Public Health Association:** Federal and state governments are encouraged to eliminate financial barriers to third-party payments for early and comprehensive hospice and palliative care, including at minimum elimination of Medicare's requirement that hospice care costs be reimbursed only when efforts to cure the patient have been terminated.
- **National Coalition on Healthcare:** Include provision of palliative care consultations in the Medicare's Value-Based Purchasing Program's quality metrics.
- Y. J. Baek, D. W. Shin, J. Y. Choi, *et al.*(2011). Late referral to palliative care services in Korea. *Journal of pain and symptom management*, 41(4), 692-9
- T. J. Smith, S. Temin, E. R. Alesi, *et al.*(2012). American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. *Journal of clinical oncology*, 30(8), 880-7
- J. E. Nelson, J. R. Curtis, C. Mulkerin, *et al.*(2013). Choosing and using screening criteria for palliative care consultation in the ICU: a report from the Improving Palliative Care in the ICU (IPAL-ICU) Advisory Board. *Critical care medicine*, 41(10), 2318-27
- D. W. Jang, M. S. Teng, B. Ojo, E. M. Genden (2013). Palliative surgery for head and neck cancer with extensive skin involvement. *The Laryngoscope*, 123(5), 1173-7
- S. J. Hwang, H. T. Chang, I. H. Hwang, *et al.*(2013). Hospice offers more palliative care but costs less than usual care for terminal geriatric hepatocellular carcinoma patients: a nationwide study. *Journal of palliative medicine*, 16(7), 780-5

Patient and caregiver satisfaction

- B. Zhang, M. E. Nilsson, H. G. Prigerson (2012). Factors important to patients' quality of life at the end-of-life. *Archives of internal medicine*, 172(15), 1133-42
- J. T. van der Steen, M. C. van Soest-Poortvliet, M. J. Gijssberts, *et al.*(2013). [Improved end-of-life care for patients with dementia: greater family satisfaction and possibly greater end-of-life comfort]. *Nederlands tijdschrift voor geneeskunde*, 157(17), A5324

Quality of care at the end-of-life

- **American Public Health Association:** APHA continues to support the intent of the CDC and CDD to identify a chronic disease point person within state health departments to coordinate end-of-life activities with relevant issues in aging and serious illness
- D. O'Mahony, M. N. O'Connor (2011). Pharmacotherapy at the end-of-life. *Age and ageing*, 40(4), 419-22
- J. R. Curtis, E. L. Nielsen, P. D. Treece, *et al.*(2011). Effect of a quality-improvement intervention on end-of-life care in the intensive care unit: a randomized trial. *American journal of respiratory and critical care medicine*, 183(3), 348-55

- B. Ohta, J. J. Kronenfeld (2011). Intensity of acute care services at the end-of-life: nonclinical determinants of treatment variation in an older adult population. *Journal of palliative medicine*, 14(6), 722-8
- J. R. Curtis, R. A. Engelberg, M. E. Bensink, S. D. Ramsey (2012). End-of-life care in the intensive care unit: can we simultaneously increase quality and reduce costs? *American journal of respiratory and critical care medicine*, 186(7), 587-92
- C. J. Wiedermann, G. F. Lehner, M. Joannidis (2012). From persistence to palliation: limiting active treatment in the ICU. *Current opinion in critical care*, 18(6), 693-9
- J. Higginson, C. J. Evans, G. Grande, *et al.*(2013). Evaluating complex interventions in end-of-life care: the MORECare statement on good practice generated by a synthesis of transparent expert consultations and systematic reviews. *BMC medicine*, 11, 111

Setting of care at the end-of-life

- B. Candy, A. Holman, B. Leurent, *et al.*(2011). Hospice care delivered at home, in nursing homes and in dedicated hospice facilities: A systematic review of quantitative and qualitative evidence. *International journal of nursing studies*, 48(1), 121-33
- D. A. Jones, S. M. Bagshaw, J. Barrett, *et al.*(2012). The role of the medical emergency team in end-of-life care: a multicenter, prospective, observational study. *Critical care medicine*, 40(1), 98-103
- E. Ubogagu, D. G. Harris (2012). Guideline for the management of terminal haemorrhage in palliative care patients with advanced cancer discharged home for end-of-life care. *BMJ supportive & palliative care*, 2(4), 294-300
- N. T. Zheng, D. B. Mukamel, T. V. Caprio, H. Temkin-Greener (2013). Hospice utilization in nursing homes: association with facility end-of-life care practices. *The Gerontologist*, 53(5), 817-27

Section 7. Long Term and Community-Based Care

Description: Long term care (LTC) encompasses a range of services needed by individuals with cognitive and functional limitations. As the population ages, the number of Americans who need long term care will more than double over the next decade, rising from 12 to 27 million.⁴⁵ Long-term services and supports (LTSS) include assistance with the activities of daily living (such as bathing and eating). These services can be delivered in an individual's home or in an institutional setting. In 2011, the US spent \$211 billion on LTSS, approximately 62 percent of which was paid by the Medicaid program.⁴⁶ Many individuals in need of LTSS receive care at home from unpaid, untrained family caregivers. LTSS care delivered in an institutional setting is very costly for patients and families – nursing home care costs approximately \$90,000 annually, and home health aide services cost \$21,000 annually.⁴⁷

Family caregivers

- **AARP:** It is vitally important that these caregivers—many of whom are in their peak earning years—do not lose their jobs due to stereotypes that they will be less productive because of caregiving and are protected from discrimination in the workplace
- **AARP:** Offering employed caregivers flexible hours, paid sick time, and family leave can enhance employee productivity, lower absenteeism, reduce costs, and positively affect profits.
- **AARP:** Examples of promising employer practices include educating and training supervisors and managers on the needs of caregiving employees, on-site support groups, referral to community-based caregiver resources, and discounted backup home care for emergencies.
- **AARP:** Increase the reach of the Family and Medical Leave Act (FMLA) by expanding the relationships covered by the law to include domestic partners, parents-in-law, grandparents, and siblings. Require employers to protect workers in businesses with fewer than 50 employees.
- **AARP:** Adopt policies at the state level that exceed the current federal eligibility requirements for the FMLA.
- **AARP:** Optimize worker productivity and retention at the federal, state, and local levels by promoting access to paid family leave insurance.
- **AARP:** Advance public awareness campaigns at the federal, state, and local levels to educate the public about all aspects of family leave policies, including the FMLA and paid family and medical leave in states with these policies.
- **AARP:** Require employers to provide a reasonable number of earned sick days that can be used to deal with personal or family illness.
- **AARP:** Implement “family-friendly” and flexible workplace policies, referral to supportive services in the community, and caregiver support programs in the workplace. Such policies and benefits can enhance employee productivity, lower absenteeism, enhance recruitment and retention, reduce costs, and positively affect profits.
- **AARP:** Improve data collection on working caregivers with eldercare responsibilities, including surveys conducted by the Department of Labor, Department of Health and Human Services, and Department of Commerce, to ensure that challenges about work-family conflict and access to workplace leave benefits and protections are addressed.

⁴⁵<http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>

⁴⁶Id.

⁴⁷<https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8474-02-five-key-facts-about-the-delivery-and-financing.pdf>

- **AARP:** The review should also look at the existing ADL and IADL measures in terms of their complexity, timing, and duration. Although several existing bodies might take on the responsibility, we suggest that the Institute of Medicine (IOM) is particularly well suited to this kind of consensus-building effort.
- **AARP:** The Joint Commission should ensure that surveyors are trained to assess family caregiver training and support. In setting standards for the delivery of high-quality healthcare, the National Quality Forum could specifically address the need to define and promote standards that include the role of family caregivers.
- **AARP:** Family caregiver assessment should be a part of all assessment tools for Medicaid HCBS waiver programs, including comprehensive assessments developed at federal and state levels, to establish responsive person- and family-centered service plans.
- **AARP:** The interRAI Minimum Data Set-Home Care (MDS-HC) instrument should be expanded to include additional questions directed specifically to family caregivers in order to assess their service and support needs.
- **AARP:** The family caregiver assessment should be part of the Medicaid HCBS client record and coded for electronic records if available.
- **AARP:** Funding should be preserved and increased for caregiver support services under the Older Americans Act's National Family Caregiver Support Program (NFCSP)
- **AARP:** States should examine their assessment tools for people in Medicaid HCBS managed care programs and for those eligible for both Medicaid and Medicare, adding a component to assess family caregiver needs whenever the client's care plan depends upon the family caregiver.
- **Alzheimer's Foundation of America:** AFA identified certain action steps in the national plan that could advance the delivery of care for people with Alzheimer's disease and their family caregivers- and that are vital to advancing this strategic plan. The analysis suggests that implementation of these provisions will eliminate costly medical interventions and will work to make significant improvements in the quality of life for diagnosed individuals.
- **Alzheimer's Foundation of America:** Support caregivers through call centers (3.B.7)
- **Alzheimer's Foundation of America:** Expand and Promote Family Caregiver Training and Support Across the Continuum of Care
- **Alzheimer's Foundation of America:** REACH is now implemented at all facilities operated by the U.S. Department of Veterans Affairs, and it should also be implemented system-wide for Medicare and Medicaid beneficiaries by CMS through the Center for Medicare and Medicaid Innovation, known as the Innovation Center. AFA urges CMS to expand and promote the Resources for Enhancing Alzheimer's Caregiver Health (REACH program) systemwide for Medicare and Medicaid beneficiaries through CMS' Innovation Center.
- **Alzheimer's Foundation of America:** AFA urges CMS and the Administration on Aging (AoA) to develop new ideas for supporting younger family members who may be helping with care, such as teens and young adults.
- **Alzheimer's Foundation of America:** Supports passage of S. 1095, the Caring for an Aging America Act.
- **Alzheimer's Foundation of America:** Educate and support people with AD and their families upon diagnosis ...Providing support services, education and training upon diagnosis is vital to ensuring that families can adequately plan for the responsibilities and life changes that occur after a loved one is diagnosed with Alzheimer's disease.

- **Alzheimer’s Foundation of America:** Urging adoption of family-friendly workplace policies, with federal incentives to carry them out. Examples of family-friendly workplace policies include: flextime; work-at-home options; job-sharing; counseling; dependent care accounts; information and referral to community services; and employer-paid services of a care manager.
- **Alzheimer’s Foundation of America:** The national plan must call for further expansion of publicly-funded “participant-directed” (aka “consumer-directed,” “cash and counseling,” “self-directed care”) programs that allow participants to hire family members—including spouses, adult children and even teens—as caregivers.
- **American Academy of Physician Assistants:** the American Academy of Physician Assistants urges Congress to approve the Home Health Planning and Improvement Act (HR 2504/S 1332) in the 113th Congress.
- **American Society of Clinical Oncology:** ASCO will advocate for adequate Medicare reimbursement to cover survivorship services provided by MDs, NPs and PAs survivorship services.
- **American Society of Clinical Oncology:** Supports legislation like the Comprehensive Cancer Care Improvement Act ; which aims to improve survivorship care throughout the cancer care continuum by supporting coverage of comprehensive cancer care planning, establishing grant programs to increase provider education of palliative care and symptom management.
- **Association of Jewish Aging Services of North America (AJAS):** Alzheimer’s Education & Expanded Coverage under Medicare In 2010, Senator Debbie Stabenow (D-MI) introduced the Health Outcomes, Planning, and Education (HOPE) for Alzheimer’s Act which will seek to ensure that Medicare covers screening for the disease as well as education on treatment options both for the patient as well as for the patient’s family caregivers. HOPE calls for clear standards (which will allow healthcare professionals to be reimbursed for these services) and the establishment of a cohesive treatment plan.
- **Center for Advocacy on the Rights and Interests of the Elderly:** When older adults are being assessed for services, the needs of their caregivers should be assessed along with the clients and the care plan should address their needs as well whenever possible.
- **Eldercare Workforce Alliance:** EWA also strongly supports the recommendation for adequate training and compensation for paraprofessional caregivers, as well as your sustained and increased emphasis on funding, supports, and resources for family caregivers.
- **Eldercare Workforce Alliance:** Family Caregiver Support Services: EWA requests \$154.5 million.
- **Eldercare Workforce Alliance:** Lifespan Respite Care: EWA requests \$2.5 million
- **Eldercare Workforce Alliance:** EWA also strongly supports the recommendation for adequate training and compensation for paraprofessional caregivers, as well as your sustained and increased emphasis on funding, supports, and resources for family caregivers. Family Caregiver Support Services: EWA requests \$154.5 million.
- **Eldercare Workforce Alliance:** We request that DOL take timely action to issue a revised interpretation of the exemption that will extend greater federal minimum wage and overtime protection under FLSA to the more than 1,500,000 paid home and community-based care workers who provide essential services to our nation’s older adults and people with disabilities.
- **Family Caregiver Alliance:** The Legislature and the Governor should enact state legislation to integrate family caregivers into health and social service programs across state departments.
- **Family Caregiver Alliance:** If a care plan relies on informal support provided by families and others, then an assessment of the caregivers’ needs should be conducted and services provided to sustain care their efforts and promote their well-being.

- **Generations United:** Generations United supports public policies that assist family caregivers of all types in caring for family members. Family- friendly national policies will require eliminating barriers to eligibility in current programs, expanding programs to allow greater access, and creating new programs to address the continuing growth in intergenerational caregiving. Policies should place special emphasis on assisting families with low to moderate incomes and limited assets, in addition to other vulnerable populations.
- **National Alliance for Caregiving:** Following an assessment of caregiver readiness and ability, the clinical practice should note the caregiver in the patient’s medical record (electronic and hard copy) and explain the goals of the patient’s care plan. The practice team should also provide instructions to the caregiver on how to assist with the patient’s care at home. Finally, the clinical practice should provide referrals to home- and community-based services that can provide additional supports for the patient (e.g., Meals on Wheels, local Alzheimer’s Association). It would also be beneficial to provide the caregiver with referrals to caregiving supports in the community, such as respite services.
- **National Alliance for Caregiving:** The National Alliance for Caregiving (the “Alliance”) strongly supports the effort to implement the Caregiver Advise, Record and Enable (“CARE”) Act across the 50 U.S. states. The model CARE Act, and its administrative counterparts, correctly identifies the family caregiver as an essential member of the healthcare team.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports additional funding for the supportive services and family caregiver programs as proposed in the Administration’s FY 2012 budget
- **Paraprofessional Healthcare Institute:** Training programs, information and tools for caregivers—both paid and unpaid—who are providing and coordinating care
- **Paraprofessional Healthcare Institute:** Resources for families learning to manage and provide care including a family caregiver assessment to determine the needs and capabilities of families members in assuming these roles
- **Paraprofessional Healthcare Institute:** Align government payment policies in order to expand the availability of quality home and community-based services by establishing parity in the reimbursement of training costs for all direct care workers.
- **Paraprofessional Healthcare Institute:** Revise the companionship exemption to the Fair Labor Standards Act to extend federal minimum wage and overtime protections to home care aides.
- **Paraprofessional Healthcare Institute:** Increase government payment for long-term care services and supports to promote parity between the compensation received by certified nursing assistants and direct-care workers who provide similar supports in home and community-based settings.
- **Paraprofessional Healthcare Institute:** Encourage states to establish minimum standards for wages and benefits paid to direct-care workers under public programs, including requiring states to demonstrate that reimbursement rates are based on market analyses of wages and benefits of comparable occupations and are adequate to attract a workforce sufficient to meeting demand for long-term care services and supports.
- **Paraprofessional Healthcare Institute:** Encourage states to target payment policies, ensuring that state and federal funds directly improve wages and benefits for direct-care workers through such measures as: wage floors; minimum percentages of service rates allocated to direct-care labor costs; incentive payments for superior performance with respect to staffing adequacy, stability, and care quality; procurement/contracting standards; and wage pass-throughs.

