



January 29, 2016

Re: Bipartisan Chronic Care Working Group Policy Options Document
chronic_care@finance.senate.gov

Dear Senators Hatch, Wyden, Isakson, and Warner:

The Advanced Medical Technology Association (AdvaMed) welcomes the opportunity to provide comments on policy options presented by the Bipartisan Chronic Care Working Group in its Policy Options Document released December 2015. AdvaMed member companies produce a wide array of medical devices, diagnostic products, and health information systems that improve the efficiency and quality of health care services by reducing the lengths of stay of patients in health care facilities, allowing procedures to be performed in less intensive and less costly settings, providing early detection of disease and infections, and improving the ability of providers to monitor the condition of acutely and chronically ill patients.

AdvaMed commends the Committee for its desire to explore a broad range of new policy options for improving the way care is delivered to Medicare beneficiaries with chronic conditions. We offer our comments on three areas: expanding coverage and payment for telehealth services to improve the efficiency and quality of care; developing quality measures for chronic conditions; and expanding access to digital coaching.

I. Expanding Coverage and Payment for Telehealth Services

We are pleased to see the Bipartisan Working Group's interest in exploring options that would increase access to telehealth services for Medicare beneficiaries with chronic conditions. The Policy Options Document includes three different approaches to expanding coverage and payment for these services: Increasing Convenience for Medicare Advantage Enrollees through Telehealth (p. 16); Providing ACOs the Ability to Expand Use of Telehealth (p. 17); and Expanding Use of Telehealth for Individuals with Stroke (p. 19). Each of these options represents a step forward in expanding access to telehealth services in an incremental fashion.

We believe that there is still another option, which merits consideration within the budgetary constraints of any expansion of telehealth services, and which at the same time will generate data-driven analysis the Working Group is looking for in order to move forward with any one option. This option has been proposed in the Telehealth Innovation and Improvement Act of 2015, S. 2343 (Gardner, Peters) and H.R. 4155 (Black). These bills propose to test through CMS's Center for Medicare & Medicaid Innovation (Innovation Center) how expanded telehealth services will impact the cost and quality of

services needed specifically by persons with chronic conditions. Another underlying purpose of these bills would be to generate official government data on cost and quality improvements that would accompany expanded services in order to allay government agencies' concerns about the budgetary impact of an expansion.

Before discussing the provisions of these bills, we note that the Innovation Center has also adopted an incremental approach to expanding the availability of telehealth services in two of its bundled payment models, the Bundled Payments for Care Improvement Initiative, implemented beginning in 2012, and the Comprehensive Care for Joint Replacement (CJR) Model, recently finalized through rulemaking and going into effect April 1, 2016. The new Next Generation ACO Model, another Innovation Center initiative, will also include increased availability of telehealth services. In each of these models, the Innovation Center uses telehealth waivers to allow sites to provide telehealth services without regard to the geographic and originating site restrictions in current Medicare law and to allow the provision of telehealth services in a beneficiary's home. In each of the models, only those services covered through the annual Medicare Physician Fee Schedule rule will be covered under the waivers.

In the final rule on the CJR Model and its discussion of expanded telehealth services (*Federal Register*, Vol. 80, No. 226, Nov. 24, 2015, p. 73448), CMS notes in response to comments it received on expanding telehealth technologies and covered services that could be paid under the models: "[T]he CJR model is not testing a telehealth model and, therefore, we do not intend to fundamentally change the scope of telehealth requirements for payment under Medicare."

We also note that the Innovation Center has not indicated that it will be using the limited expansions to test whether and how the services will improve the cost and quality of care for Medicare beneficiaries. Given the fact that the existing waivers provide only limited expansions and that they do not appear to be set up as data-driven programs to test how telehealth services can change the delivery of care, AdvaMed recommends that the approach proposed by S. 2343/H.R. 4155 be considered as an additional policy option for testing specific telehealth models to improve care for persons with chronic conditions.

