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

Dear Acting Administrator Slavitt:

The Society of Hospital Medicine (SHM) welcomes the opportunity to provide feedback on the Centers for Medicare & Medicaid Services (CMS) proposals for updating and expanding the hospital Conditions of Participation (CoP) for discharge planning. The proposed rule, CMS 3317-P *Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals and Home Health Agencies*, would expand significantly the requirements for hospitals to include in their discharge planning process and discharge plans.

SHM, representing the nation's nearly 50,000 hospitalists, is extremely interested in the requirements set forth in the proposed rule. Based on our calculations in the 2012 Medicare physician payment data, we estimate hospitalists are involved in more than 50% of all discharges – inpatient and observation status – for Medicare beneficiaries. Hospitalists are committed to providing high quality care for hospitalized patients, including leading and participating in the implementation of quality and process improvement projects. SHM strongly supports improving the discharge process, believing it will in turn increase the quality of care transitions and improve the overall quality, safety and efficiency of patient care.

The proposals outlined in the rule are designed to provide a more detailed baseline for hospital processes around discharge plans. We agree this is important. Strong discharge planning has the potential to improve patient care and transitions of care between facilities and patients' homes. However, this policy is a massive expansion of the requirements for discharge planning and of the patients to whom those requirements apply. In implementing this policy, we urge CMS to consider the potential effect of these policies for redistributing resources (time and financial) away from the riskiest or neediest patients towards a universal requirement for discharge planning. We also caution CMS that some of the proposals may represent an "ideal" and should not be codified exactly as written. Furthermore, we have some concerns that the burden of these rules may be felt disproportionately on facilities seeing sicker patients and patients without insurance or with limited financial means, as well as on facilities without the infrastructure and staff support necessary for meaningful implementation.

With that in mind, SHM offers the following specific comments on the proposals:

(b) Standard: Applicability

CMS proposes to expand the applicability requirements for which patients must be evaluated for post-discharge needs. The requirement for a discharge plan would apply to all inpatients and certain categories of outpatients, including patients under observation care, patients having same day surgeries or procedures using anesthesia or moderate sedation, and emergency department patients identified as in need of a discharge plan. We agree the majority of hospitalized patients should receive some form of discharge plan. This would help ensure patients are informed of the care they received and are aware of any follow-up needs or potential complications. This is a critical aspect of patient-centered care. However, we are concerned about the potential for eliminating provider discretion from the discharge plan and the unnecessary level of detail some categories of patient's discharge plans would contain.

Expanding applicability to all inpatients is a reasonable and laudable proposal. In many hospitals, dissemination of some form of discharge plan is already a common practice. Under the current rules, hospitals focus the most attention and resources on patients who require some form of follow-up care within a post-acute facility, either from their primary care provider or from self-care administered at home. However, each patient's needs will vary, and CMS should recognize that universal discharge plans are not always feasible.

We caution that, in practice, positive CMS policies, such as this one, often turn into universal requirements as they are implemented within complex hospital systems and become compliance oriented rather than quality oriented. If implemented as proposed, the number of patients receiving detailed discharge plans would significantly increase and stretch available resources for discharge planning. These resources may be better spent focusing on patients who require more detailed discharge plans and intensive support with the transition. As a mediating policy, SHM recommends CMS build clear and concise flexibility into the discharge plan requirements so that providers remain free to address each patient's individual discharge needs. Alternatively, CMS could consider developing several levels of discharge planning requirements that can be tailored by providers to meet the needs of each patient.

Observation status is a billing status that classifies hospitalized patients as "outpatients," yet they receive virtually identical care to those considered inpatients. Under the two-midnight rule, observation status is guided by a time-based policy, not clinical severity or nature of illness. CMS does not reimburse inpatient and observation statuses equally, implying that the same care does not require the same amount of resources. As a result, adding these discharge requirements for observation patients would require a large number of steps that may not be realistic or even feasible in less than 2 midnights. As CMS considers these patients as outpatients, it does not make sense to require the same level of detail and complexity in the discharge plan as inpatients. CMS must recognize the variety of patients with an equally wide range of needs seen under observation status and SHM urges CMS to implement flexible requirements for patients under observation status.

