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January 4, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Re: CMS 3317-P, Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (Vol. 80, No. 212, Nov. 3, 2015).

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on revisions to requirements for discharge planning for hospitals, critical access hospitals (CAHs) and home health agencies (HHAs).

The AHA generally supports the rule and agrees with CMS's goal for hospitals to have comprehensive, multi-disciplinary discharge planning processes that incorporate evidence-based practices, patient-centeredness and community engagement. Our members already employ many of the practices described in the rule to identify patient needs and create discharge plans that ensure appropriate transitions and reduce readmissions. While the overarching intent of the proposed rule and its objectives are desirable, we are concerned that the implementation of some of the proposed provisions would be complex and expensive. For example, we expect the rule, as proposed, would require hospitals to add staff, especially during the weekend and after-hours; train or retrain new and existing staff; change practitioner and administrative workflow and procedures; and alter electronic health record (EHR) systems to align with the proposed standards.

We urge CMS to make several key changes in the final rule that would lessen the burden on hospitals and CAHs. Among our key concerns, we believe CMS should: (1) change the scope of the proposed requirements so that either discharge plans or discharge instructions can be provided in certain instances to better align discharge planning efforts with the needs of each patient; (2) alter a proposal that would require discharge planning to begin within 24 hours in all cases; (3) provide flexibility to address the lack of community resources in some areas; and (4)



revisit its cost estimates to reflect the true impact of increasing the discharge planning requirements. **In addition, we urge CMS to establish an effective date that is two years from the date of the final rule.** We believe this timeframe would give hospitals and CAHs enough time to make needed changes. Hospitals also would need time to work with their EHR vendors to incorporate the changes before the effective date.

Below we address specific aspects of the rule.

APPLICABILITY AND SCOPE OF REQUIREMENTS

We are concerned that the range of patients who would be required to have a full discharge evaluation and plan, rather than a robust set of discharge instructions, is too extensive.

The discharge evaluation that CMS proposes would require hospitals to evaluate patients on at least eight different factors, including diagnosis, comorbidities, anticipated ongoing care needs, readmission risk, patient access to non-health care services, relevant psychosocial history, communication needs, and patient goals and treatment preferences. Although CMS does not distinctly define “discharge plan,” hospitals would presumably use the evaluation to create a plan for what should happen for the patient after discharge and address any patient needs identified in the evaluation. On the other hand, in the proposed rule, discharge instructions would include a standard set of information covering the following areas: instruction on post-discharge care at home, warning signs for indications of a need to seek immediate care, medications required after discharge, medication reconciliation, and written instructions for follow-up care/referrals.

In the proposed rule, hospitals and CAHs would be required to create discharge plans for all inpatients as well as some outpatients, including observation patients; same-day patients receiving anesthesia or moderate sedation; emergency department (ED) patients identified by ED practitioners as needing a discharge plan; and other categories of outpatients recommended by the medical staff and specified in the hospital’s/CAH’s discharge planning policies approved by the governing body.

The AHA agrees that all inpatients should have a discharge plan, as well as some, but not all, observation and same-day patients who receive anesthesia or moderate sedation. Patients undergoing diagnostic procedures such as colonoscopies likely require a clear, comprehensive set of discharge instructions, but not a full discharge evaluation and plan. **The practitioners responsible for the care of observation and same-day patients receiving anesthesia or moderate sedation should be able to decide whether the patients need either full discharge evaluations and plans or comprehensive discharge instructions.**

In the proposed rule, CMS says it does not expect every patient to need a comprehensive discharge plan. Rather, CMS suggests the plan should be tailored to the unique goals, preferences and needs of the patient. CMS states:

For example, based on the anticipated discharge needs, a discharge plan in the early stages of development for a young healthy patient could possibly be as concise as a plan to provide instructions on follow-up appointments, and

information on the warning signs and symptoms which may indicate the need to seek medical attention. On the other hand, the discharge needs of patients with co-morbidities, complex medical or surgical histories (or both), with mental health or substance use disorders (including indications of opioid abuse), socio-economic and literacy barriers, and multiple medications would require a more extensive discharge plan that takes into account all of these factors and the patients' treatment preferences and goals of care.