S. 2343/H.R. 4155, the Telehealth Innovation and Improvement Act of 2015, would mandate that the Innovation Center provide coverage and payment for expanded telehealth and remote monitoring services through bundled payment, ACO, and other relevant delivery reform models that it implements. The scope of the testing for expanded telehealth services would follow the general structure of the Innovation Center's demonstration authority: the Center would test expanded telehealth services where they assist providers in achieving delivery reform program goals and result in Parts A and B savings without reducing quality or improved quality and reduced program spending. We believe that a similar demonstration could be established for Medicare Advantage (MA) plans or for MA special needs plans.

The bill would require that testing of expanded services be done in the context of specific chronic conditions. While the bill enumerates a list of chronic and other conditions that could benefit from expanded telehealth services, the focus of testing could be one or several of these chronic conditions where improvements in cost and quality of care would show the greatest promise with the expansion of covered telehealth services.

The bill also proposes testing a variety of different telehealth technologies. Once again, a policy option to test expanded telehealth services does not have to include all listed technologies, but rather could focus on a subset of technologies that go beyond the limitations of current law.

The demonstration also would provide an opportunity to test different payment methodologies for expanded telehealth services—according to existing fee schedule amounts for services, a new fee schedule established for covered services, and/or risk sharing payment methodologies, such as capitated payments on a per member/per month basis that will ensure savings from covered services. We note that a number of large insurers are using risk sharing methodologies to pay for telehealth services, avoiding the need to think of each individual telehealth service as a separate reimbursed transaction, thereby encouraging providers to deploy telehealth technologies in ways that will produce the greatest efficiencies and quality improvements for the specific patient populations they serve.

The bill calls for an independent evaluator to begin assessing the impact of expanded telehealth services 3 years after implementation of the demonstration. This timeline could be shortened or lengthened to reflect the particular technology and chronic condition being tested.

The end result would be official, government-generated experience and data that would lead to an understanding of the circumstances when expanded telehealth services improved the cost and quality of care for Medicare beneficiaries with chronic conditions. These data should also allow expansions of telehealth services beyond those currently allowed through waivers.

The Working Group's Policy Options Document cites a CBO July 2015 statement responding to a question for the record on telehealth, following a hearing by the Senate Committee on the Budget. As the Working Group notes, CBO states that when telehealth services are clearly substituting for existing clinical services, then the potential to reduce Medicare program costs increases. The CBO commentary concludes: "Because Medicare coverage of telemedicine is limited, CBO does not have extensive data that would help project how expanding such coverage would affect federal spending in the Medicare program. CBO's analysis would benefit from having the results of new and well-designed academic studies examining how introducing telemedicine services would affect health care spending in the Medicare population." AdvaMed believes that the approach taken by S. 2343/H.R. 4155 offers an opportunity to do that well-designed

study to generate the empirical data needed to demonstrate to CBO and CMS that expanded telehealth services can improve the efficiency and quality of care for persons with chronic conditions.

II. Developing Quality Measures for Chronic Conditions

Developing quality measures for care needed by persons with one or more chronic conditions is a complicated task. These patients tend to have complex medical and social needs as well as time intensive and labor intensive management needs that may extend well-beyond others in the health care system. It is therefore important that these quality measures reflect the time needed by medical and paramedical professionals to manage the complex care of these patients. In the absence of this consideration, it is possible that measures developed for the chronically ill may be viewed by providers as a burden and thus the patient could ultimately be disadvantaged by being provided with abbreviated care unintentionally.

In addition, recent discussions in the National Quality Forum (NQF)-convened Measure Applications Partnership (MAP) regarding the proposal for a chronic composite measure have continued to highlight that sociodemographic factors may have a significant impact on these types of measures for this population. Chronic care measure developers should consider addressing sociodemographic factors early-on in the development phase to avoid unsuccessful implementation of proposed measures.