Patients undergoing same-day surgeries or procedures would benefit from having some form of discharge plan or summary. However, most of these patients will not require as detailed a discharge plan as contemplated in this proposed rule. Again, SHM recommends CMS recognize the differing needs of different classes of patients and their severity of illness. For example, a patient undergoing screening

colonoscopy that was arranged by his primary care provider may need a discharge summary describing the procedure done and follow up recommendations, but a detailed description of relevant co-morbidities, past history, psychosocial history, communication needs, and access to non-health services would likely be irrelevant in this patient's discharge summary, and risks confusing the patient or masking information that is truly useful and understandable for the patient.

(c) Standard: Discharge Planning Process

CMS proposes to require that hospitals implement a discharge planning process to identify the anticipated post-discharge needs of patients early in the hospital stay. SHM concurs this is a worthwhile standard and, if not already occurring at hospitals, should be a part of the discharge plan.

SHM fully supports the goals of patient centered care, and believes discharge planning should incorporate the goals, needs, and preferences of the patient. However, it is paradoxical that while patient needs and preferences on discharges should be taken into account, their wishes can also result in financial penalties to the institution. For example, if a patient does not wish to follow recommendations and go to a SNF, their wishes should be respected—however, this could result in readmission penalties to the discharging institution under the Hospital Readmission Reduction Program (HRRP). We strongly encourage CMS to align the measures and assessment tools of pay-for-performance and other incentive/penalty programs with the goals of patient-centered care. Broad discharge plan requirements provide an opportunity to do this in a well-documented way, such as developing a methodology to denote when a patient's discharge wishes were honored even if they were against clinical recommendations. Such documentation could then be taken into account when calculating readmission rates under HRRP.

1. *Require a registered nurse, social worker, or other personnel to coordinate the discharge plan*

SHM recommends CMS adjust the language in this requirement to be inclusive of the many different types of providers who could be coordinating discharge plans. The proposal should be amended to read: "Require a physician, registered nurse, social worker, or other qualified personnel to coordinate the discharge plan."

2. *Begin to identify the anticipated discharge needs within 24 hours*

SHM believes this is a redundant requirement that will mandate a check-box approach for the discharge plan. As a matter of course, clinicians regularly consider their patient's care needs, including those at and after discharge.

3. *Require regular re-evaluation of the patient's condition to identify changes*

Similar to the comment above, this requirement is built-in to the regular course of care for patients in the hospital. Clinicians are continually adjusting the course of care for their patients, and adjusting their expectations for continued hospital and post-acute care throughout a hospital stay.

4. *Require the practitioner responsible for the care of the patient to be involved in the on-going process*

SHM agrees that it is important for the attending physician or other practitioner responsible for the care of the patient to be involved in the discharge planning process. Hospitalists work alongside many other providers to provide care and to plan for the discharge needs of their patients. This already occurs as a part of the regular course of care in hospitals. However, SHM is concerned that the implementation of this requirement will in effect mandate the filling out of a form or other administrative burden to monitor compliance – quality, thoughtful care could be supplanted by administrative compliance.

5. *Must consider the caregiver/support person and community-based care availability and capability for self-care and must consider admitting diagnosis, relevant co-morbidities and past history, anticipated on-going care needs post-discharge, readmission risk, psychosocial history, communication needs, access to non-health services, and patient goals and treatment preferences*

As indicated under the “Applicability” section, depending on the reason for a hospitalization, not all patients will require the full spectrum of items this list mandates. We urge CMS to recognize these differences for patients and not to implement a universal requirement using “must do” language. CMS could achieve this goal by add a qualifying statement to the requirement to indicate these criteria apply when applicable and appropriate for a patient’s needs.

