



The CARE Act

PHSA 14313

**Providence AK Learning
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Course Purpose

To assist hospital RNs in understanding the CARE Act, a new Alaska state law related to discharge planning and processes.

To examine the CARE Act's implications for Providence Alaska Medical Center and its caregivers.



Learner Outcomes

At the end of this module, the RN caregiver will:

- Provide opportunity for patient to designate a caregiver for aftercare needs during admission process
- Include patient and designated caregiver in discharge planning process.
- Document required admission, education, and discharge elements in EPIC
- Relate a practice tip you have learned



Required Documentation

In this module, you will learn more details about required EPIC documentation. See table below.

Required Documentation		
Admission	Education	Discharge
<ul style="list-style-type: none"> • Discharge Planning Screen • Designated Caregiver Screen • Initial Disability Screen 	<ul style="list-style-type: none"> • Unresolved Education Screen <ul style="list-style-type: none"> ▪ Select teaching point(s) ▪ Select “DFC: Designated Family Caregiver” to identify education/training provided to designated caregiver 	<ul style="list-style-type: none"> • Select <i>Discharge Designated Caregiver</i> from Discharge Checklist <ul style="list-style-type: none"> ▪ Note time Designated Caregiver notified of discharge order • Complete <i>Discharge Instructions</i>, add related care handouts • Complete <i>Follow-up</i> • Completes Progress Note at discharge using SmartText .ORDCGOAL

Discharge Planning Requirements

- Current discharge planning requirements are based upon new Federal requirements related to:
 - Medicare Conditions of Participation (42 CFR Part 482)
 - Joint Commission (discharge summary standards)
- Until Senate Bill 72: The CARE Act, there were no state laws specifically for discharge planning



Alaska Senate Bill 72

- Alaska SB 72 is “An Act relating to the discharge of patients from hospitals and to caregivers of patients after discharge from a hospital.”
 - Effective date of SB 72 was January 1, 2017
 - Alaska law (SB 72) was adopted from the AARP CARE Act Model as operationalized in California and Oregon
 - CARE = **C**aregiver, **A**dvice, **R**ecord, **E**nable ACT (CARE Act)



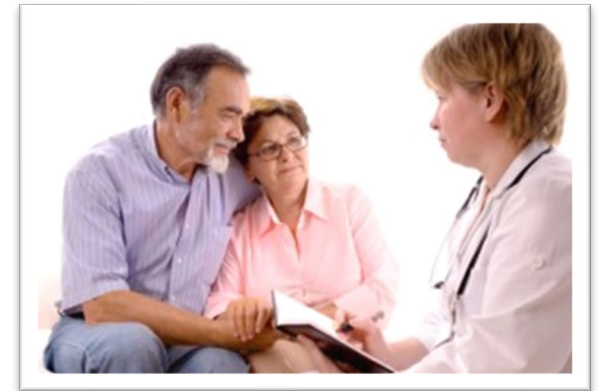
Alaska CARE Act

- Requires hospitals to adopt and maintain written discharge policies containing specified elements of the Alaska CARE Act.
- It is not necessary for the patient to designate a caregiver if discharge plan includes discharge to another facility not considered to be a private residence. (see table below for discharge destinations)

Private Residence (Yes to Designated Caregiver)	Not A Private Residence (No to Designated Caregiver)
<ul style="list-style-type: none"> • Acute care hospitals discharging patients to a private residence • What is a private residence? <ul style="list-style-type: none"> ◦ Home/Apartment ◦ Car/motor home ◦ Other location patient designates as his/her living space 	<ul style="list-style-type: none"> • Rehabilitative facility • Another hospital • A nursing home • An assisted living home • A group home • Another licensed health care facility • Patients in a “swing” bed • Subacute facilities

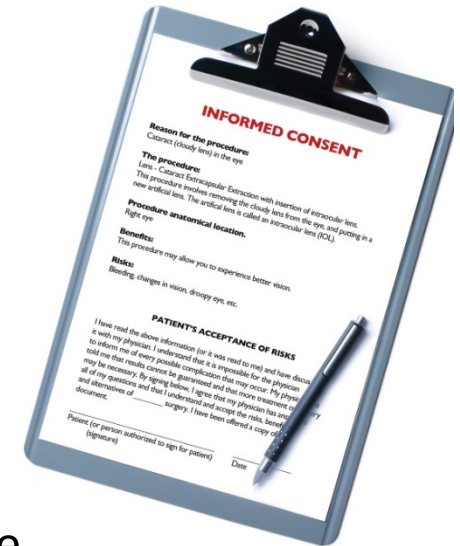
What is a Designated Caregiver?

