SB
72

<TARGET><BILL>SB 72</BILL><SUBJECT>SB
72</SUBJECT><COMM>HHSS29</COMM></TARGET>

ALASKA STATE LEGISLATURE

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North to the Future

Senator Cathy Giessel

Senate District N

CS for Senate Bill 72(L&C) CARE Act Sponsor Statement

SB 72 seeks to improve post-discharge health outcomes by improving coordination with designated caregivers, providing training in aftercare, reducing preventable and costly hospital readmissions and enabling older Alaskans to stay in their own homes longer.

At any given time, around 128,000 Alaskans are providing some type of caregiving services and supports to a loved one, friend or neighbor. Lay caregivers are increasingly being asked to perform complex nursing and medical tasks - such as dispensing numerous medications, administering injections and providing wound care - often with inadequate skill training.

Caregivers are a critical link in the transitional care for frail adults and those with disabilities; with few exceptions, caregivers are responsible for providing and coordinating much of the care received at home following discharge.

Untrained and unsupported caregiving jeopardizes the patient's recovery, as well as often puts the caregiver at risk for their own injury and burnout, frequent symptoms of those caring for others.

SB 72 contains these important provisions:

- The patient is given the opportunity to appoint a designated caregiver, with his or her consent, to provide aftercare to them following discharge from a hospital
- The designated caregiver is notified of the patient's discharge or transfer to another facility as soon as practicable
- The hospital shall consult with the designated lay caregiver and offer training to the caregiver for aftercare medical and nursing tasks
- The hospital shall adopt and maintain written discharge policies

The value of family caregiving in Alaska is valued at over a billion dollars a year….money that would otherwise likely have to come from the state coffers for paid caregiving in the home or in a facility.

SB 72 will help people continue to live independently at home and support the family caregivers who make this possible.

Senator_Cathy_Giessel@akleg.gov

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CS for Senate Bill 72(L&C)
Sectional Overview

Section 1. AS 18.20 adds new sections:

Sec. 18.20.500: Requires hospital, before discharge, assess the patient, provide patient opportunity to designate a caregiver, who consents/agrees to provide patient with aftercare

Sec. 18.20.510: Requires a hospital to provide opportunity for a designated caregiver to participate in the discharge planning of the patient; and that the hospital provide training and/or instruction to the designated caregiver on how to perform medical and nursing aftercare prior to patient's discharge

Sec. 18.20.520: Requires a hospital to notify the designated caregiver of the patient's discharge or transfer

Sec. 18.20.530: Directs the hospital to adopt and maintain written discharge policies. The policies must comply with this chapter. The written policy must specify requirements for naming of the designated caregiver and those policies may incorporate best practices for hospital discharge planning, such as those outlined in Center for Medicaid and Medicare Services (CMS) ….and that the discharge plan is appropriate for the patient's condition.

The discharge plan may not delay a discharge or transfer of a patient or oblige hospital to divulge patient's health information to the designated caregiver without patient's consent

Sec. 18.20.540: The hospital and its contractors are protected from lawsuit in regard to the discharge planning of a patient

Sec. 18.20.550: This chapter many not interfere with or supersede the powers/duties of an agent or legal guardian acting upon a health care directive

Sec. 18.20.590: Provides definitions

Section 2: effective date of January 1, 2017.

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North to the Future

Senator Cathy Giessel
Senate District N

MEMORANDUM

DATE: March 2, 2016

TO: Representative Paul Seaton
Chair, House Health and Social Services Committee

FROM: Senator Cathy Giessel

RE: Request for Committee Hearing, Senate Bill 72, "Designated Caregivers for Patients"

I respectfully request that **Senate Bill 72** "Designated Caregivers for Patients" be scheduled for a hearing before the House Health and Social Services Committee at your earliest convenience.

SB 72 seeks to improve post-discharge health outcomes by improving coordination with designated caregivers, providing training to them on discharge tasks, reducing preventable and costly hospital readmissions and enabling older Alaskans to stay in their own homes longer.

At any given time, around 128,000 Alaskans are providing some type of caregiving services and supports to a loved one, friend or neighbor. Caregivers are increasingly being asked to perform complex nursing and medical tasks - such as dispensing numerous medications, administering injections and providing wound care - often with inadequate skill training. Most of all, SB 72 will help people continue to live independently at home, and will support the family caregivers who make this possible.

Attached you will find:

1. CSSB 72 (L&C)
2. Summary of Changes
3. CSSB 72 Sponsor Statement
4. CSSB 72 Sectional Analysis
5. CSSB 72 Fiscal Note
6. CSSB 72 Letters of Support
7. CSSB 72 Backup Information

Please contact Jane Conway, 465-3623, in my office if you need any further information.

Senator_Cathy_Giessel@akleg.gov

Summary of Changes for SB 72

SB 72 vsn P (original) to vsn F CSSB 72(HSS)

(provided by Senator Giessel's office)

In summation, the original version of SB 72 went from itemizing /mandating very specific actions that the hospital would be required to do in its patient discharge plan to mandating that *the hospital* write and keep records of the discharge plan using best practices outlined in CMS (Centers for Medicare and Medicaid Services).

We did this because not all hospitals run the same, each is its own individual entity; some hospitals already provide and follow well-documented discharge plans, others do not. It is for those that SB 72 is needed. Giving the hospitals a broader mandate in SB 72 allows each one to develop their own discharge plan system that meet the mandates of SB 72 and also the federal CMS guidelines.

The bill went from 7 pages to 3 because of this simplification in language in the bill; **but these mandates remain constant throughout all versions of the bill :**

- **The patient is given the opportunity to designate a caregiver, with his or her consent, to provide aftercare to the patient following discharge from a hospital**
- **The designated caregiver is notified of the patient's discharge or transfer to another facility as soon as practicable**
- **The hospital shall consult with the designated caregiver and offer training to the caregiver for aftercare medical and nursing tasks**
- **The hospital shall adopt and maintain written discharge policies**

SB 72 (HSS) to SB 72 (L&C)

There were some small wordsmithing language changes in this version that came from a collaborative effort with ASHNHA and the Nurses' Association, none of which changed the tone or intent of the legislation whatsoever. Those changes are listed below:

Changes from CS for SB 72 (HSS) to CS SB 72 (L&C)

1. Deletes the word "lay" in these places: Page 1, lines 8, 11 14 and on Page 2, lines 1, 3, 7, 18

Explanation: Eliminates use of term "lay caregiver" as a defined term (which we've deleted from the definitions) and uses the term we're using which is "designated caregiver."

2. Page 1, line 9: Delete "in the patient's home" and Insert " in a private residence"

Explanation: Patients may not always receive aftercare in their home, but perhaps in a sibling's or child's home.

3. Page 2, lines 8-9: After "patient", delete "." and insert "," and the following new language:

"including professional follow-up as specified in the discharge plan."

Explanation: The purpose of the addition is to explicitly acknowledge that often follow up will be required by the patient's primary care provider or a specialized care provider.

4. Page 2, line 29 deletes "an instruction contractor" and adds:

" a person who contracts with the hospital to provide instruction to a designated caregiver"

Explanation: reworded this sentence so we would not have to define "instruction contractor"

5. Page 3, line 7 deletes "individual" and inserts "patient"

6. Page 3, line 16 deletes the word "lay" and adds" in a private residence" after the word "patient"

Explanation: This clarifies that the caregiving will not be occurring in a healthcare *facility*

7. Page 3, line 22-24 adds the definition of "private residence":

" private residence does not include a rehabilitative facility, a hospital, a nursing home, an assisted living facility, a group home or another licensed health care facility."

8. On page 3, lines 20-21 of version F
Delete the definition of "lay caregiver"

Explanation: Keeping this in as a definition is confusing and redundant with definition of "designated lay caregiver" in this same section. There's no need to define the term.