AdvaMed's quality measures comments will focus on priority areas that the Working Group's Policy Options Document outlined, including outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services

A. Outcome Measures: Chronic Care Measure Development Should Emphasize Patient-Centered Measures

Incorporating patient-centered factors, such as patient experience, quality of life, improvements in functional status, and evidence-based behavioral interventions is currently gaining increased importance in quality measure discussions. In this population especially, it is important to have sufficient appropriate measures regarding patient experience and quality of life. Currently there are some quality measures in CMS quality-related programs regarding the functional status outcomes for patients, but since functional status is such an important factor for those that have chronic conditions, we believe that there should be an emphasis on further developing measures in this area. For example, patients with chronic wounds experience pain, increased risk of complications, and amputation, as well as delayed healing. Creating patient-centered measures that capture functionality and experience for chronic wound patients will encourage use of

advanced wound therapies that reduce the total cost of care and improve a patient's quality of life.

Developing functional status measures may involve specific episodes of care and may include resource use over the entire episode. But multiple factors must be evaluated when developing episodes for functional measures, especially in the chronically ill population. AdvaMed emphasizes that resource use must be determined over an appropriate episode of care, which includes a sufficient period of time to assess the overall value of the services provided. One could easily draw erroneous conclusions about the relative value of care if an inappropriate time period is used. For example, a provider may have a choice between a lower-cost medical device which is expected to need replacement within a few years, necessitating another hospitalization, and a higher-cost device which will last many more years and only one admission. If resource use, or costs, are measured based on an episode of care that only considers the hospitalization and perhaps a 90-day period post-discharge, the "total" cost of the episode may appear on its face to be a better value because the initial cost of the device was lower. However, this assessment would be inaccurate as it would not consider the additional costs associated with a subsequent readmission, surgical costs and device replacement costs that could have been delayed or avoided if the higher-cost, longer lasting device was initially chosen. Identifying the episode time frame is especially important for chronically ill patients that receive treatment for several years or the rest of their lives.

B. Care Coordination: Measures to Ensure Proper Discharge/Transfer Planning including Wound Care and Nutritional Measures

AdvaMed believes that well-designed and thought-out discharge planning is a critical component of successful transitions from acute care hospitals and post-acute care (PAC) settings. This is a cornerstone of successful continuity of care for patients, especially those who are chronically ill. Recently, CMS issued a proposed rule on "Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies." The critical nature of properly documenting and providing the handoff information that will accompany the patient as they transition from one care setting to another ultimately impacts patient outcomes, including reducing complications/adverse events, reducing avoidable hospital readmissions and offers an opportunity to improve the quality and safety of patient care and reducing costs. These handoffs are particularly important for the chronically ill.

The proposed rule provided a list of "necessary medical information" that, at a minimum, is to be provided from the current treatment setting to the receiving facility or health care practitioner, regardless of whether the patient is being discharged or transferred to any post-acute care setting. These settings include home (with or without PAC services), skilled nursing facility, nursing home, long term care hospital, rehabilitation hospital or unit, assisted living center, substance abuse treatment program, hospice, or a variety of other settings. The proposed list contains important information concerning the patients'

health including course of illness/treatment, procedures, functional status, reconciliation of all discharge medications and others.

AdvaMed believes that the chronically ill would especially benefit from a well-detailed discharge planning that is communicated properly. AdvaMed provided comments to the proposed rule with recommendations for specifically including patient wound status and nutritional status at discharge. AdvaMed recommends that quality measures be developed regarding the collection and transfer of specific information, including patient wound status and nutrition status, to ensure that appropriate information is shared when discharging or transferring a chronically ill patient between care settings. Although a measure such as this could be considered a “process” measure, the resultant adherence to providing this information would very likely result in improved patient outcomes and the data from these lists could possibly be used to develop outcomes measures. Detailed recommendations related to wound and nutrition status follow in our comment letter to CMS that is in Attachment A.

