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Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**RE: CMS-3317-P: Revisions to Requirements for Discharge Planning for Hospitals,
Critical Access Hospitals and Home Health Agencies**

Dear Mr. Slavitt:

The American Association for Respiratory Care (AARC) appreciates the opportunity to comment on CMS' proposed rule to revise the discharge planning requirements at §482.43 of the Code of Federal Regulations that hospitals must meet as part of the Conditions of Participation (COPs). The AARC is a national professional organization with a membership of 50,000 respiratory therapists (RTs) who treat patients with chronic lung disease in all care settings and whose organizational activities impact over 170,000 practicing respiratory therapists across the country.

The revisions will implement provisions of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT). The IMPACT Act directs the Secretary to modify COPs and interpretive guidelines to require post-acute care providers, hospitals and critical access hospitals to take into account the patient's care goals and treatment options as part of the discharge planning process. Post-acute care providers are defined as home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals and long-term care hospitals. Further, the IMPACT Act requires use of quality measures that include standardized patient assessments and resource use data to inform the discharge plan.

We offer the following comments on specific revisions to the discharge planning requirements as well as recommendations to address some of our general concerns:

1. Design (Proposed §482.43(a))

According to CMS, the proposed changes will strengthen the current discharge planning identification process by providing more specific requirements to hospitals on what actions they must take prior to the patient's discharge or transfer to a post-acute care setting. One change would be to add a new "Design" standard that would require discharge planning process policies and procedures 1) be in writing, 2) developed with input from the "hospital's medical staff, nursing leadership, as well as other pertinent departments", and 3) reviewed and approved by the hospital's governing body.

AARC strongly supports the inclusion of the hospital's Respiratory Care Department in coordinating the post-acute care needs of its pulmonary patients. It is imperative that patients who have chronic lung disease be evaluated by respiratory therapists who are the only allied health professional educated and trained in all aspects of pulmonary medicine. Their expertise in assessing the needs of patients with COPD or other chronic conditions such as asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis, is critical to meeting CMS' goal to reduce preventable hospital readmissions once the patient is discharged.

In the last update to the Discharge Planning Interpretive Guidelines, we were encouraged by the addition of "Advisory Boxes" that reflect industry best practices. Of particular note is the following:

- A well designed discharge planning evaluation process uses a multidisciplinary team approach. Team members may include representatives from nursing, case management, social work, medical staff, pharmacy, physical therapy, occupational therapy, **respiratory therapy**, dietary, and other health care professionals involved with the patient's care. The team approach helps to ensure that all of the patient's post-discharge care needs are identified, so that they can be taken into consideration when developing the evaluation.

In conversations with some of our members, we are aware that hospitals have been slow to adapt the "multi-disciplinary" team concept and hope that by revising the regulations to require that "other relevant departments" provide input into the discharge plan we will see significant changes in the future once the regulations are finalized, especially when it comes to the needs of those who suffer from chronic lung disease.

2. Applicability (Proposed §482.43(b))

This proposed section expands the types of patients that should be evaluated for post-discharge needs to include outpatients receiving observation services, outpatients undergoing surgery that requires anesthesia or moderate sedation, and certain emergency

department (ED) patients identified by the ED physician as benefiting from a discharge plan. We agree with CMS that certain patients in the ED may be in need of a discharge plan. For example, one of the underlying causes for hospital readmissions and ED visits among patients with chronic lung disease is an acute exacerbation due to asthma or Chronic Obstructive Pulmonary Disease (COPD). Their episode may be short-term that would not require an inpatient admission, or as CMS suggests, they may end up receiving observation services. Nonetheless, it may be determined that they would benefit from a discharge plan. Respiratory therapists working with the ED physicians could provide valuable input as to the needs of these patients once they are discharged and develop an action plan as part of the discharge planning process to prevent future exacerbations.

3. Discharge Planning Process (Proposed §482.43(c))

In carrying out the discharge planning process, CMS proposes that the hospital take into account various elements to ensure that the actual discharge plan when developed is patient-centered to reflect the individual patient's goals, preferences, strengths and post-discharge needs, including consideration of the patient's risk for readmission. Some of the noteworthy elements include the following:

- Coordination in the development of the discharge plan and evaluation by qualified personnel identified in hospital policy.
- Regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan;
- Assessment of the patient's ability to perform self-care, or the availability of care from a caregiver or support person; and,
- Involvement of the patient and caregiver/support person in development of the discharge plan and the requirement to inform them of the final plan in order to prepare for post-hospital care.

In assessing the patient's care goals, treatment preferences and post-acute care needs, it is important to stress that respiratory therapists need to be part of the team when it comes to re-evaluating patients with chronic lung disease, especially since these patients present with other debilitating chronic conditions. Equally important is the ability of respiratory therapists to assess the patient's need for self-care and to help patients with their treatment options as they relate to certain types of inhalers, stationary oxygen systems and portable oxygen concentrators, noninvasive home mechanical ventilation or use of respiratory assist devices. For patients with chronic lung disease, their use and understanding of complex respiratory equipment is critical to their well-being and quality of life.

