

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Monday, January 4, 2016

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-3317-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed Rule: Medicare and Medicaid programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on the proposed rule published by CMS on November 3, 2015. The National Health Care for the Homeless Council (NHCHC) is a membership organization representing federally qualified health centers (FQHCs) and other organizations providing health services to homeless populations. In 2014, there were 268 Health Care for the Homeless (HCH) health center grantees serving over 850,000 patients in 2,000+ locations across the United States.

In states that have expanded Medicaid under the ACA, the health care landscape is changing significantly for our members and the patients we serve. For the first time in these jurisdictions, the vast majority of our clients are eligible for and enrolled in Medicaid, and able to access a more comprehensive range of health care services to meet broad and complex needs. In states that have not yet expanded Medicaid, challenges in connecting patients to specialty care and other services remain, because many of those experiencing homelessness are non-disabled, non-elderly adults and ineligible for Medicaid. In both types of states, however, hospital discharge policies are critically important to meeting patient needs, lowering overall health care costs, and reducing ED/hospital use and readmissions.

Research shows that people who are homeless average 2.3 days longer in acute hospital care compared to non-homeless patients, costing (on average) \$961 more per discharge.¹ When considering the median length of stay in hospitals, homeless patients have nearly twice as many days compared to patients who are not homeless (26 days v. 14 days); when discharge is delayed for non-medical reasons, homeless patients spend four additional days in the hospital (8 days v. 4 days).² Other research has shown that half of all hospitalizations among homeless patients result in a 30-day inpatient readmission (with most readmissions occurring quickly after initial discharge—54% occurring within one week and 75% occurring within two weeks).³ This population also has high rates of physical and mental illness, as well as mortality rates three to four times higher due to poor health, lack of housing, and lack of adequate health care.^{4,5} Because this group of patients lacks housing and typically stays in emergency overnight shelters, short-term transitional housing programs, doubled up on couches, and/or on the street, it is especially difficult to craft discharge

plans that make it possible for patients to adhere to medical advice. Challenges include keeping wounds clean/changing bandages, resting and recuperating, managing/storing many medications, retaining medical directions given at hospital discharge, independently following up on referrals, and ensuring effective care transitions.

While research shows that patients who are homeless have longer lengths of stay in hospitals, as outpatient community safety net providers, it is not uncommon for us to witness unplanned and unsafe hospital discharges either to shelters ill-equipped to handle medical needs or to the streets, parks and alleys where our outreach workers sometimes find them still wearing their hospital bracelets and/or clad in hospital gowns. While some communities are making greater progress than others, we are regularly frustrated with premature discharges of very vulnerable clients, a lack of adequate discharge planning and/or information shared with us as the patients' primary care providers, patients with little understanding of their discharge instructions (which may conflict with their usual plan of care), test results that are not available or delayed to the point of re-testing in another setting, and community data integration systems that have yet to fully include safety net providers. There are many examples of good partnerships between hospitals and HCH projects (and other homeless services providers), but these reflect local arrangements not driven by federal policy, and are the exception rather than the rule. **This proposed rule provides a timely, appropriate and welcome opportunity to improve this situation.**

We are pleased to see the proposed regulations include references to the need for supportive housing for patients who are homeless, though we have some concerns about a couple of provisions that we explain in more detail below. **We want to ensure that CMS and the hospitals addressed by this rule are aware of medical respite programs**, and our comments below indicate where references to these programs can be added to the final rule. Medical respite care is short-term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate continued hospitalization, but would be exacerbated by their living conditions (e.g., street, shelter or other unsuitable places). Medical respite care is also known as "recuperative care services," which is referenced in the Public Health Service Act as health services that are appropriate to meet the health needs of the population.⁶ There are currently 73 known medical respite programs in the U.S., but the need for such programs is much higher.⁷ Medical respite programs have been shown to result in 58% fewer inpatient hospital days (from 8.1 days to 3.4 days) and a 49% reduction in hospital admissions within a 12-month follow-up period.⁸ This type of intervention translates directly into average cost savings of \$706 per hospital-day avoided.⁹ CMS acknowledgement of these programs and encouragement for hospitals to develop supportive partnerships with community providers based on the needs of their patients would stimulate local discussions and promote the stated goals of the regulations (fewer avoidable hospitalizations/readmissions and better patient health outcomes).