C. Appropriate Use of Services: Quality Measures to Address Underuse

Although there has been much discussion in various quality initiatives regarding the overuse of medical technologies (such as imaging) procedures and services (such as screenings for various cancers), very rarely is underuse discussed. On the road to determining “appropriate use” it is essential that underuse is evaluated simultaneously with those measures related specifically to overuse. In a recent statistical study examining overuse and underuse of cervical cancer screening, the authors observed that underuse was associated with older age, fewer medical visits, and increased comorbidity.¹ This population represents a large portion of those who are chronically ill. Many chronically ill patients and their caretakers and physicians are focused on their current primary complaint and lose track of the need for medical and ancillary services which healthier individuals receive. In addition, because of impairments to their functioning, they are a prime population to benefit from technologies to address these deficiencies and restore their quality of life. Therefore it is important that underuse, in addition to overuse, be evaluated when developing quality measures, especially for patients with chronic illness.

III. Expanding Access to Digital Coaching

As a way to expand Medicare beneficiary access to digital health coaching, the Policy Options Document indicates that the Working Group is considering a requirement for CMS to “provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-

¹ Almeida CM1, Rodriguez MA, Skootsky S, Pregler J, Steers N, Wenger NS. Cervical cancer screening overuse and underuse: patient and physician factors. Am J Manag Care. 2013 Jun ; 19(6):482-9.

management of their own health.” This policy option contemplates relying on the Medicare.gov website as a source for reliable information about chronic diseases and ways to manage these diseases.

AdvaMed is very concerned that this particular strategy for providing access to online information about chronic diseases and their management, while potentially very helpful, will fall short of the potential for digital health coaching. For example, one of our companies provides digital health coaching programs that combine expertise from the fields of human behavior, medicine, and digital content development. These programs are individually tailored to recommend concrete, customized steps patients can take to improve their health based on their personal health and wellness goals. The personalized feedback the patient gets from the program may then be easily transmitted electronically to his or her treating physician or non-physician practitioner, thus facilitating care coordination.

This type of interactive and individually tailored coaching is very different from the option to provide access to information through the Medicare.gov website and is more like the access to digital health coaching programs currently being offered to tens of millions of commercially insured people, including Medicare Advantage enrollees, through insurers such as Kaiser Permanente, a number of Blue Cross/Blue Shield plans, and Aetna. A published review of digital health coaching programs found that a Blue Cross/Blue Shield Plan experienced average year-over-year cost savings of \$382 in actual medical expenses for every program participant.^[1] These savings came primarily from a reduction in hospital admissions.

We recommend that the Working Group consider providing CMS authority to contract directly for digital health coaching programs according to the specification below. These digital health coaching programs would be made available to traditional fee-for-service Medicare beneficiaries (as well as those covered under alternative payment models) at no cost to the beneficiaries.

- The Secretary would be authorized to enter into agreements with one or more eligible entities with demonstrated experience in the design, implementation, and operation of digital health coaching programs that reduce health care expenditures and improve health outcomes in patients with chronic conditions;
- The Secretary would provide on relevant CMS Internet websites and other HHS websites links to the Internet website of the digital health coaching.

^[1] Steven M. Schwartz, Brian Day, Kevin Wildenhaus, Anna Silberman, Chun Wang, and Jordan Silberman (2010) The Impact of an Online Disease Management Program on Medical Costs Among Health Plan Members. *American Journal of Health Promotion*: November/December 2010, Vol. 25, No. 2, pp. 126-133.

- The Secretary would be required to include information on the availability of digital health coaching programs as part of the information and services furnished to beneficiaries.
- The Secretary could not impose on beneficiaries cost-sharing (including deductibles, coinsurance, or copayments) in any form for access to and use of digital health coaching programs.
- The Secretary would negotiate an annual payment amount for the provision of digital health coaching programs to beneficiaries. Such payment amount would not vary by the number of times beneficiaries access and use such programs, but may be determined on a per-beneficiary basis that takes into account an estimate of the number of beneficiaries involved.
- In no case could the aggregate payment amounts under a 5-year agreement exceed \$25,000,000 for the provision of digital health coaching programs to beneficiaries during the period.
- The Secretary could renew an agreement if the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that a new or renewed agreement for such programs would reduce program spending.