Respiratory therapists are the experts in assessing the needs of pulmonary patients with respect to the complexities of such devices in order to minimize unnecessary, ineffective or wasteful interventions. Their expertise ensures that pulmonary patients receive the most appropriate respiratory equipment based on the individual's condition and needs. Therefore, it is vital that such assessment, especially if discharged to the home, is written into the discharge plan and that appropriate referrals to medical equipment suppliers are implemented prior to the patient's discharge in order to ensure there are no unnecessary delays in the patient's release or interruption in service.

4. Discharge to Home (Proposed §482.43(d))

This standard identifies elements the hospital must include in the discharge instructions if a patient is returning to their home or requires follow-up with their primary care physician, specialist or other outpatient post-acute care provider. These instructions must be given to the patient and/or the patient's caregiver/support person as well others as appropriate at the time of discharge and must include among other things: 1) instruction on post-hospital care to be used by the patient or caregiver/support person in the patient's home; 2) written information on the signs and symptoms that may indicate the need to seek immediate medical attention as well as what to do and who to contact if such signs/symptoms present; 3) medication information including potential risks and side effects; and 4) written instructions with pertinent contact information for practitioners involved in follow-up care as well as providers/suppliers to whom the patient has been referred for follow-up.

We support the requirement that the instructions must include information on "warning signs and symptoms" that may indicate the need to seek immediate medical attention. As noted earlier, pulmonary patients often present with acute exacerbations and the development of an action plan by respiratory therapists can go a long way to giving them the information they need to avoid an ED visit or readmission to the hospital. In fact, a one-year randomized controlled trial at five VA medical centers led by a respiratory therapist case manager implementing a simple disease management program reduced COPD-related hospitalizations and emergency department visits by 41%.¹ Another study² involved an in-home asthma disease management program delivered by respiratory therapists to patients previously admitted to the ED that significantly reduced hospitalizations post-discharge.

¹ Rice KL, et al. Disease management program for chronic obstructive pulmonary disease: a randomized controlled trial. *Am J Respir Crit Care Med* 2010 Oct 1;182(7):890-6. DOI: 10:1164/rccm200910-1579OC.

² Shelly DC, Legrand TS, Gardner DD, Peters JI. A randomized, controlled study to evaluate the role of an in-home asthma disease management program provided by respiratory therapists in improving outcomes and reducing the cost of care. *J Asthma*. 2009 Mar;46(2):194-201. doi: 10.1080/02770900802610068.

Self-management education and training taught by respiratory therapists also helps patients to recognize and reduce the symptoms and triggers of their chronic lung disease which can lead to reduced exacerbations and lower acute care costs. We have found that pulmonary patients who properly self-manage their chronic lung disease working with respiratory therapists can slow their disease progression and improve their health status. As part of the discharge planning process, hospitals would be well advised to include disease management services provided by respiratory therapists such as:

- Patient education on self-management of their disease;
- Direct observation and assessment of the patient's ability to self-administer aerosol medications;
- Training and education on the proper inhaler technique for use of aerosol medications with nebulizers, metered-dose inhalers, and dry-powdered inhalers;
- Collaboration with the physician or other qualified practitioner on the appropriate selection of aerosol medications;
- Smoking cessation counseling;
- Education and training on the appropriate dose of oxygen depending on the activity of the patient in order to self-manage the drug for those patients on long-term oxygen therapy;
- Developing an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms; and,
- Monitoring the disease management treatment plan to ensure patient compliance.

Proper device selection together with patient training and education by respiratory therapists on proper inhaler techniques and appropriate oxygen saturation levels can also improve medication adherence and oxygen utilization. Medication management and reconciliation is a critical element in the care of patients with chronic lung disease especially when their care involves long-term use of oxygen and inhaled medications. Moreover, because COPD has been added to the list of conditions subject to penalties for excessive readmissions, respiratory therapists have been developing best practices within their individual hospitals to reduce COPD readmissions which the AARC has compiled into a clearinghouse for use by our members.

