Public Comment Summary Report Posting

Project Title:

Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions.

1. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings
2. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings

Dates:

- The Call for Public Comment ran from November 10, 2016 to December 11, 2016.
- The Public Comment Summary Report was finalized on June 1, 2017

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop cross-setting post-acute care transfer of health information and care preferences quality measures in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The contract names are Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002). As part of its measure development process, CMS requested interested parties to submit comments on the candidate or concept measures that may be suitable for this project.

In alignment with the CMS and National Quality Strategy (NQS) objectives and goals, the purpose of this project, performed under the CMS contracts mentioned above, is to develop, maintain, re-evaluate, and implement measures reflective of quality care for PAC settings to support CMS quality missions, including the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), the Nursing Home (NH)/Skilled Nursing Facility Quality Reporting Program (SNF QRP), and the Home Health Quality Reporting Program (HH QRP). In addition, this project addresses the domains required by the IMPACT Act, which mandates specification of cross-setting quality, resource use, and other measures for post-acute care (PAC) providers.

Project Objectives:

To obtain input on the development of the following cross-setting quality measures for use in post-acute care settings, including Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies:

1. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings
2. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings

Information About the Comments Received:

- Web site used: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html
- Public comments were solicited using the following methods:
    - Posting on the CMS Public Comment website
    - Email notification to relevant stakeholders and stakeholder organizations
    - Email notification to the measures' Technical Expert Panel members
- Public comments were specifically solicited regarding the following topics:
    1. Completeness of the list of information types for the transfer of information between providers during transitions and if there are other types of information that should be included in this list or should not be included.
    2. Examples of the specific types of information and items to be collected within each of the information types listed. This feedback will help CMS develop guidance for the measures.
    3. Suitability of the list of information types for gathering data about important information provided to the patient/family/caregiver at discharge or transfer. Public comment was solicited as to whether the list includes the types of information most important to patients/families/caregivers when care from a PAC provider is ending and if there are other types of information that should be included or excluded from this list.
    4. Feedback on the Admission and Discharge measure exclusions.
    5. If the draft measure specifications capture the common routes of information transmission and whether these routes are clearly stated in a way that is understandable to provider staff in all PAC settings.
    6. Feasibility of data collection for these items.
    7. Potential impact and any unintended consequences of the measures (either positive or negative).
- CMS received 32 relevant comment letters. CMS received 19 letters that were considered out of scope.
    - Three comments were considered out of scope as they provided comment on topics other than quality measurement.
    - Two out of these three letters were referred to appropriate post-acute care help desks.
- In addition, CMS received 16 comments related to other quality measures that were not posted for solicitation of comment. Specifically, the comments were in opposition to the National Pressure Ulcer Advisory Panel's staging revisions and the change in nomenclature from "pressure ulcers" to "pressure injuries." These comments were received shortly after the public comment period had ended for the Percent of Residents with Pressure Ulcers that Are New or Worsened QM (NQF #0678). These comments are not relevant to development of the Transfer of Health Information and Care Preferences measure and, as such, are not included in this summary. Any terminology changes related to pressure ulcers will be addressed through the Percent of Residents with Pressure Ulcers that Are New or Worsened QM (NQF #0678) quality measure maintenance process.

Stakeholder Comments- General and Measure-Specific

This report provides a summary of public comments received and CMS' responses to the public comments. CMS would like to thank all commenters for sharing their comments, concerns, and suggestions. In general, we received considerable support for the concept of the transfer of health information and patient care preferences at admission and discharge. We appreciate feedback and concerns stated by commenters, and have provided responses and clarifications addressing these issues. At the end of this report, we provide a table containing the verbatim text of all public comments received.

There was some support for the measure concept as several commenters expressed that the transfer of patient health information and care preferences is critical to quality care and outcomes. However, commenters also expressed concern over the measures, including issues related to provider accountability, differences in measure calculation and populations across settings and the ability of the measures to distinguish providers in terms of quality. These concerns are detailed below. Several commenters noted the importance of the timely transfer of health information during transitions, and that the quality of the information transferred varies widely for multiple reasons. Four commenters provided their general support of the intent of these quality measures and expressed support for CMS' efforts to improve safety and coordination in care transitions and to improve the transfer of health information when patients transition across care settings. One commenter generally opposed the entire measure set, citing the lack of testing, insufficient data elements, issues of accountability, and concerns over additional burden. Additionally, nine commenters expressed concerns with the measure set in general, due to the added burden that additional data collection would pose to providers. One commenter encouraged future reliability and validity testing of the items, with time estimation questions added to the data collection to gauge provider burden. A majority of commenters encouraged additional clarification and guidance to support the items, including clearer definitions of successful and timely transfer. Furthermore, a majority of commenters also encouraged further refinement of the data elements, specifically seeking clarification about the categories of information to be transferred. In the next sections, specific comments and CMS' responses to these comments are summarized by theme.

1. PAC Accountability

Summary: Thirteen commenters expressed concern about the admission measure, stating that the receiving facility's/agency's performance on the quality measure should not be evaluated based on the receipt of information from the sending facility/agency due to the lack of control by the receiving provider. The majority of these thirteen commenters expressed concern that this measure places the burden on the receiving provider by making them accountable for the type of information sent by the previous provider. They expressed concern over the fact that they have little control over the information that is sent to them. Several commenters noted that PAC patients are often transferred from acute care hospitals, which are not incentivized to transfer health information, and the receiving PAC provider would be held accountable for any failure to transfer information by acute care hospitals. Four of these commenters encouraged CMS to not implement the PAC admission measure due to these concerns. As an alternative, some commenters encouraged CMS to incentivize hospitals to provide health information when transferring a patient to PAC settings in order to reduce burden on the receiving PAC provider. Three referred to including acute care hospitals in the measure, which we inferred to mean including acute care hospitals in the inpatient quality reporting program. One commenter recommended that the admission measure be used for benchmarking only, and that only the discharge measure be used as a quality measure.

Response: We believe that this process measure, with its emphasis on person-centered care and shared accountability, will encourage PAC providers to develop or maintain processes to ensure patient health information needed to provide quality patient care is available to staff. Having the needed information can be achieved through both active means of obtaining or getting the information or by passive means of receiving it directly from the sending/referring/discharging provider. We are aware of the difficulties involved in coordinating information exchange between acute and PAC settings and believe the admission measure will encourage stronger organizational relationships between these types of organizations. In addition, these measures are part of our pay for reporting program, therefore, PAC providers will not be penalized for not receiving information at admission, if that is the case. CMS will take the commenters' comments and concerns into consideration as we continue to develop the proposed admission measure.

2. Exclusion Criteria

Summary: Seven commenters requested that further consideration be given to the exclusion criteria for the measure set and made specific recommendations for exclusion criteria. One commenter encouraged aligning the exclusion criteria across the four PAC settings. Three commenters encouraged CMS to exclude patients with disrupted stays or service interruptions, such as unscheduled hospitalizations, emergency room visits, or observation stays, from this quality measure. Three commenters recommended excluding patients from the discharge measure who were discharged from the PAC setting due to an emergent admission/transfer to an acute care hospital. Furthermore, two commenters recommended that a different set of required information should be transferred in the event of an emergency or unplanned discharge than for a planned discharge. Another commenter specifically recommended that patients who are admitted to the PAC from home be excluded from the admission measure and that patients who leave against medical advice and patients who die be excluded from the discharge measure.

Response: We appreciate commenters' suggestions for additional exclusion criteria for the transfer of health information quality measures. In all settings, the admission measure currently excludes patients who were not under the care of another provider at the time of admission and the discharge measure excludes patients who expired. The measures, as specified, would not require additional data collection when stays are disrupted or interrupted. For home health agencies, the discharge measure also excludes patients when the agency was not made aware of the transfer in a timely manner (e.g., learned of transfer during a planned home visit) and, therefore, was unable to transfer health information. Except for this exclusion, which addresses circumstances unique to the home health setting, exclusion criteria are the same across settings. CMS will consider additional exclusions as we continue to refine these measures.

3. Different Measure Populations by Payer Source

Summary: We received seven comments related to the measure population. Five commenters expressed concern over the non-standardized populations across the four PAC settings and urged CMS to standardize the denominator for all four PAC settings. For example, one commenter specifically encouraged CMS to expand the SNF, LTCH, and IRF denominators to include Medicaid patients, noting that the home health measures include Medicaid patients. Another commenter urged that the SNF denominator include Medicare Advantage patients/residents in addition to Medicare Part A patients/residents.

Response: We appreciate the comments addressing the different measure populations by payer and will take these comments into consideration as we further develop these measures.

4. Criteria for Inclusion in the Numerator

Summary: Ten commenters provided input on what should constitute a qualifying transfer of information, as required by these quality measures. Seven commenters expressed concern over the minimum requirement for the provider to transfer at least one information type. Commenters expressed concern that these measures do not incentivize providers to transfer complete and accurate information required for the care of the patient/resident. Additionally, two commenters noted that the requirement for transferring a minimum of only one type of information fails the intent of these measures to assess care coordination and promote the transfer of complete and accurate health information. Additionally, two commenters expressed concern over the measure becoming “topped out” because providers only need to transfer one type of health information. Several commenters urged CMS to require more than one information type be transferred, and noted that these measures should focus on the quality of information exchanged, rather than the quantity. However, a few commenters indicated that they agreed with the technical expert panel (TEP) recommendation that the measures should “start simple” to permit the thoughtful development of more comprehensive measures. One commenter provided suggestions for other categories of information to be transferred for inclusion in the numerator.

Response: We thank commenters for their input regarding what constitutes a qualifying transfer of information and for the requirement for the transfer of at least one type of information. During measure development, our TEP recommended that these measures should “start simple” by capturing the transfer of at least one of the categories of information. Of note, this measure is intended to measure the process of information transfer. While we appreciate that the quality of the information transferred is important to planning and providing patient/resident care, this measure was not developed to assess the quality or accurateness of the information transferred. We believe assessing the process of information transfer will spur improvement of these processes.

5. Inability of Measures to Assess Provider Quality

Summary: Eight commenters mentioned their concerns that the measures are not indicative of provider quality. One commenter noted that the measures do not look specifically at the quality or quantity of the information being transferred. This commenter was concerned about the inferences that could be made between measure compliance and outcomes of care, especially since the transfer of information includes minimal data or may be missing critical information.

Response: We appreciate the comments received about the ability of these measures to differentiate providers in terms of quality and accurateness or completeness of the health information transferred. It is important to remember that these are process measures designed to address and improve an important aspect of care quality. Timely transfer of health information at transitions has been demonstrated to lead to improved quality of care, including reduced re-hospitalizations, lower Emergency Department visits, reduced adverse events, and fewer duplications of tests and procedures. In addition, public commenters and our TEP members identified many problems and gaps in the timely transfer of patient/resident health information at transitions. For example, some of our TEP members noted that discharge summaries are often not available to PAC providers until well after the transition occurs. These measures will capture the quality of the process of information transfer and, we believe, help to improve those processes.

6. Provider Burden

Summary: A majority of commenters noted the potential added burden to providers due to additional data collection. Four commenters encouraged a more concise format for data collection, including a separate assessment tool that might promote efficiency and standardization. Four commenters expressed concern over the duplication of the required items for these quality measures and existing pre-admission screening requirements. Specifically, one commenter noted that some of the types of information to be transferred as required by these measures are redundant with the requirements of CARF, Joint Commission requirements, and IRF pre-admission screening requirements. Two commenters echoed this concern and noted that HHA, IRF, and LTCH have structured pre-admission screening requirements that duplicate the admission quality measure. Additionally, one commenter spoke to the fact that the types of information to be transferred in these quality measures are redundant with assessment items that already exist in the assessment tools. A commenter felt that the various information categories proposed for the discharge measure are redundant and unnecessarily burdensome and that IRFs generally provide this information at discharge. In addition, a few commenters felt that the broad range of categories of information to be transferred will force providers to rely on an interdisciplinary team to collect the data for these quality measures, posing an added time burden.

Response: We appreciate the feedback from commenters concerned with additional burden that could be introduced with these new quality measures. CMS is sensitive to the issues of burden that could arise with new measures and will be mindful of factors of burden throughout the measure development process. It should be made clear that the admission measure does not require collection of assessment data in addition to that collected as part of pre-assessment screening, rather, it only collects new data regarding the patient/resident health information that was transferred at admission. There is no duplication of effort as this measure only assesses the patient/resident health information that PAC providers received or obtained at the time of admission. Also, while many providers may indeed already transfer this information at discharge, research indicates that lack of information transfer is a serious problem. This suggests that many providers do not transfer information. In addition, while this measure may be related to CARF and Joint Commission requirements, it does not duplicate them. Finally, while some providers may choose to develop a separate assessment tool to promote efficiency and standardization related to the transfer of health information and care preferences, CMS will not be providing or requiring such a tool. Pilot testing will explore these issues and report information related to provider resource use.

7. Needed Clarification/Guidance

Summary: Multiple comments regarding clarification and guidance were received. Three comments suggested that the questions in the measures were too vague. Of these three comments, two specifically targeted question two, indicating it would need extensive explanation, additional examples, and considerable guidance to be clearly understood by providers. Two commenters noted the items in the measures were too open for interpretation and there was considerable concern that interpretation of each domain would not be consistent from provider to provider and result in inconsistent measurement across providers. Additionally, several commenters sought further clarification on the timeframe requirements for the transfer of information.

Response: We thank the commenters for their input regarding requested clarification and guidance for these two measures. Thorough guidance for completing the data elements associated with these measures will be included in the coding guidance manuals for each provider setting. As is standard with all quality measures used in the quality reporting program (QRP) we will ensure that the guidance is applicable, usable and feasible for all stakeholders.

8. Specification of Measure Timeframes

Summary: Several commenters addressed the need for clarification of timeframe definitions including "admission," "start of care," "resumption of care," and "immediately prior to," and suggested providing timeframes during which the transfer of information should take place.

Response: We thank the commenters for their input regarding the specification of the timeframes included in these measures. As we continue to define and develop these measures, we will develop guidance that defines these terms and concept. This guidance will be included in the coding guidance manuals for each provider setting. Of note, these measures are developed to be collected at Admission and discharge.

9. Route of Information Transmission Data Collection Item

Summary: We received public comment regarding the inclusion of an item to assess the route by which information was transferred at patient/resident transition. Eight commenters provided feedback on this topic with two commenters supporting the inclusion of such an item, agreeing with its usefulness. These commenters noted that this would encourage interoperability and may promote the use of electronic standardized methods for data transfer. Six commenters did not support the inclusion of an item that assessed the route of data transfer, stating that burden and costs outweighed the benefits of capturing this information.

Response: We thank commenters for their input on this specific item. We would like to note that this measure does not require provider use of electronic means of information transfer.

10. Changes to Terminology

Summary**:** We received a number of comments requesting modifications to the existing measure terminology. For example, commenters requested that the term "primary physician" be used rather than "primary care physician", given that a patient's primary physician is often times not their primary care physician, especially in situations of a seriously or terminally ill patient. Additionally, a number of commenters requested that "family" be removed from the phrase, "the individual or family caregiver" in order to reflect that a patient's caregiver is not always a family member.

Response: We appreciate the comments received regarding changes to terminology and will consider additional changes to terminology as these measures are refined.

11. Types of Patient/Resident Information Transferred

Summary: The majority of comments spoke to the types of information to be transferred when an individual transitions between care settings. More than half of the commenters generally supported the list of information categories to be transferred when an individual transitions (i.e., verbatim categories posted in the public comment documents), but many commenters encouraged further refinement of these categories and provided examples for where the specific information may be located (e.g., that functional status may be found in rehabilitation notes). Several commenters made suggestions about how the different categories of information should be defined and/or what types of information should be included in each category (e.g. that functional information include both activities of daily living and mobility information). The many specific suggestions for refinements are included in the verbatim comments included in their entirety below. Some of the commenters encouraged the removal of certain items, but there was no universally agreed upon set of items to include. For example, several commenters stated that the “Administrative information” category should be reexamined, removed or narrowed, stating that it is redundant and will unnecessarily increase reporting costs.

We also received seven comments pertaining to the categories of information providers share with patients/residents and/or their caregivers at discharge. One commenter expressed that this question be removed from the discharge measure because requiring that information be transferred to the patient, family or caregiver could result in it being lost or misunderstood. Most of the comments requested that additional categories of information be included. However, there was no universally agreed upon set of items to include. The additional categories of information suggested can be found in the verbatim comments below.

Response: We appreciate the recommendations and explanations provided regarding suggested additional categories of information to include in these measures. A pilot held to test these measures will include quantitative analyses focusing on the frequency with which various categories are coded. It will also include collection of qualitative data relating to how and why pilot sites choose to select certain categories. CMS will keep these comments in mind as measure development progresses.

12. Measures Not Yet Tested for Reliability and Validity

Summary: One commenter noted that these measures have not been tested for reliability and validity and that, therefore, these measures should not yet be implemented by CMS.

Response: We appreciate the comments pertaining to testing and would like to note that these measures will undergo pilot testing starting in early 2017.

Preliminary Recommendations and Next Steps

Comments received pertaining to accountability, measure exclusions, as well as other aspects of the measure development will be taken into consideration as CMS continues to modify and test the measures that are under development. To the extent possible, we will also incorporate suggestions received during public comment on the implementation of these measures. CMS plans to test these measures in a small pilot in early 2017, with additional measure public comment periods to be held to solicit for comment in mid-2017.

Public Comment Verbatim Report

The following table lists the verbatim comments received during this public comment period. The table includes the quality measure(s) that the comments pertain to. In most cases, it could be determined that the comments applied to one or both of the transfer of health information and care preferences quality measures. For a small number of more general comments the table states “Cannot determine which specific measure(s) the comments apply to”. There have been no changes or edits to any comments received and listed in the table below. Comments received that were out of scope are separately listed at the end of the table.

ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
1.	11/10/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	I normally don't look over these things too carefully since my experience is that measures are constantly created and don't have a lot of influence in the real world. However, I was very curious about this one for several reasons. First, I didn't realize that this requirement was part of the LAW, not just the regs. Second, I tried to understand what the source of data to document provider to provider information transfer would be since there is no easy source of routinely available data. Third, I was curious about what kinds of members of the TEP would suggest what and how that might be expressed and whether that expression might find its way in the implicit recommendations in the report. I've gone through both documents available for download and come away with the following interpretation which may not be completely correct since the statements are not all that clear: • The numerator is the number of admissions that arrive from the hospital with "adequate" transfer of health and preferences information while the denominator is ALL admissions from hospital. • The data source for this numerator is not now available, so the MDS will be modified (the admission or the section with the GG disaster). • The two items are did the information arrive? and (If ANY did arrive, what type). There will ALWAYS be some information so the answer to the first question will virtually always be "yes" even if it arrives on the clipboard attached to the gurney!! • The discharge MDS will have to also be modified to accommodate the discharging (transferring) PAC setting to indicate that it sent health and preference information to the other provider with a likely separate set of items indicating that	Vincent Mor, Florence Grant Pirce Professor Department of Health Services, Policy & Practice Brown University School of Public Health	Vincent_Mor@brown.edu	Academic, Research

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			they'd offered them, handed them to faxed or emailed them to the patient/family. I have several objections to this entire set of measures: 1. hospitals are off the hook, just like they've been let off the hook of all the IMPACT measure compliance 2.IF, a measure is created for the receiving PAC entity it will NOT be able to be ascribed to a particular hospital since the MDS, IRF-PAI nor OASIS have a field to indicate WHICH hospital sent the patient. That would have to be added but with no system to identify and update the hospital provider number, etc. 3.The measure only has traction IF it can be cross walked to a particular hospital across ALL the PAC settings to which patients are sent. As a researcher, I'd love this data since from more real time MDS data we could calculate all manner of hospital specific rates for FFS and MA patients. But the mechanisms for doing this in the standard MDS or IRF-PAI structure is not now available. 4.If the first item is mostly going to be yes, the relative value of identifying what is missing and whether that is important or required or essential for care planning or continuation of the clinical care path from the hospital, etc. is far more complicated than the little check boxes now there. 5.The transfer issues for re-hospitalizations, ED visits and observation days (as well as even weekend passes at home) will be very vague and further complicate the discharge records that exist, each of which has a requirement now under IMPACT to have a separate discharge assessment.			

