Submitted Electronically

January 04, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

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

Dear Administrator Slavitt:

The National Partnership for Women & Families represents women and individuals across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality and well-coordinated patient- and family-centered care.

Planning for discharge is a critically important process for patients and their families. Effective discharge planning and dialogue can play a significant role in ensuring that patients are prepared to care for themselves following discharge. Previous approaches to hospital discharge planning, however, did not adequately reinforce the necessary skills that patients and their family caregivers and support persons need to meet post-hospital needs. Inadequate coordination and communication with patients and families can lead to poor outcomes, including medication errors and omissions, infection, injuries, worsening of the initial medical condition, exacerbation of a different medical condition and re-hospitalization.

We are heartened to see that CMS proposes to extend requirements for discharge planning to home health agencies and, for the first time, to Critical Access Hospitals that serve vulnerable patients. By ensuring that these care settings implement protocols in discharge planning similar to those of (traditional) hospitals, CMS makes needed strides in coordinating care across settings. Additionally, we strongly support strengthening and clarifying discharge requirements for hospitals and other settings, including requiring a written process, in order to support more effective discharge planning.
Many of the proposed requirements go a long way towards making discharge from the hospital to another care environment safer and helping to avoid the rise in preventable and costly hospital readmissions. We encourage CMS to pair these new requirements with training for providers to give them the skills to effectively integrate these patient engagement practices into their workflows and ensure successful implementation. Progress in this area is particularly important in shifting from volume to value and outcomes-based reimbursements.

Lastly, we fully support efforts to ensure that the discharge planning process properly prepares patients and, when applicable, their caregivers/support persons to be active partners and advocates for their health and community support needs upon discharge from the hospital or post-acute care setting. We appreciate CMS’s focus on partnering with patients and families to tailor discharge plans to patients’ individual goals, preferences, values and needs. Creating plans with patients and families, as opposed to for them, and doing so in a manner that is centered around the goals and needs they identify as most important to them personally, will result in plans that are more effective in preventing readmissions and ultimately improving health outcomes. To achieve these goals, we very strongly urge CMS to reflect this vision of partnership in revised language, changing references to developing discharge plans for patients to developing these plans with patients.

We offer the following specific comments on the proposed rule:

**Hospital Discharge**

**§482.43(a) Design**

We support the proposed new standard for design of a discharge planning process that requires medical staff, nursing leadership and other pertinent services to provide input in the development of a discharge planning process. However, we strongly urge CMS to require hospitals to also partner with patients and families in the design process. We propose that hospitals work with a small team of Patient and Family Advisors to guide creation of a discharge planning process that reflects what is most important to patients and families and effectively meets their needs. This process will require a thoughtful approach to effectively recruit, orient and support Advisors in order to support their meaningful collaboration with the hospital team. It will also be important to prepare medical staff, clinicians and leadership to partner effectively with Patient and Family Advisors and understand the value of their unique insights and perspectives. We would be happy to share effective strategies for this work. Finally, we believe a clearly defined “point person” is essential to making the design work happen. This person should have sufficient authority and resources, including staff, to ensure that the design process is completed within a specific and well-published timeframe.

As an example, Anne Arundel Medical Center redesigned their discharge process in close collaboration with its Patient and Family Advisory Council (PFAC). The SMART Discharge Protocol (Signs, Medications, Appointments, Results, and Talk) was developed to improve care for patients and families and to improve the discharge process. The Protocol was initially created as part of the Picker Institute’s [Always Events Program](http://www.aahs.org/aamcnursing/wp-content/uploads/SMART-Discharge-Protocol.pdf). Always Events refer to aspects of the patient experience that are so important to patients and families that health care providers should reliably implement the events 100 percent of the time.

---

Partnering with patients and families can also help to ensure that any materials, including discharge instructions, are clear and understandable to patients and communicated with them in the format they prefer. This may be online, in person, on paper or via other forms. We know from our work with a critical access hospital in Georgia and their PFAC that much of the information contained in their original discharge paperwork was confusing to patients and family caregivers.