For example, a "best practice" developed by respiratory therapists at the University of California, Davis includes a standard of care template for COPD acute exacerbation patients. Components of the plan include:

- Disease Pathophysiology
- Medication management
- Identification and Treatment of COPD acute exacerbations

- Breathing Retraining
- Risk Factor Reduction
- Improving Energy and Pacing Activity
- Oxygen Use

The best practice also includes collaboration with “Discharge Planning” to optimize the transition to home, development of a written action plan, and identification of “non-pharmacologic” therapies and tests that may be ordered at discharge such as:

- Pulmonary rehabilitation
- Post-bronchodilator spirometry
- Smoking cessation
- Influenza and pneumococcal vaccination

Although the proposed changes do not go into details about follow-up once the patient is discharged to the home, it is important to note that communicating with the patient should not end there. The Interpretive Guidelines set forth a best practice that requires among other things, a follow-up call within 24-72 hours by the hospital to the patient after discharge. A follow-up call by a respiratory therapist to their pulmonary patients is especially important because the patient is often overwhelmed by the complexities of the respiratory equipment they may have to use post-discharge. Furthermore, the patient will often have specific questions that only the respiratory therapist can answer because of their expertise.

General Concerns and Recommendations

While the proposed rule addresses certain requirements of the IMPACT Act , we believe there are a few areas where the current regulatory requirements go further to assure effective transitions between different providers and services than those outlined in the proposed rule. Some examples are discussed below.

Availability of Post-Acute Care Services

Current regulations at §482.43(b)(3) require not only the evaluation of the patient’s likelihood of needing post-hospital services but also the “availability of such services.” There is nothing in the proposed regulations or preamble that discusses the availability of services; rather, the only requirement is that medical information be provided to the provider/supplier at the time of discharge. In the Interpretive Guidelines, it is noted that long term care facilities often express concern that hospitals discharge patients to their facilities with care needs that exceed their care capabilities, necessitating sending the patient to the ED for care and possible readmission.

Recommendation: We encourage CMS to provide additional details in the final rule as to its intent to ensure that post-acute care transfers and referrals are available to meet the needs of the patient.

Recognition of Medical Equipment Suppliers

The Guidelines state that hospitals are expected to have knowledge of the capabilities and capacities of the various types of service providers in the area where most of the patients it serves receive post-hospital care, “in order to develop a discharge plan that not only meets the patient’s needs in theory, but also can be implemented.” According to the Guidelines, such health care services include, but are not limited to:

- Home health, attendant care, and other community-based services
- Hospice or palliative care
- **Respiratory therapy**
- Rehabilitation services (PT, OT, Speech, etc.)
- End State Renal Dialysis services
- Pharmaceuticals and related supplies
- Nutritional consultation/supplemental diets, and/or
- **Medical equipment and related supplies**

Since the IMPACT Act requirements focus primarily on post-acute care providers described in the beginning of our comments, we want to make sure that the patient’s need for medical equipment post-discharge and referrals to home medical equipment suppliers is not overlooked or marginalized in the proposed changes.

Recommendation: We suggest a minor change be made to §482.43(c)(5)(iii) by adding the bolded words in the bullet point below:

- Anticipated ongoing care needs post-discharge, **including the need for medical equipment and referrals to medical equipment suppliers.**

Arranging Post-acute Care Services Prior to Discharge

The current regulatory language in the discharge planning evaluation standard at §482.43(5) requires completion of the patient’s evaluation “on a timely basis so that appropriate arrangements for post-hospital care are made before (emphasis added) discharge, and to avoid unnecessary delays in discharge.” Although CMS proposes that the hospital begin to identify the patient’s anticipated discharge needs within 24 hours of admission or registration, there is no discussion in the preamble or regulatory text language that stresses the need to make arrangements with post-acute providers/suppliers prior to discharge even though it may be inferred.

Recommendation: We suggest that CMS clarify the intent in the final rule as to whether it expects arrangements with post-acute care providers to be made prior to discharge rather than leaving it up to the reader to make the assumption.

Patient and Caregiver/Support Person Education

In the preamble of the regulations, CMS notes that “inadequate patient education has led to poor outcomes...” As a result, CMS recommends that, as a best practice, hospitals should confirm that the patient or caregiver/support person understands the discharge instructions by using the “teach back” method. Unfortunately, there is nothing in the regulatory text to require this practice be followed. The Interpretive Guidelines are also noncommittal by stating, “CMS does not prescribe any specific methodologies, but examples include the teach-back, repeat-back approach and simulation laboratories.” While we understand the need for flexibility, it is equally important that patients and others know what is expected of them with respect to the discharge instructions and be able to repeat it back to the clinical specialist. This is especially critical given the complexities of the types of respiratory equipment pulmonary patients may be expected to use once they are discharged home.

Recommendation: To ensure that patients and/or those responsible for their care understand what is expected post-discharge, we recommend §482.43(d)(2)(ii) be revised to adding the bolded words in the bullet point below:

- Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient’s home, identified in the discharge plan, **including confirmation as to an understanding of the instructions.**

We appreciate the opportunity to provide comments. While we have some reservations as noted above, overall we support the changes CMS is recommending. When corresponding revisions to the Interpretive Guidelines are made, we encourage the continuation and inclusion of advisory boxes that promote industry best practices.

Sincerely,



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President