IV. Increasing Transparency at CMS's Innovation Center

The models and initiatives created at CMS's Innovation Center (e.g., certain ACO models and bundled payment programs) are promising for improving care coordination, quality, and reducing overall costs to the health care system. However, these initiatives alter the incentives for health care providers and change the way Medicare and Medicare Advantage plans pay for care. Modifying incentives and reimbursement can pose significant risk to Medicare beneficiaries and thus development of these initiatives should be transparent and include opportunities for review of proposals and solicitation of formal comment from the public and stakeholders who will be affected by the initiatives.

The Affordable Care Act provided the Innovation Center authority that is unique given the scope of its activities of not having to follow a formal rulemaking process. The result has been a less than transparent process which creates challenges for stakeholders to adequately prepare for and engage in the initiatives successfully and meaningfully. As Medicare seeks to move 50 percent of payments into Alternative Payment Models (APMs) by 2018, the Innovation Center's role in meeting this goal and shaping future reimbursement will only increase in importance. We expect, for instance, that many of the APMs for meeting Medicare's goal, if not the majority, will be developed and implemented by the Innovation Center, and for this reason alone, a more transparent

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process for model creation, refinement, and evaluation will be needed. Without this transparency, especially at the front end of implementation, the public will be left with only an incomplete understanding of the impact of these programs and the reasons for any specific findings about impact.

Thank you for the opportunity to comment on the Bipartisan Chronic Care Working Group's Policy Options Document and the important opportunity to improve care for patients with chronic diseases. We are available to provide any further assistance as you continue to refine your policy options in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "JC Scott", enclosed in a thin black rectangular border.

JC Scott
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January 4, 2016

Via Electronic Mail to file code CMS-3317-P

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Acting Administrator Slavitt:

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

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

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

A. Background and Rationale

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

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

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

¹ AHRQ Preventing Pressure Ulcers in Hospitals, A Toolkit for Improving Quality of Care: What are the best practices in pressure ulcer prevention that we want to use.

<http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool3.html> Accessed 1/2/2016. Stating that “comprehensive skin assessment should be performed by a unit nurse on admission to the unit, daily, and on transfer or discharge.”

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

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

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

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

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

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

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

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

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

⁵ Measure Applications Partnership; MAP 2015-2016 Considerations for Implementing Measures in Federal Programs – Draft for Public Report. National Quality Forum, December 2015.

⁶ Taft SH, Pierce, CA, Gallo, CL. From Hospital to Home and Back Again: A Study in Hospital Readmissions and Death for Home Care Patients. *Home Health Care Management and Practice* 2005; 17(6), 467-480.

⁷ Wukich DK, Armstrong DG, Attinger CE, et al. Inpatient management of diabetic foot disorders: a clinical guide. *Diabetes Care* 2013; 36:2862-71.

⁸ Jensen GL, et al. Adult Starvation and Disease-related Malnutrition: A proposal for etiology-based diagnosis in the clinical practice setting from the International Consensus Guideline Committee. *J Parenter Enteral Nutr.* 2010; 34:156-159.

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

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

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

⁹ NQF Committee Report, 'Prioritization of High-Impact Medicare Conditions and Measure Gaps, May 2010.

¹⁰ Locher JL, Wellman NS. "Never the twain shall meet:" dual systems exacerbate malnutrition in older adults recently discharged from hospitals. *J Nutr Gerontol Geriatr*. 2011; 30(1):24-8.

¹¹ Yang Y, Brown CJ, Burgio KL, Kilgore ML, Ritchie CS, Roth DL, et al. Undernutrition at baseline and health services utilization and mortality over a 1-year period in older adults receiving home health services. *J Am Med Directors Assoc*. 2011 May;12(4):287-94.

¹² What We Know and Can Do About Malnutrition. Washington, DC: The Gerontological Society of America; Fall 2015.

¹³ Tappenden KA et al. Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition. *JPEN J Parenter Enteral Nutr*. 2013 Jul;37(4):482-97

¹⁴ Tappenden, *Science Magazine Supplement* December 2014.

¹⁵ Tappenden et al, *JPEN J Parenter Enteral Nutr* 2013 37: 482.

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

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

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

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

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

Sincerely,

/S/

Don May
Executive Vice President
Payment and Health Care Delivery Policy