

# **REPORT OF THE LEGISLATIVE FAMILY CAREGIVERS WORKING GROUP**

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## **EXECUTIVE SUMMARY**

Senate Concurrent Resolution No. 107, Senate Draft 1, House Draft 1 (2015), requested the convening of a Legislative Family Caregivers Working Group to examine and assess issues relating to the role of caregivers for patients discharged from hospitals. The Working Group conducted informational briefings during which various stakeholders were invited to present information to the Working Group. The Working Group also considered current hospital discharge practices, current and proposed federal rules relating to patient discharge, caregiver legislation enacted by other states, and relevant hospital accreditation requirements.

Following its informational briefings and deliberations, the Working Group reached a consensus on a number of issues. These include support for the funding of a comprehensive range of services and programs to support the elderly and caregivers, including Aging and Disability Resource Centers in each of the four counties, fall prevention services, and programs addressing Alzheimer's disease and related dementia. The Working Group also supports serious consideration of legislation that would require hospitals to offer patients the opportunity to identify a caregiver, involve patients and caregivers in the patient discharge planning process, and prepare caregivers for post-discharge aftercare.

# **Chapter 1**

## **INTRODUCTION**

### **A. Background of the Genesis of the Report**

During the Regular Session of 2015, the Legislature adopted Senate Concurrent Resolution No. 107, Senate Draft 1, House Draft 1, entitled "Requesting the Convening of a Legislative Family Caregivers Working Group to Examine and Assess Issues Relating to the Role of Caregivers of Patients Discharged from Hospitals" (hereafter "SCR 107"). (A copy of SCR 107 is attached as Appendix A.) Many patients who are discharged home from a hospital require continued care. Yet, due to the expense of obtaining private, professional caregiver services, many patients rely on family members or other nonprofessional caregivers for care. Some advocates believe that the amount of instruction a hospital provides to a family or other nonprofessional caregiver varies from hospital to hospital, and consequently, a need exists to establish a consistent level of instruction for all nonprofessional caregivers statewide. Additionally, while most hospitals provide discharge plans, advocates believe that these plans do not always involve the family or other nonprofessional caregiver. However, hospitals have raised concerns over the possible effect of proposed mandatory legislation on liability and costs. The Legislative Family Caregivers Working Group considered these and other issues related to the role of caregivers in the discharge of patients and received presentations and other input from numerous stakeholders. This report is a culmination of the Working Group's activities in responding to the provisions of SCR 107.

### **B. Scope of the Report**

SCR 107 tasked the Legislative Family Caregivers Working Group with examining and assessing the specific issues contained in Senate Bill No. 296, Regular Session of 2015, Relating to Caregiving (hereafter "SB 296"). (A copy of SB 296 is attached as Appendix B.) SCR 107 requested the Legislative Reference Bureau (hereafter "the Bureau") to assist the Working Group with research and drafting the Working Group's report and any proposed legislation.

This report discusses the provisions of SB 296, information presented by various stakeholders including concerns and proposed solutions, current hospital practices and requirements regarding patient discharge planning and the role of a caregiver, discharge planning practices in other states, the community-based resources available to support caregivers, and proposed federal requirements on patient discharge and caregiver involvement in the discharge process.

The remaining chapters of this report provide the following:

- (1) Chapter 2 provides background on the original Family Caregivers Working Group established in 2014 and the creation of the Legislative Family Caregivers Working Group established in 2015;

- (2) Chapter 3 provides information on current patient discharge requirements and hospital discharge procedures;
- (3) Chapter 4 provides an overview of community-based resources and support services available to patients and caregivers in Hawaii;
- (4) Chapter 5 provides a summary of the various informational briefings and other information presented to the Working Group and the meeting at which the members of the Working Group discussed the report and presented comments;
- (5) Chapter 6 provides a comparison of SB 296 to the Caregiver, Advise, Record, Enable (CARE) Acts in other states;
- (6) Chapter 7 provides information on the proposed amendments to the United States Centers for Medicare and Medicaid Services standards for discharge planning; and
- (7) Chapter 8 offers the Working Group's general comments and observations.

Finally, in crafting this report, the Bureau notes that various materials reviewed for this report make reference to "informal caregiver," "designated caregiver," "family caregiver," "friend caregiver," "the person acting on the patient's behalf," "patient's family," "patient's representative," "support person," and other terms that generally seem to describe a person or persons who, without compensation, provide caregiving services to a patient after discharge. For the purpose of simplicity and ease of reading, this report generally uses the term "caregiver" when referring to unpaid, nonprofessional caregivers.



## Chapter 2

### BACKGROUND

#### A. Family Caregivers Working Group (2014)

During the 2014 Regular Session, the Legislature adopted House Concurrent Resolution No. 78, House Draft 1, Senate Draft 1 (HCR 78), which requested the Department of Health to convene a Family Caregivers Working Group to examine and assess issues contained in Senate Bill No. 2264, Regular Session of 2014, Relating to Caregiving (SB 2264). The working group consisted of various stakeholders from health organizations, government offices, and community organizations.

*(HCR 78 is available at <http://goo.gl/5uftPg> or [http://www.capitol.hawaii.gov/session2014/bills/HCR78\\_SD1\\_.pdf](http://www.capitol.hawaii.gov/session2014/bills/HCR78_SD1_.pdf) and SB 2264 is available at <http://goo.gl/QF6p1U> or [http://www.capitol.hawaii.gov/session2014/bills/SB2264\\_HD1\\_.pdf](http://www.capitol.hawaii.gov/session2014/bills/SB2264_HD1_.pdf).)*

Over the course of 2014 and 2015, the Family Caregivers Working Group met eight times, but did not reach a consensus on proposed legislation. However, the working group made multiple recommendations, including the majority recommendation to "[t]ake no action at this time to mandate hospitals to provide caregiver training"<sup>1</sup> and the consensus recommendations to consider funding studies to improve caregiving, consider funding for organizations to improve post-hospital care, and improve funding to address at-risk populations.<sup>2</sup>

#### B. Senate Bill No. 296

Senate Bill No. 296, Regular Session of 2015, Relating to Caregiving (SB 296) is intended to facilitate the ability of caregivers to provide competent, post-hospital care to family members and other loved ones. Generally, SB 296 requires hospitals to provide an opportunity for a patient to designate a caregiver, provide notice to the caregiver of a patient's discharge, and instruct the caregiver on the care needs of the patient following discharge home.<sup>3</sup> During the Regular Session of 2015, SB 296 was referred to the Senate Committees on Human Services and Housing and Health jointly, and then to the Senate Committee on Judiciary and Labor. The

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<sup>1</sup> Report to the Twenty-Eighth Legislature State Of Hawaii 2015, Pursuant to HCR 78, Session Laws of Hawaii 2014, Requesting the Department of Health to Convene a Family Caregivers Working Group to Examine and Assess the Role of Caregiving for Patients Released from Hospitals, The State of their Overall Circumstances, and the Resources in the Community Needed and Available to Assist Them. Prepared by: State of Hawaii Department of Health, March 2015 at 10 (hereafter "FCWG Report"). (The report is available at <http://goo.gl/7PWGtg> or <http://health.hawaii.gov/opppd/files/2015/06/HCR-781.pdf>). See also Chapter 5, page 31 (summarizing the presentation of the (2014) Family Caregivers Working Group report to the Legislative Family Caregivers Working Group).

<sup>2</sup> FCWG Report at 10-11.

<sup>3</sup> For a detailed discussion of SB 296, see Chapter 6, page 44.

measure was heard jointly by the Senate Human Services and Housing and Health Committees, which deferred decision making on the measure indefinitely. However, after both committees deferred decision making on the measure, the Committee on Human Services and Housing subsequently provided public notice of a decision making on the measure. At the public decision making meeting, the Committee on Human Services and Housing voted to recommend that the measure be amended and sent to the entire Senate for its consideration. The Senate Committee on Health did not reconsider its previous recommendation to defer, so the measure failed to continue in the legislative process. The appropriate subject matter committees may schedule SB 296 for a hearing during the Regular Session of 2016.<sup>4</sup>

*(SB 296 is attached as Appendix B and is available at <http://goo.gl/W04ufe> or [http://www.capitol.hawaii.gov/session2015/bills/SB296\\_.pdf](http://www.capitol.hawaii.gov/session2015/bills/SB296_.pdf).)*

### **C. Legislative Family Caregivers Working Group (2015)**

During the 2015 Regular Session, the Legislature adopted Senate Concurrent Resolution No. 107, Senate Draft 1, House Draft 1 (SCR 107), which convened the Legislative Family Caregivers Working Group to examine and assess issues contained in Senate Bill No. 296, Regular Session of 2015, Relating to Caregiving (SB 296).

*(SCR 107 is attached as Appendix A and is available at <http://goo.gl/qCpbwC> or [http://www.capitol.hawaii.gov/session2015/bills/SCR107\\_HD1\\_.pdf](http://www.capitol.hawaii.gov/session2015/bills/SCR107_HD1_.pdf).)*

SCR 107 requested that the Legislative Family Caregivers Working Group consist of the following six legislative members:

- (1) The Senate subject matter committee chair for health;
- (2) The Senate subject matter committee chair for human services;
- (3) A Senate member of the Kupuna Caucus to be appointed by the Senate President;
- (4) The House of Representatives subject matter committee chair for health;
- (5) The House of Representatives subject matter committee chair for human services;  
and
- (6) A House of Representatives member of the Kupuna Caucus to be appointed by the Speaker of the House of Representatives.<sup>5</sup>

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<sup>4</sup> Status of Senate Bill 296

[http://www.capitol.hawaii.gov/Archives/measure\\_indiv\\_Archives.aspx?billtype=SB&billnumber=296&year=2015](http://www.capitol.hawaii.gov/Archives/measure_indiv_Archives.aspx?billtype=SB&billnumber=296&year=2015) (last visited Dec. 31, 2015). For a detailed discussion of SB 296, see Chapter 6, page 44.

<sup>5</sup> SCR 107 at 3.

## BACKGROUND

Accordingly, the following legislators served on the Legislative Family Caregivers Working Group: Rosalyn H. Baker, Senator 6<sup>th</sup> District; Suzanne Chun Oakland, Senator 13<sup>th</sup> District; Les Ihara, Jr., Senator 10<sup>th</sup> District; Della Au Belatti, Representative 24<sup>th</sup> District; Daynette Morikawa, Representative 16<sup>th</sup> District; and Gregg Takayama, Representative 34<sup>th</sup> District.<sup>6</sup>

SCR 107 requested the Legislative Family Caregivers Working Group to examine and assess issues contained in SB 296, including:

- (1) The role of family caregivers;
- (2) The state of the current practice of designating family caregivers;
- (3) Notification of family caregivers when a hospital discharges a patient or transfers a patient to another licensed facility;
- (4) Family caregivers' involvement in discharge planning and instruction;
- (5) The role of hospitals and hospital staff in the instruction of family caregivers;
- (6) The role of insurance plans in paying for the instruction of family caregivers by hospitals and hospital staff; and
- (7) Legislative and regulatory recommendations on how best to involve family caregivers in the patient-discharge process and prepare family caregivers for post-discharge tasks.<sup>7</sup>

SCR 107 also requested the Working Group to solicit input and presentations from the following stakeholders: the Department of Health, AARP Hawaii, the Healthcare Association of Hawaii, the Kokua Council, representatives of private hospitals or long-term care facilities in Hawaii, the Policy Advisory Board for Elder Affairs, the Hawaii Association of Health Plans, Hawaii Health Systems Corporation, International Longshore and Warehouse Union Local 142 Hawaii, the Hawaii Family Caregiver Coalition, the respective county Area Agencies on Aging, Project Dana, and the Hawaii Alliance for Retired Americans.<sup>8</sup>

SCR 107 further requested the Legislative Family Caregivers Working Group to:

- (1) Consider the information presented by the stakeholders to the Working Group;
- (2) Consider concerns raised and any possible solutions proposed;

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<sup>6</sup> Notice of Meeting, Legislative Family Caregivers Working Group, Twenty-eighth Legislature, Interim of 2016 (Dec. 15, 2015), available at [http://capitol.hawaii.gov/session2015/HearingNotices/HEARING\\_LFCWG\\_12-15-15\\_INFO\\_.pdf](http://capitol.hawaii.gov/session2015/HearingNotices/HEARING_LFCWG_12-15-15_INFO_.pdf).

<sup>7</sup> *Id.* at 2-3.

<sup>8</sup> *Id.* at 3-4.

- (3) Review approaches that may have been taken by other states with regard to these issues;
- (4) Examine the public and private community-based resources that are available throughout the State;
- (5) Make recommendations, as appropriate; and
- (6) Report its findings and recommendations to the Legislature no later than twenty days before the Regular Legislative Session of 2016.<sup>9</sup>

Finally, as previously noted, the Concurrent Resolution requested the Bureau to assist the Legislative Family Caregivers Working Group in conducting research and drafting a report and proposed legislation, if any.<sup>10</sup>

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<sup>9</sup> *Id.* at 4.

<sup>10</sup> *Id.*

## Chapter 3

### CURRENT DISCHARGE REQUIREMENTS AND HOSPITAL DISCHARGE PROCEDURES

#### A. Centers for Medicare and Medicaid Services Requirements

The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services. The main function of CMS is to administer the federal Medicare and Medicaid programs. As part of these functions, CMS has promulgated rules with which hospitals must comply as a condition for participation in the Medicare and Medicaid programs.<sup>11</sup> CMS also publishes and maintains a State Operations Manual, which provides guidance on how to interpret and implement CMS rules. Most, if not all, major hospitals in Hawaii participate in the Medicare<sup>12</sup> and Medicaid programs and, accordingly, follow the requirements established by CMS rules.<sup>13</sup>

Federal rules and the interpretive guidelines established by the CMS's State Operations Manual require hospitals to include discharge planning in their processes for transitioning inpatients to post-acute care settings.<sup>14</sup> The State Operations Manual states:

Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs.<sup>15</sup>

The federal rules require hospitals to effectuate a discharge planning process for all patients<sup>16</sup> that involves the participation, input, and consideration of the patient, the patient's representative, the patient's caregiver, and patient's family members.<sup>17</sup> Furthermore, if required

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<sup>11</sup> 42 C.F.R. pt 482.

<sup>12</sup> Medicare Facilities, State of Hawaii, Department of Health Office of Health Care Assurance, <http://health.hawaii.gov/ohca/medicare-facilities/hospitals/>.

<sup>13</sup> FCWG Report at 6.

<sup>14</sup> 42 C.F.R. 482.43 and Centers for Medicare and Medicaid Services, State Operations Manual, Appendix A - Survey Protocol, Regulations[,] and Interpretative Guidelines for Hospitals, rev. 151 (Nov. 20, 2015) (hereafter "State Operations Manual, Appendix A"), available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf).

<sup>15</sup> *Id.* at A-0799.

<sup>16</sup> 42 C.F.R. 482.43 ("The hospital must have in effect a discharge planning process that applies to all patients.").

<sup>17</sup> State Operations Manual, Appendix A, at A-0820 ("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.").

by the discharge plan, the federal rules require the hospital to train and educate the caregiver<sup>18</sup> on how to care for the patient at home.<sup>19</sup>

The federal rules specify multiple steps in the discharge planning process for hospitals.<sup>20</sup> That process requires hospitals to:

- (1) Identify patients likely to suffer adverse effects without adequate discharge planning;<sup>21</sup>
- (2) Provide a discharge planning evaluation for patients identified in the previous step and to other patients who request a discharge planning evaluation;<sup>22</sup>
- (3) Provide a discharge plan if a discharge planning evaluation indicates a need for a discharge plan;<sup>23</sup>
- (4) Transfer the patient as necessary;<sup>24</sup> and
- (5) Reassess the discharge planning process on an on-going basis.<sup>25</sup>

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<sup>18</sup> The federal regulations in 42 C.F.R. 482.43, State Operations Manual, and Joint Commission standards, and other documents use many terms that include or mean the informal or family caregivers addressed by this report and SB 296. Accordingly, for simplicity and consistency, this report generally uses the term "caregiver" to refer to an unpaid person who provides care to a patient following discharge and includes the terms "informal caregiver," "designated caregiver," "family caregiver," "friend caregiver," "the person acting on the patient's behalf" (42 C.F.R. 482.43(b)(1)), "individual acting on the patient's behalf" (42 C.F.R. 482.43(c)(6)(iii)), "patient's family" (42 C.F.R. 482.43(c)(7)), "patient's informal caregiver" (State Operations Manual, Appendix A, at A-0820), "patient representative" (State Operations Manual, Appendix A, at A-0121), "support person" (State Operations Manual, Appendix A, at A-0799), and "patient's family members . . . involved in the patient's ongoing care" (Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission E-dition Release 6.0 Standards and Elements of Performance. Oakbrook Terrace, IL: The Joint Commission, 2013:13, at PC.04.01.05.).

<sup>19</sup> State Operations Manual, Appendix A, at A-0820 ("The hospital is required to arrange for the initial implementation of 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.").

<sup>20</sup> 42 C.F.R. 482.43.

<sup>21</sup> 42 C.F.R. 482.43(a). *See also* 42 U.S.C. section 1395x(ee)(2)(A) ("The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.").

<sup>22</sup> 42 C.F.R. 482.43(b)(1). *See also* 42 U.S.C. section 1395x(ee)(2)(B) ("Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.").

<sup>23</sup> 42 C.F.R. 482.43(c)(1) ("A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.").

<sup>24</sup> 42 C.F.R. 482.43(d) ("The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow[-]up or ancillary care.").

<sup>25</sup> 42 C.F.R. 482.43(e) ("The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.").

## 1. Identification of Patients in Need of Discharge Planning

The discharge planning process begins with the hospital identifying patients, at an early stage in their hospitalization, who are likely to suffer adverse health consequences upon discharge if they do not receive adequate discharge planning.<sup>26</sup> To determine which patients require discharge planning, the State Operations Manual notes the following important factors:

- (1) The patient's functional status and cognitive ability;
- (2) The type of post-hospital care the patient requires and whether that form of care requires the services of health care professionals or facilities;
- (3) The availability of the required post-hospital health care services; and
- (4) The availability and capability of family and friends to provide follow-up care in the home.<sup>27</sup>

Additionally, hospitals must have a policy to document the process used to identify patients who require discharge planning and must identify staff members assigned to evaluate patients who are likely to require discharge planning.<sup>28</sup>

The State Operations Manual does not specify a time-period during which a hospital must determine whether a patient requires discharge planning to meet the "early stage" requirement of the rule. However, the determination of whether a patient requires discharge planning must occur early enough to allow the hospital to complete the discharge planning evaluation and to develop an appropriate discharge plan.<sup>29</sup> The State Operations Manual also notes that CMS will not cite a hospital that makes a determination at least forty-eight hours in advance of the patient's discharge, provided that the timing of the determination does not delay the patient's discharge.<sup>30</sup> As an example, a timely discharge determination and subsequent discharge plan may result in a patient returning home supported by prearranged appropriate community services.<sup>31</sup> Conversely,

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<sup>26</sup> 42 C.F.R. 482.43(a) ("The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning."). *See also* 42 U.S.C. section 1395x(ee)(2)(A) ("The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.").

<sup>27</sup> State Operations Manual, Appendix A, at A-0800.

<sup>28</sup> *Id.* ("For hospitals that do not develop a discharge plan for every inpatient, the hospital's discharge planning policies and procedures must document the criteria and screening process it uses to identify patients likely to need discharge planning, including the evidence or basis for the criteria and process. They must also identify which staff are responsible for carrying out the evaluation to identify patients likely to need discharge planning.").

<sup>29</sup> *Id.* ("The regulation requires that 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.").

<sup>30</sup> *Id.* ("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 and there is no evidence that the patient's discharge was delayed due to the hospital's failure to complete an appropriate discharge planning evaluation on a timely basis or that the patient was placed unnecessarily in a setting other than where he/she was admitted from primarily due to a delay in discharge planning.").

<sup>31</sup> *Id.*

a delayed discharge determination could result in a delayed discharge plan. If that discharge plan requires the prearrangement of appropriate community services in the patient's home, the hospital may not have enough time to make those arrangements, and the hospital would instead discharge the patient to a facility that could accept the patient on shorter notice, such as a nursing facility.<sup>32</sup>

Finally, a patient's medical record should contain information of the patient's post-hospital needs if the hospital transfers the patient to another facility.<sup>33</sup> The receiving facility would then become responsible for the patient's discharge planning and amend the discharge plan as necessary.<sup>34</sup>

## **2. Discharge Planning Evaluation**

### **a. Who may receive or may request a discharge planning evaluation**

Hospitals must provide a discharge planning evaluation for patients who are identified by the hospital as needing discharge planning and for other patients who have requested a discharge planning evaluation.<sup>35</sup> The patient, patient's physician, and persons acting on behalf of patients may request a discharge planning evaluation.<sup>36</sup> Hospitals also must inform those individuals that they may request a discharge planning evaluation for the patient.<sup>37</sup>

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<sup>32</sup> *Id.* ("For example, a delay in identification of a patient in need of discharge planning might result in discharging the patient to a nursing facility, because such placements can be arranged comparatively quickly, when the patient preferred to return home, and could have been supported in the home environment with arrangement of appropriate community services.").