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			6.The transfer of the information to the patient is not going to yield anything actionable since patients/families may lose it, not understand it and the primary care physician of record is not likely to know what to do with the information in their own record keeping systems since the information will not be accommodated in the physicians' EMR and interoperability of PAC EMRs and primary care doc EMRs is the last thing on anyone's radar. In summary, I perfectly understand that this is a legal requirement now, but it is not workable in the current environment and the PAC providers are being made to comply simply because CMS can make them since they can't make hospitals do it. The cost of retrofitting the multiplicity of MDS and other EMR vendors in IRF PAI and SNF is HUGE for the industries; certainly not worth the value that paper compliance will yield. While CMS can readily alter its record layouts in the MDS and IRF-PAI repository and error checking models, the vendors have to deal with how the various screen shots can be added, the alerts for missingness and when a record can be filed with missing or updates allowable, not to speak of the massive training updates for admission assessment staff that are already overworked such that they'll take any data collection short cut necessary. I hate to be so negative, BUT, a day after the election I'm very sensitive to having to respond to some initiative in a way that is fundamentally Republican. But, in this case the more apt research dictum should apply, UNLESS YOU KNOW WHAT THE DATA ELEMENT WILL MEAN, HOW IT WILL BE USED, AND WHETHER THE DATA COLLECTOR HAS A REASON TO COLLECT IT PROPERLY --- DON'T ASK IT. But, that is not for you but for the staff that inserted language			

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			that is so horribly specific and unthinking in the IMPACT law.			
2.	11/16/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	1. Information exchange between SNF and Hospital/Hospital and SNF Completeness of the above list for the transfer of information between providers during transitions. Are there other types of information that should be included in this list? Are there types of information in this list that should not be included? I believe any information regarding emotional status – such as anxiety-inducing information, how the staff deals with it would be helpful as well as psychosocial status – any certain relationships to be aware of or wary of. Patient Care Preferences (e.g. Advanced Directives) and Goals of Care, to me are redundant unless there are changes (additions or deletions) to the Advanced Directive. I often do not see indications related to medications prescribed and this really needs to be delineated both ways. Kit Palmer, RN, WVH Restorative Coordinator, 360-895-4692	Kathryn Palmer, RN WVH Restorative Coordinator	mailto:KathrynP@DVA.WA.GOV	SNF
3.	11/21/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Comments are sought regarding: 1. Completeness of the above list for the transfer of information between providers during transitions. Are there other types of information that should be included in this list? Are there types of information in this list that should not be included? Add to the list of information Allergies and include the information on healthcare power of attorney. 2.Examples of the specific types of information and items to be collected within each of the types included in Questions 2 and 5, and listed above. For example, one might expect that the type of	John Sheridan Vice President, Enterprise Business Development	mailto:John.Sheridan@ABILITYNetwork.com	Health Information Technology

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			information that would be received and coded as ‘functional status’ would include if the patient was ambulatory or uses a wheelchair. For medication information, what types of information would providers expect to be included in this category? What types of patient preferences would be transferred during care transitions? This feedback will help CMS develop guidance for the measures. ON functional Status – SNFs and other Post-Acute settings measure the ADLs. Is it time the hospitals measure ADLs on admission and discharge? This information will help care givers know why the wheelchair or other assistive devices like Walker or Cane are used. For Medication – the list of active medications and discontinued medications for the past 90 days is the standard for the Continuity of Care Document. This standard that includes, Medication, dose, frequency and comments regarding patient tolerance of the medication can help care givers know if the medication is needed and useful. Types of patient preference – this measure needs offset by the patient cognition and ability to provide a useful preference. If the Mini-Mental or BIMS score shows impairment, guidance on how to respect preference when respecting preference is not safe is most appropriate. Preference might include faith, food, discharge status, gender, and activities. 3.Suitability of the above list (used also in Question 5) for gathering data about important information provided to the patient/family/caregiver at discharge or transfer. Does this list include the types of information most important to patients/families/caregivers when care from a PAC provider is ending? Are there other types of information that should be included in this list? Are			

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			there types of information in this list that should not be included? Gathering data that is most important is the economic status of the patient. What can the patient afford? Is the payer Medicare, Medicaid or other? Opportunity for freedom of preference might be influenced by the resources available to be expended to meet preferences. 4.Admission and Discharge measure exclusions Coma – Ventilator – presence of contagion or infectious disease 5.If the draft measure specifications capture the common routes of information transmission and are these routes clearly stated in a way that is understandable to providers in all PAC settings To protect HIPAA the measure should specify not an email, rather forms of Cross Community Access (XCA) or Cross Enterprise Document Sharing (XDS) – I have supervised connectivity to networks in various geography – Midwest, west and East and found the pressure to share paper or pdf documents such that the documents are not well used. Integrated electronic documents produce meta data every time the document is read. I suggest a measure on the common routes of information include a technical measure of how often the exchanged documents are read, referred to and used. 6.Feasibility of data collection for these items The CCD in the CDA (R2) format contains all but the frequency of document being read or used. Disclosure accounting from HIPAA - namely the logs on how often the document is opened on the screen and for how long it is open collects the data on document use.			

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			7.Potential impact and any unintended consequences of the measures (either positive or negative) This document will save paper, can be adapted in information technology to include special care summary information to better inform care givers.			
4.	11/21/2016	Cannot determine which specific measure(s) the comments apply to	Thank you for the opportunity to submit comments on the "Transfer of Health Information and Care Preferences When an Individual Transitions" proposed measure. I am submitting my comments solely based on my personal opinion and 17 years' experience as a home health nurse and agency director. This measure would certainly streamline the transfer of pertinent information across care settings, and in some cases will allow the receiving agency the opportunity to see that certain patients may not be appropriately suited for their services. I can personally attest to the problems that arise and the jeopardy patients can face when their care is referred to an agency that accepts assignment based on vague, incomplete and sometimes intentionally misleading information from the referral source. I am concerned about the method of data collection. I believe this data could be summarized on one form and transferred between the different providers caring for a patient. My home health agency is inundated with paperwork, face to face encounter documents, OASIS collection, emergency preparedness education (just recently made much more intensive than what we were already doing), and VBP. Pair this with the constant fear that our best efforts will not be good enough when the next RAC attack occurs, or F2F, or survey, or whatever comes out of CMS' cannon next for home health agencies, and the result is an overburdened field that is losing dedicated staff. We are TIRED. Exhausted. We love our patients. We take darn good care of	Sharon Tatum, RN BSN	mailto:statum@chal.org	HHA

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			them. We serve in a unique role that allows physicians a bird's eye view into the center of their patient's lives. Doctors have no idea how their patients live, what their environmental barriers are, why they have difficulty meeting goals or improving their patient's health, etc. Some of these patients are homeless. Some live with no running water or electricity. WE are the ones who identify and address those issues. And because we do these things, giving us yet another list of things to do, or more paperwork to complete, equates to the proverbial straw for the camel's back. I agree with this proposal, but please do not make it overly burdensome. My little agency only has two full time RNs and one LPN. I can't lose any more staff because the paperwork/documentation burden is too great.			
5.	11/25/2016	Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings Comments may also apply to the Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings	Below are comments related to the categories being considered for this initiative relative to Skilled Nursing/PAC Providers: 1.Functional status- Comment: Agree this is an important measure to help beneficiaries, consumers and providers evaluate and benchmark functional improvements across a larger database. What risk adjustment factors will be used? It is foreseeable there will be instances that functional status gains are not achieved as desired and are not related to the inability of the PAC Provider to deliver the necessary care. Further, there are times when a patient/responsible party's expected outcomes exceed the realistic possible outcomes. Thus, there is risk to the PAC that if an overestimated outcome is projected at the start of care that the PAC may be "penalized" through the reporting metric at end of the reporting period for the patient despite the PAC providing sufficient and quality care to the patient.	Chris Casteel Managing Direct of Health Operations	mailto:CCasteel@watermarkcommunities.com	Senior Living

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			2.Cognitive function and mental status- Comment: This area is questionable as to the benefit of reporting unless it is focused on acute changes affecting cognitive status functioning in cases of temporary delirium. Chronic or long term memory impairment for a patient is unlikely to significantly improve during a PAC treatment period thus reporting on acute changes and chronic long term impairments in one metric would seem to skew the data so as to not have relevant information. However, reporting on functional status maintenance, improvement or decline for a chronically memory impaired patient could hold value in demonstrating a PAC Provider's commitment in mitigating continual decline but also keeping in mind that in some instances decline will not be preventable. Understanding what risk adjustments would be applied to have meaningful data would be helpful to further comment on the benefit of reporting on this metric. 3.Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use)- Comment- Given the lack of ventilator equipped providers and that very few have the ability to infuse blood products this metric seems to present lesser value when considering a metric to be used in the PAC setting. What exactly would the measure seek to report on relative to dialysis use and the care generally provided in a PAC setting that does not have dialysis beds but rather primarily only transportation to/from dialysis and performs shunt access site care? I do see value in identifying the amount of IV fluids administered in a PAC setting as this seems to generally be an underutilized clinical capability and one that could further reduce rehospitalizations.			

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			4.Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain) - Comment: Provided this area is limited to conditions such as pain and pressure injuries/skin status I believe this is a metric that holds value for reporting. Will risk adjust for these categories follow the current methodology used for Quality Measures as with Pressure Injuries and Pain statues as they are now or will a different set of risk adjustments be applied? 5.Impairments (e.g., incontinence, sensory) - Comment: long term incontinence and sensory impairments in the elderly often show little to no improvement unless there was a proximal acute condition which created the impairment. In many chronic long term cases it is often unlikely that measurable improvement would realistically be achieved. Thus, I believe the focus on functional status as with # 1 above would be a more reliable and apt measurement for reporting in the PAC setting unless the measure risk adjusts out patients from the sample that are identified as having chronic long term conditions and that despite current or previous medical treatment have not shown improvement. 6.Medication information- Comment- Is not clear what this measure in of itself will report on to understand the benefits of such a category. Prescriber preference in various geographies for an array of conditions can vary greatly and as such may not be a truly controllable metric the PAC provider is able to impact. If the measure is simply to assess the patient's and/or responsible party's understanding of the medications as an education measure only I do see benefit in reporting that type of information. 7.Patient care preferences (e.g., advance directives) Comment- Other than statistically understanding the			

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			number of patients receiving a care from a PAC I don't see the relative value of having this a reporting metric. 8.Goals of care- Comment- I believe if kept limited to functional status, pain, pressure injury/skin status etc., and such metrics would provide value for comparison in reporting provided applicable risk adjustment measures are applied. 9.Diet/nutrition- Comment- What reporting would be provided beyond the current Quality Measure of displaying percent of patients that lose too much weight? When including "nutrition", is CMS looking to report on more information such as diet types for patients for correlations of weight gain/(loss)? 10.Administrative information- Comment- Further information needed to understand exactly what would be captured for this reporting metric. 11.Discharge instructions- Comment- Provided the measure is focused on the patient/responsible party being able to report on their comfort with and/or perceived ability to understand the needs of the patient upon discharge I do think reporting on this metric has value. Thank you for the opportunity to provide comment/question on this initiative.			
6.	11/25/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care	Below are some comments to consider for this initiative, with regard to Skilled Nursing Facilities accepting patients from the hospital setting or other PAC settings: Behavioral information should be included. Often a patient with challenging, even potentially dangerous behaviors, can be difficult to discharge, due to lack of accepting facilities willing or able to care for	Adam Zanger Healthcare Consultant/Licensed Nursing Home Administrator	zanger_51@yahoo.com	SNF

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		to Other Providers/Settings	someone with those behaviors. It is not uncommon for the behaviors to not be reported, in order to more easily find an accepting facility. This causes significant issues for the accepting facility, often resulting in readmission to the hospital, based on their lack of ability to care for the person and their behaviors. Any information about restraints or one-to-one sitters used while in the discharging facility should be shared to better inform the accepting facility of the true picture of that resident and avoid an un-necessary re-hospitalization. Advanced Directives is another item that needs to be collected and shared. It is common for the discharging facility to have no information or outdated information about orders for life sustaining treatment. This could potentially be listed under the "Administrative Information" section that is proposed. It should be necessary to share history on attempts made to collect this information, results from those attempts and when those attempts took place, if no POLST or DNR form has been completed and sent upon discharge. If the accepting facility is expected to make this determination, it often takes time and doubles the work that has already been done. If the patient cannot make this decision for themselves, family must be involved. If they are not, the accepting facility will have no choice but to leave this person as a "full code", meaning more hospitalizations for treatment that may not be needed or wanted. If there is no family and a "surrogate" needs to be named, a physician must be involved. It is much easier to get that physician involvement at a hospital as opposed to a LTC facility. Please feel free to contact me if any further assistance or clarification is needed.			

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7.	11/26/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Transfer information should include social factors that affect the patient's ability to have positive outcomes in a PAC setting. Would CMS consider collecting information about whether the patient has an able and willing caregiver, transportation available, follow up appointment with PCP, health literacy, medication reconciliation and understanding, diet, environmental safety, and self-management of disease?	Terry Altpeter, PhD, EJD, RN, CPHQ, PCC Executive Director Quality	Terry.altpeter@bhsi.com	IRF
8.	12/01/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	The list you provided is much needed however it needs to be sent in a concise format and not imbedded in 80 pages of information. Medication information needs to include medications taken at home and changes made in hospital /SNF. Hospital to SNF transfer - did they have services or support in prior level of care? If so who?	Fran Hughes	mailto:hughesf13@gmail.com	SNF
9.	12/06/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	**Project Title: Quality measures to satisfy the improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions** As President of the American Association for Respiratory Care, I am pleased to submit comments on the development of cross-cutting measures on the "Transfer of Health Information and Care Preferences When an Individual Transitions" to be used in post-acute care settings such as Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals (LTCH), and Home Health Agencies (HHA) as part of the implementation of the IMPACT Act. The AARC is a national professional organization with a	Anne Marie Hummel Director, Regulatory Affairs American Association for Respiratory Care	mailto:anneh@aarc.org	HHA, LTCH, IRF, SNF

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			membership of over 47,000 respiratory therapists who treat patients with chronic respiratory diseases such as asthma and Chronic Obstructive Pulmonary Disease (COPD) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country. CMS is seeking input on measure specifications involving the transfer of health information that encompass post-acute care admissions and readmissions to/from other providers or settings. These measures collect data on 11 types of information. CMS is particularly interested in completeness of the list, whether other items should be included in the transfer of information between providers during transitions, and the suitability of the list as it relates to important information provided to the patient/family/caregiver at discharge or transfer. The target population consists of all patients/residents admitted to a post-acute care provider from a hospital, critical access hospital, another post-acute care provider, or home and all patients/residents discharged from a post-acute care provider or whose care has ended. Of interest to the AARC are items dealing with functional status, special services, treatments and/or interventions, medication information and discharge information. Unless otherwise noted, our comments are general to all four post-acute care settings.[2] **Functional Status** According to examples provided by CMS, the type of information to be received and coded in this category is if the patient is ambulatory or uses a wheelchair. We agree that it is important to note if the patient can ambulate, but how well they can ambulate can be equally important. A patient’s need for oxygen and/or other complex respiratory			

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			equipment including aerosol delivery devices may have a significant impact on the patient's ability to ambulate, especially if the individual has severe hypoxemia and is at risk for an acute exacerbation. Patients with chronic respiratory disease often present with five or more co-morbidities and care for this population is complex. Because respiratory patients can be severely compromised by their chronic condition, a clinical assessment of oxygenation and ventilation – arterial blood gases or other methods of monitoring carbon dioxide and oxygenation – should be recorded and data available. Providing as much information as possible can play a significant role in improving long-term goals and outcomes as part of the transition to other providers/settings. Therefore, the AARC recommends adding a measure specification that recognizes limited ambulation due to compromised oxygenation. **Special Services, Treatments and/or Interventions** CMS includes ventilator support, dialysis, IV fluids, parenteral nutrition and blood product use as examples of data collection items in this category. Of critical importance to the respiratory therapy community is the care provided in LTCHs for those in need of mechanical ventilation. Ventilators may be used for both invasive and noninvasive ventilation. Advances in noninvasive positive pressure ventilation, for example, have been dramatic in the past two decades. Intensive care units across the country now routinely use noninvasive ventilation in certain forms of acute respiratory failure because of the documented reduction in morbidity and mortality as well as time in the intensive care unit and hospital. These techniques almost simultaneously have gravitated into various settings including SNFs and LTCHs where			

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			mechanical ventilation has become a relatively common component of post-acute care. Based on the patient's condition, there are numerous services respiratory therapists may perform in the treatment of patients suffering from chronic respiratory disease in the post-acute care setting depending on the type of ventilator support appropriate to their care. Not only are LTCHs responsible for addressing acute issues, they are also responsible for any past medical history such as Obstructive Sleep Apnea or home oxygen use, so it is very important that discharge planning begin at admission and all relevant information be included as part of a patient's transition from an acute care setting to a LTCH. Further, some patients are unable to be weaned in the acute care setting or traditional methods have not worked. In some LTCHs the respiratory department utilizes therapist driven protocols for weaning from ventilator and tracheostomy. For example, if the patient is on a ventilator per protocol, the respiratory therapist will do arterial blood gas analysis, EKG, and sputum sample. Protocols also allow the caregiver to adjust the weaning level and duration of weans to the tolerance of the patient. To ensure that all needs of the ventilator patient are being met, the AARC recommends a measure specification that includes information about the patient's past medical history and use of ventilator protocols if applicable. Although CMS does not provide specific examples of the type transfer information to be provided regarding interventions, the AARC recommends such information include data on whether the patient has received smoking cessation counseling as an intervention measure. Respiratory therapists see every day the ravages that tobacco use has on the			

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			quality of life for those suffering from chronic respiratory conditions. Tobacco remains the number one preventable cause of death and illness in the United States. Further, the United States Preventive Services Task Force recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. This information should be captured in the measure specifications. **Medication Information** Current CMS discharge planning guidelines require an actual list of medications to be included in the discharge plan as necessary for the transfer or referral of patients to ensure there are no unnecessary delays in the patient’s release or interruption in service. With the emphasis on “medications”, inclusion of inhalation drugs and oxygen may be overlooked. The AARC recommends that information regarding use of medications delivered via complex delivery systems be included in the measure specifications as well as whether the patient has been properly trained and educated on proper device delivery techniques. The cornerstone in the management and treatment of chronic respiratory disease is the use of inhalation drugs administered via delivery devices such as nebulizers, metered dose inhalers (MDIs) or dry powder inhalers (DPIs). For example, maneuvers such as breath holding, adequate inspiratory flow, and hand/breath coordination are indispensable to effective use of all drug delivery systems. Moreover, patients with a diagnosis of COPD, emphysema, obstructive chronic bronchitis, bronchiectasis, congestive heart failure, pulmonary fibrosis, obstructive sleep apnea, and Alpha-1 Antitrypsin			

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			Deficiency (A1AD) typically require oxygen therapy for an extended period of time. As chronic respiratory disease continues to grow in prevalence and consume a large portion of healthcare dollars, the nuances of the different delivery devices and the ability to provide accurate and reliable education to patients become increasingly important. There are numerous delivery device products on the market today with varying degrees of difficulty in administration. In order to minimize unnecessary, ineffective or wasteful interventions, it is equally important for the respiratory therapist to access the patient's need for self-care and to help patients determine the treatment options and devices that are appropriate to meet their needs as they relate to certain types of inhaled medication devices, oxygen systems and portable oxygen concentrators, or use of bi-level or Continuous Positive Pressure Airway (CPAP) devices. Patients who use metered dose inhalers, nebulizers and bi-level devices often do not comply with their physicians' orders or use inhaler medications improperly. There are numerous studies demonstrating that the improper selection and incorrect use of MDIs and DPIs not only directly impacts the clinical effectiveness of the medication but is costly to the health care system and the patient. These studies unanimously concur and support the conclusion that patient education and proper device selection is critical for optimal clinical outcomes and cost effectiveness. **Discharge Information** In discussing the types of information that should be included in the Discharge data element, the technical expert panel contracted by CMS to develop the measures noted that the type of information			

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			included for provider-to-provider transfers should be different for families at transfer to home. The type of information suggested included medication list, education on transferring and bathing, signs and symptoms, diet and other information specific to the diagnosis. The AARC recommends that the measure specifications also include a data element on chronic disease management education and training. For the patient with chronic respiratory disease, a comprehensive chronic disease management plan should consist of the following elements: • Education on self-management of the patient's disease; • Education and training in the use of prescribed self-monitoring devices such as peak flow measurement and pulse oximetry; • Education and training on the proper technique for use of aerosol medications with nebulizers, metered-dose inhalers, and dry-powdered inhalers; • Direct observation and assessment of the patient's ability to self-administer aerosol medications; • Smoking cessation counseling • Education and training on compliance with medications and respiratory devices such as oxygen equipment and nebulizers; and, • Development of an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms. A comprehensive disease management plan taught by respiratory therapists helps patients to recognize and reduce the symptoms and triggers of their chronic respiratory disease which can lead to reduced exacerbations and lower acute care costs.			

