OMB- RESPONSES TO 60-DAY PUBLIC COMMENT PERIOD (ending 09-25-07)

Under the Deficit Reduction Act of 2005, Section 5008, CMS is directed to develop a uniform patient assessment instrument for use in a three year, post acute care-payment reform demonstration, to begin in January 2008. This uniform assessment instrument is now referred to as CARE (Continuity Assessment Record & Evaluation). The purpose of the CARE tool is to collect standardized data on Medicare beneficiaries' medical conditions, functional and cognitive impairments, and social support factors affecting treatment and discharge, regardless of site of care. During the demonstration CARE will be administered to Medicare beneficiaries at time of discharge from acute care hospitals, upon admission and discharge from post acute care (PAC) providers, as well as at interim points if a significant change occurs.

CARE is comprised of a set of *common assessment items* administered to all patients across all settings, and a set of *supplemental items* only administered for specific conditions or at particular times (i.e., PAC discharge only). A shorter version of CARE will be completed for patients who expire during a stay or who have a substantial change in condition.

A "master" version of the CARE instrument has been provided for publication along with an item matrix identifying which items are part of the *common assessment set* and which items are *supplemental*.

Analysis of and response to public comments
We received 79 comments from individuals, physicians, nurses, occupational therapists, physical therapists, speech-language pathologists, social workers, case managers, hospitals, long term care hospitals, critical access hospitals, nursing facilities, home health agencies, inpatient rehabilitation facilities, professional associations, health care organizations and associations, family and caregiver associations. All comments were reviewed, analyzed and grouped into categories based on subject matter. Summaries of the public comments and our responses to those comments follow.

General Comments
The Centers for Medicare & Medicaid Services was pleased to receive many positive comments from health care providers and professionals associations supporting the need for development of a consistent, standardized patient assessment instrument to collect data on patient characteristics, treatment needs and outcomes.

Many commenters also applauded CMS's efforts to develop a tool aimed at improving beneficiaries' transitions between care settings, enhancing patient safety, and improving communication across the continuum of care.

CMS also received comments suggesting general changes and other comments suggesting changes to specific assessment items. Quite a few suggestions were for specific word changes, many of which have been incorporated into this version of CARE. Additionally, several commenters requested clarification of terms and underscored the need to provide sufficient staff training. The following summarizes comments received and responses to those comments.

1. IMPORTANCE OF STANDARDIZED PATIENT INFORMATION

Comment: Almost all commenters applauded CMS' movement toward a uniform patient assessment instrument and standardized data collection tool. Commenters supported the need for a uniform, electronic tool to enhance patient transfers by communicating critical information, such as medications and allergies, to providers in an accurate, efficient and timely way.

Commenters also applauded CMS' efforts to meet the President's e-Health initiative for implementing interoperable data standards. The internet-based electronic transfers of CARE data is expected to decrease staff time spent on follow-up phone calls to clarify hand written information and/or obtain missing, incomplete information. The development of CARE's internet platform and related data specifications are expected to enable providers to use their existing IT systems to export data, such as medication lists, without making costly changes to their current systems.

Response:
CMS acknowledges the importance of this effort and appreciates the industry's recognition of CMS's leadership in this area.

2. PROVIDER BURDEN

Comment: Some commenters felt the time required for administering the CARE tool would far exceed CMS' estimates.

Response:
To assess provider burden, the CARE tool was pilot tested in a sample of hospitals and post-acute care (PAC) settings during April and May, 2007. Feedback from the pilot tests showed that the CARE tool took the same or less time to complete than the existing federally mandated assessment instruments (MDS, IRF-PAI, OASIS).

The CARE tool has been designed with both a set of core items and a set of supplemental items. While all assessors will complete the core items, supplemental items will only be assessed where the screening item identifies the patient as having a condition requiring more specific measurement. If a patient does not have conditions triggering supplemental items, assessors will skip sections of the tool. The CARE tool has been revised since the July version published in the Federal Register and the revised tool includes *additional skip patterns* which will further reduce provider burden.

Comment: Some commenters questioned the ability of facilities to administer the proposed tool with existing staff, and noted they would not be able to add staff without a corresponding increase in reimbursement.

Some commenters anticipated increased time burdens to collect certain data elements which can only be obtained "through patient interview or observation." A few cited the

need for additional time to coordinate "communication with multiple departments and/or team members."