We also encourage discharge planning processes to provide opportunities for patients and family caregivers to practice/simulate any new procedures that they may have to undertake post-discharge to ensure they are comfortable performing these tasks and understand the information that has been provided to them. Strategies such as “Teach Back” may be useful.

§482.43(b) Applicability
Given the impact that thoughtful discharge planning can have on patient outcomes, we support proposed changes clarifying the types of patients who should be evaluated for post-discharge needs to include all inpatients and certain categories of outpatients, and agree that patients in the categories outlined in the proposed rule would benefit from discharge plans documented and provided in their preferred format.

While we recognize that these individuals have different needs and goals as it pertains to their follow-up care, it is precisely for this reason that all specified individuals should be consulted in the formation of these plans. Thus, while the determination of whether to create a discharge plan should not vary amongst these individuals, the detail of these plans and the workflows that accompany their creation will likely vary. For example, a young, generally healthy individual who is seen in the hospital for a broken arm may simply need a list of medications prescribed and care and maintenance recommendations, while a patient with heart failure will likely have a more robust and complex discharge plan that includes instructions for follow-up care in other settings, self-monitoring and lifestyle change recommendations.

§482.43(c) Discharge Planning Process
Patient and Family Caregiver Involvement in the Development of Discharge Plans
We emphasize that creating discharge plans in partnership with patients and families – instead of for them – will result in plans that better reflect unique patient/families goals, needs, circumstances and preferences.

Beginning the discharge planning process as early as possible in a patient’s experience is crucial to its success. We strongly support requiring evaluation of discharge planning needs as soon as material to the patient’s care experience, and at least within 24 hours of admission or registration; this early evaluation should focus on identifying the anticipated post-discharge goals, preferences and needs of the patient and tailoring discharge planning to these goals. In many cases, such as pregnancy or scheduled surgery, this planning should begin prior to the patient’s stay to better prepare the patient for discharge and ensure more effective discharge planning and education. For example, a hip replacement often starts discharge planning at pre-registration. Starting the discharge process as early as possible also affords needed time to identify and make connections with community-based resources and supports that may benefit a
patient upon discharge. Thoughtful scheduling of discharge planning discussions is crucial to facilitating family caregivers'/support persons’ involvement in the discussion and may require working with families to ensure they are able to participate.

CMS recognized in the proposed changes that the evolution of a patient’s condition or care may affect readiness for discharge as well as discharge plans, and subsequently proposes to expand current regulations to require that a hospital’s discharge planning process ensure an ongoing patient evaluation throughout the patient’s hospital stay or visit to identify changes that would require modification to the discharge plan. We strongly support this more continuous and active approach to ensure discharge planning reflects the patient’s conditions and needs. Additionally, recommendations may go beyond the immediate needs post discharge, and may continue for months, with various methods of communication and support to provide information as appropriate.

We also support the new requirement at §482.43(c)(4) that the practitioner responsible for the care of the patient be involved in the ongoing process of establishing the patient’s goals of care and treatment preferences that inform the discharge plan, just as they are with other aspects of patient care during the hospitalization or outpatient visit (recognizing that the practitioner responsible for a patient’s care may change over the course of a patient’s care experience, and individual practitioners interact with patients at a variety of touchpoints).

We support the new requirement at §482.43(c)(8) that hospitals assist patients, their families or their caregivers/support persons in selecting a post-acute care provider by using and sharing data on quality and resource use measures that are applicable to the patient’s goals of care and treatment preferences. We emphasize that any conversation or display of quality data must be easily understood by patients/family caregivers and support them in making a decision that is consistent with their goals and preferences. We urge that any information on quality and resource use measures be easy to understand, use plain language, reduce the cognitive burden for patients and families (for example, by visually ranking providers or including summaries), use universally understood symbols, use measures that are meaningful to patients and families and present the information in a way that makes it easy to see differences. This information should be discussed with a member of the care team to help patients/family caregivers contextualize the information, make a choice and ultimately take action. We support the revised requirement at §482.42(c)(1) for hospitals to conduct regular assessments of their discharge planning process. We urge CMS to explicitly require that patients and family caregivers be involved in the assessment process.