- A designated caregiver is a relative, significant other, or friend who agrees to provide care to the patient after hospital discharge.
 - The person designated as caregiver consents to providing aftercare for the patient.
 - The nurse documents designated caregiver name and contact information in EPIC.
- The designated caregiver for aftercare may not interfere with the powers or duties of the patient's:
 - Agent under a valid advanced health care directive
 - Legal guardian



Obtaining Patient Consent

- Patient signs the “Consent to Treat” form upon admission. The patient’s signature on this form permits staff to share his/her protected health information regarding diagnosis, treatment plan, and follow-up care for purposes of educating and training the designated caregiver.
 - The designated caregiver and patient are both given a copy of discharge instructions at the time of discharge
 - The designated caregiver **does not** have the right to view or obtain copies of the patient medical record without written permission from the patient
 - The designated caregiver role is to provide aftercare for the patient following discharge



SB 72 Alaska CARE Act Details

Section 18.20.500- Aftercare assessment and designation of caregiver by hospital

- RN completing patient's admission assessment assesses the patient's ability for self-care after discharge.
- RN provides the patient an opportunity to designate a caregiver who agrees to provide aftercare in a private residence following hospital discharge.

(See **Required Documentation** table on page 4)



- RN documents the designated caregiver name and contact information in EPIC.
- Aftercare includes assistance with:
 - Activities of daily living
 - Wound care, medication administration, medical equipment operation, mobility assistance, and other medical/nursing tasks
 - Other assistance related to patient condition at time of discharge.

SB 72 Alaska CARE Act Details

Section 18.20.510 Planning, instruction, and training

- PAMC shall give the patient and designated caregiver the opportunity to participate in discharge planning prior to patient discharge.
- Patient and designated caregiver are provided with education and training as needed for the designated caregiver to perform aftercare following patient discharge.
 - Education and training is provided by
 - RN
 - Physician or LIP
 - Therapies (PT, OT, SLP, RT)
 - Other disciplines (e.g., Dietician, Diabetic Educator, Pharmacist, etc.)



SB 72 Alaska CARE Act Details

Section 18.20.530 Discharge policies

- Discharge plan is appropriate to meet needs of patient condition and abilities of designated caregiver.
- PAMC maintains written policies to be compliant with SB 72
 - Admissions, Direct Admits, Transfers into PAMC, and Patient Placement Process (PolicyStat ID: 1626675)
 - Education, Patient and/or Family (PolicyStat ID: 3033722)
 - Discharge of Patient Process (PolicyStat ID: 3375144)
- On discharge, the RN will document:
 - Discharge instructions, add pertinent education handouts and follow up care in After Visit Summary (AVS) in EPIC
 - Progress note at discharge using SmartText **.ORDCGOAL**
 - Provides a copy of discharge plan to both patient and designated caregiver



SB 72 Alaska CARE Act Details

Section 18.20.520 Notification of Discharge

- PAMC notifies the patient's designated caregiver of the patient's discharge or transfer.
 - The RN assigned to the patient contacts the designated caregiver when the discharge order is received
 - If RN unable to call, will delegate the charge nurse to contact the designated caregiver



Summary of Learning

The Care Act allows the patient to designate a caregiver to assist him/her with aftercare following hospital discharge.

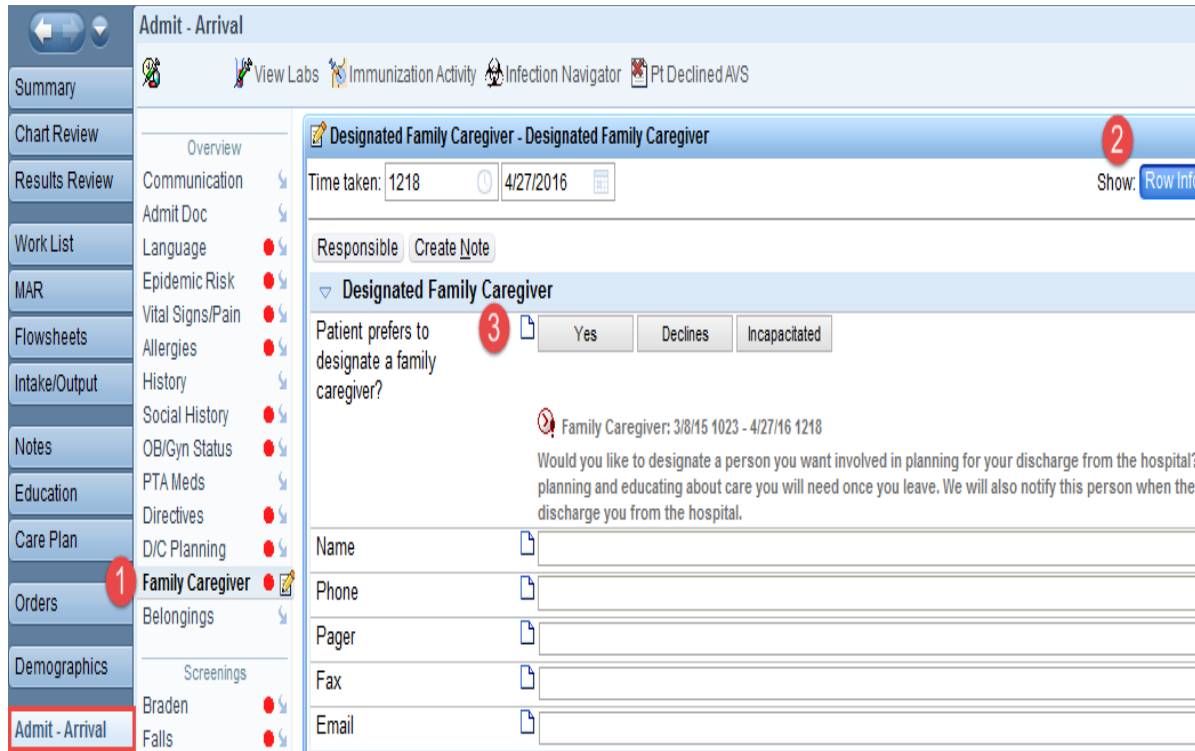
The patient and designated caregiver are given the opportunity to participate in discharge planning and receive education/training to prepare for aftercare needs at home.