Response:
The CARE tool, as published, has been developed for data collection and analysis purposes for the DRA-mandated three year demonstration, involving *volunteer* provider sites. CMS recognizes that use of the CARE tool during the demonstration will require an additional time commitment on the part of participating sites. CMS appreciates the feedback on this issue from commenters.

Comment: Questions were raised regarding the need to assess all Medicare beneficiaries discharged from acute hospitals, regardless of whether they will be using PAC or how long they were in the hospital.

Response:
The tool, as designed for the PAC-payment reform demonstration, is intended to collect data on all Medicare beneficiaries regardless of hospital length of stay and/or use of post-acute care services. Comments on the sample selection are more appropriately addressed in a different venue than the Paperwork Reduction Act Clearance process. .

3. TOOL'S ADEQUACY FOR CAPTURING INTENDED FACTORS

Comment: Concerns were raised that the CARE instrument does not adequately capture factors important to predicting placement including physician decision making processes.

Response:
The CARE instrument is not designed to capture all possible factors related to PAC discharge placement. In the interests of reducing burden, CARE is focused on capturing clinical factors that may influence resource needs and measurable factors which are predictive of outcomes associated with treatment.

Comment: The CARE instrument does not adequately capture costs and resource use measures as required in the initial legislation.

Response:
The CARE tool is not designed to capture costs and resource use. The demonstration will consist of multiple data collection efforts. The forms used to capture costs and resource use were submitted to OMB on 8/24/2007 as CMS-10246: Cost and Resource Utilization (CRU) Data Collection for the Medicare Post Acute Care Payment Reform Demonstration.

4. LEVEL OF CARE, ACCESS TO SERVICES, DISCHARGE

Comment: Several commenters related that the CARE tool may affect beneficiaries' access to services and/or may be used to determine post-discharge placement of patients

in particular level-of-care settings. A couple commenters indicated that referrals for care and services should be determined primarily by physicians, in consultation with the patient and family.

Response:
The CARE tool, as designed, in intended to capture data related to severity of illness, degree of impairment, and data which is expected to be predictive of resource utilization and outcomes. The CARE tool is not intended to dictate treatment nor direct discharge placement.

Comment: The tool should address the requirements of OBRA 87 for preadmission screening.

Response:
CMS appreciates the comment and will take this under consideration should the CARE tool be used beyond the demonstration.

5. PATIENT PREFERENCE:

Comment: The comment was raised that the CARE tool fails to address patient preferences and individual decision-making in the care process, particularly as they relate to discharge options.

Response:
The CARE tool, as developed for the demonstration, is intended to capture characteristics of patients' health status, functional status and related care needs. Wherever possible and feasible the developers incorporated opportunities for patients to "self-report" their responses to assessment items such as pain, cognition and depression. The tool's Discharge Section was enhanced, in this revised version of CARE, to assess the patient's anticipated needs and the availability of post-discharge care-givers and their abilities to meet the patients' needs.

6. INFORMATION TECHNOLOGY/E-HEALTH STANDARDS

Comment: Commenters applauded CMS' efforts to develop an efficient internet-based assessment instrument that incorporates industry-accepted, interoperable data standards. Some commenters raised concerns about potential cost to individual providers if a new tool necessitates a modification to their current IT systems. Several commenters recommended that any new tool, and its supporting IT system, be compatible with providers' existing IT systems and be able to accommodate the import and export of data from their systems.

Response:
CMS recognizes the industry's interest in data interoperability and desire for data import/export capabilities, especially for purposes of reducing providers' data collection burdens. CMS is working closely with its contracting partners to develop

these desired features. We will carefully consider comments and suggestions received as we begin the requirements gathering phase. CMS plans to hold small group discussions with IT/ e-health stakeholders to explore issues and solutions as we had done with the provider and research communities during the content development phase of the CARE instrument..

Comment: Commenters noted the importance of integrating CARE functionality into local solutions, building compatibility with existing automation strategies, and designing the data collection system to support multiple platforms.

Response:
CMS appreciates this comment and understands the complexity of existing IT systems. CMS is exploring the feasibility of different options and solutions for the demonstration and beyond.

CMS's CARE initiative is consistent with the Federal government's efforts to promote e-health standards that support greater interoperability across IT systems.

Comment: Providers were also interested in ensuring they can continue to own an electronic version of their data as it may be used internally for managing quality and other purposes.

Response:
CMS recognizes the value providers place on their data and acknowledges the important role data serves for providers' internal management purposes.

7. ONE SIZE FITS ALL: RISKS/OPPORTUNITIES

Comment: A concern was raised that this tool has a "one size fits all" approach that will lead to unrealistic expectations regarding its usefulness for clinical purposes, reimbursement, and outcomes analysis.