Consideration of Patient Goals
In 2013, the Consumer Partnership for eHealth, a consumer coalition led by the National Partnership, released a report detailing consumer priorities for health and care planning in an electronic environment. Consumers envision moving beyond the concept of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning process built on a dynamic, electronic platform.  

connects individuals, their family and other personal caregivers, paid caregivers (such as home health aides), and health care and social service providers, as appropriate, and provides actionable information to identify and achieve the individual’s health and wellness goals.

We are encouraged to see so many of these concepts captured in CMS’s proposal regarding discharge planning, particularly the intention to tailor discharge plans to the unique goals, preferences and needs of the patient. As consumers have stressed to us, their providers’ goals may or may not motivate personal behavior change. Consumers’ vision of next generation care plans involves identifying a goal that is meaningful to the individual, and then plotting a path to achieve it. Individual goals may be more quality-of-life related rather than clinical in nature. Regardless, consumers want care plans – including discharge plans – to be centered on their individual goals, supported by appropriate clinical recommendations.

CMS’s proposal to rethink discharge planning as a process that requires consideration of the patient’s unique circumstances, treatment preferences and goals of care – rather than solely a documentation exercise – is a critical step forward in achieving this vision for the future of health and care planning.

Accounting for the Availability and Capacity of Caregivers
Family and other caregivers play an integral role in the coordination of care for their loved ones. Actively encouraging family and authorized caregivers to contribute to the creation of discharge plans reinforces and facilitates their role as vital members of the care team. Moreover, proactively and explicitly engaging an individual’s family and caregivers in the development of a care plan helps to ensure that the individual’s abilities, culture, values and faith are respected and care instructions and follow-up recommendations are more likely to be understood and followed. Therefore, we strongly support the new requirement at §483.43(c)(6) that the patient and caregivers/support persons be involved in the development of the final discharge plan and informed of the final plan to prepare them for post-hospital-care.

Since many discharge plans depend on having a family caregiver, the caregiver’s own needs for information and training should be identified in the discharge planning process to ensure that the caregiver has the capacity to meet the expected responsibilities in the care plan and achieve better outcomes for the individuals’ goals. Thus, we agree that it is important to consider a family caregiver’s availability and capability to provide post-discharge support, identify areas where they may need assistance or training (for example, wound dressing or home oxygen) and provide that assistance.

Moreover, as the presence of caregivers and their caregiving status may change, a dynamic discharge planning process that takes into account shifting circumstances and the availability of supports is critical. Again, we urge CMS and hospitals to view this process as a collaborative partnership among patients, support person(s) as appropriate, and clinicians and staff that will help ensure that the patient’s discharge plan addresses the patient’s goals of care and treatment preferences as required in §482.42(c)(7).
**Connection to Community Services and Supports**

Considering the availability of community-based supports for each patient is also an important part of discharge planning. The availability of these supports – or the lack thereof – can have a significant impact on a patient’s care and outcomes post-discharge. Medical care delivery determines only an estimated 10-15 percent of health; the remaining 85-90 percent of health is determined by social and environmental determinants of health, such as health behaviors, genetics, and the socioeconomic and physical environment. The discharge planning process should take into account the full and unique range of factors affecting an individual’s ability to get and stay well – including life situation, home environment, etc. – and identify resources and supports to overcome any barriers. Community services and supports will be critical to addressing barriers and supporting patients in achieving the goals of their discharge plan.

