

**Opening Statement for Senator Whitehouse
Senate Special Committee on Aging
June 23, 2016**

Thank you, Chairman Collins, for starting us off today with your thoughtful remarks, and for your leadership of this committee. I appreciate you and Ranking Member McCaskill agreeing to hold this hearing.

Today's topic is important to me on both a professional and personal level. As Rhode Island Attorney General, I worked for years with medical professionals, faith leaders, and advocates for seniors—particularly those focused on care for the terminally ill. We worked on improving policies surrounding the assessment and management of pain, the socio-economic factors that underpin decisions about care, and legal protections to ensure patients' wishes are heard.

I also come to this hearing—as I expect many people in this room do—with the personal experience of witnessing the illness and death of loved ones. I know just how important and powerful that experience can be; not only for those who are ill, but for family members and caregivers who go through that time with them.

In a 1997 report, the Institute of Medicine described a “human care system” as one that:

“ . . . people can trust to serve them well as they die, even if their needs and beliefs call for a departure from typical practices. It honors and protects those who are dying, conveys by word and action that dignity resides in people . . . and helps people to preserve their integrity while coping with unavoidable physical insults and losses.”

Unfortunately, our system regularly fails to meet this standard. There is too often a gap between the kind of care individuals want and the care they receive. Public opinion surveys report that a majority of people in the U.S. would prefer to die at home, but most people over 65 die in either an acute care hospital or a nursing home. Thirty percent were in an intensive care unit in the month preceding their death.

We can do better by these patients. Because so many of the rules and incentives in our health care system are tied to the payment structure, we should design payment systems that support models of coordinated care that focuses on the whole person. Payment systems should reward providers for honoring patients' own preferences for their care.

That's why today I'm introducing the Removing Barriers to Person-Centered Care Act. This legislation stems from a series of roundtable discussions with Rhode Island stakeholders. During those discussions, a common theme emerged: providers are frustrated by Medicare rules and regulations that prevent them from coordinating care for individuals with serious, advanced illness to get these patients “the right care in the right setting.”

Local health care providers, working with social service organizations and faith groups, would be free to develop systems to improve care coordination and planning, and reduce unwanted medical care. Medicare would waive rules and regulations that prove frustrating to let that innovation flourish. A few examples include:

- Allowing Medicare patients to receive hospice care and curative treatment at the same time.
- Allowing patients to receive Medicare coverage in a skilled nursing home without a consecutive three-day inpatient hospital stay; and
- Allowing Medicare patients to receive home health services without the requirement that they be homebound. Under current rules, a patient's condition must have progressed such that there "exists a normal inability to leave home," denying home services to those who are seriously ill but still mobile.

Under this framework, local health care leaders could innovate and deliver care in a manner that best fits the needs and wishes of their patients.

I hope we can touch on some of these issues today. I thank our witnesses for joining us and for adding your voices to this discussion. I look forward to a health care system that puts patients first, honors their wishes, and provides them the best care available.

Thank you, Madam Chairman.