Summary of Comments

Overall, we are very pleased with the components of the discharge planning process that CMS has outlined in these draft regulations. Our comments are intended to promote the following concepts:

- Development and use of medical respite care programs
- Systematic use of ICD-10 code (Z59.0) for homelessness
- Inclusion of primary care providers in discharge planning and communication
- Greater specifics in hospital policies governing discharge of people who are homeless

Specific Comments

1. **Applicability (proposed §482.43(b)):** The discharge planning process applies to all inpatients, as well as outpatients including those in observation, those undergoing surgery or other same-day procedures, emergency department patients identified as needing a plan, and any other categories recommended by the hospital.

Comment: We agree with the scope of patients needing discharge plans, but can CMS suggest criteria for which ED patients need a plan (e.g., those with specific health conditions, frequent users, etc.)? For patients who are identified as homeless, we request CMS encourage hospitals to use the ICD-10 code for homelessness (Z59.0) and log this in the patient visit record. This can serve as an important flag for discharge planners (and others) to include housing/shelter services in the discharge plan, and help inform needs assessments and/or quality of care/utilization reviews.

2. **Process (proposed §482.43(c)(3)):** Requires process to ensure ongoing patient evaluation throughout hospital stay to identify changes in condition that would require modifications to the plan (to include readiness for discharge or transfer).

Comment: What if the patient and/or caregiver is not ready for discharge? We understand that hospitals are under tremendous pressure to shorten length of stay, but for patients who have multiple, complex health conditions and very few resources in the community, premature discharge often leads to readmissions and/or relapse of behavioral health conditions. We ask CMS clarify that the patient/caregiver perspective on “readiness for discharge” should be included in the evaluation and serve as an important consideration. We also ask that CMS encourage hospitals to consider the impact of extreme weather conditions when discharging patients who are homeless. Most communities have cold/hot weather emergency plans and hospitals should be required to coordinate discharges accordingly to help prevent weather-related deaths.

3. **Process (proposed §482.43(c)(4)):** Require the practitioner responsible for the patient’s care be involved in the ongoing process of establishing patient goals of care and treatment preferences.

Comment: We are unclear what is intended by “practitioner responsible for the patient’s care”—is this the attending physician at the hospital, or is this the patient’s primary care provider (PCP)? We suggest CMS clarify this term, and add that the hospital should notify the patient’s PCP that the patient is in the ED and/or has been admitted to the hospital. This may be achieved through shared health information exchanges or other formal mechanism. Especially for patients that have lengthy hospital stays, we believe the hospital should coordinate patient care information and/or discharge recommendations with the assigned PCP to ensure there is continuity with existing treatment plans (if any). We understand this is not usually feasible for short hospital stays, those in the ED, or for patients who do not have an identified PCP, but for patients well-known to area providers (as most homeless frequent users are), communication with community providers about next steps after discharge can help increase positive outcomes for both the patient and all providers involved in his/her care.

4. **Process (proposed §482.43(c)(5): There are several areas of this provision we comment upon:**
 - Require that hospital consider availability of caregivers and community-based care for each patient, follow-up care from community-based providers, care from caregiver/support person, and care from post-acute health care facility or long-term/residential facility...Require hospitals to identify areas where the patient (or caregiver/support person) need assistance, and address those needs in the discharge plan....Hospitals should consider the availability of and access to non-health care

services for patients, which may include...”transportation services, meal services or household services, including housing for homeless patients.”

Comment: We understand that not every community has adequate shelter space to accommodate all requests, but hospitals that discharge homeless clients (especially at night) with no provisions for accommodation risk having an ED visit within hours. We also point out that many shelters frequently cannot accommodate medical discharge instructions (e.g., bed rest, elevating feet, wound care, non-weight-bearing status, etc.). We request CMS require hospitals to assess the need for medical respite programming on a systems level, and that each discharge plan for a patient who is homeless include an assessment of that patient’s need for medical respite care services (or placement in a short-term rehabilitation setting).

- “Hospitals should be able to provide additional information on non-health care resources and social services to patients and their caregiver/support person and they should be knowledgeable about the availability of these resources in their community.”

Comment: “Should be able to provide additional information” is passive, vastly inadequate, and may only constitute handing the patient a list of homeless shelters while making no provision to ensure at least one bednight is secured at an area program. We request CMS require hospitals to confirm a shelter bed and/or document what steps had been taken to confirm a shelter bed, as is done in discharges to nursing homes. We also request CMS require hospitals to ensure patients have weather-appropriate clothing to wear at the point of discharge.

- Encourages hospitals to “consider the availability of supportive housing, as an alternative to homeless shelters that can facilitate continuity of care for patients in need of housing.”

