Holton Community Hospital
Family Practice Associates

HOLTON COMMUNITY HOSPITAL
1110 Columbine Drive, Holton, KS 66436 • 785-364-2116
FAMILY PRACTICE ASSOCIATES – HOLTON
1100 Columbine Drive, Holton, KS 66436 • 785-364-2126
FAMILY PRACTICE ASSOCIATES – HOYT
207 Highland, Hoyt, KS 66440 • 785-986-6630
FAMILY PRACTICE ASSOCIATES – WETMORE
323 2nd St, Wetmore, KS 66550 • 785-866-4775

January 30th, 2017

TO: Senate Public Health and Welfare Committee

FROM: Carrie Saia, RN
Holton Community Hospital, CEO

RE: Senate Bill 68 Enacting the Kansas Lay Caregiver Act

Thank you for the opportunity to provide written testimony in opposition to Senate Bill 68, legislation that would require the caregiving staff of my facility and facilities from hospitals across the state to perform additional unnecessary functions.

The legislation that is currently proposed to "designate a caregiver following the patient's admission into the hospital prior to the discharge of the patient" and to demonstrate compliance of this legislation by performing additional duties at specified times, is duplicative of many standards and regulations already in place our facility as well as all hospitals across the state of Kansas who receive reimbursement from the Centers for Medicare and Medicaid Services (CMS).

CMS developed health and safety standards, noted as Conditions of Participation that are the foundation for improving quality and protecting the health and safety of beneficiaries. Every hospital that receives reimbursement for services provided to a beneficiary must be able to demonstrate compliance with these Conditions of Participation, or be subject to inability to participate in the Medicare program, with loss of reimbursement. Evidence of compliance is validated through personal observation by state surveyors, under direction of the Kansas Department of Health and Environment.

The Conditions of Participation/Interpretive Guidelines (CMS §482.43) that speak to the requirements in place are:

- The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for success. Providing them with information on post-discharge options, what to expect after discharge, and as applicable, instruction and training in how to provide care is essential.
- The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the result of the evaluation. It is not necessary for the hospital to obtain a signature from the patient (or the patient's representative, as applicable) documenting the discussion.
- If the patient is not able to provide some of all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the hospital sufficiently to provide the required care.
- The patient or the patient's representative must be actively engaged in the development of the plan, so that the discussion of the evaluation results represents continuation of this active engagement.
- Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation.

Senate Public Health and Welfare

Date_____

Attachment_____

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Senate Bill 68 duplicates many of the requirements for the discharge planning process and follow-up care already in place as listed above, and puts into legislation duplication of regulations already in place. Holton Community Hospital requires an in-depth assessment of needs upon admission to the hospital for what services and care will be needed post-discharge that include, but are not limited to where the patient resides, what services will be needed, who will be assisting patient with needs, name and contact # of that person, what additional resources are needed. A specified care plan is developed to meet the identified needs, and discharge instructions are reviewed with all appropriate members prior to discharge.

Additional steps are also taken to ensure evaluation of the discharge process, which include post-discharge telephone calls to patients and patient satisfaction surveys that specifically monitor the level of satisfaction with the discharge process provided by hospital staff. CMS's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) are a specific set of nation-wide questions that larger hospitals receive reimbursement based upon their score, and many smaller rural facilities (including Holton Community Hospital) voluntarily participate and allocate resources to conduct this survey to determine if they are meeting their patient population needs. These specific questions include:

- "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health"
- "When I left the hospital, I clearly understood the purpose for taking each of my medications"

In addition to the CMS Conditions of Participation requirements and HCAHPS monitoring, numerous other facilities across the state take a step further to demonstrate quality patient care by becoming accredited through The Joint Commission. A cross-walk between each of these requirements and the proposed legislation is included with this testimony.