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			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. A comprehensive disease management program taught prior to discharge can be invaluable not only to the patient but to their families/caregivers as well and a data element that recognizes this should be included as part of the transfer of information. The AARC appreciates CMS' commitment to improving the transfer of health information through improved quality measures for those patients receiving post-acute care. We believe patients suffering from chronic respiratory conditions present with unique circumstances and hope that CMS will take into consideration additional types of information we believe are critical to the transfer process.			
10.	12/08/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Re: Project Title: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Dear RTI representative: The Spectrum Health System (SHS) appreciates the opportunity to provide comments on the proposed quality measure to satisfy the IMPACT Act Transfer of Health Information and Care Preferences When an Individual Transitions domain. SHS is an integrated health system and is the largest non-profit health care system in Western Michigan, with 12 hospitals, 170 ambulatory service sites and more than 1,938 licensed beds system wide. Additionally, the system includes a 1,200-provider medical group and Priority Health, which covers more than 700,000 lives throughout the state of Michigan. Within this system	Donne Elston, RN, BSN, RAC-CT Compliance Analyst, Sr. Spectrum Health Continuing Care	mailto:Donna.Elston @spectrumhealth.org	SNF, HH, Hospice

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			are 5 Skilled Nursing Facilities (SNF) 2 Home Health agencies, Hospice, as well as an acute rehab facility and a long term acute care hospital. SHS supports the CMS' efforts to standardize specified data elements across post-acute entities to improve data exchange and provide a comparison for measurement of quality and outcomes. We agree that consistent transfer of specified health information and care preferences would improve care transitions and may have a positive impact on reducing rehospitalizations. In addition, we agree with TEP members who stressed that the burden of data collection should be balanced by the benefits of the measure for the post-acute entity. Comments on Various Data Elements by Category: 1.Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings Inherent in establishing value is the ability to implement practices to improve outcomes. Because of this, SHS recommends CMS remove the PAC Admission Quality measure because the receiving post- acute entity has no control over the information it receives from any acute- care entity. We support the concern the TEP members expressed about not having control over the documents sent and thus having very limited to no ability to improve processes and systems for this measure. If CMS desires to improve and standardize the information sent by acute care entities to post-acute entities, then this measure needs to be collected in the hospital space.			

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			2.Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings SHS agrees with TEP members that electronic transfer of information is the most efficient method of transfer while a direct clinician-to-clinician communication has much value. However, many post-acute entities do not have electronic medical records to manage electronic transfer of information to and from all other entities. Furthermore, while a direct clinician-to-clinician communication has much value it is also very difficult to achieve on a consistent basis for ensuring all required transition information is exchanged. A variety of clinicians at the receiving entity need to review the transition documents thus a hard cover or electronic copy should be available. SHS agrees with the TEP members on the types of information important to transfer. Moreover, SHS would add that each assessment area identified such as psychosocial assessment only be included if pertinent to care transitions. Again we agree with the TEP members concern that this measure could result in an increased amount of information being shared between providers, but that the increased volume of information would result in the need to hire more staff and increased effort to sift through the information to find the information that is most relevant to patient/resident care. SHS trialed gathering the required data listed in one of our home health entities and found it required an additional 1/2 to 1 hour to identify and print the data which did not include organizing it in a way suitable for the receiving entity to obtain the information. SHS recommends CMS develop a standardized form which software vendors could utilize to pull the required documentation from the			

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			various locations in their software program into one form. Subsequently, the clinician can verify the information prior to sharing with the receiving entity. Moreover, we contend the detailed transfer of information be required only for those discharges that are transferring the care to the other entity; not for intermittent disruptions of care such as unscheduled hospitalizations, emergency room visits, or observation stays. SHS agrees with the recommendation to require different information dependent on if given to a receiving entity or the patient/family/ caregiver. We support the data elements as stated. SUMMARY Thank you for consideration of our comments. We believe that our recommended changes would result in a positive outcome for measuring services for Medicare beneficiaries across the various entities. Should you have any questions regarding these comments or if you would like any additional information, please contact Donna Elston, Compliance Analyst Senior for Spectrum Health Continuing Care at Donna.Elston@spectrumhealth.org.			
11.	12/08/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Hello, The American Geriatrics Society (AGS) appreciates the opportunity to comment on the draft specifications for the process measures: “Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings” and “Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings.” The AGS is a not-for-profit organization comprised of nearly 6,000 professionals	Anna Mikhailovich Senior Coordinator, Public Affairs and Advocacy The American Geriatrics Society	amikhailovich@americangeriatrics.org	Advocacy

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			dedicated to improving the health, independence, and quality-of-life of all older adults. We have the following comments: • The AGS is concerned about the feasibility and potential burden of these process measures. • For the measure of transfer of information occurring at post-acute care (PAC) admission, start of care, or resumptions of care, it appears that the PAC provider is responsible for obtaining the patient/resident's health information and care preferences from the prior site of care. If so, we are concerned that tracking down this information would be time consuming for PAC providers and may not be something within their control. While we strongly agree with the importance of improving communication and health information sharing (i.e. functional status, goals of care, patient care preferences, etc.) across settings, we worry that placing the onus on the receiving provider will stretch already limited resources and may not even be achievable. • For the measure of transfer of information occurring at PAC discharge or transfer, we again agree that the health information would be very helpful to PAC providers but caution that the process could potentially delay a patient's discharge or transfer. Further, we question, what would constitute an effective transfer of information. • In terms of the types of health information both received at admission and provided at discharge or transfer, we note that a summary of events is missing. For example, for patients being transferred from the hospital to a skilled nursing facility (SNF), the types of health information do not include the "hospital course." Likewise, for a patient transferred from a SNF to a home health			

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			agency, it does not list “events during SNF stay.” To simplify, this might be achieved by including primary and secondary diagnoses and procedures, with or without the inclusion of an active problem list. • For both measures, the AGS recommends adding the following items to the types of health information received at admission and provided at discharge or transfer: – Baseline functional status – Latest basic lab work – When the last dose of the medication was given (including the dosage and indication) – When the last dose of the medication should be given (if a time-limited patient) – Realistic types of discharge goals, e.g., to long-term care or home with family after rehab or assisted living – Contact person or Durable Power of Attorney for Healthcare specifically listed for advance directives – Discharging provider with contact information – Active Problem list – Primary diagnosis – Secondary diagnoses – Procedures All foreign bodies (drains, IV lines, catheters, wound vacuums, chest tubes, ostomy, G-tube/J-tube, trach) Thank you again for the opportunity to provide feedback. Should you have any questions, please don’t hesitate to get in touch			
12.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from	To Whom It May Concern: On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,400 rehabilitation	Jordan Wildermuth, MSW Manager, Health Policy & Advocacy	mailto:jwildermuth@Connect2amc.com	Advocacy

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		Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the development of cross-setting post-acute care (PAC) transfer of health information and care preferences quality measures. Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities (LTCHs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices, to name a few. Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family ARN Comments on Transfer of Health Information education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources.			

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			ARN commends CMS for its commitment to improving quality of care through the development of measures focused on the patient's perspective in alignment with the IMPACT Act domain – Transfer of Health Information and Care Preferences When an Individual Transitions. Patient and family engagement in care decisions is essential to improving quality of care and is a fundamental element of delivering patient-centered care. Our comments on the PAC) transfer of health information and care preferences quality measures are as follows: **Completeness of the above list for the transfer of information between providers during transitions. Are there other types of information that should be included in this list? Are there types of information in this list that should not be included?** ARN agrees with the types of information included in the measures, but believes that the measures could be strengthened by the inclusion of additional information. For example, we recommend that the measures include preferred discharge disposition and home setting characteristics (i.e., does the individual live independently, with older spouse/partner, etc.), as such characteristics could impact the patient's transition back to the community. The measures also should capture whether or not there has been a caregiver assessment in order to determine the caregiver's knowledge about the patient's needs. Moreover, ARN believes that influenza/pneumococcal vaccine status; providers/consultants who are active in the patient's care; and laboratory/diagnostic tests with pending results should be information included in the list. **Examples of the specific types of information and items to be collected within each of the types**			

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			included in Questions 2 and 5, and listed above. For example, one might expect that the type of information that would be received and coded as 'functional status' would include if the patient was ambulatory or uses a wheelchair. For medication information, what types of information would providers expect to be included in this category? What types of patient preferences would be transferred during care transitions? This feedback will help CMS develop guidance for the measures. ARN strongly recommends that certain types of information related to cognitive function and status and impairments be collected by the discharging provider. Given that not all PAC settings utilize the Functional Independence Measure (FIM) Tool, ARN believes it is necessary to develop parameters or descriptors associated with the collection of functional status, cognitive function, and mental status items in order to assure standardization. Additionally, we support the inclusion of prior functional status ARN Comments on Transfer of Health Information as part of the health information data that are transferred across settings, as functional status informs to previous health status and can indicate risk of further functional decline. ARN also supports the inclusion of basic medication information, such as a description of each drug and the associated safety precautions, identification of the person responsible for managing the patient's medications, identification of where the patient obtains their medications, and how the medication administration tracked/organized. We recommend that any information provided should be in simple, understandable language that is easy to read. Finally, we note that safety instructions (i.e., fall risk) always should be included in the discharge instructions.			

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			Suitability of the above list (used also in Question 5) for gathering data about important information provided to the patient/family/caregiver at discharge or transfer. Does this list include the types of information most important to patients/families/caregivers when care from a PAC provider is ending? Are there other types of information that should be included in this list? Are there types of information in this list that should not be included? A thorough understanding of expectations and needs for follow-up care will facilitate successful patient outcomes and safe and appropriate continuity of care. ARN recommends that in addition to the list of items, documentation and information communicated to the next level of care should include a patient's needs, desires, and treatment goals, as well as preferences regarding the next setting or level of care. We also strongly recommend that such information include an identified caregiver for the patient, as currently required by the Caregiver Advise, Record, Enable (CARE) Act (enacted in 32 states). As care transitions are a confusing time for the patient and family/caregiver, we urge modification of the measures so as to require facilities to communicate the capabilities and limitations of PAC facilities to ensure a patient's clinically assessed needs match the level of care determined by relevant decision-makers (which includes the patient and family/caregiver). We note that the information provided must be adapted to suit the intended audience. The family/caregiver requires different information than the patient (e.g. wound dressings, is the patient incontinent; can the patient manage his/her own incontinence; how to recognize symptoms of hypoglycemia/ congestive heart failure/			

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			hypotension; etc.). In order to communicate accurate information, the PAC provider should conduct an ongoing patient evaluation throughout the patient stay which reflects changes in the patient's condition or discharge needs, and clarify discharge planning needs as necessary. Rehabilitation nurses are uniquely qualified health care professionals that can educate patients and families on HHA, SNF, inpatient rehabilitation facility (IRF), and LTCH options, appropriately weigh a patient's treatment needs and preferences, and guide a patient through a successful care transition. Ensuring patients receive rehabilitation education will result in more appropriate transitions. ARN Comments on Transfer of Health Information December 11, 2016 **Admission and Discharge Measure Exclusions** ARN notes that an emergent discharge to an acute care setting would change the expectation of data provided and functional status may not be as important as code status and medications. **If the draft measure specifications capture the common routes of information transmission and are these routes clearly stated in a way that is understandable to providers in all PAC settings/ Feasibility of data collection for these items** ARN believes that the draft measures' specifications accurately reflect the question posed; collecting the route of information exchange, however, fails to impact the quality of care; moreover, collecting of such information represents a significant burden. For facilities with a large geographic reach, such information is highly variable and would not prove useful. For units within a hospital, such information			

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			would more likely be within an electronic medical record system. **Potential Impact and Any Unintended Consequences of the Measures (Either Positive or Negative)** ARN believes that the measures' information is important, but partially redundant, as the CARE Act requires caregivers to be provided written documentation on discharge planning and care needed at discharge. Further, the Commission on the Accreditation of Rehabilitation Facilities (CARF) requires patient portable profiles, which comprises much of the same data; the Joint Commission also has standards for discharge summaries. If the measures are to be meaningful, there must be clarification for PAC settings. Both IRF and SNF settings already are required to screen patients for appropriate admission; therefore, the issue of whether or not the proposed measures would be exclusive or inclusive of existing screening data should be addressed. We encourage CMS and RTI International to fully address such duplication. Finally, ARN urges that more than one of the 11 categories be required for reporting, as requiring only one of the items to be reported has the potential to disincentives reporting and may lead to reporting only the minimum amount. ARN believes that all of the items apart from treatment goals and administrative information should be transmitted to the subsequent provider, however tracking and reporting the transmission of all of these categories has the potential to place a significant data collection burden on PAC settings. **Conclusion** ARN Comments on Transfer of Health Information December 11, 2016			

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			ARN very much appreciates the opportunity to provide comments to RTI International on the development of cross-setting PAC transfer of health information and care preferences quality measures. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. Should you have any questions, please do not hesitate to contact me or our Health Policy Associate, Kara Gainer (kara.gainer@dbr.com /202-230-5649). We thank you for your consideration of our concerns, recommendations, and requests.			
13.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	**RE: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions** On behalf of our 93,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments on the Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Physical therapy is an integral service provided to Medicare beneficiaries in all post-acute care settings. Physical therapists furnish medically necessary services to patients to improve their overall health and function, and to optimize their quality of life. Across the post-acute care settings, physical therapists provide care to patients through a plan of care that engages and optimizes the patient's participation in achieving shared goals of improved	Heather Smith, PT, MPH Director of Quality American Physical Therapy Association	mailto:heathersmith@apta.org	Advocacy

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			functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization, thereby promoting long-term health and wellness. Physical therapists perform an examination that includes the patient's history, a systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that may limit the patient's activity and/or restrict participation. Through the evaluative process, the physical therapist develops a comprehensive plan of care to achieve the goals and outcomes of improved function. The physical therapist also instructs patients and caregivers in areas that will help to address specific impairments, activity limitations, participation restrictions, and environmental factors. This may include instruction in the use and performance of therapeutic exercises, functional activities, and assistive or adaptive devices, including prostheses and orthoses. As essential members of the health care team, physical therapists play an integral role in the transition of patients to the community. Comments on the transfer of health information measure APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA believes it is essential that we move toward a core set of items to assess patients across the continuum of care. APTA is pleased to see that this measure on transfer of health information for post-acute care settings. We believe this is an important process measure that will increase awareness and compliance with the transmission of health information during care transitions into and			

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			beyond post-acute care settings. We do have comments around the specific focus areas, which we discuss below. Completeness of the list for the transfer of information between providers during transitions. APTA believes that the list below covers much of the information needed in care transitions for patients: 1. Functional status 2. Cognitive function and mental status 3. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use) 4. Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain) 5. Impairments (e.g., incontinence, sensory) 6. Medication information 7. Patient care preferences (e.g., advance directives) 8. Goals of care 9. Diet/nutrition 10. Administrative information 11. Discharge instructions We believe the categories require further clarification and suggest including sections of the setting specific tools that include the information in order to promote the transfer of relevant information in each category. In addition, we believe that behavioral issues and social support should be conveyed in this list. Examples of the specific types of information and items to be collected within each of the types included in Questions 2 and 5, and listed above. APTA recommends that category 2 include information related to the patient's cognitive function, behavioral issues, and mental status.			

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			Information that might be provided in this category includes the items below: • Ability to understand language • Ability to follow commands • PHQ-9 score • BIMS score and relevant related information • Short and long term memory issues APTA believes that question 5 could contain a lengthy amount of information, as patients often present with multiple impairments. One recommendation is to direct providers to report the primary impairments, limiting the list to the top 5. Again, we recommend directing providers to the specific sections of the setting specific tool that include this information in order to promote some standardization of the information included in this category. Suitability of the above list (used also in Question 5) for gathering data about important information provided to the patient/family/caregiver at discharge or transfer. APTA recommends that at the end of care, specifically the final transition to home or place of residence, information be included about follow-up care. Providing specific information to patient/ family/ caregivers will allow them to be engaged in the successful transition to home. This information may include: • Next visit with physician/health care provider • Medication instructions • Activity instructions/ restrictions/precautions • Dietary instructions • Durable medical equipment needs • Access to social services and/or home and community-based services			

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			We echo the technical expert panel's comments around giving patient/ family/ caregiver with the information that is pertinent to a successful care transition, and we recognize that this may be a portion of the total information included in the transfer. Additionally, APTA agrees with the technical expert panel and recommends that patient care preferences include other important information such as the following: • Language – spoken and written • Cultural preferences • Caregivers, family members and physicians with whom patient/residents want to communicate information • Restrictions on visitors who may pose a danger Admission and Discharge measure exclusions APTA recommends that patients who are admitted directly from home be excluded from the admission measure. APTA recommends that patients who leave against medical advice and decease during a stay be excluded from the discharge measure. If the draft measure specifications capture the common routes of information transmission and are these routes clearly stated in a way that is understandable to providers in all PAC settings. APTA believes that the routes of information transmission listed below are clear and representative of the routes used in the transfer of health information. 1. Electronic means using an electronic health/medical record 2. Other electronic means (e.g., secure messaging, email, e-fax, portal, video conferencing)			

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			3. Verbal (e.g., in-person, telephone) 4. Paper-based (e.g., fax, copies/printouts) We do have concerns over the validation of this data, especially when data have been conveyed verbally. We recommend that if the information is transferred verbally, providers should be required to record that transfer of information in the medical record within a reasonable timeframe. Feasibility of data collection for these items APTA is concerned that the transfer of this information would create provider burden. We recommend that CMS develop a standardized template, with input from the provider community and stakeholders, which could be populated with the information collected in the respective reporting tools in each post-acute care setting (e.g. OASIS, MDS). The information could then be verified by providers before it is transmitted to the receiving facility or practitioner. This process would significantly decrease burden and ensure some standardization of the data transmitted to the receiving facility/ provider in addition to supporting health information exchange. One possible solution to decrease provider burden is to approach this measure through a phased integration. CMS could implement a short list of required categories of information in the measure's first iteration, with a later version of the measure requiring additional categories of information. Using this approach would allow CMS to meet statutory requirements while simultaneously developing an electronic version of this measure, as we discuss in the next section.			

