

**Human Services Interim Committee
Testimony Regarding Caregiver Supports and Services**

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**BevAnn Walth, Director of Case Management and Social Work
CHI St. Alexius Health, Bismarck, ND**

INTRODUCTION:

Good Morning Representative Hogan and Committee Members
My name is BevAnn Walth. I am the Director of Case Management and Social Work at CHI St. Alexius Health.

EXPERIENCE:

I have been at CHI ST. Alexius Health for 35 years. During my first 20 years, I worked as a social worker primarily doing discharge planning. For the past 15 years I have been in a management role with the Case Management and Social Work Departments. Our primary role is assisting with discharge evaluations and discharge planning. As part of my responsibilities, I review the CMS Conditions of Participation and The Joint Commission Standards that relate to hospital discharge planning. I have co-chaired several committees in relation to discharges, (Discharge Planning Team, Discharge Readiness Team, and Discharge Improvement Team). I am also the Chair person of the Patient Rights Chapter for Joint Commission Accreditation for over 15 years. Many of the Patient Rights Standards focus on the patient's right to make decisions about their Care Plan and their Discharge Plan.

TESTIMONY CONTENT:

Today I would like to address two primary issues regarding discharge planning as they relate to this bill being proposed. The first one I will discuss is the current regulatory standards regarding discharge planning, the second one is the actual discharge planning process that takes place in hospitals. I will start with listing the current standards and expectations placed on hospitals and then I will briefly explain each of them.

I. CURRENT REGULATORY REQUIREMENTS:

Hospital discharge planning is currently regulated by:

1. Center for Medicare and Medicaid thru Conditions of Participation (CMS CoP)
2. New CMS Proposed Rules for Discharge Planning
3. The Joint Commission Standards for Accreditation (TJC)
4. Value Based Purchasing Program (VBP)
5. Important Message from Medicare (IMM)

1. CMS developed **Conditions of Participation** that hospitals must meet in order to participate in the Medicare and Medicaid programs. The purpose of these standards is to improve quality and to protect the health and safety of beneficiaries. The discharge planning requirements were published in 1994 and

were refined in 2004. CMS updated the interpretive guidance in 2013. CMS uses state surveyors to monitor and assess hospitals compliance with these regulations.

(A copy of the Conditions of Participation is located in your packet)

2. In November of 2015, CMS released their proposed new rules for Hospital Discharge Planning. You have a 70 page document that goes into detail about these rules, but I want to point out a few that are specific to our discussion today.

The new rules require that:

- A. Patients have a written discharge plan developed
- B. Patients have specific discharge instructions provided in writing
- C. Patient's goals and preferences for their discharge plan are taken into account
- D. Patient's caregivers /support person(s) are active partners in the discharge plan/care
- E. Hospitals consider the availability and capability of the caregiver to provide home care
- F. Discharge Planning begins within 24 hrs of admission
- G. Discharge Planning Process is completed prior to the discharge.
- H. Discharge instructions are presented in a way that the patient and the caregiver can understand. CMS is recommending that hospitals consider the use of "teach back" to confirm that the patient and caregiver have a clear understanding of the instructions, especially in relation to medication.

Some of these requirements are already in place, but the new rules provide additional clarification. All of these requirements must be documented in the patient's medical record.

3. The Joint Commission evaluates and accredits nearly 21,000 health care organizations and programs in the United States. The survey process is data driven, patient-centered and focused on evaluating actual care processes. Joint Commission uses the tracer methodology which uses actual patients for assessing compliance with their standards. These tracers follow the care of the patient throughout their entire healthcare experience, from the time of admission to the time of discharge. Most of these standards and elements of performance require a Measure of Success (MOS) which hospitals must be able to validate thru written documents, collected data, and identified monitors.
4. The Value Based Purchasing Program is part of the Center for Medicare and Medicaid Services (CMS) that links Medicare payment to a value-based system in order to improve the quality of care provided in the inpatient hospital setting. Two of these measures involve discharge planning .One is actual Discharge Instructions and the other one is based on the patient's satisfaction with the Discharge Information provided. This program uses the hospital quality data reporting infrastructure to calculate VBP score which determines payment.

