



National Association of State Long-Term Care Ombudsman Programs

January 4, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

RE: COMMENTS FROM THE NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS ON 42 CFR PARTS 482, 484, 485; MEDICARE AND MEDICAID PROGRAMS; REVISIONS TO REQUIREMENTS FOR DISCHARGE PLANNING FOR HOSPITALS, CRITICAL ACCESS HOSPITALS, AND HOME HEALTH AGENCIES; PROPOSED RULE

Dear Mr. Slavitt:

The National Association of State Long-Term Care Ombudsman Programs (NASOP) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the proposed rule. When suggesting new language, NASOP has underlined and italicized the text.

Part 482 – Conditions of Participation for Term Care Facilities

482.43 Condition of participation: Discharge planning

482.43(c) Standard: Discharge planning process. The hospital's discharge planning process must ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of a discharge plan for each patient in accordance with paragraph (b) of this section. NASOP supports the expansion of the requirement that a discharge plan be developed for ALL inpatients and certain outpatients as described in 42 CFR 482.43(b)(2) thru (5). The current rule only requires that discharge planning apply to all patients, and permits hospital discretion in determining which patients receive a discharge plan. Obviously, this resulted in a great deal of inconsistency between hospital requirements and the success of transitions from hospital care. The proposed rule requiring that ALL inpatients receive a discharge plan should begin to address these inconsistencies in a positive manner.

482.43(c)(1) NASOP suggests that CMS specify patient involvement in the discharge planning process. This section really applies to the hospital's process and the proposed rule emphasizes patient

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involvement in the sections that follow. NASOP suggests adding the language from the introduction to this standard:

A registered nurse, social worker, or other personnel qualified in accordance with the hospital's discharge planning policies must coordinate the discharge needs evaluation and development of the discharge plan *focusing on the patient's goals and preferences.*

482.43(c)(2) NASOP suggests the addition of the phrase "or compromising the quality of patient care" to emphasize that a key purpose of the discharge planning process is to promote a better patient outcome, not just avoid a longer hospital stay.

The hospital must begin to identify the anticipated discharge needs for each applicable patient within 24 hours after admission or registration, and the discharge planning process is completed prior to discharge home or transfer to another facility and without unduly delaying the patient's discharge or transfer or compromising the quality of patient care. If the patient's stay is less than 24 hours, the discharge needs for each applicable patient must be identified and the discharge planning process completed prior to discharge home or transfer to another facility and without unnecessarily delaying the patient's discharge or transfer or compromising the quality of patient care.

482.43(c)(5) NASOP suggests moving item "(viii) Patient's goals and treatment preferences" from its current location at the end of the list to the first item in the list of things that the hospital must consider when evaluating a patient's discharge needs. This reinforces the concept that the patient should be driving the discharge planning process.

482.42(c)(8) NASOP suggests the following language to the requirements for characteristics of post-acute data. For a discharge in December, information retrieved from Nursing Home Compare, or a similar source, in February or March may be less relevant.

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. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is current, relevant and applicable to the patient's goals of care and treatment preferences.

482.42(9)(i) NASOP suggests the following language to emphasize that the patient should always be informed and included in any discussion involving discharge planning. It also recognizes that a

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representative/care giver may also need to be part of the discussion depending on the patient's wishes and capacity:

The discharge plan must be included in the patient's medical record. The results of the evaluation must be discussed with the patient ~~or~~ and the patient's representative.

482.42(9)(ii) NASOP also suggests the following language to emphasize that the key purpose of the discharge planning process is to promote a better patient outcome, not just avoid a longer hospital stay:

All relevant patient information must be incorporated into the discharge plan to facilitate its implementation, to promote quality post-discharge care and to avoid unnecessary delays in the patient's discharge or transfer.

482.43(d) Standard: Discharge to home.

482.43(d)(2)(ii) NASOP suggests the following language to this section and to section (v) for obvious reasons:

Legible, written information on warning signs and symptoms that may indicate the need to seek immediate medical attention.

482.43(d)(2)(v) NASOP also suggests that CMS consider a comment regarding providing the format of instructions in accordance with patient's preferences. Some patients may prefer written instructions over electronic. In rural areas, many people still do not have access to high speed Internet. If the patient cannot access the discharge instructions, they are useless.

Legible, written instructions in paper and/or electronic format according to the patient's preferences regarding the patient's follow-up care, appointments, pending and/or planned diagnostic tests, and pertinent contact information, including telephone numbers, for any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for follow-up care.

482.43(d)(3) NASOP is concerned about the language in this section. Should there be a statement that the hospital should actually use reasonable efforts to find out who the patient's practitioner is and to communicate with that person?

482.43(d)(4) NASOP is unclear as to what the post-discharge follow-up includes. We believe further explanation may be necessary.

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Part 484 – Home Health Services.

484.58 In general, NASOP supports the inclusion of “preferences” of the patient and CMS’ intent to make discharge planning a person-centered experience for the patient.

484.58(a)(4) The regulation should be specific in requiring that the updates envisioned in 483.58(a)(1) include re-checking goals and preferences of the patient. This section requires that the patient be informed of the “final” plan, but the patient should be informed of every version of the plan. Additionally, the regulation should require that the patient not only be informed of the plan but be given a copy of the plan and each revision thereof.

Part 485 – Conditions of Participation Specialized Providers

485.642 Condition of participation: Discharge planning.

NASOP believes the proposed changes to 485.642 will fill in some of the gaps in communication that result in lapses in care. We see this in working with residents we serve when they return from the hospital to the facility. NASOP believes that it is reasonable to presume that other populations will also benefit as the gaps in communication and care are filled as well.

For example, the proposed changes to 485.642(d) require written discharge instructions for a patient that is being discharged home. The requirements listed include among other things, warning signs and symptoms that require immediate medical intervention and a listing of prescriptions along with significant risks and side effects of each prescription. As we are aware, the better informed a patient is, the more of an opportunity they have to take the necessary steps for a better recovery.

In addition, the proposed change to 485.642(e) requires that the discharging hospital send necessary medical information to the receiving facility. That information includes, lab test results, a reconciliation of discharge medications with a resident’s pre-admission medications, as well as special instructions or precautions for ongoing care. We have dealt with cases in which facilities have not received new medication or new treatment information at the time of readmission of a resident to their facility. Family members have caught the omission, or the issue becomes known after the resident has had a decline in health after re-admission to the facility. The filling of this gap will be a benefit to the population we serve, and presumably to other populations as well.

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As these two examples illustrate, the changes proposed to 485.642 that require more complete and timely information about the patients' treatment and continuing follow up measures to be provided at discharge will allow patients, their caregivers and receiving facilities the opportunity to allow for a better recovery after discharge from a hospital.

NASOP thanks CMS and their staff for their work on these proposed rules. We believe that our suggestions and recommendations will further improve care for patients and residents.

Sincerely,

A handwritten signature in blue ink, appearing to read "J. Rodrigues".

Joseph Rodrigues, Chair
NASOP Advocacy Committee

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