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			Potential impact and any unintended consequences of the measures (either positive or negative) APTA has concerns about unintended consequences specific to this measure. One of our primary concerns is that the measure may lead to inaccurate assumptions about impact of the transfer of information on the success of the care transition. The measure in its current form counts the transfer of information when the information transferred was from at least 1 of the 11 categories. As the measure does not look at the quality or quantity of the information transferred, we are concerned about inferences that could be made between measure compliance and outcomes of care, especially when the transfer of information includes little data or lacks critical information regarding the patient. As we discussed above, we are also concerned about provider burden in reporting this measure. The goal of handoff communication is that the information included in the handoff be concise and useful to the providers in the next setting, and lead to a successful care transition without setback, which might include patient harm events or readmissions. For these reasons APTA recommends that CMS develop an electronic transfer of health information template that will standardize handoff of information. As all of the post-acute care settings are moving to a standardized set of data elements, we believe it would be ideal to leverage technology to pull data from the existing post-acute care data elements to populate the template. The template information could be verified by providers prior to care transition. Due to the above concerns, and as we have recommended with other measures, we suggest that this measure undergo ongoing review and that it not			

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			be used in payment adjustment, in value-based payment programs, in its initial years. Conclusion APTA thanks CMS for the opportunity to comment on the Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions, and we look forward to working with the agency, RTI International, and Abt Associates on these and other quality measures. If you have any questions regarding our comments, please contact Heather Smith, PT, MPH, director of quality, at 703/706-3140 or heathersmith@apta.org.			
14.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Project Title: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), and in concert with the Center to Advance Palliative Care (CAPC), thank you for the opportunity to comment on the following project: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. The Transfer of Health Information and Care Preferences concept consists of two measures: (1) Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and (2) Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings.	Katherine Ast, MSW LCSW Director, Quality and Research	mailto:kast@aahpm.org	Advocacy

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			AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families. CAPC is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, setting of treatment, and state of disease. AAHPM and CAPC fully support improved communication as people transition across various levels and types of care. Our members often help facilitate transitions by actively following their patients, coordinating care and communicating with the many clinicians, practitioners, therapists, case workers, etc. Palliative care clinicians support the primary care team by ensuring that it has the information needed to provide the best care to patients and their caregivers. AAHPM and CAPC believe improved communication among the care team and better documentation of a patient's preferences will ease the burden of coordinating care and ultimately lead to improved care for the patient. As such, we applaud CMS's efforts to improve safety and coordination in health care transitions. AAHPM and CAPC believe that measures being developed under the IMPACT Act should be meaningful. Truly effective transitional care interventions typically include good documentation plus interpersonal communication, education, and care coordination components for the patient, caregiver and the receiving healthcare team. While these measures proposed by RTI could show the presence and type of information that is exchanged from one setting to another setting, this information is not novel, lacks clinical depth, and seems to serve			

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			as a simple checklist of terms that may not be clinically meaningful. For example, when a patient of one of AAHPM's physicians recently moved to another setting, the paperwork listed several conditions including end-stage renal disease requiring hemodialysis, heart disease, colon cancer, chronic obstructive pulmonary disease, as well as the patient's prognosis measured in months. Despite transmitting a great deal of information, the care record failed to indicate the stages of those conditions, or which one was considered to be the "terminal" condition. Per the proposed measures, the previous treating physicians would have met the reporting requirements (indeed, information on almost all 11 domains was transferred across 3 different care settings), yet the paperwork did not include the critical information necessary to provide care. Given our members' extensive experience caring for many of the patients and residents most likely to be affected under the IMPACT Act, we urge CMS to consider the following revisions to the Transfer of Health Information and Care Preferences measures: - Please use the term "primary physician" rather than "primary care physician". Our patients' primary physicians are often not the primary care physicians while they are living with serious illness, such as cancer. - Please update the specifications to require that both the home health agency (HHA) AND the primary physician receive the information when a patient transfers from a SNF to the home. Excluding primary physicians from receipt of information when their patients transfer is inappropriate – particularly as they are asked to sign the HHA's plan of care documentation – and can result in harm to the patient.			

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			- Please remove the word “family” wherever the phrase "the individual or family caregiver" is mentioned. The term “the individual or family caregiver” suggests that a patient’s caregiver is always a family member, which may not necessarily be the case. - Please further define the 11 domains. For example, it is unclear whether "Special services" (domain 3) or "Medical conditions" (domain 4) reflects the active conditions and/or services provided while the patient was in the previous facility, or rather what the transferring provider felt to be clinically significant. - Please expand the SNF, IRF, and LTCH denominators so that they include Medicaid patients (as is already specified for HHAs). - Please consider revising the checklist for “Functional status” (domain 1) and “Cognitive function” (domain 2) so that clinicians can indicate what type of informati on is provided. This would make the measures more meaningful than simply reporting whether the information is present. To illustrate: Q5. Types of Health Information Provided to the Patient/Family/Caregiver at Discharge or Transfer Indicate the types of health information provided to patient/family/caregiver at the time of discharge or transfer. 1. Functional status (none / descriptive / formal scale) 2. Cognitive function and mental status (none / descriptive / formal scale)			

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			3. The Transfer of Health Information and Care Preferences measures should also include the following information: • Reasons for previous hospitalizations and what must be monitored in the next setting of care; • Current living situation; • Necessary follow up medical appointments and services, including whether the patient is on hospice services; • Name and contact information for the primary caregiver; and • Name and contact information for a proxy decision-maker (if not the primary caregiver). - Please change the title of “Patient care preferences” (domain 7) to “Formal written advance directive”. Please also specify that this domain, as well as “Goals of care” (domain 8) should provide written documentation of these goals. - In addition to “Patient care preferences” (domain 7) and “Goals of care” (domain 8), there should be a new domain for Medical Orders for Life-Sustaining Treatments (MOLST). (Please note that this recommendation is consistent with the TEP summary of recommendations.) This domain should include the following information: Q5. Types of Health Information Provided to the Patient/Family/Caregiver at Discharge or Transfer Indicate the types of health information provided to patient/family/caregiver at the time of discharge or transfer. 9. Medical orders for use of life sustaining treatment (yes / no). If yes, based on that discussion, check all that apply:			
15.	12/09/2016	Transfer of Information at Post-Acute Care Discharge or End of Care	**Project Title**: **Quality measures to satisfy the Improving Medicare Post-Acute Care**	Mary Carr Vice President for Regulatory Affairs	mailto:mkc@nahc.org	HHA Advocacy

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		to Other Providers/Settings Comments may also apply to the Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and	**Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions** The National Association for Home Care & Hospice (NAHC) is the largest trade association in the country representing home health care agencies. NAHC members represent the entire spectrum of home care agencies, including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding, proprietary home health agencies. NAHC members serve several million Medicare home health care beneficiaries each year. In general, NAHC supports the intent and goals of the IMPACT Act to develop cross setting measures among post-acute care (PAC) providers. And specifically supports a quality measure for the transfer of information and care preferences when individuals transfer across health care settings. NAHC wishes to offer the following recommendations and concerns. NAHC recommends the type of information to be transferred include the identity of the practitioner that will be following the patient when transferred/discharged to the community setting. Although this information might be part of the discharge instructions it is not always included. This information is critical for effective transitions and continuity of care when patients are transferred to the community setting, either from an inpatient provider or another community provider. Regarding the types of information listed in the measure, NAHC is requesting clarification on the			

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			types of information that would be considered "Administrative". Additionally, NAHC strongly recommends that acute care hospitals be similarly measured for transfer of health information and care preferences. Acute care hospitals are common senders of this information to post-acute care providers. Further, NAHC urges CMS and the measure developers to take into consideration the financial and opportunity costs associated with the proposed transfer of health information and care preference measure. Costs include staff training and the learning curve associated with achieving competence in completing new assessment items. NAHC continues to be concerned that the requirements of the IMPACT Act could result in a lengthy assessment tool that will become very burdensome for agencies to administer. Thank you for the opportunity to submit comments. If you need further information, please do not hesitate to contact me.			
16.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	**To:** RTI International, Abt Associates and the Centers for Medicare and Medicaid Services (CMS) **Re: Call for Public Comment—Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions** Delivered electronically to TOHPublicComments@rti.org On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the nearly one thousand post-acute care (PAC) facilities (IRFs, SNFs, and LTCHs) we provide services to, we are pleased to present our comments related to the project titled	Kathy Dann Director of Operations University of Buffalo	mailto:brownk@buffalo.edu	Quality and Outcomes Measurement

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			“Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions”. We appreciate the continuing efforts of RTI International, Abt Associates and CMS to allow stakeholders to comment on items and tools designed to help measure quality in healthcare, with an emphasis on developing standardized and interoperable measures within PAC settings. UDSMR strongly believes that CMS and its contractors should focus on identifying measures that • have a long history or extensive evidence of being reliable and valid; • are in use or have been used by providers in all PAC venues; • are predictors of quality, cost, and payment; and • have been endorsed, approved, and/or found to be “best in class” by industry stakeholders. While UDSMR believes that care transitions can be enhanced through care coordination and the enhanced flow of patient information, the transfer of information measures presented for consideration 1. do not ensure that the information that is to be transferred is standardized or provided in a sufficient manner to benefit the patient’s care, 2. do not take into consideration pre-admission screening requirements that are already in place for most post-acute care providers, 3. do not contain any evidence that the proposed measures have been tested and can be shown to be reliable and valid towards better care transitions or improved patient outcomes, and			

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			4. potentially produce measure values inconsistent with the quality of care delivered by the post-acute care provider. To provide additional context to our concerns above: 1. The proposed measures do not ensure that the information that is to be transferred is standardized or provided in a sufficient manner to benefit the patient's care. According to proposed measure specifications, the measures essentially assess whether a post-acute care provider received at admission and/or transferred at discharge information necessary to provide and plan care for the patient. Post-acute care providers begin by indicating a "Yes/No" response, and then proceed to check all that apply from a list containing the following options for information received or transferred: 1. Functional status 2. Cognitive function and mental status 3. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use) 4. Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain) 5. Impairments (e.g., incontinence, sensory) 6. Medication information 7. Patient care preferences (e.g., advance directives) 8. Goals of care 9. Diet/nutrition 10. Administrative information 11. Discharge instructions 12. None of these types of health information were provided CMS and the measure developers do not provide any additional context or requirements for what			

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			information is necessary to satisfy any of the options above. This potentially provides the opportunity for referring/sending/discharging providers to transfer non-standardized information that does not assist the admitting provider in planning or providing care to the patient. For example, a patient's functional status, cognitive function and mental health status currently are measured on a number of different items using many different assessment tools or documentation notes. Would the transfer of one item be sufficient to meet the requirements of this measure, or is a full assessment required based upon a standardized set of items? Without these details or requirements, providers may not receive or transfer the information necessary to properly plan and provide care to the patient. Additionally, the proposed measure specifications currently state that the measure is to be reported as the percentage of patients where information is received at admission or transferred at discharge from at least one of the eleven types of information noted above. In order to meet the measure, the referring/sending/discharging provider needs only to provide information from one of the information types noted above. While we do not expect this to happen in practice, exclusion of any of the information types above may prohibit the admitting provider from providing the necessary planning and provision of care needed for improved outcomes. We would recommend that should CMS and the measure developers continue consideration of this measure that the requirement is for the receipt or transfer of all **3** the information types noted above based upon a standardized set of data elements in order to provide post-acute care providers with information necessary to care for their patients.			

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			Finally, we would suggest that for quality measurement purposes it is not necessarily the amount of the information that is received or transferred, but whether the quality of the information leads to an improved patient experience or outcome. CMS and the measure developers should ensure that the information to be included as part of this measure has been shown to impact quality of care and outcomes. 2. The proposed measures do not take into consideration pre-admission screening requirements that are already in place for most post-acute care providers. Part of the requirements for participation in the Medicare program are that the post-acute care providers complete a pre-admission assessment prior to admission, and maintain documentation of that pre-admission assessment within the medical record. The current requirements within the pre-admission assessment guidelines also mirror the eleven information types noted previously, placing the post-acute providers responsible for obtaining this information rather than requiring the transfer of this information from the prior provider. Post-acute care providers are also subjected to audits and/or pre-authorization practices where the medical records are reviewed to determine whether a pre-admission screening was done, and payment potentially withheld or recouped from the provider should a pre-admission screening be missing or inadequately done prior to admission. With this practice in place today, we question the methodology for the proposed measures and the duplication of efforts or additional data collection burden that may result from the implementation of these measures. We ask CMS and the measure developers to consider whether the transfer of this information should come from the			

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			referring/sending/discharging provider, or through a standardized pre-admission assessment completed by the admitting provider. We also ask CMS and the measure developers to consider whether implementation of this proposed measure should remove pre-admission screening requirements from those providers currently subjected to these conditions as part of their participation in the Medicare program. 3. The proposed measures do not contain any evidence that the proposed measures were tested and shown to be reliable and valid towards better care transitions or improved patient outcomes. Without testing the item set for reliability and validity, and not analyzing whether the collection of these items will lead to improved care transition and/or patient outcomes, we do not believe that this measure is ready for implementation into any of the quality reporting programs. While CMS and the measure developers cite various articles and studies that show that improved communication and transfer of information lead to better care transitions and care coordination, none of the articles or studies utilize the proposed measurement items or methodology to determine whether the proposed measure will lead to the desired results. We recommend that should CMS proceed with these measures that consideration be given to piloting the collection of this information to determine whether or not the items are reliable and valid and produce the desired results for improved care transitions, care coordination and patient outcomes. 4. The proposed measures potentially produce measure values inconsistent with the quality of care delivered by the post-acute care provider. For the admission measure, is there evidence to suggest that an admitting provider who only receives			

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			information on 50% of patients due to issues with the prior provider is producing care quality or outcomes that are any less than a provider who receives incomplete or inadequate information on 100% of patients? This measure is only capturing whether one type of information is received from the prior care provider and does not take into consideration whether the admitting facility is obtaining this information on their own via pre-admission screenings. As a result, the measure values produced by the admission measure will be unable to differentiate the quality of care provided between post-acute care providers, and may instead inappropriately penalize providers who cannot control processes for a prior provider or who choose to obtain the information on their own to make informed patient care decisions. Similarly, for the discharge measure, is there evidence to suggest that a referring/sending/discharging provider who only transfers information on 50% of patients is producing care quality or outcomes that are any less than a provider who transfers incomplete or inadequate information on 100% of patients? While a referring/sending/discharging provider may provide any and all information to the admitting provider, processes are not currently in place to ensure that the information provided by the referring/sending/discharging provider is received and/or reviewed by the admitting provider. Additionally, the referring/sending/discharging provider could send over incomplete or non-standardized information that does not assist the admitting provider with the ability to properly plan or provide care for the patient. Finally, as we noted when discussing pre-admission assessments above, the information from referring/sending/discharging provider could differ from the information the admitting provider receives			

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			from completing their pre-admission process, potentially causing further issues with determining the proper planning and provision of care. Given the fact that the admitting provider is already collecting this information as part of a pre-admission screening process without requiring the referring/sending/discharging provider to transfer this information, should the admitting provider be measured on the performance of the other provider? We would recommend that CMS and the measure developers provide information related to whether resulting measure values will represent the opportunity to show an improvement in the quality of care for the post-acute care provider measured. Finally, we would also like to note the additional burden to be placed upon the providers to collect and submit this information. As proposed, the admission and discharge measures will add an additional eight items and an additional 4 pages to existing assessment tools that are already extensive and continually expanding due to the additional requirements CMS is implementing for quality and payment purposes. Implementation of this measure will not only require administrative burden to collect and record this information, but will also require updates to technology as well as training for staff in order to adequately and accurately record the information. We ask CMS and the measure developers to consider whether this additional burden, and the potential increased costs to the Medicare program, will result in the improvement in quality of care desired.**5** We appreciate both the opportunity to provide public comment and the careful consideration of the comments we have provided. We welcome the opportunity to work with you to provide ongoing			

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			research regarding the selection and implementation of standardized and interoperable quality indicators. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.			
17.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Re: Quality Measures to Satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) Domain of: Transfer of Health (TOH) Information and Care Preferences When an Individual Transitions The Healthcare Association of New York State (HANYS), on behalf of our 500 member non-profit and public hospitals, nursing homes, home health agencies, and other healthcare providers, welcomes the opportunity to comment on the project listed above. HANYS appreciates the opportunity to provide feedback on the TOH measure specifications and data collection proposed for providers using the assessment instruments that the Centers for Medicare and Medicaid Services (CMS) currently requires for use by home health agencies, inpatient rehabilitation facilities, long-term acute care hospitals, and skilled nursing facilities. HANYS agrees the exchange of patient-specific information helps providers to address the person-centered needs of patients transitioning between all settings of the healthcare continuum and facilitates patient safety and continuity of care. However, we have concerns about and suggestions for the terminology used, and we are concerned about the potential added burdens the data present to patients and providers. <u>Data Question Terminology</u> HANYS is concerned that the terminology used in Question 2, Types of Health Information, used for	Shari Miller Executive Assistant Health System Redesign & Regulatory Affairs	mailto:SMiller@hanys.org	HHA IRF SNF Advocacy

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
			both the Received at Admission and Provided at Discharge or Transfer measures, is unclear. More descriptive terms could be used for each information type that would help providers to more quickly and easily understand what the question references and how to answer it accurately. HANYS is also very concerned about the use of the term in Question 2, Item 10, Administrative information. This term is nondescript; we searched for more information from the project's accompanying October 2016 document, Technical Expert Panel Summary Report to help inform our understanding. In that report, items such as "demographics" and "caregiver/family contact information" were used. We agree that a patient's personal demographic information and caregiver/family contact information is critical to share during transitions. HANYS urges the terms used in Question 2, Types of Health Information, for both the Received at Admission and Provided at Discharge or Transfer measures be changed in the following ways to be made more descriptive: • item 1, Functional status—use instead the term Physical Function Status to more clearly differentiate it from cognitive function; • item 6, Medication information—use instead the term Medication Regimen to include information on a broader array of substances routinely taken by the patient; • item 9, Diet/nutrition—use instead the term Nutrition/Hydration to emphasize the importance of fluid intake; • item 11, Discharge instructions—use instead the term Discharge Plan/Instructions; and • item 10, Administrative information—use instead the term Patient/Caregiver/Family			

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			Identification Information to provide more clarity. Question Guidance HANYS agrees that the guidance yet to be developed for the measures and for completing these questions needs to be focused on a clear understanding and standardization of the information to be exchanged during a patient transition. HANYS urges the guidance for information items to include these examples: • item 1, Physical Function Status—guidance should include information on the patient's ability to perform activities of daily living and instrumental activities of daily living, including any added support needed by the patient from individuals or with the use of assistive devices; • item 5, Impairments—guidance should include information about the patient's communication abilities and any assistive devices or measures needed to maximize the patient's independence; • item 6, Medication Regimen—guidance should include information about all prescribed medications, over-the-counter medications, and dietary and/or nutritional supplements routinely taken by the patient at home; and • item 10, Patient/Caregiver/Family Identification Information—guidance should include the patient's personal demographics (e.g., address, telephone number(s), email, age, sex, marital status, insurance(s) information, etc.). Caregiver/Family information should include complete contact information (e.g., address, telephone number(s), email) for the primary individual(s) in those roles and identification of their relationship to the patient (e.g., child, spouse, sibling, parent, primary caregiver, guardian, resident representative, etc.)			

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			Suitability of Information for Patients/Families/Caregivers HANYS and our members agree it is important for patients/families/caregivers to have much of the same information that is listed in Question 2 when a patient's care from a post-acute care (PAC) provider is ending. Currently, PAC providers already include this information in the discharge process. The challenges for providers are in how that information is delivered in order to achieve effective communication. The patient-level information exchanged provider-to-provider or clinician-to-clinician at the time of a patient's transition can be and is standardized in format and content based on professionals' credentials, education, and expected level of understanding about standards of practice and care. When exchanging such information with patients/families/caregivers, providers and clinicians can make no assumptions at all until they have direct interactions with patients/families/caregivers to assess their education and expected level of understanding of care information and develop a plan for sharing that information. This communication planning process for providers begins at a patient's admission. HANYS views the information items in Question 2 as important to patients/families/caregivers. The degree of importance differs, depending on their role in the patient's care post-discharge from PAC, may require different levels of detail, will probably have to be delivered in layman's language, and may require delivering in many ways and over much time, all tailored specifically to the needs of patients/families/caregivers.			

