

Better Care, Lower Cost Act, S. 1932

Proposed Additions to Bill Text

Submitted on 3/19/14 by Theodora Ooms, MSW, and Jana Staton, Ph.D., National Healthy Marriage Resource Center and Frank Verloin de Gruy III, M.D., William Doherty, Ph.D., Barry Jacobs, Psy. D, Susan H. McDaniel, Ph.D, John Rolland, M.D, and Mary Myrick, APR

[**Bold type** signifies current text; *italicized type* signifies proposed text]

[page 2 line1] **SEC.2. FINDINGS**

[page 2, line 12. Insert two additional findings thus:]

- (3) *Family caregivers are spouses, partners, adult children, siblings, friends or neighbors who voluntarily provide various kinds of unpaid assistance to persons with chronic illness and disabilities. Family caregivers play critical roles in chronic illness prevention, monitoring medication and regimen adherence; provide numerous medical and nursing services (wound care, operating medical equipment, injections, intravenous fluids, catheterization); coordinate and manage a complex set of interactions with health and social service providers, and give ongoing assistance with activities of daily living.*
- (4) *Health care providers seldom communicate directly with family caregivers and provide them with little or no instruction or training on how to perform their roles effectively. Thus, the Medicare program needs to do much more to respect and collaborate with family caregivers who are the backbone or “glue” of the system of care for persons with multiple chronic illnesses, thus enabling millions of persons to remain living in their homes and community, and resulting in saving the costs of institutional and paid home care. Their role is especially important with respect to transitions-in-care.*

[page 2, line 12] **SEC. 3. MEDICARE BETTER CARE PROGRAM**

[page 4, line 3] **“A health plan or group of providers ... may manage and coordinate care for BCP eligible individuals through *working in collaboration with family caregivers and an integrated care network, or Better Care Program....*”**

[page 8, line 10] **(d) PATIENT AND FAMILY CAREGIVER ASSESSMENT** [Note: see reference to caregiver assessment in text at page 18, line 5]

[page 8, line 25 insert] *(iii) assesses the capacity of family caregivers to provide the necessary assistance, and their corresponding need for information, education and support.*

[page 9, line 6] **(2) INDIVIDUAL PATIENT AND FAMILY-CENTERED CHRONIC CARE PLAN**

[page 9, line 26 insert] *(iv) allow for the provider to describe how the family caregiver will be engaged as part of the health care team*

[page 10, line1] **(B) USE OF TECHNOLOGY FOR PATIENT SELF CARE**

[page 10, line 8] **...that enhance communication between patients, providers, family caregivers and communities of care...**

[page 11, line 3] **(e) QUALIFIED BCP PROVIDERS**

(2) REQUIREMENTS—A qualified BCP shall meet the following requirements:

[page 14, line 6] **(C) ... The care team shall also develop a care plan for each eligible BCP enrollee and their family caregivers and use it as a tool to execute effective care management and transitions.**

[page 14, line 12] **(D) The qualified BCP shall include physicians, nurse practitioners...who commit to caring for BCP eligible individuals and to collaborating with their family caregivers.**

[page 15, line 16] **(ii) A regional or national Chronic Care Innovation Center...to identify and implement best practices—**

(page 16, line 7) **(III) to promote evidence-based medicine and patient and family caregiver engagement;**

[page 18, line 7] **...including the use of patient and family caregiver assessments and the use of individual patient and family-centered chronic care plans for each enrollee.**

[page 31, line 11] **(F) QUALITY BONUS SYSTEM**

[page 31, line 20] **IN GENERAL— The Secretary shall establish a quality bonus system... delivering patient and family-centered care, and practicing in integrated health systems....**

[page 32, line 3] **The Secretary shall collaborate with relevant stakeholders, including... health care purchasers, and patient and consumer groups, including family caregiver organizations.**

[page 33, line 7] **(h) QUALITY AND OTHER REPORTING REQUIREMENTS**

[page 33, line 21] **(B) of patient and, where practicable, family caregiver experience of care,**

[page 34, line 9 insert] **(F) ...of family caregiver engagement in care coordination and care delivery.**

[page 47, line 1] **SEC.5 IMPROVEMENTS TO WELCOME TO MEDICARE VISIT AND ANNUAL WELLNESS VISITS**

[page 47, line 3] **(a) WELCOME TO MEDICARE VISIT**

[page 47, line 11 insert] *As part of the assessment at the Welcome visit, identify related household members, and determine whether they or others are providing ongoing caregiving assistance. With patient and family caregiver permission, include their contact information in the electronic medical record. If appropriate at this stage, conduct a family caregiver assessment to determine capacity and willingness to provide any needed assistance and collaborate with patient and health care team.*

[page 47, line 12] **ANNUAL WELLNESS VISIT**

[page 47, insert after line 26] *(D) As a component of the required annual health risk assessment (HRA), review the current role and relationship of any identified family caregiver to determine if additional education or support is needed.*

[page 48, line 5] **SEC. 6. CHRONIC CARE INNOVATION CENTERS**

(a) **Designation...** The main objectives of such Centers shall include the following:

[page 48, line 20] (2) **Rigorously examining alternative and innovative systems and strategies, including caregiver collaboration, for efficiently improving the quality and outcomes for common, serious and chronic illnesses.**

(b) **Requirements—....** Each entity must meet the following requirements:

[page 50, line 13] (3) **Actively engage in the development of new best practices for the delivery of care to the chronically ill, with a specific focus on engaging family caregivers in quality care transitions.**

[page 50, line 18] (5) **Have the ability to consult with and convene experts practiced in the meeting the needs of chronically ill patients and their family caregivers, including pharmacologists, psychiatrists, psychologists, family systems clinicians, family nurse practitioners ... and representative consumers (chronically ill patients and family caregivers.**

[page 51, line 4] **Partner with.... the medical community, medical schools and public health departments through the Agency for Health Care Research and Quality, and the Patient Centered Outcomes and Research Institute, family caregiver organizations and the National Healthy Marriage Resource Center...to routinely develop new, forward thinking and evidence based curricula, delivery strategies and practice tool and protocols that address the tremendous need for team-based care and chronic care management.**

SEC. 7. CURRICULA REQUIREMENTS FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

[page 52, line 9] **NEW CURRICULA REQUIREMENTS**

[Page 52, line 19] **The Secretary shall establish a Working Group of representatives of the medical community and medical and nursing schools, including the Academy of Family Medicine, the Society for Teachers in Family Medicine, the Association of Medical Colleges, and the National Healthy Marriage Resource Center in developing new curricula to be used in professional training and continuing education courses that meet the following requirements:**

[page 52, line 23] (ii) **The curricula addresses the need to teach health care practitioners the knowledge and skills needed for team based care, chronic care management and collaboration with family caregivers.**

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