The nurse's role is instrumental in assessing post-discharge patient needs including patient's ability to perform self-care, and ensuring the designated caregiver has the education/training necessary to safely manage the patient's on going care needs after discharge.

Next you will review slides of required EPIC documentation.



Designated Caregiver



Admit - Arrival

Summary

Chart Review

Results Review

Work List

MAR

Flowsheets

Intake/Output

Notes

Education

Care Plan

Orders

Demographics

Admit - Arrival

View Labs

Immunization Activity

Infection Navigator

PT Declined AVS

Designated Family Caregiver - Designated Family Caregiver

Time taken: 1218 4/27/2016 Show: Row Info

Responsible Create Note

Designated Family Caregiver

Patient prefers to designate a family caregiver? Yes Declines Incapacitated

Family Caregiver: 3/8/15 1023 - 4/27/16 1218

Would you like to designate a person you want involved in planning for your discharge from the hospital? V planning and educating about care you will need once you leave. We will also notify this person when the pl discharge you from the hospital.

Name

Phone

Pager

Fax

Email

- 1 Open the Admit-Arrival navigator and click on Family Caregiver.
- 2 Click Row Info to guide you in the conversation with the patient. If the patient elects to designate a caregiver, ensure the caregiver understands and agrees to the role.
- 3 Document designated caregiver name and contact information. Complete required documentation.

FYI: "Family" was added to designated caregiver in EPIC to comply with California CARE Act law.