<sup>33</sup> *Id.* ("In the event that a patient is transferred to another hospital, any pertinent information concerning the identification of the patient's post-hospital needs should be in the patient's medical record that is transferred with the patient."). *See also* 42 C.F.R. 482.43(d) ("The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow[-]up or ancillary care.") and State Operations Manual, Appendix A, at A-0837 ("Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient's physician aware of the outcome of hospital treatment or follow-up care needs.").

<sup>34</sup> State Operations Manual, Appendix A, at A-0800 ("The receiving hospital then becomes responsible for the discharge planning process for the patient.").

<sup>35</sup> 42 C.F.R. 482.43(b)(1) ("The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.") and 42 U.S.C. section 1395x(ee)(2)(B) ("Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.").

<sup>36</sup> 42 C.F.R. 482.43(b)(1).

<sup>37</sup> State Operations Manual, Appendix A, at A-0806 ("Unless the hospital has adopted a voluntary policy of developing an evaluation for every inpatient, the hospital must also have a process for making patients, including the patient's representative, and attending physicians aware that they may request a discharge planning evaluation, and that the hospital will perform an evaluation upon request.").



**b. Who makes the discharge planning evaluation**

The federal rules require that a registered nurse, social worker, or other qualified person develop the discharge planning evaluation or supervise the development of the discharge planning evaluation.<sup>38</sup> The State Operations Manual also requires that all hospital personnel who conduct discharge planning evaluations have "knowledge of clinical, social, insurance[,] financial[,] and physical factors that must be considered" in evaluating a patient's expected post-discharge care needs.<sup>39</sup>

**c. Discharge planning evaluation must include post-hospital services**

The discharge planning evaluation must include an evaluation of the likelihood that the patient will require post-hospital services and the availability of those services.<sup>40</sup> The hospital determines whether a friend or family member can become a caregiver to address the patient's care needs if the patient returns home.<sup>41</sup> If a friend or family member cannot become the patient's caregiver or otherwise meet the patient's care needs, the hospital must then determine whether available community-based services can meet those needs.<sup>42</sup> Examples of these available community-based services include home health services, attendant care services, respiratory therapy, rehabilitation services, services for home modifications, transportation services, meal services, and household services.<sup>43</sup> The State Operations Manual also expects hospitals to know the capabilities and capacities of the various community service providers and to consider those factors in the discharge planning evaluation:

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented. This includes knowledge of community services, as well as familiarity

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<sup>38</sup> 42 C.F.R. 482.43(b)(2) ("A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the [discharge planning] evaluation.") and 42 U.S.C. section 1395x(ee)(2)(G) ("A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.").

<sup>39</sup> State Operations Manual, Appendix A, at A-0807.

<sup>40</sup> 42 C.F.R. 482.43(b)(3) ("The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.") and 42 U.S.C. section 1395x(ee)(2)(D) ("A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides.").

<sup>41</sup> State Operations Manual, Appendix A, at A-0806 ("§482.43(b)(4) requires that the evaluation include assessment of the patient's capacity for self-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.").

<sup>42</sup> *Id.* ("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 the patient's needs while allowing the patient to continue living at home.").

<sup>43</sup> *Id.*

with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients. If the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient.<sup>44</sup>

**d. Discharge planning evaluation must include consideration of self-care or care at home**

The federal rules require the discharge planning evaluation to include the likelihood of the patient's capacity for self-care or the possibility of the patient being cared for in the environment in which the patient resided before entering the hospital, such as the patient's home.<sup>45</sup> Ideally, a patient will return home after discharge from the hospital, and the patient can provide all required self-care.<sup>46</sup> When a patient cannot perform the required self-care, "the [discharge planning] 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.*"<sup>47</sup>

**e. Completion time of the discharge planning evaluation**

The appropriate hospital personnel must complete the discharge planning evaluation on a timely basis.<sup>48</sup> Timely discharge planning will help to avoid unnecessary delays in a patient's discharge and provide the discharge nurse or other hospital personnel with adequate time to make appropriate arrangements for the patient's post-hospital care.<sup>49</sup>

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<sup>44</sup> *Id.*

<sup>45</sup> 42 C.F.R. 482.43(b)(4) ("The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.").

<sup>46</sup> State Operations Manual, Appendix A, at A-0806 ("In general, the goal upon discharge is for a patient to be able to return to the setting in which they were living prior to admission.").

<sup>47</sup> *Id.* (emphasis added).

<sup>48</sup> 42 C.F.R. 482.43(b)(5) ("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.") and State Operations Manual, Appendix A, at A-0810 ("After a patient has been identified as needing an evaluation, or after a request for an evaluation has been made by the physician, patient and/or patient's representative, the evaluation must be completed timely."). See also 42 U.S.C. section 1395x(ee)(2)(C) ("Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.").

<sup>49</sup> 42 C.F.R. 482.43(b)(5).

**f. Placement of the discharge planning evaluation in the patient's medical record**

The patient's medical record must include the discharge planning evaluation.<sup>50</sup> If needed, the discharge nurse or other hospital personnel will use this information to establish a discharge plan.<sup>51</sup> The federal rules also require the hospital to discuss the results of the discharge planning evaluation with the patient or the caregiver<sup>52</sup> and to document that communication in the medical record.<sup>53</sup> Because the federal rules already require the active participation of the patient or the caregiver in developing the discharge plan,<sup>54</sup> it appears that the communication of the discharge planning evaluation is not intended to present an additional requirement for the hospital.<sup>55</sup>

**3. The Discharge Plan**

**a. Creation of the discharge plan**

If a discharge planning evaluation indicates a need for a discharge plan, a nurse, social worker, or other appropriately qualified person must develop a discharge plan or supervise the development of a discharge plan.<sup>56</sup> Even if the discharge planning evaluation does not indicate a need for a discharge plan, the patient, patient's caregiver, or the patient's attending physician may

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<sup>50</sup> 42 C.F.R. 482.43(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."). *See also* 42 U.S.C. section 1395x(ee)(2)(E) ("The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).").

<sup>51</sup> 42 C.F.R. 482.43(b)(6). *See also* State Operations Manual, Appendix A, at A-0812 ("The key requirement is that the evaluation results are included in the patient's medical record and are used in the development of the features of the discharge plan.").

<sup>52</sup> *See supra* note 50 and accompanying text.

<sup>53</sup> State Operations Manual, Appendix A, at A-0811 ("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.").

<sup>54</sup> 42 C.F.R. 482.13(b)(1) ("The patient has the right to participate in the development and implementation of his or her plan of care.") and 42 C.F.R. 482.13(b)(2) ("The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care[,], . . . being informed of his or her health status, *being involved in care planning* and treatment, and being able to request or refuse treatment.") (emphasis added). The language "as allowed under State law" appears to refer to situations where state law allows for a patient to delegate informed decision making authority to a representative, such as under an advance health care directive. State Operations Manual, Appendix A, at A-0131 ("A patient may wish to delegate his/her right to make informed decisions to another person (as allowed under State law)."). It appears that if a representative is not designated pursuant to the process established by state law, the representative would not be included in the hospital decision making.

<sup>55</sup> State Operations Manual, Appendix A, at A-0811 ("*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.*") (emphasis added).

<sup>56</sup> 42 C.F.R. 482.43(c)(1) ("A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan."). *See also* 42 U.S.C. section 1395x(ee)(2)(G) ("Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.").

request a discharge plan, and a hospital must provide one.<sup>57</sup> Similar to development of the discharge planning evaluation, personnel developing the discharge plan itself, must have "knowledge of clinical, social, insurance[,] financial[,] and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met."<sup>58</sup>

**b. Hospital duty to arrange for implementation of the discharge plan**

Federal rules require a hospital to arrange for the initial implementation of the discharge plan.<sup>59</sup> The State Operating Manual specifically states that 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."*<sup>60</sup> In addition, if specified in a discharge plan, a hospital must arrange transfers to other facilities and referrals to home health agencies, hospice agencies, physicians, practitioners, physical therapists, medical equipment suppliers, and community resources.<sup>61</sup>

**c. The hospital must reassess the discharge plan**

Federal rules require the hospital to reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.<sup>62</sup> A hospital must also conduct a routine reassessment of all plans or have a process for triggering a reassessment if a patient's condition or available caregiver, community-based services, or other available supports change.<sup>63</sup>

**d. Counseling and caregiver instruction on the discharge plan**

Federal rules require that, as needed, the patient and family members or interested persons be counseled to prepare them for the patient's post-hospital care.<sup>64</sup> This counseling includes notifying the patient's caregiver of post-discharge options, what to expect after

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<sup>57</sup> 42 C.F.R. 482.43(c)(2) ("In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.") and State Operations Manual, Appendix A, at A-0806 ("[A discharge planning] evaluation must also be completed if the patient, or [sic] the patient's representative, or the patient's attending physician requests one.").

<sup>58</sup> State Operations Manual, Appendix A, at A-0818.

<sup>59</sup> 42 C.F.R. 482.43(c)(3) ("The hospital must arrange for the initial implementation of the patient's discharge plan."). *See also* 42 U.S.C. section 1395x(ee)(2)(F) ("Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.").

<sup>60</sup> State Operations Manual, Appendix A, at A-0820 (emphasis added).

<sup>61</sup> State Operations Manual, Appendix A, at A-0820 and A-0837. *See also* 42 C.F.R. 482.43(d) ("The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow[-]up or ancillary care.").

<sup>62</sup> 42 C.F.R. 482.43(c)(4).

<sup>63</sup> State Operations Manual, Appendix A, at A-0821.

<sup>64</sup> 42 C.F.R. 482.43(c)(5).

discharge and, if applicable, instruction on how to provide care.<sup>65</sup> The instruction must include educating the caregiver on disease processes, medications, treatments, diet, nutrition, expected symptoms, when to seek additional help, and who to contact for help.<sup>66</sup> A hospital must tailor the caregiver's instruction to the patient's needs and must provide legible, plainly written, culturally sensitive, and age appropriate written discharge instructions.<sup>67</sup> The hospital must also document in the patient's medical record the instruction and materials that are provided to the caregiver.<sup>68</sup>

**e. Home health agencies and skilled nursing facility information in the discharge plan**

The hospital must include a list of available home health agencies or skilled nursing facilities in the discharge plan of patients whose discharge planning evaluation indicates a need for home health care or post-hospital extended care services.<sup>69</sup> The list must include the available home health agencies (HHAs) that participate in the Medicare program and serve the geographic area where the patient resides or the skilled nursing facilities (SNFs) that participate in the Medicare program and are located within the geographic area requested by the patient.<sup>70</sup> The hospital must present the list to the patient or the caregiver and document the presentation in the patient's medical record.<sup>71</sup> In addition, the hospital must disclose any financial interest it has in a home health agency or skilled nursing facility that appears on the list.<sup>72</sup>

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<sup>65</sup> State Operations Manual, Appendix A, at A-0820 ("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.").

<sup>66</sup> *Id.* ("A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including . . . [i]mproved education . . . to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help.").

<sup>67</sup> *Id.*

<sup>68</sup> *Id.* ("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.").

<sup>69</sup> 42 C.F.R. 482.43(c)(6)(i) ("This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.").

<sup>70</sup> 42 C.F.R. 482.43(c)(6) ("The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.").

<sup>71</sup> 42 C.F.R. 482.43(c)(6)(iii) ("The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.").

<sup>72</sup> 42 C.F.R. 482.43(c)(8) ("The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.").

**f. Patient freedom of choice in the discharge planning process**

Federal rules require the hospital to inform the patient and the patient's family of their freedom to select among participating Medicare providers for post hospital care.<sup>73</sup> The hospital may not otherwise limit a patient or patient family's selection of qualified providers and, when possible, must respect the patient's and family's preferences.<sup>74</sup>

**4. Patient Transfer or Referral of a Patient**

The federal rules require the hospital to transfer or refer patients, as needed, to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care.<sup>75</sup> In addition, a hospital must also provide necessary medical information for patients discharged home so that the patient's personal physician can ascertain the outcome of the hospital treatment or follow-up care needs.<sup>76</sup> For patients discharged home, the medical information must include:

- A brief description of care information reflecting the instruction provided to the caregiver;
- If applicable, a list of all follow-up appointments, including date and time, with practitioners with whom the patient has an established relationship and that were scheduled prior to discharge; and
- If applicable, referrals to potential primary care providers for patients who have no established relationship with a provider.<sup>77</sup>

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<sup>73</sup> 42 C.F.R. 482.43(c)(7) ("The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.").

<sup>74</sup> *Id.* See also 42 U.S.C. section 1395x(ee)(2)(H)(i) ("Consistent with section 1395a of this title, the discharge plan shall . . . not specify or otherwise limit the qualified provider which may provide post-hospital home health services.").

<sup>75</sup> 42 C.F.R. 482.43(d) ("The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow[-]up or ancillary care.").

<sup>76</sup> State Operations Manual, Appendix A, at A-0837 ("Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient's physician aware of the outcome of hospital treatment or follow-up care needs.").

<sup>77</sup> *Id.* ("The 'medical information' that is necessary for the transfer or referral includes . . . For patients discharged home: [a b]rief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s); [i]f applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time[]; and [i]f applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.").

## 5. Reassessment of Discharge Planning Process

Federal rules require the hospital to reassess the effectiveness of its discharge planning process on an on-going basis, including a review of discharge plans to ensure that they are responsive to discharge needs.<sup>78</sup> Hospitals must also track readmissions of patients to their own facilities to identify potentially preventable readmissions.<sup>79</sup> If the hospital identifies potentially preventable readmissions, the hospital must determine whether its employees conducted an appropriate discharge planning evaluation, issued an appropriate discharge plan, and properly implemented the discharge plan in those cases.<sup>80</sup>

### B. Joint Commission Requirements for Discharge Planning

The Joint Commission<sup>81</sup> is a private nonprofit organization that accredits health care organizations and programs in the United States. All major hospitals in Hawaii are accredited by the Joint Commission<sup>82</sup> and various state statutes either require a hospital's Joint Commission accreditation or allow the Department of Health to require Joint Commission accreditation as part of licensure.<sup>83</sup>

The Joint Commission has established standards and procedures for discharging patients. Specifically, the Joint Commission E-dition standards require accredited hospitals to:

- Coordinate the patient's care, treatment, and services based on the patient's needs;<sup>84</sup>

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<sup>78</sup> 42 C.F.R. 482.43(e) ("The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.") and State Operations Manual, Appendix A, at A-0843 ("The hospital must have a mechanism in place for ongoing reassessment of its discharge planning process.").

<sup>79</sup> State Operations Manual, Appendix A, at A-0843 ("The reassessment process must include a review of discharge plans in closed medical records to determine whether they were responsive to the patient's post-discharge needs. One indicator of the effectiveness of the discharge plan is whether or not the discharge was followed by a preventable readmission. Accordingly, hospitals are expected to track their readmission rates and identify potentially preventable readmissions.").

<sup>80</sup> *Id.*

<sup>81</sup> The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organization.

<sup>82</sup> FCWG Report at 7. *See also* Medicare Facilities, State of Hawaii, Department of Health Office of Health Care Assurance, <http://health.hawaii.gov/ohca/medicare-facilities/hospitals/>.

<sup>83</sup> *See* Section 321-14.5(c), HRS, ("The rules [adopted in accordance with chapter 91, HRS,] may provide that accreditation by the [J]oint [C]ommission on [A]ccreditation of [H]ealthcare [O]rganizations demonstrates a hospital's compliance with all licensing inspections required by the State."); section 431M-1, HRS ("Hospital' means a facility licensed as a hospital by the department of health and accredited by the Joint Commission on Accreditation of Health Care Organizations."); and section 587D-1, HRS ("Hospital' means a facility licensed as a hospital by the department of health and accredited by the Joint Commission on Accreditation of Healthcare Organizations.").

<sup>84</sup> Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission E-dition Release 6.0 Standards and Elements of Performance. Oakbrook Terrace, IL: The Joint Commission, 2013:13, at PC.02.02.01 ("The hospital coordinates the patient's care, treatment, and services based on the patient's needs.").

- Have a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer;<sup>85</sup>
- Discharge or transfer a patient based upon the patient's assessed needs and the organization's ability to meet those needs;<sup>86</sup>
- Inform and educate the patient about follow-up care, treatment, and services before discharge or transfer;<sup>87</sup>
- Upon determining the patient's discharge or transfer needs, promptly share that information with the patient and the caregiver;<sup>88</sup>
- Before the patient is discharged, inform the patient and the caregiver of the types of continuing care, treatment, and services the patient will require after discharge;<sup>89</sup>
- Educate the patient and the caregiver about how to obtain continuing care, treatment, and services the patient will require after discharge;<sup>90</sup>
- Provide written discharge instructions that the patient and the caregiver can understand;<sup>91</sup>
- Upon discharge, provide information about the patient's care, treatment, and services to other service providers that will provide care, treatment, or service to the patient;<sup>92</sup>
- Document the patient's discharge information in the patient's medical record;<sup>93</sup> and

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<sup>85</sup> *Id.* at PC.04.01.01 ("The hospital has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer.").

<sup>86</sup> *Id.* at PC.04.01.03 ("The hospital discharges or transfers the patient based on his or her assessed needs and the organization's ability to meet those needs.").

<sup>87</sup> *Id.* at PC.04.01.05 ("Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.").

<sup>88</sup> *Id.* at PC.04.01.05, elements of performance 1 ("When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care.").

<sup>89</sup> *Id.* at PC.04.01.05, elements of performance 2 ("Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.").

<sup>90</sup> *Id.* at PC.04.01.05, elements of performance 7 ("The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.").

<sup>91</sup> *Id.* at PC.04.01.05, elements of performance 8 ("The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand.").

<sup>92</sup> *Id.* at PC.04.02.01 ("When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.").

<sup>93</sup> *Id.* at RC.02.04.01 ("The hospital documents the patient's discharge information.").



- Inform the patient about the patient's own care, treat the patient as an active partner in the patient's own care, and inform the patient of his or her care responsibilities.<sup>94</sup>

### C. Hawaii Administrative Rules

The Hawaii Department of Health Administrative Rules establish a patient's right to receive discharge planning under subchapter 1 of chapter 93, which governs broad service hospitals.<sup>95</sup> Section 11-93-26, Hawaii Administrative Rules, states, in pertinent part:

§11-93-26 Patient's rights. (a) Written policies regarding the rights and responsibilities of patients during their stay in the facility shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:

- ...
- (17) Have the right to receive discharge planning by qualified hospital staff to ensure appropriate post-hospital placement.<sup>96</sup>

### D. Current Hospital Practices Regarding Discharge and Naming Caregivers

#### 1. Discharge Planning

Hospitals follow the requirements for discharge planning established by the federal Centers for Medicare and Medicaid Services and the Joint Commission.<sup>97</sup> As noted by the (2014) Family Caregivers Working Group in its report:

Hospitals recognize the need to comply with Medicare's CoP [Conditions of Participation] and with the JC [Joint Commission] standards regarding discharge planning. As a result, hospitals provide instructions and information to caregivers to ensure the care needs of the patient after discharge are understood. This improves post-

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<sup>94</sup> *Id.* at RI.02.01.01 ("When the hospital communicates with patients about their responsibilities, it is treating patients as active partners in care and not merely as passive recipients of services. These responsibilities are defined in policy to support consistent expectations about patient responsibilities among staff and licensed independent practitioners, and to support consistent communication with patients. Such consistency is particularly important when addressing patient responsibilities concerning rules, instructions, and financial commitments. The patient-provider partnership is enhanced when patients understand the importance of providing the information needed to facilitate care and of asking for clarification if something is unclear. Patients have a responsibility to interact with staff and licensed independent practitioners in a civil manner, consistent with the hospital's obligation to maintain a respectful and considerate relationship with all patients. Mutual respect supports communication and collaboration in a manner that contributes to the safety and quality of care, treatment, and services.").

<sup>95</sup> Section 11-93-2, Hawaii Administrative Rules, defines "broad service hospital" as "a hospital which is staffed and equipped to provide inpatient medical or surgical care, or both, for acute and chronic illness, injury, or obstetrics."

<sup>96</sup> Section 11-93-26, Hawaii Administrative Rules.

<sup>97</sup> FCWG Report at 7.

hospital care and reduces inappropriate readmissions. Hospitals participate in a variety of programs aimed at reducing such readmissions.<sup>98</sup>

Information presented to the Legislative Family Caregivers Working Group by representatives of the Healthcare Association of Hawaii, Castle Medical Center, Queen's Health Systems, Hawaii Medical Service Association, and Kaiser Permanente Hawaii confirmed that hospitals in Hawaii adhere to federal CMS rules and Joint Commission standards.<sup>99</sup>

In addition to CMS rules and the Joint Commission standards, the Hawaii Medical Service Association (HMSA), the State's largest health insurer by market share, has implemented discharge policies and procedures for HMSA participating hospitals. These policies include employing specific persons dedicated to discharge planning, called discharge planning champions, to improve discharge planning and reduce preventable readmissions.<sup>100</sup>

## 2. Caregiver Designation

It appears that most, if not all, hospitals in Hawaii currently allow patients to name a caregiver. The (2014) Family Caregivers Working Group found:

According to the hospitals that described their processes, designated caregivers are identified and the patient's discharge plan is based on who the caregiver is. Hospitals offer to involve patients and caregivers in discharge planning, discharge instructions, and follow-up care needs. Hospitals attempt to follow-up with patients on a scheduled basis in an effort to ensure compliance with care instructions and to avoid inappropriate readmissions.<sup>101</sup>

Moreover, it seems that a discharge planning evaluation and a discharge plan that complies with CMS rules would effectively require a hospital to determine if a patient has designated a caregiver.<sup>102</sup> Otherwise, it is difficult to imagine how a hospital could issue a discharge plan or determine whether a discharge plan should be issued without first determining whether a patient can provide self care or will have a caregiver upon discharge, the extent of that patient's or caregiver's abilities, and the extent of community-based services needed to support the patient or caregiver.<sup>103</sup>

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<sup>98</sup> *Id.*

<sup>99</sup> See Chapter 5, page 39.

