Testimony for Health and Welfare Committee- Dan Hawkins, Chair 2/1/2016

Hello, My name is Eileen McGivern . I am the Vice President of Community Initiatives and Wellness at Brewster. I am a graduate of Washburn University with a BSN and have been a Registered Nurse for over 30 years. Brewster includes a CCRC located here in Topeka which includes independent and assisted living, rehabilitation and long term care nursing units. Brewster at Home is our home and community-based entity that includes 70 seniors who live in their own independent homes in our greater community and come to the Brewster Place campus for fitness and wellness initiatives, intellectual programs, art classes and other offerings. Additionally, we offer Live Well at Home, a life care program where people choose to live their entire lives in their homes and have wellness support, care coordination and receive services as they age in place. We currently serve 8 members in Topeka and Lawrence whom receive all the services of a CCRC, in their homes.

Through my work with Elders, I have developed a keen interest in the progress of *HB 2058, The Caregiver Advise, Record and Enable Act.* In 2013, Brewster served as the Community Based

Organization for a CMS /Medicare Care Transitions Project Demonstration. Brewster was one of 112 sites that participated in this national project to provide transitional services to Medicare recipients and their families.

The goal of the project was to reduce 30 day re-admissions to the acute care hospitals in Topeka and provide an evidence –based coaching model to recipients in Topeka and the surrounding eight counties. The coaching model provided a home- visit 24 hours after discharge from the hospital, activation of the patient and caregiver, a medication reconciliation, goal setting and connection to community resources. The patient and caregivers were followed for 30 days and given additional coaching as needs changed. Through our work, we were able to reduce readmissions to the acute care hospital from 17.8 to 2.8 %.

During our project, it became evident how vital to success were caregivers! Due to the sheer exhaustion of the patients during their hospital stay and upon discharge, it was nearly impossible for the Medicare recipients to process and retain the information given to them regarding their discharge instructions. The discharge instructions, which often include changes in medications or addition of new medications, can be several pages in length with medical terminology unfamiliar to the patient. Often the medical literacy of the patient is at such a low level, that the comprehension of the discharge plan is impossible. Hearing, vision and cognition deficits further reduces the chance of understanding the discharge plan and ultimately can contribute readmission to the hospital, post discharge. All of these challenges could be alleviated, if there was a caregiver to support the patient.

In analyzing data at the end of our project, it quickly became evident that patients, who had designated caregivers, were most successful. The caregivers were able to support the patient by reiterating the instructions to the patient, providing important insight for the coaches and served as support for the patient as they developed new ways to manage their chronic conditions. Culturally, some Medicare recipients insisted that I coach the caregiver and not the Medicare recipient. The Caregivers were active partners in recognizing exacerbations of chronic conditions and then executing the pre-determined plan that was formulated with the Coach at the home visit. This directly contributed to the success of our overall reduction of acute care readmissions.

As our society has changed over the years, family members may live miles away. Neighbor hoods are empty during the day as couples both work outside the home. People are living longer in their homes in the community and caregiver support is even more important than ever. Thank you for your time and I am happy to answer any questions.

Eileen McGivern RN, BSN

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