- **Paraprofessional Healthcare Institute:** Enhance the content of entry-level and advanced training for direct-care workers, by identifying the competencies required for workers to provide quality services to long-term care consumers in any setting.
- **Paraprofessional Healthcare Institute:** Develop consensus competencies for personal and home care aides (for whom there are currently no federal training requirements) by building on ongoing efforts to identify core competencies, skills and knowledge to provide quality, person-centered care.
- **Paraprofessional Healthcare Institute:** Create career pathways that allow workers to advance from entry-level through higher levels of mastery by identifying core competencies necessary for all direct-care workers, additional competencies needed by nursing assistants and home health aides, and advanced competencies to serve in enhanced roles as key members of care teams in integrated and coordinated care models.
- **Paraprofessional Healthcare Institute:** Fund train-the-trainer programs to support nurse educators and others in using adult learner-centered methods in delivering direct-care worker training.
- **Paraprofessional Healthcare Institute:** Encourage state and local workforce investment boards to support the expansion of training for direct-care workers, particularly through the Workforce Investment Act (WIA) public workforce investment system.
- **Paraprofessional Healthcare Institute:** Establish a national joint venture of the Centers for Medicare and Medicaid Services and the Department of Labor to identify and promote best practices in direct-care worker training and training system design, to support state efforts and sponsor large- scale state demonstrations based on an apprenticeship training model.
- **Paraprofessional Healthcare Institute:** Make workforce an explicit part of CMS's review processes by including greater oversight and guidance to states about the adequacy and quality of their direct-care workforce in Home and Community-Based Services waiver applications/renewals and Medicaid State Plan Amendments.
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Home and community based care

- **American Association of Service Coordinators:** Service coordinators working with low-income seniors save taxpayer dollars by providing access to community-based supports and services that keep them aging-in- place in their own apartments instead of having to move to more costly institutional settings such as a nursing home
- **American Disabled for Attendant Program Today:** The Community Choice Act establishes a national program of community-based attendant services and supports for people with disabilities, regardless of age or disability. This bill would allow the dollars to follow the person, and allow eligible individuals, or their representatives, to choose where they would receive services and supports. Any individual who is entitled to nursing home or other institutional services will now be able to choose where and how these services are provided.
- **American Disabled for Attendant Program Today:** HUD, coordinating with HHS/CMS, will work at the state and local levels with federally authorized community-based organizations such as Independent Living Centers and Area Agencies on Aging, to facilitate the coordination of and implementation of the ACCESS ACROSS AMERICA program.
- **American Disabled for Attendant Program Today:** Demand that the Obama administration fulfill its duty to aggressively protect the civil rights of disabled Americans and enforce the Americans with Disabilities Act/Olmstead decision
- **American Disabled for Attendant Program Today:** File complaints with the Health and Human Services Office of Civil Rights and the U.S. Department of Justice that document the violation of rights of individuals who have been forced into institutional settings, denied community services, or have had their community services reduced as well as complaints that document the state policies and budget cuts that violate our rights
- **American Disabled for Attendant Program Today:** Work with the Department of Justice (DOJ) to develop “most integrated setting” criteria for determining when DOJ will step in and affirmatively enforce the Olmstead decision
- **American Disabled for Attendant Program Today:** With CMS, develop guidance with CMS for the states on the Olmstead decision that requires state Medicaid programs to comply with the “most integrated setting” requirement of the ADA, including a model Olmstead Plan that assures the freedom of Americans with disabilities who want to live in the most integrated setting;
- **American Disabled for Attendant Program Today:** With CMS, modify Section Q of the Minimum Data Set so that people who indicate they want to return to community living are actively assisted to do so;
- **Generations United:** Encourage a national conversation about the financing of long-term care and continue to promote the goals embodied in the Community Living Assistance Services and Supports (CLASS) program.
- **Generations United:** Discourage states from cutting Medicaid home and community-based services, and encourage them to adopt new options under the Affordable Care Act, including the Community First Choice and Balanced Incentives Programs.
- **National Association of State Units on Aging:** Each of our members oversees the implementation of the Older Americans Act (OAA), and many also serve as the operating agency in their state for Medicaid waivers that serve older adults and individuals with disabilities. Together with our members, we work to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers.

- **National Association of State Units on Aging:** With bipartisan, bicameral support, reauthorize and strengthen the Older Americans Act (OAA) to better meet the needs of current and future seniors.
- **Association of Jewish Aging Services of North America (AJAS):** Community Living Assistance Services and Supports (CLASS) Implementation Advocacy for the CLASS act was a significant priority to both LeadingAge and JFNA during the last congressional session. AJAS is on record as a consistent supporter of this legislation which was included in the Affordable Care Act (ACA).
- **American Association for Geriatric Psychiatry:** Positive Aging Act: AAGP supports the “Positive Aging Act.” In addition, grants for community-based mental health treatment outreach teams would be available to provide services in primary healthcare facilities where older adults receive medical treatments, as well as adult day care centers, senior centers, assisted living facilities and other settings where older adults reside or receive social services.
- **Center for Medicare Advocacy, Inc.:** Do not impose home health copays or otherwise restrict home health coverage. Congress should oppose any copay proposal for Medicare home health services. Congress eliminated the home health copayment in 1972 for the very reasons that it should not be imposed now – such out-of-pocket costs would deter care at home and create incentives for more expensive institutional care.[3] Further, Congress should also oppose any proposal to cap payments for episodes of care that would reduce beneficiary access or otherwise restrict the number of home health visits to which beneficiaries are entitled.
- **Center for Medicare Advocacy, Inc.:** On behalf of the Leadership Council of Aging Organizations (LCAO), a coalition of national not-for-profit organizations representing over 60 million older Americans, we are writing to express strong opposition to Medicare policy proposals to increase Part B and D premiums for select Medicare beneficiaries, to increase the Part B deductible, and to introduce a home health copayment. It would be particularly problematic to pay for increased reimbursement to physicians, which will in turn increase Part B premiums, by shifting even more costs to older adults and people with disabilities
- **Center for Medicare Advocacy, Inc.:** The introduction of a \$100 home health copayment per home health episode, as drafted by the Subcommittee, would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.[9] According to an Avalere analysis, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years
- **American Geriatrics Society:** Expand older adults’ healthcare options to include in-home and other care that enables them to live independently as long as possible
- **National Academy of Social Insurance:** Oppose Copayments for Medicare Home Health Services and Expand Delivery Reforms such as the Independence at Home Program and Care Transitions Program
- **Global Alliance of Mental Illness Advocacy Networks:** Encourage a national conversation about the financing of long-term care and continue to promote the goals embodied in the Community Living Assistance Services and Supports (CLASS) program.
- **Global Alliance of Mental Illness Advocacy Networks:** Discourage states from cutting Medicaid home and community-based services, and encourage them to adopt new options under the Affordable Care Act, including the Community First Choice and Balanced Incentives Programs.
- **National Association of Nutrition and Aging Services Programs:** NANASP urges that a final reauthorization preserve and strengthen the nutrition program, including protecting

nutrition dollars, promoting greater local autonomy in decision making on funding, maintain separate titles for congregate and home-delivered meals, maintain voluntary contributions, provide greater use of registered dietitians in programs and provide adequate funding for each of the 5 years of the reauthorization.

- **Alzheimer's Foundation of America:** Educate and support people with AD and their families upon diagnosis ...Providing support services, education and training upon diagnosis is vital to ensuring that families can adequately plan for the responsibilities and life changes that occur after a loved one is diagnosed with Alzheimer's disease.
- **Alzheimer's Foundation of America:** Urging adoption of family-friendly workplace policies, with federal incentives to carry them out. Examples of family-friendly workplace policies include: flextime; work-at-home options; job-sharing; counseling; dependent care accounts; information and referral to community services; and employer-paid services of a care manager.
- **Alzheimer's Foundation of America:** AFA urges CMS to expand and promote the Resources for Enhancing Alzheimer's Caregiver Health (REACH program) systemwide for Medicare and Medicaid beneficiaries through CMS' Center for Medicare and Medicaid Innovation (CMMI) Center.
- **American Academy of Physician Assistants:** the American Academy of Physician Assistants urges Congress to approve the Home Health Planning and Improvement Act (HR 2504/S 1332) in the 113th Congress.
- **American Society on Aging :** The American Society on Aging stands with our colleagues across the nation in asking Congress to reauthorize the Older Americans Act (OAA).
- **Eldercare Workforce Alliance :** We hope you will support a total of \$44.7 million in funding for geriatrics programs in Title VII and Title VIII of the Public Health Service Act and \$173.9 million in funding for programs administered by the Administration for Community Living.
- **Eldercare Workforce Alliance:** Administration for Community Living Family Caregiver Support and White House Conference on Aging: Appropriations Request: \$175.9 million
- **Eldercare Workforce Alliance:** Urges Congress to support the Community Living Assistance Services and Supports (CLASS) program and oppose its repeal in any deficit reduction legislation.
- **Eldercare Workforce Alliance:** We request that DOL take timely action to issue a revised interpretation of the exemption that will extend greater federal minimum wage and overtime protection under FLSA to the more than 1,500,000 paid home and community-based care workers who provide essential services to our nation's older adults and people with disabilities.
- **Paraprofessional Healthcare Institute:** Revise the companionship exemption to the Fair Labor Standards Act to extend federal minimum wage and overtime protections to home care aides.
- **Paraprofessional Healthcare Institute:** Increase government payment for long-term care services and supports to promote parity between the compensation received by certified nursing assistants and direct-care workers who provide similar supports in home and community-based settings.
- **Paraprofessional Healthcare Institute:** Align government payment policies in order to expand the availability of quality home and community-based services by establishing parity in the reimbursement of training costs for all direct care workers.
- **Leadership Council of Aging Organizations:** Congress should oppose any copay proposal for Medicare home health services.

- **Leadership Council of Aging Organizations:** Congress should also oppose any proposal to cap payments for episodes of care that would reduce beneficiary access or otherwise restrict the number of home health visits to which beneficiaries are entitled.
- **Trust for America's Health:** We recommend \$100 million for the CDC Partnerships to Improve Community Health grant program in FY2015.
- **Trust for America's Health:** TFAH recommends funding REACH at \$50 million to fund additional grants to local communities directly affected by health disparities.
- **National Academy of Social Insurance :** Ending the “home bound” requirement for Medicare home health services and the three-day hospitalization requirement for Medicare coverage of skilled nursing care would inch Medicare closer to providing an LTSS benefit without changing the basic elements of the program.
- **National Academy of Social Insurance:** Expand Medicare Part A to include first-dollar coverage of custodial nursing home care as well as HCBS aimed at diverting people from nursing homes, preventing unnecessary hospitalization and reducing readmissions.
- **Center for Advocacy on the Rights and Interests of the Elderly:** Increase Title III funding for neighborhood based supports and develop opportunities to mobilize neighbors to help with activities such as transportation.
- **National Coalition on Healthcare:** Implement MedPAC's recommendations for expansion of the PACE program.
- **Consortium for Citizens with Disability:** Oppose Copayments for Medicare Home Health Services and Expand Delivery Reforms such as the Independence at Home Program and Care Transitions Program Most beneficiaries with disabilities and chronic conditions prefer to receive services in their homes and communities, rather than in institutions.
- **National Medical Association:** Improved access to care by increasing funding for community health centers and the National Health Service Corps which will place over 8,500 healthcare professionals in medically underserved areas.
- **LeadingAge:** We oppose any additional across-the-board cutbacks in Medicare reimbursement rates for skilled nursing facilities, home healthcare or hospice. Recent cutbacks include reduced market basket updates, an arbitrary cut in reimbursement for bad debt, an 11.1 percent across-the-board cut in skilled nursing facility reimbursement, and 2 percent sequestration applied to payments to all healthcare providers.
- **LeadingAge:** We support the Medicare Adult Day Services Act (H.R. 3334), which would authorize Medicare coverage of home health services provided in a certified adult day services center.
- **LeadingAge:** We support the Home Healthcare Planning Improvement Act (H.R. 2504/S. 1332), which would allow Medicare coverage of health services provided by a nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant under a physician's supervision.
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Long term care support services insurance

- **National Academy of Social Insurance:** Catastrophic Coverage. This option would create a Medicare Part A benefit that covers out-of-pocket expenses after a lengthy waiting period defined either in time (beneficiary has paid for three years of home care services) or expenditures (beneficiary has paid for \$50,000 in home care services).
- **National Academy of Social Insurance:** Incorporating LTSS coverage into Medicare Advantage (MA) plans would highlight new methods of organizing care and emphasize the potential benefits of care integration.
- **National Academy of Social Insurance:** Expanding Medicare Part A to include first-dollar coverage of custodial nursing home care as well as HCBS aimed at diverting people from nursing homes, preventing unnecessary hospitalization and reducing readmissions.
- **National Academy of Social Insurance:** Comprehensive public insurance. Expanding Medicare to cover LTSS more fully can be accomplished in number of ways. One option is to create a new voluntary part of Medicare (such as a Medicare Part E) with benefits comparable to private insurance... Alternatively, the comprehensive LTSS package could be incorporated as a component of Medicare Part A.
- **National Academy of Social Insurance:** It is time to change the paradigm for LTSS financing, moving away from a welfare program in which assistance is provided on a means-tested basis and toward an insurance-based model that allows people to spread risk and plan ahead for their LTSS needs.

New models of care in long term care

- **American Disabled for Attendant Program Today:** The Community Choice Act provides an alternative and will fundamentally change our long term care system and the institutional bias that now exists. Building on the Money Follows the Person concept, the two million Americans currently residing in nursing homes and other institutions would have a choice. In addition, people would not be forced into institutions order to get out on community services; once they are deemed eligible for the institutional services, people with disabilities and their families will be able to choose where and how they receive services. Instead of making a new entitlement, the Community Choice Act, makes the existing entitlement more flexible.
- **American Disabled for Attendant Program Today:** Access Across America is a proposal to HUD for a national program to help people coming out of nursing homes, or at risk of going into a nursing homes, because they cannot get affordable, integrated and accessible housing. This program coordinates the receipt of subsidized housing vouchers with Medicaid-eligible persons transitioning out of nursing homes or at risk of going into a nursing home due to a housing crisis, who are receiving home and community-based services and supports.
- **American Disabled for Attendant Program Today:** Improve the timing and coordination of affordable, accessible, integrated housing with the receipt of home and community support services;
- **Association of Jewish Aging Services of North America (AJAS):** ACOs, an idea supported across party lines, represents the greatest opportunity to date to spur innovation within Medicare delivery while controlling costs within the program. Though hospital participation is an essential ingredient, providers across the non-profit spectrum will be included in the ACO for the model itself to be effective. We strongly believe that long-term care communities not only need to be included, but looked at as formidable partners within the ACO continuum.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine (AMDA) work with the appropriate parties to allow medical providers in long term care and Medical Directors of nursing facilities to participate in multiple Accountable Care Organizations (ACOs);
- **Alzheimer's Foundation of America:** Medical homes for people with alzheimer's disease (2.E.1)
- **Alzheimer's Foundation of America:** Independence at home demonstration (2.E.2)
- **Alzheimer's Foundation of America:** Medicare coordinated care models for people with Alzheimer's disease (2.G.1)
- **Alzheimer's Foundation of America:** Greater access to home- and community-based care services under both Medicare and Medicaid to allow individuals with Alzheimer's disease to stay in the home setting as long as possible.
- **Alzheimer's Foundation of America:** AFA is proposing that CMS adopt new care delivery models that recognize the benefit of care coordination integrated with access to home care services. Advance coordinated and integrated health and long-term services and supports for individuals living with AD.
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Older Americans Act

- **Eldercare Workforce Alliance:** The Eldercare Workforce Alliance supports the Older Americans Reauthorization Act of 2013, particularly its provisions to support older adults and their family caregivers.
- **National Association of States United for Aging and Disabilities:** Reauthorize and strengthen the Older Americans Act (OAA) to better meet the needs of current and future seniors.
- **National Indian Council on Aging:** Administration on Aging increase appropriation of funding for Title VI of the Older American Act based on the number of eligible AI/AN in each of the designated service areas
- **Center for Advocacy on the Rights and Interests of the Elderly:** the Older Americans Act (OAA) should clarify relationships among Area Agencies on Aging (AAAs), Centers for Independent Living (CILs) and other agencies and ensure a “no wrong door” policy for accessing services.
- **National Committee to Preserve Social Security & Medicare:** Make improvements to the core programs of the Older Americans Act – including congregate and home-delivered meals, assistance for family caregivers, transportation and senior services - which would help ensure economic security and the ability of seniors to receive the supports and services they need to stay healthy and active in their homes and communities.
- **National Association of Area Agencies on Aging:** Congress must increase funding for the OAA and other supportive services to help older Americans remain living successfully and independently in their homes and communities. n4a calls on Congress to sustain the capacity of OAA programs by holding these vital programs harmless (at least a 5.26 percent increase over FY 2012) to allow them to keep pace with projected population growth and price increases in FY 2014.
- **National Association of Area Agencies on Aging:** Sustain the capacity of OAA programs by increasing total funding by at least 5.26 percent above FY 2012 levels.¹⁵ This hold harmless number will allow them to keep pace with projected population growth and price increases in FY 2014.n4a supports at least a 5.26 percent across-the- board increase in OAA funding to hold these vital programs harmless, and encourages appropriators to give special attention to three OAA programs: Title III B Supportive Services, Title VI Grants for Native Americans and Title III E National Family Caregiver Support Program.