Response:
The CARE tool, as developed for the demonstration, is designed to capture a wide range of data regarding severity of patient illness and functional impairments which are expected to be predictive of resource utilization and outcomes. The common assessment items, administered in all care settings, are limited to items that apply to *all patients* regardless of care setting or degree of illness and/or impairment. The supplemental items are specific to certain patient populations, such as those with more extensive treatment needs or patients expected to exhibit a wider range of change with regard to medical/health status and/or functional outcomes. The presence of certain clinical indicators prompts the respondent to complete selected assessment items to provide more detailed data on particular subpopulations of patients. The absence of certain clinical indicators allows the respondent to skip irrelevant items and reduces overall time burden for completion of CARE.

8. ATTESTATION, LICENCE NUMBER:

Comment: Why is there a field requiring the clinician's license number?

Response:
An *optional* field is provided for clinicians to record a license number if required by State law or professional practice standards.

9. PRIVACY, PROTECTED HEALTH INFORMATION (PHI):

Comment: One commenter noted the need to protect the privacy of beneficiaries' health information related to mental illness and that patient privacy must be considered when transmitting PHI. Another commenter recommended Notice of Privacy Practice (NPP) to let patients know information is being captured in CARE.

Response:
All internet-users of CARE must electronically accept an on-line statement agreeing to strict adherence to all rules, regulations, laws regarding PHI for all patients and beneficiaries. Only authorized individuals whose identity has been authenticated will be granted electronic access to CARE applications.

10. DATA ANALYSIS AND RESULTING POLICY DEVELOPMENT

Comment: A number of commenters expressed a philosophical stance on how to shape the policy recommendations coming out of the research in the demonstration or had concerns with how particular areas of analysis would be performed.

Response:
CMS acknowledges the comments related to the future policy implications of the demonstration. We are sensitive to the concerns of many provider communities as to how the research will be performed and what policy changes will arise from it. We have contracted with a highly respected research firm to conduct careful, systematic, and objective research and we will continue to seek out commentary and suggestions from a wide variety of sources in order to produce the best result possible. However, concerns with the market selection, analysis plan, interpretation of findings for the demonstration, and future policy directions are more appropriately addressed in a different venue than the Paperwork Reduction Act Clearance process

Comment: A comment was received that various rules (such as the Inpatient Rehabilitation Facility "75% Rule" and Length of Stay requirements) will compromise ability to look at outcomes.

Response:
CMS acknowledges this concern. CMS does not intend to make inferences about the outcomes that could have been achieved if existing laws and regulations were not enforced. The study design does, however, include efforts to include some of the

larger facilities that may be less affected by the 75 percent rule to examine differences in treatments provided by different types of providers. In general, however, concerns with the analysis plan and the interpretation of findings for the demonstration are more appropriately addressed in a different venue than the Paperwork Reduction Act Clearance process.

11. CAREGIVER AND DISCHARGE SECTION

Comment: Several national organizations and a number of individuals commented that the proposed CARE instrument did not adequately assess patients' needs at the time of returning home or to a community setting, nor did it address the adequacy of arrangements for care by a family member or friend.

Response:
CMS acknowledges that many patients returning home or to a community setting rely on "informal" help from family and friends. In light of the growing recognition of the importance of volunteer caregivers in supporting sick, frail, disabled, and recuperating beneficiaries, the Discharge Section of CARE has been enhanced, in this revised version, to describe the patient's care needs and caregiver availability upon discharge to home or community setting. The items are largely adapted from OASIS.

Comment: The CARE tool asked about the patient's ability to pay for medications and to manage those medications, as well as transportation and the effects of caregiver availability. The comments noted that it might be very difficult in the current environment to answer the question of affordability and encouraged a focus just on self-management of critical issues.

Response:
The revised CARE tool includes a set of items measuring the need for assistance with Instrumental Activities of Daily Living (IADLs), medication management, and safety. This checklist of critical service needs efficiently focuses attention on the patient's needs, and whether caregivers are able to provide that help, will need training or other support, or will not be able to meet that need. Since the situations vary enormously, the assessment also offers the option that the ability of the caregiver to meet the need is simply not clear at this time.

Comment: In the instrument as proposed, three questions about advance care plans were asked in the "Admissions" section and two questions about risk of hospitalization and frailty were asked in a separate **Section IX**. A number of commenters encouraged this line of questions by stating that gaining an understanding of the patient's goals, decisions, and likely future was central to good care and to continuity. However, multiple commenters also raised concerns with these questions. Some were concerned that the questions about the future were too speculative, and that they might be used to limit access to treatments.