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSSB 72(L&C)
Fiscal Note Number:	2
(S) Publish Date:	2/29/2016

Identifier: SB072CS(HSS)-DHSS-HFLC-2-20-16
Title: DESIGNATED CAREGIVERS FOR PATIENTS
Sponsor: GIESSEL
Requester: Senate L&C

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Health Facilities Licensing and Certification
OMB Component Number: 2944

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version:

Updated for the CS. The Department changed the division and component named on this fiscal note to reflect the division/component most directly impacted by the legislation.

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2400
Division:	Health Care Services	Date:	02/20/2016 02:35 PM
Approved By:	Sana Efird, Asst. Commissioner, Finance and Management Services	Date:	02/20/16
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Analysis

This bill is intended to promote effective aftercare for patients discharged from a hospital by requiring the hospital to give the patient the opportunity to formally designate a caregiver to provide aftercare in the patient's home. The bill has the potential to improve post-hospital health outcomes by ensuring that a trained lay caregiver has taken responsibility for aftercare, and may result in fewer hospital readmissions.

The bill adds to the hospital's responsibilities, which may require additional personnel time and effort.

The bill allows non-compliance with the provisions of the statute if compliance would delay discharge, and specifies that the provisions of the statute do not constitute a "right of action" against a hospital, its employees or contractors. The lay caregiver does not supersede the powers/duties of an agent or legal guardian acting upon a health care directive.

If implemented, the DHSS Division of Health Care Services, Health Facilities Licensing and Certification component will add this lay caregiver provision to the portion of its hospital survey checklist around patient discharge planning, include it in hospitals' reviews, and would issue a citation if a hospital were out of compliance with the terms stipulated in this legislation. These provisions do not represent an additional cost to the Department.

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSSB 72(HSS)
Fiscal Note Number:	1
(S) Publish Date:	2/3/2016

Identifier: SB072-DHSS-SDSA-1-28-16
Title: DESIGNATED CAREGIVERS FOR PATIENTS
Sponsor: GIESSEL
Requester: Senate HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior and Disabilities Services Administration
OMB Component Number: 2663

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? no
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Updated for new fiscal year; no other changes.

Prepared By:	Duane Mayes, Director	Phone:	(907)296-2083
Division:	Senior and Disabilities Servcies	Date:	01/04/2016 12:00 AM
Approved By:	Sana Efird, Asst. Commissioner, Finance and Management Services	Date:	01/14/16
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Analysis

This bill requires a hospital to give a discharging patient the opportunity to name a caregiver to provide aftercare; a patient is not required to choose or name a caregiver, and the named caregiver is not obligated to provide aftercare. It requires a hospital to attempt to contact the named caregiver, notify the named caregiver of when the patient will be discharged, meet and instruct the named caregiver in aftercare tasks, and record this information in the patient's medical record. The hospital may contract out the duty to instruct the caregiver. The bill allows non-compliance with the provisions of the statute if compliance would delay discharge, and specifies that the provisions of the statute do not constitute a "right of action" against a hospital, its employees or contractors.

These provisions do not represent an additional cost to the Department.

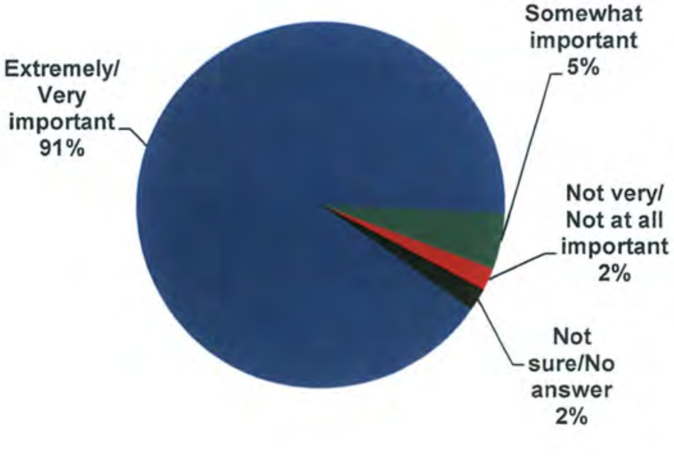
2015 AARP Caregiving Survey: Opinions of Alaska Registered Voters Age 45 and Older Who Are Family Caregivers

Most Alaska registered voters age 45 and older have experiences as family caregivers, or believe they are likely to be caregivers in the future. Alaska registered voters age 45 and older say they have provided care—either currently (18%) or in the past (38%)—on an unpaid basis for an adult loved one who is ill, frail, elderly or who has a disability. Of those who have never provided care, one half say they are at least somewhat likely they will do so. **Typical current family caregivers in Alaska are women (57%) and over 55 years old (72%). They are likely to be married (78%), have some college education (58%), and are employed (50%). The average age of the person they care for is 73 years old.**

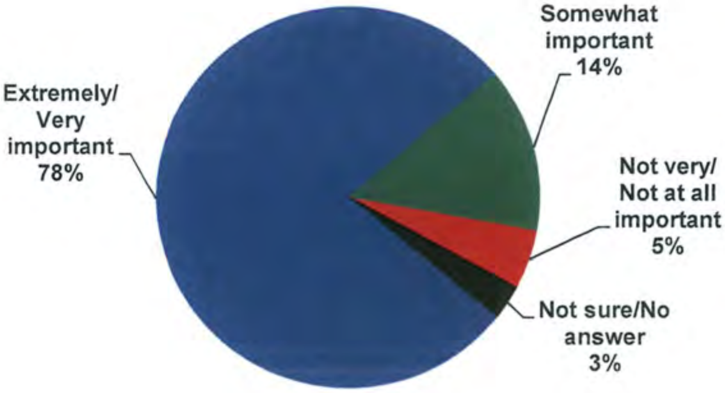
Both current and former caregivers have provided care in a myriad of ways, with more than two-thirds assisting with complex care like medication management (69%) and other medical tasks (67%). More than eight in ten have helped loved ones in their care with household management activities like shopping (87%), preparing meals (86%), chores (84%) and transportation (82%). Two-thirds are also helping to manage finances for their loved ones (66%).

Many (57%) current and past caregivers say it is likely that they will need to provide care again in the future. As such, nearly all of these caregivers believe it is important to be able to provide care so that their loved ones can keep living independently in their own home. Many also say having more caregiver resources and training that allows family caregivers to continue to provide in-home care is important.

Importance of Being Able to Care So Loved Ones Can Live Independently*
(n=397, Respondents Who Are Current or Past Caregivers)

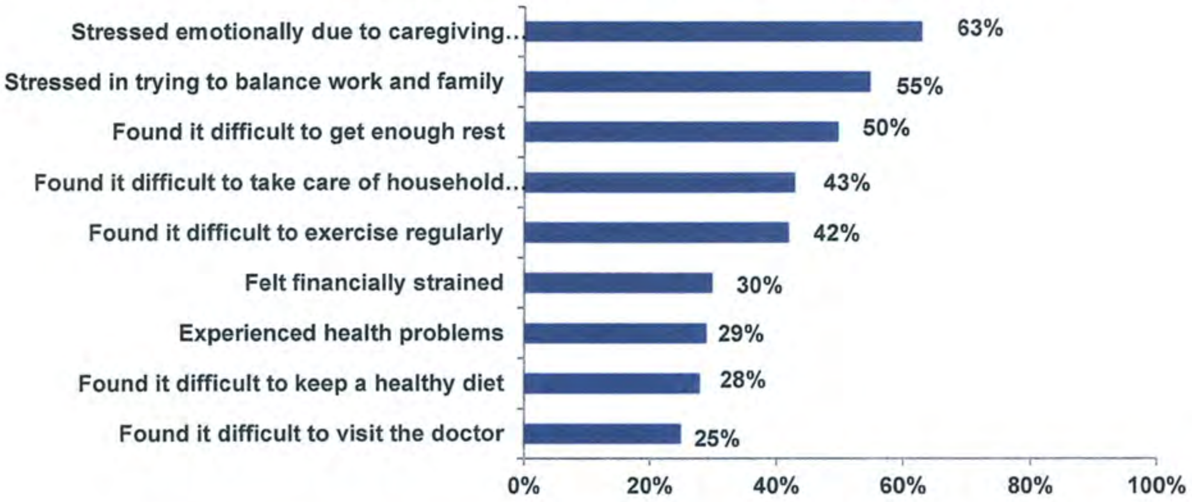


Importance of Having More Resources and Training for Caregivers*
(n=397, Respondents Who Are Current or Past Caregivers)



*Due to rounding the chart may not total 100%

Alaska respondents who are current or past caregivers report feeling emotionally (63%) and financially stressed (30%). They are also stressed about not being able to take care of their needs and the needs of their other family members. Caregivers report they are finding it difficult to get rest (50%), exercise regularly (42%), keep a healthy diet (28%), or visit their own doctor (25%). They also express feeling stressed about trying to balance their work and family (55%) and take care of their household (43%).