SHM agrees that, when appropriate, caregivers and other support persons should be part of the discharge planning process and in the final discharge plan. We note that, in practice, caregivers are not always available to providers despite numerous outreach efforts, and that for some patients there may be unaddressed HIPAA issues with this requirement. This requirement assumes that patients will want to share their diagnosis, treatment course and discharge plan with caregivers. For example, a patient who needs help with getting to a methadone clinic may not wish to disclose their addiction with family members or other caregivers. We caution that this requirement must account for the privacy needs of patients.

We agree that consideration of community health and non-health services is an important element of many patients’ post-discharge needs, but note that it is a resource- and time-intensive requirement. This provision should be flexible enough to ensure that patients who would benefit from such high intensity discharge planning are able to receive it, but does not force it upon those who either don’t need it or would derive very little benefit from it.

6. *Must include the patient and caregiver/support person(s) in the development of discharge plan*

We agree that this is a worthwhile goal for the development of effective discharge plans. However, we again note there are HIPAA considerations for patient privacy that cannot be overridden by this requirement. If a patient does not wish to include caregivers or support persons in the course of their care, for whatever reason, providers should not be under a mandate that goes against these wishes. CMS could address this issue by adding qualifying statements such as “when applicable and appropriate for a patient’s needs” and “at the discretion of the patient” to the requirement.

7. *Must address the patient’s goals of care and treatment preferences*

SHM agrees that the patient's goals and preferences are an important consideration for the discharge plan and must be included in the discharge planning process. This is an important consideration for ensuring patients are as involved in their care as reasonably possible.

8. *Must assist in selection of post-acute provider including sharing data on quality measures and resource use measures*

SHM agrees that there is a role for the hospital and the care team for assisting patients in locating appropriate follow-up care, particularly if there are no community providers with which the patient has already developed a relationship. However, we have concerns about the feasibility and utility of requiring providers to take quality and resource use measures into consideration when providing post-acute care selection guidance to patients. It is frequently difficult to find any post-acute care for patients, particularly when factoring in patient preferences (geography, etc.) and insurance restrictions. This requirement, as written, would be extremely time and resource intensive and in many cases, it is unlikely to yield useful or actionable information for patients. To qualify this statement, we suggest the following language: Must use best judgement in assisting with selection of post-acute provider to meet the needs of the patient including sharing data on quality measures and resource use measures as applicable.

9. *Discharge plan must be documented and completed on a timely basis and must not unnecessarily delay discharge*

- i. *Discharge plan must be included in the patient's medical record***
- ii. *Include all relevant patient information to facilitate its implementation***

We fully agree that the discharge plan itself should not be an impediment to a timely discharge. However, there are a number of circumstances where elements of the discharge plan may affect the timing of discharge. For example, it may take additional time to find an appropriate bed in a nursing facility for the patient. Additionally, the needs of a patient receiving acute care in a hospital can change very rapidly and the actual discharge needs of a patient may not be immediately clear. We agree the discharge plan should be completed in a timely manner, but this requirement must be approached with caution so as to not serve as an impediment to ensuring patients are able to access the right care both inside and outside of the hospital.

(d) Standard: Discharge to Home

2. *Discharge instructions must include:*

- iii. *Prescriptions and OTC medications required after discharge, including any significant risks or side-effects***

This requirement aims to ensure that Medicare patients, many of whom take multiple medications at any given time, are able to understand risks and potential side effects of their various medication regimens. SHM recommends CMS take a more targeted approach to this requirement so as to not overload patients with too much information about all of the potential drugs they may take over the course of their post-hospital care. This could be achieved by modifying the requirement to apply only to new medications started in the hospital. In addition, this requirement should only apply to new OTC drugs that were prescribed or recommended by the patient's care team.

iv. Reconciliation of all discharge medications with all pre-hospitalization medications (prescribed and OTC)

Medication reconciliation is a critical aspect of discharge care and needs to be done accurately in order to be effective. We note that medication reconciliation can sometimes be difficult for over the counter (OTC) medications, as many patients do not know the proper names or doses of their OTC supplements. This difficulty could be mediated by adding “if available” after OTC in the requirement. Another option could be a requirement to ensure that all new medications are covered at discharge and a thorough review of all medications occurs within 48 hours of discharge. Regardless, we concur medication reconciliation should be included as a requirement for the discharge plan.