Response:

Comments received indicated this concept is not well enough understood to be useful and instead was perceived as posing risks for patient and provider and was removed. Finally, the questions on advance care plans drew a few comments seeking precision with regard to their legal status.

In response, CMS now proposes three questions, in this revised version of CARE, designed to characterize the clinical situation and ensure continuity of existing advance care decisions, while addressing the issues that raised concerns before. The first question establishes the frame for acknowledging an accord on patient-centered goals and the appropriate period for re-assessment. The second question enables downstream providers to understand the patient's fragility and overall expected course. The third question honors the authority of patients to determine their own surrogates (e.g., through Health Care Proxy and Durable Powers of Attorney) and to decide in advance certain critical elements of their own care. The answers to these three questions are central to high quality, patient-centered care and will be important components for seamless transitions. These items are worded in ways that are more appropriate to clinical respondents and they allow respondents to answer only what they already know.

12. POTENTIAL FOR FUNCTIONAL IMPROVEMENT

Comment: Several individuals commented about the ability of the instrument to distinguish between patients who would benefit from short intensive rehabilitation programs vs. longer less intensive programs and the ability to identify patients who have the potential for functional improvement

Response:

The CARE tool contains several items that can be used to identify patients who have the potential for functional improvement. For example, as is currently done in pre-admission assessments, the patient's diagnosis, co-morbidities, medical status, functional status and cognitive skills can all be taken together to make these determinations, . As described in the Government Accountability Office's 2005 report "MEDICARE: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities" functional status is currently used to identify patients appropriate for intensive rehabilitation. We considered adding an item related to functional goals and potential for improvement, but were unable to identify a standardized question with established, proven reliability, for use in this version of the CARE tool.

13. MEASURING FUNCTIONAL STATUS

Comment: Some commenters indicated that the functional status of patients should be based on the *most dependent performance* rather than the person's usual performance.

Response:
CMS elected to collect the person's usual functional status because it is a more stable estimate of a person's functional level and is not influenced by one episode of a poor performance during an assessment period. Clinicians could continue to document differences in functional status observed at different times of the day and in different environments for treatment purposes but reporting would be based on "usual" performance.

Comment: The rating scale for functional assessment items is different from the rating scales currently used. Why are supervision and minimum assistance combined?

Response:
In developing the rating scale, CMS considered analyses of the rating scales included in the current federally-mandated patient assessment instruments, as well as the MDS 3.0 instrument under development. Supervision and limited/minimal assistance were combined into one level because both require care provided throughout the period in contrast to setup assistance which is short-term prior preparation or clean-up assistance only.

Comment: One commenter was concerned about potential errors due to the use of a 6-point rating scale for some functional status items and a 4-point rating scale for other items.

Response:
CMS recognizes this concern and has revised the instrument so that a 6-point rating scale is used for all the functional status items.

14. RELIABILITY, VALIDITY: DATA USES FOR QUALITY, RELATIONSHIP TO EXISTING INSTRUMENTS (FIM, MDS)

Comment: Two commenters wrote that given the PAC demonstration's stated goals, patient care would be better served with a known, reliable, and functional measurement tool and that the reliability of the CARE tool has not been tested. One commenter further added that the FIM instrument is a much more reliable tool for functional assessment because of the associated training, testing and credentialing required of clinical staff members who use the tool. Another commenter questioned the advisability of changing

data reporting from established assessment tools to a new instrument instead of building on the body of experience, from current systems

Response:
The items for the CARE tool were drawn from current reliable instruments, including the FIM. We agree that some of these items have not been collected in all settings but our pilot test and related work testing the existing measures on each of these populations and cross walking the results will provide some information on the reliability of these items. In the demonstration, the predictive power of these items relative to the respective assessment item collected on each patient (e.g., IRFPAI, MDS, or OASIS, depending on the site of care) will be tested. Expert analysis will be conducted to examine the floor and ceiling effects of these items across providers.

Comment: One commenter expressed concerns that the accuracy of the data will vary based on who completes the CARE tool. In particular, the commenter pointed to the Functional Status section (VI) and recommended that this section should be completed by rehabilitation professionals from the appropriate discipline.

Response:
CMS agrees that data accuracy is important and for that reason has developed and will provide comprehensive, detailed training materials, as well as a comprehensive, detailed, user-friendly User's Manual. Additionally, CMS will also conduct inter-rater reliability tests to examine these issues.

