701 Pennsylvania Ave., NW, Suite 800
Washington, DC 20004-2654
Tel: 202 783 8700
Fax: 202 783 8750
www.AdvaMed.org

AdvaMed
Advanced Medical Technology Association

January 4, 2016

Via Electronic Mail to file code CMS-3317-P

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
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 Acting Administrator Slavitt:

AdvaMed appreciates the opportunity to provide our comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule pertaining to discharge planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. AdvaMed member companies produce the medical devices, diagnostic products and health information systems that are transforming health care through earlier disease detection, less invasive procedures and more effective treatments. Our members range from the largest to the smallest medical technology innovators and companies.

AdvaMed agrees that well-designed and thought-out discharge planning is a critical component of successful transitions from acute care hospitals and post-acute care (PAC) settings. This is a cornerstone of successful continuity of care for patients. The critical nature of properly documenting and providing the handoff information that will accompany the patient as they transition from one care setting to another ultimately impact patient outcomes, including reducing complications/adverse events, reducing avoidable hospital readmissions and offers an opportunity to improve the quality and safety of patient care while addressing health care costs.

I. The Proposed List of "Necessary Medical Information" Provided at Discharge/Transfer Should Include Information on the Status/Assessment of Patients' Wounds and Nutrition.

A. Background and Rationale

The proposed rule provides a list of "necessary medical information" that, at a minimum, is to be provided from the current treatment setting to the receiving facility or health care practitioner, regardless of whether the patient is being discharged or transferred to any post-acute care setting. These settings include home (with or without PAC services), skilled nursing facility, nursing home, long term care hospital, rehabilitation hospital or unit, assisted living center, substance abuse treatment program, hospice, or a variety of other settings. The proposed list contains important information concerning the patients' health including course of illness/treatment, procedures, functional status, reconciliation of all discharge medications (both prescribed and over-the-counter) and *other information necessary to ensure a safe and effective transition of care that supports the post-discharge goals for the patient* [emphasis added].

Although it is conceivable that other essential medical information – such as those dealing with wounds and nutritional status – may be included as *"other information necessary to ensure a safe and effective transition of care that supports the post-discharge goals for the patient,"* it is highly unlikely that these specific concerns will be addressed on a consistent basis across all patient care settings. It is not enough to assume that providers will include wound care and nutrition/malnutrition in a discharge plan without being prompted. Discharge/transfer planning is an arduous and challenging process, and although providers are well-intentioned, there is a higher chance that if certain information is requested on a list, then it will be provided. Hence, in order to lend additional consistency to the necessary medical information that is provided on transfer/discharge, these two areas – wound care and nutrition/malnutrition – should be specifically called-out on each list. Mention of these areas would additionally serve to alert the receiving facility and practitioners that these concerns should be incorporated into their own admission notes, current treatment plan and daily "SOAP" (subjective, objective, assessment and plan) or similar types of notes.

The addition of wounds and nutritional status to patient discharge/transfer plans is consistent with the goals and recommendations under the IMPACT Act, AHRQ recommendations,[1] numerous clinical guidelines,[2,3] multi-stakeholder quality improvement initiatives,[4] numerous

---

[1] AHRQ Preventing Pressure Ulcers in Hospitals, A Toolkit for Improving Quality of Care: What are the best practices in pressure ulcer prevention that we want to use. http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool3.html Accessed 1/2/2016. Stating that "comprehensive skin assessment should be performed by a unit nurse on admission to the unit, daily, and on transfer or discharge."

[2] Mueller C, Compher C, Ellen DM. A.S.P.E.N. Clinical guidelines: Nutrition screening, assessment, and intervention in adults. Journal of Parenteral and Enteral Nutrition. 2011;35:16–24.

[3] Thomas DR, Ashmen W, Morley JE, et al. Nutritional management in long-term care: Development of a clinical guideline. Council for Nutritional Strategies in Long-Term Care. The Journal of Gerontology. 2000;55(12):M725–734.

[4] Dialogue Proceedings / Launching the Malnutrition Quality Improvement Initiative. Avalere and The Academy of Nutrition and Dietetics. November 2014.

current and forthcoming quality measures and recommendations from other publications and organizations. The IMPACT Act specifically calls out "skin integrity and changes in skin integrity" as one of the domains to be addressed by quality measures across post-acute care settings. Also, CMS has identified "major injury due to new or worsened pressure ulcers" as one of the four high-priority domains for future measure considerations for home health agencies and other post-acute care settings under the IMPACT Act.[5]

B. Recommendation for Including Patient Wound Status at Discharge/Transfer

It is essential that the hospital discharge/transfer planning process specifically addresses the status of any patient wounds. Wound deterioration is one of the principal causes for rehospitalizing patients each year from post-acute care settings such as adult home care facilities. It is also estimated that 21% of these hospitalizations are potentially preventable through improved clinical care processes such as proper discharge planning.[6] The proper care of these wounds can significantly lower follow up care on readmissions, infections and complications. Whether these wounds represent the primary or secondary reason for the hospitalization, a detailed understanding of the patients' wound care needs documented in their care plan will facilitate improved beneficiary care. This is especially relevant to those patients that have peripheral vascular disease such as diabetic leg/foot ulcers where it is important to arrange for timely outpatient follow-up with the appropriate provider(s) prior to hospital discharge.[7]

AdvaMed recommends that the necessary medical information at discharge should include information on whether the discharge/transfer patient has a wound (including the type of wound, dimensions of the wound, history of the wound and treatment course, wound infection history with results of cultures and sensitivities, etc.). The information should also identify if the patient is at-risk of developing wounds, based on any underlying conditions, such as diabetes, malnutrition, medication status (for example, chronic steroid dependence which would contribute to fragility of skin integrity) and any other relevant factors. Discharge/transfer planning should also include appropriate referral to suppliers of DMEPOS products needed for continuity of care for wound care treatment in the community.