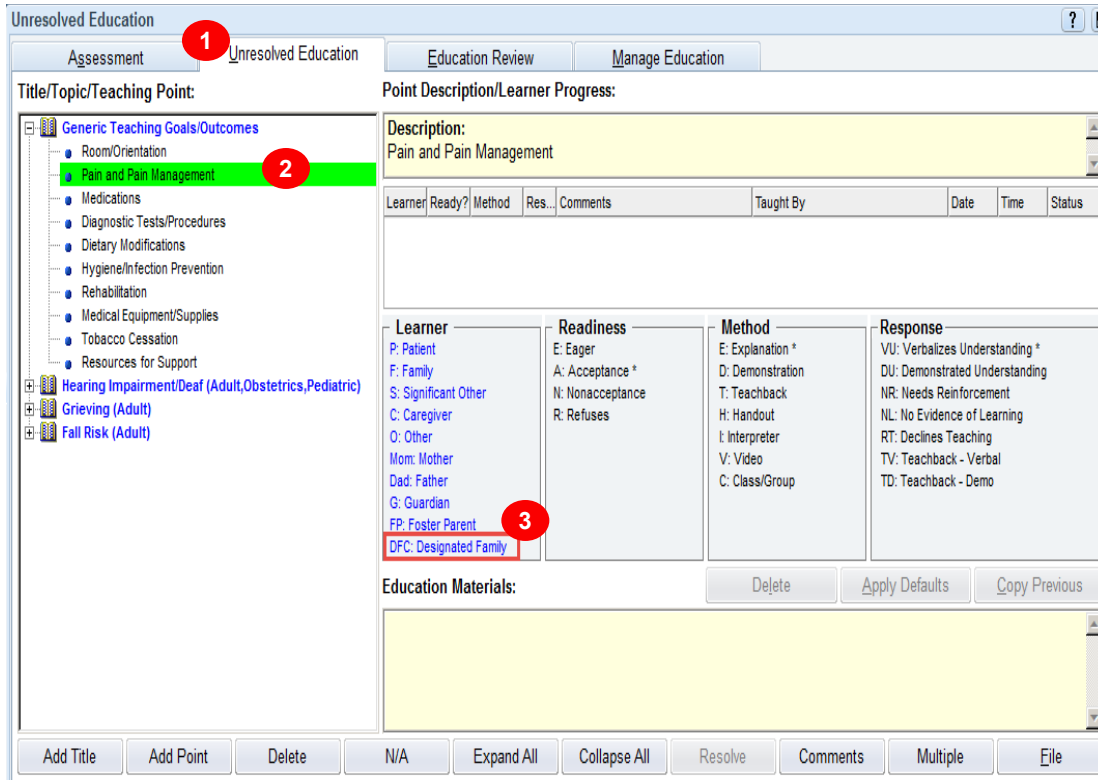
Flowsheet

Vital Signs Complex	Intake/Output	Adult PCS Body System	Discharge Planning	CM/SW Assessment	LDA
Mode: <input type="button" value="Accordion"/> <input type="button" value="Expanded"/> <input type="button" value="View All"/>					
Information Data	<input checked="" type="checkbox"/>				1m 5m 10m 15m 30m 1h 2h 4h 8h
Readmission Information	<input checked="" type="checkbox"/>				Admission
Contact Information	<input checked="" type="checkbox"/>				10/22/15
Designated Family Caregiver	<input checked="" type="checkbox"/>				0800
Discharge Needs Assessment	<input checked="" type="checkbox"/>	Designated Family Caregiver			
PT/OT Anticipated Equipment Needs at ...	<input checked="" type="checkbox"/>	Patient prefers to designate a family caregiver?			
CM/SW Interventions	<input checked="" type="checkbox"/>	Name			
CM/SW Discharge Plan Progress	<input checked="" type="checkbox"/>	Phone			
Planned Discharge	<input checked="" type="checkbox"/>	Pager			
		Fax			
		Email			

The documentation completed in the Admit-Arrival or Admission navigator will populate into the Flowsheets. If the patient cannot answer at the time of admission, follow-up conversations regarding selection of a designated caregiver can be documented directly into the Flowsheet.

1. Select either the Discharge Planning flowsheet or the CM/SW Assessment flowsheet.
2. Add a column.
3. Complete the documentation.

Patient/Caregiver Education



Unresolved Education

Assessment **1** Unresolved Education Education Review Manage Education

Title/Topic/Teaching Point: **2**

- Generic Teaching Goals/Outcomes
 - Room/Orientation
 - Pain and Pain Management**
 - Medications
 - Diagnostic Tests/Procedures
 - Dietary Modifications
 - Hygiene/Infection Prevention
 - Rehabilitation
 - Medical Equipment/Supplies
 - Tobacco Cessation
 - Resources for Support
- Hearing Impairment/Deaf (Adult,Obstetrics,Pediatric)
- Grieving (Adult)
- Fall Risk (Adult)

Point Description/Learner Progress:

Description:
Pain and Pain Management

Learner	Ready?	Method	Res.	Comments	Taught By	Date	Time	Status
---------	--------	--------	------	----------	-----------	------	------	--------

Learner
P: Patient
F: Family
S: Significant Other
C: Caregiver
O: Other
Mom: Mother
Dad: Father
G: Guardian
FP: Foster Parent
DFC: Designated Family **3**

Readiness
E: Eager
A: Acceptance *
N: Nonacceptance
R: Refuses

Method
E: Explanation *
D: Demonstration
T: Teachback
H: Handout
I: Interpreter
V: Video
C: Class/Group

Response
VU: Verbalizes Understanding *
DU: Demonstrated Understanding
NR: Needs Reinforcement
NL: No Evidence of Learning
RT: Declines Teaching
TV: Teachback - Verbal
TD: Teachback - Demo

Education Materials: Delete Apply Defaults Copy Previous

Add Title Add Point Delete N/A Expand All Collapse All Resolve Comments Multiple File

Open the **Education** navigator

- 1** Select **Unresolved Education**
- 2** Select desired teaching point
- 3** Identify designated caregiver as the learner by selecting **“DFC: Designated/Family Caregiver”** in the Learner column and complete education documentation

Discharge Checklist

Alaska law requires notification of the designated caregiver upon receiving the discharge order. Ideally, the designated caregiver is present to review/receive discharge instructions prior to patient discharge.