Quality of care in nursing homes

- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** If a facility employs physicians or advanced healthcare practitioners directly or indirectly through an affiliated corporation, then the facility should disclose this relationship to new residents and the potential for a conflict of interest.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** All residents being admitted to a LTC facility should be provided with a list of available attending physicians currently accepting new residents. a. This list should identify which, if any, physicians are employed by the facility or an affiliated corporation. b. The list should be provided prior to admission. c. Residents should have the right to freely choose from among the physicians on this list.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** State Departments of Health should be required to monitor and report on the quality of care being provided by corporate entities in LTC settings.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Toward that end, AMDA feels strongly that the problem of insufficient access to qualified physicians in long-term care is best met by increasing the number of qualified physicians in long-term care.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** AMDA policy on Performance Review supports performance review conducted under the auspices of the Quality Assessment & Assurance process for all attending physicians caring for residents in long-term care facilities, including performance review of the medical director when the medical director is also serving as attending physician. Reaffirms Policy B07
- **Center for Medicare Advocacy, Inc.:** Enforce the Nursing Home Reform Act of 1987. We encourage Congress to fully enforce the nationwide quality standards and the state survey and certification process defined in the Act.
- Z. A. Marcum, S. M. Handler, R. Wright, J. T. Hanlon (2010). Interventions to improve suboptimal prescribing in nursing homes: A narrative review. *The American journal of geriatric pharmacotherapy*, 8(3), 183-200
- B. Roe, L. Flanagan, B. Jack, *et al.* (2011). Systematic review of the management of incontinence and promotion of continence in older people in care homes: descriptive studies with urinary incontinence as primary focus. *Journal of advanced nursing*, 67(2), 228-50
- E. Weening-Dijksterhuis, M. H. de Greef, E. J. Scherder, *et al.* (2011). Frail institutionalized older persons: A comprehensive review on physical exercise, physical fitness, activities of daily living, and quality-of-life. *American journal of physical medicine & rehabilitation*, 90(2), 156-68
- P. Costa, J. W. Poss, T. Peirce, J. P. Hirdes (2012). Acute care inpatients with long-term delayed-discharge: evidence from a Canadian health region. *BMC health services research*, 12, 172
- S. Zimmerman, W. Anderson, S. Brode, *et al.* (2012). Comparison of Characteristics of Nursing Homes and Other Residential Long-Term Care Settings for People With Dementia.
- M. E. Dellefield, A. Kelly, J. F. Schnelle (2013). Quality assurance and performance improvement in nursing homes: using evidence-based protocols to observe nursing care processes in real time. *Journal of nursing care quality*, 28(1), 43-51
- D. L. Friesner, D. M. Scott, M. W. Dewey, *et al.* (2013). What types of nursing facilities are more likely to adopt a pharmacist's medication review recommendations? *The Consultant pharmacist*, 28(8), 490-501

Reducing hospitalizations

- **Center for Medicare Advocacy, Inc.:** First, if nursing homes are encouraged not to hospitalize residents, many residents who need hospital care will be endangered.
- **Center for Medicare Advocacy, Inc.:** Third, numerous studies show that improving staffing levels in nursing homes can reduce the perceived (and actual) need to hospitalize nursing home residents.
- J. G. Ouslander, G. Lamb, R. Tappen, *et al.*(2011). Interventions to reduce hospitalizations from nursing homes: evaluation of the INTERACT II collaborative quality improvement project. *Journal of the American Geriatrics Society*, 59(4), 745-53
- J. M. Longman, J. B. Singer, Y. Gao, *et al.*(2011). Community based service providers' perspectives on frequent and/or avoidable admission of older people with chronic disease in rural NSW: a qualitative study. *BMC health services research*, 11, 265
- G. Arendts, S. Quine, K. Howard (2013). Decision to transfer to an emergency department from residential aged care: a systematic review of qualitative research. *Geriatrics & gerontology international*, 13(4), 825-33
- S. Mikolaizak, P. M. Simpson, A. Tiedemann, *et al.*(2013). Systematic review of non-transportation rates and outcomes for older people who have fallen after ambulance service call-out. *Australasian journal on ageing*, 32(3), 147-57

Rehabilitation

- **Association of Jewish Aging Services of North America (AJAS):** Continued Support for the Medicare Therapy Cap Moratorium and Eventual Repeal. Medicare currently provides coverage for therapy services (physical, occupational and speech therapy), but limits or “caps” the amount of therapy an individual can receive in a given year. Caps on therapy often hinder an individual’s ability to regain physical strength and daily living skills that are required to live independently. An individual may exhaust his or her permitted therapy early in the year and have a new need for therapy later – as a result of a new medical setback (surgery, injury from a fall, heart attack, etc.).
- L. Ziden, M. Kreuter, K. Frandin (2010). Long-term effects of home rehabilitation after hip fracture - 1-year follow-up of functioning, balance confidence, and health-related quality of life in elderly people. *Disability and rehabilitation*, 32(1), 18-32
- D. Elliott, S. McKinley, J. Alison, *et al.*(2011). Health-related quality of life and physical recovery after a critical illness: a multi-centre randomised controlled trial of a home-based physical rehabilitation program. *Critical care (London, England)*, 15(3), R142
- P. Chaiyawat, K. Kulkantrakorn (2012). Effectiveness of home rehabilitation program for ischemic stroke upon disability and quality of life: a randomized controlled trial. *Clinical neurology and neurosurgery*, 114(7), 866-70
- J. C. Jackson, E. W. Ely, M. C. Morey, *et al.*(2012). Cognitive and physical rehabilitation of intensive care unit survivors: results of the RETURN randomized controlled pilot investigation. *Critical care medicine*, 40(4), 1088-97
- N. K. Brusco, N. F. Taylor, J. J. Watts, N. Shields (2014). Economic evaluation of adult rehabilitation: a systematic review and meta-analysis of randomized controlled trials in a variety of settings. *Archives of physical medicine and rehabilitation*, 95(1), 94-116 e4

Technology in long term care

- **Association of Jewish Aging Services of North America (AJAS):** FMAP provisions that were part of the American Recovery & Reinvestment Act (ARRA PL. 111- 5), included funding to hospitals and independent physician practice associations for improved health information technology services such as the introduction of electronic health records (EHRs) into respective health providers. However, several health disciplines, such as aging service providers, were not eligible to receive grants. AJAS will vigorously support efforts that will lead to the eligibility of providers of long-term services and supports.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** investigate the current availability of and work with appropriate stakeholders to help develop ideal bidirectional electronic message and document exchanges (i.e., communicating electronically among nursing homes and other community healthcare providers) for use in post-acute and long-term care (PA/LTC) settings;
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine advocate with Congress and appropriate Federal agencies to establish incentives and appropriate reimbursement levels for PA/LTC physicians and facilities in order to adopt these technologies.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine (AMDA) work with legislators, regulatory agencies, and pharmacy organizations to promulgate secure, regulatory-compliant electronic means of prescribing controlled substances to ensure ready patient access to needed medications in the post-acute and long-term care (PA/LTC) setting.
- **American Healthcare Association:** To provide HIT funding to long term & post-acute settings comparable to the support acute & ambulatory care settings receive, plus direct the HHS Secretary to use discretionary funding to promote HIT adoption by long term & post-acute care providers.
- **American Healthcare Association:** AHCA/NCAL applauds the provisions in the Health Information Technology for Economic & Clinical Health (HITECH) Act included in the American Recovery & Reinvestment Act of 2009 (ARRA, now Public Law 111-5), which promote HIT adoption. Unfortunately, the HITECH Act leaves out long term and post-acute care providers. AHCA/NCAL urges Congress to remedy this oversight by providing comparable support for HIT adoption by long term and post-acute care as was ordered to providers in acute and ambulatory care settings. In the meantime, the Secretary of Health & Human Services (HHS) should use discretionary funding, perhaps from the Center for Medicare & Medicaid Innovation (CMI), to promote HIT in long term and post-acute care settings.
- S. Bedaf, G. J. Gelderblom, D. S. Syrdal, *et al.*(2013). Which activities threaten independent living of elderly when becoming problematic: inspiration for meaningful service robot functionality. Disability and rehabilitation. Assistive technology
- K. M. Godwin, W. L. Mills, J. A. Anderson, M. E. Kunik (2013). Technology-driven interventions for caregivers of persons with dementia: a systematic review. American journal of Alzheimer's disease and other dementias, 28(3), 216-22
- S. Edirippulige, M. Martin-Khan, E. Beattie, *et al.*(2013). A systematic review of telemedicine services for residents in long term care facilities. Journal of telemedicine and telecare

Other

- **Generations United:** In Lieu of the CLASS Act Congress created the Long Term Care Commission in the America Tax- Payer Relief Act of 2012. The CLASS program is important because it offers a solution to this financing challenge that is different from what is currently available in the private market. While a national conversation about financing of long-term care is needed, CLASS should not be abandoned.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long-Term Care Medicine support treating e-cigarettes as tobacco products with the subsequent restrictions inherent with all tobacco products within post-acute and long-term care facilities;
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine and its state affiliate chapters support and work with appropriate parties towards creating an exemption for physicians prescribing pain medication in nursing home facilities from controlled substance prescribing requirements⁵ such as the Florida Statute 456.44, subsection 3.
- **American Healthcare Association:** Controlled Substances Act (CSA) explicitly permits a practitioner to rely on an “agent” to prepare and transmit prescription drug orders, the DEA currently does not recognize any “agency” relationship between a practitioner and a long term care nurse. As a practical matter, this means that practitioners cannot rely on nurses in these care environments to document their orders and transmit those orders to the pharmacy.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine Board of Directors create a task force to develop a social media policy relevant to long term care.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine work with similarly concerned parties and the Centers for Medicare & Medicaid Services to address the apparent limitations of the recent Office of Inspector General interpretation of 42 CFR § 486.106, and to determine a reasonable policy for ordering portable X-rays by designated and appropriately trained providers that meets the needs of the frail population in the long term care continuum while protecting against potential fraud and abuse.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** Dedicated to Long Term Care Medicine collaborate with the Centers for Medicare & Medicaid Services to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques and pharmacotherapy to manage behavioral and psychological symptoms of dementia throughout the long term care continuum.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** States enacting legislation to remove CPOM for LTC facilities prohibitions should include the following items:a. The requirement for a written contract which stipulates language prohibiting the corporate entity from interfering, regulating, diminishing, or supplanting independent physician judgment. This includes, but is not limited, to the following items: i. The determination for the need for skilled care services.ii. Referral to other healthcare services including home health agencies and hospice organizations.
- **AMDA- Society for Post-Acute and Long-Term Care Medicine:** AMDA respects the privacy of all residents as well as their choice in sharing personal information regarding sexual orientation and gender identity. It therefore strongly encourages facilities, physicians, and LTC care providers to create this as an optional demographic information category on the new patient intake form, as well as all other documents.
- **American Healthcare Association:** To continue to oppose efforts to limit the rights of consumers and healthcare providers to use pre-dispute arbitration agreements as an alternative to litigation in long term care settings.

- **American Healthcare Association:** AHCA/NCAL urges lawmakers to continue to support the use of arbitration and to reject any attempts to limit its use in long term care settings. Fair and timely resolution to legal concerns is in the best interest of patients, residents, taxpayers, and the nation's entire healthcare sector – and pre-dispute arbitration should remain an option for both long term care residents and the providers who care for them.
- K. Charlton, C. Nichols, S. Bowden, *et al.*(2012). Poor nutritional status of older subacute patients predicts clinical outcomes and mortality at 18 months of follow-up. *European journal of clinical nutrition*, 66(11), 1224-8
- C. B. Pimentel, K. L. Lapane, B. A. Briesacher (2013). Medicare part D and long-term care: a systematic review of quantitative and qualitative evidence. *Drugs & aging*, 30(9), 701-20
- J. J. Arias (2013). A time to step in: legal mechanisms for protecting those with declining capacity. *American journal of law & medicine*, 39(1), 134-59

Section 8. Prevention and Wellness

Description: Prevention activities seek to avoid the onset of disease entirely, detect the onset of disease early through screening, and stop disease from progressing or worsening. In addition to healthcare services such as cancer screening and vaccinations, patient education to promote nutrition and physical activity can help prevent the onset or worsening of disease.

Cardiac rehabilitation

- S. L. Grace, K. L. Russell, R. D. Reid, *et al.* (2011). Effect of cardiac rehabilitation referral strategies on utilization rates: a prospective, controlled study. *Archives of internal medicine*, 171(3), 235-41
- Z. D. Gellis, C. Kang-Yi (2012). Meta-analysis of the effect of cardiac rehabilitation interventions on depression outcomes in adults 64 years of age and older. *The American journal of cardiology*, 110(9), 1219-24
- L. E. Dobson, R. J. Lewin, P. Doherty, *et al.* (2012). Is cardiac rehabilitation still relevant in the new millennium? *Journal of cardiovascular medicine (Hagerstown, Md.)*, 13(1), 32-7

Falls and injury prevention

- L. Day, C. F. Finch, J. E. Harrison, *et al.* (2010). Modelling the population-level impact of tai-chi on falls and fall-related injury among community-dwelling older people. *Injury prevention*, 16(5), 321-6
- N. Bonuel, A. Manjos, L. Lockett, T. Gray-Becknell (2011). Best practice fall prevention strategies. *CATCH!. Critical care nursing quarterly*, 34(2), 154-8
- S. Corrieri, D. Heider, S. G. Riedel-Heller, *et al.* (2011). Cost-effectiveness of fall prevention programs based on home visits for seniors aged over 65 years: a systematic review. *International psychogeriatrics / IPA*, 23(5), 711-23
- J. Church, S. Goodall, R. Norman, M. Haas (2011). An economic evaluation of community and residential aged care falls prevention strategies in NSW. *New South Wales public health bulletin*, 22(3-4), 60-8
- T. E. Shubert (2011). Evidence-based exercise prescription for balance and falls prevention: a current review of the literature. *Journal of geriatric physical therapy* (2001), 34(3), 100-8
- K. J. Gormley (2011). Falls prevention and support: translating research, integrating services and promoting the contribution of service users for quality and innovative programmes of care. *International journal of older people nursing*, 6(4), 307-14
- Tiedemann, C. Sherrington, J. C. Close, S. R. Lord (2011). Exercise and Sports Science Australia position statement on exercise and falls prevention in older people. *Journal of science and medicine in sport / Sports Medicine Australia*, 14(6), 489-95
- Moayyeri, J. E. Adams, R. A. Adler, *et al.* (2012). Quantitative ultrasound of the heel and fracture risk assessment: an updated meta-analysis. *Osteoporosis international*, 23(1), 143-53
- S. Polinder, M. Segui-Gomez, H. Toet, *et al.* (2012). Systematic review and quality assessment of economic evaluation studies of injury prevention. *Accident; analysis and prevention*, 45, 211-21
- L. D. Gillespie, M. C. Robertson, W. J. Gillespie, *et al.* (2012). Interventions for preventing falls in older people living in the community. *The Cochrane database of systematic reviews*, 9, CD007146