Holton Community Hospital strives to provide the highest quality of care to the patients we serve. Our care team looks to encompass each integral person involved to help each patient be successful not only during hospitalization but along the continuum of care. I understand the position those supporting SB68, but strongly believe that additional mandated legislation for requirements that are already a part of current regulations will not support achieving this goal. I would be happy to look at other avenues that would support their position. For these reasons, on behalf of Holton Community Hospital, and many of my colleagues and peers, I request that you oppose this legislation.

Thank you for your consideration of my comments.

Cami Sain

State and Federal Discharge Planning Requirements & Caregiver Bill Mandates

Type of Requirement	CMS §482.43 Condition of Participation + HCAHPS Surveys (Hospital Consumer Assessment of Healthcare Providers and Systems)	Joint Commission	Caregiver Legislation SB 68
Settings of Care Requiring Discharge Planning	Inpatient admissions only. "Accordingly, under the regulation, hospitals are required to have a discharge planning process that applies to all inpatients; discharge planning is not required for outpatients." ***Interpretive Guidelines §482.43***	"The hospital has written discharge planning policies and procedures applicable to all patients." ***PC.04.01.01 (26)***	**Inpatient Status** Section 1 "Discharge" means the release of a patient from hospital care to the residence or another location identified by the patient or legal guardian as the temporary residence of the patient following an inpatient admission.
Timeframes for Initial Assessment for Discharge Planning	Identification of high-risk patients who need discharge planning must occur at least **48 hours in advance of the patient's discharge**. "The identification of patients must be made at an early stage of the patient's hospitalization. This is necessary in order to allow sufficient time to complete discharge planning evaluations and develop appropriate discharge plans, for those patients who need them. Ideally the identification process will be completed when the patient is admitted as an inpatient, or shortly thereafter. However, no citations will be made if the identification of patients likely to need discharge planning is completed at least 48 hours in advance of the patient's discharge..." ***Interpretive Guidelines §482.43(a)***	"The hospital begins the discharge planning process early in the patient's episode of care, treatment and services." ***PC.04.01.03 (1)*** "The hospital conducts reassessments of its discharge planning process within its established time frames for reassessment." ***PC.04.01.03 (10)*** "The hospital coordinates care, treatment, and services within a time frame that meets the patient's needs." ***PC.02.02.01 (17)***	**No specific timeframe is indicated.** Section 1. A hospital shall provide each patient, or the patient's legal guardian with an opportunity to designate a caregiver following the patient's admission into a hospital and prior to the discharge of the patient.
Assessment of a Patient's Ability	The Medicare CoP requires that the evaluation include assessment of the patient's capacity for self-	"The hospital identifies any needs the patient may have for psychosocial or physical	Nothing in the legislation allows for the hospital to determine if the patient is able to provide any self-care at home.

for Self-Care	care or, alternatively, to be cared for by others in the environment, i.e., the setting, from which the patient was admitted to the hospital. "The evaluation must consider what the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care. The evaluation must include assessment of whether the patient will require specialized medical equipment or permanent physical modifications to the home, and the feasibility of acquiring the equipment or the modifications being made. <u>If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the hospital sufficiently to provide the required care."</u> ***Interpretive Guidelines §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)*** "If neither the patient nor the patient's family or informal caregiver(s) are able to address all of the required care needs, then the evaluation must determine whether there are community-based services that are available to meet	care, treatment, and services after discharge or transfer." ***PC.04.01.03 (2)***	

