Discharge Planning
The CARE Act
WHY ARE WE HERE?

• Understand the context for new state legislation related to patient discharge planning and processes
• Examine the substance of the new CARE Act law and how it impacts hospitals
WHERE ARE WE STARTING?

Current state of discharge planning requirements

**Federal**
- Medicare Conditions of Participation (42 CFR Part 482)
- Joint Commission (discharge summary standards)

**State**
- No state specific discharge requirements until this legislation
New Discharge Legislation

**SB 72:** An Act relating to the discharge of patients from hospitals and to caregivers of patients after discharge from a hospital.

**Effective Date:** January 1, 2017

Amends AS 18.20 by adding a new section Article 5: Discharge of Hospital Patients 18.20.500 – 18.20.590
AARP CARE Act – Model

- Caregiver, Advise, Record, Enable Act (CARE Act)
- Developed at the national level, aggressively pushed by local chapters.
- Model legislation requires hospitals to:
  1. Provide patients the opportunity to designate a family caregiver admitted to the hospital.
  2. Notify the caregiver before discharge, and
  3. Provide instructions to the caregiver for medical tasks that will be performed at home.
Care Act Initial Language

- Discharge means patient’s release from medical care, treatment or observation.
- Caregiver requirement attaches upon “entry,” as defined as entering hospital regardless of whether patient is formally admitted to hospital.
- Must offer all patients opportunity to designate a caregiver with 24 hours of “entry” and record in clinical record.
- Hospital staff must secure authorization to release patient information to caregiver.
- Hospital staff must notify a designated caregiver four hours before patient discharge or transfer, consult with caregiver on discharge plan and provide a live demonstration of after care tasks.
- No qualifiers regarding need for aftercare by a caregiver, would attach discharge requirements to all patients.
SB 72: Alaska CARE Act

- A hospital shall adopt and maintain written discharge policies
- The policies must include the following components:
  - Hospital staff assess the patient’s ability for self-care after discharge
  - The patient provided opportunity to designate a caregiver
  - The patient and caregiver are given opportunity to participate in the discharge planning
  - The patient and lay caregiver are provided instruction or training prior to discharge, as necessary for the caregiver to perform medical and nursing aftercare following discharge
  - The patient’s caregiver is notified of the patient’s discharge or transfer
Key Definitions

**Discharge**
A patient’s release from the hospital following the patient’s admission to the hospital.

**Hospital**
Meaning given in AS 18.20.130 but does not include a hospital that is limited to the treatment of mental disorders.

**Private residence**
Does not include a rehabilitative facility, a hospital, a nursing home, an assisted living facility, a group home or another licensed health care facility
Key Definitions

**Designated caregiver**
A caregiver designated by the patient who agrees to provide aftercare to the patient in a private residence.

**Aftercare**
- Assistance with the activities of daily living or activities that are instrumental to the activities of daily living.
- Wound care, medication administration, medical equipment operation, mobility assistance, and other medical or nursing tasks.
- Other assistance related to the patients condition at the time of discharge.
SB 72: Alaska CARE Act Details

18.20.500 - Aftercare assessment and designation of caregiver
- Before discharging a patient, a hospital shall assess the patient’s ability for self-care after discharge and provide the patient with an opportunity to designate a caregiver who agrees to provide aftercare in a private residence after discharge from the hospital.

18.20.510 - Planning, instruction and training
- A hospital shall give the patient and the designated caregiver the opportunity to participate in planning for the patient’s discharge from the hospital.
- Before discharge, a hospital shall provide the patient and the designated caregiver with instruction and training as necessary for the designated caregiver to perform medical and nursing aftercare following discharge.

18.20.520 - Notification of discharge
- A hospital shall notify a patient’s designated caregiver of the patient’s discharge or transfer.
Discharge Policies

18.20.530 – Discharge policies

- A hospital shall adopt and maintain written discharge policies: The policies must comply with 18.20.500-590

- Hospital must specify the requirements for documenting the identity of a patient’s designated caregiver and the details of the discharge plan for the patient including professional follow-up as specified in the discharge plan.

- Discharge policies must ensure discharge planning is appropriate to the condition of the patient and meet the needs and condition of the patient and the abilities of the patient’s designated caregiver.
Discretion and Disclaimers

Hospital Discretion
Discharge policies of a hospital may incorporate established evidence-based practices that include:
1) Standards for accreditation adopted by a nationally recognized accreditation organization, or
2) The conditions of participation for hospitals adopted by CMS.

Disclaimer
Hospitals not required to adopt discharge policies that would:
1) Delay a patient’s discharge or transfer to another facility
2) Require the disclosure of protected health information without obtaining a patient’s consent as required by state and federal laws governing health information privacy and security.
CARE Act and Medicare COP

**Alaska Care Act (SB72)**

Maintain written discharge policies

Assess the patient’s ability for self-care after discharge.

Provide opportunity to designate caregiver who agrees to provide aftercare

Opportunity for patient/caregiver to participate in discharge planning process.

**Medicare Conditions of Participation**

- The hospital must have in effect a discharge planning process that applies to all patients. The hospital’s policies and procedures must be specified in writing.

- (b)(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient’s capacity for self-care

  **Not specified – implied caregiver involvement**

- (c)(7) The hospital, as part of the discharge planning process, must inform the patient or family of their freedom to choose among participating Medicare providers of post hospital care services and must where possible, respect patient and family preferences when they are expressed.
## CARE Act and Medicare COP

<table>
<thead>
<tr>
<th>Alaska Care Act (SB72)</th>
<th>Medicare Conditions of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and designated caregiver instruction and training</td>
<td>✔️ (c )(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.</td>
</tr>
<tr>
<td>Caregiver notification at discharge</td>
<td>Not specified</td>
</tr>
<tr>
<td>Documenting caregiver and discharge plan details</td>
<td>✔️ (b)(6) The hospital must include the discharge planning evaluation in the patient’s medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.</td>
</tr>
<tr>
<td>Discharge planning appropriate for the needs of the patient</td>
<td>✔️ (c )(6) The hospital must reassess the patient’s discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.</td>
</tr>
<tr>
<td></td>
<td>✔️ (e) The hospital must reassess its discharge planning process on an on-going basis. To ensure they are responsive to discharge needs.</td>
</tr>
</tbody>
</table>
Links

Alaska SB 72 CARE Act
http://www.legis.state.ak.us/PDF/29/Bills/SB0072Z.PDF

42 CFR 482.43 - Condition of participation: Discharge planning
https://www.law.cornell.edu/cfr/text/42/482.43

Hospital Discharge Planning in Medicare: Current Requirements and Proposed Changes
https://www.nhpf.org/library/the-basics/Basics_HospitalDischargePlanning_02-09-16.pdf
Resources for Care Transitions

Alzheimer’s Association
(http://www.alz.org/documents/national/topicsheet_hospitaldischarge.pdf)
Support to address the unique needs of persons with dementia.

Care Transitions Program (http://caretransitions.org)
Provides a wide range of resources for professionals, patients, and family caregivers.

Institute for Patient- and Family-Centered Care
http://www.ipfcc.org/advance/Advisory_Councils.pdf
Offers practical advice for establishing patient and family advisory councils.

National Transitions of Care Coalition (http://www.ntocc.org)
Provides a wide variety of tools and resources.

Next Step in Care (http://www.nextstepincare.org)
The most comprehensive site supporting both family caregivers and health professionals.

Project BOOST
(http://www.hospitalmedicine.org/about_shm/webformz/form_wfz_imptk_boost.aspx?iFormSubmissionKey=21301dd3-5c5f-4a68-a5e7-15fa1d0c01eb)