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			Provider Burden HANYS is very concerned that completion of these questions presents an additional burden to providers. It is a standard practice in PAC that patient care is comprehensive and interdisciplinary, so too is the development and execution of a plan of care, discharge planning, and the completion of the various PAC assessment tools, into which these questions will be added. Generally, each PAC assessment tool is constructed so each discipline is responsible for completing a section or defined group of questions. These TOH Questions 1 and 2 are not constructed that way; instead, each question requires the consideration and input of different disciplines before each question can be answered accurately. PAC providers will find it problematic and burdensome to complete these single questions. HANYS urges that provider guidance for the TOH information items include practical strategies to support integration of the interdisciplinary process into a completion process for these questions. Again, thank you for the opportunity to comment on these data specifications. If you have any questions regarding our comments, please contact me at dlebarro@hanys.org, or at (518) 431-7702.			
18.	12/09/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Re: IMPACT Act of 2014 Cross-Setting Quality Measure: Transfer of Health Information and Care Preferences When an Individual Transitions. Dear Sir or Madam: On behalf of our 39 hospitals in Arizona, California and Nevada, Dignity Health appreciates the opportunity to comment on the IMPACT Act of 2014 Cross-Setting Quality Measure: Transfer of Health Information and Care Preferences When an Individual Transitions.	Clara Evans Director, Public Policy & Fiscal Advocacy, Dignity Health	mailto:Clara.Evans@dignityhealth.org	HHA, IRF, SNF

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
			The fifth-largest hospital system in the nation, Dignity Health is proud of our Commitment to our mission to provide quality, affordable care to all, especially the poor and disenfranchised. Post-acute care (PAC) providers deliver patient interventions to the most frail, and often within a care team setting, creating treatment plans in concert with a number of specialists to address complex health care needs. Dignity Health has a robust Home Health program that provided 306,119 home care visits to approximately 24,655 patients annually in California and Nevada in fiscal year 2016, and operates 11 Inpatient Rehab Facilities (IRFs) and 5 Skilled Nursing Facilities (SNFs) across the system. Dignity Health is proud of our partnership with the government. Approximately 70% of the patients Dignity Health serves are enrolled in a government program, primarily either Medicare or Medicaid, but only 50% of our revenue is from the government. This dynamic makes Dignity Health particularly sensitive to increased reporting requirements and changes in reimbursement policies. Dignity Health believes humanity is the very core of health care and encourages the development of measures that truly measure quality and create opportunities to improve care across the spectrum, not just too simply “check the box.” As CMS works to implement standardized data sets, and moves toward bringing PAC into value based care, Dignity Health urges CMS to consider the additional resources required to implement assessment tools and submit data. While we agree with the standardization of data elements, PAC providers have are underfunded and have limited capital for additional investment. CMS should consider including risk adjustments for providers that serve			

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			the most vulnerable communities and continue working with providers to establish a vision for PAC and the important role they play in the spectrum of care. To provide appropriate feedback, Dignity Health convened home health staff to review the assessment tool and gathered the feedback below: 1) The project objectives for this are stated as: 1) transfer of information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings; and 2) Transfer of information at Post-Acute Care Discharge or End of Care to Other Providers/Settings. In as much as there is the time point category for Home Health is labeled as “Transfer to an Inpatient Facility,” we suggest adding this to the various sections within the draft specifications document to help ensure the intent that this is to be measured. For example Section 5, 5.1.1 Measure Title could be “Transfer of Information at Post-Acute Care Discharge, Transfer to Inpatient Facility or End of Care to Other Providers/Settings.” 2) Home Health providers often have to dig through all the current transferred materials received for a referral and potential admission to collect the necessary and desirable information. Received information is not standardized and therefore it is highly time consuming to extract. When there is missing information, Home Health staff must often contact the referring site or try to obtain from the prospective patient. The group wonders about the Future consequences of providers not transferring the information. 3) Often, when requesting the information from the referral provider, some referring providers rely upon			

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			the Home Health Agency (HHA) to obtain patient information through only the patient. HHAs or other PAC providers should not be expected to depend upon receiving transfer information from patients and suggest that CMS require referring providers to transfer patient information. 4) In review of the types of information included in the measure, we suggest additional details for administrative information and suggest primary language, the date last seen by their PCP (if known), and social supports available at the setting to which the patient is transferred. This is particularly important information for Home Health. 5) Much time was used in our discussion as to how the types of information in the measure would be communicated to the next provider. We agree the electronic transfer of information would be the most efficient method of transfer, but are concerned with the lack of consistency and standardization of this important data. While we understand the occasional need for direct clinician-to-clinician communication (a warm hard-off), this method is time Consuming and subject to errors. We support the concept of interoperability and standardization of the data, electronically, and believe that CMS should take the lead in its establishment for all provider types and make this a future requirement for all data transfers between providers, including physicians. This electronic data should securely travel with the patient, be obtainable by the patient and other authorized providers and should be easily readable. 6) Within our discussion of timely transfer, the data should be transferred within 4 normal working hours of the referral. This would not meet every scenario if a patient was to be referred outside of normal working hours, in which case the transfer of all			

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			immediately available information would be transferred within the 4 hours from the referral and any remaining information within normal working hours. CONCLUSION Dignity Health appreciates the opportunity to respond to this request for comments and hopes our input is helpful. If you have any questions, please feel free to reach out to Clara Evans, Director of Public Policy & Fiscal Advocacy at Clara.Evans@DignityHealth.org or at (916) 851.2007.			
19.	12/10/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	I am very concerned with two features of this metric First, it is not clear what the receiving provider should do with partial or partly erroneous information. The standard does not seem to be that the information is adequate and correct, but merely that some information in some category showed up. If the transition required information on cognitive status, but what was transitioned was information on medication, should the receiving provider answer the first question “yes” or “no?” If the receiving provider answers “yes,” then this will be a rapidly capped-out metric, since some list of medications usually does get transferred. It may be wrong or out-of-date, and it may not specify what should be altered or stopped, but it is “something.” If the receiving provider answers “no” in this situation, there will be no information as to the shortcomings. Since downstream providers are so profoundly dependent upon upstream providers, it seems that the tendency will be to answer “yes,” so as not to offend the referral source. This is clearly not what the IMPACT statute envisioned. Second, the attention to preferences is skeletal at best. The preferences can simply be ignored,	Joanne Lynn, MD Director, Center for Elder Care and Advanced Illness Altarum Institute	mailto:Joanne.Lynn@altarum.org	Research Advocacy

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			because the sending provider meets the requirement by sending any information in any category. The preferences category can be met by sending along the advance directive alone. It is critical in transition to be clear as to the client's capacity for decision-making, the surrogate decision-maker (if needed), and a more appropriate array of preferences, rather than just an advance directive or decision about CPR. Again, this is clearly not within the intent of the IMPACT statute. I believe that this metric should be seriously reconsidered and a much more adequate metric should be put in place. A metric about the adequacy of information at transfer should both ask about adequacy of each domain and should see that the transition partners have a practice of providing feedback.			
20.	12/10/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions To Whom It May Concern: The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 186,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. We appreciate the opportunity to submit comments in response to the draft associated with the transfer of health information and care preferences for patients who move across care settings during an episode of care. Our primary concern is that—as currently constructed—the category of cognitive function and	Sarrah Warren, MA Director, Health Care Regulatory Advocacy American Speech-Language-Hearing Association (ASHA)	mailto:SWarren@asha.org	Advocacy

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			mental status is incomplete and should be expanded to include communication status. This is critically important to ensure that the transfer of information includes communication barriers due to communication disorders; in addition to non-English speaking or bilingual considerations. Inclusion of communication status would also help to ensure that appropriate consideration is given to how providers should communicate with an individual who has a communication disorder. Communication breakdown is often identified as a significant factor, which underlies adverse events in both acute and post-acute settings as well as in the rate of avoidable readmissions. Verbal and written instructions for self-care, medications, and contacting providers to schedule follow-up appointments are essential components of transitions. The risk of communication breakdown is compounded when patients have communication disorders. Failure to specifically address the communication status of the patient could significantly undermine the patient's care following transition and result in poor outcomes and avoidable readmission. It is critical that data elements be included in the transfer of health information that provide information about patients' communication status, so that these individuals can be accurately identified and provided appropriate patient-centered care. Additionally, communication status is likely to be an important element for conducting case-mix risk adjustment analyses. Thank you for your consideration of our recommendation. If you have any questions, please contact Sarah Warren, MA, ASHA's director for health care regulatory advocacy, at 301-296-5696 or swarren@asha.org.			

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21.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Re: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of Transfer of Health Information & Care Preferences When an Individual Transitions Dear TOHPublicComments@rti.org: I am writing on behalf of the National Association for the Support of Long Term Care (NASL) and in response to the Centers for Medicare & Medicaid Services' (CMS') request for comment on quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of "Transfer of Health Information & Care Preferences When an Individual Transitions." NASL comments address the four post-acute care (PAC) settings of Home Health Agencies (HHAs), Inpatient Rehabilitation Facilities (IRFs), Long Term Care Hospitals (LTCHs) and Nursing Homes (NHs)/Skilled Nursing Facilities (SNFs). NASL is a national trade association representing providers of both senior housing care and ancillary services and products to the long term and post-acute care sector. NASL member companies provide senior housing care; health information technology (health IT) systems and solutions; speech-language pathology, physical, occupational and respiratory therapy; laboratory services, portable x-ray/EKG and ultrasound; and deliver complex medical equipment and specialized supplies for the LTPAC sector. NASL also is a founding member of the Long Term & Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.	Donna Doneski Director of Policy & Membership National Association for the Support of Long Term Care (NASL)	mailto:donna@nasl.org	Advocacy Health Information Technology

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
			NASL and our membership work with the Office of the National Coordinator for Health Information Technology (ONC) and through groups such as HL-7, NCPDP and the Standards & Interoperability (S&I) Framework. NASL members also are working on Healthcare Innovation Challenge Grants from the Center for Medicare & Medicaid Innovation (CMMI) and on Health Information Exchange (HIE) initiatives. We are proud to note that – even though LTPAC providers are ineligible for EHR incentives under Meaningful Use– several NASL member companies have developed software products that have been certified and are listed on ONC's Certified Health IT Product List (CHPL). As steadfast advocates for health IT adoption and use, our responses reflect input from NASL members that have a keen interest in improving the exchange of health information across care settings. NASL Comments to CMS/RTI Transfer of Health Information Quality Measures Completeness of Data To Transfer When a Patient Transitions to Another Setting NASL reviewed the list of data elements that are proposed in the measure specifications, including: 1. Functional status 2. Cognitive function and mental status 3. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use) 4. Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain) 5. Impairments (e.g., incontinence, sensory) 6. Medication information 7. Patient care preferences (e.g., advance directives) 8. Goals of care			

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			9. Diet/nutrition 10. Administrative information 11. Discharge instructions NASL agrees that the proposed list represents important clinical information for receiving providers to have when a patient transitions to any of the four PAC settings. We also believe that improving the timely transfer of important patient health information and care preferences can ease care transitions for the patient while improving patient safety and avoiding adverse events. While hospital discharge summaries often contain critical information, the more delayed communication of that information, the less helpful it is to patient care. So, NASL seeks clarification as to whether there will be an established time frame for receiving or sending this patient health information. Admission & Discharge Measure Exclusions NASL believes that the exclusion criteria should align across all four PAC settings, which is unclear from the measure as drafted. Data Collection & Benchmarking – Route of Health Information Transmission We understand the rationale for wanting to determine how health information is transmitted (i.e., using electronic means such as an electronic health/medical record (EHR/EMR); via other electronic means such as secure messaging, email, e-fax, a web portal or video conferencing; by way of verbal communication –either in-person or telephone; or paper-based communication via fax or printouts). Still, we are concerned about the provider burden that would accompany such a requirement. We also worry that providers could be effectively penalized with a low score on the measure, which			

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			would reflect negatively on the provider, when the receiving provider has no control over what, or if, information is transmitted by the sending provider. For example, there appears to be no consequence for a hospital that does not send data to a SNF. We remind CMS that providers in these PAC settings are largely ineligible for incentives under its Meaningful Use Incentive Program. So, CMS should consider aligning the timeframe with which hospitals and other providers that are incentivized under Meaningful Use have to deliver patient health and care information to other settings, including post-acute care providers. Timely transfer of accurate patient health information from hospitals and other settings decreases provider burden to acquire essential patient health information and increases overall efficiency of care and service delivery. However, we question the value of tracking the mode with which information is received. By our estimation, the benefit of knowing the mode of transfer does not outweigh the burden associated with collecting this information on each patient, especially paper-based communications. Providers that already adopted health IT would be forced to take a step backward by having their health IT vendors program their IT systems to capture the mode by which information is transferred. Moreover, LTPAC health IT vendors already devoting limited resources to improve exchange of health information across care settings would have to redirect those resources to reprogram existing systems to capture this data. If CMS still wishes to record the mode of transfer, we believe the measure should only record if data is transferred electronically (e.g., EHRs/EMRs, CCDs or secure messaging).			

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			NASL wishes to share a related point, which we made in our attached comments to CMS in response to the Cardiac Care Bundle Proposed Rule. NASL encourages CMS to consider using the Secretary of HHS' authority under the IMPACT Act to specify a quality measure that could incentivize consistent health IT adoption in the LTPAC settings. Specifically, the IMPACT Act requires CMS to specify a measure that requires post-acute care (PAC) providers – Long Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs) and Home Health Agencies (HHAs) – to transfer an individual's health information and care preferences when transitioning to another setting, including a different PAC provider, a hospital or home by October 1, 2018. NASL would encourage the Secretary to construct this measure in such a way that providers that can electronically transfer this information would rate higher on this measure. This may incentivize PAC providers to adopt and use health IT to meet that quality measure, and certainly would reward those who have made the transition to electronic transfer of patient data. It also would establish a business case, absent a mandate, which could encourage health IT adoption. NASL understands that quality measures are intended, at least in part, to affect provider behavior. So, we recommend that CMS either track only electronic modes of transfer, or structure this measure to reward providers who can exchange health information electronically. Thank you for the opportunity to provide this feedback. We hope that CMS will continue to use NASL as a resource and we welcome additional questions or conversations.			

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
22.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Measure Development Team RTI International Re: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Dear Measure Development Team, The National Association of Long Term Hospitals (NALTH) is pleased to submit comments on quality measures in the domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. NALTH is the only hospital trade association in the nation that is devoted exclusively to the needs of patients who require services provided by long term care hospitals (LTCHs). NALTH is committed to research, education and public policy development that further the interests of the very ill and often debilitated patient populations who receive services in LTCHs throughout the nation. NALTH's membership is composed of the nation's leading LTCHs, including free-standing, hospital-within-hospital, for-profit, and non-profit LTCHs. On behalf of our member hospitals, we wish to express our gratitude for the opportunity to share our comments. We have carefully reviewed the draft data element specifications for two measures: 1.Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings 2.Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings Our comments are presented below.	Lane Koenig Director of Policy and Research National Association of Long Term Hospitals	mailto:lane.koenig@knghealth.com	LTCH Advocacy

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
			Comments NALTH believes that transfer of health information and patient preference upon admission and discharge is important for improving transitions in care and ensuring the safety of patients. The information to be reported as specified in the draft specification is feasible to collect. However, staff at long-term care hospitals report challenges in obtaining such data elements from short-term acute care hospitals (STACHs). Moreover, some of the information related to the admission measures is redundant with data collected with the LTCH CARE tool admission assessment and admission assessment conducted by other post-acute care providers. As a result, NALTH recommends the following: Because the performance on the admission measure would be, at least in part, determined by the referral STACH, CMS should not use the admission measure to assess the performance of LTCHs or other PAC providers in any future value-based purchasing program. The admission measures should focus on items not already collected in the LTCH CARE tool. For example, we recommend excluding functional status since it is already collected elsewhere in the LTCH CARE tool during admission and discharge. Similarly, cognitive function and mental status, select medical services (e.g., ventilator support, dialysis), medical conditions and co-morbidities, and administrative information are also assessed on the LTCH CARE tool. Clarifications			

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			NALTH is seeking additional clarifications on the measure specifications. First, the measures are to be assessed at the following time points: admission, start of care, and resumption of care. The measure contractor should clarify when and how admission and start of care are different. In addition, the measure contractor should clarify if resumption of care refers to care beginning after a service interruption. NALTH believes that completing this information again after an interruption in service of less than 3 days is burdensome and not useful. Finally, LTCHs are allowed to conduct the admission assessments up to 3 days after admission. Would the measure follow the same requirements? If you have any questions about these comments, please contact Lane Koenig, PhD, NALTH Director of Research and Quality, at lane.koenig@knghealth.com.			
23.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Re: Draft Specifications for the Transfer of Health Information and Care Preferences for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicaid and dual eligible (Medicare and Medicaid) beneficiaries in community based settings, outpatient settings, and post-acute care (PAC) settings. Occupational therapy practitioners provide medically necessary and skilled	Jeremy Furniss, OTD, OTR/L, BCG, CDP Director of Quality Division of Academic & Scientific Affairs American Occupational Therapy Association, Inc.	mailto:jfurniss@aota.org	Advocacy

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			intervention to empower beneficiaries of Medicare post-acute care (PAC) services to live their lives to the fullest. The practitioners we represent are very active in inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), home health agencies (HHA), and long-term care hospitals (LTCH), working to ensure that beneficiaries are able to safely and successfully participate in meaningful everyday activities. INTRODUCTION AOTA appreciates the opportunity to comment on the proposed measure. AOTA supports the use of the CARE tool to standardize data collection of functional status and change in functional status. We are in agreement with the implementation of a measure to meet the requirements of IMPACT and improve the safety and care of patients by improving the transfer of information between facilities. AOTA outlines questions and comments regarding the numerator statement and the denominator inclusions. NUMERATOR REQUIREMENTS AOTA is concerned that the numerator statement may be too broad to capture true gaps in care and that the performance on the admission measure may be attributed to the wrong facility. We recommend the admission measure to be harmonized with a QRP for acute care/inpatient hospitalization. The measure is meant to identify a gap in practice for improvement. In this case, the discharging institution is best positioned to improve the transfer of information at PAC admission; however, the measure is completed on the PAC assessment. This may present an attribution			

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			problem, especially if used in publically reported measures. AOTA also encourages more conversation related to requiring only one of the areas of information. While this may be appropriate as providers acclimate to this process measure, it may not be meaningful. Supports balancing the burden of reporting with the utility of the measure, but we are not currently convinced that requiring only one is the right balance. We would recommend including the following areas for discussion related to the numerator statement: • functional status • cognitive function and mental status • medical conditions and co-morbidities • impairments • medication information • diet/nutrition AOTA would also recommend the consideration of implantable devices. This may be accomplished by including this important element in the special services or another category. While we understand the need for incremental implementation of measures given the large number of new measures and the duplication of information required to complete a subset of the new measures, AOTA recommends requiring more than one are of information to meet he numerator. We believe that additional types of information transfer are required to inform quality improvement in PAC. Furthermore, requiring only one item to meet this measure may produce misleading performance indicators. If CMS intends to implement this measure with only one area of information, AOTA strongly recommends a timeline to encourage providers to begin adopting processes to transfer more than one type of information.			