As we read it, the young, healthy patients CMS describes above need discharge instructions, rather than a discharge plan, and we are confused as to whether CMS is saying that a discharge plan can be limited to discharge instructions.

We believe that hospitals' and CAHs' medical staffs should articulate through their policies and procedures the appropriate levels of discharge activities and planning for each type of patient. Medical staffs (or for CAHs, professional health care staffs) would determine which patients should receive discharge instructions only, which should receive discharge instructions with specified enhancements, and which should receive a full discharge plan. Therefore, we believe CMS should change the regulatory language, as described below, to allow for the flexibility to tailor the discharge planning activities to the needs of each patient. We believe that not all patients need the hospital to engage in a full evaluation as described in § 482.43(c)(5). Further, we do not believe all outpatients need a medication reconciliation, especially outpatients undergoing diagnostic procedures, unless their medications or drug therapies or regimens are changed during the visit.

We recommend you adopt the following language:

(c) *Standard: Discharge planning process.* The hospital's/CAH's discharge planning process must ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of:

- (1) a discharge plan for each inpatient; and
- (2) either a discharge plan or discharge instructions, as determined by the practitioner responsible for the care of the patient and in accordance with medical staff policies and procedures, for applicable patients identified in (b)(2) through (b)(5) of this section.

(d)(2): The discharge instructions must include, but are not limited to, the following:

- (i) Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient's home;
- (ii) Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the caregiver/support person(s) should do and whom they should contact if these warning signs or symptoms present;

(iii) Prescriptions and over-the-counter medications that are required after discharge, including the name, indication, and dosage of each drug, along with any significant risks and side effects of each drug as appropriate to the patient;

(iv) Reconciliation of all discharge medications with the patient's pre-hospital admission/registration medications (both prescribed and over-the-counter), if applicable; and

(v) If applicable, written instructions in paper and/or electronic format 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.

Emergency-level transfers. We agree that hospitals should not be required to conduct discharge evaluations and create discharge plans for emergency-level transfers for patients who require a higher level of care, though the hospital/CAH should send necessary information with the patient.

COMMUNITY RESOURCES

CMS should clarify in the final rule that compliance with the new standards will be evaluated within the context of a provider's community resources. Successful discharge planning often involves collaboration with or use of community resources, although many communities have limited resources in terms of supportive housing and other services. For example, when it comes to behavioral health resources, our members can face challenges trying to identify a post-acute care provider or program. The Health Resources and Services Administration estimates the U.S. has 4,000 mental health professional shortage areas. Moreover, some of our members have indicated it is difficult to find psychiatrists to implement telepsychiatry.

Social workers also may be in limited supply. The rule would likely require hospitals and CAHs to add social workers to their staffs to handle the increase in the number of patients required to have a discharge plan. CMS recently acknowledged a possible limitation of social workers in a separate proposed rule updating the requirements for long-term care facilities. CMS must consider these types of shortages as it finalizes the rule for discharge planning. At the very least, CMS should allow for flexibility with regard to the "other personnel" who may coordinate and develop the discharge plan, allowing hospitals and CAHs to outline the qualifications based on patient needs and knowledge of community resources.

ALIGNMENT OF STANDARDS ACROSS PROGRAMS

CMS proposes that hospitals and CAHs would be required to provide detailed medical information to the receiving facility when transferring patients. CMS does not propose a specific form, format or methodology for this communication, but does specify 21 required elements that the agency has tried to align with the common clinical data set for the 2015 Edition of Health Information Technology (Health IT) certification criteria. These requirements include incorporating information on unique device identifiers (UDIs) for patients with implantable devices. **We caution that there will be practical challenges in collecting and submitting this information electronically and believe that inclusion of UDI information, specifically, is premature.**

CMS should ensure that the criteria for the information required to be sent upon transfer are aligned as much as possible across current meaningful use requirements, discharge planning standards, and quality measures, such as the quality measure Transition Record with Specified Elements Received by Discharged Patients (NQF #0647), which is part of the Inpatient Psychiatric Facility Quality Reporting Program. CMS also must consider the behavioral health privacy regulations at 42 CFR Part 2 as it finalizes this provision.