Experiences of Alaska Caregivers Age 45-Plus*
(n=397, Respondents Who Are Current or Past Caregivers)

*Graph shows respondents who responded "yes" to each type of stressor.

AARP Alaska commissioned a telephone survey of 800 registered voters age 45 and older to learn about their experiences with family caregiving. This report highlights results from registered voters interviewed between February 24 and March 6 2015. The data was not weighted. The survey has a margin of error of ±3.5 percent. The survey annotation will be made available at www.aarp.org/research.

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.

State Research brings the right knowledge at the right time to our state and national partners in support of their efforts to improve the lives of people age 50+. State Research consultants provide strategic insights and actionable research to attain measurable state and national outcomes. The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

AARP staff from the Alaska State Office, Campaigns, State Advocacy and Strategy Integration and State Research contributed to the design, implementation and reporting of this study. Special thanks go to AARP staff including Ken Helander, Ann Secrest, and Ken Osterkamp, AARP Alaska; Chryste Hall, Campaigns; Kristina Moorhead, State Advocacy and Strategy Integration; Rachelle Cummins, Jennifer Sauer, Aisha Bonner, Brittne Nelson, Darlene Matthews and Cheryl Barnes, State Research. Please contact Cassandra Burton at 202-434-3547 for more information regarding this survey.

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AARP Research

For more information about this survey, please contact Cassandra Burton at:

202.434.3547 or e-mail ccantave@aarp.org

FAMILY CAREGIVERS HELP SENIORS IN ALASKA

AARP is fighting to support family caregivers and the parents, spouses, and other loved ones they help live independently at home. AARP recently surveyed Alaska voters age 45-plus about caring for their families. Here's what we learned:

Alaska voters are Family Caregivers: If you're not a caregiver now and weren't one in the past, you'll likely be one in the future:

Current or Former Caregivers

Likely Caregivers in the future

Alaska Family Caregivers help their older loved ones with daily activities like shopping, transportation, meals, and chores. They also:

Manage medications

Handle nursing and medical tasks

Alaska voters 45-plus believe living independently at home, with caregiver assistance is the ideal situation when basic tasks become difficult. They strongly support policy options to help.

They want hospitals to better support family caregivers when their loved ones are admitted, specifically:

Hospitals should demonstrate medical and nursing tasks

Hospitals should keep family caregivers informed of major decisions, like discharges

Hospitals should record the name of the family caregiver in the medical record

They say it's important for Family Caregivers and their older loved ones to have support, specifically:

Community services to help you or a loved one stay at home

Community services so family caregivers can take a break

Resources and training available for family caregivers

The average Alaska Family Caregiver is over 55 years old. She cares for a loved one age 73 and works full or part-time too.

All Alaska's Family Caregivers face challenges:

- 63% Emotionally stressed
- 55% Stressed trying to balance job & family
- 50% Find it hard to get enough rest
- $ 69% Use their own money to help

I ♥ Caregivers℠

AARP Real Possibilities

Source: 2015 survey of 800 Alaska Registered Voters Age 45-plus. Margin of sampling error ±3.5%

ALASKANS ARE FAMILY CAREGIVERS

Across Alaska 128,000 family caregivers give their hearts every day, helping their parents, spouses, and other loved ones stay at home. AARP recently surveyed 800 Alaska voters age 45-plus about caring for their families. Here's what we learned:

56% Current or Former Caregivers

50% Likely Caregivers in the future

While they wouldn't have it any other way, family caregiving is a huge job. They:

69% Use their own money to help provide care

66% Who work modify their schedules

69% Oversee medication

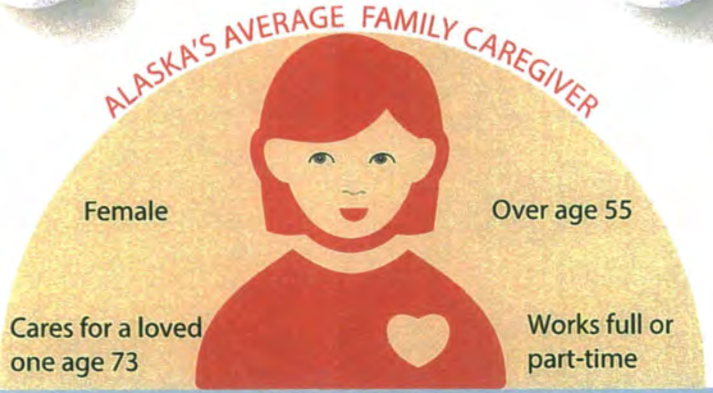
67% Manage medical tasks

84% Aid with household chores

66% Help manage finances

82% Provide transportation to appointments

87% Help with shopping



Female

Over age 55

Cares for a loved one age 73

Works full or part-time

Family caregivers need support to make their big responsibilities a little bit easier. Alaska voters support:

88% Services to help older Alaskans stay at home

79% Resources and training for family caregivers

90% Community services so family caregivers can take a break

95% Hospitals demonstrating medical and nursing tasks

Source: 2015 survey of 800 Alaska Registered Voters Age 45-plus. Margin of sampling error ±3.5%