Comment: Further, the commenter states that the Functional section should include items relevant to function cognition, communication, and swallowing and suggests the use of the Functional Communication Scales from ASHA's NOMS rather than, or in addition to, assessing them in other sections of the tool.

Response:
The CARE instrument includes a performance-based cognitive assessment that requires a conversation with the patient. The two communication items, expression and comprehension are based on the MDS 3.0 items and have been revised to more precisely capture the range of communication skills across a PAC population. These items incorporate input from ASHA members and can be used as screening items to identify the need for further professional assessment.

There are 2 items related to swallowing. The first item, taken from the MDS 3.0, lists signs and symptoms of a swallowing disorder. The second swallowing item is adapted from the IRF-PAI (Inpatient Rehabilitation Facility-Patient Assessment Instrument) and measures the extent of the food intake modification needed in the presence of a swallowing or chewing problem.

Comment: One commenter stated that the reliability of the CARE instrument needs to be quantified using appropriate statistical methods and research designs. This includes the need for intra- and inter-rater reliability particularly when data acquisition occurs across

multiple PAC settings, personnel types and modalities. This commenter further recommends that CMS publish a description of the studies it will use to determine the reliability of the data collected for the completion of the CARE instrument and that CMS provide information regarding tests of validity applied in selecting the various data elements of the CARE instrument as well as the tests of validity that will be used to assess the instrument at the end of the project.

Response:
Reliability testing is included in the demonstration. Further comments on the analysis and reliability testing are more appropriately addressed in a different venue than the Paperwork Reduction Act Clearance process.

Comment: One commenter stated that due to the stringent timeline established by Congress, the CMS contractor, have not had the opportunity to develop and test the questions as thoroughly as their analysts and the post acute community would have preferred. The commenter further encourages the project team to carefully evaluate the data, cross-checking it against existing sources and submitting it to academic and industry scrutiny prior to making recommendations as to its use.

Response:
CMS appreciates this comment. The CARE tool is based on years of existing evidence from each of the scientific communities, input from the provider and research communities through technical expert panels, and the results of recent CMS assessment initiatives. The CARE tool has been developed for the purposes of the demonstration. Analyses of the demonstration data will likely lead to further revisions. Further comments on the demonstration analytic plans are more appropriately addressed in a different venue than the Paperwork Reduction Act Clearance process.

Comment: One commenter requested that CMS and its contractor consider the validity of each of the questions closely, including inter-rater reliability given that multiple persons will be completing the instrument.

Response:
CMS recognizes the importance of this step and these types of analysis will be completed as part of the tool development process.

Comment: One commenter recommended that the Instrument's items should be assessed and completed by a licensed, trained professional (e.g., PT, OT, RN or SLP). They expressed concern that a signature is not required from the individual conducting the assessment and that there is a risk in the variability of the technical skills of those scoring the items which may result in major discrepancies with reliability and validity of the data.

Response:

Every assessor is required to complete the attestation page which identifies the section, date, and licensure information, and signature of those assessing a patient. During the demonstration, every assessor will be required to participate in a training session.

15. TRAINING AND USER'S MANUAL

Comment: Several commenters suggested rigorous training during the early phases of the demonstration, including delineating differences between the CARE items and existing instruments currently in use. In addition, commenters suggested that ongoing monitoring of the data would be necessary to ensure accuracy and that plans for follow-up training would be necessary due to staff turnover.

Response:
CMS agrees that training is a key component to the success of the demonstration. Coordinators from participating providers will be required to take a one day training provided by the research team. Coordinators will be trained in the use of the tool, in responses to assessors' questions, and will be provided a privacy-protected list-serve in which to participate where coordinators can share information, inquiries, and stay in touch with project staff on an on-going basis throughout the 9 month data collection process. In addition, multiple training sessions will be scheduled at each site throughout the 9 month data collection period to ensure that practices are consistent with the training and to assist coordinators affected by turnover in their clinical staff within participating units.

A User's Manual will also be provided to study participants. This manual has more detailed definitions, examples and a glossary. It will be used during training sessions and provided to all individuals involved in data collection during the demonstration.

In addition to the in-person training and User's Manual, a help desk for individuals involved in the demonstration will be available during the entire data collection process.

Comment: A range of comments stated that it will be important to provide assessment training and to set minimum standards for assessors so that the data will accurately reflect the patient's medical, functional, cognitive, and social support factors.