We appreciate that CMS has tried to align its proposed discharge planning requirements with the common clinical data set for the 2015 Edition of Health IT certification criteria. However, we caution that, while health IT vendors are in the process of developing EHRs with the new criteria, they are not required to be available for use by eligible hospitals and CAHs until January 2018. More significantly, there will be some practical challenges in aligning the proposed transfer requirements to the 2015 Edition Certification Criteria due to a lack of mature IT standards in some areas. For example, certification criteria supporting data segmentation of sensitive health information related to behavioral health are included in the 2015 edition, but the criteria lack mature IT standards and have not been widely adopted.

A related problem exists with regard to UDIs for implantable devices. The transition to the UDI has just begun and may not be complete until 2020. It will be a complex transition, as there are three separate agencies that use different standards to create the UDI, *which can be as long as 75 characters*. In addition to accommodating multiple UDI formats, EHRs also will need to accept the data from different forms of automated ID technology (such as a barcode or radio frequency identification tag). At the same time, hospitals are learning how best to use the UDI and change operations to accommodate it. The AHA supports the deployment of the UDI because of the safety and efficiency benefits it will bring. However, working through the standards development and implementation issues to support effective use of the UDI is a precursor to including the UDI as a data element in the common clinical data set.

We believe that hospitals should *not* be required to meet Stage 3 of the Meaningful Use/EHR Incentive Program, which utilizes the 2015 certification criteria, until at least 75 percent of hospitals have met Stage 2, using the 2014 certification criteria. Fewer than 40 percent of hospitals attested to Stage 2 meaningful use readiness in 2014. We note that the 21 elements of information proposed to be provided to a receiving facility correspond with numerous data

elements currently required in summary of care reports that support transitions of care in the Meaningful Use/EHR Incentive Program for Stage 2. (See Table 1 at end of this letter.) Therefore, the AHA recommends that CMS recognize eligible hospitals that successfully attest to Stage 2 as meeting the corresponding data elements proposed for discharge planning transfer requirements.

PATIENT-CENTEREDNESS

We agree with CMS's framework for establishing a discharge planning process that focuses on the patient's goals and preferences and prepares patients to be active partners in post-discharge care. This includes, for example, developing discharge plans with the patient's input, discussing the evaluation results with the patient, informing him or her of the final plan, taking his or her preferences and needs into account when arranging post-acute care, and more.

We believe that providers will be successful in engaging most patients and incorporating their preferences into a discharge plan. In the final rule, however, we urge CMS to provide clarification about how the agency will expect hospitals and CAHs to demonstrate the incorporation of the patient's goals and wishes into the plan. In addition, we ask CMS to address the fact that some patients may be reluctant to participate in the process for a variety of reasons. For example, sometimes a patient may leave against medical advice. In addition, many hospitals treat undocumented patients who may be guarded as to identity, residence and next of kin. Other times, patients may feel embarrassed to admit they need social services. In these situations, hospitals should try to work with patients as much as possible but should not be penalized if patients prefer more privacy or decline medical or discharge planning assistance. Hospitals must always provide safe care and also treat patients in a way that will not deter them from seeking needed care in the future.

TIMING OF DISCHARGE PLAN EVALUATION AND COMPLETION

CMS proposes that hospitals and CAHs must begin to identify discharge needs for patients within 24 hours after admission/registration. **We urge CMS to change this provision.** We agree that the discharge planning should occur in a timely manner and should be an ongoing process that occurs concurrently with, and not after, the provision of inpatient care. However, while this provision is well-intentioned, we do not support it for the following reasons:

- Some smaller hospitals, and especially CAHs, would have trouble meeting this requirement due to staff and resource limitations;
- The 24-hour timeframe does not make sense for patients with longer stays, such as long-term care hospital (LTCH) patients, whose average length of stay is 25 days, and inpatient rehabilitation facility (IRF) patients, who have an average length of stay of 13 days;
- Certain patients, such as solid organ transplant patients, burn patients or trauma patients, have long stays;

- Occasionally, it will be challenging for hospitals to begin discharge planning for certain patients who may arrive unconscious or confused when no caregiver or support person is present or patients whose diagnosis is not yet known; and
- For inpatient psychiatric patients, an interdisciplinary team meeting to coordinate the patient's care may take place soon after a patient is admitted. This team meeting could be the most ideal point in which to begin assessing discharge needs, but it may not take place within 24 hours.