<sup>100</sup> See also Chapter 4, page 29.

<sup>101</sup> FCWG Report at 6.

<sup>102</sup> See *supra* notes 40-47 and accompanying text.

<sup>103</sup> See also State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, at A-0806 ("State Operations Manual, Appendix A") ("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 the patient's needs while allowing the patient to continue living at home.").

## Chapter 4

### COMMUNITY-BASED RESOURCES AND SUPPORT SERVICES AVAILABLE TO PATIENTS AND CAREGIVERS

#### A. The Role of Caregivers - Generally

Caregivers play an important role in a patient's care.<sup>104</sup> While the precise role of a caregiver varies in each instance, many caregivers assist a patient with various activities of daily living (basic self-care tasks, including bathing, continence, dressing, eating, toileting); instrumental activities of daily living (complex activities needed for independent living, including cooking, driving, shopping, keeping track of finances, shopping, managing medications, communicating, and cleaning); and other tasks necessary for the health, safety, and welfare of the patient.<sup>105</sup> Caregivers include paid professional caregivers<sup>106</sup> and unpaid family and informal caregivers who may include relatives and friends who take care of the patient without compensation.<sup>107</sup>

Many individuals who receive inpatient care cannot afford a professional caregiver upon discharge and must rely on family members or friends.<sup>108</sup> Most of these unpaid caregivers have little or no previous formal medical training, but desire appropriate training or instructions in the care of the patient.<sup>109</sup>

This chapter examines the community-based resources and support services that may be available to patients and caregivers.

#### B. Aging and Disability Resource Centers and Area Agencies on Aging

##### 1. Services and Functions of Aging and Disability Resource Centers and Area Agencies on Aging

The federal Older Americans Act<sup>110</sup> and other federal laws authorize and provide funding incentives for states to establish aging and disability resource centers (ADRC) to serve as a

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<sup>104</sup> FCWG Report at 5.

<sup>105</sup> See Sections 8-17 and 431:10H-201, HRS; SB 296; and Leslie Kernisan, Activities of Daily Living: What Are ADLs and IADLs? (<https://www.caring.com/articles/activities-of-daily-living-what-are-adls-and-iadls>).

<sup>106</sup> Section 321-11.2(a), HRS.

<sup>107</sup> Section 349-31, HRS, and 42 U.S.C. section 3002(18)(B) ("caregiver" means an individual who has the responsibility for the care of an older individual, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an older individual.").

<sup>108</sup> See SCR 107 ("WHEREAS, because of costs and other factors, family caregivers are increasingly called upon to provide such care;").

<sup>109</sup> FCWG Report at 5 ("Caregivers desire appropriate caregiver training or instructions.").

<sup>110</sup> 42 U.S.C. section 3001 *et seq.* The Older Americans Act is a federal initiative aimed at providing comprehensive services to older adults.

starting point for persons to gather information on available long-term care services, programs, and resources in the community and to seek assistance in the care process.<sup>111</sup> ADRCs provide a coordinated system for individuals to access information on public and private long-term care programs, receive counseling in assessing existing or anticipated long-term care needs, receive assistance in developing and implementing a plan for long-term care, and use as a convenient point of entry to access to publicly-supported long-term care programs.<sup>112</sup> Hawaii law establishes a statewide ADRC with sites in each county.<sup>113</sup>

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<sup>111</sup> 42 U.S.C. sections 3012(b)(8), 3027(a), and 3032k(c)(2)(H). *See also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 2405 (appropriating \$10,000,000 each year for fiscal years 2010 through 2014 for aging and disability resource centers)".

<sup>112</sup> As defined by the Older Americans Act,

"Aging and Disability Resource Center" means an entity established by a State as part of the State system of long-term care, to provide a coordinated system for providing -

- (A) comprehensive information on the full range of available public and private long-term care programs, options, service providers, and resources within a community, including information on the availability of integrated long-term care;
- (B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and
- (C) consumers access to the range of publicly-supported long-term care programs for which consumers may be eligible, by serving as a convenient point of entry for such programs.

42 U.S.C. § 3002(4). *See also* State Executive Office on Aging; City & County of Honolulu, Department of Community Services, Elderly Affairs Division; Hawaii County Office of Aging; and Maui County Office on Aging combined presentation (hereafter "Executive Office on Aging presentation") at the August 20, 2015, informational briefing, Chapter 5, page 34.

<sup>113</sup> Hawaii state statute establishes aging and disability resource centers in Hawaii:

**[§349-32] Aging and disability resource centers; established.** (a) A statewide aging and disability resource center may be established with sites in each county to streamline access to long-term supports and services by integrating the full range of long-term supports and services into a single, coordinated system.

(b) The aging and disability resource center may be the single point of entry in every county where persons of all ages, incomes, and disabilities may access information in a person-centered manner on the full range of long-term supports and services options, including but not limited to:

- (1) Federal, state, and county revenue-funded programs and services including those funded by medicaid, medicare, the Older Americans Act, the Department of Veterans Affairs, and kupuna care;
- (2) A centralized application process for publicly funded long-term services and supports;
- (3) Privately administered programs and services;
- (4) Supports and services for persons with Alzheimer's disease and other related dementia;
- (5) Transportation services;
- (6) Housing options;
- (7) Elder rights protection;
- (8) Hospital and nursing home discharge planning and care transition;
- (9) Health, prevention, and wellness programs;
- (10) Support for grandparents raising grandchildren and other relatives age fifty-five years or older caring for children;
- (11) Informal and family caregiver support services; and
- (12) Community resources and services for individuals with disabilities.

(c) The aging and disability resource centers shall target delivery of services to:

- (1) Persons sixty years of age and older;

*Footnote continued on next page.*

The ADRC Hawaii describes itself as follows:

The Hawaii Aging and Disability Resource Center (ADRC) helps older adults, individuals with disabilities, and family caregivers find options for long term supports and services available to them in the State of Hawaii. The ADRC is a highly visible and trusted source where people of all incomes and ages can turn for information. ADRC staff will help to determine if you are eligible for government paid programs, assist you in finding providers you may pay for yourself, and work with you to develop an individual plan for meeting your future long-term care needs. The assistance is paid for by the State and Counties (at no cost to you).<sup>114</sup>

Each county also has an area agency on aging, which, among other things, is the designated operating entity of the aging and disability resource center<sup>115</sup> and is responsible for implementing the Older Americans Act in their respective county.<sup>116</sup> The County of Kauai Agency on Elder Affairs,<sup>117</sup> City and County of Honolulu Elderly Affairs Division,<sup>118</sup> Maui County Office on Aging,<sup>119</sup> and the Hawaii County Office of Aging,<sup>120</sup> respectively, serve as the county ADRC and area agency on aging.<sup>121</sup>

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- (2) Persons of any age with physical disabilities, severe mental illness, dementia, and developmental or intellectual disabilities;
  - (3) Informal and family caregivers providing assistance to persons needing long-term supports and services;
  - (4) Professionals seeking long-term supports and services on behalf of their clients; and
  - (5) Persons planning for their future long-term supports and services needs.
- (d) The executive office on aging shall coordinate the implementation of the statewide aging and disability resource center.

(e) The aging and disability resource center may be a function of each area agency on aging within the respective geographic service area.

Section 349-32, HRS.

<sup>114</sup> ADRC Hawaii - Home, <https://www.hawaiiadrc.org/site/1/home.aspx>.

<sup>115</sup> Executive Office on Aging presentation at the August 20, 2015, informational briefing ("The AAAs are the designated operating entities of the Aging and Disability Resource Center (ADRC)."). *See also* section 349-31, HRS ("Area agency on aging" means the agency in each county designated by the executive office on aging, under section 305(a)(2)(A) of the Older Americans Act, P.L. 89-73, as amended, to facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers.").

<sup>116</sup> Hawaii State Plan on Aging, October 1, 2015 - September 30, 2017, Executive Office on Aging, at 5 (hereafter "2015 State Plan on Aging"), available at [https://www.hawaiiadrc.org/Portals/\\_AgencySite/State%20Plan/HI%20State%20Plan%20on%20Aging%202015-17.PDF](https://www.hawaiiadrc.org/Portals/_AgencySite/State%20Plan/HI%20State%20Plan%20on%20Aging%202015-17.PDF).

<sup>117</sup> County of Kauai Agency on Elderly Affairs, <https://www.kauaiadrc.org>.

<sup>118</sup> City and County of Honolulu Elderly Affairs Division, <http://www.elderlyaffairs.com>.

<sup>119</sup> Maui County Office on Aging, <https://www.mauicountyadrc.org>.

<sup>120</sup> Hawaii County Office of Aging, <https://www.hcoahawaii.org>.

<sup>121</sup> An entity may serve as both an ADRC and an area agency on aging. Section 349-32(e), HRS ("The aging and disability resource center may be a function of each area agency on aging within the respective geographic service area."). *See also supra* note 113 and accompanying text.

Each area agency on aging facilitates the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their caregivers.<sup>122</sup> Responsibilities of each area agency on aging include planning, developing, and administering services to older adults and caregivers residing in their district geographic planning and service area.<sup>123</sup> Each area agency on aging also contracts with area service providers to provide services such as chore performance, adult day care respite, homemaker services, housekeeping services, assisted transportation, legal assistance, attendant care, case management, congregate meals, personal care assistance, home-delivered meals, and caregiver services.<sup>124</sup>

Funding for area agencies on aging originates from both the federal and state governments.<sup>125</sup> Federal grants provide funding to implement and expand the State and county ADRCs.<sup>126</sup> The State Executive Office on Aging receives various funds, including funds from the federal Administration on Aging under Title III E<sup>127</sup> of the Older Americans Act for family caregiver support programs and state funds from the Legislature (for Kupuna Care, ADRCs, and other programs).<sup>128</sup> The State Executive Office on Aging allocates these funds to each area agency on aging, which then expends those funds for contracts with service providers in their respective geographical areas.<sup>129</sup> Further information on Older Americans Act, Title III E programs appears in Chapter 5.<sup>130</sup>

Generally, an individual contacts an ADRC. The individual can initiate a telephone call to the ADRC on his or her own behalf or on behalf of a person the individual is caring for. An individual may also be referred by a social service agency, health care organization, or other organization.<sup>131</sup> The staff performs an initial intake to assess the needs of the individual.<sup>132</sup> Through the intake, the staff preliminarily determines whether the individual may require long-term services and supports.<sup>133</sup> If the staff preliminarily determines that the individual may

<sup>122</sup> Section 349-31, HRS. *See also* 42 U.S.C. section 3002(6).

<sup>123</sup> *See* Executive Office on Aging presentation at the August 20, 2015, informational briefing, Chapter 5, page 34.

<sup>124</sup> *Id.* For more specific examples of services contracted by each county area agency on aging, *see* the Executive Office on Aging presentation at the August 20, 2015.

<sup>125</sup> 2015 State Plan on Aging at 6.

<sup>126</sup> Executive Office on Aging, [http://hawaiiadrc.org/site/436/executive\\_office\\_on\\_aging.aspx](http://hawaiiadrc.org/site/436/executive_office_on_aging.aspx) (explaining that in 2010, the Executive Office on Aging received various federal grants, including the ADRC Expansion Grant, to fund the Hawaii Systems Change Initiative that proposed a five-year plan for implementing ADRCs in Hawaii).

<sup>127</sup> 42 U.S.C. sections 3030s to 3030s-2. Title III of the Older Americans Act authorizes the federal government to issue grants for state and community programs on aging. Part E of Title III, establishes requirements for grants to family caregiver support programs.

<sup>128</sup> State Plan on Aging at 6 and Act 151, Session Laws of Hawaii 2014 (appropriating \$1,900,000 to the Department of Health for fiscal year 2014-2015 for the aging and disability resource center).

<sup>129</sup> *Id.*

<sup>130</sup> *See* Chapter 5, page 34.

<sup>131</sup> Executive Office on Aging presentation at the August 20, 2015, informational briefing.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* *See also* Kristen J. Colello, Cong. Research Serv., R43495, Long-Term Services and Supports: In Brief, at 2 (2014) available at <https://www.fas.org/sgp/crs/misc/R43495.pdf>. The term "long-term services and supports" refers to the broad range of health and health related services and supports required by individuals who lack the capacity for self-care due to a physical disability, cognitive disability, mental disability, or other condition. Long-term

*Footnote continued on next page.*

require long-term services and supports,<sup>134</sup> the staff performs triage to determine the appropriateness of an in-home assessment and helps the individual to develop a support plan.<sup>135</sup> Through an in-home assessment and support plan, the staff can more accurately determine the individual's need for long-term services and supports and if the individual qualifies for any services available under federal law to individuals sixty years of age or older.<sup>136</sup> After determining the individual's needs for long-term services and supports, the area agency on aging authorizes and arranges the delivery of needed services to the individual.<sup>137</sup>

## **2. Implementation of City and County of Honolulu Aging and Disability Resource Center Status**

In 2011, the Executive Office on Aging developed a Five-Year Plan to meet the federal Administration on Aging's criteria for a fully functional statewide ADRC, which includes a fully-functioning ADRC in each county.<sup>138</sup> Objective 3-1:1 established the goal of implementing the ADRCs for Maui County by 2012, the Kauai County by 2013, Hawaii County by early 2015, and the City and County of Honolulu by July 2015.<sup>139</sup>

The ADRC for the City and County of Honolulu (Honolulu ADRC) has been in operation since July 2015.<sup>140</sup> However, the Honolulu ADRC does not appear to be fully operational. Indeed, a recent news article reported that "advocates for seniors, service providers[,] and clients

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services and supports are not intended to cure a patient's medical condition and do not include medical or acute care services. Examples of long-term services and supports include a home health aide to assist with bathing and dressing, a contractor to build a wheelchair ramp in a home, an organization to provide transportation for a cognitively impaired individual, specialized equipment to assist a physically impaired person, intensive nursing care provided to a ventilator-dependent child, and assisted living facilities that provide meals and other household services. *See also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 10202(f)(1) (defining "long-term services and supports" as including, among other things, nursing facility services, services in an intermediate care facility, home[-] and community-based services, home health care services, and personal care services).

<sup>134</sup> Executive Office on Aging presentation at the August 20, 2015, informational briefing. If the patient does not require long-term services and supports, the ADRC refers the individual to general information and assistance.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* Most provisions of the Older Americans Act apply to older individuals, and the Act defines "older individual" as "an individual who is 60 years of age or older." 42 U.S.C. section 3002(40).

<sup>137</sup> Executive Office on Aging presentation at the August 20, 2015, informational briefing.

<sup>138</sup> Hawaii State Plan on Aging, October 1, 2011 - September 30, 2015, Executive Office on Aging (hereafter "2011 State Plan on Aging"), available at <http://health.hawaii.gov/ea/files/2013/07/Hawaii-State-Plan-On-Aging.pdf> and Hawaii Systems Change Initiative, March 15, 2011, available at [https://www.hawaiiadrc.org/Portals/\\_AgencySite/HI%20ADRC%205-Year%20Operational%20Plan%2003-15-11.pdf](https://www.hawaiiadrc.org/Portals/_AgencySite/HI%20ADRC%205-Year%20Operational%20Plan%2003-15-11.pdf).

<sup>139</sup> 2011 State Plan on Aging at 27 ("3-1:1 Administer and adhere to the detailed implementation tasks and corresponding timelines in the Hawaii Systems Change Five-Year Plan, resulting in fully functioning Aging and Disability Resource Center sites in all Planning and Services Areas (Maui County - 4/2012, Kauai County - 1/2013, Hawaii County - 3/2015, Honolulu County - 7/2015).").

<sup>140</sup> Email from the Director of the City and County of Honolulu Elderly Affairs Division (the operating entity for the Honolulu ADRC) to the Legislative Reference Bureau (Jan. 15, 2016).

complain the [ADRC] system moves too slowly" in providing referrals to services.<sup>141</sup> In preparing this report, the Bureau received correspondence from the Honolulu ADRC emphasizing that the ADRC is still in the early stages of implementation and urging the public's patience.<sup>142</sup> Although the Honolulu ADRC appears to be making progress in developing and expanding the services it provides, it will take more time and resources in order for the Honolulu ADRC to become fully functioning.<sup>143</sup> The Director noted that if the Honolulu ADRC were to "model . . . efforts after the other counties, they were given 4-5 years to become close to a fully functional ADRC. . . . Fully functional may take more than 5 years and there are several pieces that require partnerships that are not in place yet."<sup>144</sup>

According to the Executive Office on Aging, in recent years, the Legislature has appropriated state funds for the development and operation of ADRCs statewide to the Executive Office on Aging, which in turn allocates funds to the county ADRCs.<sup>145</sup> The Executive Office on Aging receives the majority of its funding, including the funds it allocates to the county ADRCs, through the biennial General Appropriations Acts or Supplemental Appropriations Acts (also known as the state budget acts) enacted by the Legislature.<sup>146</sup> Starting with the 2013-2014 fiscal year, the Legislature increased the annual appropriation to the Executive Office on Aging in the state budget acts for, among other things, the ongoing developing of ADRCs statewide.<sup>147</sup> In addition to the appropriations made through the state budget acts, during the 2014 regular session, a separate act also appropriated funds for the continued development of the ADRCs statewide.<sup>148</sup>

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<sup>141</sup> Jim Mendoza, Seniors, caregivers complain about delays at city's 'one-stop shop' for services, Hawaii News Now, Jan. 6, 2016, available at <http://www.hawaiinewsnow.com/story/30904755/seniors-complain-about-delays-at-citys-one-stop-shop-for-services>.

<sup>142</sup> *Supra* note 140.

<sup>143</sup> *Id.* The Technical Assistance Exchange, an affiliate of the United States Department of Health and Human Services, has developed criteria of fully functioning aging and disability resource centers. The criteria involve six categories known as program components or core functions. The Director noted that the Honolulu ADRC is currently focusing the majority of its efforts on four of the categories: options counseling, streamlined eligibility determination for public programs, person-centered transition support, and quality assurance and continuous improvement. The Honolulu ADRC has also been working, to some degree, to fulfill the other two categories: information, referral, and awareness and consumer populations, partnerships, and stakeholder involvement. *See also* Criteria of Fully Functioning Aging and Disability Resource Centers, March 2012, [http://www.adrc-tae.acl.gov/tiki-download\\_file.php?fileId=31765](http://www.adrc-tae.acl.gov/tiki-download_file.php?fileId=31765).

<sup>144</sup> *Supra* note 140.

<sup>145</sup> Telephone conversation with Caroline Cadirao, Executive Office on Aging Grants Manager (Jan. 19, 2016).

<sup>146</sup> Act 106, Session Laws of Hawaii 2012, Relating to the State Budget (appropriated \$5,948,402 and \$5,933,014 in general funds to the Executive Office on Aging (HTH904) for fiscal years 2011-2012 and 2012-2013, respectively), Act 122, Session Laws of Hawaii, Relating to the State Budget (appropriated \$8,083,402 and \$7,651,402 in general funds to the Executive Office on Aging (HTH904) for fiscal years 2013-2014 and 2014-2015, respectively), and Act 119, Session Laws of Hawaii 2015, Relating to the State Budget (appropriated \$7,679,368 and \$7,386,896 in general funds to the Executive Office on Aging (HTH904) for fiscal years 2015-2016 and 2016-2017, respectively).

<sup>147</sup> Testimony of the Executive Office on Aging, House Bill No. 497, House Committees on Human Services and Health, 2015 Regular Session, (Feb. 13, 2015) ("We are grateful for the \$1.4 million that the Legislature has made as part of the EOA base budget for the ongoing development of the ADRCs statewide."). *See also supra* note 146 (depicting an approximately \$2 million increase in general fund appropriation from fiscal year 2012-2013 to fiscal year 2013-2014).

<sup>148</sup> Section 3 of Act 151, Session Laws of Hawaii 2014, Relating to Aging ("There is appropriated out of the general revenues of the State of Hawaii the sum of \$1,900,000 or so much thereof as may be necessary for fiscal year 2014-

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With the Honolulu ADRC coming on-line in July 2015, the Executive Office on Aging reports that it has allocated a total of \$1,129,998 in state funds to the Honolulu ADRC for its operations and related expenses as follows: \$529,000 in May 2015, \$71,998 in June 2015, and \$529,000 in January 2016.<sup>149</sup> The Director estimated that if expected federal and state funding levels remain the same, the Honolulu ADRC will require at least \$750,000 to \$800,000 in additional funds to be fully funded next year; however, this amount may change if existing funding allocations decrease.<sup>150</sup>

### **C. Pali Momi Medical Center Programs to Reduce Preventable Patient Readmissions**

Pali Momi Medical Center has implemented two initiatives to improve discharge planning and transition of care for patients at its hospital.