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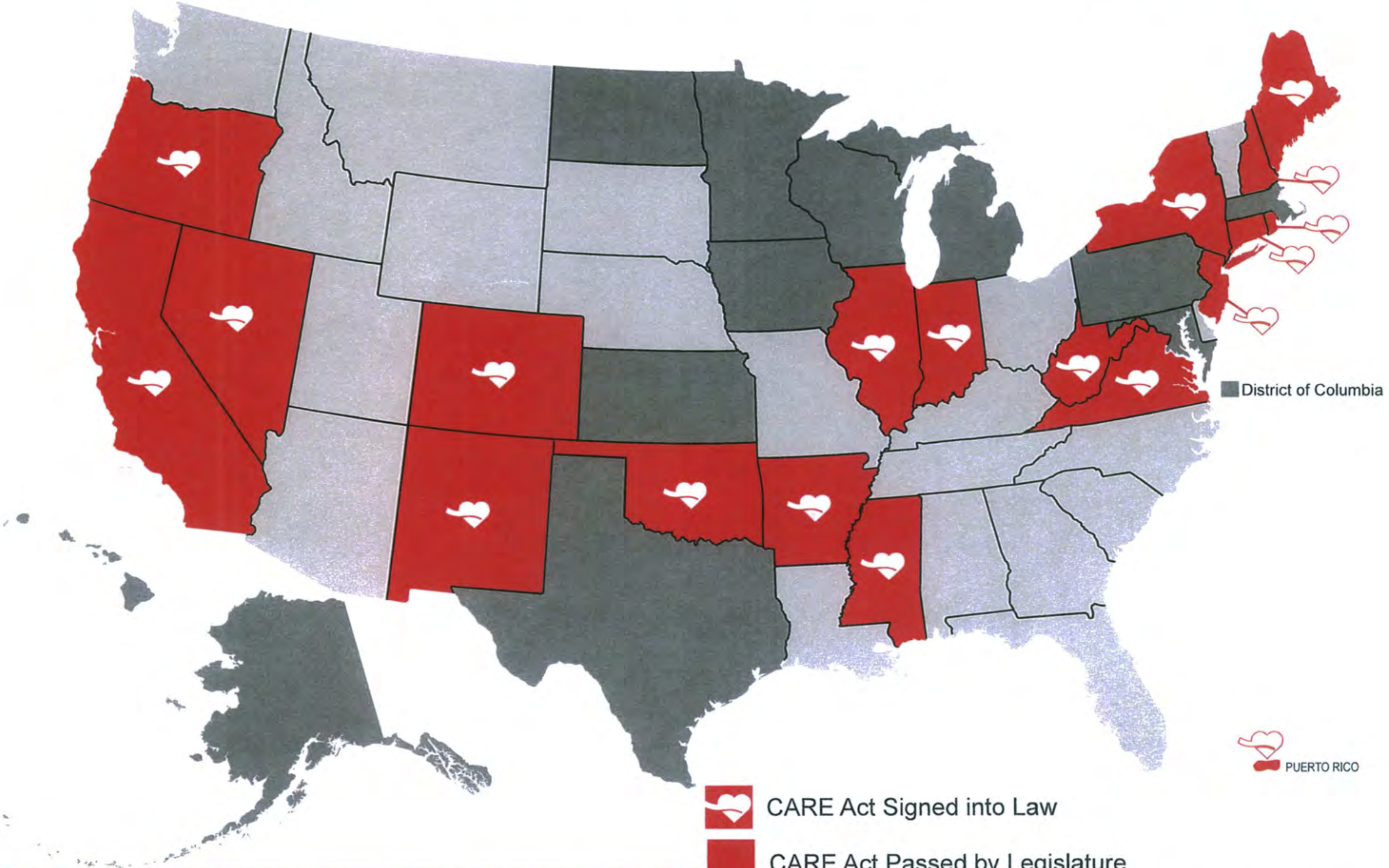
The Caregiver Advise, Record, Enable (CARE) Act

The CARE Act is a commonsense solution that supports family caregivers when their loved ones go into the hospital, and provides for instruction on the medical tasks they will need to perform when their loved one returns home.



🟥 CARE Act Signed into Law

🟥 CARE Act Passed by Legislature

⬛ CARE Act Introduced in 2015

CARE Act goes into effect:
Oklahoma, 11/5/14; Colorado, 5/8/15; New Jersey, 5/12/15; West Virginia, 6/8/15; New Mexico, 6/17/15; Mississippi, 7/1/15; Virginia, 7/1/15; Arkansas, 7/22/15; Connecticut, 10/1/15; Nevada, 10/1/15; Maine, 10/15/15; California, 1/1/16; Indiana, 1/1/16; New Hampshire, 1/1/16; Oregon, 1/1/16; Illinois, 1/27/2016; Rhode Island, 3/1/16; New York, 4/23/16; Puerto Rico TBD

**Updated on 1/8/2016

I ❤ Caregivers
AARP Real Possibilities
aarp.org/iheartcaregivers

Support Alaskans with Disabilities, Seniors, and their Family Caregivers

Thousands of Alaskans are caring for an older family member or a loved one with a disability, helping them to live independently in their own homes. These unpaid family caregivers have huge responsibilities and we can take some common sense steps that would make a world of difference to them. That's why AARP urges legislators to enact **The Caregiver Advise, Record, Enable Act (SB 72)** to better support family caregivers as they safely help Alaskans remain at home.

What is The CARE Act

The CARE Act recognizes the critical role family caregivers play in keeping their loved ones out of costly institutions. The bill features three important provisions:

- The name of a family or other unpaid caregiver is recorded when a loved one is admitted into a hospital;
- The caregiver is notified when the loved one is to be discharged back home; and
- The hospital must provide a demonstration — either in person or recorded instruction — of the medical tasks, such as wound care, medication management, injections, and transfers that the family caregiver will perform at home.

Why Alaska Needs Senate Bill 72

- Most care recipients (69%) did not have a home visit by a health care professional after discharge from the hospital.
- Almost half (46%) of family caregivers perform medical or nursing tasks for their loved ones with multiple chronic physical and cognitive conditions.
- Three out of four (78%) who provide these medical or nursing tasks manage medications, including administering intravenous fluids and injections.
- Most family caregivers report that they received little or no training to perform these tasks.

AARP report "Home Alone: Family Caregivers Provide Complex Chronic Care," October 2012
Full report at http://bit.ly/1MvQ5Mn

For more information, contact Ken Helander at AARP Alaska at 907-762-3314 or khelander@aarp.org

Family Caregivers in Alaska

- The vast majority of older and disabled Alaska residents want to live independently at home.
- Most Alaskans who receive assistance at home rely exclusively on unpaid family caregivers for help.
- More than 128,000 family caregivers in Alaska help their loved ones to live independently, keeping them out of costly institutions, such as nursing homes.
- In Alaska, family caregivers provide unpaid care valued at about **$1.1 billion** annually.
- Family caregivers perform a variety of caregiving duties, including help with bathing and dressing, nutrition, wound care, medication management, transportation, and more.

KEY FINDING FROM SURVEY: 95% of Alaskan voters age 45 and older feel hospitals should be required to demonstrate medical and nursing tasks to caregivers.

SOURCE: 2015 AARP Caregiving Survey: Opinions of Alaska Registered Voters Age 45 and Older on Support for The Caregiver Advise, Record, Enable (CARE) Act. For a copy of survey, contact Ann Secrest at AARP Alaska, asecrest@aarp.org or 907-762-3302.

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TABLE B1

Number of Family Caregivers and the Economic Value of Caregiving, by State, 2013

State	State Population	Number of Caregivers	Number of Care Hours (millions)	Economic Value per Hour	Total Economic Value (millions)
Alabama	4,830,000	761,000	708	$10.89	$7,720
Alaska	735,000	84,900	79	$15.05	$1,190
Arizona	6,630,000	804,000	749	$12.60	$9,430
Arkansas	2,960,000	452,000	421	$11.20	$4,710
California	38,300,000	4,450,000	4,140	$13.94	$57,700
Colorado	5,270,000	584,000	543	$13.68	$7,430
Connecticut	3,600,000	459,000	427	$13.87	$5,930
Delaware	926,000	123,000	114	$13.86	$1,580
District of Columbia	646,000	75,200	70	$12.44	$870
Florida	19,600,000	2,670,000	2,490	$11.93	$29,700
Georgia	9,990,000	1,330,000	1,240	$11.29	$14,000
Hawaii	1,400,000	154,000	144	$14.59	$2,100
Idaho	1,610,000	196,000	183	$12.06	$2,210
Illinois	12,900,000	1,560,000	1,450	$12.77	$18,500
Indiana	6,570,000	837,000	779	$12.17	$9,480
Iowa	3,090,000	317,000	295	$13.08	$3,860
Kansas	2,890,000	345,000	321	$12.01	$3,850
Kentucky	4,400,000	648,000	603	$11.57	$6,980
Louisiana	4,630,000	660,000	615	$10.53	$6,470
Maine	1,330,000	178,000	165	$13.41	$2,220
Maryland	5,930,000	771,000	717	$13.09	$9,390
Massachusetts	6,690,000	844,000	786	$14.75	$11,600
Michigan	9,900,000	1,280,000	1,190	$12.21	$14,500
Minnesota	5,420,000	585,000	544	$14.45	$7,860
Mississippi	2,990,000	501,000	467	$11.53	$5,380
Missouri	6,040,000	792,000	737	$11.52	$8,490
Montana	1,020,000	118,000	110	$12.97	$1,430
Nebraska	1,870,000	195,000	182	$13.81	$2,510
Nevada	2,790,000	348,000	324	$13.19	$4,270
New Hampshire	1,320,000	173,000	161	$14.42	$2,330
New Jersey	8,900,000	1,120,000	1,040	$13.07	$13,600
New Mexico	2,090,000	277,000	257	$12.19	$3,140
New York	19,700,000	2,580,000	2,400	$13.02	$31,300
North Carolina	9,850,000	1,280,000	1,190	$11.27	$13,400
North Dakota	723,000	62,100	58	$14.88	$860
Ohio	11,600,000	1,480,000	1,380	$11.95	$16,500
Oklahoma	3,850,000	524,000	488	$12.45	$6,070
Oregon	3,930,000	469,000	437	$13.06	$5,700
Pennsylvania	12,800,000	1,650,000	1,540	$12.47	$19,200
Rhode Island	1,050,000	134,000	124	$14.26	$1,780
South Carolina	4,770,000	706,000	657	$11.49	$7,550
South Dakota	845,000	84,600	79	$13.12	$1,030
Tennessee	6,500,000	981,000	913	$11.24	$10,300
Texas	26,400,000	3,350,000	3,120	$11.39	$35,500
Utah	2,900,000	336,000	313	$13.26	$4,150
Vermont	627,000	74,900	70	$14.55	$1,010
Virginia	8,260,000	1,030,000	956	$12.36	$11,800
Washington	6,970,000	828,000	771	$13.83	$10,700
West Virginia	1,850,000	282,000	263	$10.62	$2,790
Wisconsin	5,740,000	578,000	538	$13.15	$7,070
Wyoming	583,000	66,200	62	$13.27	$817
United States	**316,000,000**	**40,000,000**	**37,000**	**$12.51**	**$470,000**