SHM recommends against requiring consultation with a state’s Prescription Drug Monitoring Program, particularly for non-controlled substances and low- to no-risk patients. Although PDMPs are important tools for combatting opioid abuse, implementing this as a requirement would add a significant amount of time and administrative burden to the workflow associated with discharge planning.

v. Written instructions regarding follow-up care

SHM agrees with the proposal to require written follow-up instructions on paper, electronic, or both. We emphasize that average literacy and, in particular, health literacy, rates are low among many patients. Written instructions are important and should be provided in an easily accessible, easy-to-read manner, and at no higher than the sixth-grade reading level.

Regarding the requirement that the written instructions include follow-up care and appointments, we caution that patients discharged on weekends, evenings or over holidays may not have appointments set up in advance. Further, it is sometimes difficult to know ahead of time the exact follow-up needs of the patient prior to the end of their stay, which can prevent scheduling this follow-up care earlier in the hospital stay. We recommend this requirement be amended by changing the language to: “written instructions in paper and/or electronic format regarding the patient’s follow up care, appointments if available or recommendations for appointments, pending and/or planned diagnostic tests... ”.

3. The hospital must send the following information to the follow-up care practitioner if they have been identified:

ii. Pending test results within 24 hours of their availability

SHM is deeply concerned about the requirement for disseminating all pending test results within 24 hours of their availability. Significant administrative resources would be required to achieve this universal goal for all pending test results. This is a costly and time consuming undertaking without any demonstrated evidence that requiring rapid transmission of all test results would improve patient care. Also, the lack of widespread EHR interoperability would make this nearly impossible to streamline. We recommend narrowing the requirement to account for urgency. A more realistic requirement would ensure that “urgent” or “actionable” test results are communicated with follow-up care providers in a timely manner.

4. The hospital must establish a post-discharge follow-up process

SHM agrees with the importance of post-discharge follow-up communication and applauds the forward thinking nature of this proposal. However, requiring it in all hospital settings may result in unnecessary

duplication of effort. For example, in an Accountable Care Organization (ACO) and other integrated healthcare systems, these follow-up conversations are handled by primary care providers, transitional nurses or other designated individuals – not the hospital. Rather than mandate that it be the hospital’s responsibility in every instance, we suggest that a responsible party be identified if it is not the hospital.

(e) Standard: Transfer of Patients to Another Health Care Facility

2. List of necessary information

SHM believes it is important for facilities to share information on their patients during transfers and believes the information required in the proposal for a transfer is generally appropriate.

It would be difficult for a facility to provide information about immunization and unique device identifiers, particularly if it is not relevant to the hospital stay. SHM recommends adding a qualifier to these requirements such as “if available” or “if applicable.”

SHM also recommends considering the inclusion of CDs or other electronic storage devices as a means to access imaging studies, if applicable. This recognizes that we have yet to achieve true EHR interoperability and could help reduce the number of redundant diagnostic procedures.

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

CMS proposes to require that the hospital not specify or otherwise limit qualified providers or suppliers available to the patient. Although SHM agrees with the need for transparency of financial relationships between healthcare providers, clarification is needed on how this requirement will apply to and impact providers in ACOs and BPCI - where established relationships with post-acute care providers are a necessary component of their work in improving the quality and reducing costs of care.

Conclusion

SHM believes discharge planning is an integral piece of the care for hospitalized patients. We provided comments on the proposals based on hospitalists’ experience of hospital systems and current discharge plan processes. If you have any questions or require further information, please contact Josh Boswell, Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,



Robert Harrington, Jr., MD, SFHM
President, Society of Hospital Medicine