#### **1. Pharmacy Medication Reconciliation on Admission Program**

In 2012, Pali Momi Medical Center established the Pharmacy Medication Reconciliation on Admission Program to analyze the medication regimens of patients for the purpose of eliminating inconsistencies, conflicts, discrepancies, and reducing other problems associated with taking multiple medications. The program was created with the goal of improving patients' post-discharge care and reducing preventable patient readmissions.<sup>151</sup> According to the presentation provided by Pali Momi Medical Center, the Pali Momi Pharmacy Medication Reconciliation on Admission Program:

- Employs two medication reconciliation specialized pharmacy technicians trained in medication names, medication strength and dosage, medication uses, computer programing for viewing outpatient prescriptions filled, patient communication, and tracking program statistics;
- Adjusts patient medication regimes as needed;
- Assigns in-patient pharmacists to review and finalize any medication changes;
- Updates the patients' medical records to reflect the medication changes; and

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2015 for the aging and disability resource center."), as amended by section 19 of Act 126, Session Laws of Hawaii 2015, Relating to the Funding of Government Programs (reducing the fiscal year 2014-2015 appropriation for the aging and disability resource center to \$1,710,000). It is unclear what portion, if any, of these funds may have been used for the Honolulu ADRC's start-up costs before it opened in July 2015.

<sup>149</sup> Telephone conversation with Caroline Cadirao, Executive Office on Aging Grants Manager (Jan. 19, 2016).

<sup>150</sup> Email from the Director of the City and County of Honolulu Elderly Affairs Division (the operating entity for the Honolulu ADRC) to the Legislative Reference Bureau (Jan. 15, 2016).

<sup>151</sup> Pali Momi Medical Center presentation at the October 8, 2015, informational briefing.

- Communicates to patients' physicians upon completion of the medication reconciliation.<sup>152</sup>

From the period of August 2014 to July 2015, the Pali Momi Pharmacy Medication Reconciliation on Admission Program analyzed the medication regimes of over seven thousand patients.<sup>153</sup> These patients took an average of 9.4 medications on admission. Pali Momi Medical Center reported that its Pharmacy Medication Reconciliation on Admission Program made an average of 3.8 medication changes per patient screened by the program.<sup>154</sup>

## 2. Pharm2Pharm

In 2013, in another effort to reduce hospital readmissions, Pali Momi Medical Center implemented the Pharm2Pharm program to reduce hospital readmissions.<sup>155</sup> The Pharm2Pharm program helps patients manage their medications by connecting patients with pharmacists to discuss medication management and verify an appropriate medication list.<sup>156</sup> Through the Pharm2Pharm program, Pali Momi employees review patient medication and laboratory results, provide patient education during the patient's hospital stay and at discharge, make follow-up phone calls to the patient, and make patient referrals to the community registered pharmacist.<sup>157</sup>

Pali Momi explained that the Pharm2Pharm program improved health care at its hospital by ensuring that all of a patient's professional caregivers had access to the same information about the patient.<sup>158</sup> The program reduced errors and omissions by providing an established chain of communication and improved patient readmission tracking.<sup>159</sup> The Pali Medical Center reported that the Pharm2Pharm program saved an average of \$11,467 per patient in acute care costs.<sup>160</sup>

Pali Momi noted that a federal Centers for Medicaid and Medicare Services grant provided funding for the Pharm2Pharm program through December 31, 2015.<sup>161</sup> Unfortunately, the grant was not renewed, and it is unclear whether Pali Momi will continue the program.<sup>162</sup>

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<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.* ("Aug 2014 to July 2015 Statistics[:] Over 7,000 Patients[, a]verage of 9.4 meds per patient on admission[, and a]verage of 3.8 med changes made through reconciliation[.]")

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> *Id.*

<sup>162</sup> Telephone conversation with Lois Nash, Director of Pharmacy Services, Pali Momi Medical Center (Jan. 5, 2016).

## **D. Hawaii Medical Service Association Programs to Reduce Preventable Patient Readmissions**

Hawaii Medical Service Association (HMSA), the largest health insurer in Hawaii by market share,<sup>163</sup> has implemented two programs to improve patient care and reduce preventable patient readmissions.

### **1. Advanced Hospital Care Program**

In 2009, HMSA implemented the Advanced Hospital Care Program aimed at improving patient care, reducing preventable patient readmissions, aligning hospital and insurance company goals, and reducing insurance claims and reimbursement costs.<sup>164</sup> HMSA allowed any hospital that had a patient base large enough to generate relevant performance data to participate in the program. Based on this selection criteria, eleven hospitals in the State participated.<sup>165</sup>

In the first year of participation, HMSA paid hospitals for appointing a discharge planning champion, developing a multi-disciplinary team, developing data capture methodology, and developing a process to notify all physicians involved in the patient's care of that patient's discharge.<sup>166</sup> In the second year of participation, HMSA paid hospitals for reducing potentially preventable readmissions and meeting or exceeding national benchmarks for patient care.<sup>167</sup> Following implementation of the Advanced Hospital Care Program, preventable hospital readmissions in the program decreased every year, from 5.9% in 2009 to 4.6% in 2014.<sup>168</sup> The program also reduced an average of 1,110 annual admissions and saved approximately \$14.5 million in hospital costs per year.<sup>169</sup>

### **2. Care Model, Hospital Transitions Category**

In mid-2014, HMSA implemented a multiple-category Care Model to improve multiple aspects of patient care, including the category of hospital transitions.<sup>170</sup> Under the hospital transitions category of the Care Model, HMSA employs a Care Transition Specialist and a Post-Discharge Care Manager to assist HMSA members with their discharge home and to provide up

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<sup>163</sup> Report of the Insurance Commissioner of Hawaii 2014, Summary of Insurance Business for the Year 2013, Department of Commerce and Consumer Affairs, Gordon I. Ito, Insurance Commissioner at 44, available at <http://cca.hawaii.gov/ins/files/2014/11/Final.pdf>.

<sup>164</sup> Advanced Hospital Care fact sheet available at <https://legacy.premierinc.com/about/news/11-may/premier-hmsa-advanced-hospital-care-fact-sheet-5-12-11.pdf> and HMSA presentation at the October 8, 2015, informational briefing.

<sup>165</sup> HMSA presentation at the October 8, 2015, informational briefing. The HMSA presentation did not specify the eleven participating hospitals.

<sup>166</sup> *Id.*

<sup>167</sup> *Id.* The HMSA presentation did not specify whether the payments in the second year were in addition to or instead of first year payments.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

to ninety days of support.<sup>171</sup> Before discharge, the Care Transition Specialist engages the patient and the patient's caregiver to determine their willingness to participate in the program.<sup>172</sup>

If accepted into the program, a Post-Discharge Care Manager conducts a comprehensive assessment of the patient in the hospital before discharge.<sup>173</sup> This assessment may include an assessment of the patient's functional status, social support, health literacy, cognitive deficits, medication knowledge, and adherence to medication regimes along with a screening for depression.<sup>174</sup> An HMSA care team member then helps with the patient's medication reconciliation to prevent patient confusion about discharge drug therapy, works with case managers and the patient's primary care physician to develop a patient support plan, starts in-home services as needed, and connects the patient with needed community resources.<sup>175</sup>

Following discharge to the patient's home or transfer of the patient to a skilled nursing or long-term care facility, an HMSA care team member helps to administer the discharge plan and engages the patient (by telephone or in-person) to verify follow-up appointments, verify medication management, and address any patient issues that could lead to readmission.<sup>176</sup> The care team member also keeps the patient's primary care physician informed of any developments.<sup>177</sup>

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<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

<sup>175</sup> *Id.*

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

## Chapter 5

### INFORMATIONAL BRIEFINGS AND DISCUSSION

Between June and December 2015, the Legislative Family Caregivers Working Group conducted five informational briefings and one meeting to discuss possible recommendations. The informational briefings occurred on July 16, August 20, September 10, October 8, and November 10, 2015. The discussion meeting occurred on December 15, 2015.

*(Notices of the informational briefings, notice of the discussion, and related documents are available at <http://goo.gl/uGdVMu> or <http://capitol.hawaii.gov/specialcommittee.aspx?comm=lfcwg&year=2015>.)*

A summary of the topics covered and information presented at each Working Group meeting follows.

#### A. July 1, 2015, Informational Briefing

At the July 1, 2015, information briefing, a representative from the Hawaii Department of Health presented the report of the Family Caregivers Working Group that was prepared pursuant to HCR 78 (2014).<sup>178</sup> The representative described the makeup of the working group, which consisted of stakeholders from government organizations, healthcare providers, health insurers, and non-profit organizations. As noted in the presentation of the working group report, the working group made the following findings and recommendations:

- Caregivers play a vital role in a patient's recovery;<sup>179</sup>
- Caregivers rarely have a background in clinical training or other medical field experience;<sup>180</sup>
- Public and private health insurance normally covers some of the costs of professional caregivers and medical resources;<sup>181</sup>
- Caregivers need a better method for connecting with medical resources in the community;<sup>182</sup>

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<sup>178</sup> See *supra* note 1 and accompanying text.

<sup>179</sup> FCWG Report at 5.

<sup>180</sup> *Id.*

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

- Primary care physicians play a significant and integral role in providing care to the patient upon discharge;<sup>183</sup>
- State and private non-profit and public organizations may provide care coordinators;<sup>184</sup>
- Neighbor island aging and disability resource centers require stable funding, especially if current Medicare funding were to cease;<sup>185</sup>
- Federal, state, grant, or other funding is necessary to establish an Oahu aging and disability resource center;<sup>186</sup>
- Private non-profit and public organizations offer caregiver training through organizations such as Kapiolani Community College Kupuna Education Center, AARP,<sup>187</sup> and Queen's Foster Family Community Care Program;<sup>188</sup>
- Hospitals currently follow discharge planning processes according to their own policies and procedures. These procedures include identifying caregivers, involving the caregiver in the discharge plan and discharge instructions, and following up with patients to ensure compliance with care instructions;<sup>189</sup>
- The federal Centers for Medicare and Medicaid Services' conditions for participation and the Joint Commission establish discharge planning standards that apply to most hospitals;<sup>190</sup>
- Financial disincentives and incentives motivate hospitals to avoid inappropriate patient readmissions. For example, Medicaid reduces payment amounts to hospitals that have an excess amount of readmissions within thirty days of a patient's discharge.

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<sup>183</sup> *Id.*

<sup>184</sup> *Id.* at 6.

<sup>185</sup> *Id.* It appears that Medicare continues to fund the neighbor island aging and disability resource centers.

<sup>186</sup> *Id.*

<sup>187</sup> In 1999, the American Association of Retired Persons changed its name to AARP. AARP Looks to Shift Perceptions of Its Brand and Show "Real Possibilities" for 50+ America With Its New Ad Campaign, AARP (Feb. 26, 2013) <http://www.aarp.org/about-aarp/press-center/info-02-2013/AARP-LOOKS-TO-SHIFT-PERCEPTIONS-OF-ITS-BRAND-AND-SHOW-REAL-POSSIBILITIES.html> ("**Note for reporters:** AARP changed its name in 1999 from the American Association of Retired Persons to just four letters: AARP") (emphasis in original).

<sup>188</sup> FCWG Report at 6.

<sup>189</sup> *Id.* ("Hospitals begin the discharge planning processes at or prior to admission of the patient. The processes are described in their respective policies and procedures (P&P).").

<sup>190</sup> *Id.* at 7 ("All hospitals who participate in Medicare are required to adhere to state licensing requirements and to Medicare's conditions of participation (CoP) and certification requirements on discharge planning . . . Hospitals accredited by the Joint Commission (JC) follow JC's discharge planning standards. All major hospitals in Hawaii and several smaller hospitals on the neighbor islands are accredited by the JC."). See also Chapter 3, page 7.

Additionally, Hawaii Medical Service Association has implemented a pay-for-quality program to encourage hospitals to reduce readmissions through discharge planning;<sup>191</sup>

- Hospitals currently provide instructions and information to caregivers so that the patient may continue to receive the necessary care after discharge;<sup>192</sup> and
- Mandating that hospitals train caregivers will likely expose those hospitals to legal liability. The Working Group questioned whether the indemnity language contained in SB 2264 (2014) ("Nothing in this chapter shall be construed to give rise to a cause of action against a hospital or hospital employee") would prevent lawsuits against hospitals or hospital employees. However, the Working Group also noted that it does not possess the legal expertise to make a definitive determination or finding on this issue.<sup>193</sup>

The Department of Health representative to the 2014 Family Caregivers Working Group noted that they could not reach a unanimous agreement on a recommendation to take no action to mandate that hospitals provide caregiver training.<sup>194</sup> However, members unanimously agreed on the following recommendations:<sup>195</sup>

- Consider state funding for one or more definitive studies by an objective organization to assess gaps in caregiver training, a market study to determine the availability, utilization, and costs of existing community resources, and an assessment on the apparent lack of primary care provider availability and post-hospitalization involvement for at-risk populations, while taking into account the complexity of the health care industry and the many highly involved public and private stakeholders.<sup>196</sup>
- Consider state funding options for county offices on aging and/or for aging and disability resource centers statewide to improve their abilities to work with hospitals and other professional and family caregivers to improve post-hospitalization care to patients who are discharged to home and to reduce inappropriate readmissions especially if or when federal funding ceases. This includes finding ways to replicate

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<sup>191</sup> *Id.* at 7 ("Hospitals are provided financial disincentives and incentives to avoid inappropriate readmissions. Medicare imposes penalties based on readmission rates. HMSA initiated a pay-for-quality reward program for hospitals where 20% of the program is weighted to discharge planning and readmission reduction."). *See also* Chapter 4, page 29.

<sup>192</sup> FCWG Report at 7 ("Hospitals recognize the need to comply with Medicare's CoP and with the JC standards regarding discharge planning. As a result, hospitals provide instructions and information to caregivers to ensure the care needs of the patient after discharge are understood.").

<sup>193</sup> *Id.* at 9 ("Mandating the hospitals to be responsible for training family caregivers would likely open hospitals to lawsuits and significant legal fees. Statutory language to indemnify hospitals from such liability is questionable as to whether that will prevent lawsuits and whether such language will hold up in courts. The working group does not possess the legal expertise to make a definitive determination or finding on this issue.").

<sup>194</sup> *Id.* at 10 ("Recommendation number one (1) is recommended following a majority vote of the working group participants while unanimous consensus was reached on the remaining recommendations by all working group participants . . . 1. Take no action at this time to mandate hospitals to provide caregiver training.").

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

on Oahu the successes of aging and disability resource centers on the neighbor islands.<sup>197</sup>

- Consider improving state funding for at-risk populations to better cover the cost of physician office visits and hospital services to encourage more physicians to become primary care providers for this population.<sup>198</sup>

*(The 2014 Family Caregivers Working Group report is available at <http://goo.gl/7PWGtg> or <http://health.hawaii.gov/opppd/files/2015/06/HCR-781.pdf>.)*

## **B. August 20, 2015, Informational Briefing**

The August 20, 2015, informational briefing addressed resources available to caregivers. Representatives from the State Executive Office on Aging; City & County of Honolulu, Department of Community Services, Elderly Affairs Division; Hawaii County Office of Aging; and Maui County Office on Aging attended the briefing and made a combined presentation on the roles of their offices and the community resources and support services available for caregivers in their respective communities.<sup>199</sup>

### **1. Aging and Disability Resource Centers and Area Agencies on Aging**

The State Executive Office on Aging explained the role of aging and disability resource centers and area agencies on aging. Information on these organizations appears in Chapter 4.<sup>200</sup>

### **2. Older Americans Act, Title III E, National Family Caregiving Support Program**

The State Executive Office on Aging; City & County of Honolulu, Department of Community Services, Elderly Affairs Division; Hawaii County Office of Aging; and Maui County Office on Aging presented information on the National Family Caregiving Support Program authorized by the Older Americans Act, Title III E.<sup>201</sup> The National Family Caregiving Support Program authorizes grants to states to establish a system of support services to complement the care provided by caregivers. Specifically, the authorized grants fund programs to provide free or subsidized:

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<sup>197</sup> *Id.*

<sup>198</sup> *Id.* at 11.

<sup>199</sup> State Executive Office on Aging; City & County of Honolulu, Department of Community Services, Elderly Affairs Division; Hawaii County Office of Aging; and Maui County Office on Aging combined presentation (hereafter "Executive Office on Aging presentation") at the August 20, 2015, informational briefing.

<sup>200</sup> See Chapter 4, page 21.

<sup>201</sup> 42 U.S.C. sections 3030s to 3030s-2.



- (1) Information to caregivers about available services;
- (2) Assistance to caregivers in gaining access to the services;
- (3) Individual counseling, organization of support groups, and caregiver training to assist the caregivers in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems relating to their caregiving roles;
- (4) Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- (5) Supplemental services, on a limited basis, to complement the care provided by caregivers.<sup>202</sup>

**a. County of Kauai Title III E Programs**

Caregiving support programs in the County of Kauai include individual counseling, caregiver training, support group sessions, and access to caregiver related information services by the Alzheimer's Association, Aloha Chapter.<sup>203</sup>

**b. County of Maui Title III E Programs**

Caregiving support programs in the County of Maui include adult day care respite services available for full days on all days of the week; in-home respite care when adult day care is not an appropriate option; and caregiver support, training, and education sessions.<sup>204</sup>

**c. City and County of Honolulu Title III E Programs**

Caregiving support programs in the City and County of Honolulu include caregiver respite services from Kokua Kalihi Valley that offer temporary substitute supports or living arrangements for care recipients so that caregivers may have a brief rest or relief. Additionally, caregiver support through counseling, support groups, caregiver training, or information services are available from Project Dana, the University of Hawaii Elder Law Program, Hawaii Family Services, Alzheimer's Association of Hawaii, Kokua Kalihi Valley, and Child and Family Services.<sup>205</sup>

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<sup>202</sup> 42 U.S.C. section 3030s-1(b). *See also supra* note 127 and accompanying text.

<sup>203</sup> Executive Office on Aging presentation at the August 20, 2015, informational briefing.

<sup>204</sup> *Id.* In contrast to the other counties, the presentation did not include information on the names of individual organizations that provide services within the county of Maui.

<sup>205</sup> *Id.*

#### **d. County of Hawaii Title III E Programs**

Caregiving support programs in the County of Hawaii include homemaker, personal care, and assisted transportation services from CareResources Hawaii, Nurse Pro-Care, Seniors Helping Seniors, Mastercare Inc, and Metrocare Hawaii-PLUS. Additionally, caregiver counseling is provided by Hawaii Island Adult Care and Mastercare Inc. An annual caregiver conference also teaches caregivers how to care for themselves and how to prevent falls, prevent elder abuse, improve the quality of life at home, provide palliative care, and prevent fraud.<sup>206</sup>

*(The presentation made by the Executive Office on Aging is available at <http://goo.gl/XgKLM6> or [http://capitol.hawaii.gov/session2015/studies/2015%2008%2020\\_LFCWG\\_EOA%20Presentation\\_Updated.pdf](http://capitol.hawaii.gov/session2015/studies/2015%2008%2020_LFCWG_EOA%20Presentation_Updated.pdf).)*

### **C. September 10, 2015, Informational Briefing**

The September 10, 2015, information briefing addressed the challenges faced by caregivers and proposed opportunities for improvement. The AARP Hawaii, Kokua Council, Policy Advisory Board for Elder Affairs, Hawaii Family Caregiver Coalition, Project Dana, and Hawaii Alliance for Retired Americans presented information on difficulties faced by caregivers, information supporting the CARE Act,<sup>207</sup> opportunities to improve the system of caregiving, opportunities for additional community support for caregivers, and personal experiences illustrating the difficulties of being a caregiver.

#### **1. AARP Hawaii**

AARP Hawaii presented information indicating that, nationwide, Hawaii has the highest percentage of people over eighty-five years of age.<sup>208</sup> Typically, the longer an individual lives, the higher the likelihood that individual will require care.<sup>209</sup> Among individuals age forty-five and older, sixty-two percent expect to become a caregiver in the future.<sup>210</sup>

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<sup>206</sup> *Id.*

<sup>207</sup> See Chapter 6, page 44.

<sup>208</sup> AARP Hawaii presentation at the September 10, 2015, informational briefing citing Across the States Profiles of Long-Term Services and Supports, AARP Public Policy Institute, 2012, at 108, available at [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf).

<sup>209</sup> *Id.* Note: the AARP Hawaii presentation did not include accurate citations to the cited document and the Bureau could not find support for this statement in the cited document.

<sup>210</sup> *Id.* Note: the AARP Hawaii presentation did not include accurate citations to the cited document and the Bureau could not find support for this statement in the cited document. However, this information does appear in 2014 AARP Caregiving Survey: Opinions and Experiences of Hawaii Registered Voters Age 45 and Older, at 1, available at [http://www.aarp.org/content/dam/aarp/research/surveys\\_statistics/general/2014/2014-Hawaii-Caregiving-Survey-Opinions-and-Experiences-of-Hawaii-Registered-Voters-Age-45-and-Older-AARP-res-gen.pdf](http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2014/2014-Hawaii-Caregiving-Survey-Opinions-and-Experiences-of-Hawaii-Registered-Voters-Age-45-and-Older-AARP-res-gen.pdf).