Note: State numbers may not add up exactly to the U.S. totals because of rounding.

AARP Public Policy Institute
"Valuing the Invaluable: 2015 Update
- Senator Giessel

AARP Public Policy Institute
CELEBRATING 25 years

Home Alone: Family Caregivers Providing Complex Chronic Care

Susan C. Reinhard, RN, PhD
AARP Public Policy Institute

Carol Levine, MA, and Sarah Samis, MPA
United Hospital Fund

Produced by the AARP Public Policy Institute (PPI) and the United Hospital Fund with support from The John A. Hartford Foundation

In a recent national survey, almost half (46 percent) of family caregivers reported performing medical/nursing tasks for care recipients with multiple chronic physical and cognitive conditions. These tasks include managing multiple medications, providing wound care, preparing food for special diets, using monitors, and operating specialized medical equipment. These tasks were in addition to assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Most caregivers said that they received little or no training to perform these medical/nursing tasks.

Family caregivers have traditionally provided assistance with bathing, dressing, eating, and household tasks such as shopping and managing finances. While these remain critically important to the well-being of care recipients, the role of family caregivers has dramatically expanded to include performing medical/nursing tasks of the kind and complexity once provided only in hospitals and nursing homes and by home care professionals. This change has occurred because of the prevalence of chronic conditions in an aging population, economic pressures to reduce hospital stays, and the growth of in-home technology. Formal home care services are short-term and limited.

To document and analyze this major shift, PPI and the United Hospital Fund (UHF) undertook the first nationally representative population-based online survey of 1,677 family caregivers. Caregiver age, socioeconomic status, and education were similar to demographics reported in other national surveys. The care recipients were older (average age 75), mostly female, and mostly Medicare beneficiaries.

This *In Brief* provides highlights of the survey results and recommendations that are fully addressed in the Research Report, *Home Alone: Family Caregivers Providing Complex Chronic Care*, released by PPI and UHF in October 2012. The report explores the complexity of tasks that caregivers provide and challenges the common perception of family caregiving as a set of personal care and household chores that most adults already do or can easily master.

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Shaping New York's Health Care: Information, Philanthropy, Policy

KEY FINDINGS

Family Caregivers Perform Complicated Medical/Nursing Tasks

The most commonly performed medical/nursing tasks were medication management (78 percent), help with assistive mobility devices (43 percent), preparing food for special diets (41 percent), and wound care (35 percent).

Even though the number of family caregivers saying that they operate medical equipment, such as mechanical ventilators and tube feeding systems, was small (14 percent), 49 percent reported it as hard to do. These family caregivers are performing tasks in a home environment that would challenge even seasoned professionals.

Caregivers Are Responsible for Complex Medication Management

Many family caregivers managed many different kinds of medications. Three out of four (78 percent) family caregivers who performed medical/nursing tasks were managing medications, including administering intravenous fluids and injections.

Almost half were administering five to nine prescription medications a day. Medication management was reported to be difficult because it took so much time, it created anxieties about making a mistake, and some care recipients were uncooperative.

Most family caregivers learned how to manage at least some of the medications on their own. Despite frequent emergency department visits and overnight hospital stays, few family caregivers reported receiving assistance and training from health professionals.

Training Is Limited for Often Challenging Wound Care

More than a third (35 percent) of family caregivers who provided medical/nursing tasks reported doing wound care such as ostomy care and postsurgical dressing changes. While fewer caregivers performed wound care tasks than medication management, a higher percentage of them (66 percent) identified it as difficult because of fear of making a mistake and discomfort with the level of bodily intrusiveness required.

Family caregivers who deemed wound care difficult received more training from health professionals than did caregivers doing medication management. About a third reported some training by a hospital nurse or physician, and a quarter received training from a home care nurse, but most did not get any training to perform these tasks. Four out of ten family caregivers performing wound care thought more training would help them.

Family Caregivers Feel They Have No Choice

More than half (57 percent) of family caregivers who reported that they felt pressured to take on medical/nursing tasks said they did not feel they had a choice. Of these, many (43 percent) felt they had a personal responsibility (there was no one else to do it, or insurance would not cover it). And some cited pressure from the care recipient (12 percent) or another family member.

Most Care Recipients Do Not Receive Home Visits by Health Professionals

Most care recipients (69 percent) did not have home visits by a health care professional. Of those who did have home visits, roughly seven in ten were visited by a nurse. Twenty-seven percent of caregivers reported no additional help at home.

Family Caregivers Often Serve as Primary Care Coordinators

Family caregivers of chronically ill persons frequently served as care coordinators. More than half (53 percent) of family caregivers who performed medical/nursing tasks coordinated care—twice the rate of those who mainly provided ADL or IADL care.

Very few family caregivers (3 percent) reported working with a care manager from an insurance company or government program or hiring a private geriatric care manager.

Performing Medical/Nursing Tasks May Prevent Nursing Home Placement

Family caregivers who performed medical/nursing tasks were most likely to believe they were making an important contribution, primarily preventing nursing home placement (51 percent). The more medical/nursing tasks they performed, the more likely they were to report this positive effect.

Quality of Life Is Affected

Family caregivers performing medical/nursing tasks were most likely to report feeling stressed and worried about making a mistake. They were also more likely to report talking to so many health care professionals and suppliers as a source of stress. More than half reported feeling down, depressed, or hopeless in the last two weeks, and more than a third reported fair or poor health. These negative impacts increased with the number of the care recipients' chronic conditions.

MAJOR RECOMMENDATIONS

The report highlights an urgent need for both individual and collective action to help family caregivers better cope with handling medical/nursing tasks at home. If adopted, these recommendations should result in consistently improved home care and fewer hospitalizations.

The report notes that no single profession or health care provider is solely responsible for ensuring that family caregivers are trained and supported. This challenge requires the coordinated efforts of all sectors—hospitals, home care agencies, community agencies, nursing homes, hospices, and physician and other clinician practices—and a level of teamwork that challenges attitudes and behaviors firmly entrenched in the current system.

Based on the survey findings, the report recommends the following:

- Because health care professionals' and policymakers' understanding of family caregiving and eligibility of care recipients is typically based on measures of ADLs and IADLs, a consensus-building body should revisit these measures to acknowledge the types of tasks described in this report. The measures commonly used for a half-century no longer adequately capture what family caregivers do.[1] The Institute of Medicine is particularly well suited to this kind of consensus-building effort.
- Individual health care professionals must fundamentally reassess and restructure the way they interact with family caregivers in daily practice. Every health care clinician and social service professional should feel personally responsible for ensuring that patients and families in their care understand how to perform the challenging tasks outlined in this report.
- Health care organizations should support individual professionals and provide resources to ensure that family caregivers' needs for training and support are met.