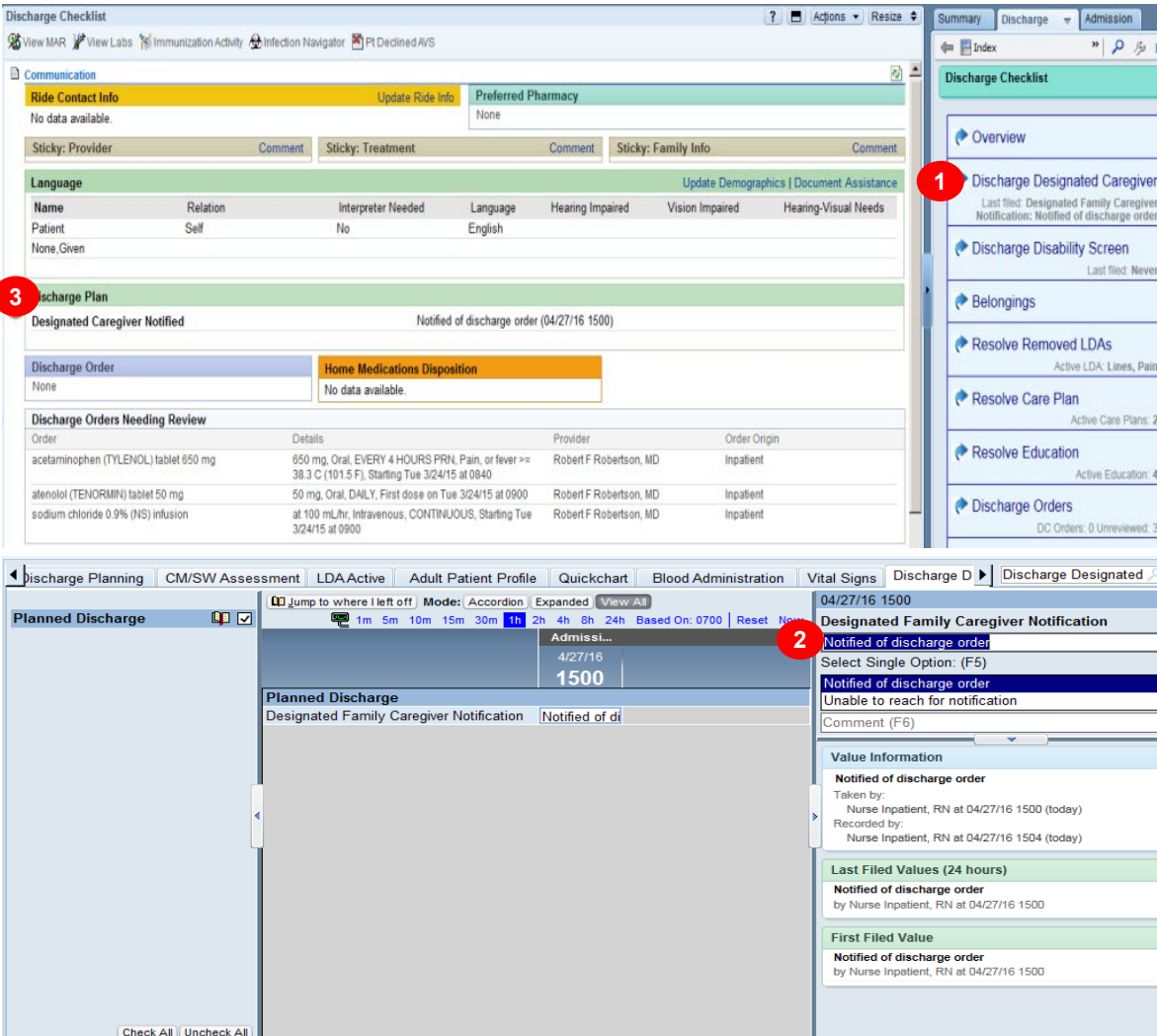
There is a link in the Discharge Checklist to document the Designated Family Caregiver was notified.

1 Click **Discharge Designated Caregiver**.

2 Complete documentation for Designated Caregiver Notification following receipt of discharge order.

3 This information populates the Discharge Plan widget.

- The nurse delegates the call to the charge nurse if unable to call the designated caregiver. The charge nurse completes documentation in steps 1-2 above.