- K. Balzer, M. Bremer, S. Schramm, *et al.*(2012). Falls prevention for the elderly. GMS health technology assessment, 8, Doc01
- R. Huang, L. Mallet, C. M. Rochefort, *et al.*(2012). Medication-related falls in the elderly: causative factors and preventive strategies. *Drugs & aging*, 29(5), 359-76
- N. A. Singh, S. Quine, L. M. Clemson, *et al.*(2012). Effects of high-intensity progressive resistance training and targeted multidisciplinary treatment of frailty on mortality and nursing home admissions after hip fracture: a randomized controlled trial. *Journal of the American Medical Directors Association*, 13(1), 24-30
- S. Child, V. Goodwin, R. Garside, *et al.*(2012). Factors influencing the implementation of fall-prevention programmes: a systematic review and synthesis of qualitative studies. *Implementation science*, 7, 91
- N. M. Kosse, K. Brands, J. M. Bauer, *et al.*(2013). Sensor technologies aiming at fall prevention in institutionalized old adults: a synthesis of current knowledge. *International journal of medical informatics*, 82(9), 743-52
- J. C. van Haastregt, G. A. Zijlstra, M. R. Hendriks, *et al.*(2013). Cost-effectiveness of an intervention to reduce fear of falling. *International journal of technology assessment in healthcare*, 29(3), 219-26
- Tiedemann, C. Sherrington, T. Orr, *et al.*(2013). Identifying older people at high risk of future falls: development and validation of a screening tool for use in emergency departments. *Emergency medicine journal*, 30(11), 918-22
- M. Lovarini, L. Clemson, C. Dean (2013). Sustainability of community-based fall prevention programs: a systematic review. *Journal of safety research*, 47, 9-17
- Meyer, S. Hill, B. Dow, *et al.*(2013). Translating Falls Prevention Knowledge to Community-Dwelling Older PLWD: A Mixed-Method Systematic Review. *The Gerontologist*
- T. E. Murphy, D. I. Baker, L. S. Leo-Summers, *et al.*(2013). Integration of fall prevention into state policy in Connecticut. *The Gerontologist*, 53(3), 508-15
- J. Lee, A. I. Geller, D. C. Strasser (2013). Analytical review: focus on fall screening assessments. *PM&R: the journal of injury, function, and rehabilitation*, 5(7), 609-21
- C. Tricco, E. Cogo, J. Holroyd-Leduc, *et al.*(2013). Efficacy of falls prevention interventions: protocol for a systematic review and network meta-analysis. *Systematic reviews*, 2, 38

Management of chronic disease, cognitive impairments, or cancer

Cancer

- N. L. Stout, K. Andrews, J. M. Binkley, *et al.*(2012). Stakeholder perspectives on dissemination and implementation of a prospective surveillance model of rehabilitation for breast cancer treatment. *Cancer*, 118(8 Suppl), 2331-4
- B. L. Burnette, A. Dispenzieri, S. Kumar, *et al.*(2013). Treatment trade-offs in myeloma: A survey of consecutive patients about contemporary maintenance strategies. *Cancer*, 119(24), 4308-15

Cardiovascular disease

- N. K. Choudhry, J. Avorn, R. J. Glynn, *et al.*(2011). Full coverage for preventive medications after myocardial infarction. *The New England journal of medicine*, 365(22), 2088-97

- W. Putnam, B. Lawson, F. Buhariwalla, *et al.*(2011). Hypertension and type 2 diabetes: what family physicians can do to improve control of blood pressure-an observational study. *BMC family practice*, 12, 86
- R. M. Trinkle, A. Flabouris (2011). Medical reviews before cardiac arrest, medical emergency call or unanticipated intensive care unit admission: their nature and impact on patient outcome. *Critical care and resuscitation*, 13(3), 175-80
- M. Gulliksson, G. Burell, B. Vessby, *et al.* (2011). Randomized controlled trial of cognitive behavioral therapy vs standard treatment to prevent recurrent cardiovascular events in patients with coronary heart disease: Secondary Prevention in Uppsala Primary Healthcare project (SUPRIM). *Archives of internal medicine*, 171(2), 134-40
- Y. Fukuda (2011). [Quasi-experimental study of effects of “Healthcare Advice with Particular Focus on Metabolic Syndrome”]. *Nihon eiseigaku zasshi. Japanese journal of hygiene*, 66(4), 736-40
- D. Margolius, T. Bodenheimer, H. Bennett, *et al.*(2012). Health coaching to improve hypertension treatment in a low-income, minority population. *Annals of family medicine*, 10(3), 199-205
- H. Sepehripour, T. T. Lo, D. J. McCormack, A. R. Shipolini (2012). Is there benefit in smoking cessation prior to cardiac surgery? *Interactive cardiovascular and thoracic surgery*, 15(4), 726-32
- C. de Waure, G. J. Lauret, W. Ricciardi, *et al.* (2013). Lifestyle interventions in patients with coronary heart disease: a systematic review. *American journal of preventive medicine*, 45(2), 207-16
- V. Janssen, V. De Gucht, E. Dusseldorp, S. Maes (2013). Lifestyle modification programmes for patients with coronary heart disease: a systematic review and meta-analysis of randomized controlled trials. *European journal of preventive cardiology*, 20(4), 620-40
- S. Gandhi, P. Dorian, N. Greenlaw, *et al.*(2014). Characteristics and evidence-based management of stable coronary artery disease patients in Canada compared with the rest of the world: insights from the CLARIFY registry. *The Canadian journal of cardiology*, 30(1), 132-7

Diabetes

- **Trust for America’s Health:** It is important that Medicare coverage for intensive behavioral therapy for diabetes include coverage for programs offered by appropriately trained lay providers, if the programs or similar program have been shown to be effective when offered by such providers.
- G. A. Pape, J. S. Hunt, K. L. Butler, *et al.*(2011). Team-based care approach to cholesterol management in diabetes mellitus: two-year cluster randomized controlled trial. *Archives of internal medicine*, 171(16), 1480-6
- W. Putnam, B. Lawson, F. Buhariwalla, *et al.*(2011). Hypertension and type 2 diabetes: what family physicians can do to improve control of blood pressure-an observational study. *BMC family practice*, 12, 86
- J. Lopez-Bastida, M. Boronat, J. O. Moreno, W. Schurer (2013). Costs, outcomes and challenges for diabetes care in Spain. *Globalization and health*, 9, 17

Mental health

- B. Parke, A. Beath, L. Slater, A. M. Clarke (2011). Contextual factors influencing success or failure of emergency department interventions for cognitively impaired older people: a scoping and integrative review. *Journal of advanced nursing*, 67(7), 1426-48

- F. Aminzadeh, F. J. Molnar, W. B. Dalziel, D. Ayotte (2012). A review of barriers and enablers to diagnosis and management of persons with dementia in primary care. *Canadian geriatrics journal*, 15(3), 85-94
- D. Fuentes, M. P. Aranda (2012). Depression interventions among racial and ethnic minority older adults: a systematic review across 20 years. *The American journal of geriatric psychiatry*, 20(11), 915-31
- S. Toot, M. Devine, A. Akporobaro, M. Orrell (2013). Causes of hospital admission for people with dementia: a systematic review and meta-analysis. *Journal of the American Medical Directors Association*, 14(7), 463-70
- Vasionyte, G. Madison (2013). Musical intervention for patients with dementia: a meta-analysis. *Journal of clinical nursing*, 22(9-10), 1203-16

Patient education, empowerment, and community/peer interventions

- **Association of Jewish Aging Services of North America (AJAS):** Alzheimer's Education & Expanded Coverage under Medicare In 2010, Senator Debbie Stabenow (D-MI) introduced the Health Outcomes, Planning, and Education (HOPE) for Alzheimer's Act which will seek to ensure that Medicare covers screening for the disease as well as education on treatment options both for the patient as well as for the patient's family caregivers.
- **American Society of Clinical Oncology:** SCO is committed to playing an important role in educating oncology, patients and the public about available evidence supporting the connection between obesity and cancer
- **American Public Health Association:** There are evidence-based interventions that can be used to educate the public on the prevention of these disorders... programs include a focus on topics such as arthritis education (Experts in Arthritis)
- **American Public Health Association:** Encourage legislation to increase preventive services through public education campaigns similar to those that have been successfully implemented in other countries
- C. Clar, K. Barnard, E. Cummins, *et al.* (2010). Self-monitoring of blood glucose in type 2 diabetes: systematic review. *Health technology assessment (Winchester, England)*, 14(12), 1-140
- O. V. Buchthal, A. L. Doff, L. A. Hsu, *et al.* (2011). Avoiding a knowledge gap in a multiethnic statewide social marketing campaign: is cultural tailoring sufficient? *Journal of health communication*, 16(3), 314-27
- J. Kaczorowski, L. W. Chambers, L. Dolovich, *et al.* (2011). Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). *BMJ (Clinical research ed.)*, 342, d442
- M. A. Riddell, C. Renwick, R. Wolfe, *et al.* (2012). Cluster randomized controlled trial of a peer support program for people with diabetes: study protocol for the Australasian Peers for Progress study. *BMC public health*, 12, 843
- J. A. Long, E. C. Jahnle, D. M. Richardson, *et al.* (2012). Peer mentoring and financial incentives to improve glucose control in African American veterans: a randomized trial. *Annals of internal medicine*, 156(6), 416-24
- S. Gupta, C. Carmichael, C. Simpson, *et al.* (2012). Electric fans for reducing adverse health impacts in heatwaves. *The Cochrane database of systematic reviews*, 7, CD009888

- D. H. Thom, A. Ghorob, D. Hessler, *et al.* (2013). Impact of peer health coaching on glycemic control in low-income patients with diabetes: a randomized controlled trial. *Annals of family medicine*, 11(2), 137-44
- P. Martin, R. Tamblyn, S. Ahmed, C. Tannenbaum (2013). An educational intervention to reduce the use of potentially inappropriate medications among older adults (EMPOWER study): protocol for a cluster randomized trial. *Trials*, 14, 80
- W. Palmas, S. E. Findley, M. Mejia, *et al.* (2014). Results of the northern Manhattan diabetes community outreach project: a randomized trial studying a community health worker intervention to improve diabetes care in Hispanic adults. *Diabetes care*, 37(4), 963-9

Preventing chronic diseases and functional decline

Cardiovascular disease

- M. Clark, M. Haykowsky, J. Kryworuchko, *et al.* (2010). A meta-analysis of randomized control trials of home-based secondary prevention programs for coronary artery disease. *European journal of cardiovascular prevention and rehabilitation*, 17(3), 261-70
- P. Barton, L. Andronis, A. Briggs, *et al.* (2011). Effectiveness and cost effectiveness of cardiovascular disease prevention in whole populations: modelling study. *BMJ*, 343, d4044
- T. H. Jafar, M. Islam, R. Bux, *et al.* (2011). Cost-effectiveness of community-based strategies for blood pressure control in a low-income developing country: findings from a cluster-randomized, factorial-controlled trial. *Circulation*, 124(15), 1615-25
- P. Mitchell, R. J. Simpson (2012). Statin cost effectiveness in primary prevention: a systematic review of the recent cost-effectiveness literature in the United States. *BMC research notes*, 5, 373
- P. M. Ridker, A. Pradhan, J. G. MacFadyen, *et al.* (2012). Cardiovascular benefits and diabetes risks of statin therapy in primary prevention: an analysis from the JUPITER trial. *Lancet*, 380(9841), 565-71

Cancer

- C. Hassan, D. K. Rex, G. S. Cooper, *et al.* (2012). Primary prevention of colorectal cancer with low-dose aspirin in combination with endoscopy: a cost-effectiveness analysis. *Gut*, 61(8), 1172-9
- N. G. Hirst, L. G. Gordon, P. A. Scuffham, A. C. Green (2012). Lifetime cost-effectiveness of skin cancer prevention through promotion of daily sunscreen use. *Value in health*, 15(2), 261-8
- (2013). [Guidelines for application of molecular tests identifying HR HPV DNA in the prevention of cervical cancer. Statement of experts from PGS (PTG) and NCLD (KIDL)]. *Ginekologia polska*, 84(5), 395-9

Delirium

- L. Hempenius, B. L. van Leeuwen, D. Z. van Asselt, *et al.* (2011). Structured analyses of interventions to prevent delirium. *International journal of geriatric psychiatry*, 26(5), 441-50
- P. K. Sykes (2012). Prevention and management of postoperative delirium among older patients on an orthopedic surgical unit: a best practice implementation project. *Journal of nursing care quality*, 27(2), 146-53

Diabetes

- J. Hill (2012). Preventing type 2 diabetes: a role for every practitioner. *Community practitioner*, 85(10), 34-6
- S. Ockene, T. L. Tellez, M. C. Rosal, *et al.*(2012). Outcomes of a Latino community-based intervention for the prevention of diabetes: the Lawrence Latino Diabetes Prevention Project. *American journal of public health*, 102(2), 336-42
- P. M. Ridker, A. Pradhan, J. G. MacFadyen, *et al.*(2012). Cardiovascular benefits and diabetes risks of statin therapy in primary prevention: an analysis from the JUPITER trial. *Lancet*, 380(9841), 565-71
- V. Perez Siwik, R. M. Kutob, C. Ritenbaugh, *et al.*(2012). Families United/Familias Unidas: development and implementation of a family-based group office visit model for the primary prevention of type 2 diabetes. *The Diabetes educator*, 38(6), 811-21

Functional decline

- J. F. Robare, C. M. Bayles, A. B. Newman, *et al.*(2011). The “10 keys” to healthy aging: 24-month follow-up results from an innovative community-based prevention program. *Health education & behavior*, 38(4), 379-88
- F. Clark, J. Jackson, M. Carlson, C. P. Chou, *et al.*(2012). Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: results of the Well Elderly 2 Randomised Controlled Trial. *Journal of epidemiology and community health*, 66(9), 782-90
- N. McLaren, M. A. Lamantia, C. M. Callahan (2013). Systematic review of non-pharmacologic interventions to delay functional decline in community-dwelling patients with dementia. *Aging & mental health*, 17(6), 655-66
- J. J. Arias (2013). A time to step in: legal mechanisms for protecting those with declining capacity. *American journal of law & medicine*, 39(1), 134-59
- S. Bedaf, G. J. Gelderblom, D. S. Syrdal, *et al.*(2013). Which activities threaten independent living of elderly when becoming problematic: inspiration for meaningful service robot functionality. *Disability and rehabilitation. Assistive technology*

Mental health

- S. Y. Lee, M. K. Franchetti, A. Imanbayev, *et al.*(2012). Non-pharmacological prevention of major depression among community-dwelling older adults: a systematic review of the efficacy of psychotherapy interventions. *Archives of gerontology and geriatrics*, 55(3), 522-9
- K. Connellan, M. Gaardboe, D. Riggs, *et al.*(2013). Stressed spaces: mental health and architecture. *Herd*, 6(4), 127-68

Stroke

- R. Kansal, S. V. Sorensen, R. Gani, *et al.*(2012). Cost-effectiveness of dabigatran etexilate for the prevention of stroke and systemic embolism in UK patients with atrial fibrillation. *Heart (British Cardiac Society)*, 98(7), 573-8

General

- **Trust for America's Health:** Congress should restore its investment in CDC's National Center for Chronic Disease Prevention and Health Promotion to FY2010 levels
- **Trust for America's Health:** TFAH recommends \$40 million for the National Environmental Public Health Tracking Network to expand the program to link environmental and health data to identify problems and effective solutions that will reduce the burden of chronic disease.
- **National Coalition on Healthcare:** Expand Medicare coverage without cost-sharing to proven secondary and tertiary preventive interventions.
- **Healthcare Leadership Council:** HLC supports chronic care management and disease prevention as essential components of healthcare delivery through better public and private sector development of evidence-based wellness practices. Encouragement of workplace wellness programs and interventions that have proven to reduce costs by improving health before the onset of disease – including those that are delivered outside the clinical healthcare setting – are key areas of focus.
- P. M. Lantz, E. Golberstein, J. S. House, J. Morenoff (2010). Socioeconomic and behavioral risk factors for mortality in a national 19-year prospective study of U.S. adults. *Social science & medicine* (1982), 70(10), 1558-66
- V. Patel, S. Chatterji, D. Chisholm, *et al.*(2011). Chronic diseases and injuries in India. *Lancet*, 377(9763), 413-28
- E. Mayo-Wilson, S. Grant, J. Burton, *et al.*(2014). Preventive home visits for mortality, morbidity, and institutionalization in older adults: a systematic review and meta-analysis. *PloS one*, 9(3), e89257

Nutrition and diet

Dietary components

- **Trust for America's Health:** The DV for sodium should be lowered to 1,500 mg.
- **Trust for America's Health:** We support that dietary fiber continued to be required on the Nutrition Facts panel but urge the FDA to also include a line for added fibers to protect against misleading consumers that added fibers with no health value offer some sort of nutritional or health benefit.
- **Trust for America's Health:** We support both FDA's proposed mandatory listing for essential vitamins and minerals of public health significance, particularly for vitamin D, iron, and potassium.
- **Trust for America's Health:** We support FDA's proposal to continue to require total calories be listed and to increase the prominence of the declaration on the Nutrition Facts panel.
- **Trust for America's Health:** We urge FDA to go a step further and include a percentage DV for calories, especially in light of the fact that FDA consistently uses 2,000 calories per day as a reference point for calculating DVs for nutrients and other ingredients.
- **Trust for America's Health:** Strongly supports the Food and Drug Administration's (FDA) efforts to revise the Nutrition and Supplement Facts Labels towards the goal of improving healthier eating habits for all Americans.
- **Trust for America's Health:** TFAH supports the addition of a line for added sugars and recommends that the FDA also include a Daily Value (DV) for this line.
- **Trust for America's Health:** We believe additional rulemaking should be conducted by the FDA in order to require a more useful, legible ingredient list that includes grouping all sugars together.

