



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 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

Dear Acting Administrator Slavitt:

Serving Seniors opened its doors in 1970 to serve meals to low income senior adults of San Diego. By the 1980's, we recognized that many critical needs were not being addressed by other community agencies, and thus began providing outreach, transportation, case management, and referral services to our clients in an effort to remove obstacles to independent living. This responsiveness functioned as an early template for our current service model, which was designed to provide a full spectrum of services to meet the wellness needs particular to low-income seniors. Our Homeless Prevention Program, which finds permanent, affordable housing for homeless seniors, was added to our service offerings in 2002. This was complimented by the 2003 opening of our first affordable housing unit, the Potiker Family Senior Residence, followed in 2007 by the Potiker City Heights Residence.

The Gary and Mary West Senior Wellness Center was unveiled to the community in 2010 as an innovative, integrated solution to promoting independence and healthy living for seniors, and remains today as the cornerstone of our organization. Through the Wellness Center, we are able to offer daily hot meals, access to on-site health professionals including oral health, social services management, community activities, and classes. The unique center was over-built with the specific purpose of allowing ample space for our collaborative partners to provide their services on-site in an effort to expand and strengthen our multi-disciplinary approach to senior wellness.

In 2014, our name was officially changed from Senior Community Centers to Serving Seniors in order to more accurately reflect the mission and scope of our work, which now extends

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into advocacy for public policy that will be beneficial to the low-income elderly population. Today, our pioneering model for mission delivery services allows us to reach 5,000 people annually, making us the leading provider of services to high-risk seniors living in San Diego.

We are deeply appreciative of CMS' strong recognition of the importance of community-based services, and how not having a thorough understanding of available community services can impact the discharge planning process. We firmly agree with CMS that, *"The lack of consistent collaboration and teamwork among health care facilities, patients, their families, and relevant community organizations may negatively impact selection of the best type of patient placement, leading to less than ideal patient outcomes and unnecessary re-hospitalizations."*

It is for these reasons Serving Seniors is pleased to provide comment on CMS' proposed revisions to the discharge planning requirements that hospitals must meet in order to participate in the Medicare and Medicaid programs.

Design (Proposed § 482.43(a))

CMS proposes to establish a new standard, "Design", and would require that hospital medical staff, nursing leadership, and other pertinent services provide input in the development of the discharge planning process. CMS also proposes to require that the discharge planning process be specified in writing and be reviewed (initially and periodically) and approved by the hospital's governing body.

Generally, Serving Seniors supports this proposal. However, we are concerned that community-based organizations, despite their increasingly important role in assisting patients being discharged to the community, have not been specifically identified as a key participant in providing input into the development of the discharge planning process. In the proposed rule, CMS emphasizes the value of "consistent collaboration and teamwork among health care facilities, patients, their families, and relevant community organizations" in facilitating assuring successful patient outcomes and reducing unnecessary re-hospitalizations. If involved in the design phase, community-based organizations can help the hospital develop a discharge planning process that would quickly identify patients who are mostly likely to need assistance from community-based organizations and streamline the process for this transition upon discharge. Therefore, **we urge CMS to specify that community-based organizations be among the required stakeholders that the hospital consults when developing its discharge planning processes.**

Applicability (Proposed § 482.43(b))

At proposed § 482.43(b), "Applicability," CMS proposes to require that many types of patients be evaluated for post discharge needs including, but not limited to patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, emergency department patients who have been identified by a practitioner as needing a discharge plan, and any other category of outpatient as recommended by the medical staff, approved by the governing body and specified in the hospital's discharge planning policies and procedures.