Comment: We have concerns with this provision, as it appears to bypass the HUD-required Continuum of Care (CoC) process for coordinated entry to supportive housing prioritized by need. It usually takes 2-3 months (or longer) for supportive housing to be arranged for a specific patient, coordinated across the CoC and other providers. We believe hospitals should be encouraged to initiate the local process for supportive housing (if one has not already occurred), but the hospital should be collaborating with those organizing this work and contact the CoC staff responsible for doing an assessment. Not every patient who is homeless and in the hospital is a candidate for supportive housing, but at the same time, not every hospital patient identified as homeless is already engaged in community services—hence CMS should require hospitals to coordinate/partner/collaborate with the homeless services community and ensure the discharge policy specifically outlines what steps need to occur when discharging patients who are homeless.

- Encourages hospitals to develop partnerships with community-based services to improve transitions of care that might support better patient outcomes.

Comment: Hospitals should be required to develop these partnerships, as they are at the center of community planning for health care needs as part of their mission. This includes participation in the local Continuum of Care (CoC) and other community efforts to bring together shelter and services for people who are homeless. CMS should also require hospitals to assess the need for developing a medical respite care program, which could be folded into their existing requirements for community needs assessments and/or community benefit requirements. This is also an opportunity for CMS to encourage hospitals to be active participants—or be conveners—for developing specialized programming for vulnerable populations (like those who are homeless) in the community.

5. **Process (proposed §482.43(c)(6):** Requires patients and caregiver/support person to be involved in developing the discharge plan and informed of the final plan.

Comment: Hospitals should be required to identify the patient's primary care provider (or other service provider such as a case worker) at the point of admission and communicate/coordinate with him/her on the discharge plan. For patients who are well-known to the health services community, this is particularly important to ensure there is alignment with existing care plans that have been developed in outpatient settings. If the patient is uninsured or does not have an assigned/known provider, hospitals should be required to work with the patient to select one (enrolling in health insurance if needed). This process may not be able to be completed during the hospital stay since Medicaid applications typically require multiple steps, but all patients who are uninsured but eligible for health insurance should leave the hospital with at least part of this process complete, and an established relationship with an enrollment assister who will ensure completion of the process.

6. **Discharge to Home (proposed §482.43(d)):** Includes patients returning to their residence, or to the community if they do not have a residence, who require follow-up with a primary care provider or specialist; home health agency; hospice, or other type of outpatient health care.

Comment: The language "to the community" is vague and creates a very real concern for those working with homeless populations who see patients discharged to the streets or to shelters ill-equipped to handle medical needs. We request this introductory phrasing be made more specific, such as "or to an appropriate provider if they do not have a residence."

7. **Discharge to Home (proposed §482.43(d)(2)):** Requires discharge instructions include written information on warning signs and symptoms that patients/caregivers should be aware of with respect to the patient's condition; requires discharge instructions include all medications (prescribed and over-the-counter) for use after discharge; requires all medications be reconciled (includes discharge medications and pre-hospitalization/visit medications), with any discrepancies corrected; requires reconciliation process to consider how patients would obtain post-discharge medications; requires written instructions be provided to patient, and this include follow-up care, appointments, pending/planned tests, needed telephone numbers for follow-up care.

Comment: For those identified as homeless and/or being discharged to a shelter, as well as other patients assessed as highly vulnerable and facing potential difficulty in accessing urgently needed medication, CMS should require hospitals provide sufficient medications to last until the follow-up appointment set up by discharge planner. This is particularly necessary when there is a weekend or holiday in between discharge and follow-up. We also believe CMS should require hospitals to provide the medications directly to the patient (not simply prescriptions that will not or cannot be filled) for those identified as having barriers to accessing a pharmacy. All too often, we see patients released with multiple prescriptions, but no ability to fill them (due to numerous barriers such as transportation, health literacy, insurance coverage, and copays).

8. **Discharge to Home (proposed §482.43(d)(4)):** Requires hospitals to establish a post-discharge follow-up process for patients discharged home. This can include a telephone call program.

Comment: Individuals experiencing homelessness often have barriers to follow up communication as phone numbers change frequently (or minutes run out) and mail is notoriously unreliable since mailing addresses may not reflect where the patient is actually staying. We recommend CMS require hospitals to include in their follow-up procedure an alternative point of contact for the hospital's use should the patient not be able to be contacted (this could be a case manager, PCP, or friend/family member). This is often information the patient could provide to assist with the discharge plan, and could include an appropriate release of information provision.