In Hawaii, an estimated 154,000 individuals provide unpaid care to one or more family members.<sup>211</sup> These unpaid caregivers contribute 144 million hours per year, worth an estimated \$2.1 billion.<sup>212</sup> Each caregiver annually spends over \$5,531 in out-of-pocket expenses on caregiving related expenses.<sup>213</sup>

AARP Hawaii noted that caregivers also face pressure. Specifically, among caregivers age forty-five years and older, sixty-three percent have reported feeling stressed in general, fifty-one percent have reported stress in trying to balance work and family, fifty percent have reported difficulty getting enough rest, forty-two percent have reported that they found it difficult to exercise regularly, thirty-nine percent have reported difficulty taking care of their households, and twenty-nine percent have reported experiencing health problems.<sup>214</sup>

AARP Hawaii observed that family care is becoming more complex.<sup>215</sup> Hawaii's caregivers are called on to provide increasingly complex types of care at home, including managing multiple medications intravenously and through injections, cooking for patients with special diets, caring for wounds, using and helping with a patient's use of assistive devices, using monitors, and operating specialized medical equipment.<sup>216</sup>

Further, AARP Hawaii noted that most families are not prepared for caregiving responsibilities that typically follow a patient's hospital treatment and discharge home.<sup>217</sup> Individuals of all ages can require hospitalization, including injuries from motor vehicle accidents and recreational activity accidents.<sup>218</sup> In addition, accidents and health events more commonly associated with the elderly, including falls, strokes, and heart attacks, can also lead to hospitalization and required care following discharge home.<sup>219</sup> Oftentimes, family and friends are willing to provide care at the home of the patient, without charge, and the hospital should offer timely instruction on proper care of the patient.<sup>220</sup>

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<sup>211</sup> AARP Hawaii presentation at the September 10, 2015, informational briefing citing "Valuing the Invaluable – AARP 2015". Note: the Bureau could not find this document, however, Valuing the Invaluable: 2015 Update Undeniable Progress, but Big Gaps Remain, July 2015, AARP Public Policy Institute, at 19, available at <http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf>, contains information supporting this statement.

<sup>212</sup> *Id.*

<sup>213</sup> AARP Hawaii presentation at the September 10, 2015, informational briefing citing "Valuing the Invaluable – AARP 2015". Note: the Bureau could not find support for the \$5,531 in out-of-pocket expenses figure in Valuing the Invaluable: 2015 Update Undeniable Progress, but Big Gaps Remain, July 2015, AARP Public Policy.

<sup>214</sup> AARP Hawaii presentation at the September 10, 2015, informational briefing citing 2014 AARP Caregiving Survey: Opinions and Experiences of Hawaii Registered Voters Age 45 and Older at 6, available at [http://www.aarp.org/content/dam/aarp/research/surveys\\_statistics/general/2014/2014-Hawaii-Caregiving-Survey-Opinions-and-Experiences-of-Hawaii-Registered-Voters-Age-45-and-Older-AARP-res-gen.pdf](http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2014/2014-Hawaii-Caregiving-Survey-Opinions-and-Experiences-of-Hawaii-Registered-Voters-Age-45-and-Older-AARP-res-gen.pdf).

<sup>215</sup> AARP Hawaii presentation at the September 10, 2015, informational briefing. The remaining information presented by AARP did not include any documentation of further details or citations of support.

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

<sup>218</sup> *Id.*

<sup>219</sup> *Id.*

<sup>220</sup> *Id.*

AARP Hawaii suggested that hospitals are in the best position to help the caregiver because:

- Hospital staff are medically-trained and understand the patient's condition;
- Hospitals are best suited to provide instruction to caregivers in a timely manner;
- Hospitals are currently required to inform and instruct the patient of the discharge plan; and
- Hospitals can provide the caregiver with information so that upon the patient's return home, the caregiver knows what to do in the event of an emergency.<sup>221</sup>

AARP Hawaii commented that while the Centers for Medicare and Medicaid Services' Conditions of Participation and the standards issued by the Joint Commission mention caregiver involvement, they:

- Do not *require* hospitals to provide each patient with the opportunity to name a caregiver and have that information recorded in the patient's medical record;
- Allow the hospital, *not the patient*, to decide whether to involve a caregiver in the discharge process; and
- Do not provide clear standards *requiring* that the information provided by the hospital to the caregiver who is involved in the discharge process include an offer of instruction and a demonstration of aftercare tasks.<sup>222</sup>

## 2. Comparison of SB 296 to Other States' CARE Acts

Representatives from the Legislative Reference Bureau provided an overview of SB 296 (known as the CARE Act) and a comparison of caregiver laws enacted in other states. Sixteen states<sup>223</sup> have enacted a version of the CARE Act and two states<sup>224</sup> had acts pending signature by the governor at the time of the briefing, both of which have since been signed into law. Most substantive provisions of SB 296 have corresponding provisions in other states' CARE Acts. The only substantive provision found in SB 296 that does not appear in the other states' CARE Acts is the requirement that the discharge plan contain a written summary and description of the instructions provided. Conversely, a few other states' CARE Acts include provisions that limit

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<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> These states, and the year of their caregiver act enactment, are: Arkansas (2015), Colorado (2015), Connecticut (2015), Illinois (2015), Indiana (2015), Maine (2015), Mississippi (2015), Nevada (2015), New Hampshire (2015), New Jersey (2014), New Mexico (2015), Oklahoma (2014), Oregon (2015), Rhode Island (2015), Virginia (2015), and West Virginia (2015).

<sup>224</sup> These states, and the year of their caregiver act enactment, are: California (2015) and New York (2015).

insurers' reimbursement obligations and provide additional limitations of liability for hospitals and hospital employees, while SB 296 does not contain these provisions.

A detailed comparison of SB 296 to other states' CARE Acts appears in Chapter 7 and Appendix C of this report.

*(The presentation made by AARP Hawaii is available at <http://goo.gl/leqnLW> or [http://capitol.hawaii.gov/session2015/studies/2015.09.10\\_Caregiver\\_Presentation.pdf](http://capitol.hawaii.gov/session2015/studies/2015.09.10_Caregiver_Presentation.pdf) and the presentation made by the Legislative Reference Bureau is available at <http://goo.gl/XP4GS9> or [http://capitol.hawaii.gov/session2015/studies/2015.09.10\\_LRB\\_Presentation\\_State%20CARE%20Acts%20Overview.pdf](http://capitol.hawaii.gov/session2015/studies/2015.09.10_LRB_Presentation_State%20CARE%20Acts%20Overview.pdf).)*

## **D. October 8, 2015, Informational Briefing**

The October 8, 2015, informational briefing addressed the existing hospital discharge practices among several major hospitals that serve Hawaii. Representatives from the Healthcare Association of Hawaii, Hawaii Medical Service Association, Queen's Health Systems, and Pali Momi Medical Center presented information on the policies and requirements followed by health care providers for discharging patients and initiatives to reduce preventable patient readmissions.

### **1. Hospital Practices that Follow Centers for Medicare and Medicaid Services and Joint Commission Requirements**

The Healthcare Association of Hawaii<sup>225</sup> and Queen's Health Systems described practices for designating and involving caregivers in the discharge process and noted that hospitals follow the federal Centers for Medicare and Medicaid Services (CMS) rules for discharge planning and requirements established by the Joint Commission. Detailed information on the discharge requirements established by CMS and the Joint Commission appears in Chapter 3 of this report.<sup>226</sup>

### **2. Queen's Health Systems**

#### **a. Queen's Health Systems Patient Assessments**

Queen's Health Systems (Queen's) noted that patients have their own unique needs. The Queen's social workers must assess and incorporate numerous factors when developing a discharge plan, including the patient's ability for self-care, the patient's living situation, the patient's family dynamics, the patient's goals following discharge, the available resources to fulfill the patient's and caregiver's needs, and the capabilities and limitations of the caregiver to provide care, including any limitations on time, abilities, and finances.

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<sup>225</sup> The Healthcare Association of Hawaii is a nonprofit organization that represents healthcare providers.

<sup>226</sup> See Chapter 3, page 7.

**b. Example of Addressing a Patient's After-Care Needs**

To illustrate its hospitals' patient assessment practices, Queen's provided examples of how its staff addresses the care needs of various patients. In one example, an elderly man with progressive renal failure sought treatment at Queen's. The patient listed his wife as his primary caregiver, and Queen's hospital staff spent considerable time attempting to train and educate the patient and his wife on how to provide necessary care following discharge. However, both the patient and his wife had some degree of cognitive decline, which decreased the effectiveness of the training and education. Meanwhile, the Queen's hospital's case management and social work team attempted to identify community resources for the patient. The case management and social work team also independently located and trained the patient's grandson and assisted the grandson in improving his grandparents' overall living situation through the use of available community resources.

**c. Shortcomings of Community Resources**

Queen's noted two specific concerns potentially faced by patients and their caregivers after discharge. First, hospital discharge planning team members have reported that current community resources require more support<sup>227</sup> than their current levels.<sup>228</sup> Ideally, the State should expand the community resources available, which will help to truly address the needs of patients and their caregivers.<sup>229</sup> Second, hospitals have reported that middle class families often have difficulty accessing caregiver resources.<sup>230</sup> Hospitals have found that, oftentimes, the incomes of middle class families are insufficient to fund private care assistance but too high to qualify for low-income Medicaid services.<sup>231</sup>

**3. Pali Momi Medical Center**

Pali Momi Medical Center presented information on its Pharmacy Medication Reconciliation on Admission program and Pharm2Pharm program. For more information on these programs, see Chapter 4 of this report.<sup>232</sup>

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<sup>227</sup> Details of the nature of the required support, e.g. funding or legislative support, was not provided to the Legislative Family Caregivers Working Group.

<sup>228</sup> Queen's Health Systems presentation at the October 8, 2015, informational briefing ("Queen's provides discharge instructions to the patient's primary care provider; however, according to members of the discharge planning team, there is a real need for community resources to be better supported and, ideally, expanded in order to truly address the needs of patients and their caregivers.").

<sup>229</sup> *Id.*

<sup>230</sup> *Id.* ("Access to needed resources is particularly difficult for middle class families, who are often unable to access services available to wealthy patients or low-income patients who qualify for services through Medicaid.").

<sup>231</sup> *Id.*

<sup>232</sup> See Chapter 4, page 27.

#### 4. Hawaii Medical Service Association

Hawaii Medical Service Association presented information on its Advanced Hospital Care program and Care Model program. For more information on these programs, see Chapter 4 of this report.<sup>233</sup>

#### E. November 10, 2015, Informational Briefing

The November 10, 2015, informational briefing addressed current models and demonstration projects related to improving care management support and coordination following hospitalization.

##### 1. Transamerica Center for Health Studies

Hector De La Torre, Executive Director of the Transamerica Center for Health Studies,<sup>234</sup> presented findings on their research that community health workers can increase individuals' access to health care through outreach services, cultural linkages, health education, screening, detection, and patient-provider communication.<sup>235</sup> Additionally, programs promoting healthy lifestyles and lifestyle changes, including smoking cessation, physical activity, appropriate use of medication, and blood pressure, blood sugar, and lipid monitoring can help to reduce or help the early detection of diseases that might otherwise result in hospitalization.<sup>236</sup>

The Transamerica Center for Health Studies also described findings that Hawaii ranks fourth in the nation for the percentage of Medicaid expenditures for individuals age 65 years and older.<sup>237</sup> In Hawaii, twenty-seven percent of Medicaid expenditures are for this population, compared to the national average of twenty-one percent.<sup>238</sup> Additionally, costs for long-term care in Hawaii, including homemaker services, home health aides, and nursing home care, rank among the highest in the nation.<sup>239</sup>

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<sup>233</sup> Chapter 4, page 29.

<sup>234</sup> The Transamerica Center for Health Studies researches and analyzes health care issues relevant to consumers and employers in the United States. The Transamerica Center for Health Studies is a division of Transamerica Institute, a nonprofit private foundation, and is funded by contributions from Transamerica Life Insurance Company. <https://www.transamericacenterforhealthstudies.org/about-transamerica-health-studies>.

<sup>235</sup> Transamerica Center for Health Studies presentation at the November 11, 2015, informational briefing.

<sup>236</sup> *Id.*

<sup>237</sup> *Id.* (citing Medicaid Spending by Enrollment Group, Kaiser Family Foundation, <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>).

<sup>238</sup> Transamerica Center for Health Studies presentation at the November 11, 2015, informational briefing.

<sup>239</sup> *Id.* (citing Compare Long term Care Costs Across the United States, Genworth <https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html>).

## **2. State of Hawaii Employer-Union Health Benefits Fund**

The State of Hawaii Employer-Union Health Benefits Fund (EUTF) presented information on the types of transitional care benefits and services covered under health insurance plans that are available to currently employed EUTF beneficiaries through either HMSA or Kaiser.

### **a. Hawaii Medical Service Association**

Health plans offered to EUTF beneficiaries by Hawaii Medical Service Association include the following transitional care benefits and services:

- Educating members and caregivers on hospital discharge instructions;
- Verifying and calendaring physician follow-up appointments;
- Educating patients on proper medication usage;
- Working with a patient's physician to prevent medication conflict;
- Coordinating health care and social service needs; and
- Coordinating follow-up appointments.

### **b. Kaiser Permanente**

Under Kaiser Permanente health plans available to EUTF beneficiaries, a patient care coordinator coordinates a patient's needs with the medical staff, hospital departments, and the caregiver. Specifically, Kaiser Permanente benefits and services include:

- Coordination of follow-up physician appointments;
- Coordination of any required or recommended follow-up tests or therapies;
- Coordination of medical services to be provided in a patient's home; and
- Provision of a brochure of instructions and patient resources to assist the patient with discharge and transition home.<sup>240</sup>

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<sup>240</sup> It is not clear whether the resources provided by Kaiser Permanente specifically include care instructions.



**F. December 15, 2015, Discussion of the Report and Comments**

At the December 15, 2015, meeting, the Legislative Family Caregivers Working Group discussed the report. Each Working Group member had an opportunity to offer comments and observations, which are presented in Chapter 8. The Legislative Family Caregivers Working Group also invited the public to submit written comments. Twenty-eight individuals and organizations submitted written comments, which were circulated to all members of the Working Group and reviewed by the Bureau.

## Chapter 6

### COMPARISON OF SB 296 WITH CARE ACTS IN OTHER STATES

Among other things, Senate Concurrent Resolution No. 107 (2015) requested the Working Group to examine and assess issues related to caregivers contained in SB 296 (known as the CARE Act) and to review other states' approaches to caregiving and the hospital discharge process. Accordingly, the Working Group examined CARE (Caregiver Advise, Record, and Enable) Acts that have passed in other states for comparisons to Senate Bill No. 296 (2015).

Eighteen other states have enacted some type of CARE Act that addresses the role of caregivers in the hospital discharge process. These states, and the year of their caregiver act enactment, are: Arkansas (2015), California (2015), Colorado (2015), Connecticut (2015), Illinois (2015), Indiana (2015), Maine (2015), Mississippi (2015), Nevada (2015), New Hampshire (2015), New Jersey (2014), New Mexico (2015), New York (2015), Oklahoma (2014), Oregon (2015), Rhode Island (2015), Virginia (2015), and West Virginia (2015).

Of those states' CARE Acts, all include substantially similar provisions to SB 296. Generally, all states' CARE Acts include:

- Requirements for a patient to be given the opportunity to designate a caregiver;
- Requirements for a hospital to notify a caregiver upon the discharge of a patient or transfer to a another facility;
- Provisions for specific instructions to be provided by the hospital to the caregiver regarding the patients' discharge and follow-up care;
- Provisions relating to noninterference with advanced healthcare directives;
- Liability limitations for hospitals; and
- Provisions that address non-interference with a patient's discharge or transfer.

The most significant difference in the language of the foregoing provisions between SB 296 and other states' CARE acts is that SB 296 requires that the discharge instructions provided to a caregiver specifically include a "written summary and description of the instructions [that were] provided."<sup>241</sup> No other state's caregiver act specifically includes this requirement. Of seemingly less significance, SB 296 explicitly defines what is meant by "contact information," whereas other states do not.<sup>242</sup>

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<sup>241</sup> SB 296, section 2, § -4(b)(3).

<sup>242</sup> SB 296, section 2, § -1.

Finally, several other states' CARE Acts include provisions that do not appear in SB 296. These provisions include language that limits insurers' reimbursement obligations to caregivers<sup>243</sup> and that provides additional limitations of liability for hospitals and hospital employees.<sup>244</sup>

Table 6.1 lists the substantive provisions of SB 296 and the other states that have corresponding provisions in their CARE acts. A more detailed table containing citations to the relevant provisions of the other states' acts may be found in Appendix C of this report.

Because all of the CARE acts that were reviewed appear to have been enacted within the last two years, there was little data available to the Working Group to assess the effectiveness of those laws in improving patient outcomes.

**Table 6.1 Comparison of Hawaii Senate Bill No. 296 (2015)  
to Other States' Caregiver, Advise, Record, Enable (CARE) Acts**

Substantive Provisions of Senate Bill 296 (2015)	States with Comparable CARE Act Provisions
§ -1 <b>Definitions.</b> For the purpose of this chapter:	14 states: AR, CO, CT, IL, ME, MS, NH, NJ, NM, NY, OK, OR, RI, WV
"After-care" means any assistance provided by a caregiver to a patient following the patient's discharge from a hospital that is related to the patient's condition at the time of discharge, including but not limited to assisting with basic activities of daily living, instrumental activities of daily living, and other tasks as determined to be appropriate by the discharging physician or other health care professional licensed pursuant to chapter 453.	16 states: AR, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NM, NY, OK, OR, RI, WV
"Caregiver" means any individual duly designated by a patient to provide after-care to the patient in the patient's residence. The term includes but is not limited to a relative, spouse, partner, friend, or neighbor who has a significant relationship with the patient.	16 states: AR, CA, CO, CT, IL, IN, MS, NV, NH, NJ, NM, NY, OK, OR, RI, WV
"Contact information" means legal name, phone number, email address, mailing address, and home address, where available.	No other states
"Discharge" means a patient's exit or release from a hospital to the patient's residence following any medical care or treatment rendered to the patient following an inpatient admission.	13 states: AR, IL, IN, ME, MS, NH, NJ, NM, NY, OK, OR, RI, WV

<sup>243</sup> Arkansas, Connecticut, Indiana, Mississippi, New Jersey, Oklahoma, Rhode Island, and West Virginia. For example, section 26:2H-5.30(7)(d)(1), New Jersey Revised Statutes, states, "A caregiver shall not be reimbursed by any government or commercial payer for after-care assistance that is provided pursuant to this act."

<sup>244</sup> Section 25-1-128(6), Colorado Revised Statutes states, "Nothing in this section: . . . (c) Creates additional civil or regulatory liability for a hospital or hospital employee; (d) Supersedes or replaces existing rights or remedies under any other law; or (e) Affects a license issued to a hospital pursuant to section 25-3-102."