- **Trust for America's Health:** Strongly supports the Food and Drug Administration's (FDA) efforts to revise the Reference Amounts Customarily Consumed (RACCs) for certain food and beverage products. We likewise recommend that FDA include additional information on the label that clarifies that RACCs are not meant to be considered a recommended portion size.
- **Trust for America's Health:** TFAH urges FDA to revise the serving sizes for certain categories of foods
- **Trust for America's Health:** The DGAC should recommend strengthening the trans fat recommendation to "avoid all sources of industrially-produced trans fat.
- **Trust for America's Health:** The DGAC should recommend that people replace foods high in saturated fat with low-fat versions of those foods and consume fruits, vegetables, whole grains, and foods rich in monounsaturated and/or polyunsaturated fats, such as fish and nuts, in place of meats, dairy products, baked goods, and other foods high in saturated fats.
- **Trust for America's Health:** We urge the DGAC to retain the key recommendation to consume less than 300 mg per day of dietary cholesterol,
- **Trust for America's Health:** The DGAC should recommend that the 2015 DGA policy report issued by the federal agencies include explicit recommendations for both reducing consumption of red and processed meats, and choosing mainly healthy alternative protein sources.
- **Trust for America's Health:** We recommend that the DGAC update the 2010 DGAC review of the evidence on recommended intakes of milk, milk products, and non-milk sources of calcium and vitamin D (including supplements).
- K. Bibbins-Domingo, G. M. Chertow, P. G. Coxson, *et al.*(2010). Projected effect of dietary salt reductions on future cardiovascular disease. *The New England journal of medicine*, 362(7), 590-9
- C. Dahm, R. H. Keogh, E. A. Spencer, *et al.*(2010). Dietary fiber and colorectal cancer risk: a nested case-control study using food diaries. *Journal of the National Cancer Institute*, 102(9), 614-26
- S. M. Moe, M. P. Zidehsarai, M. A. Chambers, *et al.*(2011). Vegetarian compared with meat dietary protein source and phosphorus homeostasis in chronic kidney disease. *Clinical journal of the American Society of Nephrology*, 6(2), 257-64
- R. Abusabha, D. Namjoshi, A. Klein (2011). Increasing access and affordability of produce improves perceived consumption of vegetables in low-income seniors. *Journal of the American Dietetic Association*, 111(10), 1549-55
- Raynaud-Simon, C. Revel-Delhom, X. Hebuterne (2011). Clinical practice guidelines from the French Health High Authority: nutritional support strategy in protein-energy malnutrition in the elderly. *Clinical nutrition (Edinburgh, Scotland)*, 30(3), 312-9
- M. Chung, J. Lee, T. Terasawa, *et al.*(2011). Vitamin D with or without calcium supplementation for prevention of cancer and fractures: an updated meta-analysis for the U.S. Preventive Services Task Force. *Annals of internal medicine*, 155(12), 827-38
- C. Salisbury, P. S. Chan, K. L. Gosch, *et al.*(2011). Patterns and predictors of fast food consumption after acute myocardial infarction. *The American journal of cardiology*, 107(8), 1105-10
- E. Zomer, A. Owen, D. J. Magliano, *et al.*(2012). The effectiveness and cost effectiveness of dark chocolate consumption as prevention therapy in people at high risk of cardiovascular disease: best case scenario analysis using a Markov model. *BMJ (Clinical research ed.)*, 344, e3657

- G. Bjelakovic, D. Nikolova, C. Gluud (2013). Meta-regression analyses, meta-analyses, and trial sequential analyses of the effects of supplementation with beta-carotene, vitamin A, and vitamin E singly or in different combinations on all-cause mortality: do we have evidence for lack of harm? *PLoS one*, 8(9), e74558
- S. B. Rafnsson, V. Dilis, A. Trichopoulou (2013). Antioxidant nutrients and age-related cognitive decline: a systematic review of population-based cohort studies. *European journal of nutrition*, 52(6), 1553-67
- I. Conklin, E. R. Maguire, P. Monsivais (2013). Economic determinants of diet in older adults: systematic review. *Journal of epidemiology and community health*, 67(9), 721-7
- H. Hemila, P. Louhiala (2013). Vitamin C for preventing and treating pneumonia. *The Cochrane database of systematic reviews*, 8, CD005532
- R. Saulle, L. Semyonov, G. La Torre (2013). Cost and cost-effectiveness of the Mediterranean diet: results of a systematic review. *Nutrients*, 5(11), 4566-86

Educational interventions

- **Trust for America's Health:** The DGAC should likewise recommend that USDA and HHS provide practical advice for consumers on how to follow the DGA recommendations when eating at restaurants.
- **Trust for America's Health:** The DGAC should recommend strengthening and expanding the advice on reducing portion size to include consumer education messages,
- K. Young, F. Bunn, D. Trivedi, A. Dickinson (2011). Nutritional education for community dwelling older people: a systematic review of randomised controlled trials. *International journal of nursing studies*, 48(6), 751-80
- M. C. Gulliford, N. Bhattarai, J. Charlton, C. Rudisill (2014). Cost-effectiveness of a universal strategy of brief dietary intervention for primary prevention in primary care: population-based cohort study and Markov model. *Cost effectiveness and resource allocation*, 12(1), 4

Labeling

- S. Campos, J. Doxey, D. Hammond (2011). Nutrition labels on pre-packaged foods: a systematic review. *Public health nutrition*, 14(8), 1496-506

Nutritional support programs

- **Generations United:** Protect, strengthen and expand proven hunger and nutrition programs such as the Supplemental Nutrition Assistance Program, and promote innovative intergenerational approaches to meeting hunger needs such as those in shared sites where children and seniors interact and share resources.
- **Association of Asian Pacific Community Health Organizations:** Remove the federal five year bar (for lawfully present immigrants) from Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Medicare and the Exchanges.
- **Generations United:** Additional resources should be directed to senior nutrition programs to meet the increasing demand for congregate and home-delivered meals because of the growth of the age 85 and older population, which is expected to double from 3 million in 1990 to 7 million by 2020.
- **Generations United:** Enhance Supplemental Nutrition Assistance Program (SNAP) access and benefits through Farm Bill reauthorization.

- **Generations United:** Protect Supplemental Nutrition Assistance Program (SNAP) and other nutrition programs from negative structural changes, budget cuts and block grant proposals, particularly in the context of deficit reduction proposals.
- **Generations United:** Promote the expansion of the Commodity Supplemental Food Program (CSFP) to reach seniors in all 50 states.
- **Generations United:** Increase food distribution through The Emergency Food Assistance Program (TEFAP).
- **National Association of Nutrition and Aging Services Programs:** NANASP supports S. 1562 and H.R. 4122. They are bills that would expand and modernize the Act for the next 5 years but preserve the separate titles for congregate and home delivered nutrition and maintain voluntary contributions for participants.
- **National Association of Nutrition and Aging Services Programs:** As a last resort, NANASP would also support the straight reauthorization bill, H.R. 3850.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports an FY 2015 funding level of \$819 million for senior nutrition programs,
- **National Association of Nutrition and Aging Services Programs:** NANASP opposes any cuts to key USDA nutrition programs that support seniors, particularly those seniors who have lower incomes. These nutrition programs include the Supplemental Nutrition Assistance Program (SNAP), the Senior Farmers Market Nutrition Program, and the Commodity Supplemental Food Program.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports the continuation of the existing Titles III C1 (congregate meals) and C2 (home delivered meals) programs as well as the continued use of voluntary contributions in the program.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports the Senate version of the Farm Bill because it does less harm to key nutrition programs including SNAP, the Emergency Food Assistance Program (TEFAP), SNAP Education (SNAP-Ed), the Commodity Supplemental Food Program (CSFP), and the Senior Farmers Market Nutrition Program.
- **National Association of Nutrition and Aging Services Programs:** Fully endorses a position of promoting and protecting funding for the Older Americans Act (OAA). NANASP specifically is recommending a 3 percent increase in funding for the elderly nutrition programs under the OAA to keep up with inflation.
- **National Association of Nutrition and Aging Services Programs:** NANASP urges that a final reauthorization preserve and strengthen the nutrition program, including protecting nutrition dollars, promoting greater local autonomy in decision making on funding, maintain separate titles for congregate and home-delivered meals, maintain voluntary contributions, provide greater use of registered dietitians in programs and provide adequate funding for each of the 5 years of the reauthorization.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports renewal of the Farm bill, a renewal which would avert major reductions in the SNAP program as well as strengthen and protect CSFP and the Senior Farmers' Market Nutrition Program.
- **National Association of Nutrition and Aging Services Programs:** Endorses its call for a 10 percent increase in funding for the Older Americans Act nutrition programs in FY 2012
- **National Association of Nutrition and Aging Services Programs:** NANASP stands strongly opposed to the House passed Agriculture Appropriations bill and urges the Senate to restore the cuts to these critical nutrition programs helping the vulnerable of all ages.

- **National Association of Nutrition and Aging Services Programs:** NANASP urges that a reauthorization accomplish a strengthening of the nutrition programs especially with respect to the protection of all nutrition dollars from being transferred to non-nutrition programs.
- **Trust for America’s Health:** TFAH strongly supports the SNAP program as a critical to both combatting hunger and improving nutrition among some of the most vulnerable Americans.
- **Trust for America’s Health:** We recommend that USDA strengthen retailer eligibility criteria by requiring retailers to stock more healthy food by strengthening both the criteria A and B definitions of staple foods
- **Trust for America’s Health:** We recommend that USDA require that SNAP retailers only be permitted to market their SNAP eligibility or SNAP benefits in conjunction with staple foods that meet the Dietary Guidelines for Americans.
- **Trust for America’s Health:** We strongly urge USDA to, where feasible, ease application restrictions towards the goal of encouraging farmers’ markets to participate in the SNAP program.
- **Trust for America’s Health:** Programs such as “Double Your Dollars” or “money-back” for eligible purchases of fruits and vegetables should be brought to scale to further increase the purchase of healthy foods.
- **Trust for America’s Health:** Support SNAP use at farmers’ markets, in Community Supported Agriculture (CSA), and other farm- to-consumer venues, by ensuring people can use their SNAP Electronic Benefit Transfer at these places.
- **Partnership for Prevention:** Partnership has previously recommended, for example, that Congress give the Federal Trade Commission the authority to regulate advertising of “junk food” to children and give the Food and Drug Administration the authority to regulate tobacco.
- E. A. Frongillo, W. S. Wolfe (2010). Impact of participation in Home-Delivered Meals on nutrient intake, dietary patterns, and food insecurity of older persons in New York state. *Journal of nutrition for the elderly*, 29(3), 293-310
- P. Singer, R. Anbar, J. Cohen, *et al.*(2011). The tight calorie control study (TICACOS): a prospective, randomized, controlled pilot study of nutritional support in critically ill patients. *Intensive care medicine*, 37(4), 601-9
- M. Beck, M. Holst, H. H. Rasmussen (2013). Oral nutritional support of older (65 years+) medical and surgical patients after discharge from hospital: systematic review and meta-analysis of randomized controlled trials. *Clinical rehabilitation*, 27(1), 19-27
- R. J. Stratton, X. Hebuterne, M. Elia (2013). A systematic review and meta-analysis of the impact of oral nutritional supplements on hospital readmissions. *Ageing research reviews*, 12(4), 884-97
- Z. van Asselt, M. A. van Bokhorst-de van der Schueren, T. J. van der Cammen, *et al.*(2012). Assessment and treatment of malnutrition in Dutch geriatric practice: consensus through a modified Delphi study. *Age and ageing*, 41(3), 399-404

Screening and early detection

Cancer

Breast

- **Association of Asian Pacific Community Health Organizations:** We support the Prevention and Public Health Fund, which, among other functions, supports important nutrition and obesity prevention programs, community-level efforts to reduce chronic diseases such as the Racial

and Ethnic Approaches to Community Health (REACH) program, and services that provide breast cancer screenings to low-income communities.

- S. W. Duffy, L. Tabar, A. H. Olsen, *et al.*(2010). Absolute numbers of lives saved and overdiagnosis in breast cancer screening, from a randomized trial and from the Breast Screening Programme in England. *Journal of medical screening*, 17(1), 25-30
- S. J. Atlas, R. W. Grant, W. T. Lester, *et al.*(2011). A cluster-randomized trial of a primary care informatics-based system for breast cancer screening. *Journal of general internal medicine*, 26(2), 154-61
- K. Park, W. H. Hong, S. Y. Kye, *et al.*(2011). Community-based intervention to promote breast cancer awareness and screening: the Korean experience. *BMC public health*, 11, 468
- J. T. Schousboe, K. Kerlikowske, A. Loh, S. R. Cummings (2011). Personalizing mammography by breast density and other risk factors for breast cancer: analysis of health benefits and cost-effectiveness. *Annals of internal medicine*, 155(1), 10-20
- L. Henneman, D. R. Timmermans, C. M. Bouwman, *et al.*(2011). 'A low risk is still a risk': exploring women's attitudes towards genetic testing for breast cancer susceptibility in order to target disease prevention. *Public health genomics*, 14(4-5), 238-47
- C. Nickson, K. E. Mason, D. R. English, A. M. Kavanagh (2012). Mammographic screening and breast cancer mortality: a case-control study and meta-analysis. *Cancer epidemiology, biomarkers & prevention*, 21(9), 1479-88
- D. H. Howard, E. K. Adams (2012). Mammography rates after the 2009 US Preventive Services Task Force breast cancer screening recommendation. *Preventive medicine*, 55(5), 485-7
- M. P. Gardner, A. Adams, M. Jeffreys (2013). Interventions to increase the uptake of mammography amongst low income women: a systematic review and meta-analysis. *PloS one*, 8(2), e55574

Cervical

- S. Franceschi, L. Denny, K. L. Irwin, *et al.*(2011). Eurogin 2010 roadmap on cervical cancer prevention. *International journal of cancer. Journal international du cancer*, 128(12), 2765-74
- M. Dreier, B. Borutta, J. Toppich, *et al.*(2012). [Mammography and cervical cancer screening-a systematic review about women's knowledge, attitudes and participation in Germany]. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany))*, 74(11), 722-35

Colon

- **C3: Colorectal Cancer Coalition:** Pass legislation to eliminate Medicare beneficiary coinsurance for colorectal cancer screening colonoscopy.
- **C3: Colorectal Cancer Coalition:** Reintroduction of the Colorectal Cancer Prevention, Early Detection and Treatment Act. This legislation would essentially expand and improve upon the CRCCP. The bill is authorizing legislation, which means that even if the legislation is enacted into law, funding to implement the law would still need to be appropriated.
- H. Brenner, L. Altenhofen, M. Hoffmeister (2010). Eight years of colonoscopic bowel cancer screening in Germany: initial findings and projections. *Deutsches Arzteblatt international*, 107(43), 753-9
- K. E. Lasser, J. Murillo, S. Lisboa, *et al.*(2011). Colorectal cancer screening among ethnically

diverse, low-income patients: a randomized controlled trial. *Archives of internal medicine*, 171(10), 906-12