The AHA recommends that CMS finalize the proposed language stating that the discharge planning process should be completed in a timely manner but strike the wording related to a universal 24-hour requirement. Instead, CMS could incorporate this timeframe as a strong expectation in the interpretive guidance and give providers, as well as CMS surveyors, the flexibility to use their best judgment as to what is necessary and practical in a particular case. For example, a hospital compliance survey could include a review of discharges to determine whether the planning process is generally initiated in a timely way or whether the provider's policies and procedures unduly delay patient discharges too often.

We urge CMS to make it easier to comply with this proposed standard by identifying some of the types of activities and information collection that would meet its intent. Specifically, CMS could provide examples in the final rule of efficient mechanisms to collect what it believes are the most relevant types of data. For example, CMS could explain how the identification of discharge needs could begin as part of an initial nursing assessment.

Finally, we ask CMS to clarify in the final rule that, while the discharge planning process must not *unduly* or *unnecessarily* delay a patient's discharge, sometimes the plan does reasonably postpone a patient's discharge. For example, hospitals and CAHs may need to keep a patient until a bed becomes available in another facility. In addition, an ED practitioner may ask for a discharge plan in accordance with proposed § 482.43(b)(4). The practitioner, however, may request the discharge plan at the conclusion of addressing the patient's medical needs, at which point the staff would need time to conduct an evaluation and create a plan. Further, emergency care may be provided in the middle of the night, when coordination with social service agencies may be difficult.

PARTICIPATION OF CAREGIVERS AND SUPPORT PERSONS

We agree with CMS's approach that a patient's caregiver or support person should be involved, as much as possible, with the consent of the patient. **We ask CMS to clarify in the final rule the following:**

- that caregivers and support persons should be involved, *as applicable*, but that CMS is not expecting that all patients will have caregivers and support persons;
- the extent of the involvement of patients and caregivers should be consistent with the patient's wishes and with the Health Insurance Portability and Accountability Act (HIPAA);

- how CMS expects hospitals to address situations in which a support person or caregiver is uncooperative. We believe that providers should always place the best interest of the patient first and should have the flexibility to draw appropriate boundaries in terms of another individuals' involvement, in the event it is necessary to do so; and
- how hospitals and CAHs should document the involvement of caregivers and support persons.

INVOLVEMENT OF THE PRACTITIONER RESPONSIBLE FOR THE CARE OF THE PATIENT

We ask for clarification regarding the definition of “the practitioner responsible for the care of the patient.” The rule states that the practitioner responsible for the care of the patient should be involved in the ongoing process of establishing the patient's goals and treatment preferences. In the case of an ED patient or an observation patient admitted through a hospitalist service, this provision may cause confusion. We ask CMS to clarify whether such practitioner will always be a hospital-based provider or whether he or she also could be the patient's personal physician.

For HHAs, CMS would require that the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan. **We ask CMS to clarify in the final rule that one way HHAs may demonstrate compliance with this provision is by documenting any outreach to the physician to coordinate his or her involvement.** The physician's level of involvement is ultimately up to the physician.

IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT

The proposed rule would require hospitals, CAHs and HHAs to assist patients (and others, such as families/caregivers/support persons/representatives) in selecting a post-acute provider by using and sharing relevant data that includes (but is not limited to) the quality and resource use measures for HHAs, skilled nursing facilities (SNFs), IRFs and LTCHs. As this provision is a new statutory requirement, in the final rule CMS should:

- **Clarify the exact data that hospitals (including children's hospitals), CAHs and HHAs will be expected to use; identify where these data will be available; and explain what additional data about post-acute care providers also may be furnished to patients (such as marketing materials).** CMS already has finalized numerous IMPACT Act quality measures for SNFs, IRFs, LTCHs and HHAs. However, we are unsure of whether data collection and public reporting for these measures will be complete by the discharge planning final rule's effective date. CMS should identify what data should be used in the interim.
- **Provide guidelines for discussions with patients as hospitals, CAHs and HHAs share the quality measure and resource use data.** Specifically, CMS should provide concise, consumer-friendly information on each measure and how performance of a particular measure should be used to evaluate whether a specific post-acute provider is appropriate

for a patient. Some patients may not understand the relevance of a Medicare Spending Per Beneficiary measure to their decision-making or how to consider the relevance of disparate measures that label different providers as high quality.

- **Provide clarification on how hospitals, CAHs and HHAs may assist patients in choosing a post-acute care provider without raising concerns about improperly steering patients to particular providers.** Our understanding of CMS's goal is to ensure that consumers have objective information to inform their choices of post-acute providers. Such information would include factors such as quality and resource use measure performance; the patient's goals, needs and treatment preferences; bed availability; and cost/insurance network status. We believe hospitals should be able to make recommendations to patients based on these factors, especially when the patient asks for the hospital's opinion.

In addition, hospitals, CAHs and HHAs also should be allowed to identify post-acute care providers with which they have agreements to facilitate care coordination between sites of service and promote better outcomes. Specifically, CMS should align its clarification in this area with CMS's final rule for the Comprehensive Care for Joint Replacement (CJR) bundled payment initiative. In that rule, the agency agreed that hospitals should be allowed to identify preferred providers and suppliers. In the discharge planning rule, too, hospitals, CAHs, and HHAs should be able to identify providers and suppliers who best contribute to improved efficiency and better outcomes, as long as the ultimate choice is left up to the patient and any financial dealings that could create a conflict of interest are disclosed to the patient.

DISCHARGE TO HOME

Discharge instructions. We agree that that discharge instructions should be provided to patients and/or caregiver/support persons, as well as any post-acute care provider, if the patient is referred to post-acute services. We also agree with the proposed content of the discharge instructions, if they are modified slightly, as illustrated above. Given the abundance of paperwork required at discharge, we seek ways to help our members reduce information overload for their patients.

Forwarding information to a follow-up care practitioner. If a follow-up care practitioner is known and identified, the rule would require a hospital/CAH to send: (1) a copy of the discharge instructions and summary within 48 hours of discharge; (2) pending test results within 24 hours of their availability; and (3) all other necessary information, as specified in the proposed section on transfers. **CMS should make several revisions to these proposed requirements.**

With regard to the requirement to provide a copy of the discharge instructions and discharge summary within 48 hours, CMS should provide flexibility to ensure the transmission of information is the most efficient and effective. If a follow-up care practitioner is known, hospitals and CAHs should be allowed to contact the follow-up practitioner within two business days to coordinate the transmission of the information. Otherwise, providers may need to send

the information via a less effective route (i.e., mail rather than fax or electronic means). In addition, contacting the next care provider alerts that provider that the information is forthcoming and reduces the chance that it will get lost prior to a follow-up appointment.

We believe that a requirement to send pending test results within 24 hours of their availability is too burdensome in some instances. Critical test results should be sent within 24-36 hours; other test results should be sent within 3-5 business days. For all results to be dictated and sent within 24 hours could be a significant burden on physicians.

POST-DISCHARGE FOLLOW-UP PROCESS

We agree that hospitals and CAHs should have the flexibility to decide the scope and mechanism of follow-up programs. In the rule, hospitals and CAHs would need to establish a post-discharge follow-up process for patients discharged to home, although CMS does not specify the mechanism or timing of follow-up programs. CMS would defer to hospitals and CAHs to determine how best to meet the needs of their patient populations. We agree with this approach. Hospitals and CAHs should have the flexibility to determine the mechanism, timing and scope of follow-up programs. However, we welcome the opportunity to work with CMS to identify various best practices that can be incorporated into the interpretive guidance as suggestions or examples of effective programs.