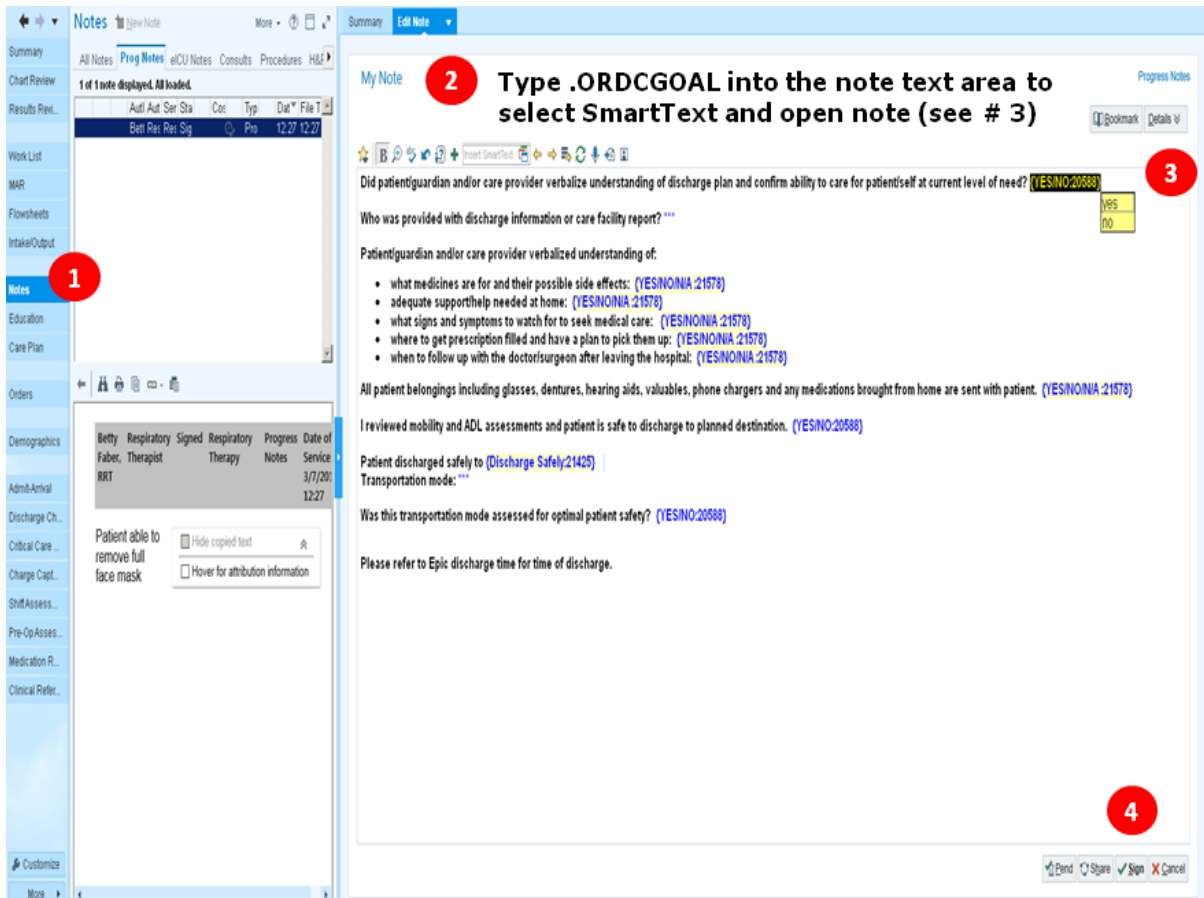
The screenshot shows the 'Discharge Checklist' software interface. It includes a top navigation bar with 'Summary', 'Discharge', and 'Admission' tabs. A left sidebar contains a 'Discharge Checklist' menu with options like 'Overview', 'Discharge Designated Caregiver', 'Discharge Disability Screen', 'Belongings', 'Resolve Removed LDAs', 'Resolve Care Plan', 'Resolve Education', and 'Discharge Orders'. The main content area is divided into several sections: 'Communication' (with 'Ride Contact Info' and 'Preferred Pharmacy'), 'Language' (with a table of patient language details), 'Discharge Plan' (with a 'Designated Caregiver Notified' status), 'Discharge Order' (with 'Home Medications Disposition'), and 'Discharge Orders Needing Review' (with a table of orders). A bottom section shows 'Planned Discharge' and 'Discharge Designated' details. Three red circles with numbers 1, 2, and 3 are overlaid on the interface: 1 points to the 'Discharge Designated Caregiver' link in the sidebar; 2 points to the 'Discharge Designated' section in the bottom right; 3 points to the 'Discharge Plan' section in the main content area.