- U. Ladabaum, G. Wang, J. Terdiman, *et al.*(2011). Strategies to identify the Lynch syndrome among patients with colorectal cancer: a cost-effectiveness analysis. *Annals of internal medicine*, 155(2), 69-79
- H. Sonoda, S. Kohnoe, T. Yamazato, *et al.*(2011). Colorectal cancer screening with odour material by canine scent detection. *Gut*, 60(6), 814-9
- D. J. Lee, N. S. Consedine, B. A. Spencer (2011). Barriers and facilitators to digital rectal examination screening among African-American and African-Caribbean men. *Urology*, 77(4), 891-8
- C. Khalid-de Bakker, D. Jonkers, K. Smits, *et al.*(2011). Participation in colorectal cancer screening trials after first-time invitation: a systematic review. *Endoscopy*, 43(12), 1059-86
- C. L. Lewis, A. T. Brenner, J. M. Griffith, *et al.*(2012). Two controlled trials to determine the effectiveness of a mailed intervention to increase colon cancer screening. *North Carolina medical journal*, 73(2), 93-8
- E. M. Stoop, M. C. de Haan, T. R. de Wijkerslooth, *et al.*(2012). Participation and yield of colonoscopy versus non-cathartic CT colonography in population-based screening for colorectal cancer: a randomised controlled trial. *The lancet oncology*, 13(1), 55-64
- A. Tucker, S. P. Tucker (2012). Increasing colorectal cancer screening compliance through community education. *Gastroenterology nursing*, 35(6), 416-9
- A. S. James, V. Richardson, J. S. Wang, *et al.*(2013). Systems intervention to promote colon cancer screening in safety net settings: protocol for a community-based participatory randomized controlled trial. *Implementation science*, 8, 58
- T. C. Davis, C. L. Arnold, C. L. Bennett, *et al.*(2014). Strategies to improve repeat fecal occult blood testing cancer screening. *Cancer epidemiology, biomarkers & prevention*, 23(1), 134-43

Lung

- J. M. Croswell, S. G. Baker, P. M. Marcus, *et al.*(2010). Cumulative incidence of false-positive test results in lung cancer screening: a randomized trial. *Annals of internal medicine*, 152(8), 505-12, W176-80
- U. Pastorino, M. Rossi, V. Rosato, *et al.*(2012). Annual or biennial CT screening versus observation in heavy smokers: 5-year results of the MILD trial. *European journal of cancer prevention*, 21(3), 308-15
- N. Becker, E. Motsch, M. L. Gross, *et al.*(2012). Randomized study on early detection of lung cancer with MSCT in Germany: study design and results of the first screening round. *Journal of cancer research and clinical oncology*, 138(9), 1475-86
- R. Manser, A. Lethaby, L. B. Irving, *et al.*(2013). Screening for lung cancer. *The Cochrane database of systematic reviews*, 6, CD001991
- J. K. Field, D. M. Hansell, S. W. Duffy, D. R. Baldwin (2013). CT screening for lung cancer: countdown to implementation. *The Lancet. Oncology*, 14(13), e591-600
- J. F. Rasmussen, V. Siersma, J. H. Pedersen, *et al.*(2014). Healthcare costs in the Danish randomised controlled lung cancer CT-screening trial: a registry study. *Lung cancer*, 83(3), 347-55

Prostate

- **American Urological Association:** Preserve access to appropriate prostate-specific antigen (PSA) screening.
- D. J. Rosario, J. A. Lane, C. Metcalfe, *et al.*(2012). Short term outcomes of prostate biopsy in men tested for cancer by prostate specific antigen: prospective evaluation within ProtecT study. *BMJ (Clinical research ed.)*, 344, d7894

General

- A. Jemal, F. Bray, M. M. Center, *et al.*(2011). Global cancer statistics. *CA: a cancer journal for clinicians*, 61(2), 69-90
- (2012). Cancer screening - United States, 2010. *MMWR. Morbidity and mortality weekly report*, 61(3), 41-5
- S. Hendren, P. Winters, S. Humiston, *et al.*(2014). Randomized, controlled trial of a multimodal intervention to improve cancer screening rates in a safety-net primary care practice. *Journal of general internal medicine*, 29(1), 41-9

Cardiovascular disease

- M. M. Lieve, P. Moulin, C. Thivolet, *et al.*(2011). Detection of silent myocardial ischemia in asymptomatic patients with diabetes: results of a randomized trial and meta-analysis assessing the effectiveness of systematic screening. *Trials*, 12, 23
- P. S. Moran, M. J. Flattery, C. Teljeur, *et al.*(2013). Effectiveness of systematic screening for the detection of atrial fibrillation. *The Cochrane database of systematic reviews*, 4, CD009586

Chronic kidney disease

- **American Society of Nephrologists:** The National Kidney Disease Education Program (NKDEP) at the National Institutes of Health has advocated for screening patients who have a family history of kidney disease.
- **American Society of Nephrologists:** NKDEP and the American Heart Association also recommend CKD screening for patients with a clinical diagnosis of cardiovascular disease, who are also at high risk of kidney disease.
- **American Society of Nephrologists:** ASN recommends screening of patients with hypertension and diabetes for CKD. Existing guidelines from a number of professional organizations, including the American Diabetes Association, the National Kidney Foundation, and the Joint National Commission on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, also recommend screening these high risk populations for CKD.

Diabetes

- N. R. Waugh, D. Shyangdan, S. Taylor-Phillips, *et al.*(2013). Screening for type 2 diabetes: a short report for the National Screening Committee. *Health technology assessment (Winchester, England)*, 17(35), 1-90
- B. Weltermann, S. Reinders, M. Bettin, S. Gesenhues, M. Hermann (2013). [Screening for diabetic retinopathy in type 2 diabetes: a critical review of an annual routine]. *Zeitschrift fur Evidenz, Fortbildung und Qualitat im Gesundheitswesen*, 107(6), 403-9

Hepatitis

- **Association of Asian Pacific Community Health Organizations:** We are providing these joint comments to encourage the Department of Health and Human Services (“HHS”) to include routine testing for the hepatitis B virus infection (“HBV”) — as recommended by the Centers for Disease Control and Prevention (“CDC”) — in the Health Resources and Services Administration (“HRSA”) guidelines on preventive care and screening for women, as described in the Public Health Services Act (“PHSA”) § 2713(a)(4).
- P. O. Coffin, J. D. Scott, M. R. Golden, S. D. Sullivan (2012). Cost-effectiveness and population outcomes of general population screening for hepatitis C. *Clinical infectious diseases*, 54(9), 1259-71
- D. B. Rein, B. D. Smith, J. S. Wittenborn, *et al.*(2012). The cost-effectiveness of birth-cohort screening for hepatitis C antibody in U.S. primary care settings. *Annals of internal medicine*, 156(4), 263-70
- C. Rossi, K. Schwartzman, O. Oxlade, *et al.*(2013). Hepatitis B screening and vaccination strategies for newly arrived adult Canadian immigrants and refugees: a cost-effectiveness analysis. *PloS one*, 8(10), e78548
- R. E. Myers, H. Bittner-Fagan, C. Daskalakis, *et al.*(2013). A randomized controlled trial of a tailored navigation and a standard intervention in colorectal cancer screening. *Cancer epidemiology, biomarkers & prevention*, 22(1), 109-17

Mental health

- **Association of Jewish Aging Services of North America (AJAS):** Alzheimer’s Education & Expanded Coverage under Medicare In 2010, Senator Debbie Stabenow (D-MI) introduced the Health Outcomes, Planning, and Education (HOPE) for Alzheimer’s Act which will seek to ensure that Medicare covers screening for the disease as well as education on treatment options both for the patient as well as for the patient’s family caregivers.
- **Alzheimer’s Foundation of America:** AFA urges Administration support for a public awareness campaign to drive early detection.
- **Alzheimer’s Foundation of America:** AFA urges the Centers for Medicare and Medicaid Services (CMS) to include cognitive screening in the Medicare Annual Wellness Exam.
- **Alzheimer’s Foundation of America:** Accelerate efforts to identify early and presymptomatic stages of Alzheimer’s disease.
- **Alzheimer’s Foundation of America:** Ensure timely and accurate diagnosis...AFA recommends that memory screening efforts be expanded. Federal and state health facilities can be utilized as screening sites, and CMS can promote screenings through outreach to its public health partners.
- G. Sowden, C. A. Mastromauro, J. L. Januzzi, *et al.*(2010). Detection of depression in cardiac inpatients: feasibility and results of systematic screening. *American heart journal*, 159(5), 780-7
- B. C. Stephan, T. Kurth, F. E. Matthews, *et al.*(2010). Dementia risk prediction in the population: are screening models accurate? *Nature reviews. Neurology*, 6(6), 318-26
- J. M. Watson, H. Crosby, V. M. Dale, *et al.*(2013). AESOPS: a randomised controlled trial of the clinical effectiveness and cost-effectiveness of opportunistic screening and stepped care interventions for older hazardous alcohol users in primary care. *Health technology assessment*, 17(25), 1-158

General and other

- B. Yueh, M. P. Collins, P. E. Souza, *et al.*(2010). Long-term effectiveness of screening for hearing loss: the screening for auditory impairment--which hearing assessment test (SAI-WHAT) randomized trial. *Journal of the American Geriatrics Society*, 58(3), 427-34
- P. Guggenbuhl, R. Dufour, S. Liu-Leage, *et al.*(2011). Efficiency of bone density testing by dual-biphotonic X-rays absorptiometry for diagnosis of osteoporosis according to French guideline recommendations: the PRESAGE study. *Joint, bone, spine*, 78(5), 493-8
- C. Czoski-Murray, M. Lloyd Jones, C. McCabe, *et al.*(2012). What is the value of routinely testing full blood count, electrolytes and urea, and pulmonary function tests before elective surgery in patients with no apparent clinical indication and in subgroups of patients with common comorbidities: a systematic review of the clinical and cost-effective literature. *Health technology assessment*, 16(50), i-xvi, 1-159
- D. Dabare, T. T. Lo, D. J. McCormack, V. W. Kung (2012). What is the role of screening in the management of abdominal aortic aneurysms? *Interactive cardiovascular and thoracic surgery*, 14(4), 399-405
- W. L. Titsworth, J. Abram, A. Fullerton, *et al.*(2013). Prospective quality initiative to maximize dysphagia screening reduces hospital-acquired pneumonia prevalence in patients with stroke. *Stroke*, 44(11), 3154-60
- E. Grunfeld, D. Manca, R. Moineddin, *et al.*(2013). Improving chronic disease prevention and screening in primary care: results of the BETTER pragmatic cluster randomized controlled trial. *BMC family practice*, 14, 175
- H. Y. Wu, J. W. Huang, Y. S. Peng, *et al.*(2013). Microalbuminuria screening for detecting chronic kidney disease in the general population: a systematic review. *Renal failure*, 35(5), 607-14
- P. J. Eulitt, R. J. Tomberg, T. D. Cunningham, *et al.*(2014). Screening elders in the emergency department at risk for mistreatment: a pilot study. *Journal of elder abuse & neglect*, 26(4), 424-35

Tobacco cessation

- **Partnership for Prevention:** Partnership has previously recommended, for example, that Congress give the Federal Trade Commission the authority to regulate advertising of “junk food” to children and give the Food and Drug Administration the authority to regulate tobacco.
- **AMDAs- Society for Post-Acute and Long-Term Care Medicine:** A resolution to the American Medical Association House of Delegates meeting supporting the concept that e-cigarettes be considered tobacco products with all of the legal and policy restrictions with smoking in post-acute and long-term care settings.
- **American Society of Clinical Oncology:** Fund all tobacco cessation programs at the CDC-recommended levels to ensure tobacco cessation services are comprehensive and available to all Americans
- **American Society of Clinical Oncology:** Utilize the tobacco tax and Master Settlement Agreement funds to fully fund comprehensive tobacco control programs
- **American Society of Clinical Oncology:** Support the Smoking Prevention and Tobacco Control Act policies
- **American Society of Clinical Oncology:** Pursue policies that ensure Medicaid patients with cancer have access to the full range of services to diagnose and treat their disease, including tobacco cessation, genetic testing and clinical trials

Vaccinations

Influenza

- **Trust for America's Health:** For FY 2015 influenza activities, TFAH recommends \$160 million for CDC's seasonal and pandemic influenza program.
- T. Jefferson, C. Di Pietrantonj, L. A. Al-Ansary, *et al.*(2010). Vaccines for preventing influenza in the elderly. The Cochrane database of systematic reviews, (2), CD004876
- E. J. Luna, V. L. Gattas (2010). Effectiveness of the Brazilian influenza vaccination policy, a systematic review. *Revista do Instituto de Medicina Tropical de Sao Paulo*, 52(4), 175-81
- A. Phrommintikul, S. Kuanprasert, W. Wongcharoen, *et al.*(2011). Influenza vaccination reduces cardiovascular events in patients with acute coronary syndrome. *European heart journal*, 32(14), 1730-5
- P. O. Lang, A. Mendes, J. Socquet, *et al.*(2012). Effectiveness of influenza vaccine in aging and older adults: comprehensive analysis of the evidence. *Clinical interventions in aging*, 7, 55-64
- D. Lau, J. Hu, S. R. Majumdar, *et al.*(2012). Interventions to improve influenza and pneumococcal vaccination rates among community-dwelling adults: a systematic review and meta-analysis. *Annals of family medicine*, 10(6), 538-46
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- J. J. Ott, J. Klein Breteler, J. S. Tam, *et al.*(2013). Influenza vaccines in low and middle income countries: a systematic review of economic evaluations. *Human vaccines & immunotherapeutics*, 9(7), 1500-11
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- R. E. Thomas, T. Jefferson, T. J. Lasserson (2013). Influenza vaccination for healthcare workers who care for people aged 60 or older living in long-term care institutions. The Cochrane database of systematic reviews, 7, CD005187
- B. Michiels, K. Van Puyenbroeck, V. Verhoeven, *et al.*(2013). The value of neuraminidase inhibitors for the prevention and treatment of seasonal influenza: a systematic review of systematic reviews. *PLoS one*, 8(4), e60348
- T. C. Chan, I. Fan-Ngai Hung, J. Ka-Hay Luk, *et al.*(2014). Effectiveness of influenza vaccination in institutionalized older adults: a systematic review. *Journal of the American Medical Directors Association*, 15(3), 226 e1-6

Pneumonia

- M. H. Rozenbaum, A. J. van Hoek, D. Fleming, *et al.*(2012). Vaccination of risk groups in England using the 13 valent pneumococcal conjugate vaccine: economic analysis. *BMJ (Clinical research ed.)*, 345, e6879
- C. I. Michaelidis, R. K. Zimmerman, M. P. Nowalk, K. J. Smith (2013). Cost-effectiveness of a program to eliminate disparities in pneumococcal vaccination rates in elderly minority populations: an exploratory analysis. *Value in health*, 16(2), 311-7
- A. Vila-Corcoles, O. Ochoa-Gondar (2013). Preventing pneumococcal disease in the elderly:

recent advances in vaccines and implications for clinical practice. *Drugs & aging*, 30(5), 263-76

- S. Moberley, J. Holden, D. P. Tatham, R. M. Andrews (2013). Vaccines for preventing pneumococcal infection in adults. *The Cochrane database of systematic reviews*, 1, CD000422

Other

- **National Association of Nutrition and Aging Services Programs:** NANASP supports public and private efforts to raise awareness about immunizations for older adults...follow the Centers for Disease Control and Prevention (CDC) guidelines, which call for yearly influenza and one-time shingles, pneumococcal (pneumonia) and Tdap (tetanus, diphtheria, pertussis) vaccinations.
- K. E. Schmader, M. N. Oxman, M. J. Levin, *et al.*(2012). Persistence of the efficacy of zoster vaccine in the shingles prevention study and the short-term persistence substudy. *Clinical infectious diseases*, 55(10), 1320-8
- A. Verma, P. Torun, E. Harris, *et al.*(2012). Population Impact Analysis: a framework for assessing the population impact of a risk or intervention. *Journal of public health (Oxford, England)*, 34(1), 83-9

