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January 4, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3317-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via http://www.regulations.gov

Re: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (CMS-3317-P)

Dear Mr. Slavitt:

Community Catalyst respectfully submits the following comments to the Proposed Rule on Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies as published in the Federal Register (80 Fed. Reg. 68126) ("Proposed Rule").

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders. Our new Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning, and sharing knowledge to bring the consumer experience to the forefront of health system redesign.

Comprehensive, effective discharge planning is essential for the safe transfer of Medicare and Medicaid beneficiaries from one setting to another and for the reduction of preventable complications or hospital readmissions. We believe the Proposed Rule is a substantial step forward on the path to improving care, and the quality of life, for consumers, particularly frail older adults, people with complex disabilities and those with multiple chronic conditions. In particular, we commend CMS on the following and encourage inclusion in the Final Rule:

Design: We are pleased with the newly proposed standard for developing discharge planning process policies and procedures (482.43(a) and 485.642(a)). ***We recommend, however, that the design of these policies and procedures include input from patient and family representatives***, in addition to the hospital's medical staff, nursing leadership and other relevant departments**.** We appreciate CMS' reminder to hospitals to continue to abide by federal civil rights laws when developing a discharge planning process. ***We recommend that the Final Rule include an explicit requirement that the discharge policies and procedures accommodate the needs of patients whose primary language is not English.***

Applicability: We strongly support the expansion of the population that receives discharge planning to all inpatients and certain categories of outpatients. We especially support extending the discharge planning requirements to *all* patients on "observation status."

Discharge Planning Process:

- We commend CMS for its proposal that hospitals, CAHs, and PAC providers must take into account the patient's goals and preferences in the development of their discharge plans. A goal-driven approach has many advantages:
    - It frames the patient-provider discussion in terms of individually desired rather than universally applied health states.
    - It simplifies decision-making for patients with multiple conditions by focusing on outcomes that span conditions and aligns treatments toward common goals
    - It prompts patients to prioritize which health states are important to them, thus allowing them to be in control when treatment options require trade-offs
    - It allows for effective shared decision-making between patient and provider about which treatment strategies will meet the patient's goals.[1]
- We support the Proposed Rule's requirement that discharge planning begin earlier, within 24 hours of a patient's hospital stay.
- We agree with the requirement that hospitals assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data on quality measures and data on resource use measures. We also appreciate that for patients who are enrolled in managed care organizations, the hospital must make the patient aware that they need to verify the participation of HHAs or SNFs in their network. However, we believe the requirement, "[i]f the hospital has information regarding which providers participate in the managed care organization's network, it must share this information with the patient…" is insufficient. Patients and family members are often overwhelmed by the amount of information they receive and don't have the time or resources to investigate all the options. ***We recommend, instead, that hospitals be required to assist patients and families by providing information on the PAC providers that are within the patient's managed care network. This includes coordinating with the Veterans Administration if the patient is a veteran. In addition, discharge planners must be trained to provide detailed information about PAC providers that have specialized programs such as those for people with multiple sclerosis or dementia or for those with***

[1] See, e.g., Reuben, D and Tinetti, M., *Goal-Oriented Patient Care — An Alternative Health Outcomes Paradigm*, N Engl J Med 2012; 366:777-779. March 1, 2012 (available at http://www.nejm.org/doi/full/10.1056/NEJMp1113631)

both Medicare and Medicaid (e.g. PACE programs). Finally, discharge planners must be trained to provide patients and families with information about PAC providers that meet the cultural needs and preferences of the patient, e.g. staff that speak the primary language of the patient, food that conforms to the patient's religion or ethnicity.

- We appreciate the expansion of the types of information that must be sent by the hospital to the receiving facility. In particular, we are pleased that the patient's goals and preferences are among the information to be provided. However, because the amount of information coming from a hospital can be voluminous and the way it is presented is highly variable, ***we recommend the use of common templates for transfer documents so that the most critical information about the patient is readily accessible to the receiving facility.*** While what constitutes the most critical information will vary by patient, in general, the most critical information for the receiving facility is:
    - Current medications and medication allergies
    - Most recent lab tests and which ones will need to be repeated soon after arrival at the new facility
    - Signs that the patient is not doing well and may require immediate attention
    - What specific conditions or issues that receiving facility should watch for
    - While written documentation is important, we urge CMS to also require the provider responsible for the patient's care (or his/her designee) to speak by telephone to the PAC provider responsible for the patient's care in order to facilitate a "warm handoff."
- We greatly appreciate the requirement that hospitals give special attention to the particular discharge planning needs of those patients with mental health conditions, including substance use disorders. ***We recommend, however, that hospitals also give special attention to children and youth with chronic health needs/medical complexity/disabilities, including behavioral health needs, as community resources are limited for all, but especially for this most vulnerable population.***
- ***We recommend discharge planners receive training on evidence-based models of transitional care for older adults. These models include the Care Transitions Intervention as well as The Bridge Model, which have been demonstrated to lower hospital readmission rates and decrease stress for patients and family caregivers.***

We strongly support CMS' focus on patients' goals and preferences and appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues. Please contact me at ahwang@communitycatalyst.org with any questions. Thank you for your time and attention to the important issue of consumer-centered care.

Respectfully submitted,

Ann Hwang, MD
Director
Center for Consumer Engagement in Health Innovation