

January 4, 2016

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3317-P
P.O. Box 8016
Baltimore, MD 21244-8016
Re: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies;
CMS- 3317-P

Dear Acting Administrator Slavitt:

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national non-profit organization that advocates on behalf of long-term care consumers across care settings. Our membership consists primarily of consumers of long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. Consumer Voice has 40 years' experience advocating for quality long-term care.

Consumer Voice commends CMS for proposing revised regulations governing discharge from hospitals, home health agencies and critical access hospitals. This is an area that has long been of concern to long-term care consumers, their family members and advocates, including long-term care ombudsmen.

The proposed rule would greatly improve the discharge planning process in a number of important ways. It would:

- Make the process more thorough and comprehensive;
- Hold hospitals and post-acute care providers more accountable for the safety and well-being of patients;
- Better ensure patient and family caregiver involvement by making the process more consumer-directed and centered around consumer preferences and goals; and
- Improve transitions from one care setting to another so they are smoother and more effective.

At the same time, we find that the proposed rule does not adequately inform individuals of the full scope of their rights related to discharge. The regulation does not present requirements in terms of rights. For instance, the proposed rule would mandate that the discharge plan address the patient's goals of care and treatment preferences, but would not state this as a patient right, nor ensure the patient is notified of this right. Similarly, the proposed rule would require the

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a 501(c)(3) nonprofit membership organization founded in 1975 by Elma L. Holder that advocates for quality care and quality of life for consumers in all long-term-care settings.

hospital to inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services, but would not state this as a patient's right to choose Medicare providers.

Patients, patient representatives, and caregivers/support persons cannot exercise their rights if they do not know what their rights are. They need a statement of rights that is thorough, comprehensive and accurate. Consumer Voice therefore urges CMS to:

1. Translate, at a minimum, the following proposed requirements into rights:
 - a. The patient and caregivers must be involved in the development of the discharge plan, and informed of the final plan (see our recommended changes to this below).
 - b. The discharge planning process must be completed prior to discharge home.
 - c. The discharge plan must address the patient's goals of care and treatment preferences.
 - d. The hospital must assist the patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.
 - e. The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.
 - f. The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.
 - g. Discharge instructions must be provided at the time of discharge to the patient and/or the patient's caregiver/support person(s)
2. Mandate these rights be included in the written notice of a beneficiary's rights. Currently, hospitals must deliver valid, written notice of a beneficiary's rights as a hospital inpatient, including discharge appeal rights (§ 405.1205 Notifying beneficiaries of hospital discharge appeal rights). We recommend that a section of these rights be dedicated to discharge rights and include the rights we discussed under #1 above.

Designating a section on discharge rights as part of hospital/home health agency/critical access hospital patient rights would better ensure that individuals and their caregivers/support persons know what the provider's responsibilities are and what they have the right to expect. This information makes patients and caregivers/support persons more comfortable and willing to participate in their or the patient's healthcare by asking questions, expressing their wishes and speaking up – thus promoting greater consumer involvement in the discharge planning process. Greater consumer participation has been shown to empower patients and improve services and health outcomes.¹

¹ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3964421/>

Consumer Voice also recommends that CMS develop a discharge planning fact sheet that is given to all individuals and their caregivers/support people at the beginning of their episode of care. This would help patients and families know what the process entails and what to anticipate. Such information could help reduce the stress and anxiety of wondering what will happen next.

There are a number of additional ways in which the rule should be strengthened to provide increased support, information and assistance to patients and caregivers/support person(s). We discuss these areas below.

PART 482 CONDITIONS OF PARTICIPATION FOR HOSPITALS

482.43 Condition of participation: Discharge Planning

Consumer Voice applauds CMS for requiring that the process focus on the patient's goals and preferences. Currently the consumer's wishes are frequently overlooked; rather than being involved in the discharge process, he or she is left out of any discussion of options and simply told where he/she will be going next.

482.43(a) Standard: Design

482.43(a) (1) Process developed with input

We are pleased to see that the process must be developed with input from medical staff and nursing leadership, but we recommend that input from social work staff also be obtained. Social workers understand the emotional and psychosocial stresses and strains individuals and their family caregivers experience and can provide guidance on how the process can be established to reduce rather than augment stressors. We also strongly urge CMS to require that at least one patient representative and one family representative provide input as well. If CMS is committed to establishing a person-centered discharge planning process, patients and family members must be part of shaping the process from the very beginning. This is the way to truly build patient and family engagement into the process. Finally, we support the recommendation made by the Center for Medicare Advocacy (CMA) that there be a point person with sufficient resources and authority who can shepherd the design process through.