C. Recommendation for Including Patient Nutritional Status at Discharge/Transfer

Continuity of nutritional care is essential for older adults. Increasing the risk of malnutrition is the presence of high-impact and costly chronic conditions, including conditions such as cardiovascular disease, stroke, diabetes, cancer, chronic obstructive pulmonary disease (COPD), renal disease, depression, and dementia.[8,9] There is a growing body of evidence that

---

[5] Measure Applications Partnership; MAP 2015-2016 Considerations for Implementing Measures in Federal Programs – Draft for Public Report. National Quality Forum, December 2015.
[6] Taft SH, Pierce, CA, Gallo, CL. From Hospital to Home and Back Again: A Study in Hospital Readmissions and Death for Home Care Patients. *Home Health Care Management and Practice* 2005; 17(6), 467-480.
[7] Wukich DK, Armstrong DG, Attinger CE, et al. Inpatient management of diabetic foot disorders: a clinical guide. *Diabetes Care* 2013; 36:2862-71.
[8] Jensen GL, et al. Adult Starvation and Disease-related Malnutrition: A proposal for etiology-based diagnosis in the clinical practice setting from the International Consensus Guideline Committee. J Parenter Enteral Nutr. 2010; 34:156-159.

demonstrates the negative impact that poor transitional care, including non-receipt of nutritional services post-hospital discharge, has on contributing to negative patient outcomes and increased health care utilization and costs. Under-nourished older adults are more likely to experience adverse outcomes upon discharge and are more likely to be readmitted to the hospital. In addition, several studies have emphasized the need for special assistance to assure adequate nutrition during the early post-discharge period.[10,11]

Patients and family caregivers want and need this information. A recent survey by the Gerontological Society of America's National Academy on an Aging Society found that Americans understand identifying and treating malnutrition is important for older adult health and would like more information about the problem. Further, the survey identified that family caregivers wished older adults in their care were using more community nutrition resources such as home meal delivery programs.[12] Additionally, the interdisciplinary Alliance for Patient Nutrition recommends in their consensus paper that hospitals "Develop a Comprehensive Discharge Nutrition Care and Education Plan" that includes clear, standardized written instructions for nutrition care at home, including rationale for and details on diet instruction and any recommendations on oral nutrition supplements, vitamin and/or mineral supplements that can be given to the patient and his or her caregiver upon hospital discharge.[13] Implementation of patient-driven/team-based malnutrition care plans, and care coordination between providers, patients, and community-based services are critical for improving outcomes for malnourished and at-risk patients and to achieve patient goals of care.[14,15]

AdvaMed recommends that information should be incorporated into the necessary medical information regarding whether the patient is malnourished or at risk of being malnourished for various reasons. The discharge/transfer plan should contain information on the number of calories per day and the type of diet and/or oral nutrition supplements, vitamin and/or mineral supplements that the patient has actually been consuming during their course prior to discharge/transfer.

---

[9] NQF Committee Report, 'Prioritization of High-Impact Medicare Conditions and Measure Gaps, May 2010.
[10] Locher JL, Wellman NS. "Never the twain shall meet:" dual systems exacerbate malnutrition in older adults recently discharged from hospitals. *J Nutr Gerontol Geriatr.* 2011; 30(1):24–8.
[11] Yang Y, Brown CJ, Burgio KL, Kilgore ML, Ritchie CS, Roth DL, et al. Undernutrition at baseline and health services utilization and mortality over a 1-year period in older adults receiving home health services. *J Am Med Directors Assoc.* 2011 May;12(4):287-94.
[12] What We Know and Can Do About Malnutrition. Washington, DC: The Gerontological Society of America; Fall 2015.
[13] Tappenden KA et al. Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition. JPEN J Parenter Enteral Nutr. 2013 Jul;37(4):482-97
[14] Tappenden, *Science Magazine Supplement* December 2014.
[15] Tappenden et al, *JPEN J Parenter Enteral Nutr* 2013 37: 482.

D. Implement malnutrition-related quality measure and nutritional status domain in future Quality programs

Implementation of an effective care transition plan for patients diagnosed as malnourished or at risk for malnutrition is critical to improving outcomes and patient safety by reducing complications which can lead to readmissions including infections, falls, and pressure ulcers.

Addressing malnutrition aligns with the CMS National Quality Strategy Goal of identifying cross-cutting measures that are important to patients and providers. As such, there is an opportunity to address this measure gap and to align incentives for providers by standardizing a malnutrition-related measure across acute and post-acute care quality programs.

As malnutrition is an independent risk factor for poor outcomes and increased costs across healthcare settings, AdvaMed recommends CMS adopt a malnutrition-related quality measure in Quality Reporting and Value Based Purchasing programs as soon as feasible to address potential patient-safety risks and to improve patient outcomes across the care continuum. In the Post-Acute Care quality programs we recommend that CMS implement a "nutritional status domain" highlighting nutritional status as a key indicator of adult health.

AdvaMed and our member companies would like to thank CMS for the opportunity to comment on this proposed rule on discharge planning. Please feel free to contact me or Steve Brotman at sbrotman@advamed.org or 202-434-7207 with any questions. Thank you for your consideration.

Sincerely,

/S/

Don May
Executive Vice President
Payment and Health Care Delivery Policy