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			DENOMINATOR REQUIREMENTS The proposed populations to be measured are not consistent across PAC settings. While this is likely a feasibility concern at this point, this may produce inaccurate comparison across settings. The entire population discharged from LTCH may be compared to Part A and Part C beneficiaries in HHA and IRF and compared to only Part A beneficiaries of SNF. AOTA recommends either beginning with a consistent population base or include specific information cautioning comparison of this measure across settings. CONCLUSION AOTA appreciates the opportunity to comment on the proposal. We are eager to participate in ongoing discussions with CMS and contractors related to the implementation of IMPACT and the advancement of quality measurement in all settings in the transfer of information.			
24.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	RE: Draft Specifications for the Transfer of Health Information and Care Preferences for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies – November, 2016 To whom it may concern: The American Health Care Association /National Center for Assisted Living (AHCA/NCAL) represents more than 13,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail,	Daniel Ciolek Associate Vice President, Therapy Advocacy American Health Care Association	mailto:dciolek@ahca.org	Advocacy

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			elderly and individuals with disabilities who receive long term or post-acute care in our member centers each day. AHCA/NCAL is pleased to have the opportunity to comment on the draft specifications related to quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. We also appreciate the additional insights provided in the accompanying Technical Expert Panel Summary Report. Overall, we believe that the proposed measures are moving in a positive direction and we encourage continued development. In the enclosed comments, we outline key areas of support, areas of concern and recommendations to address those areas of concern that we have been able to compile in the comment period provided.			
25.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	RE: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions AdvaMed appreciates the opportunity to provide our comments to the Centers for Medicare & Medicaid Services (CMS) regarding quality measures to satisfy the Improving Medicare Post- Acute are Transformation Act of 2014 (IMPACT Act) domain of Transfer of Health information and Care Preferences When an individual Transitions. AdvaMed member companies produce the medical devices, diagnostic products and health information systems that are transforming health care through earlier disease detection, Jess invasive procedures and more effective treatments. Our members range from the largest to the smallest medical technology innovators and companies.	Steen Brotman, MD, JD Senior Vice President Payment & Health Care Delivery Policy	mailto:sbrotman@AdvaMed.org	Health Information Technology

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			Inclusion of Information on the Status/Assessment of Patient's Wounds and Nutrition in "Types of Health Information" Occurring at Post-Acute Care (PAC) Admission, Start of Care, Resumption of Care and at Post-Acute Care (PAC) Discharge or Transfer. AdvaMed supports the proposed quality measure specification and the specific inclusion or examples of patient's wounds and nutrition as medically necessary "Types of Health Information for providers to transfer when an individual transitions. The addition of wounds and nutritional status to discharge/transfer plans is consistent with the goals and recommendations of the IMPACT Act, AHRQ recommendations, numerous clinical guidelines,2 3 multi-stakeholder quality improvement initiatives, numerous, current and forthcoming quality measures and recommendations from other publications and organizations. We believe that specific inclusion of these areas on the list will 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. Our recommendations regarding the measure specifications open for comment appear below. **Recommendation for Including Patient Would Status in Transfer of Information at Post-Acute Care (PAC) Admission, Start of Care or Resumption of Care and at Post-Acute Care (PAC) Discharge or Transfer** It is essential that the hospital discharge transfer of health information specifically addresses the status of any patient wounds. Wound deterioration is one			

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			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. The proper care of these wounds can significantly lower follow up care on readmissions, infections and complications. A detailed understanding of the wound care needs documented in the patient 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.6 The transfer of health information upon PAC admission and upon PAC 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. AdvaMed supports the draft measure specifications that include wound care status in the "Conditions and Co-morbidities" section of "Types of Health			

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			Information" received at PAC Admission, start of care, resumption of care and upon PAC Discharge or Transfer. 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 measures consideration s for home health agencies and other post-acute care settings under the IMPACT Act. Information at Post-Acute Care (PAC) Admission, Start of Care or Resumption of Care and at Post-Acute Care (PAC) Discharge or 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 Importantly a recent AHRQ Statistical Brief presenting data on hospital discharges involving malnutrition demonstrates malnourished inpatients tend to be older, have up to 100% longer lengths of stay and can have significant increases in episode costs; up to $25,000 versus $12,500 per episode for non-malnourished adults. This new study estimates the economic impact of malnutrition in the hospital to be $42 billion.9 There is a growing body of evidence that 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			

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			assistance to assure adequate nutrition during the early post-discharge period FY2017 Final Rule for the Medicare Inpatient Prospective Payment System CMS acknowledged that including nutritional status and a nutrition care plan during transitions of care to an individual, a caregiver or provider are important components of care.12 We support the draft measure specifications that include diet/nutrition in "Types of Health Information" received at PAC Admission, start of care, resumption of care and upon PAC Discharge or Transfer. We urge CMS to consider including more specific nutrition examples in the list to alert providers to include nutritional status and diet orders when feasible as necessary medical information as an individual transitions. Transferring health information that includes whether a beneficiary has a diagnosis of malnutrition or has been identified as at-risk of malnutrition via screening or assessment is critical for individuals, caregivers and providers to provide continuity of nutrition care. Our recommendations for revisions are as follows: 1. #3. Special services, treatments, or interventions; i.e., ventilator support, dialysis, IV fluids, parenteral or enteral nutrition, blood product use. 2. #4. Medical conditions and co-morbidities (e.g., pressure injuries and skin status, nutritional status. and pain 3. #9. Diet/Nutrition Orders including tl1eraoeutic nutrition and counseling Individuals and caregivers want and need this information. A recent survey by the Gerontology Society of America's National Academy on an Aging			

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			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. 13 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 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. 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. Implementation of an effective care transition plan for patients diagnosed as malnourish shed 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 and the goals and recommendations of the IMPACT Act. 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.			

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			As malnutrition is an independent risk factor for poor outcomes and increased costs across healthcare settings, AdvaMed recommends that CMS adopt a malnutrition-related quality measure in Quality Reporting g 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 Posts-Acute Care quality programs we recommend that CMS implement a "nutritional status domain" highlighting nutrition al status as a key indicator of adult health.			
26.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	**Delivered electronically to** TOHPublicComments@rti.org. To RTI International and the Centers for Medicare and Medicaid Services: This comment letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) in response to the Call for Public Comment on two quality measures under development for post-acute care (PAC) providers pursuant to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The measures are: 1. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings; and 2. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings. AMRPA is the national trade association whose members provide rehabilitation services across the spectrum of health care settings including inpatient rehabilitation facilities (IRFs), hospital outpatient departments (HOPDs), and settings independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs). AMRPA members	Mimi Zhang Policy and Research Associate American Medical Rehabilitation Providers Association (AMRPA)	mailto:mzhang@amrpa.org	IRF LTCH SNF Advocacy

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			help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. AMRPA has reviewed the report prepared by RTI International, Draft Specifications for the Transfer of Health Information and Care Preferences for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies, and we offer the following comments. **I. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings** **A. General Comments** As PAC providers, IRFs receive approximately 85 percent of patients as referrals from acute care hospitals. Hence the acute care hospital is the primary provider from which IRFs receive discharge and other patient health information. Unfortunately, the quality of that information varies widely for multiple reasons. Acute care hospitals do not have to provide the type of proposed information requested on transferring a patient. We believe the only requirements they must follow to participate in Medicare are those as set forth in the Hospital Conditions of Participation. If there is a way to develop this measure to incentivize acute care hospitals to provide complete information when transferring the patients, we urge that it be tackled. **B. Use as a Quality Measure** AMRPA does not support the use of this proposed measure as a quality measure. A quality metric generally presumes an outcome or result on which the measured provider's behavior or actions could affect. That is not the case for this proposed measure			

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			which fundamentally assesses the behavior of an upstream entity – namely, did they transfer information to the receiving PAC provider. Hence, we recommend that the discussion about the measure be reframed so it is classified instead as a benchmarking and data collection effort, similar to the proposed assessment questions on the Route of Health Information Transfer. Essentially this measure asks the receiving PAC provider: a) Did you receive any information and, if so, then b) Did you receive it in the stated categories? In its proposed usage as a quality measure utilizing a numerator and denominator, this metric implies that a higher percentage equates to better performance. However, measuring receipt of information on admission as a percentage will measure only the referring entities' behavior, not the IRFs', and IRFs should not be penalized or otherwise held accountable for the behavior of the referring provider. Furthermore, at no time does the measure imply there is an affirmative duty placed on the receiving provider to contact the sending provider for the information. Hence, if IRFs are expected to do so, that would be an additional burden they must incur and there is a concern that it could cause tension with referring providers. Notably, most IRFs obtain practically all the information sought through this measure when the IRF's clinicians conduct the required Patient Admission Screening (PAS) prior to admitting a new IRF patient. The PAS could be transferred to this proposed measure but would not reflect what information the referring entity provided. **C. Specific Information Requested** In reviewing the proposed eleven categories of health information, we recommend that			

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			psycho/social information also be collected. In addition, we are concerned that obtaining accurate medication information is difficult. For purposes of this proposed measure, however, the question is whether or not it was provided, not if it seemed appropriate or accurate. With respect to the eleven categories, we offer the following comments: Several of the items are redundant and therefore increase the reporting burden. Items such as “Administrative information” should be reexamined and narrowed. Functional status should be retained and encompass mobility and self-care at a minimum. Cognitive function and mental status should be retained. Special services should be retained. Medical conditions and co-morbidities should be retained. Impairments should be retained. Medication instruction should be retained and explained. Patient care preferences should be retained and also expanded to include preference regarding language used and religion as examples. Goals of care needs to be clarified whether they cover the goals of care in acute care or the referring providers’ projected goals of care for the PAC provider. Diet/nutrition should be retained. According to the proposed specifications, if one of the eleven categories of information is transferred, the PAC provider would check that category in the assessment form and the measure numerator is considered fulfilled. However, this begs the question of whether PAC providers will just check one in order to save time, regardless of how many types of information is received. If so, then there would be no			

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			benefit to the provider in checking more than one category. Again, the intent of this measure is more appropriate for data collection and benchmarking purposes, and not for quality and performance measurement purposes. **D. Denominator Specifications** One of the objectives of the IMPACT Act is to collect comparable data across all the four PAC providers encompassed within the Act. To do so implies that utilized measures are essentially identical if there is to be a true comparison. However, the populations to be used in the denominators for the various providers are different for this proposed measure. For example, for IRFs the population for the denominator is Medicare Part A (traditional fee for service Medicare) and Part C (Medicare Advantage) patients. For SNFs, it is only Part A residents. As a result, the final data collected would be comparable within provider types but not across provider type. AMRPA recommends this approach be reconsidered. It is critically important that CMS prioritize cross-setting standardization as it develops and implements PAC quality measures. We are concerned that these measures could result in selective sampling of the patient population that would skew the collected data and distort or otherwise invalidate meaningful comparisons across measures and across PAC settings. AMRPA believes that the measures should be applied to a uniform Medicare patient population that is inclusive of Medicare Parts A and C beneficiaries. **II. Transfer of Information at Post-Acute Care: Discharge or End of Care to Other Providers/Settings** **A. General Comments**			

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			AMRPA supports collection of data of this nature. Furthermore, we support efforts to delineate the information to be included at the time of transfer from the PAC provider and to the families, patient, and caregivers as well. **B. Use as a Quality Measure** AMRPA believes this proposed measure lends itself more readily to being characterized as a quality measure as the information was in the control of the PAC provider. **C. Specific Information Requested to be Transferred** Again, similar to the Transfer of Information at Admission measure, various information categories proposed for the discharge measure are redundant and unnecessarily burdensome. In reality, IRFs generally provide this information at discharge. However, to pull it from the patient record and then cross-reference it by the measure's categorical definitions may be an extra burdensome task. We are foremost concerned with the heavy obligation this measure would create for provider. Items such as "Administrative information" should be reexamined and narrowed, as they are redundant and therefore increase reporting costs and obligations unnecessarily. While we support the intent of Questions 3-5, since "Question 5: Types of Health Information Provided to the Patient/Family/Caregiver at Discharge or Transfer" duplicates the eleven information categories from "Question 2: Types of Health Information Provided at Discharge or Transfer," the two could be combined to serve a single function. Alternatively, if Question 5 is retained, it should be			

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			pared down in scope to focus on the categories of information most meaningful to the patient/family/caregiver at discharge and to minimize provider burden. Of the eleven categories, “Goals of care” needs to be clarified as to whether it refers to the goals of care at the discharge PAC setting or the projected goals of care for the receiving PAC setting. **D. Denominator Specifications** The Medicare populations proposed for this measure denominator are, again, different for the various PAC settings. AMRPA recommends that CMS and its contractors prioritize cross-setting standardization as it develops PAC quality measures. Doing so ensures that cross-setting quality measures implemented under the framework of the IMPACT Act are truly standardized and generate valid and meaningful comparisons across settings. **III. Summary** AMRPA appreciates the opportunity to comment on the report Draft Specifications for the Transfer of Health Information and Care Preferences for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies. In summary: A. We do not support the use of “Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings” as a quality measure. We recommend that the assessment questions pursuant to this measure be reframed as befitting data collection for benchmarking purposes. B. We recommend that CMS refrain from creating unnecessary burden for PAC providers by eliminating			

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			some categories of required information or collapsing some assessment questions as we suggest. C. We recommend that Medicare beneficiary population for the measures' denominators be aligned and consistent across the PAC settings. D. We urge CMS to incorporate acute care hospitals in the assessment of transfer of patient information. CMS should focus on efforts that would incentivize hospitals to provide complete information when transferring/discharging patients to PAC settings. If you have any questions regarding our recommendations, please contact Carolyn Zollar, J.D., Executive Vice President for Government Relations and Policy Development (czollar@amrpa.orgmzhang@amrpa.org), or Mimi Zhang, Policy and Research Associate () at 202-223-1920.			
27.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Dear RTI International: As the largest provider of inpatient rehabilitation facility ("IRF") services in the nation, and in partnership with Encompass Home Health, the fourth largest Medicare home health ("HH") provider, we appreciate the opportunity to submit comments on your work for of the Centers for Medicare and Medicaid Services ("CMS") regarding the development of Transfer of Health Information and Care Preferences ("TOHI") measures. Given our presence in the post-acute ("PAC") sector, we have a legitimate interest in helping RTI International ("RTI") craft measures that prove useful across the spectrum of PAC providers and achieve the IMPACT Act's vision of standardized PAC quality data. We have several comments that offer constructive insight toward the development and design of these measures. We respectfully encourage RTI and CMS to analyze and	Andrew Baird HealthSouth Director, Government Relations	mailto:Andrew.Baird@healthsouth.com	IRF

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			consider these comments and how they would improve the framework for this suite of post-acute care measures. I. Measuring PAC Providers' TOHI Success Without Upstream Counterparts According to the measure specifications, the pair of TOHI measures are designed to "ensure] that a provider is accountable for transferring important information at transitions."1 Successful transfer of health and care preference information between two providers is, of course, dependent on both the receiving entity and the upstream transferring entity. The measure domain's description in the IMPACT Act explicitly specifies that these measures should cover transitions from upstream hospitals to PAC providers. However, to the best of our knowledge, there are no corresponding TOHI measures for upstream providers (primarily acute hospitals) that assess the capability of those providers to transfer the required health and care preference information to their PAC partners. This "gap" around hospital information transfer is a barrier to the accurate measurement of TOHI success at the PAC level because it may result in a low TOHI success rate for PAC providers with unresponsive or uncooperative acute hospital partners. Accordingly, we ask that CMS and RTI clarify whether and how a PAC provider who is unable to obtain the information captured by these TOHI measures from an acute hospital, despite reasonable best efforts, will be impacted for purposes of these measures. I. RTI, Draft Specifications for the Transfer of Health Information and Care Preferences for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies 3 (2016). 2			

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			II. The TOHI Measures Should Cover the Same Patient Populations for Each PAC Setting Under the current draft design of the TOHI measures, the patient populations covered by the measures are different for each PAC setting. In other words, the denominators differ in scope between each PAC setting. The skilled nursing facility (“SNF”) versions cover Part A Medicare beneficiaries only, the IRF versions cover Part A and Part C (Medicare Advantage (“MA”), the long term care hospital (“LTCH”) versions cover all LTCH patients (regardless of payer source), and finally, the HH versions cover Part A, Part C, and Medicaid patients. The measure specifications offer no rationale for this variation in patient populations between PAC settings, and it is concerning that such significant variation exists within measures that are intended to be standardized across those settings. IMPACT Act measures are required by law to be standardized across settings, yet this aspect of the TOHI measure design contravenes that standardization principle and presents no reasonable interpretation of the standardization requirement to justify its departure. As proposed, these differences in the payer populations rotely mirror the pre-existing site-specific requirements for submitting patient assessment instruments. That is, the TOHI quality measure patient domains are based on the site-specific requirements governing patient assessment submission (not on clinical rationale): Under Medicare, IRFs are required to submit IRF-PAIs for Part A and C patients, SNFs are required to submit the MDS for Part A patients only, LTCHs are required to submit the LTCH CARE tool for all patients, and HHAs are required to submit the OASIS for Part A, Part C, and Medicaid patients.			

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			These differing patient assessment requirements are longstanding policies within each setting that have no connection to the IMPACT Act's requirement for measure standardization. They are therefore an arbitrary and inappropriate basis for standardized quality measurement. For example, the IRF version of the TOHI measure measures IRFs on all Part A and Part C patients. This seems to be the case only because IRFs are already required to submit all Part A and Part C patient assessments under Medicare. And this Medicare submission policy is premised on the fact that CMS uses both Part A and Part C patients to measure compliance with the IRF-specific 60% Rule – a rule that applies only to IRFs and no other types of PAC providers. It comes off as clumsy to use that site-specific policy detail (and others which drive the other site-specific assessment submission requirements), as the reason for varying the patient populations within the TOHI measures. Resolving these discrepancies is not difficult either. By simply specifying that the TOHI measures are only based on Part A patient assessments for all PAC providers (instead of rotely following the assessment submission requirements), CMS and RTI could resolve these discrepancies. Furthermore, this troublesome variation in patient populations is also substantively problematic due to the inherent differences in the patient profiles associated with the different payer sources. For example, MA patients (Part C) generally present in institutional PAC settings (IRF, LTCH, SNF) with more severe rehabilitation needs and more complex medical profiles than do traditional Part A patients. However, as currently drafted, only IRFs and LTCHs would be measured on their MA populations, while SNFs would not be, creating a discrepancy in the types of patients these measures capture. This			

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			difference is particularly relevant to questions 2 and 5 in the TOHI measures ("Q2" "Q5") because higher levels of patient severity and complexity can impact a provider's capacity/ability to successfully communicate all of a patient's health information and care preference specifics to another entity, whether a successive PAC provider or a family caregiver. Similar points can be made regarding the relative complexity of the home health Medicaid population versus the home health Part A population. That instance of variation is perhaps the most egregious since Medicare Part A home health benefits fundamentally require different clinical needs than home health Medicaid patients (Part A patients required skilled home care, whereas Medicaid does not require skilled care). These levels of variance stand to drastically impact the accuracy and reliability of comparative review of PAC quality performance. Our concern here is not only based on the discord between measure design, but also in the fact that this information is slated to be used in the real world, by hospitals and other providers, when making discharge planning decisions. In 2015, CMS published the Hospital Discharge Planning Rule, CMS-3317-P, which explicitly requires hospitals to utilize the data from IMPACT Act measures when determining which PAC settings are most appropriate. If the data that comprises individual providers' performance on these measures is skewed based on which patients they cover (i.e., a home health agency with a relatively high Medicaid population may have significant difficulty receiving health information for Medicaid patients if they are often coming from social assistance institutions and not formal hospital settings, per Section I of this comment), this measure design artificially changes how they "appear" to a discharging hospital. Therefore, we strongly			

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			recommend that RTI endeavor to design the TOHI measures so that they are applied consistently across PAC settings. III. Capturing Repeat Attempts to Receive Health Information and Care Preferences These TOHI measures request that the transfer of health information and care preferences be assessed at two time points during a patient's stay – at admission and discharge. The measure specifications, however, only state that the admission TOHI measure should be collected at "admission, start of care, resumption of care" and do not give any more detail as to collection timing, particularly in regard to repeat attempts to receive or obtain information from an upstream provider that occur after a patient arrives and begins receiving care.2 It may often be the case that the transfer of patient health information and care preferences do not coincide with a patient's arrival at a PAC provider, but only after the PAC provider has affirmatively requested it from the upstream provider – a sequence which could occur a day or more after the patient's initial arrival. Accordingly, the "admission, start of care, resumption of care" phrasing is ambiguous about whether the recording clinician would complete the admission TOHI measure only at the time when the patient arrives, or after a reasonable time has elapsed (a "grace period" to allow the upstream to provide the required information). Additionally, if the upstream provider is materially delayed in furnishing the PAC provider with the health and care preference information, but still does so after the "admission" time frame has passed (or after the clinician has completed the measure items), it could create confusion in a recording clinician as to whether s/he should erase the initial responses to the admission TOHI measure items and re-enter them to reflect the			

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			eventual (but delayed) information transfer, or instead simply leave the responses as they were at the time admission. This problem ultimately represents a time-utilization issue: if there is uncertainty about whether and how to complete a measure, some clinicians may waste time trying to track down information days after a patient's admission – time that could otherwise be spent on patient care. The problem could be exacerbated in larger PAC providers that receive patients from many and different types of upstream providers, each of whom may have different protocols are transferring health information at discharge. Accordingly, in order to avoid the confusion and time mismanagement problems, we respectfully recommend that RTI and CMS clarify that the TOHI admission measure items should be completed by a clinician at the time a patient arrives at the PAC provider. IV. Time Burden Estimates As noted above, these TOHI measures will rely on the affirmative data collection from clinical staff in the various PAC settings. Unlike other measure proposals that generate new administrative requirements on clinicians, the RTI measure specifications do not include any time or burden estimates associated with collecting this data. Given the significant time burdens that have grown out of other IMPACT Act measures, we respectfully request that the next draft specification document for these TOHI measures include an estimate about how much time (and corresponding cost impacts) that these measures will generate. Since these measures are categorically less meaningful on account of being "process measures" (as opposed to "outcome measures"), we believe that provider burden should be kept to a minimum. V. Timing of Public Comments Submission			