Name	Relation	Interpreter Needed	Language	Hearing Impaired	Vision Impaired	Hearing-Visual Needs
Patient	Self	No	English			
None Given						

Order	Details	Provider	Order Origin
acetaminophen (TYLENOL) tablet 650 mg	650 mg, Oral, EVERY 4 HOURS PRN, Pain, or fever >= 38.3 C (101.5 F), Starting Tue 3/24/15 at 0940	Robert F Robertson, MD	Inpatient
atenolol (TENORMIN) tablet 50 mg	50 mg, Oral, DAILY, First dose on Tue 3/24/15 at 0900	Robert F Robertson, MD	Inpatient
sodium chloride 0.9% (NS) infusion	at 100 mL/hr, Intravenous, CONTINUOUS, Starting Tue 3/24/15 at 0900	Robert F Robertson, MD	Inpatient

Admiss...	1500
4/27/16	1500

Discharge Nursing Note



1 At the bedside before the patient leaves, open the **Notes** navigator

2 Type **.ORDCGOAL** into the note text area to select **SmartText** and open note (see # 3)

3 Select Progress note and type **.ORDCGOAL into text area, then** select the **SmartText** to add note

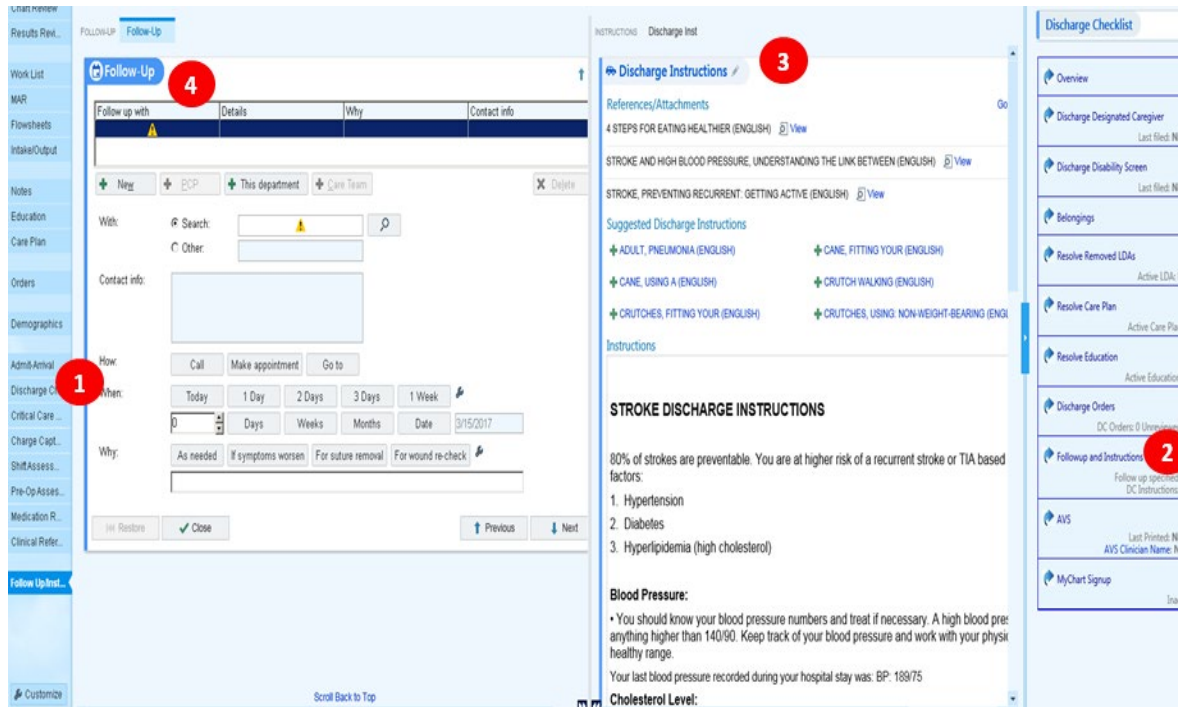
4 Place cursor at the beginning of text

- Press F2 to obtain pull down menu to answer questions.
- You must type in a response to questions containing ***

4 When all questions are answered, select “sign” at bottom to file the note

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- 2** Select Progress note and type **.ORDCGOAL into text area, then** select the **SmartText** to add note
- 3** Place cursor at the beginning of text
 - Press F2 to obtain pull down menu to answer questions.
 - You must type in a response to questions containing ***
- 4** When all questions are answered, select “sign” at bottom to file the note