- Professional organizations should lead and support professionals in their efforts to improve communication with and training for family caregivers.
- Leaders in medical, nursing, social work, allied health professional training, and continuing education should examine their curricula to determine where and how the importance of acknowledging, supporting, and training family caregivers can be added or strengthened. New approaches are needed that blend technical and communication skills. Training must be adapted to respond to changes in the family member's condition or the family caregiver's needs and capabilities.
- Accrediting and standard-setting organizations must take seriously their evaluation of how well institutions incorporate family caregiver needs and require corrective steps to address deficiencies.
- Federal policymakers should proactively consider family caregivers in developing new models of care that focus on coordination and quality improvement. Explicitly including family caregivers in federal funding requirements for new models of care focused on care coordination and quality improvement is an essential first step.
- State policymakers should proactively consider family caregivers in funding and policy development. State governments should incorporate family caregiver assessments in publicly funded programs,[2] including the new demonstrations for people eligible for both Medicare and Medicaid. States should enable registered nurses to delegate medical/nursing care tasks to qualified direct care workers who serve people in their homes.
- Caregiver advocacy and support organizations should include in their service and policy agendas resources that address the needs of family caregivers who have taken on the triple burden of personal care, household chores, and medical/nursing tasks. Caregiver organizations have used ADLs and IADLs in describing their constituents and in advocating for funding and services. They, like their health care professional colleagues, must expand their view to include the special needs of family caregivers who perform medical/nursing tasks.
- Further research is needed around subpopulations of family caregivers performing medical/nursing tasks, such as ethnic or cultural minorities.

Family caregivers are the default providers for the complex care of people with multiple chronic conditions. It is time to clearly spell out the respective responsibilities of health care providers, payers, and family caregivers with transparency and accountability.

Endnotes

[1] S. C. Reinhard, "The Work of Caregiving: What Do ADLs and IADLs Tell Us?" in *Family Caregivers on the Job: Moving Beyond ADLs and IADLs*, ed. Carol Levine (New York, NY: United Hospital Fund of New York, 2004), 181–83.

[2] L. Feinberg and A. Houser, *Assessing Family Caregiver Needs: Policy and Practice Considerations* (Washington, DC: AARP Public Policy Institute, 2012).

In Brief 199, November 2012

This *In Brief* is a synopsis of the AARP Public Policy Institute Research Report of the same title, number 2012-10.
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March 19, 2015

Sen. Cathy Giessel
Alaska State Capitol, Room 427
Juneau, AK 99801

Re: SB 72 – Designated Caregivers for Patients – SUPPORT

Dear Sen. Giessel,

On behalf of AARP Alaska's 86,000 members, many of whom are caregivers, we are pleased to support SB 72, Designated Caregivers for Patients. This bill addresses a specific problem many unpaid caregivers face with providing complex care to a loved one discharged back home from a hospital, and ensures that three critical things happen to make a hospital discharge to home more successful and less stressful, for both the patient and the caregiver: (1) designation, (2) notification and (3) education.

First, designation: the hospital inquires of the patient (or their representative) if there is someone who will be providing post-discharge aftercare at home. It could be a family member, friend, or even a neighbor. The hospital is not obligated to find a caregiver where there is none, and a named person is not obligated to accept the role of caregiver. Certainly not all patients will require assistance of a family member. If the patient identifies such a person, the hospital records the name and contact information in the patient's record and the patient is asked for permission to share medical information with the named caregiver.

Second, notification: as soon as practicable, the named caregiver is notified of the patient's planned discharge. This gives the caregiver the time needed to stock supplies, make necessary home modifications, and otherwise attend to the myriad tasks necessary to assume responsibility for their charge.

Third, education: upon notification the caregiver is offered live or recorded visual instruction on how to perform the tasks identified in the discharge plan and answer any questions the caregiver might have pertaining to performance of the care tasks. If the named caregiver declines instruction, the hospital has no further obligation.

By ensuring these three critical things happen, SB 72 will benefit not just caregivers and the care recipients, but also hospitals (through lower readmission rates) and the state (through family caregivers providing a service that would otherwise fall in the public realm).

Caregiving for a family member, friend or neighbor is a daunting and sacrificial undertaking, filled with uncertainties and anxiety. In Alaska, at any given time there are about 88,000 unpaid or "lay" caregivers providing some level of support to another person. A 2011 report by the AARP Public Policy Institute valued the unpaid care provided by Alaskan caregivers at 1.1 billion dollars annually, a figure certain to be larger today as Alaska's older population continues to grow at a rate that leads the nation. Without this army of family/friend caregivers, the responsibility for care and for paying for it would shift increasingly to the state. We believe it is not only right, but fiscally prudent to support and strengthen family caregivers.

Families remain the most important source of support to older individuals, even though many family members wouldn't even identify themselves as a "caregiver," but rather just see themselves doing what any other family member would do. Nevertheless, people who take on this task for a loved one experience stress, financial hardship, physical strain, competing demands, and consequently are themselves highly vulnerable to physical and emotional problems.

A recent study by AARP Public Policy Institute, the Hartford Foundation, and United Hospital Fund (*Home Alone: Family Caregivers Providing Complex Chronic Care*, 2012), found that increasingly family caregivers report performing medical/nursing tasks for care recipients with complex physical and/or cognitive conditions. These tasks can include managing multiple medications, providing wound care, giving injections, providing mobility and transfer assistance, and operating specialized medical equipment...in addition to more customary tasks of assisting with activities of daily living and personal care. And most caregivers reported they received little or no training to perform these tasks.

More than half (57%) of family caregivers who reported that they felt pressured to take on medical/nursing tasks said they did not feel they had a choice. Of these, 43% felt they had a personal responsibility (there was no one else to do it, or insurance would not cover it). Family caregivers who performed medical/nursing tasks were most likely to believe they were making an important contribution, primarily preventing nursing home placement (51%).

Most care recipients (69%) did not have a have a home visit by a health care professional. Even when professional home care is part of the discharge plan there is a window of 24-48 hours before the home care agency is to make their initial visit. A lot can go wrong for a patient and their caregiver in that period of time.

Family caregivers who performed medical/nursing tasks were most likely to report feeling stressed and worried about making a mistake. More than half reported feeling down, depressed, or hopeless in the last two weeks, and more than a third reported fair or poor health. These negative impacts increased with the number of the care recipients' chronic conditions.

SB72 sets out relatively simple steps in hospital procedure that can make a very significant difference for a family caregiver. Although some hospitals are actively developing just such procedures (and they should be commended for doing so), others are not. For any caregiver to be expected to assume responsibility for complex care of a loved one without proper preparation or demonstration of the tasks is unreasonable. In this time of severely diminished state resources, we firmly believe strengthening families for self-sufficiency is prudent public policy and good health practice.

Thank you, Sen. Giessel, for your leadership with SB 72. We encourage passage and enactment.

Sincerely,

Ken Helander
Advocacy Director

Terry Snyder
AARP Alaska State President

AARP Real Possibilities in
Alaska

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April 5, 2016

Rep. Paul Seaton, Chair
House Health and Social Services Committee
Alaska State Capitol, Room 102
Juneau, AK 99801

Re: SB 72 – Designated Caregivers for Patients – SUPPORT

Dear Rep. Seaton,

On behalf of AARP Alaska's 89,000 members, many of whom are caregivers, thank you for hearing SB 72. We are pleased to support SB 72, Designated Caregivers for Patients, and urge passage out of the House Health and Social Services Committee. This bill addresses a specific problem many unpaid caregivers face with providing complex care to a loved one discharged back home from a hospital, and ensures that hospital policy includes three critical elements to make a hospital discharge to home more successful and less stressful, for both the patient and the caregiver: (1) designation, (2) notification and (3) education.