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

We believe a requirement for providers to consult PDMPs in the discharge planning or medication reconciliation processes would conflict with some state PDMP laws. CMS specifically asks for comments on: (1) whether providers, in evaluating patient discharge needs, should be required to consult with their state's PDMP to review a patient's risk of non-medical use of controlled substances and substance use disorders; and (2) whether PDMPs should be used in the medication reconciliation process.

According to the Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) associated with Brandeis University, 49 states plus Washington, D.C., and Guam have already established PDMPs. States are trying to make these programs more effective and efficient, such as implementing memorandums of understanding to share information across state lines and exploring ways to refresh the data in a timelier manner. We understand CMS's desire to capitalize on a resource that has the potential to better inform the discharge planning process for some patients. However, the state PDMP statutes were not enacted primarily to assist in discharge planning and thus have not been designed with that function in mind. For example:

- States restrict the purpose for which the information can be used, as well as how it can be shared. One state pharmacy board told us that it would be impermissible to use the PDMP data for discharge planning purposes, or for prescribers or pharmacists to share the data with others, such as social workers. In fact, many state laws or regulations include

confidentiality provisions. Further, the PDMP report cannot be included in the patient's chart, according to this board, based upon privacy regulations at 42 CFR Part 2.

- States restrict who may register and access these databases. In the hospital setting, prescribers are typically allowed to register to access the PDMP for patients they treat. Thus, the prescribing practitioner, or possibly a pharmacist (though some states restrict how a pharmacist can use the data), would need to check the state PDMP for every applicable patient designated under the discharge planning rules, *including those who are not prescribed controlled substances*. We believe such a requirement would be very burdensome and unnecessary in many cases.
- Although many states allow for the use of a “prescriber delegate” who may check the PDMP in lieu of a prescriber, delegates also must register. If CMS expands the number of patients for whom PDMP data would need to be retrieved, it would seem optimal for hospitals to standardize that data retrieval as a staff or registered nurse (RN) function. However, delegates typically must be a specific, pre-registered person associated with the prescriber and his or her Drug Enforcement Administration (DEA) registration number. Thus, a hospital prescriber and delegate's schedules would always need to be aligned for this type of standardization to work. Further, the delegate might need to be an employee of the prescriber. Very few states allow use of a hospital's DEA registration number to check the PDMP, according to the PDMP TTAC.

As CMS finalizes the proposed rule, the agency should examine the various state PDMP law limitations, as well as any potential restrictions of privacy regulations such as 42 CFR to ensure the final standards are legally permissible.

COST ESTIMATES

The AHA agrees that hospitals and CAHs should have strong patient safety standards that are consistent across the country. However, the cost of implementing new and more robust standards may be difficult for some providers to bear. **Nearly a third of all community hospitals have negative operating margins. In addition, although CAHs may receive cost-based reimbursement from Medicare, nearly 40 percent of CAHs reported a negative operating margin in 2013, according to the AHA Annual Survey.**

The rule anticipates that the per-facility cost of the rule will be \$22,000 annually for hospitals, and \$6,400 for CAHs. However, these figures greatly underestimate the cost of implementation. A key area of cost relates to staff. The proposed rule would require hospitals and CAHs to hire additional staff, including clerical staff, social workers, and RNs, to accommodate the increased number of discharge plans required. Some hospitals have told us that they would need to double their staff of discharge plan coordinators in order to meet the rule's proposed requirements, including one hospital that anticipates it will need to hire about 15 additional people. Another hospital anticipates hiring a discharge planning coordinator at a cost of \$60,000 annually. We are

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particularly concerned about the additional staff requirements for CAHs, which currently may not have social workers on duty every day of the week.

In addition to the need to hire additional staff, hospitals and CAHs also would need to implement changes to EHRs to build in the needed elements of the initial assessment, incorporate the elements of the evaluation and the transfer criteria, and possibly align the records with a modified clinician workflow. Further, hospitals and CAHs will need to ensure that EHR vendors will be able to make needed changes before the effective date of the final rule. The rule also does not take into account the labor, training and workflow changes that will be required to implement the discharge-related provisions of the IMPACT Act.