We are pleased that the proposed changes require hospitals to consider the availability of and access to non-health care services such as transportation, meal services or household services (or both) and housing services for homeless patients. We agree with CMS that while these services may not be traditional health care services, they are often essential to the patient’s ongoing care post-discharge and ability to live in the community. We further agree that hospitals should be able to provide additional information on non-health care resources and social services to patients and their caregivers/support persons and should be knowledgeable about the availability of these resources in their community, when applicable, including services and organizations such as Area Agencies on Aging (AAAs), Aging and Disability Resources Centers (ADRCs), Centers for Independent Living (CILs) and others. Developing collaborative partnerships with providers of community-based services can help hospitals to facilitate smoother transitions and better patient outcomes. We applaud CMS for encouraging these partnerships, and urge the agency to continue to call on hospitals to partner with community-based services in effective and collaborative ways.

**Provision of Information in Non-English Languages**

We appreciate CMS’s recognition that hospitals should take reasonable steps to provide individuals with limited English proficiency or physical, mental or intellectual disabilities meaningful access to the discharge planning process. Progress must be made in making health information available in non-English languages for nearly 60 million Americans who speak languages other than English at home in order to effectively implement discharge plans; a Spanish speaker who receives her hospital discharge instructions in English only will not be able to use that information, for example. Moreover, we strongly agree that discharge plans should be accessible to individuals regardless of their visual impairments or disabilities, and support CMS’s intention to promote accessible information.

**Technological Tools to Support Individuals’ Health Upon Discharge**

We appreciate CMS’s recognition that technological tools can support individuals’ health and care upon discharge. While human interaction drives the process of care planning, technology can help make necessary information more readily available and actionable, connect all people who have a role in an individual’s care plan, and provide a shared platform for the ongoing maintenance and management of an individual’s care and wellbeing. Electronic tools and

---

communication that allow all care team members to work towards goals identified by the patient can facilitate a dynamic discharge planning process.

To improve both care quality and health outcomes, it is critical that health information technology facilitate the safe and secure sharing of information, not just between providers but among patients, families and other designated caregivers (including social services and supports). Giving consumers the tools to access and manage their own health information electronically (including patient-specific education) is foundational to patient engagement and ensuring that patients receive high quality care.

Moreover, giving patients electronic tools, such as secure messaging functions (often enabled through patient portals or other patient-facing applications), to easily track and share information with providers in real-time helps providers address their patients’ symptoms and concerns in a more timely fashion. Secure messaging serves as an innovative, low-cost post-discharge tool and technology that can help providers identify individuals at risk for adverse events and/or readmissions. Secure messaging can also help patients communicate with providers about their condition, care decisions, and daily symptoms or living status.

§482.43(e) Discharge to Home

We support CMS’s effort to more fully describe what is expected of hospitals in the way of better preparing the patient or their caregivers/support persons regarding post-discharge care. We agree it is important to provide discharge instructions at the time of discharge to patients/support persons, practitioners or facilities such as a home health agency (HHA) or hospice agency, and the patient’s primary care physician (PCP), or other (physicians of record). Sharing discharge instructions with a patient’s providers in the community will help to ensure better coordination of care and safer transitions, while alleviating burden on the patient/support persons.

Discharge instructions should be carefully designed to be easily understood by the patient or the patient’s caregiver/support person (or both). Partnering with patients and family caregivers in designing the discharge process and personalized materials will help to ensure clear communication and education. However, we agree with CMS that hospitals should as a best practice also confirm a patient or patient’s caregivers/support persons understanding of the instructions, for example, by using “teach-back” instruction methods.

We support the clarification of the requirement in §482.42(c)(5) that hospitals must provide instruction to the patient/caregivers about care duties based on the needs of the patient as determined in the discharge plan (which might not be the same for patients and caregivers). We emphasize that the learning needs should be specifically elicited from the patient/caregiver. We support requiring discharge instructions to include information about the condition or treatment, what to do in the home, and clear instructions on who to contact if warning signs and symptoms persist – and add that contact information should include those who will respond after regular business hours and on weekends/holidays.

