Massachusetts CARE Act - Hospital FAQ

October 23, 2017

The Massachusetts Health and Hospital Association (MHA) developed this document to provide general guidance and to assist with understanding the underlying intent of the statutory language for hospitals implementing the Massachusetts Care Act (Chapter 332 of the Acts of 2016). This document is not intended to provide legal guidance, and healthcare providers should always consult with internal legal staff prior to relying on specific guidance that may change current operations or practice. Please note that the guidance in this document does not reflect the perspective of AARP or the Massachusetts Department of Public Health. MHA plans to update this document based on further questions or issues that its membership may raise.

1. Do you have a clearer definition of a caregiver?

   No, but we recommend that providers follow the strict language of the law. A caregiver is a person who will provide basic aftercare activities for the patient when the patient is discharged home. When a patient is being admitted, you should provide that patient with the opportunity to choose a caregiver who is going to help them get home and take care of their day-to-day needs when they are home, if home is where they are discharged to. If the patient is not discharged home, then you will only need to notify the caregiver of where the patient is being discharged to. Keep in mind that there is nothing for the caregiver to do (or the hospital beyond notification) if the patient is being sent to any other medical level of care that is not the home.

2. Do we have to notify caregivers that they were designated and document that they agree to be caregiver?

   No, you do not need to tell a caregiver that they were designated, but you do need to notify them when a discharge is occurring. If they decline and choose not to do anything, you can note that in the record to help show you attempted to contact them. But you do not need to contact the caregiver to obtain their consent to do anything.

3. Is there required "contact information" that needs to be collected on a caregiver once the patient designates a caregiver? Is a name and phone number sufficient or do we need to include other details, such as relationship to patient and home address?

   There is no definition of "contact information" or specific requirements of what has to be collected for contact information when a patient designates a caregiver. Hospitals should collect the information that passes a general test of "being appropriate" and provides the best way to communicate with the caregiver in a timely manner to give advance notice of a patient's discharge or transfer in a way that doesn't cause delays to the actual discharge or transfer. Collecting and documenting in the patient's record that includes just the caregiver's name and phone number is more than appropriate. If the hospital chooses, it can also obtain e-mail, mailing address, and other means that is a preferred method of contact. Hospitals have flexibility to determine the most appropriate process based on current practices and policies.

4. Is verbal consent to provide personal health information acceptable or is a written signature required?

   Hospitals should check with their legal counsel/risk management staff to determine what they deem to be acceptable. A hospital can obtain verbal consent from a patient to release certain medical information. However, we strongly recommend that the methods of obtaining consent should align with existing hospital policy for releasing or authorizing release of medical information.

5. Can the verbiage "patient has designated (insert caregiver name) as his/her caregiver" give implied consent to release discharge materials to this caregiver? Or do we need to document who the caregiver is and what the patient has given consent to release to him/her?

   Each hospital's risk management and legal counsel should review this particular question and make the determination for their individual hospital about whether this constitutes consent for the release of personal health information. From MHA's perspective, this is likely not enough to assume consent for release of health information. As a result we strongly encourage hospitals to use the same process that is already in place for allowing the release of health information to someone other than the patient. Again, while the law was designed to be flexible for hospital operations, it is important that the hospital not develop separate processes or practices for the release of health information.

6. Is there a defined time frame that hospitals have to notify a caregiver about a patient's discharge? (i.e. 24 hours prior to planned discharge, etc.)

   There is not a defined time frame in which hospitals have to notify a caregiver about a patient's discharge. Notification 24 hours prior to the patient's discharge is a good standard, but providers should also be aware that the notice can occur the morning or during the day of the discharge. While a discharge may need to occur quickly to ensure a patient is discharged or transferred to another level of care that has an immediate opening, providers should allow for some reasonable time period based on when the discharge orders or determination has been made by the treating provider or clinical team.

7. Is leaving a voicemail message for a caregiver an acceptable form of notification?

   For the purposes of notifying the caregiver that the patient is being discharged and transferred to another location, a voicemail would be reasonable. But we caution providers to use a rule of reason and to be guided by the time frame when the discharge order or determination was made by the treating provider or clinical team. Further, the law provides that a discharge and transfer to another level of care should not be delayed due to the inability to contact a caregiver. The goal is to ensure that you reasonably contacted the caregiver, which may include a voicemail, so the caregiver was reasonably notified of a discharge that would entail transfer to another level of care.

   For the purposes of notifying the caregiver of a discharge to home, leaving a voicemail may be reasonable if there is enough time for the caregiver to contact the hospital. For example, contacting the caregiver 10 minutes prior to a discharge at home and leaving a voicemail may not be appropriate. We again caution providers to use a rule of reason and be guided by the time

frame when the discharge order or determination was made by the treating provider or clinical team. Based on that determination, a notification should be made in a reasonable time, which may include leaving a voicemail for the caregiver. While the law does not require a provider to wait for a caregiver to return a call, it is unreasonable to have a patient wait for an extended period of time or an additional day if the caregiver does not respond in order to discuss the basic medical tasks needed after discharge.