First, designation: the hospital inquires of the patient (or their representative) if there is someone who will be providing post-discharge aftercare at home, which is very different that the typical "next of kin" admission query. It could be a family member, friend, or even a neighbor. The hospital is not obligated to find a caregiver where there is none, and a named person is not obligated to accept the role of caregiver. Certainly not all patients will require assistance of a family member when they return home. If the patient identifies such a person, the hospital records the name and contact information in the patient's record and the patient is asked for permission to share medical information with the named caregiver.

Second, notification: as soon as practicable, the named caregiver is notified of the patient's planned discharge. This gives the caregiver the time needed to stock supplies, make necessary home modifications, and otherwise attend to the myriad tasks necessary to assume responsibility for their care at home.

Third, education: upon notification the caregiver is offered live or recorded visual instruction on how to perform the tasks identified in the discharge plan and to ask any questions the caregiver might have pertaining to performance of the care tasks. If the named caregiver declines instruction, the hospital has no further obligation.

By ensuring that hospital policy requires that these three critical things happen, SB 72 will benefit not just caregivers and the care recipients, but also hospitals (through lower readmission rates) and the state (through family caregivers providing a service that would sooner fall into the public realm and cost state dollars).

Caregiving for a family member, friend or neighbor is a daunting and sacrificial undertaking, filled with uncertainties and anxiety. In Alaska, at any given time there are about 88,000 unpaid or "lay" caregivers providing some level of support to another person. A 2011 report by the AARP Public Policy Institute valued the unpaid care provided by Alaskan caregivers at 1.1 billion dollars annually, a figure certain to be larger today as Alaska's older population continues to grow at a rate that leads the nation. Without this army of family/friend caregivers, the responsibility for care and for paying for it would shift increasingly to the state. We believe it is not only right, but fiscally prudent to support and strengthen family caregivers.

Families remain the most important source of support to older individuals, even though many family members wouldn't even identify themselves as a "caregiver," but rather just see themselves doing what any other family member would do. Nevertheless, people who take on this task for a loved one experience stress, financial hardship, physical strain, competing demands, and consequently are themselves highly vulnerable to physical and emotional problems.

A recent study by AARP Public Policy Institute, the Hartford Foundation, and United Hospital Fund (*Home Alone: Family Caregivers Providing Complex Chronic Care*, 2012), found that increasingly family caregivers report performing medical/nursing tasks for care recipients with complex physical and/or cognitive conditions. These tasks can include managing multiple medications, providing wound care, giving injections, providing mobility and transfer assistance, and operating specialized medical equipment...in addition to more customary tasks of assisting with activities of daily living and personal care. And most caregivers reported they received little or no instruction on how to perform these tasks.

Most care recipients (69%) did not have a have a home visit by a health care professional. Even when professional home care is part of the discharge plan there is a window of 24-48 hours before the home care agency is required to make their initial visit. A lot can go wrong for a patient and their caregiver in that period of time. No family or lay caregiver should ever be faced with care for which they are not prepared. It is too dangerous and certainly stressful.

SB72 sets out relatively simple steps for hospital procedure that can make a very significant difference for a family caregiver. Although some hospitals are actively developing just such policies (and they should be commended for doing so), others are not. For any caregiver to be expected to assume responsibility for complex care of a loved one without proper preparation or demonstration of the tasks is unreasonable. In this time of severely diminished state resources, we firmly believe strengthening families for self-sufficiency is prudent public policy and good health practice.

Thank you, Rep. Seaton, for hearing SB 72. We encourage passage and enactment.

Sincerely,

Ken Helander
Advocacy Director
762-3314
khelander@aarp.org

Terry Snyder
AARP Alaska State President

Cc:
Rep. Liz Vazquez
Rep. Neal Foster
Rep. Louise Stutes
Rep. David Talerico
Rep. Geran Tarr
Rep. Adam Wool
Sen. Cathy Giessel

THE STATE
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Department of
Health and Social Services

ALASKA COMMISSION ON AGING

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April 7, 2015

Senator Kathy Giessel
Alaska State Capitol, Room 427
Juneau, Alaska 99811-1182

Regarding: Support SB 72, Designated Caregivers for Patients

Dear Senator Giessel:

The Alaska Commission on Aging is pleased to express our support for SB 72, Designated Caregivers for Patients, to improve health outcomes for patients discharged by the hospital, enhance caregiver competence in providing aftercare tasks, and reduce costly hospital readmissions. This legislation includes three important components: (1) Allows patients to voluntarily designate a caregiver, who may be a family member or friend, to provide post-discharge care, pending their abilities and willingness to perform such tasks and documents the caregiver's name and contact information in the patient's record; (2) Notifies the caregiver of the patient's discharge home to provide time for the caregiver to make necessary preparations; and (3) Consults with the designated caregiver describing the patient's aftercare needs and offers training in the tasks to be performed. When family and other informal caregivers receive appropriate supports and training, research shows they are more confident in their abilities to provide quality care, enjoy a higher quality of life, and can provide care much longer – thus preventing the need for unnecessary hospital readmissions and institutional care.

Discharge from the hospital is a critical point in a patient's recovery, particularly for older people with chronic health conditions. When patients leave the hospital, especially older ones, they may have new medications to take, new symptoms to monitor, and follow-up doctor appointments - which all require focused attention at a time when the person is most vulnerable. Family and other trusted informal caregivers are essential to an older person's recovery and are responsible for most of the aftercare that happens at home. However, without proper training in performing complicated medical tasks such as administering complex medications, providing wound care, giving injections, mobility and transferring an individual out of a wheelchair, preparing food for special diets, and operating medical equipment, untrained caregivers can jeopardize the patient's recovery or increase their own risk for personal injury.

Unpaid family caregiving is the essential bedrock for long-term care and a rapidly growing component of Alaska's health care system. The Commission supports SB 72 and appreciates your leadership, Senator Giessel, on this important legislation to enable older Alaskans to stay in their own home longer by providing much needed training and support to families caring for their loved ones at home who are recovering from hospital stays.

Sincerely,

Mary E. Shields

Mary E. Shields
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello

Denise Daniello
ACoA Executive Director

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March 23, 2015

To Whom it May Concern:

I am writing in support of Senate Bill 72 (SB72) Designated Caregivers for Patients, as introduced by Senator Cathy Giessel.

The mission of the American Lung Association is to save lives by improving lung health and preventing lung disease through education, advocacy and research.

This bill aligns with one of our mission goals, to reduce the burden of lung disease on patients and their families.

Chronic Obstructive Pulmonary Disease (COPD) is just one lung disease that afflicts senior Alaskans. COPD is the fourth leading cause of death in Alaska, and it's a leading cause of disability across the country.

Managing a chronic lung disease takes a team, including doctors, respiratory therapists, pharmacists, patients, and patient caregivers. This bill would ease the burden of lung disease on patients and their families by facilitating communication between caregivers, patients, and physicians.

Sincerely,

Marge Stoneking
Executive Director

ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION

February 2, 2016

Senator Cathy Giessel
State Capitol Room 427
Juneau, AK 99801

Dear Senator Giessel,

The Alaska State Hospital and Nursing Home Association (ASHNHA) is writing this letter in support of SB72 – also known as the CARE Act. As you know, the act helps to ensure that family members who are assisting their loved one after being discharged from a hospital will receive the proper training on how to help with their loved one's healing process. ASHNHA supports efforts to reduce patient readmissions to a hospital and give family caregivers the confidence to handle the stress that can come with in-home caregiving.

Alaska hospitals are actively pursuing a combination of strategies to reduce readmissions through improved care management. As a part of every patient's discharge assessment, the hospital works to determine who will be involved in ongoing care and to include that individual in transition planning and information about medications and follow-up care. Integrating CARE Act requirements into existing hospital discharge policies will allow hospitals to strengthen their involvement of family caregivers while continuing to meet rigorous CMS conditions of participation.