9. **Transfer of Patients to Another Health Care Facility (proposed §482.43(e)):** Clarifies expectations regarding what constitutes the necessary medical information that must be communicated to a receiving facility to meet the patient’s post-hospitalization health care goals, support continuity in the patient’s care, and reduce the likelihood of hospital readmission. Requires the information include a wide range of factors, to include demographics, contact information for responsible care practitioner and caregiver/support person, test results, social supports, behavioral health issues, functional assessment, reconciliation of all medications, patient’s goals and treatment preferences, and anything else needed to ensure a safe and effective transition.

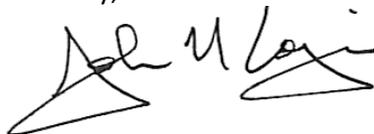
Comment: We request CMS require discharge information include an assessment of housing instability or other health-related factors that could impact successful transition to community and likelihood of readmission. Discharge information should also be required to be communicated to the patient’s PCP. This is another opportunity to ensure the ICD-10 code for homelessness (Z59.0) is used in the patient visit record, and to document whether a CoC/community homeless services housing assessment has been initiated and what steps are needed to ensure this process does not lapse due to being transferred to another facility.

10. **Requirements for Post-Acute Care Services (proposed §482.43(f)):** For patients enrolled in managed care organizations, requires hospitals to make the patient aware that they need to verify the participation of the home health agency or skilled nursing facility in their network (if the hospital has this information already, it must share this information with the patient).

Comment: This puts the burden on the patient to navigate the health insurance plan, which may be beyond the patient’s ability. We request CMS require hospital discharge plans to ensure the post-acute care services are aligned with MCO/insurance networks and that any discharge medications, follow-up providers, and/or any other instructions are covered under the patient’s plan. We strongly urge CMS to be very clear that putting the onus on vulnerable patients to navigate the health insurance system is not at all an effective practice. We also request CMS require hospitals to indicate very clearly on the discharge plan when something is out of network or not covered by patient plan. Lastly, we re-iterate our desire to see more medical respite care programs available as discharge options for patients who are homeless to provide greater (cost-effective) options for post-acute care services.

Thank you for the opportunity to comment on these proposed rules for hospital discharge planning. Please contact us if you should wish to discuss any aspect of these comments further. I can be reached at jlozier@nhchc.org or at 615-226-2262.

Sincerely,



John N. Lozier, MSSW
Executive Director

Notes:

¹ Hwang, S., et al. (April 2011.) Hospital costs and length of stay among homeless patients admitted to medical, surgical and psychiatric services. *Medical Care* 49 (4): 350-354. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21368678>.

² Feigal, L., et al. (November 2014.) Homelessness and discharge delays from an urban safety net hospital. *Public Health* 128: 1033-1035. Available at: [http://www.publichealthjrn.com/article/S0033-3506\(14\)00129-2/fulltext](http://www.publichealthjrn.com/article/S0033-3506(14)00129-2/fulltext).

³ Doran, K., et al. (September 2013.) The revolving hospital door: hospital readmissions among patients who are homeless. *Medical Care* 51 (9): 767-773. Available at: http://journals.lww.com/lww-medicalcare/Abstract/2013/09000/The_Revolving_Hospital_Door_Hospital_Readmissions.3.aspx.

⁴ Lebrun-Harris, et al. (June 2013.) Health status and health care experiences among homeless patients in federally supported health centers: findings from the 2009 patient survey. *Health Services Research* 48 (3): 992-1071. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23134588>.

⁵ O'Connell, J.J. (Ed.) (2004.) The health care of homeless persons, a manual of communicable diseases and common problems in shelters and on the streets. Boston Health Care for the Homeless Program. Available at: <http://homeless.samhsa.gov/Resource/The-Health-Care-of-Homeless-Persons-A-Manual-of-Communicable-Diseases-and-Common-Problems-in-Shelters-and-on-the-Streets-20227.aspx>.

⁶ 42 U.S.C. 254b(b)(2)(B). Available at: <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapII-partD-subpartI-sec254b.pdf>.

⁷ National Health Care for the Homeless Council (2015). *2015 Medical Respite Program Directory, Descriptions of Medical Respite Programs in the United States*. Available at: <https://www.nhchc.org/wp-content/uploads/2011/10/2015-medical-respite-program-directory.pdf>

⁸ Buchanan, D., et al. (July 2006.) The effects of respite care for homeless patients: a cohort study. *American Journal of Public Health* 96 (7): 1278-1281. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1483848/>.

⁹ Ibid.