8. If the caregiver refuses to perform the aftercare tasks, does the patient need to designate another care giver?

   No. It is a good practice for hospital staff to notify the patient that the caregiver refused to perform the aftercare tasks. Please note, however, that the hospital does not have to require the patient to choose another caregiver nor does the patient have to choose another person. This is a patient choice and if they choose another person, then the hospital should attempt to work with that new caregiver. However, the discharge/transfer should not be delayed if there is a new caregiver and as a result of being notified of a new caregiver, the hospital cannot coordinate to have the person notified or come to the hospital to discuss the aftercare tasks in a reasonable timeframe prior to discharge.

9. Does the caregiver act apply to all inpatient admissions including behavioral health or maternity patients?

   Yes, the provisions apply to all patients, including those admitted for psychiatric or maternity care with the understanding that you are talking about basic medical tasks. If you are talking about a discharge plan for a behavioral health patient to a setting other than home and it does not deal with basic medical tasks for follow up care that is needed, then you would not have a specific process to follow.

10. How would this apply to maternity discharges?

    The law applies to anyone over the age of 18 discharged from any inpatient setting. However, this process is not meant to replace or change your current communication process, such as those that are already established for a maternity level of care. What is changing is the documentation that a caregiver is notified and that you contacted them prior to the discharge.

11. Does this apply to Critical Access Hospitals?

    Yes this applies to all acute care hospitals including Critical Access Hospitals. Please note that MHA encourages all hospitals (including post-acute hospitals such as rehabilitation, psychiatric, long-term care, and others) to also consider adopting similar standards as many patients will be admitted from an acute care hospital where this policy will be implemented. Therefore, there may be an expectation from patients and families to adopt similar notification processes to improve overall care coordination between levels of care.

12. Does the patient need to designate a caregiver if they are returning to a nursing home where they are currently living for long-term care?

    Yes, all patients who come to a hospital must be given the choice and ability to choose a caregiver (regardless of where they were admitted from and where they may be discharged to). A patient does not have to choose a caregiver. If the patient so chooses a caregiver, but is only going back to a nursing home, then the hospital is only notifying the caregiver that the patient is being discharged back to their nursing home. Under the law, the only hospital requirement in this scenario is to notify the caregiver of the discharge/transfer back to the nursing home or other residential facility that provides skilled nursing care. There is no further requirement to provide additional details, discharge plans, or aftercare being done at the nursing home.

13. Does a caregiver need to be documented if the discharge plan is to discharge to a short-term rehab?

    Yes, similar to the question above, every patient who is being admitted to an acute care hospital must be given the chance to designate a caregiver. However, if the patient is being discharged to any location except for their residence (such as short-term rehab or assisted living facility) then you only need to notify the caregiver of that discharge back to the level of care. You do not need to provide additional information regarding aftercare being done at the location (provided that this location is a medical level of care) the patient is being discharged to.

14. When you are talking about an inpatient admission does this include observation status?

    Technically no, this only applies to a patient formally admitted into an inpatient status within an acute are hospital. While all hospitals have a process for providing information to a patient following the receipt of their healthcare services, this law only applies to the formal discharge from an inpatient service. The law, as drafted, does not apply to patients being discharged from an observation, outpatient, and ED level of care. While compliance of the law would be focused on the inpatient only discharges, there is still an expectation by regulators and patients that there is communication with a patient on follow up care and needs when a patient is discharged or leaves following receipt of services in an observation, outpatient, or ED level of care.

15. Has anyone implemented the collection of the caregiver information yet? If yes, where are people recording this?

    Yes, there are hospitals who have implemented the collection of the caregiver information. To date, we have been informed that hospitals are recording caregiver contact information in the EMR as part of the admissions process, and then the nursing staff are indicating on the patient record when the caregiver was notified and what information (if any) was provided.

16. Are most organizations handling this in their registration systems, or as part of clinical documentation assessment? If clinical documentation, is it by nursing or registration?

    Some hospitals that have already implemented this into their workflows have reported that they are collecting this information when hospital staff contacts patients prior to a scheduled service to

collect basic demographic information (including now the caregiver information), or upon admission. If the information is collected at the site of care, the collection and dissemination of information is being done by the nursing staff.

17. Is this for Medicare enrollees only?

    No, this applies to all patients, regardless of payer type, who are over the age of 18.

18. Do we have to notify the caregiver that they were designated and that they agree to be caregiver?

    No, you do not need to tell a caregiver that they were designated, but you do need to notify them when a discharge or a transfer is occurring. If they decline and choose not to do anything, you can note that in the record to help show you attempted to contact them. Please be advised that the hospital should not be delaying the discharge or transfer due to an inability to contact the caregiver or if they are not able to come to the hospital to review the basic medical tasks that may be outlined in the discharge plan.

19. Is MHA developing a form/document they recommend using?

    No, MHA is not planning to develop a form or document for broad hospital use to document the caregiver's information. However, MHA has developed a PowerPoint presentation that all hospitals can use in any setting to help educate current and future staff on the new law. We have also developed fact sheets that can be used with patients and clinical staff to help them understand the law and provide an easy handout for patients and communities to ensure consistent information is being provided statewide.