Discharge Instructions

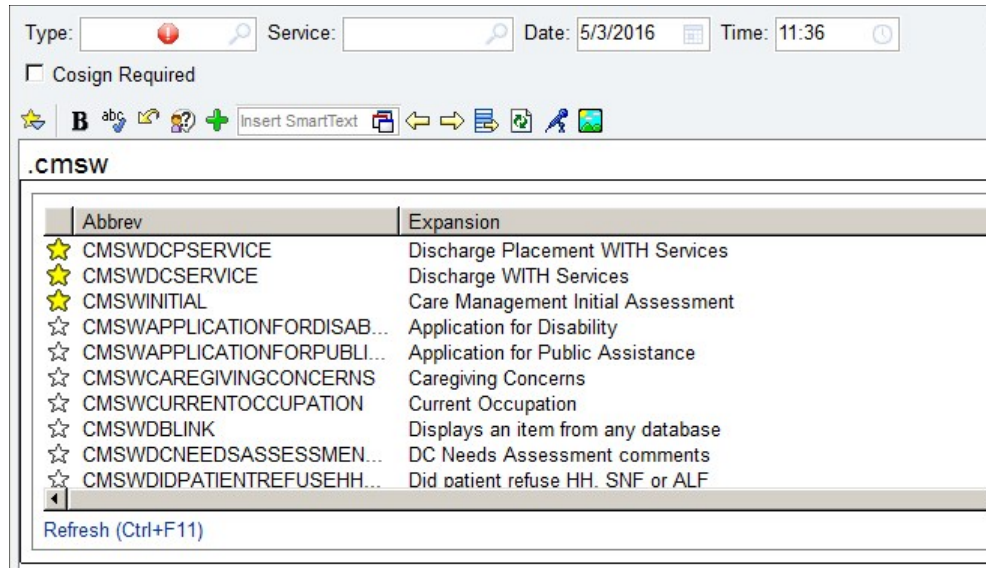


The screenshot displays the EHR interface for managing discharge instructions. The left sidebar contains various patient management tools. The main area is split into three panes. The 'Follow-Up' pane (left) shows a table for tracking follow-up appointments and a form for scheduling. The 'Discharge Instructions' pane (center) displays a list of instructions, including 'STROKE DISCHARGE INSTRUCTIONS' with a list of conditions like Hypertension, Diabetes, and Hyperlipidemia. The 'Discharge Checklist' pane (right) lists various tasks to be completed, such as 'Discharge Designated Caregiver' and 'Discharge Disability Screen'. Red circles with numbers 1-4 indicate the sequence of actions: 1. Selecting the 'Follow-Up' tab in the sidebar; 2. Selecting 'Follow-up and Instructions' in the checklist; 3. Selecting 'Discharge Instructions' in the center pane; 4. Selecting the 'Follow-Up' button in the top left of the center pane.

- 1 Open Discharge Checklist navigator
- 2 Select **Followup and Instructions**
- 3 Select **Discharge Instructions**
 - Complete discharge instructions
 - Add education handouts
 - Print **two** copies of discharge instructions, give one to the patient and the other to the designated caregiver
- 4 Don't forget **Follow-up** appointments

Case Management Only

- Continue to use CM/SW Assessment flowsheet
 - Designated caregiver information is included in flowsheet and SmartPhrases that have been updated
- Updated SmartPhrases you may find helpful:
 - .CMSWDCPSERVICE (Discharge placement with services)
 - .CMSWDCSERVICE (Discharge with Services)
 - .CMSWINITIAL (Care Management Initial Assessment)



The screenshot shows a software interface with a search bar at the top containing 'Type:', 'Service:', 'Date: 5/3/2016', and 'Time: 11:36'. Below the search bar is a 'Cosign Required' checkbox and a toolbar with icons for text formatting and smart text insertion. The main area displays a table of SmartPhrases under the heading '.cmsw'.

Abbrev	Expansion
★ CMSWDCPSERVICE	Discharge Placement WITH Services
★ CMSWDCSERVICE	Discharge WITH Services
★ CMSWINITIAL	Care Management Initial Assessment
☆ CMSWAPPLICATIONFORDISAB...	Application for Disability
☆ CMSWAPPLICATIONFORPUBLI...	Application for Public Assistance
☆ CMSWCAREGIVINGCONCERNS	Caregiving Concerns
☆ CMSWCURRENTOCCUPATION	Current Occupation
☆ CMSWDBLINK	Displays an item from any database
☆ CMSWDCNEEDSASSESSMEN...	DC Needs Assessment comments
☆ CMSWDIDPATIENTREFUSEHH...	Did patient refuse HH, SNF or ALF

Refresh (Ctrl+F11)

Key Points

The Care Act allows the patient to designate a caregiver to assist him/her with aftercare following hospital discharge.

The patient and designated caregiver are given the opportunity to participate in discharge planning and receive education/training to prepare for aftercare needs at home. The nurse's role is instrumental in assessing post-discharge patient needs including patient's ability to perform self-care, and ensuring the designated caregiver has the education/training necessary to safely manage the patient's on going care needs after discharge.



Additional Resources

For Epic Assistance:

- If you are experiencing problems and require technical assistance, please contact the Epic Support Team 1-855-415-8188. The Epic Support Team is also accessible by calling your regional service desk and selecting option 1.

For other questions:

- *Please contact your clinical educator, clinical manager, or clinical nurse specialist.*