§482.43 (b) Standard: Applicability

Consumer Voice applauds CMS for extending the requirement for discharge planning to all inpatients, not just those whom hospital staff believe should have a discharge plan. CMS rightly notes in the preamble that the average length of stay in hospitals has decreased significantly. Consequently, patients leave "quicker and sicker." As a result, discharge planning is essential for all patients so they receive appropriate post-discharge care. We are also glad to see that discharge planning would be required for people in the hospital under observation stays. Many of these individuals are indistinguishable from inpatients and therefore have the same, or even greater, needs for thorough discharge planning because they would not qualify for Medicare coverage of a skilled nursing facility stay.

§482.43 (c) Discharge planning process

We appreciate that the planning process would ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of a discharge plan. We would encourage CMS to require that the plan address any concerns that the patient might have as well.

§482.43 (c) (1) Coordination of discharge evaluation and development of discharge plan

Consumer Voice supports the involvement of a registered nurse or social worker coordinating the discharge needs evaluation and developing the discharge plan. However, we are concerned that a physician has not been included and that the language “or other personnel qualified in accordance with the hospital’s discharge planning policies” is too vague and could result in personnel who lack the necessary expertise, training and knowledge leading this very critical process. For that reason we recommend this language be deleted and replaced with “physician.” The evaluation and plan should be further strengthened by calling for all three of these health care professionals to provide input and for input to also be obtained from the patient’s primary care physician (PCP), if possible. Information from the PCP would provide the hospital with more comprehensive data about the individual and help facilitate a smoother transition back into the PCP’s care.

§482.43 (c) (2) Timing

We commend CMS for proposing to require hospitals to begin identifying anticipated discharge needs for each applicable patient within 24 hours after admission or registration and complete the process prior to discharge home or to another facility. This will better guarantee that there is sufficient time to create a meaningful discharge plan that will work for the individual and his/her caregiver/support person.

We ask CMS for two clarifications to improve the discharge process. The first is to clarify that “completing the process prior to discharge home or to another facility” includes confirming that services and equipment are in place prior to the individual leaving the hospital. We are aware of cases where patients returned home without the hospital bed they needed or without home delivered meals having been arranged. The second clarification is to explicitly state that anticipating discharge needs includes engaging patients, if possible, and their caregivers/support persons in the process within this time frame. Including consumers from the very start involves them as active partners and prevents situations where they do not learn about their discharge until the day before or even just a few hours before it occurs. These situations often leave patients and caregivers/support persons feeling helpless, uninformed, unprepared and angry.

§482.43 (c) (5) Caregiver/support person

We agree that the hospital must consider the availability and capability of a caregiver/support person to perform required care after discharge. This gives hospital staff information about discharge needs. However, the hospital must also consider the willingness of a caregiver/support person to do so. Not all caregivers/support person(s) are comfortable providing care or in a position to do so. Consumer Voice joins AARP and the Altarum Institute in recommending that hospital staff engage family caregivers in a conversation about post-discharge care and needs. The conversation should include exploration of what specific supports the family caregiver requests and needs. The proposed rule should also require documentation of this conversation in the patient’s medical record.

In addition, we suggest that if more than one family member will be expected to participate in caregiving, then all family members so identified must agree to provide care and be included in the planning process. This would prevent situations where one family member makes all the decisions and fails to involve - or even communicate with - siblings who end up being called upon in a discharge plan to provide care even though they live several hours away and/or work full time.

§482.43 (c)(5) i-viii Points to consider in evaluating discharge needs

Consumer Voice is pleased to see CMS is specifically identifying eight points a hospital must consider in evaluating discharge needs. This detail will assist in developing a stronger discharge plan.

§482.43 (c)(6) Patient and caregiver/support person involvement in creating the discharge plan

We strongly support involving the patient and caregiver/support person in developing the discharge plan and are glad to see this explicitly and clearly stated. However, patients or their legal decision makers should not simply be “informed” of the final plan. This undermines the very person-centered approach that CMS is working to achieve. Instead, Consumer Voice urges CMS to require that the patient or the patient’s legal representative, if the patient lacks decision making capacity, must agree with and consent to the discharge plan before it can be finalized. This would better guarantee that the patient’s wishes, preferences and goals are incorporated into the plan. In addition, CMS should mandate that the patient, patient legal representative and caregiver/support person be provided with a copy of the plan.