Finally, we agree discharge instructions must include all medications prescribed and over-the-counter for use after the patient’s discharge. In addition to the information laid out in this section,
and all sections, we would urge that the “indication” language include a plain language description – for example, “high blood pressure” instead of “hypertension.”

**Availability and Sharing of Discharge Plan**

Patients cannot effectively set or achieve health goals outlined through discharge plans without accessible, electronic information about their health and health care. A critically important technological tool or method hospitals could provide to patients to successfully implement and track progress for discharge plans is easy, electronic access to their clinical health data (including patient-specific educational materials, as relevant). Wherever possible, Meaningful Use-eligible hospitals should leverage existing view/download/transmit possibilities, and integrate education about how and why to use online access, as part of the discharge planning process.

A 2014 National Partnership survey clearly shows that patients’ online access to health information has a positive impact on a wide range of activities that are essential to better care and improved health outcomes, including knowledge of health and ability to communicate with providers. Meaningful, convenient patient access to information about their health status and treatment received is crucial for patients to be able to manage their healthcare options, control costs and take charge of their health and their future. Hospitals should ensure that patients (and caregivers, as appropriate) can electronically access, understand and use their complete health information, including provider notes. Comprehensive health data should be available to all patients using diverse and accessible technology platforms, including mobile technologies, in the patient’s preferred language, and free of charge.

**Medication Reconciliation**

We fully agree that the medication reconciliation process should be a partnership between the patient and the health care team. Patients and their caregivers are valuable sources of information and should be included in the reconciliation process for specific information, especially information that is likely to change between encounters with the health care system. Engaging patients and family caregivers in medication reconciliation would help to ensure the accuracy and reliability of data included in the discharge plan, while simultaneously empowering patients and their caregivers to be active partners in their health and healthcare.

We encourage CMS to leverage forthcoming requirements for the Meaningful Use EHR Incentive Program regarding medication reconciliation. As this requirement will ultimately broaden the types of information reconciled (i.e., reconciliation of problem lists in 2018 and beyond), we envision that the reconciliation process will provide an opportunity for discussion, engagement and partnership with patients and families before discharge.

**Transmitting Summaries of Care upon Transfers**

As CMS recognizes, utilizing electronic health records (EHRs) to transmit Summary of Care documents is an efficient way to provide necessary information upon transitions of care. We strongly support the use of Certified EHR Technology (CEHRT), as it incorporates an updated Consolidated CDA (C-CDA) standard when providing summary of care records for transitions of

---

care. The updated C-CDA includes the structural elements for care plans, patient goals, and health outcomes that are important to consumers’ vision of collaborative health and care planning, and are critical to achieving CMS’s goals of collaborative discharge plans.

In response to CMS’s request for comment on the proposed medical information required in transitions of care, we strongly support alignment with the Common Clinical Data Set (as finalized in the 2015 Edition of Certified Health IT). Of note, we support the inclusion of the following data elements in the data set as critical pieces of information for safe and effective transitions of care: assessment and plan of treatment, goals, health concerns, and care team members. Furthermore, we support the proposed medical information requirements that go above and beyond the Common Clinical Data Set, including advance directives (including both physician and medical orders for life-sustaining treatment) consultation results, functional status assessment, social supports, and special instructions of ongoing care. We assume that, due to the intended alignment with the Common Clinical Data Set, the demographic information captured will also include sexual orientation and gender identity.

We strongly believe that all patients, their families, and their health care providers should have consistent and timely access to health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the patient’s care.

*~*~*~*~*~*~*

Thank you once again for the opportunity to provide input on the proposed changes to the discharge planning process. We appreciate CMS’s efforts to capture the important role that discharge planning plays in patients’ care, and the need to center the discharge plan around the needs and goals of the patient. We look forward to working with CMS, providers, and patients and families across the nation to improve the discharge process and bolster meaningful engagement and improve health outcomes.