

December 18, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: 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

Dear Acting Administrator Slavitt:

On behalf of the Visiting Nurse Associations of America (VNAA) thank you for the opportunity to comment on the proposed discharge planning rule for home health agencies and hospitals.

VNAA is a national organization that supports, promotes and advances mission-driven, nonprofit providers of home and community-based health care, hospice and health promotion services. VNAA members are safety net providers in their communities and provide care to all patients regardless of their ability to pay or the severity of their illness. They primarily serve the most clinically complex and vulnerable patients who will benefit from care delivered in their homes, and play a critical role in coordinating medical and social services for patients. Data for 23 VNAA members included in the VNAA Non-Profit Industry Research Database shows that VNAA members treat a higher percentage of Medicaid beneficiaries and individuals who are more functionally dependent and clinically severe than national average.¹ The care VNAA members give is high quality. In CMS' first release of the Home Health Compare Star Ratings, the percentage of VNAA members earning four to five stars was nearly double the national average.²

Overall, VNAA is encouraged by the proposed regulations. A more comprehensive, standardized approach to sharing information at discharge or transfer will help improve care transitions, quality of care, and the patient and caregiver experience. Today, many home health agencies do not receive discharge or transfer summaries from upstream providers or receive them until many days after care has been initiated by the home health agency. This regulation would significantly improve the transmission and timeliness of critical information from acute or other post-acute care settings to home

¹ The VNAA Non-Profit Industry Research Database includes clinical and financial data on 23 member organizations. This data is compared to the OCS national database of 1,160 home health agencies across the country.

² Home Health Compare

health agencies. Such information will facilitate agencies' ability to provide the highest quality of care to the beneficiaries they serve.

We note that much of what is included in this regulation is dependent on the adoption of both interoperable health information technology and health information exchange. Without such infrastructure, hospitals and home health agencies will be unable to comply with these proposed requirements in an efficient manner. We again call on CMS to consider options for incentivizing the adoption and meaningful use of such technology, particularly through the expansion of incentives to providers who were excluded from HITECH, such as post-acute care providers.

Finally, we ask that upon finalization CMS give agencies one year to implement the new rules. As discussed in more detail below, agencies will need time to develop a process, train staff, modify their electronic medical records, and ensure sufficient electronic connectivity or other means for sharing information more quickly across providers.

We provide more specific questions and comments on the proposal in the following sections.

§482.43(e)

CMS proposes to require that hospitals provide a minimum set of content for patients being discharged or transferred to another facility, including a home health agency.

VNAA Comments: VNAA commends CMS for requiring that hospitals provide detailed information to receiving providers at the time of discharge or transfer. We recognize that the collection of this robust set of information may be time consuming for hospitals. However, we encourage CMS to require that hospitals meet the content requirements by providing specific information, e.g., not more generalizable information via checklists. It is important that receiving providers have specific, detailed information on each patient to ensure highest quality care. We also recommend that CMS encourage (not require) hospitals to send the discharge or transfer summary as far in advance of the actual discharge or transfer as possible. With advance notice, receiving providers can ensure that they are prepared to fully meet the needs of the patients they are receiving.

We also recommend that CMS provide additional guidance to hospitals on what constitutes sufficient information with respect to certain elements as follows:

- **Functional status.** A patient who seems to function well in the hospital setting may not do well at home. For example, the bathroom may be on a different floor than the sick room or there may be stairs between rooms that will need to be navigated, etc. Patients may not consider such information important unless specifically probed. Instead of asking yes or no questions (e.g., "Do you think you will function well with activities of daily living when you return home?") we recommend that hospitals be directed to ask more probing questions. Examples of stronger questions include:
 - "How do you plan to get to the bathroom from your sick room?"
 - "What are the barriers to that task?"
 - "Who would install grab bars or other assistive devices that could help you?"
 - "How will you get your prescription medications?"

Hospitals should include information on functional status specific to the setting in which the individual is being discharged.

- **Advance care plans.** VNAA recommends that hospitals provide specific information including what discussions have occurred, what options were considered and the final decisions (in the form of signed forms).
- **Transportation needs.** VNAA recommends that hospitals provide information on any transportation needs, including specialized transportation needs, that a patient may have to facilitate the transfer and plan for appropriate follow-up care.
- **Risk assessments.** VNAA agrees with CMS' proposed requirement that hospitals conduct risk assessments as a component of discharge planning. Hospitals should be required to share the results of these assessments with the receiving provider for a more complete understanding of the patients care needs.

484.58(a)(1)-(5)

CMS proposes to require that home health agencies develop and implement an effective discharge planning process as a Medicare Condition of Participation (CoP). The process must take into account a patient's discharge goals, preferences, and needs, including how these needs may change over the course of a patient's home health episode and the availability and capabilities of any caregivers. The physician who oversees the plan of care, the patients, and any caregivers must be involved in the development of the plan.