Substantive Provisions of Senate Bill 296 (2015)	States with Comparable CARE Act Provisions
"Entry" means a patient's entrance into a hospital for the purposes of receiving in-patient medical care.	4 states: NH, NJ, NY, RI
"Hospital" means a state licensed facility.	12 states: AR, CO, CT, IL, MS, NH, NJ, NM, NY, OK, RI, WV
"Legally authorized representative" means legal guardians, health care agents, and surrogates (designated or selected by a consensus of interested persons).	5 states: AR, IL, IN, NV, NH
"Patient" means an individual admitted to a hospital as an inpatient. "Patient" does not include a pediatric patient or a patient who is not capable of designating a caregiver due to a health care condition or other circumstances, as determined by the health care provider.	4 states: AR, IL, NY, RI
"Residence" means a dwelling that the patient considers to be the patient's home and shall not include any rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed by the State.	14 states: AR, CO, CT, IL, IN, ME, MS, NH, NJ, NM, NY, OK, RI, WV
<b>§ -2 Opportunity to designate caregiver.</b> (a) A hospital shall provide each patient or, if applicable, the patient's legally authorized representative, with an opportunity to designate one or more caregivers following the patient's entry into a hospital and prior to the patient's discharge to the patient's residence or transfer to another facility, in a timeframe that is consistent with the discharge planning process; <con't>	18 states: AR, CA, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NM, NY, OK, OR, RI, VA, WV
<con't> provided that in the event that the patient is unconscious or otherwise incapacitated upon entry into a hospital, the hospital shall provide the patient or patient's legally authorized representative with an opportunity to designate a caregiver within a given timeframe, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity.	13 states: CA, CO, IL, ME, MS, NV, NH, NJ, NY, OK, RI, VA, WV
(b) If the patient or patient's legally authorized representative declines to designate a caregiver pursuant to subsection (a), the hospital shall promptly document this in the patient's medical record.	15 states: AR, CA, IL, IN, ME, MS, NV, NH, NJ, NM, NY, OK, RI, VA, WV
(c) If the patient or the patient's legally authorized representative designates an individual as a caregiver under this chapter, the hospital shall:	13 states: CO, CT, IL, IN, ME, MS, NV, NH, NJ, NY, OK, RI, WV
(1) Promptly request the written consent of the patient or the patient's legally authorized representative to release medical information to the patient's caregiver following the hospital's established procedures for releasing personal health information and in compliance with all federal and state laws and regulations. <con't>	12 states: AR, CO, IN, ME, MS, NV, NH, NJ, NY, OK, RI, WV

Substantive Provisions of Senate Bill 296 (2015)	States with Comparable CARE Act Provisions
<con't>If the patient or the patient's legally authorized representative declines to consent to release medical information to the patient's caregiver, the hospital is not required to provide notice to the caregiver under section -3 or provide information contained in the patient's discharge plan under section -4; and	9 states: AR, MS, NH, NJ, NY, OK, OR, RI, WV
(2) Record the patient's designation of caregiver, the relationship of the caregiver to the patient, and the contact information of the patient's caregiver in the patient's medical record.	15 states: AR, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NY, OK, RI, VA, WV
(d) A patient may elect to change the patient's designated caregiver at any time. The hospital shall record this change in the patient's medical record, along with the contact information for the newly designated caregiver, before the patient's discharge to the patient's residence or transfer to another facility.	14 states: AR, CO, IL, ME, MS, NV, NH, NJ, NM, NY, OK, RI, VA, WV
(e) A designation of caregiver by a patient or a patient's legally authorized representative under this section does not require the caregiver to perform any after-care for the patient.	16 states: AR, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NM, NY, OK, RI, VA, WV
(f) This section shall not be construed to require a patient or a patient's legally authorized representative to designate an individual as a caregiver.	14 states: AR, CO, CT, IL, IN, ME, MS, NH, NJ, NM, NY, OK, RI, WV
<b>§ -3 Notice to caregiver.</b> A hospital shall notify the patient's caregiver of the patient's discharge or transfer to another licensed facility as soon as possible and at the latest, upon issuance of a discharge order by the patient's attending physician. <con't>	17 states: AR, CA, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NY, OK, OR, RI, VA, WV
<con't>If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or affect the medical care provided to the patient, or discharge of the patient.<con't>	16 states: AR, CA, CO, CT, IL, IN, ME, MS, NV, NJ, MN, NY, OK, OR, RI, WV
<con't>The hospital shall promptly document the attempt to contact the designated caregiver in the patient's medical record. <con't>	8 states: CA, CO, ME, NV, NJ, NY, RI, WV
<b>§ -4 Instruction to caregiver; discharge plan.</b> (a) As soon as possible and prior to a patient's discharge from a hospital, the hospital shall consult with the patient's caregiver regarding the caregiver's capabilities and limitations and issue a discharge plan to the caregiver that describes the patient's after-care needs, if any, at the patient's residence. <con't>	17 states: AR, CA, CO, CT, IL, IN, ME, NV, NH, NJ, NM, NY, OK, OR, RI, VA, WV
<con't>The consultation and issuance of a discharge plan shall occur on a schedule that takes into consideration the severity of the patient's condition, the setting in which care is to be delivered, and the urgency of the need for caregiver services.<con't>	5 states: CA, IL, NJ, OR, RI

Substantive Provisions of Senate Bill 296 (2015)	States with Comparable CARE Act Provisions
<con't>In the event the hospital is unable to contact the caregiver, the lack of contact shall not interfere with, delay, or affect the medical care provided to the patient or the discharge or transfer of the patient. <con't>	9 states: AR, CA, IL, NV, NJ, NY, OK, OR, RI
<con't>The hospital shall promptly document the attempt to contact the caregiver in the patient's medical record. <con't>	4 states: CA, NJ, NY, RI
<con't>The discharge plan shall include but not be limited to the following:	8 states: IL, NV, NH, NJ, NY, RI, VA, WV
(1) The name and contact information of the designated caregiver;	8 states: CO, NV, NH, NJ, NY, RI, VA, WV
(2) A description of all after-care necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the caregiver;	11 states: AR, CO, IL, NV, NH, NJ, NY, OR, RI, VA, WV
(3) Contact information for any health care community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan; and contact information for a hospital employee who can respond to questions regarding the discharge plan following the instruction provided pursuant to this section.	11 states: CA, CO, IL, IN, NV, NH, NJ, NY, RI, VA, WV
(b) The hospital issuing the discharge plan shall provide the caregiver with instruction in all after-care described in the discharge plan.<con't>	12 states: AR, CA, CO, CT, IL, NV, NH, NJ, NY, RI, VA, WV
<con't>Training and instructions for caregivers may be conducted in person or through video technology, at the discretion of the caregiver.<con't>	4 states: CT, IL, NV, NY
<con't> Any training or instructions provided to a caregiver shall be provided in non-technical language, to the extent possible. Instruction shall include but not be limited to the following:	9 states: CA, CT, IL, ME, NV, NH, NJ, RI, WV
(1) A live or recorded demonstration of the tasks, performed by an individual designated by the hospital who is authorized to perform the after-care task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law;	11 states: CO, CT, IL, IN, NV, NH, NJ, NM, NY, RI, VA
(2) An opportunity for the caregiver to ask questions regarding caregiver instructions and receive answers in a culturally competent manner, in accordance with the hospital's requirements to provide language access services under state and federal law; and	15 states: AR, CA, CO, CT, IL, IN, ME, MS, NV, NH, NJ, NY, RI, VA, WV
(3) A written summary and description of the instructions provided.	No other states
(c) Any caregiver instruction required under this chapter shall be documented in the patient's medical record. At a minimum, the patient's medical record shall reflect the date, time, and content of the instruction.	9 states: CO, CT, NV, NH, NJ, NY, RI, VA, WV

Substantive Provisions of Senate Bill 296 (2015)	States with Comparable CARE Act Provisions
(d) The department of health may adopt rules pursuant to chapter 91 to carry out the purpose of this chapter, including rules to further define the content and scope of any instruction provided to caregivers under this chapter.	7 states: CO, ME, NH, NJ, NY, RI, VA
<b>§ -5 Non-interference with existing health care directives.</b> Nothing in this chapter shall be construed to interfere with the rights of an agent operating under a valid health care directive under section 327G-3.	13 states: CO, CT, IL, IN, ME, MS, NH, NJ, NY, OK, RI, VA, WV
<b>§ -6 Limitation of liability.</b> (a) Nothing in this chapter shall be construed to give rise to a private cause of action against a hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital.	14 states: AR, CO, CT, IL, IN, MS, NH, NJ, NM, NY, OK, RI, VA, WV
(b) A hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital shall not be held liable for the services rendered or not rendered by the caregiver to the patient at the patient's residence.	11 states: AR, CT, IL, IN, NV, NJ, NM, NY, RI, VA, WV
This section shall not create additional civil or regulatory liability for a hospital or hospital employee	1 state: CO
This subchapter shall not confer upon the caregiver any authority to make healthcare decisions on behalf of the patient.	1 state: AR
This subchapter shall not remove the obligation of a third-party payer to cover a healthcare item or service that the third-party payer is obligated to provide to a patient under the terms of a valid agreement, insurance policy, plan, or certification of coverage or health maintenance organization contract.	4 states: AR, CT, NJ, NM
A caregiver shall not be reimbursed by any government or commercial payer for after-care assistance that is provided pursuant to this act.	7 states: CT, IN, MS, NJ, OK, RI, WV
Nothing in this act shall be construed to impact, impede, or otherwise disrupt or reduce the reimbursement obligations of an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization, or any other entity issuing health benefits plans.	3 states: CT, NJ, RI
<b>§ -7 Discharge; transfer of patient.</b> Nothing in this chapter shall delay the discharge of a patient or the transfer of a patient from a hospital to another facility.	10 states: CA, CT, IL, IN, NV, NH, NJ, NM, OR, RI

## Chapter 7

### PROPOSED AMENDMENTS TO CENTERS FOR MEDICARE AND MEDICAID SERVICES STANDARDS FOR DISCHARGE PLANNING

#### A. Background

As discussed in Chapter 3 of this report, CMS is a federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs. CMS has enacted requirements for hospitals as a condition for participation in the Medicare and Medicaid programs, including 42 C.F.R. 482.43, which requires hospitals to include discharge planning in their processes for transitioning inpatients to post-acute care settings.<sup>245</sup> The current version of 42 C.F.R. 482.43 (current rule) requires hospitals to carry out a discharge planning process for all patients.<sup>246</sup> However, the current rule does not require that a caregiver be involved in the discharge process. On November 3, 2015, CMS published a proposed amended version of 42 C.F.R. 482.43 (proposed rule).<sup>247</sup> The proposed rule would require the involvement of caregivers in the discharge process.

*(The citation to the document containing the proposed rule is 80 FR 68125 and is available to download at <https://goo.gl/YzsnlO> or <https://federalregister.gov/a/2015-27840>.)*

In its comments on the proposed rule, CMS notes:

We propose to continue our efforts to reduce patient readmissions by improving the discharge planning process that would require hospitals to take into account the patient's goals and preferences in the development of their plans and to better prepare patients and their caregiver/support person(s) (or both) to be active participants in self-care and by implementing requirements that would improve patient transitions from one care environment to another, while maintaining continuity in the patient's plan of care.<sup>248</sup>

Specifically, the proposed rule would require:

- The caregiver's involvement in the development of the discharge plan;<sup>249</sup>

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<sup>245</sup> 42 C.F.R. pt 482. See also Chapter 3, page 7.

<sup>246</sup> 42 C.F.R. section 482.43 ("The hospital must have in effect a discharge planning process that applies to all patients.").

<sup>247</sup> Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, And Home Health Agencies; Proposed Rule, 80 Fed. Reg. 68125 (proposed Nov. 3, 2015) (to be codified at 42 C.F.R. pt. 482, 484, and 485) (hereafter "80 Fed. Reg." or "proposed 42 C.F.R. 482.43").

<sup>248</sup> 80 Fed. Reg. at 68130.

<sup>249</sup> Proposed 42 C.F.R. 482.43(c)(6) ("The patient and caregiver/support person(s) must be involved in the development of the discharge plan, and informed of the final plan to prepare them for post-hospital care.").



- The hospital to consider the availability and capabilities of the caregiver as part of the discharge planning process;<sup>250</sup>
- The hospital to provide instruction on post-hospital care to the caregiver;<sup>251</sup> and
- The hospital to provide the post-hospital care instructions in a written form.<sup>252</sup>

For reference, section 2 of SB 296 establishing hospital requirements regarding caregivers, proposes requiring hospitals to: (1) provide a patient with the opportunity to designate a caregiver (§ -2); (2) notify the caregiver of a patient's discharge or transfer (§ -3); and (3) provide discharge instructions to the caregiver (§ -4).

## **B. Comparison of Proposed Rule with SB 296**

It appears that the proposed rule, if adopted, would overlap with several provisions contained in SB 296 that address the caregiver's involvement in the discharge process. Most of these corresponding or overlapping provisions are found in section 2, § -4, of SB 296 and are detailed in Table 7.1 later in this chapter.

However, there are some differences between SB 296 and the proposed rule, which bear on this discussion. Whereas SB 296 (section 2, § -2) requires a hospital to provide a patient with the opportunity to designate a caregiver, the proposed rule does not specifically *require* a hospital to allow a patient to name a caregiver. However, the proposed rule clearly appears to imply or presume that a patient can name a caregiver since the proposed rule requires the caregiver's participation in the discharge planning process.<sup>253</sup>

Also in contrast to SB 296 (section 2, § -3), the proposed rule does not specifically require a hospital to notify a caregiver of a patient's discharge or transfer to another facility. Again, however, this notification requirement would appear to be implied or presumed in the

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<sup>250</sup> Proposed 42 C.F.R. 482.43(c)(5) ("The hospital must consider caregiver/support person and community based care availability and the patient's or caregiver's/support person's capability to perform required care including self-care, care from a support person(s), follow-up care from a community based provider, care from post-acute care practitioners and facilities, or, in the case of a patient admitted from a long term care facility or other residential facility, care in that setting, as part of the identification of discharge needs.").

<sup>251</sup> Proposed 42 C.F.R. 482.43(d)(2)(i) ("The discharge instructions must include . . . the following: (i) Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient's home, as identified in the discharge plan").

<sup>252</sup> Proposed 42 C.F.R. 482.43(d)(2)(v) ("The discharge instructions must include . . . the following: . . . (v) Written instructions in paper and/or electronic format regarding the patient's follow-up care, appointments, pending and/or planned diagnostic tests, and pertinent contact information, including telephone numbers, for any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for follow[-]up care.").

<sup>253</sup> See Proposed 42 C.F.R. 482.43(c)(5) ("The hospital must consider caregiver/support person . . . availability and the patient's or caregiver's/support person's capability to perform required care") and 42 C.F.R. 482.43(c)(6) ("The patient and caregiver/support person(s) must be involved in the development of the discharge plan, and informed of the final plan to prepare them for post-hospital care."). See also *supra* note 249 and accompanying text.

proposed rule, given that the hospital must provide discharge instructions to the caregiver at the time of discharge.<sup>254</sup> Additionally, in contrast to the requirements of SB 296 (section 2, § -4) that a hospital provide instructions to the caregiver *prior to the patient's discharge*, the proposed rule requires that hospitals provide care instructions to the patient and/or the caregiver *at the time of discharge*.<sup>255</sup> However, the proposed rule requires the patient and caregiver involvement in the *development of the discharge plan*, which presumably would occur *prior to actual discharge*.<sup>256</sup>

Further, while SB 296 (section 2, § -4(c)) requires that the caregiver instruction be documented in the patient's medical record, the proposed rule does not contain a directly corresponding provision. However, CMS notes its intent that medical staff discuss the patient's care goals and treatment preferences with the patient or caregiver and that those goals and preferences be documented in the medical record.<sup>257</sup>

While not in direct conflict with the proposed rule, the provision in SB 296 (section 2, § -4) requiring a discharge plan to include the "contact information for a hospital employee who can respond to questions regarding the discharge plan following the instruction provided pursuant to this section"<sup>258</sup> appears broader than the corresponding provision of the proposed rule, which requires the discharge instructions to include written information on warning signs and symptoms and who the caregiver should contact if the warning signs or symptoms present.<sup>259</sup>

Finally, it should be noted that the remaining provisions of SB 296, in section 2, §§ -5, -6, and -7, do not directly deal with caregiving involvement in the discharge process and do not appear to correspond with any provisions in the proposed rule.

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<sup>254</sup> Proposed 42 C.F.R. 482.43(d)(1)(i) ("Discharge instructions must be provided at the time of discharge to: . . . The patient and/or the patient's caregiver/support person(s)").

<sup>255</sup> Proposed 42 C.F.R. 482.43(d)(1) ("Discharge instructions must be provided at the time of discharge").

<sup>256</sup> Proposed 42 C.F.R. 482.43(c)(5) ("The hospital must consider caregiver/support person . . . availability and the patient's or caregiver's/support person's capability to perform required care") and (6) ("The patient and caregiver/support person(s) must be involved in the development of the discharge plan, and informed of the final plan to prepare them for post-hospital care."). See also 80 Fed. Reg. at 68132.

<sup>257</sup> 80 Fed. Reg. at 68132 ("During the discharge planning process, we would expect that the appropriate medical staff would discuss the patient's post-acute care goals and treatment preferences with the patient, the patient's family or their caregiver/support persons (or both) and subsequently document these goals and preferences in the medical record."). See also Table 7.1, page 53.

<sup>258</sup> SB 296, Section 2, § -4(a)(3).

<sup>259</sup> Proposed 42 C.F.R. 482.43(d)(2)(ii) ("The discharge instructions must include . . . (v) Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the caregiver/support person(s) should do and who they should contact if these warning signs or symptoms present . . ."). See also 80 Fed. Reg. at 68134 ("The written information would include instructions on what the person should do if these warning signs and symptoms present. Furthermore, the discharge instructions would include information about who to contact if these warning signs and symptoms present. This contact information may include practitioners such as the patient's primary care practitioner, the practitioner who was responsible for the patient's care while in the hospital or hospital emergency care departments, specialists, home health services, hospice services, or any other type of outpatient health care service.").

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Table 7.1, which follows, directly compares the text of SB 296, section 2, § -4, in the order in which it appears in the bill (left column), with corresponding provisions of the proposed rule (right column).

**Table 7.1 Comparison of Hawaii Senate Bill No. 296,  
Section 2, § -4 (2015) to the Proposed Federal Rule  
to be Codified as 42 C.F.R. section 482.43**

Text from S.B. 296, Section 2, § -4	Language in the Proposed Section 482.43 or Comments (conflicting language in bold)
(a) As soon as possible and <b>prior to a patient's discharge</b> from a hospital, the hospital shall consult with the patient's caregiver regarding the caregiver's capabilities and limitations	Discharge instructions must be provided <b>at the time of discharge</b> (482.43(d)(1))  The hospital must consider caregiver/support person and community based care availability and the patient's or caregiver's/support person's capability to perform required care . . . The patient and caregiver/support person(s) must be involved in the development of the discharge plan, and informed of the final plan to prepare them for post-hospital care. (482.43(c)(5) and (6))  <i>In its comments on the proposed rule, CMS notes:</i>  <i>During the discharge planning process, we would expect that the appropriate medical staff would discuss the patient's post-acute care goals and treatment preferences with the patient, the patient's family or their caregiver/support persons (or both) and subsequently document these goals and preferences in the medical record. (80 Fed. Reg. at 68132)</i>
and issue a discharge plan to the caregiver	Discharge instructions must be provided . . . to: (1) the patient and/or the patient's caregiver/support person(s) (482.43(d)(1)(i))
that describes the patient's after-care needs, if any, at the patient's residence.	The discharge instructions must include . . . (i) Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient's home as identified in the discharge plan (482.43(d)(2)(i))
The consultation and issuance of a discharge plan shall occur on a schedule that takes into consideration the severity of the patient's condition, the setting in which care is to be delivered, and the urgency of the need for caregiver services.	The hospital's discharge planning process must ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of a discharge plan for each patient (482.43(c))  <i>and</i>  (i) The discharge plan must be included in the patient's medical record. The results of the evaluation must be discussed with the patient or patient's representative. (ii) All relevant patient

Text from S.B. 296, Section 2, § -4	Language in the Proposed Section 482.43 or Comments (conflicting language in bold)
	information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the patient's discharge or transfer. (482.43(c)(9)(i) and (ii))
In the event the hospital is unable to contact the caregiver, the lack of contact shall not interfere with, delay, or affect the medical care provided to the patient or the discharge or transfer of the patient. The hospital shall promptly document the attempt to contact the caregiver in the patient's medical record.	<i>No corresponding provision.</i>
The discharge plan shall include but not be limited to the following:  (1) The name and contact information of the designated caregiver;	<i>No corresponding provision.</i>
(2) A description of all after-care necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the caregiver;	The discharge instructions must include. . . (i) Instruction on post-hospital care to be used by the patient or the caregiver/ support person(s) in the patient's home as identified in the discharge plan (482.43(d)(2)(i))  <i>and</i>  The hospital must consider . . . caregiver's/support person's capability to perform required care (482.43(c)(5))
(3) Contact information for any health care community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan;	The discharge instructions must include . . . (v) Written instructions in paper and/or electronic format regarding . . . any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for followup care. (482.43(d)(2)(v)).  <i>In its comments on the proposed rule, CMS notes:</i>  <i>We would expect hospitals to be well informed of the availability of community-based services and organizations that provide care for patients who are returning home or who want to avoid institutionalization, including ADRCs [(Aging and Disability Resource Centers)], AAAs [(Area Agencies on Aging)], and CILs [(Centers for Independent Living)], and provide information on these services and organizations when appropriate. (80 Fed. Reg. at 68131)</i>
and contact information for a hospital employee who can respond to questions regarding the discharge plan following the instruction provided pursuant to this section.	The discharge instructions must include . . . (ii) Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the

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Text from S.B. 296, Section 2, § -4	Language in the Proposed Section 482.43 or Comments (conflicting language in bold)
	<p>caregiver/support person(s) should do and who they should contact if these warning signs or symptoms present (482.43(d)(2)(ii))</p> <p><i>In its comments on the proposed rule, CMS notes:</i></p> <p><i>The written information would include instructions on what the person should do if these warning signs and symptoms present. Furthermore, the discharge instructions would include information about who to contact if these warning signs and symptoms present. This contact information may include practitioners such as the patient's primary care practitioner, the practitioner who was responsible for the patient's care while in the hospital or hospital emergency care departments, specialists, home health services, hospice services, or any other type of outpatient health care service. (80 Fed. Reg. at 68134)</i></p>
<p>(b) The hospital issuing the discharge plan shall provide the caregiver with instruction in all after-care described in the discharge plan. Training and instructions for caregivers may be conducted in person or through video technology, at the discretion of the caregiver. Any training or instructions provided to a caregiver shall be provided in non-technical language, to the extent possible. Instruction shall include but not be limited to the following:</p> <ol style="list-style-type: none"> <li>(1) A live or recorded demonstration of the tasks, performed by an individual designated by the hospital who is authorized to perform the after-care task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law;</li> <li>(2) An opportunity for the caregiver to ask questions regarding caregiver instructions and receive answers in a culturally competent manner, in accordance with the hospital's requirements to provide language access services under state and federal law; and</li> </ol>	<p>The hospital must consider the following in evaluating a patient's discharge needs . . .</p> <p>(iii) Anticipated ongoing care needs post-discharge; . . . (vi) Communication needs, including language barriers, diminished eyesight and hearing, and self-reported literacy of the patient, patient's representative or caregiver/support person(s), as applicable (482.43(c)(5)(iii) and (vi))</p> <p><i>In its comments on the proposed rule, CMS notes:</i></p> <p><i>Discharge instructions can be provided to patients and their caregivers/support person(s) in different ways, including in paper and electronic formats, depending on the needs, preferences, and capabilities of the patients and caregivers. We would expect that discharge instructions would be carefully designed to be easily understood by the patient or the patient's caregiver/support person (or both) . . . as a best practice, hospitals should confirm patient or the patient's caregiver/support person's (or both) understanding of the discharge instructions. We recommend that hospitals consider the use of "teach-back" during discharge planning and upon providing discharge instructions to the patient. "Teach-back" is a way to confirm that a practitioner has explained to the patient what he or she needs to know in a manner that the patient understands. Training on the use of "teach-back" to ensure patient understanding of transition of care planning and appropriate medication use is readily</i></p>

Text from S.B. 296, Section 2, § -4	Language in the Proposed Section 482.43 or Comments (conflicting language in bold)
	<i>available and we refer readers to the following resource for information on the use of "teach-back": <a href="http://www.teachbacktraining.org">http://www.teachbacktraining.org</a>. (80 Fed. Reg. at 68133).</i>
(3) A written summary and description of the instructions provided.	The discharge instructions must include . . . (v) Written instructions in paper and/or electronic format regarding the patient's follow-up care (482.43(d)(2)(v))  <i>In its comments on the proposed rule, CMS notes:  The major elements of any follow-up care would be required to be written so that the patient, caregiver/support person can refer to them post-hospitalization. (80 Fed. Reg. at 68135)</i>
(c) Any caregiver instruction required under this chapter shall be documented in the patient's medical record. At a minimum, the patient's medical record shall reflect the date, time, and content of the instruction.	<i>No corresponding provision.  However, its comments on the proposed rule, CMS notes:  During the discharge planning process, we would expect that the appropriate medical staff would discuss the patient's post-acute care goals and treatment preferences with the patient, the patient's family or their caregiver/support persons (or both) and subsequently document these goals and preferences in the medical record. (80 Fed. Reg. at 68132)</i>
(d) The department of health may adopt rules pursuant to chapter 91 to carry out the purpose of this chapter, including rules to further define the content and scope of any instruction provided to caregivers under this chapter.	<i>No corresponding provision.</i>

### C. Timeline for Publication of the Proposed Rule

At this time, it is not clear when CMS expects to adopt the proposed rule and publish the final version of 42 C.F.R. 482.43 (final rule). Although the notice and comment period ends January 4, 2016,<sup>260</sup> publication of the final rule may take up to three years.<sup>261</sup> However, publication is likely to take place much sooner. For example, CMS adopted the most recent amendments to 42 C.F.R. 482.43 within ninety days of the publication of the proposed

<sup>260</sup> 80 Fed. Reg. 68125.