Weight management and physical activity

Cardiovascular disease

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- J. A. Chase (2011). Systematic review of physical activity intervention studies after cardiac rehabilitation. *The Journal of cardiovascular nursing*, 26(5), 351-8
- L. Pope, J. Harvey-Berino, P. Savage, *et al.*(2011). The impact of high-calorie-expenditure exercise on quality of life in older adults with coronary heart disease. *Journal of aging and physical activity*, 19(2), 99-116
- S. J. Keteyian, E. S. Leifer, N. Houston-Miller, *et al.* (2012). Relation between volume of exercise and clinical outcomes in patients with heart failure. *Journal of the American College of Cardiology*, 60(19), 1899-905
- P. Lynga, H. Persson, A. Hagg-Martinell, *et al.* (2012). Weight monitoring in patients with severe heart failure (WISH). A randomized controlled trial. *European journal of heart failure*, 14(4), 438-44
- L. Young, L. Zimmerman, B. Pozehl, *et al.*(2012). Cost-effectiveness of a symptom management intervention: improving physical activity in older women following coronary artery bypass surgery. *Nursing economic\$,* 30(2), 94-103
- N. Oldridge (2012). Exercise-based cardiac rehabilitation in patients with coronary heart disease: meta-analysis outcomes revisited. *Future cardiology*, 8(5), 729-51

Mental health

- C. Anderson-Hanley, P. J. Arciero, A. M. Brickman, *et al.*(2012). Exergaming and older adult cognition: a cluster randomized clinical trial. *American journal of preventive medicine*, 42(2), 109-19
- M. Underwood, S. E. Lamb, S. Eldridge, *et al.*(2013). Exercise for depression in care home residents: a randomised controlled trial with cost-effectiveness analysis (OPERA). *Health technology assessment (Winchester, England)*, 17(18), 1-281

- D. Forbes, E. J. Thiessen, C. M. Blake, *et al.*(2013). Exercise programs for people with dementia. The Cochrane database of systematic reviews, 12, CD006489
- J. C. Davis, S. Bryan, C. A. Marra, *et al.*(2013). An economic evaluation of resistance training and aerobic training versus balance and toning exercises in older adults with mild cognitive impairment. PloS one, 8(5), e63031
- K. H. Pitkala, M. M. Poysti, M. L. Laakkonen, *et al.*(2013). Effects of the Finnish Alzheimer disease exercise trial (FINALEX): a randomized controlled trial. JAMA internal medicine, 173(10), 894-901

General

- **American Public Health Association:** Osteoporosis prevention and awareness (Fit to a T).
- **American Public Health Association:** Calls on public health agencies to make available evidence-based musculoskeletal programs and resources to public health and healthcare workers. These are offered through organizations such as the Arthritis Foundation and Bone and Joint Decade/Initiative.
- **American Public Health Association:** Recommends advocacy for public health legislation that supports the prevention and management of musculoskeletal disorders, such as the physical activity recommendations as outlined in Healthy People 2010.
- **Association of Asian Pacific Community Health Organizations:** We support the Prevention and Public Health Fund, which, among other functions, supports important nutrition and obesity prevention programs, community-level efforts to reduce chronic diseases such as the Racial and Ethnic Approaches to Community Health (REACH) program, and services that provide breast cancer screenings to low-income communities.
- American Society of Clinical Oncology: ASCO is committed to ensuring access to evidence-based interventions and strategies to reduce the cancer-related consequences of obesity... advocate for reimbursement and coverage of these services for appropriate individuals, and for the availability of services at the community level.
- **National Association of Nutrition and Aging Services Programs:** NANASP supports the Senate Farm Bill's SNAP-Ed provisions which would maintain SNAP-Ed at current funding levels and add physical activity as an eligible use of the program.
- **American Public Health Association:** APHA urges...activities...incorporate or address the following objectives in relevant legislation, land-use planning guidance, or public health priority-setting regulations: Public health officials, physicians, nurse practitioners, and other health professionals should advise patients and the public at large about the benefits of green exercise, personal and community gardening, and nature-based play and recreation and form alliances with parks departments, departments of planning and design, area aging agencies, greening and garden organizations, cooperative extension services, school districts, and nature centers to increase access to green spaces where people live, work, and play and to raise awareness about their value.
- C. M. Champagne, S. T. Broyles, L. D. Moran, *et al.*(2011). Dietary intakes associated with successful weight loss and maintenance during the Weight Loss Maintenance trial. Journal of the American Dietetic Association, 111(12), 1826-35
- L. K. John, G. Loewenstein, A. B. Troxel, *et al.*(2011). Financial incentives for extended weight loss: a randomized, controlled trial. Journal of general internal medicine, 26(6), 621-6
- M. G. Mackey, P. Bohle, P. Taylor, *et al.*(2011). Walking to wellness in an ageing sedentary university community: design, method and protocol. Contemporary clinical trials, 32(2), 273-9

- E. Weening-Dijksterhuis, M. H. de Greef, E. J. Scherder, *et al.*(2011). Frail institutionalized older persons: A comprehensive review on physical exercise, physical fitness, activities of daily living, and quality-of-life. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists*, 90(2), 156-68
- C. Foster, J. Richards, M. Thorogood, M. Hillsdon (2013). Remote and web 2.0 interventions for promoting physical activity. *The Cochrane database of systematic reviews*, 9, CD010395
- M. Reiner, C. Niermann, D. Jekauc, A. Woll (2013). Long-term health benefits of physical activity--a systematic review of longitudinal studies. *BMC public health*, 13, 813
- E. Tak, R. Kuiper, A. Chorus, M. Hopman-Rock (2013). Prevention of onset and progression of basic ADL disability by physical activity in community dwelling older adults: a meta-analysis. *Ageing research reviews*, 12(1), 329-38
- S. N. Morrisroe, L. V. Rodriguez, P. C. Wang, *et al.*(2014). Correlates of 1-year incidence of urinary incontinence in older Latino adults enrolled in a community-based physical activity trial. *Journal of the American Geriatrics Society*, 62(4), 740-6

Other

- **Healthcare Leadership Council:** HLC supports chronic care management and disease prevention as essential components of healthcare delivery through better public and private sector development of evidence-based wellness practices. Encouragement of workplace wellness programs and interventions that have proven to reduce costs by improving health before the onset of disease – including those that are delivered outside the clinical healthcare setting – are key areas of focus.
- **National Medical Association:** Providing grants to small employers that establish wellness programs
- **Alzheimer’s Foundation of America:** PhRMA encourages the Agency to address the development of antibacterial preventative therapies, as there is a lack of regulatory guidance where prevention is the principal focus.
- **National Business Group on Health:** Promote favorable policy toward onsite health centers.
- **American Urological Association:** Reform the US Preventive Services Task Force (USPSTF) recommendation process.
- **American Hospital Association:** Insurers and employers should offer insurance products with lower premiums for patients who receive recommended preventive services or who improve their health.
- **American Society on Aging:** The American Society on Aging stands with our colleagues across the nation in asking Congress to reauthorize the Older Americans Act (OAA).
- **Leadership Council of Aging Organizations:** LCAO supports efforts to extending primary care services and providing preventive care services with no copayment requirements to Medicare beneficiaries.
- **National Medical Association:** Establishing the National Prevention, Health Promotion and Public Health Council to coordinate prevention, wellness, and public health activities.
- **National Medical Association:** Eliminates cost-sharing for proven preventive services in Medicare and Medicaid by 2011.
- **Bipartisan Policy Center:** Maintain preventive care and the annual wellness visit with no beneficiary costsharing.

- **Trust for America's Health:** We recommend \$100 million for the CDC Partnerships to Improve Community Health grant program in FY2015.
- **Trust for America's Health:** TFAH recommends a specific budget item of \$4 million for the Built Environment and Health initiative to support CDC's ability to maintain resources aimed at helping states and communities build healthier communities
- **National Medical Association:** Providing grants to small employers that establish wellness programs
- **Alzheimer's Foundation of America:** PhRMA encourages the Agency to address the development of antibacterial preventative therapies, as there is a lack of regulatory guidance where prevention is the principal focus.
- **National Business Group on Health:** Promote favorable policy toward onsite health centers.

Section 9. Malpractice

Description: Defensive medicine – a practice in which physicians order excessive or unnecessary tests and treatments out of fear of a potential lawsuit – leads to somewhere between \$45.6 billion to \$650 billion (or more) per year in healthcare system spending.⁴⁸ Proposals to reform malpractice often focus on creating evidence-based standards of care that would help shield doctors who adhered to the standards from liability. A cost effective, high value healthcare system would work to eliminate wasteful and unnecessary care associated with the practice of defensive medicine.

- **American Healthcare Association:** We oppose efforts to limit the rights of consumers and healthcare providers to use pre-dispute arbitration agreements as an alternative to litigation in long term care settings.
- **American Healthcare Association:** Ensure observation stays count toward the required three-day stay by co-sponsoring the Improving Access to Medicare Coverage Act of 2013 (H.R. 1179/S. 569). The American Healthcare Association/National Center for Assisted Living (AHCA/NCAL) strongly supports the use of arbitration as a reasonable, intelligent option for patients, residents, and providers seeking resolution of legal disputes.
- **American Healthcare Association:** AHCA/NCAL urges lawmakers to continue to support the use of arbitration and to reject any attempts to limit its use in long term care settings. Fair and timely resolution to legal concerns is in the best interest of patients, residents, taxpayers, and the nation’s entire healthcare sector – and pre- dispute arbitration should remain an option for both long term care residents and the providers who care for them.
- **AHIP:** We believe that the current medical liability system should be replaced with a new dispute resolution process consisting of an independent third-party review process designed to provide fair compensation and quick resolution of disputes, while promoting healthcare quality nationwide through reliance on evidence-based medicine.
- **AHIP:** Physicians should be granted a legal presumption that they have acted appropriately if their actions are evidence-based.
- **AHIP:** New cases should be reviewed by an objective expert panel before they can be filed in court.
- **AHIP:** Adopt innovative approaches to resolving medical disputes that promote patient-provider communication, improve quality and safety, and promote fairness.
- **AHIP:** Certificate of merit. To avoid spending scarce justice system resources on less meritorious cases, we support evaluation of the merits of claims by independent medical experts prior to filing.
- **AHIP:** Safe harbors for evidence-based care. We support the establishment and evaluation of safe harbors and medical malpractice protections for clinicians who effectively document and practice recognized and appropriate standards of care.
- **AHIP:** Neutral medical expertise at trial. Today, medical liability suits rely on medical “experts” who are paid for their services by either the plaintiff’s or the defendant’s lawyers. To ensure that courts and juries can benefit from more objective and neutral medical analysis, courts should be empowered to retain their own medical experts.
- **American Hospital Association:** Government should establish “safe harbor” protections for providers who follow evidence-based clinical practice guidelines.
- **American Hospital Association:** Allow courts to limit lawyers’ contingency fees.

⁴⁸<http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf>

- **American Hospital Association:** Cap non-economic damages.
- **American Hospital Association:** Model federal proposals on proven state models of reform.
- **American Hospital Association:** Provide prompt compensation to injured patients based on an agreed-upon payment schedule.
- **American Hospital Association:** Establish “safe harbor” protections for providers who follow evidence-based clinical practice guidelines.
- **American Hospital Association:** Cap non-economic damages.
- **American Hospital Association:** Allow the courts to limit lawyers’ contingency fees.
- **American Hospital Association:** Make each party liable only for the amount of damages directly proportional to its responsibility.
- **American Hospital Association:** Enact a reasonable statute of limitations after the date of the manifestation or discovery of an injury.
- **American Hospital Association:** AHA also supports an administrative compensation system (ACS) in which decisions on compensation in medical liability cases are made by trained, impartial adjudicators outside of the regular tort system, based on whether the injury was avoidable.
- **American Hospital Association:** the AHA advocates for a more sensible liability system that uses evidence-based standards, separates the serious cases from others, and produces prompt and fair compensation for injured patients.
- **Cato Institute:** Enforce private contracts that include medical malpractice reforms .
- **Cato Institute:** Reject federal medical malpractice reforms.
- **Healthcare Leadership Council:** HLC is committed to addressing the nation’s liability lawsuit crisis to foster an environment that encourages organizations to adopt evidence-based medicine and reduces the practice of defensive medicine. By building on such initiatives, systems can be better engineered to curb excessive cost growth while also improving patient care.
- **National Medical Association:** Caps on non-economic damages in malpractice litigation.
- **National Medical Association:** Reforming the process by which insurance companies set the premiums paid for malpractice insurance coverage
- **National Medical Association:** Careful consideration of medical courts as a viable alternative to the tort system.
- **Bipartisan Policy Center:** Pursue Medical Liability Reform- Provide continued opportunities for states to test alternative models designed to reduce insurance and utilization costs associated with medical liability litigation by appropriating the \$50 million in state demonstration grants authorized in the ACA for the development, implementation, and evaluation of promising alternatives to current tort litigation.
- **Bipartisan Policy Center:** The federal government should consider offering a financial incentive to states that enact adoption of evidence-based quality measures that could be used as a provider defense in medical liability cases.

Section 10. Drug and Therapeutic Access and Effectiveness

Description: Proposed interventions to improve patient access to, and the effectiveness of, drugs and therapeutic treatments focus on: reforming the Food and Drug Administration’s approval process; expanding coverage of effective medications, including preventive medications; and redesigning payment and delivery systems to optimize adherence to courses of treatment.

Approval process

- **AHIP:** “Similarly, government support of an expedited approval process for generic drugs and an approval pathway for generic biologics will speed up our nation’s ability to offer consumers high-quality, lower cost alternatives.”
- **Cato Institute:** eliminate the U.S. Food and Drug Administration’s efficacy requirement for new drugs,
- **PhRMA:** We also urge FDA to implement the related FDASIA requirements intended to facilitate and expedite drug development and approval.
- **PhRMA:** supports focused attention by FDA on clarifying and expediting the regulatory framework governing antibacterial approval in order to help facilitate an increase in the number of innovative antibacterials available to combat antimicrobial resistance.
- **PhRMA:** FDA should preserve the primary purpose of prescription labeling as well as preserve the intent of Accelerated Approval to expedite patient access to treatments for serious conditions
- **AHIP:** Prohibiting patent settlements between drug companies. Congress should bar certain anti- competitive settlements that prevent generics from entering the market in a timely manner—thereby expanding the availability of low-cost, but equally effective, generic drugs.
- **American Hospital Association:** Speed up the availability of generic biologics, and prohibit brand-name companies from entering into “pay-for- delay” agreements with generic companies.
- **Gray Panthers:** Gray Panthers calls for laws and policies through which the National Institutes of Health and related public health institutions will retain an economic share in the patent rights associated with the research that they sponsor;
- **Bipartisan Policy Center:** Address Anti-Competitive Settlements between Brand and Generic Drug Manufacturers
- **Bipartisan Policy Center:** Close the REMS Loophole that Inhibits Development of Generic Drugs

Coverage and access

Cancer

- **American Society of Clinical Oncology:** endorsed the Cancer Drug Coverage Parity Act of 2013 (H.R. 1801) ... which would require private health insurance plans offering intravenous chemotherapy benefits to provide parity for orally administered and self-injectable anticancer medications
- **American Society of Clinical Oncology:** Legislative language should be clarified to include supportive care drugs to ensure they are subject to the same safeguards as other drugs used within an anticancer regimen
- **American Society of Clinical Oncology:** Cancer Drug Coverage Parity Act of 2013 (H.R. 1801)

- **American Society of Clinical Oncology:** Support Efforts to Exempt Cancer Drugs from Sequestration (H.R. 1416)
- V. Shankaran, S. Jolly, D. Blough, S. D. Ramsey (2012). Risk factors for financial hardship in patients receiving adjuvant chemotherapy for colon cancer: a population-based exploratory analysis. *Journal of clinical oncology*, 30(14), 1608-14

Mental health

- **American Medical Association:** CMS withdraws proposal to limit coverage of key drugs In an important win for Medicare patients, the Centers for Medicare & Medicaid Services (CMS) rescinded its proposal to remove antidepressants, immunosuppressants and antipsychotics from their protected class status.
- **Leadership Council of Aging Organizations:** We oppose provisions that would hurt vulnerable older adults, such as scaling back the six protected drug classes. We strongly urge you not to scale back the Medicare Part D six protected drug classes, particularly excluding antidepressants, immunosuppressants, and antipsychotics.