VNAA Comments: VNAA members agree that discharge planning is a necessary activity to ensure highest quality of patient care and patient experience of care. Currently, home health agencies do discharge and transfer planning and summaries in coordination with patients and other providers. This is an ongoing process that occurs throughout a home health stay. However, in most cases, these processes do not meet the proposed standards outlined in the rule, particularly as they relate to content (discussed in more detail below.) Home health agencies will need to make modifications to their processes, conduct staff training, and update electronic health record (EHR) software to comply with the proposed regulations.

VNAA seeks clarifications on several elements of the proposed discharge planning process requirements. CMS defers decisions around the timing of sharing discharge and transfer summaries to agencies, as long as they share the summaries on a timely basis. We are concerned that this is overly vague and subject to wide interpretation by home health agencies, other providers and patients who may be relying on the information in the summary, and by the Medicare Administrative Contractors (MACs). We seek additional guidance from CMS about what may constitute timely basis. May an agency adopt one of the following and meet the timeliness requirement: (1) provide summary upon transfer, (2) provide summary within a certain time frame of transfer (e.g., three days), or (3) provide a summary within a certain timeframe of agency knowledge of the transfer meets the timely basis standard? We also ask that CMS comment on how timely basis should be interpreted when transfers occur over the weekend when many small agencies may not have all types of personnel working.

There are some limitations to developing the ideal discharge/transfer planning process. VNAA agencies are committed to using EHRs and sharing information electronically as much as possible. However, significant barriers to electronic transfer of information remain. For example, in many communities, the hospital's EHR may not integrate with the home health agency's EHR. Many smaller providers may not yet have generated the resources to transition to EHRs or connect to health information exchanges. We encourage CMS to provide incentives for providers to send and receive electronic information via a health information exchange.

484.58(a)(6)

CMS proposes that HHAs must assist patients (and their caregivers) who are being transferred to another HHA or discharged to a SNF, IRF, or LTCH in the selection of a post-acute care provider. HHAs must use and share data on quality and resource use performance that is relevant and applicable to the patient's goals of care and treatment preferences.

VNAA Comments: Providers should be able to assist patients and their caregivers select an appropriate, high quality post-acute care provider. In order to provide standardized guidance to patients, agencies will need to develop a process to assess patient goals of care and needs and identify relevant quality and resource use data for the needed type of provider in the geographic area. Similar to the development of a discharge planning process, this will require staff time and resources to develop and train staff on the new procedures. We seek additional guidance from CMS to ensure that all stakeholders, including we, as the sending provider, the receiving providers, patients and their families, CMS, and the MACs, agree on what constitutes appropriate protocol. For example, will it be appropriate for home health agency staff to educate patients on how to use the CMS Home Health Compare website, including which data points are available for comparison and how to compare individual facilities to other facilities or to the state and national averages? Or, will agencies need to sit with patients and caregivers and guide them through the entire process? Also, are agencies permitted (or required) to provide other information, such as whether a provider offers specialty programs, how that provider works with other community providers, and any unique services the provider offers?

While VNAA members are committed to assisting their patients and caregivers with this process, this will be a time-intensive process given the often numerous facilities in an area. We ask that CMS recalculate the burden of this proposed rule by incorporating the time it will take for agencies to assist patients with the selection of a post-acute care provider when required.

484.58(b)

CMS proposes a minimum set of content for discharge and transfer summaries.

VNAA Comments: VNAA agrees with CMS' perspective that patients, caregivers, and other relevant clinicians should receive comprehensive information on the patient upon discharge or transfer. We strongly recommend that CMS move to a standardized format for the collection of such data to facilitate the transfer of information across providers. We also recommend a number of modifications to the proposed set of content.

Recommended Additions: VNAA recommends that CMS explicitly require several critical pieces of information that were not included in the proposed rule. These include:

- Name of the provider (facility, physician, advanced practice nurse, etc.) who will continue to provide care following discharge from home health care, if known.
- Name of any community-based social service provider known to be continuing service for the patient or from whom the patient may seek future assistance, such as Meals-on-Wheels, companion programs, housing programs, etc.
- Information on upcoming health-related appointments. These would include, but not be limited to, physician appointments, community social services and supports (e.g., Meals-on-Wheels), non-medical home health, adult day care, outpatient therapy, and mental health follow-up appointments.

- Instructions for patients and caregivers on what to do if unexpected symptoms or events occur. It may involve contacting a physician or behavioral health counselor or calling the home health agency office.