Response:
CMS is sensitive to these issues. The CMS contractor will also be providing extensive support to sites in the form of staff training and tool documentation to participating sites, as well as on-going support to each site's coordinators to ensure high quality data collected in the least burdensome, most efficient, and systematic manner at each provider site. Within each provider, assessors and other clinicians will also receive training so that they understand the difference between the CARE tool items and those in their current assessment tools.

16. REPORTING REQUIREMENTS

Comment: Will CARE fulfill some already existing CMS reporting requirements or will this be an additional reporting requirement? Many of the items look similar to those on the MDS, IRFPAI, and OASIS tools. Concerns were raised that this data collection requirement would add to provider reporting burden.

Response:
At this time, the CARE tool has been developed for the DRA-mandated three year demonstration beginning in 2008. All providers in the demonstration participate on a volunteer basis. They will be responsible for collecting data required by the CARE tool and any other currently mandated assessment instrument applicable to that setting. CMS appreciates the additional effort being volunteered by all participating providers.

17. CMS RESPONSES TO COMMENTS ON SPECIFIC CARE ITEMS

This section highlights changes to *specific CARE items* where numerous comments were received.

III. A. Primary Diagnosis

Comment: Clinicians will not have accurate information on the primary diagnosis ICD-9 CM code.

Response:
This section was broken into two sections to reduce provider burden and improve data accuracy. The first section identifies the diagnosis as reported by clinicians for continuity of care purposes and excludes ICD-9 CM codes. A later section (section IX) was added for coding professionals to identify the ICD-9 CM code and related diagnosis labels.

III. B. Other Diagnoses, Comorbidities, and Complications

Comment: Clinicians will not have accurate information on the primary diagnosis ICD-9 CM code.

Response:
This section was broken into two sections to reduce provider burden and improve data accuracy. The first section identifies the diagnosis as reported by clinicians for continuity of care purposes and excludes ICD-9 CM codes. A later section (section IX) was added for coding professionals to identify the ICD-9 CM code and related diagnosis labels.

III. C. Procedures

Comment: Clinicians will not have accurate information on the primary diagnosis ICD-9 CM code.

Response:
This section was broken into two sections to reduce provider burden and improve data accuracy. The first section identifies procedures as reported by clinicians for continuity of care purposes and excludes ICD-9 CM codes. A later section (section IX) was added for coding professionals to identify the ICD-9 CM code and related procedure labels.

IV. Cognitive Status

B. Brief Interview for Mental Status

Comment: This item is important for identifying cognitive impairments but is onerous to be asked of all beneficiaries, including the healthier patients discharged from the acute hospital.

Response:
This item was deleted from the acute discharge core items and is only asked on the PAC cases.

C1. Short-Term Memory

Comment: This item seems subjective and difficult to use on all populations.

Response:
This item was deleted.

C2. Long-Term Memory

Comment: This item seems subjective and difficult to use on all populations.

Response:
This item was deleted.

C3. Observational Assessment of Cognitive Status

Comment: This item is burdensome to record on all cases, including those who have been interviewed.

Response:

Modified the directions to only complete this item if the patient could not be interviewed.

G5a. Pain Effect on Function

Comment: Patients may sleep at times other than night. This item should not limit the time reference.

Response:
Deleted the phrase "at night."

Section V. Impairments

Comment: Each impairment type needs its own screening question to reduce burden for respondents whose patients have one type of impairment but not others.

Response:
Each impairment type has a screening item to identify the subset of items that may need to be assessed on any one patient. This reduces burden.

VIII. Frailty/Life Expectancy

Comment: Many respondents were uncomfortable with this question, depending on the patient's severity of illness and the providers' familiarity with end of life cases. Concerns were raised about liability issues and the appropriateness of various types of staff to answer this question.

Response:
These items were deleted and replaced with the overall plan of care items which asks the clinician to describe the patients' overall health status.

VIII. A2. Discharge Status- Attending Physician

Comment: This tool will be used to improve information flow when the patient is transferred to the next site of care. Identifying the attending physician is a key piece of transfer information.

Response:
Added A2. Attending Physician to the discharge form.

VIII. C. Other Discharge Needs

Comment: This section lacked critical information for safe transitions of beneficiaries to home regarding availability of an identified caregiver and the caregiver's ability to assist the patient with post discharge needs.

Response:
Deleted several individual items and replaced with Support Needs / Caregiver Assistance using a less burdensome check off matrix to identify the beneficiary's need for assistance the caregivers' abilities to meet that need.