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			The due date for public comments on these TOHI measures is December 11th. Not only is the 11th a Sunday, but it is also only two days before these measure will voted on for approval by the National Quality Forum ("NQF") Measure Application Partnership's ("MAP's") PAC Committee. Not only does placing the comment due date on a Sunday likely decrease the amount of comments that submitted from the public, but even for those that are, the two day turnaround period between the comment deadline and the MAP voting at NQF is likely too short for RTI to make any changes to the measure, even those that are warranted. For that reason, we question whether public comments will be able to be considered and, if warranted, acted on before the measures are put before the NQF MAP. In the future, we hope that the measure development process will allow sufficient time to fully process public comments that are received at one step before additional steps are taken towards implementation. VI. Conclusion Thank you for your attention to these comments. We hope our views and insights will prove constructive in the development of these TOHI measures, especially at this relatively early stage in the development process. Should you wish to discuss any content contained in this letter, please contact us at the information below.			
28.	12/12/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and	Regarding Public Comments for: 1. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings 2. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Judy Kulus, VP of Curriculum Development American Association of Nurse Assessment Coordination (AANAC)	mailto:jkulus@aanac.org	Advocacy

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Submitted to: TOHPublicComments@rti.org Dear Sir or Madam, The American Association of Post-Acute Care Nursing, AAPACN, (doing business as the American Association of Directors of Nursing Services [AADNS] and the American Association of Nurse Assessment Coordination [AANAC]), represents over 15,000 long-term care nurses across the country. AAPACN supports the goals of the Centers for Medicare & Medicaid Services to improve care, improve health and make care more affordable as identified by CMS as the Triple Aim. We also are supportive of the goals of the IMPACT Act, which aligns the post-acute care (PAC) assessments by standardizing the data elements for use in quality reporting. After reviewing the proposed quality measures for the Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and the Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings, we have the following recommendations: AANAC.org I AADNS-LTC.org I 800.768.1880 I 844.796.9634 I 400 S. Colorado Blvd, Ste. 600, Denver, CO 80246 • We recommend that the QMs include in the method of communication, whether the information was sent or received in the patient's preferred language. Consider adding whether the communication between settings and/or with the patient/resident was in their own language, written, or braille, etc. • We recommend that the Q2 list include whether the transfer of information included family support and/or participation. Sending			

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			information about the patient's family support would be helpful to the receiving provider. • We recommend that Q2 include the option, "spiritual orientation/religion". Sending information about important spiritual and/or religious values would be helpful to the receiving provider. • In reviewing Q2. Types of Health Information Received at Admission, Discharge, or Transfer (for both QMs), there are no definitions provided for the items listed such as "Functional Status, Cognitive Function and Mental Status, etc." We recommend that there be guidance provided regarding what constitutes the successful transfer of information. To that end, could the resident's functional status or cognitive function be defined or stated as "last known". In cases where a patient/resident is transferred emergently, the best information about them in each of the 10 areas listed in Q2 might be the last known. • Consider differentiating the required information to be transferred by whether the transfer was un-planned/emergent or planned/end of care. While much of the information may be the same regardless of whether a transfer was planned or unplanned, the ability to send some information may be hampered in an unplanned transfer. • Perhaps defining the resident status in the 10 items in terms of "usual" function would be clearer to the assessor to evaluate if the information was sent or received. • Additionally, we are wondering if, in the case of the SNFs, does the Numerators for the QMs include only residents on Medicare Part A or will they also include Part C beneficiaries as well (as in the case of the IRF-PIE)? We observed that the draft QMs indicate that for SNFs, the numerator			

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			does not indicate that the information is taken only from beneficiaries on a Part A stay. However, the Denominator, states that it gathers information from SNF patients who are on Medicare Part A. • When answering Q2, how is the assessor going to evaluate whether the information received from a different PAC provider was adequate to check that it was received? It is much easier to evaluate the information sent by a provider (since the patient/resident is known by the provider) than it is to evaluate that adequacy of information received from another entity. Please add additional definitions and instructions regarding what information should be included in the transfer to meet the transfer standard. • Lastly, the questions proposed in the draft QMS for addition to the MDS, IRF-PIE, and OASIS are very vague. Particularly Q2 and Q5 related to items 1 through 10. We recommend that these be listed with more specificity in order to adequately evaluate that the item was received or sent between providers. • Thank you for the opportunity to respond to this request for comments.			
29.	12/11/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	RE: Quality Measure Development to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions Dear Acting Administrator Slavitt: The Healthcare Nutrition Council (HNC), representing manufacturers of enteral nutrition formulas, parenteral nutritional formulas, supplies and equipment, submits these comments on Quality Measure Development to satisfy the Improving Medicare Post-Acute Care Transformation Act of	Nick Gardner Executive Director Healthcare Nutrition Council	mailto:NGardner@kellencompany.com	Advocacy

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ID	Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
			2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Our primary recommendation to CMS can be summarized as follows: 1. HNC supports the proposed transfer of health information measure concepts a. Transfer of information occurring at PAC admission, start of care or resumption of care b. Transfer of information occurring at PAC discharge or transfer 2. We commend CMS for acknowledging the importance of nutrition in patient recovery and health status by including nutrition in "Types of Health Information" received at Admission or provided upon Discharge. We urge CMS to consider revising the current language in "Types of Health Information" for each measure to include the following: a. Special services, treatments, or interventions; i.e., ventilator support, dialysis, IV fluids, parenteral or enteral nutrition, blood product use. b. Diet/Nutrition Orders including therapeutic nutrition 3. We also recommend CMS include the patient's nutritional status in transfer of information; i.e., diagnosis or last nutrition assessment. We urge CMS to consider revising the current language in "Types of Health Information" for each measure to include the following: a. Medical conditions and co-morbidities (e.g., pressure injuries and skin status, nutritional status, and pain. Because of nutrition's vital role in patient care, HNC believes that collecting and providing information about nutrition and nutrition interventions when a			

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			patient transitions between healthcare providers is essential and will lead to fewer and shorter hospitalizations/rehospitalizations, better overall patient health particularly during an important transitional period, and better patient outcomes. In particular, patient setbacks resulting from transition to post-acute care can be mitigated by proper nutrition and the continuation of therapeutic nutrition when indicated. It is widely recognized that nutritional status plays a significant role in health outcomes and healthcare costs. Malnutrition generally is defined as "an acute, subacute or chronic state of nutrition, in which varying degrees of over nutrition or undernutrition with or without inflammatory activity have led to a change in body composition and diminished function. "Malnutrition has also been defined as a state of nutrition in which a deficiency, excess, or imbalance of energy, protein, and other nutrients cause measurable adverse effects on body function and clinical outcomes. There are three common types of malnutrition diagnoses for adults in clinical practice settings: (1) starvation-related malnutrition; (2) chronic disease-related malnutrition; and (3) acute disease or injury-related malnutrition. In these comments, we refer to chronic disease-related malnutrition, acute disease or injury-related malnutrition as well as generically as disease-related malnutrition. Disease-related malnutrition can have similar distinct nutrient requirements altered across all spectrums of body mass index, ranging from under to overweight individuals. For over 30 years, large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-term care residents are undernourished. Significantly, patients' nutritional			

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			status often is not evaluated or diagnosed in a timely manner despite the common occurrence and clinical relevance of malnutrition. In a recent study conducted by the Agency for Healthcare Research and Quality using the Healthcare Cost and Utilization Project database, only about 7 percent of hospitalized patients are diagnosed with malnutrition. With as many as half of hospitalized patients and 35 to 85% of older long-term care residents undernourished, the extremely low number of diagnosis for malnutrition represents a diagnosis and gap that needs to be addressed. Given the prevalence of malnutrition among individuals in long-term care settings or those transitioning into post-acute care, it remains essential that information about a patient's nutritional status and diet orders including any information on prescribed use of therapeutic nutrition be collected and transmitted during care transition. Furthermore, given low diagnosis rates of malnutrition in many patients, it would be beneficial for information on the last or frequency of any previous nutrition assessments also be provided. Such information will allow the new facility to better assess whether the patient may need initial or additional nutrition screening to determine whether they may be malnourished and/or could benefit from a specialized diet or some kind of nutrition intervention. Given the potential for patients to become malnourished as a result of certain disease states and/or hospital procedures, this is particularly important in the context of transition from post-acute care. As noted, malnutrition often is associated with acute and chronic diseases and injury, such as cancer, stroke, chronic obstructive pulmonary disease, heart failure, infection, trauma and surgical procedures.			

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			These diseases and conditions may cause an individual to become malnourished with malassimilation and/or inappropriate provision of nutrients. Overall patient care and outcomes are affected by nutrition care management, which includes timely diagnosis and application of appropriate treatment of malnutrition. Key measureable outcomes that can be positively affected by appropriate nutrition intervention, such as oral nutrition supplements, enteral or parenteral nutrition, include the following: • Morbidity, Complications and Mortality: Malnourished patients are more likely to experience complications, such as pneumonia, pressure ulcers, nosocomial infections, and death, addition, malnutrition is a risk factor for other severe clinical events, such as falls and worse outcomes after surgery or trauma. Malnutrition has a negative impact on patients with specific chronic diseases and conditions, such as stroke patients, and patients with heart failure, cancer, or COPD. • Length of Stay: Malnourished patients, as well as patients at risk for malnutrition, have significantly longer hospitalizations than well-nourished patients and patients not at risk for malnutrition • Readmission, Institutionalization and Ongoing Services: Disease-related malnutrition is a common reason for patients to be readmitted to hospitals. One recent study found that malnourished patients with heart failure were 36 percent more likely to be readmitted to the hospital within 30 days than nourished patients with heart failure. Additionally, hospitalized patients at risk of malnutrition are more likely to be discharged to another facility or require ongoing healthcare services after being discharged from the hospital than patients who			

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			are not at risk for malnutrition. A recent retrospective health economic study found that providing oral nutritional supplements to Medicare patients aged 65+ with any primary diagnosis was associated with a 16% reduction in length of stay and a 15.8% cost savings – an average of $3,079 -- per episode. • Health Care Costs: Disease-related malnutrition, particularly when not diagnosed and treated, increases the cost of care due to the factors described above: increased morbidity, complications and mortality, longer hospitalizations, and more readmissions, continued institutionalizations and ongoing health care services. • A 2014 study estimates that the annual burden of disease-related malnutrition for older adults aged 65 years and older across eight diseases was $51.3 billion. The authors hypothesize that their findings likely underestimate the total burden of disease-related malnutrition since its rates are much higher in hospitalized patients. The cost impact of untreated malnutrition is illustrated below: • Costs Related to Increased Morbidity and Complications: High-risk malnourished patients are 2.1 times more likely to develop pressure ulcers than well-nourished patients. One study cited the average cost for hospital treatment of a stage IV pressure ulcer acquired in the hospital (including the treatment of associated medical complications) to be $129,248. The average cost of hospital treatment of a stage IV pressure ulcer acquired in the community (including the treatment of associated medical complications) was $124,327. • Costs Related to Hospitalizations: Hospitalized malnourished patients, patients at risk for disease-related malnutrition and patients who			

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			experience declines in their nutritional status while hospitalized have higher health care costs than well-nourished patients, patients not at risk for malnutrition, and Patients frequently experience declines in their nutritional status while hospitalized. • Costs Related to Readmissions: Malnourished patients and patients with nutrition related or metabolic issues are frequently readmitted to the hospital. Studies have demonstrated that readmissions are 24-55% more costly than initial admissions and account for 25 percent of Medicare expenditures. One study found that there were 11,855,702 Medicare fee-for-service patients discharged from hospitals between October 1, 2003 and September 30, 2004 who were at risk for rehospitalization; 19.6 percent of the patients were readmitted within 30 days, resulting in a cost of $17.4 billion. Timely, appropriate clinical nutrition therapies can improve or maintain patients' nutritional status, and result in less morbidity and fewer complications, shorter hospital stays, fewer hospitalizations, reduced hospital readmissions and savings. It is for these reasons that CMS must continue to ensure that information about a patient's nutrition status and nutrition interventions are communicated during care transitions. For example, oral nutritional supplements (ONS) for hospitalized patients are associated with reductions in hospital lengths of stay, admission rates and costs. Specialized nutritional products designed to meet the unique nutritional needs of major surgery patients with distinct nutrient ingredients have been proven to significantly reduce post-operative infectious complications which include nosocomial pneumonia, surgical site infections, anastomotic leaks, and urinary tract infections.			

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			Similar to ONS, early usage of parenteral nutrition products in combination with enteral nutrition products or when enteral alone are not feasible also results in many of the beneficial patient outcomes noted above. For example, the early administration of combined parenteral and enteral nutrition has been shown to decrease ICU stays and decreases in nosocomial infections, antibiotic use, and lead to shorter duration of mechanical ventilation. Other recent research has shown no significant difference in 30 and 60 day mortality or infection rates associated with the route of delivery, either parenteral or enteral, of early nutritional support in critically ill adults. Regardless of the route of delivery, the research clearly shows that early diagnosis and effective treatment of malnutrition can improve patient outcomes, reduce morbidity and lower overall costs of care. Whether ONS or parenteral, the demonstrated benefits of these nutrition interventions can only be realized after a transition if the patient continues to receive the indicated treatment. Thus, it is vital that information about the patient’s nutritional status and diet orders including use of therapeutic nutrition products and the last nutrition assessment be provided in a transition so that the patient can continue to receive the appropriate care through the transition process. We urge CMS to take action on the health and economic impact of disease-related malnutrition to help achieve our shared goals of “Better Care, Smarter Spending and Healthier People.” This is particularly important in the context of beneficiaries transitioning in and out of post-acute care, since their conditions can be complex and delicate. Good nutrition care can help decrease disability which is critical for older adults to remain independent and in their own homes.			

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			In 1974, a seminal paper was published that identified several factors that contribute to malnutrition such as: lack of awareness of increased nutritional needs for injury/illness and the role of nutrition in infection; not prioritizing nutrition for surgical patients; gaps in communication between clinical teams and physicians; and delayed nutrition intervention.li These issues are still relevant in our current healthcare delivery system, including those transitioning in and out of post-acute care and may adversely affect timely diagnosis, patient care, outcomes, and healthcare costs. However, screening patients for malnutrition, providing follow-up assessments when indicated, documenting the medical diagnosis in the electronic medical record, transferring this information during a transition of care, and furnishing appropriate nutrition interventions can be cost-effective, improve patient care and outcomes. Documenting this information and ensuring that it is transmitted during a care transition will help to ensure patients receive consistent care through a transition lessening the potential for rehospitalization and increasing the quality of care. The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) has published a consensus statement that provides an overview of the general characteristics used to diagnose malnutrition and strategies to implement these criteria as part of a comprehensive malnutrition program. Detecting risk factors and accurately diagnosing malnutrition can be done easily by routinely screening patients in all settings for malnutrition and providing patients with timely, follow-up assessments, if needed. Once a			

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			diagnosis is determined, and if further nutritional intervention is indicated, then providing patients with appropriate nutrition therapies, including oral nutrition supplements, enteral or parenteral nutrition, and nutrition-related services in a timely manner can improve or maintain patients' nutritional status. As a result of detecting, preventing, diagnosing, and treating disease-related malnutrition, individuals will experience less morbidity and fewer complications, shorter hospital stays, and fewer hospitalizations and hospital readmissions. Quality of life indicators, such as increased or sustained mobility, will also increase. HNC commends CMS for recognizing the importance of evaluating and maintaining patients' nutritional status, such as the recent inclusion of malnutrition electronic clinical quality measures on the Measures Under Consideration list for the Hospital Inpatient Quality Reporting Program and authorization for dietitians to write therapeutic diet orders for hospitalized patients. HNC encourages CMS to continue pursuing policies that promote identifying, preventing, diagnosing, and treating disease-related malnutrition in a timely manner. We believe this project offers another opportunity for CMS to prioritize collection and transmission of information about an individual's nutrition status throughout the continuum of care. As such, HNC urges that CMS ensure that malnourished patients or those identified as at risk for development of the condition, including those transitioning in and out of post-acute care, be identified and furnished with timely, clinically indicated nutritional treatments. This includes maintaining and expanding information that is required to be transmitted to the new care setting on diet/nutrition, any therapeutic nutrition			

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			interventions, and any information on last nutrition screening when a patient transitions. Overall, HNC recommends CMS adopt quality measures and other policies to encourage timely and coordinated nutrition screening, assessment, diagnosis, and appropriate nutrition interventions across all care settings. HNC suggests that CMS incorporate such measures into a future quality programs soon as feasible; i.e. Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-Term Care Hospital Quality Reporting, Inpatient Rehabilitation Facility Quality Reporting, Nursing Home (NH)/Skilled Nursing Facility Quality Reporting, Home Health Quality Reporting (HH QRP) and other appropriate initiatives. Thank you for the opportunity to comment on this project. If you have any questions or would like additional information, please contact me at ngardner@kellencompany.com or 202-207-1116.			
30.	12/12/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	To: RTI International, Abt Associates and the Centers for Medicare and Medicaid Services (CMS) Delivered electronically to TOHPublicComments@rti.org On behalf of Gundersen Health System, I write in response to the Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions Gundersen Health System provides integrated care for patients in predominantly rural areas along the Mississippi River in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin region with over 6,000 employees, Gundersen provides	Deb Head, Rehab Program Manager Gundersen Health System	mailto:djhead@charter.net	IRF SNF

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			integrated healthcare services including: clinical care, level II trauma care, medical education, and air and ground ambulance services and Inpatient Rehabilitation. Gundersen has consistently achieved top national rankings in many areas of medical excellence including being named as a Healthgrades Top 50 hospital in overall care, many clinical specialty services, and patient experience. I appreciate this opportunity to provide our comments. The transfer of information from one setting to another can enhance the coordination of care. However, I have some concerns related to the measures presented. • Duplication of data collection and documentation related to pre-admission screening requirements in most of the PAC settings. • Unclear how these measures will validate quality of care delivered by the PAC provider, both sending and receiving the information. • Types of Health Information received and sent do not appear to be defined, leaving the application of the measure open to wide variation from one provider to the next. To further explain my comments above; 1) Duplication of data collection and documentation. At least three of the PAC settings cannot accept admission of a person into their programs without meeting very specific admission criteria; Home Health, IRF and LTCH. These three settings already require extensive documentation review, collection of information and making sure most and in some settings all of the information mentioned in this proposed measure is required prior to admission. Will adoption of this measure lead to a relaxation of the pre-admission			

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			requirements of the three PAC settings listed above? Or will it truly be one more duplication of documentation requirements added to several other duplications? Many of the elements of the IMPACT Act have already added significant duplication leading to higher costs, extensive time and decreased efficiency with very little added benefit to the patient. Again, this information is already required within the context of current regulations within some of the settings. 2) It is unclear how the how these measures will validate quality of care delivered by the PAC provider, both sending and receiving the information. It is a check box if you feel you provided the information listed or if you received the information listed. From the current documents it appears to be left to the discretion of the person completing the form to determine what is acceptable. This leads to vague and non-descript interpretation of the measure. The sending provider can perceive they met the intent of the measure and mark affirmatively. However if the information lacks the detail necessary for the receiving provider, they will be forced to duplicate the efforts and seek the necessary information needed for appropriate care planning for the patient. The sending provider would get credit for providing information regardless of how valuable or not the information sent proved to be. Additionally if you provided information in good faith however the next provider had inadequate systems in place to keep track of the information you provided you as a sending provider could get erroneously penalized by the fact that the receiving provider did not have adequate systems in place and did not indicate they received information you did provide to them. It appears prone to false positives and false negative responses.			