	the patient's needs while allowing the patient to continue living at home." ***§482.43(b) (3)*** "During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?" – Question 19 ***HCAHPS Survey*** "During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?" – Question 20 ***HCAHPS Survey***		
Discharge Delays	"The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge." ***§482.43(b)(5)***		Section 1. In the event the hospital is unable to contact the designated caregiver, such lack of contact shall not interfere with, delay, or otherwise affect the medical care, or appropriate discharge provided to the patient, consultation with the caregiver or discharge instructions.
Patient / Caregiver Engagement in Discharge Plan	The Medicare CoP requires ongoing consultation with the patient and his or her family on the discharge process. "The patient or the patient's representative must be actively engaged in the development of the plan, so that the discussion of the evaluation results represents a continuation of this active engagement." ***Interpretive Guidelines §482.43(b)(6)*** "The patient has the right to participate in the development and implementation of his or her plan of care. The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding	"The patient, the patient's family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer." ***PC.04.01.03: (3)*** "Prior to discharge, the hospital arranges or assist in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services." ***PC.04.01.03: (4)***	This legislation prescribes when the patient's caregiver must be consulted and educated prior to discharge. Section 1. If a patient has designated a caregiver, the hospital, shall notify the designated caregiver concerning the discharge or transfer of the patient to another licensed facility as soon as practicable prior to discharge, or transfer. Section 1. At or before discharge, the hospital shall (A) provide the caregiver with any discharge instructions for the patient, including any aftercare needs of the patient; and (B) educate the caregiver concerning the aftercare of then patient in a manner that is consistent with current accepted practices, based on the learning needs of the caregiver and that allows the caregiver the opportunity to ask questions about any aftercare tasks.

	his/her care and the patient's rights include...being involved in care planning and treatment. Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation." ***§482.13(b)*** "The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction and training in how to provide care is essential. The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance." ***Interpretive Guidelines §482.43©(3) & §482.43©(5)*** "As needed, the patient and family members or interested persons		

	must be counseled to prepare them for post-hospital care." *§482.43© (5)* "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. 1 Strongly disagree 2 Disagree 3 Agree 4 Strongly agree" - Question 23 ***HCAHPS Survey***		
Documentation of Discharge Planning	"The hospital … must discuss the results of the evaluation with the patient or individual acting on his or her behalf. The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation. It is not necessary for the hospital to obtain a signature from the patient (or the patient's representative, as applicable) documenting the discussion." ***Interpretive Guidelines §482.43(b)(6)*** "The hospital must document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as applicable." ***Interpretive Guidelines §482.43©(3) & §482.43©(5)***		
Education/ Training	"The hospital is required to arrange for the initial implementation of	"For hospitals that elect The Joint Commission Primary	This legislation mandates that hospital staff provide education to all designated caregivers

	the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. The education and training provided to the patient or the patient's caregiver(s) by the hospital must be tailored to the patient's identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training." ***Interpretive Guidelines §482.43©(3) & §482.43©(5)*** "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. 1 Strongly disagree 2 Disagree 3 Agree 4 Strongly agree" – Question 24 ***HCAHPS Survey*** "When I left the hospital, I clearly understood the purpose for taking each of my medications. 1 Strongly disagree 2 Disagree 3 Agree 4 Strongly agree 5 I was not given any medication when I left the hospital" –	Care Medical Home option: The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education." ***PC.02.02.01 (25)***	prior to discharge, related to the specific needs of the patient for care at home.

	Question 25 ***HCAHPS Survey***		
Sharing of Patient Information	None	"The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, providers of care, treatment, and services." ***PC.02.02.01 (1)***	In the event that the patient or the patient's legal guardian designates an individual as a caregiver under this act:
Requirement to Designate a Caregiver **Requirement for Written Consent from Patient** **Patient Declines Consent to Release Medical Information**	None	None	Section 1. Hospitals shall provide each patient or the patient's legal guardian, with an opportunity to designate a caregiver following the patient's admission into the hospital and prior to the discharge of the patient. Section 1. Prior to discharge, a patient may elect to change the patient's designated caregiver in the event that the original designated caregiver becomes unavailable, unwilling, or unable to care for the patient. Section 1. Nothing in this section shall be construed to require an individual that has been designated as a caregiver by a patient to accept the role of caregiver. Section 1. Nothing in this section shall be construed to require a patient to designate a caregiver.

Documentation of Patient's Caregiver **Designation if Patient is a Minor Child**			
Notification of Discharge to Caregiver	None	None	Section 1. If a patient has designated a caregiver, the hospital, shall notify the designated caregiver concerning the discharge, or transfer of the patient to another licensed facility as soon as practicable prior to discharge or transfer.