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January 4, 2016

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

Re: Comments on the proposed rule: Medicare and Medicaid Programs: Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, Centers for Medicare Medicaid Services (CMS), Department of Health and Human Services (HHS).
Federal Register, Vol. 80, No. 212, Tuesday, November 3, 2015, pp. 68126-68155
Filing code: CMS-3317-P.

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on the proposed discharge-planning rule.

I wish to limit my comments to address elder abuse and how the subject proposed rule can play a vital role in our shared efforts in this arena—and in helping our most vulnerable elders, while advancing the intent of the rule.

Context

I am writing not as a professional in the health care field but as an advocate for elder justice, informed and compelled by the sad circumstances surrounding my grandmother, the late Brooke Astor, New York philanthropist—and victim of elder abuse by her son, my father.

With the help of many others, I was able to save my grandmother by filing a petition in 2006 for guardianship, with temporary guardianship awarded three days later — but not before she was admitted to a New York hospital to receive urgent care. (NBC News, 7/27/06) A week later she was discharged. We were able to reopen her country house so she could spend her last year where she wished—in care and comfort, and free from fear and abuse.

It was during my grandmother's hospital stay that I realized the critical importance and trusted role our health system and its professionals play for our elders. But I remain concerned how many elders are admitted (and readmitted) to hospitals as a result of victimization and abuse, including neglect. When elder abuse and poly-victimization occurs and includes isolation, a patient's first encounter with trusted professionals may be upon(re)admission to a hospital.

At times a person of trust (typically a family member) who is the patient's caregiver is abusing and isolating them, stealing their money, and not providing care (so the perpetrator will inherit more, sooner). This is what my father was doing for years, up to a week before my guardianship petition and her hospital admission. In this context, it is important to understand the role of family members and/or caregiver/support person—and the instruments (POA, health care proxy, guardianship) they hold.

As an elder-justice advocate since 2010 (work found in Beyond Brooke), I am aware of many elders whose abuse goes undetected, even after readmission to a hospital. And I realize how legislation (including the subject rule), policies, programs, and professionals (in concert) can help advance detection of and response to elder abuse.

The proposed rule provides an opportunity and constructive context to include language and procedures to address awareness of elder abuse, evaluate patients, respond to suspected elder abuse (as needed), and monitor (with involvement of community services) the patient and their circumstances after discharge and should they be readmitted.

Preamble

As noted by the World Health Organization (Elder abuse, *Fact sheet N°357*, updated October 2015),

> Multiple sectors and interdisciplinary collaboration can contribute to reducing elder abuse, including:
>
> - the social welfare sector (through the provision of legal, financial, and housing support);
> - the education sector (through public education and awareness campaigns); and
> - the health sector (through the detection and treatment of victims by primary health care workers).
>
> In some countries, the health sector has taken a leading role in raising public concern about elder abuse, while in others the social welfare sector has taken the lead.

The subject rule provides one more measured means to have our health care system advance elder justice in concert with other sectors.

The following comments relate to admission (or readmission) as much as discharge, recognizing, in the words of the proposed rule,

> "Ideally, discharge planning begins at the time of inpatient admission or outpatient registration." *Federal Register*/Vol. 80, No. 212/Tuesday, November 3, 2015/Proposed Rules p. 68131.
>
> We propose at § 482.43(c)(3) to require that the hospital's discharge planning process ensure an ongoing patient evaluation throughout the patient's hospital stay or visit to identify any changes in the patient's condition that would require modifications to the discharge plan. (ibid)
>
> We propose to re-designate § 482.43(b)(4) as § 482.43(c)(5) to require, that as part of identifying the patient's discharge needs, the hospital consider the availability of caregivers and community-based care for each patient… (ibid)

Recommendations

Upon (re)admission, registration —

- Make sure established protocols (including the interview tool, with performance metrics) help identify, address, and document (potential, suspected) elder abuse.
- Apply a (selective) screening and/or diagnostic evaluation for potential elder abuse that aims for high sensitivity.
- Evaluate the patient in the absence of their caregiver.
- Evaluate the patient's support system (caregivers and their legal assignments, including but not limited to durable power of attorney, health care proxy, and guardianship).
- As needed, assess the primary caregiver(s) and their 'capacity' and 'concern(s).' Even where (potential or real) abuse is not an issue,
    - Family caregivers very often serve as the coordinators for 'case management.' Yet they may not have the proper, adequate skills.
    - Family caregivers are very often the legal entity by which all needed goods and services will be procured. This should be verified.
    - In situations of limited financial resources, family caregivers may fail to complete a discharge plan in its entirety, or choose to only compete portions of the plan.
- Employ established protocols and validated instruments for evaluating suspected and identifying actual elder abuse—based on state statutes.

- Recognize and address barriers to fulfilling mandated and professional responsibilities vis-à-vis elder abuse.
- Augment with training and formative, regular assessment of policies, program, procedures, and outcomes related to elder abuse awareness, detection, and response.
- Seek ways to enhance the trust relationship between the patient and practitioners.
- If a patient is being readmitted, assess whether the previous, written discharge plan(s) were achieved with goods and services rendered successfully by primary caregiver, specialists, and community service providers.
    - If the plans were not realized, investigate the underlying cause. In some instances it may be due to elder abuse (including neglect).
- Frail, elderly patients with chronic medical conditions/co-morbidities are a high-risk group at discharge. Their health and wellbeing may be aggravated by elder abuse.

Reporting and Monitoring —

- As mandated by the state, suspected abuse is reported to appropriate authorities, APS and law enforcement, with court-ordered protection as required.
- Coordinate awareness, training, and response to elder abuse with Adult Protective Services and law enforcement.
- In some cases elder abuse may not be discernable upon admission, but elder abuse may be evident:
    - After discharge — informed by an evaluation of the patient and their care (or lack of) with reference to the discharge plan and its monitoring with/by professionals in the community.
    - If the patient is readmitted — here, a pattern of (suspected) abuse may be evident based on:
        - Evaluation of the implementation of the discharge plan, coupled with,
        - Evidence of recurring (or new) medical and psychological conditions

Intervention —

- Focus reporting and response on how to help the (alleged or actual) victim with services as much as how to 'arrest' the perpetrator.
- Balance the autonomy and safety of the elder.
- Assume a person-centered, multi-disciplinary approach, coordinated by Adult Protective Services in concert with law enforcement and, as needed, the courts.

(continued…)

Discharge —

- Include in the design (Proposed § 482.43(a)) of the Discharge planning (§ 482.43) performance metrics to inform formative assessment of policies, plans, procedures and their success or need for change.
- Engage a 'caseworker' to help the discharged patient with their discharge plan to make sure it is being carried out.
- Coordinate discharge with specific support systems with defined roles and goals of each professional, metrics for measurement and assessment, and a 'critical path method' of defining and realizing a person-center approach to health care and wellbeing.
    - Specific community support services will have expertise in elder justice issues involving elder abuse.

The subject rule provides one more measured means to have our health care system advance elder justice in concert with other sectors.

Equally, by addressing elder abuse as part of the process of (re)admission) and discharge planning, hospitals will further help elders while advancing the intent of the rule.

Thank you for considering my comments—and for the work you do each day.

Sincerely,

Philip C. Marshall