Rehabilitation therapy

- **Association of Jewish Aging Services of North America (AJAS):** Continued Support for the Medicare Therapy Cap Moratorium and Eventual Repeal Medicare currently provides coverage for therapy services (physical, occupational and speech therapy), but limits or “caps” the amount of therapy an individual can receive in a given year. Caps on therapy often hinder an individual’s ability to regain physical strength and daily living skills that are required to live independently. An individual may exhaust his or her permitted therapy early in the year and have a new need for therapy later – as a result of a new medical setback (surgery, injury from a fall, heart attack, etc.).
- **American Healthcare Association:** In the long term, AHCA supports a repeal of therapy caps as well as the development of a new and permanent prospective payment system built upon solid clinical factors and without artificial or arbitrary caps. This new system should be applicable to all settings, and reflective of clinical diagnoses, rehabilitation complexity, patient comorbidities, and duration of episodes of care.
- **Center for Medicare Advocacy, Inc.:** Eliminate outpatient therapy caps. At a minimum, the therapy cap exceptions process should be permanently extended and revised
- **National Academy of Social Insurance:** We call on lawmakers to ensure access for these patients in need of therapy services by addressing, permanently, the outpatient therapy caps alongside ongoing efforts in Congress to fix Medicare payment under the physician fee schedule.
- **American Hospital Association:** While the AHA supports extending the outpatient therapy exceptions process, we oppose the temporary expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.
- **Consortium for Citizens with Disability:** Increasing the 60 Percent Rule for Inpatient Rehabilitation Hospitals and Units We oppose raising the 60 percent rule, which was established by Congress in 2007, up to a 75 percent compliance threshold, a percentage that would arbitrarily restrict access to intensive, coordinated rehabilitation hospital services.
- **Consortium for Citizens with Disability:** Protect Medicare Outpatient Therapy Services We call on lawmakers to ensure access for these patients in need of therapy services by addressing, permanently, the outpatient therapy caps alongside ongoing efforts in Congress to fix Medicare payment under the physician fee schedule.

- **ITEM Coalition:** The ITEM Coalition urges Congress to establish a new and separate benefit category for Complex Rehabilitation Technology products and services that recognizes the customized nature of the technology and the range of services necessary to meet the unique medical and functional needs of people with disabilities and complex medical conditions
- **American Society of Clinical Oncology:** FDA needs sufficient resources to continue to address drug shortages
- **National Academy of Social Insurance:** we recommend that Congress Ensure access to complex rehabilitation technology by including H.R. 942/S.948, the Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013
- **National Academy of Social Insurance:** A requirement that CMS work with independent, third party non-profit organizations familiar with consumers with disabilities and chronic illnesses who require the long term use of complex rehabilitation technology
- **Consortium for Citizens with Disability:** In any Medicare reform bill, we recommend that Congress: Ensure access to complex rehabilitation technology by including H.R. 942/S.948, the Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013;
- **Consortium for Citizens with Disability:** Medicare currently does not have unique device coverage for the more complex and long-term needs of individuals with disabilities and chronic medical conditions. However, HR 942/S. 948 would ensure these individuals can access devices to remain independent in their homes and communities and avoid costly institution-based care.
- **American Hospital Association:** the AHA will continue to oppose any proposals to raise the threshold of the IRF 60 percent Rule or to pay skilled-nursing rates for selected IRF cases. Access to IRF care must be ensured for beneficiaries who clinically require the unique combination of hospital-level care and intensive rehabilitation, such as brain injury, spinal cord injury and stroke patients.
- T. K. Fehring, K. Fehring, S. M. Odum, D. Halsey (2013). Physical therapy mandates by Medicare administrative contractors: effective or wasteful? *The Journal of arthroplasty*, 28(9), 1459-62

Other

- **Bipartisan Policy Center:** Require all Medicare Advantage Plans to include prescription drug coverage
- **American Medical Association:** Physicians press CMS to cover drugs for hospice patients The AMA has joined a number of medical specialty societies and patient advocacy organizations in calling for the Centers for Medicare & Medicaid Services (CMS) to withdraw guidance it issued to Medicare Part D prescription drug plans that indicates they should require prior authorization before covering drugs for patients who enter hospice care.

Effectiveness of pharmaceutical and therapeutic interventions

- **Biotechnology Industry Organization:** governments should adopt reimbursement methodologies that appropriately value the objectively demonstrated therapeutic benefit of a pharmaceutical.
- **Biotechnology Industry Organization:** Any conditions on reimbursement should be reasonable and should take into account the best interests of the patient. Restrictions on reimbursement should be strictly based on sound science and best medical practice, rather than on short-term cost considerations

- **AHIP:** Encourage alternative payments and incentive structures—such as coverage with evidence development—for new drugs and technologies.
- **American Public Health Association:** State governments and state health departments are urged to promote effective pain care and pain management in the case of serious illnesses and at the end-of-life through the development of policies that remove barriers to use of essential pain medications including opioid analgesics
- **PhRMA** - Accordingly, PhRMA provides the following recommendations regarding priority for review and revision of antibiotic-related guidances as well as additional areas for future guidance development (listed in approximate order of highest priority to lowest):
 1. Hospital-Acquired and Ventilator- Associated Bacterial Pneumonia (draft issued November 26, 2010)
 2. Complicated Intra-Abdominal Infection (draft issued September 28, 2012)
 3. Complicated Urinary Tract Infection (draft issued February 23, 2012)
 4. Endocarditis and Bloodstream Infections
 5. Uncomplicated and Complicated Gonorrhea
 6. Diabetic Foot Infection
 7. Uncomplicated Urinary Tract Infection
 8. Prosthetic Joint Infection
 9. Osteomyelitis
 10. Bacterial meningitis
- S. C. Faucett, J. W. Genuario, A. N. Tosteson, K. J. Koval (2010). Is prophylactic fixation a cost-effective method to prevent a future contralateral fragility hip fracture? *Journal of orthopaedic trauma*, 24(2), 65-74
- R. C. Hendel, M. Cerqueira, P. S. Douglas, *et al.*(2010). A multicenter assessment of the use of single-photon emission computed tomography myocardial perfusion imaging with appropriateness criteria. *Journal of the American College of Cardiology*, 55(2), 156-62
- L. Manchikanti, V. Singh, M. V. Boswell (2010). Interventional pain management at crossroads: the perfect storm brewing for a new decade of challenges. *Pain physician*, 13(2), E111-40
- S. A. Biggs, R. V. Duarte, J. H. Raphael, R. L. Ashford (2011). Influence of a latent period in QALY analysis: pilot study of intrathecal drug delivery systems for chronic non-malignant pain. *British journal of neurosurgery*, 25(3), 401-6
- T. B. Cumming, A. G. Thrift, J. M. Collier, *et al.*(2011). Very early mobilization after stroke fast-tracks return to walking: further results from the phase II AVERT randomized controlled trial. *Stroke*, 42(1), 153-8
- M. Pennant, R. Orlando, P. Barton, *et al.*(2011). Prucalopride for the treatment of women with chronic constipation in whom standard laxative regimens have failed to provide adequate relief. *Health technology assessment (Winchester, England)*, 15 Suppl 1, 43-50
- Harris, B. A. Cooper, J. J. Li, *et al.*(2011). Cost-effectiveness of initiating dialysis early: a randomized controlled trial. *American journal of kidney diseases*, 57(5), 707-15
- D. Hartwell, J. Jones, E. Loveman, *et al.*(2011). Topotecan for relapsed small cell lung cancer: a systematic review and economic evaluation. *Cancer treatment reviews*, 37(3), 242-9
- H. Naci, G. de Lissovoy, C. Hollenbeak, *et al.*(2012). Historical clinical and economic consequences of anemia management in patients with end-stage renal disease on dialysis using erythropoietin stimulating agents versus routine blood transfusions: a retrospective cost-effectiveness analysis. *Journal of medical economics*, 15(2), 293-304
- V. L. Baczek, W. T. Chen, J. Kluger, C. I. Coleman (2012). Predictors of warfarin use in atrial fibrillation in the United States: a systematic review and meta-analysis. *BMC family practice*, 13, 5

- P. Mitchell, R. J. Simpson (2012). Statin cost effectiveness in primary prevention: a systematic review of the recent cost-effectiveness literature in the United States. *BMC research notes*, 5, 373
- Z. I. Abbott, K. V. Nair, R. R. Allen, V. R. Akuthota (2012). Utilization characteristics of spinal interventions. *The spine journal*, 12(1), 35-43
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- U. Lange, U. Muller-Ladner, J. Teichmann (2012). [Physiotherapy in outpatients with osteoporosis. Insufficient evidence for therapy success]. *Zeitschrift fur Rheumatologie*, 71(4), 319-25
- L. H. Oderda, J. R. Young, C. V. Asche, G. A. Pepper (2012). Psychotropic-related hip fractures: meta-analysis of first-generation and second-generation antidepressant and antipsychotic drugs. *The Annals of pharmacotherapy*, 46(7-8), 917-28
- M. K. Ong, L. Zhang, H. Xu, *et al.* (2012). Medicare Part D benzodiazepine exclusion and use of psychotropic medication by patients with new anxiety disorders. *Psychiatric services*, 63(7), 637-42
- R. Nipp, R. Sloane, A. V. Rao, K. E. Schmader, H. J. Cohen (2012). Role of pain medications, consultants, and other services in improved pain control of elderly adults with cancer in geriatric evaluation and management units. *Journal of the American Geriatrics Society*, 60(10), 1912-7
- M. L. Gilmore, D. J. Wolfe (2013). Antipsychotic prophylaxis in surgical patients modestly decreases delirium incidence--but not duration--in high-incidence samples: a meta-analysis. *General hospital psychiatry*, 35(4), 370-5
- L. Manchikanti, F. J. Falco, V. Pampati, *et al.*(2013). Cost utility analysis of caudal epidural injections in the treatment of lumbar disc herniation, axial or discogenic low back pain, central spinal stenosis, and post lumbar surgery syndrome. *Pain physician*, 16(3), E129-43
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Payment and benefit design

Co-payments and tiering

- **National Association of Nutrition and Aging Services Programs:** we maintain strong opposition to any proposal to increase the amount of co-pays that low-income seniors under Part D might have to pay for brand-name drugs.
- **National Coalition on Healthcare:** Implement MedPAC's proposal to encourage generic use in the low-income subsidy population.
- **National Academy of Social Insurance:** We oppose a proposal to increase brand name copayments for dual eligibles with the Low- Income Subsidy (LIS), more commonly known as Extra Help, for Medicare Part D.
- **AHIP:** Adopting the "least costly alternative" standard for coverage for Medicare Part B drugs.
- **PhRMA:** CMS should also assure that a therapeutic alternative in the class be available to patients in a preferred tier before a medicine may be placed in the specialty tier.
- **Bipartisan Policy Center:** Adjust the Part D LIS Cost-Sharing to Encourage the Use of High-Value Drugs
- **National Medical Association:** Should a prior authorization model be employed for EHB? Prescription drugs should be covered with co-pays equal to or less than the average coverage levels for current small group and individual market plans. Brand names should be preferred over generics if it is the prescribing physician's best judgment that the brand name is the better option for that particular patient. The NMA is therefore not in favor of mandated formularies, because they are an undesirable tool for containing pharmaceutical costs.
- **Medicare Rights Center:** Offering generic drugs for zero co-payments to Medicare beneficiaries with Extra Help would yield savings for both the federal government and for beneficiaries, while providing increased access to prescriptions and better health outcomes to the most vulnerable people with Medicare.
- **AHIP:** Modify traditional Medicare benefits to allow tiered cost-sharing for providers, drugs, and services, provided that the modifications do not alter the overall actuarial value of Medicare for beneficiaries.
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Cost shifting

- **National Academy of Social Insurance:** Oppose changes to Part D that Shift Costs to Medicare Beneficiaries
- **National Association of Nutrition and Aging Services Programs:** would oppose those proposals which would result in any cost shifting or higher premiums for beneficiaries or reduction in choice of plans.

Other

- **American Hospital Association:** Monitor high prescribers and users of prescription drugs in the Medicaid program.

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Pharmaceutical and therapeutic prevention

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- G. Z. Duray, C. Torp-Pedersen, S. J. Connolly, S. H. Hohnloser (2011). Effects of dronedarone on clinical outcomes in patients with lone atrial fibrillation: pooled post hoc analysis from the ATHENA/EURIDIS /ADONIS studies. *Journal of cardiovascular electrophysiology*, 22(7), 770-6
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- E. Jodar Gimeno (2012). Identifying and managing patients at high risk for fractures: conclusions from the second Spanish multidisciplinary forum-parathyroid hormone use in osteoporotic patients at high risk for fractures. *Drugs in R&D*, 12(4), 199-206
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- G. C. Hu, C. Y. Hsu, H. K. Yu, *et al.*(2014). Association between the volume of inpatient rehabilitation therapy and the risk of all-cause and cardiovascular mortality in patients with ischemic stroke. *Archives of physical medicine and rehabilitation*, 95(2), 269-75

Pricing, discounts, and competitive bidding

- **American Society of Clinical Oncology:** ASCO urges Congress to enact H.R. 806/S. 808to help ensure that community-based oncology physician practices can purchase cancer drugs for prices within the Medicare payment amount.
- **American Society of Clinical Oncology:** ASCO urges Congress to enact H.R. 806/S. 808 to remove prompt-pay discounts that are extended to wholesalers from the ASP methodology
- **American Society of Clinical Oncology:** Preserve the Average Sales Price formula for Part B drugs until appropriate payment reform alternatives that keep practices healthy are in place
- **National Academy of Social Insurance:** we recommend that Congress Dramatically improve the DME competitive bidding process by including H.R. 1717, the Medicare DMEPOS Market Pricing Program Act of 2013
- **National Academy of Social Insurance:** “Provisions of H.R. 1717, the Medicare DMEPOS Market Pricing Program Act of 2013, specifically: The establishment of an independent market mechanism to set DME pricing and establish binding bids from participating suppliers of durable medical equipment, supplies and related services;”
- **American Hospital Association:** “Require manufacturers of brand-name drugsto pay the federal government a rebate on drugs purchased by enrollees in the low- income subsidy program for the Medicare Part D benefit.”

- **American Hospital Association:** Use Medicare's buying power to increase rebates from pharmaceutical companies.
- **American Hospital Association:** Extend the 340B drug discount program to additional hospitals and for the purchases of drugs used during inpatient hospital stays for all eligible hospitals, and oppose any attempts to scale back this vital program.
- **Gray Panthers:** Gray Panthers advance the position that the way to solve Medicare's problems, and the healthcare problems of the nation, is not to restrict Medicare, but to improve its benefits, including a drug program under Medicare without gaps, based on fair and affordable prices; and extend them to everyone in the United States
- **Gray Panthers:** until affordable prescription drugs are available to people in the United States, that there be no constraint on governments from negotiating for lower prices or purchasing lower cost prescriptions from other countries.
- **Medicare Rights Center:** Passage of Medicare Part D rescinded prescription drug rebates – a critical tool that allows the federal government to secure lower drug prices – for beneficiaries dually eligible for Medicare and Medicaid.
- **Medicare Rights Center:** Allowing the federal government to offer a drug plan and negotiate drug prices
- **Medicare Rights Center:** Expansion of competitive bidding, which uses market principles to control costs for durable medical equipment, prosthetics, orthotics, and supplies,x to a national scale could be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services
- **Medicare Rights Center:** One promising option involves allowing the federal government secure lower prices on pharmaceutical drugs for Medicare beneficiaries, a practice that already exists in Medicaid. Restoring Medicaid-level drug rebates for low-income Medicare beneficiaries would save over \$141 billion in federal spending over ten years.
- **Leadership Council of Aging Organizations:** We recommend that Congress restore drug rebate prices for Medicare beneficiaries who are dually eligible for Medicare and Medicaid and for beneficiaries with Extra Help.
- **Leadership Council of Aging Organizations:** We support several of the proposed consumer protections, including consolidating plans, increasing plan oversight, and improving drug price fairness, accuracy, and affordability.
- **National Committee to Preserve Social Security & Medicare:** Support allowing Medicare to receive the same rebates as Medicaid for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy, beginning in 2016. Increasing manufacturer discounts for brand name drugs in Medicare Part D to 75 percent, effectively closing the coverage gap "donut hole" for brand name drugs in 2016, four years sooner than under current law.
- **Consortium for Citizens with Disability:** Provisions of H.R. 1717, the Medicare DMEPOS Market Pricing Program Act of 2013, specifically: The establishment of an independent market mechanism to set DME pricing and establish binding bids from participating suppliers of durable medical equipment, supplies and related services;
- **Urban Institute:** Health Policy Center - Require drug manufacturers to pay a minimum rebate on brand-name drugs covered under exchange plans.
- **Bipartisan Policy Center:** Convert from Average Wholesale Price to Average Sales Price for Remaining Part B Drug and Vaccine Reimbursements

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