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			As currently built in the pre-admission process (for example in an IRF) you have a vested interest in getting all necessary information upon transfer from one setting to another for appropriate care planning and to meet federal regulation by CMS. You are not forced to be rated by the negative or positive actions of other providers yet it is in the best interest of the referral sources to work together for the best information transfer for quality patient care. 3) Types of Health Information received and sent do not appear to be defined, leaving the application of the measure open to wide variation from one provider to the next. As referenced previously the value of the information sent may or may not meet the needs of the information needed by the next provider potentially making it of little value and creating duplicate efforts to acquire useful information for quality patient care. In summary, transfer of information is important however in an effort to standardize, the measures appear to be made vague to allow them to be used across settings. This risks making the measures of little value across the board and not meeting the ultimate goal of improved patient care, feasible for all PAC settings, useful for describing case mix and valid and reliable information (it is my opinion that vague information cannot be validated or reliable). This can lead to increased cost, decreased efficiency for little value when some of the work is already done for some settings such as pre-admission screens. CMS has tools that are already proven and demonstrate the aims they seek to achieve, one example is the FIM tool for function and cognition function. I urge you to re-consider adding more data elements when in some cases there are already resources in place that can achieve the desired results. We end up collecting volumes of data for the sake of collecting data that is not value added and			

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			not true integration for better patient care and decreased costs. Thank You for your time and attention. If you have any questions about these comments or require additional information, please contact me at 608-797-3064.			
31.	12/12/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	RE: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. To Whom It May Concern: I am writing on behalf of the Alliance for Home Health Quality and Innovation (Alliance) regarding the quality measures to satisfy the IMPACT Act domain of "Transfer of health information and care preferences when an individual transitions." By way of background, the Alliance is a non-profit 501(c) (3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. For more information about our organization, please visit: http://ahhqi.org/.	Teresa Lee, JD, MPH Executive Director Alliance for Home Health Quality and Innovation	mailto:tlee@ahhqi.org	HHA Advocacy

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			I. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings The Alliance has two concerns about this measure involving transfer of information at admission, start or resumption of care. First, it is appropriate to have measures on transfer of information, however this measure holds the receiver of the information (in this case, the home health agency) accountable for transfer of information. In post-acute care in particular, home health agencies receive patients from short-term acute care hospital. It is important to note that the sender of the information does not have a similar measure. The sender (the short-term acute care hospital) should be measured on whether they have transferred the patient's information. Second, the measure should allow for transfer from a "licensed independent provider." In some cases, the party sending information may be an APRN or other type of provider. The measure should take this into consideration. II. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings The Alliance has three concerns about this measure involving transfer of information at discharge or end of care. First, it is appropriate to have a HHA measure for transfer of information at post-acute care discharge. However, information should always be transferred to a party at discharge. At the very least, information should be transferred to the physician who established the plan of care.			

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			Second, the measure should allow for transfer to a “licensed independent provider.” In some cases, the party may send information to an APRN or other type of provider. The measure should take this into consideration. Finally, the term "timely" should be defined for purposes of the measure.			
32.	12/15/2016	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	Project Title: Quality measures to satisfy the Improving Medicare Post- Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Contract names are Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002) Dear Mr. Slavitt: The American Academy of Physical Medicine and Rehabilitation (AAMP&R), the society that represents more than 9,000 physiatrists, appreciates the opportunity to submit comments on the draft specifications for the functional status quality measures for skilled nursing facilities. Physical medicine and rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.	Paul Smedburg Director, Advocacy & Government Affairs American Academy of Physical Medicine & Rehabilitation	mailto:psmedberg@aapmr.org	Advocacy

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			AAPM&R appreciates that CMS is seeking input on the development of cross-setting quality measures for use in post-acute care settings such as Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies. We recognize our comment letter was submitted past the deadline but want to offer some comments and recommendations for your consideration. Our comments below recognize that the purpose of this project is to develop, maintain, re-evaluate, and implement measures reflective of quality care for PAC settings to support CMS quality missions, including the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), the Nursing Home (NH)/Skilled Nursing Facility Quality Reporting Program (SNF QRP), and the Home Health Quality Reporting Program (HH QRP) and will address the domains required by the IMPACT Act, which mandates specification of cross-setting quality, resource use, and other measures for post-acute care providers. In general, AAPM&R believes the 11 measure specifications listed in the 'Areas of Focus' which collect data on the types of information received or provided at patient/resident transitions between healthcare providers is a relatively good list. We do, however, want to provide some comments and suggestions for your consideration as you evaluate quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. Areas of Focus – Comments 1. Completeness of the list for the transfer of information between providers during transitions.			

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			The list of 11 items identifies important elements necessary for smooth transitions of care. a. An additional category should be psychosocial information that is relevant to the goals of the admissions. b. We do not see any elements that could be eliminated, but believe that there should be formats designed to make aggregating all of this information from charts easier than it would be at present. 2. Examples of the specific types of information and items to be collected within each of the types under information items. a. Function i. The functional information should include both activities of daily living and mobility items. 1. For both the information should include caregiver requirements. 2. A triage approach would be helpful to avoid collecting information not necessary for those with minimal problems. 3. However, the transfer information should include some quantification of degree of functional loss in those with significant problems. 4. It is important to include whether ambulation is by wheelchair or walking. b. Medication i. Preadmission medications and dosages should be at all transitions, but most importantly in the one of discharge to the community.			

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			ii. Medications and dosages in the setting prior to the transition should be available to the next setting. c. Patient preferences i. Patient and family preferences for treatment facilities and level of post discharge care should be available at each level of care. 3. Suitability of the list (used also in Question 5) for gathering data about important information provided to the patient/family/caregiver at discharge or transfer. a. The items are suitable for both transfer and discharge. We have no additional suggestions for additions or subtractions. 4. Admission and Discharge measure exclusions a. Information related to function would be less important if the transfer was back to acute care because of a medical emergency. b. Otherwise, we cannot think of admission or discharge circumstances where the information items could be excluded. 5. If the draft measure specifications capture the common routes of information transmission and are these routes clearly stated in a way that is understandable to providers in all PAC settings. a. Not all settings have experience in collecting all of this information. There will need to be training and procedural manuals to help facilities collect this information. 6. Feasibility of data collection for these items.			

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			a. Not all settings have experience in collecting all of this information. There will need to be training and procedural manuals to help facilities collect this information. b. Even in facilities that already collect most of this information will have a challenge in aggregating from the various parts of their charts. i. Methods perhaps related to the electronic health record may need to be developed to make the data burden reasonable. 7. Potential impact and any unintended consequences of the measures. a. Positive impact on patient care through routinely having necessary information to provide thorough care of patients. b. Negative impact of increased staff time to collect information in a comprehensive report. c. Negative impact of possible delays in discharge pending aggregation of all of the necessary information. AAPM&R also wants to take this opportunity to highlight the effect of physiatrist leadership across post-acute care settings has on patient outcomes. AAPM&R strongly believes that physiatrists are optimally suited by way of the unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society across post-acute care settings. We appreciate the opportunity to comment on the project ‘Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of			

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			2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions’. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Paul C. Smedberg, Director of Government Affairs & Advocacy at PSmedberg@aapmr.org or at (202)-420-5907.			
Below are the verbatim comments that are out of scope and not addressed in this report. Note that duplicate comments such as form letters received by different commenters are not repeated in the verbatim summary.						
	11/16/2016		Hello, Can I please get clarification regarding a valid home care referral regarding the coordination between the referring physician and the following physician?	Kathleen Regina Reimbursement Coordinator Brookhaven Memorial Hospital Medical Center	kregina@bmhmc.org	SNF
	11/22/2016		I am a Home Health RN case manager working in rural California. While I understand the goals of capturing this information, Home Health patients are not in controlled environments and therefore should not be held and judged against other post-acute settings. How can Home Health patients, who have the supervision of licensed staff several hours a week fairly compare with a LTAC or SNF which have around the clock licensed staff supervision and a controlled environment? Especially if this Home Health patient has refused a higher level of post-acute care and wants to go home! The hospital needs to discharge, pt has a skilled nursing need and pt wants to be home. We see it all the time, especially in the rural setting where I live. Folks are stubborn, especially at home. We educate and some listen--and remove their throw rugs and use their walkers etc. Home Health clinicians cannot make their pts homes into a SNF or LTAC.	Anita Bothwell, RN	anitamarie@gmail.com	HHA

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			Please reconsider including Home Health in this quality measure.			
	11/17/2016		In reference to the Q & A on M1060, it does not seem reasonable to prohibit use of the most recent data for height and weight given by the facility or MD referral. We assess the patient within 2 days of receiving the referral, and many patients either have no scale, or cannot stand safely to be accurately weighed. Nurses already are burdened with carrying a nursing bag and a laptop computer into the home, and could not also physically carry a scale, unless travelling by car. In urban areas, many RNs are going on foot to see patients. Any agency scale used in the home has to be on a barrier and cleaned after each use so this takes more time and materials, and ultimately cost. Presently patients are instructed to get a scale, but various barriers often prevent compliance. Please give nurses time to actually care for patients. Data collection has a good purpose, but if requirements are so stringent, this puts added stress on clinicians, and will eventually result in people leaving the profession of homecare!	Donna Cooper, RN, MSN Education Coordinator	dcooper@dsfhs.org	HHA
	12/11/2016		I am writing to comment on the proposed NPUAP staging revisions. My opinion comes from considerable expertise in **acute care** and **skilled nursing care settings**: more than 20 years as an advanced practice nurse with board certification in wound care; Wound Team Leader at Hartford Hospital, a 900 bed level-1 trauma academic medical center in Connecticut; owner of a wound consultation private practice providing wound consultation in skilled nursing facilitates; adjunct faculty at Yale University School of Nursing; author of clinical practice guidelines and active involvement in wound professional societies.	Lisa Corbett	Lcorbett5@cox.net	SNF

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			The recent NPUAP consensus conference and proposed staging revisions have stirred significant controversy in the wound world. The methodology lacked rigor, leaders did not disclose conflicts and the scientific evidence supporting the changes simply does not exist. Adoption of these revisions by NQF will further cloud an already very murky patient safety and regulatory landscape pertaining to pressure ulcers. As an expert clinician close to the bedside, I would recommend that NQF postpone adoption of the terminology changes pending consideration of the following clinical concerns: 1. **The legal and ethical implications of calling these wounds an "injury".** As healthcare systems integrate evidence into practice, we are reducing adverse events related to pressure. However, my research, and findings of others, has shown that the rising source of pressure wounding is from disease comorbidity and aging, with precursors of age-in-place community living preference and/or critical illness. Attributions of pressure wounding as an "injury" implies "always" omission of care origins – a trajectory that is not founded in real clinical practice, nor science. Feeding the malpractice machine with foundations of pressure wounding as "always preventable injury" is economically self-serving to a few and not productive to the conversation about wound etiology and patient safety. Further, it causes un-needed alarm by the public, portraying healthcare providers as careless. 2. **Scientific etiology of the unstageable pressure ulcer**. The NPUAP has quietly re-categorized the unstageable pressure ulcer over the years (see below, "Evolution of Definitions") with the latest definition inconsistent even with the organizations' own nomenclature. These changes are based on			

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			opinion and have dire regulatory consequences. Until this category can be clarified with scientific evidence, it should not be considered basis for the NQF language. To qualify for NQF language, an event must be: unambiguous; largely, if not entirely, preventable; serious; indicative of a problem in a healthcare setting's safety systems; and important for public accountability. I would contend that the NPUAP unstageable definition does not meet any of these requirements and that further adoption of NPUAP pressure injury revisions merely cements an already broken process into the regulatory world. **NPUAP Evolution of definitions, 2010 to 2016** NPUAP/EPUAP (2010): "Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV" [1] NPUAP/EPUAP (2014): "Unstageable: Depth Unknown: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined" [2] NPUAP (2016): "Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed			

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			because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed "[3] 1. Clinical Practice Guidelines and Quick Reference Guide for Pressure Ulcer Prevention. National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP), 2010 Retrieved from www.guidelines.gov 2. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014 Retrieved from www.npuap.org 3. The National Pressure Ulcer Advisory Panel NPUAP 2016 Staging Consensus Conference. Retrieved from http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 3. **The NPUAP definitions, and potential subsequent adoption by NQF for regulatory operationalization in states and across healthcare settings, creates an unrealistic burden to clinicians and does not improve patient safety.** As stakeholder practitioners who are beholden to these definitions, we have knowledge and evidence that following the NPUAP and NQF guidance has done little to improve patient safety. Most state reportable adverse events involve the "unstageable" pressure ulcer. This definition has inaccurately inflated adverse event rates and erroneously fueled the public perception of harm occurring in healthcare settings.			

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			As practitioners, we can attest to the practice of coding gaming, hiding and go-a-rounds that these definitions have created. We spend precious expert clinical time parsing words; often needlessly debriding patients' wounds and conducting fruitless root cause analyses. We know that there is a difference between a wound that is covered by fibrotic or devitalized material and one that has full thickness necrosis. We know that in the majority of cases (20 of the 23 "unstageable" wounds in my acute care database FY 2016) there are no gaps in the evidence-based preventive care provided to patients. The "unstageable" wound is a transitional phase representing either the end-of-life trajectory or a temporary acute/critical illness with eventual resolution to healing. Instead of moving toward scientific clarity, the NPUAP and NQF unstageable definitions enslave us to a wasteful clinical practice of futility and hypocrisy, barely impacting patient safety. In summary, I request that the NQF take a pause amongst the furor and postpone adoption of the NPUAP Pressure Injury definitions until further analysis. The evidence has long demonstrated that the pressure ulcer staging system is flawed. Implementation of the modified NPUAP staging system is premature and will have significant implications across our healthcare system. Instead of merely passing through the consensus opinions of a few, NQF should rely on science to define harm to patients.			
	12/11/2016		AAWC Form Letter (submitted by 12 commenters): To Whom It May Concern: Please do NOT adopt the NPUAP's proposed staging revisions. The change to "pressure injury" would be especially detrimental.	Association for the Advancement of Wound Care Submitted by the following 12 commenters:		

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			I agree with the position statement by the AAWC (Association for the Advancement of Wound Care) Board of Directors as stated below: As a Board Certified Clinical Wound Specialist (CWS), my prime directive is the protection and evidence-based treatment of the patients I serve. 1. The evidence has long demonstrated that the pressure ulcer staging system is flawed. 2. The existing staging systems do not accommodate the current evidence of pressure ulcer formation. 3. Failure to correctly identify the extent of pressure related tissue damage has resulted in misdirected pressure ulcer prevention protocols and resources. 4. Implementing the modified NPUAP staging system is premature at this point. Implementing these changes on a national level will have significant implications and patient outcomes will be negatively affected. 5. The AAWC is an inter professional organization with 2400 members and would like to collaborate with stakeholders including the NPUAP to develop an evidence-based solution to the current PU staging system. The AAWC BOD recommends forestalling the implementation of the recently proposed NPUAP staging system. A new classification of identifying pressure related tissue damage must be developed based on current global evidence. I implore you NOT to adopt the NPUAP's staging revisions. Many in the wound care community disagree with the NPUAP's proposed changes. The revisions need to be placed on hold since there is so much controversy, especially with the term "pressure injury". Dr. Bohn, the AAWC President recently wrote an editorial about the objections to the NPUAP's	Karen Brown (krbrn@hotmail.com) Emily Greenstein (Emily.greenstein@sanfordhealth.org) Kaye Martin (kaye.martin44@gmail.com) Raphael Yaakov (ryaakov@serenagroups.com) Colin Maher (colinmaher@pymanor.com) Karen Walker (karenwalker@pymanor.com) Kristen Earl (kristenearl@pymanor.com) Sandi Joingco (sandi_j@prodigy.net) Nancy Anne Faller (nafaller@aol.com) Gerri Slowikowski (Geraldine.slowikowski@ynhh.org) John Dorsky (jdorksky@mdconsult.us) Joy Schank (joyschank@yahoo.com)		

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			staging revisions. The link below is to his editorial in OWM (Ostomy Wound Management Journal). http://www.o-wm.com/article/guest-editorial-maintaining-our-objections-npuap-changes			
	12/8/2016		This letter on behalf of ***Wound Healing Society (WHS)*** is in response to the public comment period in which the NPUAP is requesting that NQF change the terminology for quality measures related to pressure ulcers. WHS is a non-profit organization whose mission is to improve wound healing outcomes through science, professional education, and communication. The NPUAP has recently replaced the term "pressure ulcer" with "pressure injury" in their staging system, stating that the ***"change in terminology more accurately describes pressure injuries to both intact and ulcerated skin."*** **1** By way of background, pressure ulcer staging has been used to define and describe the amount of visible tissue loss. NQF uses the pressure ulcer staging system to facilitate determining the rate of new ulcers in acute care, home Care and long-term care. If the terminology is not clear, then the reporting is, by definition, flawed. The current classification/staging system is inadequate. Specifically, the numerical system falsely implies a linear progression from superficial to deep ulcers, leading to misunderstanding of the nature of pressure-induced tissue damage. Furthermore, the term 'ulcer' is applied universally to tissue damage that may not have a break in the skin. Within the wound care field there is a convention that a '**wound' is acute**, while an '**ulcer' is chronic**, i.e., present for more than 30 days. Yet with the current terminology, pressure 'ulcers' may be newly diagnosed and continuing to evolve, or present for months, with changing appearance as they heal, making it nearly impossible to describe the amount	Lisa Hetherington, CAE Executive Director Wound Healing Society	WHS@faseb.org	

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			of visible tissue loss. Thus, although the term ‘ulcer’ is a poor descriptor, the change to ‘injury’ does not substantially improve the current classification system. In fact, we believe that the term ‘injury’ may have substantial negative ramifications, particularly based on the Miriam-Webster definition that implies wrong-doing: *“1 a: an act that damages or hurts; b: violation of another's rights for which the law allows an action to recover damages 2: hurt, damage, or loss sustained”.* The NQF quality measures are in place to help facilities and home health agencies track and report to facility the quality improvement of the wounds of patients who move frequently between facilities and home. The current system is very unclear for pressure ulcers that are in the process of healing or are worsening. Specifically, if a Stage 4 pressure ulcer is filled with granulation tissue, how is the evaluator to know whether this is a healing Stage 4 or a healing Stage 3? Changing the nomenclature to pressure injury adds nothing to clarify prognosis, etiology or treatment strategies. Descriptive tools are required that help the clinician develop a plan of care based on the wound and on the intrinsic and extrinsic risk factors with an emphasis on those that can be modified to promote healing. The **WHS** has a long history of teaching the ‘Basics of Wound Care’ to a broad audience, including clinicians, industrial representatives and researchers. Our approach to education for prevention and treatment is based on the principles of wound etiology, i.e., pressure, shear and friction, and on understanding the whole patient in terms of modifiable risk factors. Given the legal, financial and			

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			scientific implications of a change in nomenclature, the **WHS favors a complete overhaul of the pressure ulcer staging system** with inclusion of scientific evidence that incorporates the severity of the tissue damage as well as the intrinsic and extrinsic risk factors that affect prognosis. We believe this should be an international, interdisciplinary effort to develop a universal classification system that is descriptive, prognostic and useful for patient care and research. We urge the NQF not to adopt the NPUAP's proposed change in pressure ulcer terminology at this time and to support development of a classification scheme that improves communication across the healthcare system. Executive Board Wound Healing Society (WHS)			
	12/2/2016		To Whom it may concern I agree with the AAWC: mplementation of the recently proposed NPUAP staging system. A new classification of identifying pressure related tissue damage must be developed based on current global evidence. I disagree with the NPUAP's proposed changes. The revisions need to be placed on hold since there is so much controversy, especially with the term "pressure injury". Dr. Bohn, the AAWC President recently wrote an editorial about the objections to the NPUAP's staging revisions. The link below is to his editorial in OWM (Ostomy Wound Management Journal). The AAWC BOD recommends forestalling the i http://www.o-wm.com/article/guest-editorial-maintaining-our-objections-npuap-changes	Linda Carroll	Linda.Carroll@bpthosp.org	

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			I believe a more prudent approach would include forestalling the implementation of the proposed changes to the NPUAP staging system until further investigations are made. Any changes that are made in identification of pressure ulcers, should benefit and assist **only** the patient.			