5. The Important Message from Medicare (IMM) is a notice given to hospitalized inpatient's covered by Medicare, informing them of their hospital discharge appeal rights. The notice informs patients of their right to receive medically necessary hospital services and services they may need after discharge. It also lets the patient know they have the right to be involved in any decisions about their hospital stay and gives them contact information if they have any quality of care concerns. There is an entire section that addresses Medicare Discharge Rights. If a patient feels they are being discharged too soon they can file an appeal with the QIO. (Quality Improvement Organization) Hospitals are required by CMS to provide the initial notice within 2 days of admission. This notice must be signed by the patient. This notice is then given again within 2 days prior to discharge.

II. DISCHARGE PLANNING PROCESS

Hospitals may have different discharge processes but we are all required to follow the rules and standards established by the Center for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC).

Discharge planning really does begin at the time of admission. The case manager and/or social worker meets with the patient and/or family to assess the living situation and identify who is available to help the patient at home at the time of discharge. Based on the assessments that are done at that time, along with the patient and family, we identify what post discharge needs the patient might need. We have a multi disciplinary team that meets every morning and reviews all the patients on that unit. The team consists of the physician, nurse, case manager, social worker, and any therapists directly involved with caring for the patient. During these daily meetings we review the care plan for each patient, talk about any changes in their status, review the patients goals, their discharge plans, discuss any barrier for discharge and any concerns that either the patient or the care team have regarding the patient. If the patient would benefit from receiving services, the social worker provides the patient and family/caregiver a list of possible resources and then makes referrals accordingly. If the patient needs medical equipment we will try and get that equipment set up right away.

The team continually reevaluates the discharge plans with the patient and family depending on any changes that may occur during the hospitalization. When the patient is ready for discharge, the patient and/or family is given a written copy of discharge instructions. The nurse reviews the instructions and goes over the medications prescribed. If needed, we do have pharmacists that can also provide medication education. We make sure all the referrals have been made and the contact information is documented in the medical record and in the discharge instructions. Follow up appointments are too made prior to the patients discharge.

There are times that the care team thinks the patient is going to need more care than can be provided at home. We will talk to the patient and the family about our concerns and will recommend a different discharge option. But, ultimately the patient has the right to make that decision and as long as they are competent we must respect that decision. So sometimes patients are discharged home and the caregiver is placed in a position that they may not be able to provide the care needed.

Before I close, I do want to talk about some of the changes we are seeing in how healthcare is being provided to patients. These changes will have a very positive impact on discharge planning. We now have Accountable Care Organizations (ACO) and Bundled Payment Programs in our region. The goal of these programs is to assist providers in improving clinical outcomes and prevent re admissions. This includes the Medicare Shared Program and the new Comprehensive Care for Joint Replacement program. These are both Medicare programs and patients in these programs have a navigator or coach assigned to them to assist with their medical care plan. Patients are seen prior to discharge, during the hospitalization, and at their follow up clinic appointments to make sure that there are no problems following discharge. BCBS also has a new program called Patient Centered Medical Home (PCMH). This program is based in the clinics and also uses nurse navigators who provide similar services to all of their beneficiaries.

CLOSING COMMENTS:

As you can see, hospitals already have numerous regulations, rules, and standards for discharge planning. CMS and TJC have survey programs and processes in place to make sure we are compliant. This past year, CHI St. Alexius Health had eight surveys either by CMS or TJC. Every certified program that hospitals have is subject to these surveys. Stroke, Cancer, Bariatric, Psychiatry, Transitional Care, and Rehab to mention just a few. Turtle Lake, which is a Critical Access Hospital, had three surveys of their own.

Between our 2 local hospitals we have thousands of discharges every year.

Does everything always go right with our discharge processes? No, of course not.

But I can assure you, it is not because we do not have enough regulations in place.

Hospitals do not take discharge planning lightly. We know that if we have a failed discharge, the chance of readmission increases. We are constantly looking at ways that we can improve the process.

The health and safety of our patients are very important to all of us and we will continue to work very hard to make sure that every discharge is a safe discharge.

Representative Hogan and Committee Members, thank you for your time and attention.

RELATED ACRONYMS

CMS	Center for Medicare and Medicaid Services
CoP	Conditions of Participation
TJC	The Joint Commission
MOS	Measure of Success
VBP	Value Based Purchasing
IMM	Important Message from Medicare
ACO	Accountable Care Organization
MSSP	Medicare Shared Savings Program
CCJR	Comprehensive Care for Joint Replacement
PCMH	Patient Centered Medical Home
QIO	Quality Improvement Organization