<sup>261</sup> 42 U.S.C. section 1395hh(a)(3)(B) ("Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances.").

*PROPOSED AMENDMENTS TO CENTERS FOR MEDICARE AND MEDICAID  
SERVICES STANDARDS FOR DISCHARGE PLANNING*

amendments.<sup>262</sup> It is not clear at this time whether the publication of the final rule on discharge planning will occur during the 2016 Regular Session.

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<sup>262</sup> The previous amendment to 42 C.F.R. 482.43 took eighty-six days from publication of the proposed rule to publication of the final rule. CMS published those proposed rules on May 18, 2004, with a comment cutoff period of July 12, 2004. (69 Fed. Reg. 28196 (May 18, 2004)). On August 11, 2004, CMS published the final rule. (69 Fed. Reg. 48916 (Aug. 11, 2004).)

## **Chapter 8**

### **LEGISLATIVE FAMILY CAREGIVERS WORKING GROUP COMMENTS AND OBSERVATIONS**

Based on the information presented to the Legislative Family Caregivers Working Group over the course of its meetings and deliberations, the Working Group recognized that, due in part to the requirements established by the Centers for Medicare and Medicaid Services and the Joint Commission, most hospitals in the State appear to already substantially involve caregivers in the patient discharge process. This includes effectively allowing patients to name a caregiver, involving caregivers in the discharge planning process, and providing instruction to caregivers on post-discharge care. However, the Working Group acknowledged that variations in the discharge process may exist among hospitals, depending upon the hospital and the patient's health insurance provider and health insurance plan.

At the December 15, 2015, meeting of the Working Group, each member had an opportunity to offer comments and observations.

#### **A. Points of General Consensus**

Based on the Working Group members' comments and observations, there was consensus among the members for the following general ideas:

- Hospitals should provide patients the opportunity to designate a caregiver.
- Hospitals should notify a patient's caregiver when the patient is discharged from the hospital.
- The proposed federal Centers for Medicare and Medicaid Services rules relating to discharge planning, likely to be finalized later this year, will provide for greater caregiver involvement in patient post-discharge care and generally encompass most of the substantive provisions proposed by SB 296.
- Caregivers should be provided a consistent level of instruction and support regardless of the patient's hospital, health insurance provider, and level of health insurance coverage.
- Instruction to caregivers needs to be sufficient so that (1) hospitals can accurately assess a caregiver's capabilities to provide the needed care and (2) the patient and caregiver have a realistic expectation of their capabilities. The discharge planning process should take the patient's and caregiver's capabilities into account and include in the discharge plan appropriate provisions for community-based resources and support services available in the community.



- Hospitals should follow-up with patients and caregivers in a timely manner after the patient's discharge home.
- Increase the availability of community-based resources and support services for post-discharge care, including more funding to ensure that all patients and caregivers have access to sufficient community-based services in all communities throughout the State. It was particularly noted that Oahu's ADRC was in need of additional funding support.

In view of the foregoing, the Working Group supports funding a comprehensive range of services and programs for kupuna and caregivers. These include services and programs such as the Aging and Disability Resource Centers in each of the four counties, fall prevention services, and programs addressing Alzheimer's disease and related dementia.

The Working Group also supports serious consideration of legislation to require hospitals to offer patients the opportunity to identify a caregiver; involve patients and caregivers in the patient discharge planning process; and prepare caregivers for post-discharge aftercare.

## **B. Additional Remarks**

In addition, individual members of the Working Group made the following observations on caregiver-related issues:

### **1. Caregiver Instruction Provided by the Hospital**

- Ensure that all hospitals follow a baseline standard with respect to the level and scope of post-discharge care instructions provided to patients and caregivers.
- Patient post-discharge care instructions provided to the caregiver by the hospital should include hands-on instruction to allow for adequate assessment of whether the caregiver is capable of performing the necessary tasks.
- After providing post-discharge instructions, but before the patient's discharge, hospitals should offer the caregiver the option to receive additional instruction, either provided by the hospital staff or an organization contracted by the hospital to provide these services.
- Recognizing that the level of instruction and involvement of caregivers in the discharge process, and in turn the caregivers' own understanding and abilities, varies depending upon the hospital, health insurance provider, and health insurance plan, consider how to ensure that the cost of caregiver instruction and support be covered by either the hospital or through health insurance plans.

## **2. Expanded Community Resources**

- The State should increase funding for "long-term services and supports"<sup>263</sup> in the community. In particular, the State should fully fund Kupuna Care, a state program within the Department of Health Executive Office on Aging that provides affordable and quality home- and community-based services as part of the state system on long-term care.<sup>264</sup>

## **3. Workforce Development and Training**

- Support efforts to increase the number of community health workers available through education, training, and workforce development opportunities for current and prospective community health workers.
- The University of Hawaii community college system should offer family caregiver training at all campuses, such as non-credit community enrichment classes, and the State should support these programs with additional funding as necessary.

## **4. Wellness and Prevention**

- The State should fund prevention programs focused on medical conditions that require hospitalization, particularly among seniors. In particular, the State should fund fall prevention services for the elderly and support programs that emphasize the importance of early detection and diagnosis of Alzheimer's disease and related dementia.

## **5. Other Considerations and Related Concerns**

- Consideration should be given to expanding the present state family leave law to ensure that paid family leave is available to all employees.<sup>265</sup>
- The State should work to increase the Medicaid reimbursement rate for medical services to increase access to health care among low-income patients.

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<sup>263</sup> See *supra* note 133 and accompanying text regarding the term "long-term services and supports."

<sup>264</sup> See section 349-3.1, HRS. Kupuna Care offers an alternative to traditional long-term care options for families and individuals by providing a variety of caregiving and support services, such as adult day care, personal care, and transportation assistance to "enable Hawaii's seniors to lead independent, meaningful, and dignified lives in their own homes and communities." Act 188, Session Laws of Hawaii 2015 (appropriating \$3,000,000 to the Kupuna Care program for the 2015-2016 fiscal year).

<sup>265</sup> Currently, sections 398-1 and 398-3, HRS, entitle an employee, who works for six consecutive months for an employer who employs one hundred or more employees, to four weeks of family leave each calendar year. Section 398-4, HRS, allows for that family leave to be unpaid, paid, or a combination of both. Further, section 398-4, HRS, requires an employer to allow an employee to use accrued sick leave, up to ten days per year, for family leave.

- The University of Hawaii Center on Aging should be fully staffed so that it has the resources necessary to develop a statewide training curriculum for health professionals.

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## SENATE CONCURRENT RESOLUTION

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REQUESTING THE CONVENING OF A LEGISLATIVE FAMILY CAREGIVERS  
WORKING GROUP TO EXAMINE AND ASSESS ISSUES RELATING TO THE  
ROLE OF CAREGIVERS OF PATIENTS DISCHARGED FROM HOSPITALS.

1 WHEREAS, many patients who are discharged from the hospital  
2 require continued care at home; and

3  
4 WHEREAS, because of costs and other factors, family  
5 caregivers are increasingly called upon to provide such care;  
6 and

7  
8 WHEREAS, based on estimates from 2009, there were 247,000  
9 family caregivers in Hawaii; and

10  
11 WHEREAS, caregiver advocates in Hawaii believe that the  
12 amount of instruction that family caregivers currently receive  
13 from hospitals depends largely on the individual hospital  
14 treating the patient; however, there is a need to provide a  
15 minimum and consistent level of instruction for all caregivers  
16 statewide; and

17  
18 WHEREAS, hospitals face greater pressure from the federal  
19 government and private insurers to avoid the readmission of  
20 patients within thirty days of their initial discharge; and

21  
22 WHEREAS, hospitals presently provide discharge plans for  
23 all patients, which may or may not involve family caregivers;  
24 and

25  
26 WHEREAS, the hospital members of the Healthcare Association  
27 of Hawaii remain concerned about how legislation would affect  
28 factors such as liability, cost, and implementation; and



1 WHEREAS, S.B. No. 296, introduced during the Regular  
2 Session of 2015, includes provisions that seek to address many  
3 of these concerns; and  
4

5 WHEREAS, the working group that was created by H.C.R. No.  
6 78, H.D. 1, S.D. 1, Regular Session of 2014, was unable to reach  
7 consensus and unable to submit a written report of its findings  
8 and recommendations to the Legislature no later than twenty days  
9 prior to the convening of the Regular Session of 2015, as  
10 directed; and  
11

12 WHEREAS, the working group created by H.C.R. No. 78, H.D.  
13 1, S.D. 1, Regular Session of 2014, is scheduled to dissolve on  
14 June 30, 2016; now, therefore,  
15

16 BE IT RESOLVED by the Senate of the Twenty-eighth  
17 Legislature of the State of Hawaii, Regular Session of 2015, the  
18 House of Representatives concurring, that a Legislative Family  
19 Caregivers Working Group be convened to examine and assess  
20 issues contained in S.B. No. 296, Regular Session of 2015,  
21 including but not limited to:  
22

- 23 (1) The role of family caregivers;
- 24
- 25 (2) The state of the current practice of designating  
26 family caregivers;
- 27
- 28 (3) Notification of family caregivers when a hospital  
29 discharges a patient or transfers a patient to another  
30 licensed facility;
- 31
- 32 (4) Family caregivers' involvement in discharge planning  
33 and instruction;
- 34
- 35 (5) The role of hospitals and hospital staff in the  
36 instruction of family caregivers;
- 37
- 38 (6) The role of insurance plans in paying for the  
39 instruction of family caregivers by hospitals and  
40 hospital staff; and  
41



- (7) Legislative and regulatory recommendations on how best to involve family caregivers in the patient-discharge process and prepare family caregivers for post-discharge tasks; and

BE IT FURTHER RESOLVED that the Legislative Family Caregivers Working Group is requested to consist of the following six legislative members: the Senate and House subject matter committee chairs for health and for human services; and a Senate and a House member of the Kupuna Caucus, appointed by the Senate President and the Speaker of the House, respectively; and

BE IT FURTHER RESOLVED that the Legislative Family Caregivers Working Group is requested to solicit input and presentations from the following stakeholders on the foregoing issues to be considered by the Working Group:

- (1) The Department of Health;
- (2) AARP Hawaii;
- (3) The Healthcare Association of Hawaii;
- (4) The Kokua Council;
- (5) Representatives of private hospitals or long-term care facilities in Hawaii;
- (6) The Policy Advisory Board for Elder Affairs;
- (7) The Hawaii Association of Health Plans;
- (8) Hawaii Health Systems Corporation;
- (9) International Longshore and Warehouse Union Local 142 Hawaii;
- (10) The Hawaii Family Caregiver Coalition;
- (11) The respective county Area Agencies on Aging;
- (12) Project Dana; and



1  
2 (13) The Hawaii Alliance for Retired Americans; and

3  
4 BE IT FURTHER RESOLVED that the Legislative Family  
5 Caregivers Working Group is requested to:

- 6  
7 (1) Consider the information presented by the stakeholders  
8 to the Working Group;  
9  
10 (2) Consider concerns raised and any possible solutions  
11 proposed;  
12  
13 (3) Review approaches that may have been taken by other  
14 states with regard to these issues;  
15  
16 (4) Examine the public and private community-based  
17 resources that are available throughout the State; and  
18  
19 (5) Make recommendations, as appropriate; and  
20

21 BE IT FURTHER RESOLVED that the Legislative Reference  
22 Bureau is requested to assist the Legislative Family Caregivers  
23 Working Group in:

- 24  
25 (1) Conducting research; and  
26  
27 (2) Drafting a report and proposed legislation, if any;  
28  
29 on matters pertinent to the issues considered by the Working  
30 Group; and  
31

32 BE IT FURTHER RESOLVED that the Legislative Family  
33 Caregivers Working Group submit a report to the Legislature not  
34 later than twenty days before the Regular Session of 2016 and  
35 cease to exist thereafter; and  
36

37 BE IT FURTHER RESOLVED that the working group that was  
38 created by H.C.R. No. 78, H.D. 1, S.D. 1, Regular Session of  
39 2014, cease to exist on the date of the adoption of this  
40 Concurrent Resolution by both houses of the Legislature; and  
41





1 BE IT FURTHER RESOLVED that certified copies of this  
2 Concurrent Resolution be transmitted to the Governor, Director  
3 of Health, Director of the Legislative Reference Bureau, Hawaii  
4 County Office of Aging, Maui County Office of Aging, County of  
5 Kauai Agency on Elderly Affairs, Elderly Affairs Division of the  
6 City and County of Honolulu Department of Community Services,  
7 AARP Hawaii, Healthcare Association of Hawaii, Kokua Council,  
8 Policy Advisory Board for Elder Affairs, Hawaii Association of  
9 Health Plans, Hawaii Health Systems Corporation, International  
10 Longshore and Warehouse Union Local 142 Hawaii, Hawaii Family  
11 Caregiver Coalition, Project Dana, and Hawaii Alliance for  
12 Retired Americans.



JAN 23 2015

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# A BILL FOR AN ACT

RELATING TO CAREGIVING.

**BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:**

1       SECTION 1. The legislature finds that Hawaii's population  
2 of older adults is rapidly increasing and the State relies  
3 heavily on unpaid caregivers, including family and friends, to  
4 provide long-term care and support. In 2012, Hawaii had the  
5 highest percentage of residents over the age of eighty-five in  
6 the United States and this population, most likely to need long-  
7 term care, is projected to grow 65 per cent over the next twenty  
8 years. The AARP Public Policy Institute estimated that in 2009,  
9 there were 247,000 caregivers in Hawaii who provided  
10 approximately 162,000,000 hours of unpaid care in the State, at  
11 a value of \$2,000,000,000.

12       The legislature further finds that the role of caregivers  
13 is expanding. While family caregivers have traditionally  
14 assisted with bathing, dressing, eating, and household tasks,  
15 including shopping and managing finances, it is now common for  
16 family caregivers to perform complex medical and nursing tasks  
17 that historically were only provided in hospitals and nursing



1 homes, including medication management, help with assistive  
2 mobility devices, preparation of special diets, and wound care.  
3 The rise in caregivers providing medical or nursing care is  
4 attributed to an increase in the prevalence of chronic  
5 conditions in older adults, economic pressures to reduce  
6 hospital stays, and reduction of formal home-care services due  
7 to the growth of in-home technology.

8       The legislature additionally finds that despite the  
9 critical and expanding role of caregivers serving Hawaii's aging  
10 population, caregivers are often left out of hospital  
11 discussions involving the patient's care and are expected to  
12 provide post-hospital care, including medical and nursing tasks,  
13 without any training or support from professionals.

14       According to the Hawaii Health Information Corporation, in  
15 2013, there were approximately five thousand five-hundred  
16 hospital readmissions, each lasting thirty days. These  
17 readmissions are associated with approximately \$239,000,000 in  
18 costs, and recently, 56 per cent of Hawaii's hospitals were  
19 penalized for excessive readmissions under the federal hospital  
20 readmissions reduction program.



1 To successfully address the challenges of a surging  
2 population of older adults and others who have significant needs  
3 for long-term care and support, including avoiding costly  
4 hospital readmissions, the State must develop methods to help  
5 caregivers support their loved ones at home and in the  
6 community. Ensuring that caregivers receive basic, uniform  
7 training and assistance from a facility where a family member is  
8 treated, regardless of the location of the facility, will  
9 support family caregivers.

10 The purpose of this Act is to enable caregivers to provide  
11 competent, post-hospital care to family members and other loved  
12 ones, at a minimal cost to the taxpayers, to complement  
13 initiatives that are being pursued by county agencies,  
14 hospitals, and insurance companies in efforts to reduce  
15 readmission rates and better train family caregivers.

16 SECTION 2. The Hawaii Revised Statutes is amended by  
17 adding a new chapter to be appropriately designated and to read  
18 as follows:

19 **"CHAPTER**

20 **HOSPITAL REQUIREMENTS REGARDING LAY CAREGIVERS**

21 **§ -1 Definitions.** For the purpose of this chapter:



1 "After-care" means any assistance provided by a caregiver  
2 to a patient following the patient's discharge from a hospital  
3 that is related to the patient's condition at the time of  
4 discharge, including but not limited to assisting with basic  
5 activities of daily living, instrumental activities of daily  
6 living, and other tasks as determined to be appropriate by the  
7 discharging physician or other health care professional licensed  
8 pursuant to chapter 453.

9 "Caregiver" means any individual duly designated by a  
10 patient to provide after-care to the patient in the patient's  
11 residence. The term includes but is not limited to a relative,  
12 spouse, partner, friend, or neighbor who has a significant  
13 relationship with the patient.

14 "Contact information" means legal name, phone number, email  
15 address, mailing address, and home address, where available.

16 "Discharge" means a patient's exit or release from a  
17 hospital to the patient's residence following any medical care  
18 or treatment rendered to the patient following an inpatient  
19 admission.

20 "Entry" means a patient's entrance into a hospital for the  
21 purposes of receiving in-patient medical care.



1 "Hospital" means a facility licensed under section  
2 321-14.5.

3 "Legally authorized representative" means legal guardians,  
4 health care agents, and surrogates (designated or selected by a  
5 consensus of interested persons).

6 "Residence" means a dwelling that the patient considers to  
7 be the patient's home and shall not include any rehabilitation  
8 facility, hospital, nursing home, assisted living facility, or  
9 group home licensed by the State.

10 **§ -2 Opportunity to designate caregiver.** (a) A  
11 hospital shall provide each patient or, if applicable, the  
12 patient's legally authorized representative, with an opportunity  
13 to designate one or more caregivers following the patient's  
14 entry into a hospital and prior to the patient's discharge to  
15 the patient's residence or transfer to another facility, in a  
16 timeframe that is consistent with the discharge planning  
17 process; provided that in the event that the patient is  
18 unconscious or otherwise incapacitated upon entry into a  
19 hospital, the hospital shall provide the patient or patient's  
20 legally authorized representative with an opportunity to  
21 designate a caregiver within a given timeframe, at the



1 discretion of the attending physician, following the patient's  
2 recovery of consciousness or capacity.

3 (b) If the patient or patient's legally authorized  
4 representative declines to designate a caregiver pursuant to  
5 subsection (a), the hospital shall promptly document this in the  
6 patient's medical record.

7 (c) If the patient or the patient's legally authorized  
8 representative designates an individual as a caregiver under  
9 this chapter, the hospital shall:

10 (1) Promptly request the written consent of the patient or  
11 the patient's legally authorized representative to  
12 release medical information to the patient's caregiver  
13 following the hospital's established procedures for  
14 releasing personal health information and in  
15 compliance with all federal and state laws and  
16 regulations. If the patient or the patient's legally  
17 authorized representative declines to consent to  
18 release medical information to the patient's  
19 caregiver, the hospital is not required to provide  
20 notice to the caregiver under section -3 or provide



1 information contained in the patient's discharge plan  
2 under section -4; and

3 (2) Record the patient's designation of caregiver, the  
4 relationship of the caregiver to the patient, and the  
5 contact information of the patient's caregiver in the  
6 patient's medical record.