DEVELOPMENT OF INTERPRETIVE GUIDANCE

We urge CMS to use an open and transparent process for developing the interpretive guidance for the finalized regulations. CMS could, for example, post the draft guidance electronically for a period of 30 to 60 days and provide an email address for stakeholders to offer comments. We appreciate the fact that CMS provides flexibility with regard to many of the proposed standards and believe that interpretive guidance will be important in terms of defining adequate compliance with those requirements.

Thank you again for the opportunity to comment. If you have any questions, please contact me or Evelyn Knolle, senior associate director of policy, at eknolle@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Table 1: Information Supporting Patient Transfers and Meaningful Use Measures

Proposed Rule; Information Included in Support of Transfers	Meaningful Use Stage 2 Requirement	2014 Edition Certification Criteria
Hospitals and CAHs, when transferring patients, would be required to provide specific medical information to the receiving facility. CMS does not propose a specific form, format or methodology for this communication, but does specify 21 specifically required elements	Objective: Health Information Exchange. Measure: The EH or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals. To satisfy the required information in the summary of care record, CMS requires EHs and CAHs to use the Common Meaningful Use Data Set defined by ONC in the final 2014 Edition certification criteria rule.	Transitions of Care: the ability to receive, display and incorporate transition of care/referral summaries, and the ability to create and transmit transition of care/referral summaries. §170.202(a), 170.205(a)
Specifically required data elements	Data elements required in Stage 2 Meaningful Use Health Information Exchange Objective	2014 Edition EHR functionality that supports Stage 2 requirements
Name, sex, date of birth, race, ethnicity and preferred language	Included in summary of care record supporting transitions of care.	Included in Base EHR capabilities and Common Meaningful Use Data Set §170.207(f) and (g)
Contact information for practitioner responsible for the care of the patient and the patient's caregiver(s)/support person(s)		
Advance directive	[menu option in original Stage 2]	Optional certification criteria to record whether a patient has an advance directive
Course of illness/treatment	[menu option in original Stage 2 to record electronic notes in patient record]	Optional certification criteria to enable a provider to electronically record, change access and search electronic notes]
Procedures	Procedures are included in the summary of care record supporting transitions of care	Included in the Common Meaningful Use Data Set §170.207 (a)(3) or (b)(2)
Diagnoses	Encounter diagnosis is included in the summary of care record supporting transitions of care	Included in Common Meaningful Use Data Set §170.207(i) or §170.207(a)(3)
Laboratory tests and the results of pertinent laboratory and other diagnostic testing	Laboratory test(s) are included in the summary of care record supporting transitions of care	Included in the Common Meaningful Use Data Set. §170.207(c)(2)
Consultation results		

Proposed Rule; Information Included in Support of Transfers	Meaningful Use Stage 2 Requirement	2014 Edition Certification Criteria
Functional status assessment		
Psychosocial assessment, including cognitive status		
Social supports		
Behavioral health issues		
Reconciliation of all discharge medications with the patient's prehospital admission/registration medications (both prescribed and over the counter)	Medication Reconciliation is a Stage 2 objective: eligible hospitals or CAH that receive a patient from another setting of care or provider or believes an encounter is relevant performs medication reconciliation	Included in the summary of care record §170.207(d)(2)
All known allergies, including medication allergies	Medication allergies are included in the summary of care record supporting transitions of care.	Patient's active medication allergy list is included in the summary of care record. §170.207(d)(2)
Immunizations	Immunization data expressly included where applicable to accompany the summary of care record in support of transitions of care	Standard supporting the inclusion of immunization data in the summary of care record §170.207(e)(2)
Smoking status	Smoking status included in the summary of care record in support of transitions of care	Included in the Common Meaningful Use Data Set. §170.207(h)
Vital signs	Vital signs included in the summary of care record in support of transitions of care	Included in the Common Meaningful Use Data Set
Unique device identifier(s) for patient's implantable device(s), if any	N/A	N/A
All special instructions or precautions for ongoing care, as appropriate		
Patient's goals and treatment preferences		
All other necessary information, including a copy of the patient's discharge instructions, the discharge summary and any other documentation as applicable, to ensure a safe and effective transition of care that supports the post- discharge goals for the patient.		