§482.43 (c)(8) Data about post-acute care providers

Consumer Voice applauds CMS for recognizing that patients, their families or representatives need information to help them select the post-acute care provider that is right for the patient.

Nevertheless, we recommend that CMS require hospitals to furnish more than quality measures and resource use measures since quality measures are based on provider self-reporting and the cost-effectiveness of a provider is not generally a determining factor for consumers. We urge CMS to require that data from the following sources also be shared:

- Home Health Compare
- Nursing Home Compare
- Surveys for home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals

Moreover, these data should not be limited to what the hospital believes is relevant and applicable to the patient’s goals and treatment preferences. These data are important because they show the provider’s overall performance, which is in many cases of greater interest to consumers.

We also believe that the hospital should provide individuals and their family caregiver/support person with information about and contact information for the long-term care ombudsman program. Ombudsmen are not only familiar with the nursing facilities in their areas, they are skilled and knowledgeable in educating consumers about choosing a nursing home.

Furthermore, it is not enough for hospitals to use and share technical data – they must do more. These data are complex and can be difficult to understand. CMS should require that hospital staff be trained on how to explain the data to consumers and how to use the information when choosing providers.

§482.43 (c)(10) Assessment of hospital discharge planning process

We appreciate that CMS is proposing that hospitals assess their discharge planning process and include a review of a representative sample of discharge plans. This would permit the process to improve on a continuous basis. We offer three suggestions to strengthen this evaluation process. First, CMS should specify how frequently such assessments should be conducted; otherwise some hospitals may do it too rarely to benefit patients. Second, the review of sample discharge plans should include written or oral feedback from patients and caregivers/support persons on

their post-discharge experience and whether they felt the plan was appropriate and effective. Consumer input is essential in determining if the process is successful. Third, the assessment should specifically include a certain percentage of patients who died or had to return to the hospital very shortly after discharge (perhaps 3-5 days) and who died or were readmitted to the hospital within 15 days of discharge. These time frames would help in evaluating possible premature discharges, serious problems in post-discharge plans or significant care issues with the receiving facility or home health agency.

482.43(d) Standard: Discharge to Home

Consumer Voice supports all the steps CMS proposes be taken when the patient is being discharged to home. They are each an essential part of a safe and effective transition home. We are particularly pleased to see that medication reconciliation is part of the process since medication reconciliation can reduce rehospitalizations, reduce adverse events related to medications and improve health outcomes.

We make these five recommendations to further enhance the proposed regulation:

- Require that hospitals conduct a home visit for all inpatients and individuals under observation stay for longer than 24 hours when discharge to home is being pursued. In order to develop a successful and thorough discharge plan, hospital staff must see the individual's environment to assess his/her needs.
- Specify that discharge instructions be in writing. It is very important that consumers and their family caregivers have a document they can refer back to after discharge.
- Require that hospital staff must confirm and document in the record patient understanding of all aspects of the discharge plan by using teach-back when applicable. According to *American Nurse Today*,² "closing the loop" or the "show me" method confirms the patient understands the information the care provider has imparted and enhances patient knowledge. *American Nurse Today* also reports that "Successful education can improve health outcomes, reduce hospital readmissions, decrease healthcare costs, and improve patient and family satisfaction."
- Require that a copy of the discharge instructions and the discharge summary be sent to the practitioner responsible for follow-up at time of discharge. The sooner the practitioner receives this information, the sooner he or she can begin follow-up. Waiting 24 hours just delays this process.
- Specify what the follow-up discharge process should entail. Simply requiring that there be a follow-up process with no time frames is too vague, and hospitals that do not develop a robust process could put patients at risk. In the Preamble, CMS cites a study identifying several components of transitional care that were significantly associated with reduced short-term readmission rates. At a minimum we urge CMS to require that those components – a home visit within three days, care coordination by a nurse and communication between the hospital and the primary care provider – be part of any follow-up process. We also recommend that CMS require that a follow-up call be made within 24 hours; family caregivers who have agreed to provide or assist with care may find they are insufficiently prepared for the demands of the transition to home.