7 (d) A patient may elect to change the patient's designated  
8 caregiver at any time. The hospital shall record this change in  
9 the patient's medical record, along with the contact information  
10 for the newly designated caregiver, before the patient's  
11 discharge to the patient's residence or transfer to another  
12 facility.

13 (e) A designation of caregiver by a patient or a patient's  
14 legally authorized representative under this section does not  
15 require the caregiver to perform any after-care for the patient.

16 (f) This section shall not be construed to require a  
17 patient or a patient's legally authorized representative to  
18 designate an individual as a caregiver.

19 § -3 Notice to caregiver. A hospital shall notify the  
20 patient's caregiver of the patient's discharge or transfer to  
21 another licensed facility as soon as possible and at the latest,





1 upon issuance of a discharge order by the patient's attending  
2 physician. If the hospital is unable to contact the designated  
3 caregiver, the lack of contact shall not interfere with, delay,  
4 or affect the medical care provided to the patient, or discharge  
5 of the patient. The hospital shall promptly document the  
6 attempt to contact the designated caregiver in the patient's  
7 medical record.

8       § -4 Instruction to caregiver; discharge plan. (a) As  
9 soon as possible and prior to a patient's discharge from a  
10 hospital, the hospital shall consult with the patient's  
11 caregiver regarding the caregiver's capabilities and limitations  
12 and issue a discharge plan to the caregiver that describes the  
13 patient's after-care needs, if any, at the patient's residence.  
14 The consultation and issuance of a discharge plan shall occur on  
15 a schedule that takes into consideration the severity of the  
16 patient's condition, the setting in which care is to be  
17 delivered, and the urgency of the need for caregiver services.  
18 In the event the hospital is unable to contact the caregiver,  
19 the lack of contact shall not interfere with, delay, or affect  
20 the medical care provided to the patient or the discharge or  
21 transfer of the patient. The hospital shall promptly document



1 the attempt to contact the caregiver in the patient's medical  
2 record. The discharge plan shall include but not be limited to  
3 the following:

4 (1) The name and contact information of the designated  
5 caregiver;

6 (2) A description of all after-care necessary to maintain  
7 the patient's ability to reside at home, taking into  
8 account the capabilities and limitations of the  
9 caregiver;

10 (3) Contact information for any health care community  
11 resources, and long-term services and supports  
12 necessary to successfully carry out the patient's  
13 discharge plan; and contact information for a hospital  
14 employee who can respond to questions regarding the  
15 discharge plan following the instruction provided  
16 pursuant to this section.

17 (b) The hospital issuing the discharge plan shall provide  
18 the caregiver with instruction in all after-care described in  
19 the discharge plan. Training and instructions for caregivers  
20 may be conducted in person or through video technology, at the  
21 discretion of the caregiver. Any training or instructions



1 provided to a caregiver shall be provided in non-technical  
2 language, to the extent possible. Instruction shall include but  
3 not be limited to the following:

4 (1) A live or recorded demonstration of the tasks,  
5 performed by an individual designated by the hospital  
6 who is authorized to perform the after-care task,  
7 provided in a culturally competent manner and in  
8 accordance with the hospital's requirements to provide  
9 language access services under state and federal law;

10 (2) An opportunity for the caregiver to ask questions  
11 regarding caregiver instructions and receive answers  
12 in a culturally competent manner, in accordance with  
13 the hospital's requirements to provide language access  
14 services under state and federal law; and

15 (3) A written summary and description of the instructions  
16 provided.

17 (c) Any caregiver instruction required under this chapter  
18 shall be documented in the patient's medical record. At a  
19 minimum, the patient's medical record shall reflect the date,  
20 time, and content of the instruction.



(d) The department of health may adopt rules pursuant to chapter 91 to carry out the purpose of this chapter, including rules to further define the content and scope of any instruction provided to caregivers under this chapter.

**§ -5 Non-interference with existing health care directives.** Nothing in this chapter shall be construed to interfere with the rights of an agent operating under a valid health care directive under section 327G-3.

**§ -6 Limitation of liability.** (a) Nothing in this chapter shall be construed to give rise to a private cause of action against a hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital.

(b) A hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital shall not be held liable for the services rendered or not rendered by the caregiver to the patient at the patient's residence.

**§ -7 Discharge; transfer of patient.** Nothing in this chapter shall delay the discharge of a patient or the transfer of a patient from a hospital to another facility."



1 SECTION 3. If any provision of this Act, or the  
 2 application thereof to any person or circumstance, is held  
 3 invalid, the invalidity does not affect other provisions or  
 4 applications of the Act that can be given effect without the  
 5 invalid provision or application, and to this end the provisions  
 6 of this Act are severable.

7 SECTION 4. This Act does not affect rights and duties that  
 8 matured, penalties that were incurred, and proceedings that were  
 9 begun before its effective date.

10 SECTION 5. This Act shall take effect on July 1, 2016.  
 11

INTRODUCED BY:

*[Handwritten signature]*  
                    

*[Handwritten signature: Joanne Chun Oakland]*

*[Handwritten signature]*  
                    

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**Report Title:**

Kupuna Caucus; Human Services; Hospitals; Caregivers; Training

**Description:**

Requires hospitals to provide patients the opportunity to designate a caregiver upon entry to a hospital. Establishes hospital requirements regarding caregivers, including designation of a caregiver, notification to a caregiver, and a discharge plan for patients. Provides hospitals, hospital employees, and consultants or contractors that have a contractual relationship with a hospital with immunity regarding caregiving. Effective 7/1/16.

*The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.*



## Appendix C

### Comparison Table of State Caregiver Advise, Record, Enable (CARE) Acts

Major Substantive Provisions	HI	AR	CA	CO	CT	IL	IN	ME	MS	NV	NH	NJ	NM	NY	OK	OR	RI	VA	WV
<b>§ -1 Definitions.</b> For the purpose of this chapter:	1	2		1	504c a	5		1	1		42	25	K	II	2	1	1		1
"After-care" means any assistance provided by a caregiver to a patient following the patient's discharge from a hospital that is related to the patient's condition at the time of discharge, including but not limited to assisting with basic activities of daily living, instrumental activities of daily living, and other tasks as determined to be appropriate by the discharging physician or other health care professional licensed pursuant to chapter 453.	1	2(1)		1a	504c a4	5	1	1A	1a	4	42 I	25	K1	II 2	2(1)	1a	1(1)		1(1)
"Caregiver" means any individual duly designated by a patient to provide after-care to the patient in the patient's residence. The term includes but is not limited to a relative, spouse, partner, friend, or neighbor who has a significant relationship with the patient.	1	2(2)	m	1b	504c a1	5	5		1d	5	42 II	25	K4	II 3	2(4)	1c	1(2)		1(4)
"Contact information" means legal name, phone number, email address, mailing address, and home address, where available.	1																		
"Discharge" means a patient's exit or release from a hospital to the patient's residence following any medical care or treatment rendered to the patient following an inpatient admission.	1	2(4)				5	3	1B	1b		42 III	25	K2	II 4	2(2)	1b	1(3)		1(2)
"Entry" means a patient's entrance into a hospital for the purposes of receiving in-patient medical care.	1										42 IV	25		II 5			1(4)		
"Hospital" means a state licensed facility.	1	2(5)		1c	504c a3	5			1c		42 V	25	K3	II 1	2(3)		1(5)		1(3)
"Legally authorized representative" means legal guardians, health care agents, and surrogates (designated or selected by a consensus of interested persons).	1	2(6)				5	4			6	42 VI								
"Patient" means an individual admitted to a hospital as an inpatient. "Patient" does not include a pediatric patient or a patient who is not capable of designating a caregiver due to a health care condition or other circumstances, as determined by the health care provider.		2(7)				5								II 6			1(6)		

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"Residence" means a dwelling that the patient considers to be the patient's home and shall not include any rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed by the State.	1	2(8)		1d	504c a2	5	6	1C	1e		42 VII	25	K5	II 7	2(5)		1(7)		1(5)
<b>§ -2 Opportunity to designate caregiver.</b> (a) A hospital shall provide each patient or, if applicable, the patient's legally authorized representative, with an opportunity to designate one or more caregivers following the patient's entry into a hospital and prior to the patient's discharge to the patient's residence or transfer to another facility, in a timeframe that is consistent with the discharge planning process; <con't>	2a	3a1	c	2a	504c d	10a	7a	2A	3(1)	8 (1)	43 I	26a	A	JJ1	3A	2b	2a	A i	2a1
<con't> provided that in the event that the patient is unconscious or otherwise incapacitated upon entry into a hospital, the hospital shall provide the patient or patient's legally authorized representative with an opportunity to designate a caregiver within a given timeframe, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity.	2a		cA	2b		10b		2B	3(1) a	8 (2)	43 Ia	26b		JJ1A	3A1		2a1	A ii	2a2
(b) If the patient or patient's legally authorized representative declines to designate a caregiver pursuant to subsection (a), the hospital shall promptly document this in the patient's medical record.	2b		cB	2d		10c	7b	2C	3(1) b	9 (2)	43 Ib	26c	F	JJ1B	3A2		2a2	A ii	2a3
(c) If the patient or the patient's legally authorized representative designates an individual as a caregiver under this chapter, the hospital shall:	2c			3a	504c e	10d	7c	3	3(1) c	9 (1)b	43 Ic	26d		JJ1E I	3A3		2a3		2a4
(1) Promptly request the written consent of the patient or the patient's legally authorized representative to release medical information to the patient's caregiver following the hospital's established procedures for releasing personal health information and in compliance with all federal and state laws and regulations. <con't>	2c1			3a			7c1	3	3(1) c	9 (1)b	43 Ic1	26d 1		JJ1E I	3A3	6b	2a3 ii		2a4
<con't>If the patient or the patient's legally authorized representative declines to consent to release medical information to the patient's caregiver, the hospital is not required to provide notice to the caregiver under section -3 or provide information contained in the patient's discharge plan under section -4; and	2c1	3d1							3(1) d		43 Ic1	26d 1a		JJ1E II	3A4	6b	2a3 iiA		2a5

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(2) Record the patient's designation of caregiver, the relationship of the caregiver to the patient, and the contact information of the patient's caregiver in the patient's medical record.	2c2			3b	504c e1	10d	7c2	2C	3(1) e	9 (1)a	43 lc2	26d 2		JJ1C	3A5	3a	2a3 i	A ii	2a6
(d) A patient may elect to change the patient's designated caregiver at any time. The hospital shall record this change in the patient's medical record, along with the contact information for the newly designated caregiver, before the patient's discharge to the patient's residence or transfer to another facility.	2d	3a2		3c		10e		2C	3(2)	7 (3)	43 ld	26e	C	JJ1D	3B		2a4	B	2b
(e) A designation of caregiver by a patient or a patient's legally authorized representative under this section does not require the caregiver to perform any after-care for the patient.	2e	3b		3d	504c d	10f	13	2D	3(3)	7 (4)	43 ll	26g	D	JJ2	3C		2b	E	2c
(f) This section shall not be construed to require a patient or a patient's legally authorized representative to designate an individual as a caregiver.	2f	3c		2c	504c d	10g	7a & 12	2D	3(4)		43 lll	26f	E	JJ3	3D		2c		2d
<b>§ -3 Notice to caregiver.</b> A hospital shall notify the patient's caregiver of the patient's discharge or transfer to another licensed facility as soon as possible and at the latest, upon issuance of a discharge order by the patient's attending physician. <con't>	3	5a	d	4	504c e2	15	8c	4	5	10	44	27		KK	4	2e	3a	C	3
<con't>If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or affect the medical care provided to the patient, or discharge of the patient. <con't>	3	5b	d	4	504c e2	15, 20c, & 30	11	4	5	12 (2)		27	G & H	KK	4	6a	3a		3
<con't>The hospital shall promptly document the attempt to contact the designated caregiver in the patient's medical record.	3		d	4				4		12 (1)a		27		KK			3a		3
<b>§ -4 Instruction to caregiver; discharge plan.</b> (a) As soon as possible and prior to a patient's discharge from a hospital, the hospital shall consult with the patient's caregiver regarding the caregiver's capabilities and limitations and issue a discharge plan to the caregiver that describes the patient's after-care needs, if any, at the patient's residence. <con't>	4a	6a1	e	5a	504c e3	20a	9a2	5		11 (1)	45 l	28a	B & B3	LL1	5	2c, 2d, & 5	4a	D	4a

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<con't>The consultation and issuance of a discharge plan shall occur on a schedule that takes into consideration the severity of the patient's condition, the setting in which care is to be delivered, and the urgency of the need for caregiver services.<con't>	4a		j			20a						28a				6a	4a		
<con't>In the event the hospital is unable to contact the caregiver, the lack of contact shall not interfere with, delay, or affect the medical care provided to the patient or the discharge or transfer of the patient. <con't>	4a	6c	d			20a				12 (2)		28a		LL1	5	6a	4e		
<con't>The hospital shall promptly document the attempt to contact the caregiver in the patient's medical record. <con't>	4a		d							12 (1)a		28a		LL1					
<con't>The discharge plan shall include but not be limited to the following:	4a					20a				11 (1)	45 I	28a		LL1			4b1	C	4a
(1) The name and contact information of the designated caregiver;	4a1			5a I						11 (1)a	45 Ia	28a 1		LL1A			4b1 i	C i	4a1
(2) A description of all after-care necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the caregiver;	4a2	6b2		5a II		20a 1				11 (1)b	45 Ib	28a 2		LL1B		5	4b1 ii	C ii	4a2
(3) Contact information for any health care community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan; and contact information for a hospital employee who can respond to questions regarding the discharge plan following the instruction provided pursuant to this section.	4a3		f & h	5a III		20a 2	9b			11 (1)c	45 Ic	28a 3		LL1C			4b1 iii	C iii	4a3
(b) The hospital issuing the discharge plan shall provide the caregiver with instruction in all after-care described in the discharge plan. <con't>	4b	6b2	e	5b	504c e3	20b				11 (2)	45 II	28b		LL2			4c	D	4b
<con't> Training and instructions for caregivers may be conducted in person or through video technology, at the discretion of the caregiver. <con't>	4b				504c e3	20b				11 (2)				LL2A I					
<con't> Any training or instructions provided to a caregiver shall be provided in non-technical language, to the extent possible. Instruction shall include but not be limited to the following:	4b		e		504c e3	20b		6		11 (2)	45 II	28b					4c		4b1

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(1) A live or recorded demonstration of the tasks, performed by an individual designated by the hospital who is authorized to perform the after-care task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law;	4b1			5b I	504c e3	20b 1	10b			11 (2)	45 IIa1	28b 1	B1a	LL2A I			4c1 i & iii	D	
(2) An opportunity for the caregiver to ask questions regarding caregiver instructions and receive answers in a culturally competent manner, in accordance with the hospital's requirements to provide language access services under state and federal law; and	4b2	6a2	e	5b II & III	504c e3	20b 2 & 3	10a	6	7	11 (2)	45 IIa2 & 3	28b 2 & 3		LL2A II & III			4c1 ii & iii	D	4b2 & 3
(3) A written summary and description of the instructions provided.	4b3																		
(c) Any caregiver instruction required under this chapter shall be documented in the patient's medical record. At a minimum, the patient's medical record shall reflect the date, time, and content of the instruction.	4c			5c	504c e4					12 (1)a	45 IIb	28c		LL2B			4c2	C	4c
(d) The department of health may adopt rules pursuant to chapter 91 to carry out the purpose of this chapter, including rules to further define the content and scope of any instruction provided to caregivers under this chapter.	4d			7				8			45 III	32		LL3			4d	I	
<b>§ -5 Non-interference with existing health care directives.</b> Nothing in this chapter shall be construed to interfere with the rights of an agent operating under a valid health care directive under section 327G-3.	5			6a	— d4	25	15a	7	9(1)		46 II	29a		MM 1	6A		5a	H	5a
<b>§ -6 Limitation of liability.</b> (a) Nothing in this chapter shall be construed to give rise to a private cause of action against a hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital.	6a	7a2		6b	— a	30	15b		9(2)		46 I	30a	I1	MM 2	6B		7a	F	5b
(b) A hospital, hospital employee, or a consultant or contractor that has a contractual relationship with a hospital shall not be held liable for the services rendered or not rendered by the caregiver to the patient at the patient's residence.	6b	7b			— b	30	15c			13		30b	J	MM 3			7b	G	5c
This section shall not create additional civil or regulatory liability for a hospital or hospital employee				6c															
This subchapter shall not confer upon the caregiver any authority to make healthcare decisions on behalf of the patient.		7a1																	

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This subchapter shall not remove the obligation of a third-party payer to cover a healthcare item or service that the third-party payer is obligated to provide to a patient under the terms of a valid agreement, insurance policy, plan, or certification of coverage or health maintenance organization contract.		7a3			___c							30c	l2						
A caregiver shall not be reimbursed by any government or commercial payer for after-care assistance that is provided pursuant to this act.					— d1		16		11			30d 1			7		6a		6
Nothing in this act shall be construed to impact, impede, or otherwise disrupt or reduce the reimbursement obligations of an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization, or any other entity issuing health benefits plans.					— d2							30d 2					6b		
<b>§ -7 Discharge; transfer of patient.</b> Nothing in this chapter shall delay the discharge of a patient or the transfer of a patient from a hospital to another facility.	7		k1		— d3	30	11			12 (2)	46 III	31	H			6a	4e		

For citation to the full statute or act, add the information in each cell to the blanks below as follows:

- HI (Hawaii): Hawaii Senate Bill No. 296, Section. 2, § \_\_\_\_ (2015). For example, "2a" represents "Hawaii Senate Bill No. 296, Section. 2, § **2(a)** (2015)."
- AR (Arkansas): Ark. Code. Ann. section 20-77-260\_\_\_\_. The first number is part of the section number. For example, "3a1" represents "Ark. Code. Ann. section 20-77-260**3(a)(1)**"
- CA (California): Cal. Health & Safety Code section 1262.5\_\_\_\_. For example, "c" represents "Cal. Health & Safety Code section 1262.5**(c)**."
- CO (Colorado): Colo. Rev. Stat. section 25-1-128\_\_\_\_. For example, "2a" represents "Colo. Rev. Stat. section 25-1-128**(2)(a)**."
- CT (Connecticut): 2015 Conn. Acts 15-32, 19a- \_\_\_\_ Reg. Sess. Note: the first number is the section number. For example, "504c d" represents "2015 Conn. Acts 15-32, 19a-**504c(d)** Reg. Sess."
- IL (Illinois): 210 Ill. Comp. Stat. 91/\_\_\_\_. The first number is the section number. For example, "10a" represents 210 Ill. Comp. Stat. 91/**10(a)**."
- IN (Indiana): Ind. Code. Section 16-21-12-\_\_\_\_. The first number is the section number. For example, "7a" represents "Ind. Code. Section 16-21-12-**7(a)**."
- ME (Maine): Me. Rev. Stat. tit. 22, section 1711-G\_\_\_\_. For example, "2A" represents "Me. Rev. Stat. tit. 22, section 1711-G**(2)(A)**."
- MS (Mississippi): Miss. Code Ann. section 41-133-\_\_\_\_. The first number is the section number. For example, "3(1)" represents "Miss. Code Ann. section 41-133-**3(1)**."
- NV (Nevada): 2015 Nev. Stat. Chapter 37 (Senate Bill No. 177), sec. \_\_\_\_ . The first number is the section number. For example, "8(1)" represents "2015 Nev. Stat. Chapter 37 (Senate Bill No. 177), sec. **8(1)**."
- NH (New Hampshire): N.H. Rev. Stat. section 151:\_\_\_\_. The first number is the section number. For example, "43 I" represents "N.H. Rev. Stat. section 151:**43(I)**."
- NJ (New Jersey): N.J. Rev. Stat. section 26:2H-5.\_\_\_\_. The first number is part of the section number. For example, "26a" represents "N.J. Rev. Stat. section 26:2H-5.**26(a)**"
- NM (New Mexico): N.M. Stat. section 24-1-37\_\_\_\_. For example, "A" represents "N.M. Stat. section 24-1-37**(A)**."
- NY (New York): N.Y. Pub. Health Law section 2994-\_\_\_\_. The first number is the section number. For example, "JJ1" represents "N.Y. Pub. Health Law section 2994-**JJ(1)**."
- OK (Oklahoma): Okla. Stat. tit. 63, section 311\_\_\_\_. The first number is part of the section number. For example, "3A" represents "Okla. Stat. tit. 63, section 311**3(A)**."
- OR (Oregon): 2015 Or. Laws Chapter 263, (House Bill 3378 A) sec. 2\_\_\_\_. For example, "2b" represents "2015 Or. Laws Chapter 263, (House Bill 3378 A) sec. **2(2)(b)**."
- RI (Rhode Island): R.I. Gen. Laws section 23-17.27-\_\_\_\_. The first number is the section number. For example, "2a" represents "R.I. Gen. Laws section 23-17.27-**2(a)**."
- VA (Virginia): Va. Code section 32.1-137.03\_\_\_\_. For example, "A i" represents "Va. Code section 32.1-137.03**(A)(i)**."
- WV (West Virginia): W. Va. Code section 16-5X-\_\_\_\_. The first number is the section number. For example, "2a1" represents "W. Va. Code section 16-5X-**2(a)(1)**."