ASHNHA appreciates your work and the work of AARP to bring consistency to existing efforts to reduce readmissions and involve caregivers. Senate Bill 72 will help ensure patients across Alaska are discharged with a plan that meets their needs and the abilities of their caregiver without limiting innovation or adding significant burden on providers.

Please let us know if there is anything we can do to support this legislation moving forward.

Sincerely,

Becky H

Becky Hultberg
President/CEO

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3/27/2015

Sen. Cathy Giessel
Alaska State Capitol, Room 427
Juneau AK 99801

RE: SB 72 – Designated Caregivers for Patients – SUPPORT

Dear Senator Giessel;

Hospitals are currently being penalized for high levels of readmissions within 30 days. This readmission measure is a strong indicator that poor quality is occurring in the end-to-end healthcare delivery process. The end-to-end process includes all the touch points where a consumer encounters problems before admission; a health crises; hospital intake and diagnosis; in care and discharge planning; and at transition to home.

What ***can*** go wrong, unfortunately, often ***does*** go wrong. If an individual consumer or their family or care giver is not engaged with useful and actionable information – outcomes are often poor. Imagine if someone does not know how to deliver care: What if a caregiver does not know how to change dressings or other post-care; when and how much medicine a patient must take; what to look for and what to do if something feels or appears to be very wrong?

In fact, these after-discharge care elements are so important that state licensing and accrediting organizations require that education be done, and done well. Doing aftercare well requires education and practice for skill building. This education and skill-development is not done consistently despite many years of requirements. SB 72 shines light on the need for consumer and caregiver support and protection.

SB 72 does not specify treatment or lock hospitals and nursing homes into protocols which will change or go stale. SB 72 simply says that the right thing must be done. The right thing is to engage the consumer, family, and caregiver by designating and educating at discharge.

Thank you for your attention

Ann L Lovejoy

Ann L. Lovejoy, MBA, M.Ed
Population Health Project Manager

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Cc: Jane Conway, chief of Staff

April 7, 2015

Good morning Ms. Conway and Sen. Giessel,

I am writing this email today to offer my support for SB 72, Designated Caregivers for Patients.

I spent the entire year of 2014 as a caregiver to my 70 year old Mother who received treatment for stage 3 colon cancer. I've been in a caregiver role for many years, but this was the first time I was thrust completely into the health care system as an advocate for the patient.

Although I believe my Mom received the best of care available in Alaska, and for the most part I was prepared in my role as family caregiver and care coordinator for her; after her major surgery in September, I felt unprepared for how to care for her post-surgery. And although I gave the hospital all of the pertinent information required to be a part of her direct care, including but not limited to a notarized Medical Power of Attorney, I still found myself not included in conversations directly related to her care needs upon discharge. It seemed as if the providers would brief her when it was convenient to them, with no one following up with me, even when my Mother asked that a follow up occur. My Mom was pretty sick and having memory issues; instructions on wound care for both her ostomy and her surgery wounds wasn't registering with her. Even with home health services in place upon discharge, we still went home with a lot of questions and concerns. Because of this, I video-taped a nurse visit for ostomy care, so I could show Mom on a regular basis, as well as brief myself since it was quite a detailed process.

Mom's surgeons were both wonderful with making sure I was present for any additional care home health services would not provide. But the hospital itself wasn't often that accommodating.

I work in health care, from an education perspective. I understand the concerns of more "regulations and rules" for hospitals to follow, when really they'd like to simply focus on doing their jobs. However, I believe making sure family/informal caregivers are completely briefed upon release is imperative to the natural support systems in place in the patient's family. The two systems need to work together to provide complete care. Plus, overwhelming family caregivers creates adverse outcomes for patients. I can personally attest to being uncomfortable at first with the intimate care needs of my Mom.

I support this bill, and believe it is one more step toward a true patient centered medical model.

Thank you for your service in Juneau,

Sheila Soule, M.Ed., MPH

THE STATE
of ALASKA
GOVERNOR BILL WALKER

**Department of
Health and Social Services**

Senior and Disabilities Services
Governor's Council on Disabilities & Special Education
Patrick J. Reinhart, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503
Main: 907.269.8990
Fax: 907.269.8995

February 22, 2016

Senator Cathy Giessel
Alaska State Legislature
Capitol Building, Room 427
Juneau, Alaska 99801

RE: SB 72 – The Alaska CARE Act

Dear Senator Giessel,

The Governor's Council on Disabilities and Special Education (the Council) would like to extend its support for SB 72. Your sponsorship of this bill is greatly appreciated as we feel that it will positively impact Alaska's most vulnerable patients, including individuals with disabilities and complex medical needs.

More and more Alaskans are becoming primary caregivers for their relatives, often without proper training on their complex medical needs. Lay persons are increasingly expected to perform complicated nursing tasks for their family, friends, and neighbors who have been released from the hospital: from dispensing medications, to giving injections, to providing wound care. The health of medically fragile Alaskans is often placed in the hands of informal caregivers who lack training and support for the tasks they are expected to perform. These caregivers are then putting themselves and others at risk of injury, burnout, and time missed from work.

The Council strongly supports SB 72 so that caregivers are named in medical records, where the hospital is then required to notify the caregiver of the patient's discharge or transfer information. The hospital will then be required to consult with the caregiver about the discharge plan and provide instruction on the patient's aftercare needs and tasks. These unpaid caregivers are a growing segment of our population who need such support and training to reduce potential medical errors after discharge. SB 72 will be a positive step toward allowing more Alaskans to live independently at home, which is a major goal of the Council. Thank you for working to ensure that the Alaska informal caregiver system is fully accessible to all of the residents of this great state.

Sincerely,

Amy Simpson, Chair
Governor's Council on Disabilities &
Special Education

Art Delaune, Chair
Legislative Committee

Taneeka Hansen

From: Rep. Paul Seaton
Sent: Monday, March 07, 2016 12:36 PM
To: Taneeka Hansen
Subject: FW: SB72

From: Keren Kelley [mailto:Keren@homerseniors.com]
Sent: Monday, March 07, 2016 11:36 AM
To: Rep. Paul Seaton <Rep.Paul.Seaton@akleg.gov>
Subject: SB72

We understand Senate Bill 72 is in House Committee at this point. We urge you to consider approving this bill. There isn't a cost to approve this bill. This bill is about doing what is "right" for discharged patients. It is important that a hospital not discharge a senior to the community without "someone" helping them at home. We have had one senior who was discharged without instructions and had to be sent back to the hospital three times.

We support Senate Bill 72.

Thank you Keren

Keren L. Kelley, MPA, LNHA

Executive Director

Homer Senior Citizens, Inc.

3935 Svedlund St

Homer, Alaska 99603

(907) 235-4551 l Fax (907) 235-3739

www.homerseniors.com

Taneeka Hansen

From: AARP Alaska <AARPAK@aarp.org> on behalf of Polly James <aarpwebact@action.aarp.org>
Sent: Wednesday, April 06, 2016 2:16 PM
To: Rep. Paul Seaton
Subject: Vote YES on SB 72

Categories: Taneeka

Apr 6, 2016

State Representative Paul Seaton
State Capitol, Room 102
120 Fourth Street
Juneau, AK 99801-1182

Dear State Representative Seaton,

88,000 Alaskan caregivers need you to pass Senate Bill 72 out of S
(HSS) Committee. SB 72 supports families of hospitalized patients and helps prevent needless readmissions, reduces caregiver stress, and will save the state money by preventing costly institutional care.

In this time of fiscal uncertainty for our state, the more we can support families in their caregiving role, the more we reduce reliance on state dollars. SB 72 demonstrates our commitment to the families of disabled persons and our elders.

I urge you to VOTE YES and move SB 72 out of committee.

Sincerely,

Ms. Polly James
PO BOX 165
ANCHOR POINT, AK 99556-0165
ajamesaz@aol.com