Recommended Revisions/Deletions: The proposed content may not be relevant for a large number of home health patients and we seek modification to the list of required elements or flexibility from CMS in providing the full set of information. CMS appears to only require that home health agencies provide discharge or transfer summaries to other providers, not patients. We seek clarification on this point. Other comments reflect that there are a number of elements related to services not available through home health agencies, such as lab test results and implantable device numbers. This information should be obtained directly from the provider responsible for ordering or providing such services and supports. If the home health agency must include this information in their discharge or transfer summaries, several risks arise. First, there is a considerable risk of submitting inconsistent data due to having to manually enter the information a second time (most providers cannot electronically share and incorporate data elements from another providers' EHR). Second, such requests for information may take time and delay the availability of the summary. We recommend that CMS instead give providers more flexibility to determine what information on the list is relevant for an individual patient and give providers flexibility to use documentation formats that convey the information in a complete yet concise way, such as via checklist. More information on specific elements of concern follow:

- **Consultation Results:** VNAA is unclear about what constitutes a consultation result. If CMS intended "medical consultants," then this should not be included among the home health discharge items. Home health neither orders nor organizes such medical consultations. These are arranged and performed by physicians and other practitioners and should be reported by them. If the term is used more broadly to include services provided by the agency through a medical social worker or wound care nurse, then we agree that including such information in the discharge plan of care is appropriate.
- **Laboratory Tests:** Broad laboratory testing is not a common service provided by home health agencies; indeed, phlebotomy is not considered a skill by CMS standards. While some agencies order labs and receive results, most either do not collect labs at all or collect them on behalf of a primary care physician who receives the results. While home health agencies should absolutely share information on any labs for which they are responsible (both ordering the lab and receiving the results), we recommend that CMS not require home health agencies to track down labs ordered by other providers while the patient was concurrently receiving home health services. This information may not be known to the home health agency and would risk being incomplete.
- **Immunization Status:** Immunization status should be reported only if there is documented evidence. For example, if a home health nurse gives a flu vaccine, this fact should be recorded. We are concerned that relying on patient recall will lead to reporting errors.
- **Unique Device Identifiers:** Unique device identifiers are not within the purview of home health agencies and should not be included on the home health discharge summary. These are implanted by other clinicians in other settings. Not only are they never initiated in homecare, requiring homecare agencies to include unique identifiers introduces an opportunity for error that could prove dangerous for a patient in the future.

We again stress the importance of aligning EHRs with the final content requirements. We ask that CMS help providers work with vendors to understand the requirements for the development of standardized fields that can more easily be shared across providers.

Impact on Home Health Agencies

CMS estimates that compliance with the discharge planning process will require:

Discharge planning process: Eight hours of time from each a physician (\$187/hourly), a registered nurse (\$67/hourly), and an administrator (\$98/hourly) for a total of 24 hours or \$2,816 per HHA.

Discharge or transfer summary content: 10 minutes per patient. Of those 10 minutes, CMS estimates that 2 minutes would be covered by a physician, 3 minutes by a social worker (\$52/hourly), and 5 minutes by an RN. The average estimated annual cost for an HHA would be approximately \$21,710 per HHA.

Sending discharge or transfer summaries: 2.5 minutes per patient, resulting in an estimated \$1,984 per average HHA.

VNAA Comments: CMS grossly underestimates the amount of time agencies will need to comply with the proposed requirements, including the development of the discharge planning process, the collection of all of the relevant information, and the transmission of the information to the patient and downstream provider. As noted previously, CMS has not considered the significant amount of time it will take agencies to assist patients and caregivers with the selection of a post-acute care provider using data targeted to the needs and preferences of the patient. We note that the time to comply with the regulations should drop dramatically upon availability of a standardized format and interoperable EHRs and health information exchange. We are particularly concerned that such increased demands on home health agency resources come at a time when home health agency reimbursement is being slashed due to rebasing, sequestration, and the most recent case mix adjustment. Our input on additional components for CMS consideration following:

Development of Discharge Planning Process: As part of the development of the planning process, agencies will need to train staff on the new processes once developed and work with EHR vendors to modify standard forms and electronic work flows. Training will require at least one hour per clinical and administrative staff person involved in the discharge/transfer process. Several staff people will spend several hours working on modified forms with the EHR vendor.

Collection of Content: CMS estimates that it will take a nurse or other clinician approximately 10 minutes to complete the content requirements for the discharge/transfer summary. Our members' experiences indicate that an hour is more consistent with current documentation practices. For example, for a nurse to gather most of the data from the EHR would take approximately 15 minutes. S/he would then come to the office to obtain the remaining information that is in paper form in the patient chart. Not considering travel time, this would reasonable take an additional 15 minutes. Travel, communication with the physician, gathering of additional data, verifying data, and creating the summary, would take at least an additional 30 minutes.

Transmission of Summaries: The back office time required to send out a summary will take well over the 2.5 minutes CMS estimates. Agencies will need approximately an hour to conduct quality control measures required by CMS. The actual printing and sending of the summary takes on average 5 minutes.

VNAA thanks you for the opportunity to provide comments. The proposed rule contains a number of policy decisions that, if finalized, will have a significant positive impact on patient care but also a major administrative impact on the home health industry. Please contact me if you have any questions on our comments. I may be reached at tmoorhead@vnaa.org.

Sincerely,

A handwritten signature in blue ink that reads "Tracey Moorhead". The signature is written in a cursive, flowing style.

Tracey Moorhead
President and CEO