482.43(e) Standard: Transfer of patients to another health care facility

² American Nurse Today. Using Teach-Back for Patient Education and Self-Management. Ping Xu, MSN, MS, RN. March 2012 Vol. 7 No. 3

We are pleased to see the elements CMS proposes to include in the necessary medical information that must be sent to the receiving facility and that this information would be sent at the time of transfer. This is essential because Consumer Voice is aware of many cases when individuals have been transferred with little to no medical information, placing them at risk. We suggest that the list be expanded to include the patient's routines, preferences, and likes/dislikes, to the extent hospital staff are able to identify this information. Staff in the receiving facility need to know from the time of admission how to support and care for a resident in an individualized and person-centered manner.

Consumer Voice agrees with CMS that a standardized set of contact information is important for patients and their caregivers/support person(s) and encourages CMS to require that this information be given to the patient along with a copy of the discharge instructions. We support CMA's proposal that this list include how to contact the Medicare Ombudsman as well as social services agencies, including legal assistance providers and sources to assist beneficiaries in accessing necessary medications, supports and services. We would add that the list should include information about the services provided by the long-term care ombudsman program and how to reach the local ombudsman.

Based on experiences shared with us by families, we also recommend that CMS address the timing of this transfer. To ensure that the patient receives the necessary care immediately, transfer should occur at a time when there are adequate nursing staff, and preferably a registered nurse at the receiving facility. Currently, a transfer may occur late at night when staff may not be prepared or equipped to provide appropriate care. Here is what one family member shared with us:

In my mother's case, the transfer didn't actually take place until 10 p.m., at which time the receiving facility, which was highly recommended by the hospital, was completely unprepared for her arrival. Within hours, we had to call 911 and she was transported by ambulance back to the hospital from which she came and where she spent the next 24 hours fighting for her life in the emergency room.

We suggest that, at a minimum, CMS require hospitals to make reasonable efforts to transfer patients during the day when the receiving facility is more likely to be better staffed and to have a registered nurse on duty.

Finally, Consumer Voice encourages CMS to consider requiring the receiving facility to also make reasonable efforts to conduct an in-person assessment of the patient to determine if they can care adequately for the individual. We hear of situations in which a person is transferred from the hospital to a facility only to be sent back to the hospital in less than 72 hours because the care needs are too intense and/or complex for the facility to handle.

482.43(f) Standard: Requirements for post-acute care services

482.43(f)(1) List of HHAs, SNFs, IRFs, LTCHs

Consumer Voice agrees with CMS that patients should be provided with list of HHAs, SNFs, IRFs, and LTCHs in the geographic region. However, it would be more helpful to patients to receive a list of all available post-acute providers. We join AARP in noting that this would help eliminate potential bias in favor of SNFs, who may heavily promote their services to the hospital. Consumer Voice has heard frequently from family members about hospitals sending their loved

ones to facilities with whom the hospital has a good relationship rather than honoring the patient's choice.

We share AARP's concern that the requirement that HHAs must request to be listed by the hospital could unnecessarily restrict a patient's choice of HHAs. We ask CMS to delete this proposed requirement.

482.43(f) (2) Informing patients of freedom to choose

We are pleased to see that CMS would require hospital staff to inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and when possible, respect the patient's or the patient's representative's goals of care. As noted above, we have heard of cases when patients have not been given a choice. To further strengthen this rule, we recommend that if respecting the patient's or the patient representative's preferences is not possible, the hospital be required to document in the patient's record why the hospital could not do so.

Part 484 HOME HEALTH SERVICES

§ 484.58 Condition of participation: Discharge Planning

Consumer Voice welcomes these new proposed regulations for home health agency discharge planning and believes they would improve the quality and safety of patient care. We are perplexed, however, that a number of important provisions found under the hospital discharge planning section have not been included for home health agencies. These provisions would further strengthen the discharge planning process and ensure a better transition process. We have outlined these provisions below and recommend that they be incorporated into the home health agency requirements:

- Specifying who should be involved in designing the discharge planning process as it did with hospital discharge planning and to involve social work staff and patient and family representatives as we recommended earlier. (See our comments for proposed 482.43(a) (1))
- Requiring that this discharge planning process be assessed and including interviews with patients and family caregivers/support persons as we called for in our comments on proposed §482.43 (c)(10)
- Establishing who must coordinate the discharge needs evaluation and development of the discharge plan and replacing "other personnel qualified in accordance with the hospital's discharge planning policies" with "physician" as we suggested in our comments for §482.43 (c) (1)
- Considering a family caregiver's/support person's willingness to provide care as described in our comments for §482.43 (c) (5)
- Mandating what discharge instructions must include and that they be provided to the patient and/or the patient's caregiver/support person(s). Patients need instructions and information for ongoing care, such as upcoming doctor's appointments, any therapy home programs to be followed, diet to be followed, and medications to be taken.
- Requiring that a post-discharge follow-up process be developed when home health services end. While this process does not need to be as comprehensive as it should be in hospitals, some type of follow-up should still be required. Such a process should include, at a minimum, calling the patient and their family caregiver/support person to see how the patient is doing, if any services/care being delivered are working well and providing information and referral assistance if necessary.

§ 484.58(a)(7) Documentation and completion of evaluation of discharge needs and discharge plan

Consumer Voice supports the proposed requirement that the evaluation of the patient's discharge needs be documented and completed on a timely basis. However, we are concerned that the rule would not require the HHA to consider specific elements in evaluating an individual's discharge needs, as it proposes for hospitals. These are important elements to take into consideration when developing a discharge plan and would help improve patient outcomes. We urge CMS to mandate that home health agencies incorporate the components outlined in proposed § 482.43(c)(5)(i)-(viii): Admitting diagnosis or reason for registration; (ii) Relevant co-morbidities and past medical and surgical history; (iii) Anticipated ongoing care needs post-discharge; (iv) Readmission risk; (v) Relevant psychosocial history; (vi) Communication needs, including language barriers, diminished eyesight and hearing, and self-reported literacy of the patient, patient's representative or caregiver/support person(s), as applicable; (vii) Patient's access to non-health care services and community based care providers; and (viii) Patient's goals and treatment preferences.

§ 484.589(b) Standard: Discharge or transfer summary content

We are pleased to see the elements CMS proposes to include in the necessary medical information that must be sent to the receiving facility or health care practitioner. As we suggested for hospitals, we recommend that the list be expanded to include the patient's routines, preferences, and likes/dislikes, to the extent home health agency staff are able to identify this information. Staff in the receiving facility and health care practitioners need to know from the start how to support and care for an individual in an individualized and person-centered manner.

Consumer Voice also urges CMS to require that this medical information be sent at the time of transfer. We hear of cases in which individuals have been transferred or discharged with little to no medical information, placing them at risk.

Part 485 –CONDITIONS OF PARTICIPATION SPECIALIZED PROVIDERS – CRITICAL ACCESS HOSPITALS

§ 485.642 Condition of participation: Discharge planning

Consumer Voice applauds CMS for including proposed requirements for discharge planning in critical access hospitals. This is a very positive step since such provisions do not currently exist and are needed in this setting just as much as in hospitals. We are pleased to see that the regulations proposed for critical access hospitals are almost identical to those for hospitals and believe this is important given the similarity in setting. Our comments and suggested revisions for hospitals therefore apply to critical access hospitals too.

We note that there are a few instances where the proposed language for hospitals and critical access hospitals is slightly different (for instance, in § 485.642 (d)(2)(iii), prescriptions for medications required after discharge do not include over the counter medications, and written instructions for follow-up care are not mandated to be in paper and/or electronic format at § 485.642 (d)(2)(v). We do not see the reason for these differences and encourage CMS to make the language exactly the same.

The greatest difference between critical access hospitals and hospitals is that the proposed rule for critical access hospitals completely omits the standard for requirements for post-acute care

services, §482.43(f). We understand that there may be fewer post-acute options for patients in rural areas. Nevertheless, that does not justify eliminating the provision to provide the patient with a list of HHAs, SNFs, IRFs, or LTCHs available to the patient, nor the other requirements found in that standard. Patients and family caregivers/support persons need to know the full range of their options so they can make the best decision for themselves or a loved one. However, in rural areas, the list should also include providers outside the geographic area, if requested by the patient or caregiver/support person. While most patients and their family caregivers/support persons want to remain close to their homes, there may be instances where there are so few options they find acceptable that they would consider a setting farther away.

Consumer Voice appreciates CMS's work to improve the discharge planning process which is so critical to the quality of life and quality of care of individuals in the post-acute care system. We thank CMS for its consideration of our comments.

Sincerely,



Lori Smetanka, J.D.
Interim Executive Director



Robyn Grant
Director of Public Policy and Advocacy