We support this proposal, but again **urge CMS to specify that community-based organizations be among the required stakeholders that the hospital consults when developing its discharge planning processes.**

Discharge Planning Process (Proposed § 482.43(c))

Among other things, CMS proposes to re-designate § 482.43(b)(4) as § 482.43(c)(5) to require, that as part of identifying the patient's discharge needs, the hospital consider the availability of caregivers and community-based care for each patient, whether through self-care, follow-up care from a community-based providers, care from a caregiver/support person(s), care from post-acute health care facilities or, in the case of a patient admitted from a long-term care or other residential care facility, care in that setting. CMS further proposes that hospitals consider the availability of and access to non-health care services for patients, which may include home and physical environment modifications including assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients. These services may not be traditional health care services, but they may be essential to the patient's ongoing care post-discharge and ability to live in the community. Hospitals should be able to provide additional information on non-health care resources and social services to patients and their caregiver/support person(s) and they should be knowledgeable about the availability of these resources in their community, when applicable. In addition, CMS encourages hospitals to consider the availability of supportive housing, as an alternative to homeless shelters that can facilitate continuity of care for patients in need of housing.

We strongly support this proposal, and believe this further supports our recommendation that community-based organizations are engaged in the design of the discharge planning process. Early engagement of community-based organizations is key for patients with complex needs that extend beyond the traditional healthcare delivery system. We are eager to engage in the process in order to facilitate safe and appropriate transitions for the most complex patients from the hospital, emergency department or any other healthcare setting, as needed.

In addition, we **urge CMS to develop a quality measure for use in its current and future quality improvement programs (e.g., hospital outpatient quality reporting program (OQR), the Physician Quality Reporting System (PQRS) and future programs under the Medicare Access and CHIP Reauthorization Act (MACRA) programs (i.e. the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs))** that would take into consideration whether healthcare entities covered by these new requirements consulted with community-based organizations in developing the discharge plan for patients who were identified as needed community-based services. This recommendation is in follow-up to an earlier recommendation we made to CMS previously as part of our MACRA Request for Information (RFI) comments where we urged CMS to use clinical practice improvement activities under MIPS and the establishment of APMs as an opportunity to improve access to and coordination with community-based services and long-term services and supports (LTSS).

Discharge to Home (Proposed § 482.43(d))

CMS proposes to re-designate and revise the current requirement at § 482.43(c)(5) as § 482.43(d), "Discharge to home," to require that the discharge plan include, but not be limited to, discharge instructions for patients described in proposed § 482.43(b) in order to better prepare them for managing their health post-discharge. The phrase "patients discharged to home" would include those patients returning to the community if they do not have a residence, who require follow-up with their primary care provider (PCP) or a specialist; HHAs; hospice services; or any other type of outpatient health care service. CMS also proposes a new § 482.43(d)(4) to require, for patients discharged to home, that the hospital must establish a post-discharge follow-up process.

We support the proposal, but again, **we urge CMS to consider our aforementioned recommendations in order to facilitate more seamless transitions for patients with complex needs that extend beyond the traditional healthcare delivery system.**

Community-based organizations want to be engaged in the discharge planning process from the time the patient arrives at the hospital or healthcare facility and is identified as having complex healthcare and socio-economic needs. We believe we can assist hospitals and other facilitates for whom these requirements apply in designing a discharge planning process that would more quickly identify patients who will need community-based services upon discharge and begin coordinating these services in conjunction with hospital staff immediately following the patients arrival and triage at the hospital or other healthcare facility.

Further, we believe it is critical to hold healthcare providers accountable for including community-based organizations as part of the discharge planning process and would encourage CMS to fund the development of quality measures that would consider whether hospitals and other healthcare providers engaged with community-based organizations to facilitate the discharge of certain categories of patients to the community and/or for LTSS.

We welcome the opportunity to work with CMS to remove the barriers to successful aging to improve the lives of our nation's seniors. Medical care can no longer be viewed in a silo if we want to achieve the goal of enabling seniors to live in their own home for as long as they wish. The opportunity to create a better care delivery system is now. We appreciate the opportunity to provide comments on the aforementioned issues of importance to our members. Should you have any questions, please contact me.

Sincerely,



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