CONNECTICUT LEGAL RIGHTS PROJECT

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COMMITTEE ON AGING PUBLIC HEARING FEBRUARY 10, 2015
TESTIMONY OF SALLY R. ZANGER, STAFF ATTORNEY

Connecticut Legal Rights Project has concerns about proposed bill SB 204.
Senators Flexer and Osten, Senators Kelly and Bolinski, members of the committee.

The Connecticut Legal Rights Project (CLRP) is a legal services organization that advocates for low-income individuals in institutions and in the community throughout the state who have, or are perceived to have, psychiatric disabilities. We support initiatives that integrate individuals into the community.

CLRP has concerns about SB 204, which proposes to amend the general statutes (without specifying which of the general statutes) to require the use of best practices for protecting senior citizens in from interaction with sexual offenders

We agree with the purpose of the bill, to keep vulnerable senior citizens safe. However, the proposal casts a net that is both too wide, and too narrow. People who are on the sex offender registry are not all pedophiles or sexual predators. Some people who are on the sex offender registry are there for crimes they committed 10 or 20 years ago, when they were teenagers, barely out of their teens, or when they were under the influence of substances they no longer use. The bill assumes that senior citizens need to be protected from "interacting" with sexual offenders. "Interacting" is very very broad. Some people live in senior housing, in the same senior housing as their parents, and assist those senior parents with their day-to-day chores. On the other hand there are undoubtedly predators working in facilities who have never been caught or prosecuted and are not on any sex offender registry. It is important to draft and craft legislation that will actually protect people, not simply restrict individuals on the sex offender registry, who are already known to us. As the bill notes at the end, it is not clear at all what it means in terms of risk to the community for a person to be on the sex offender registry. I do not in any way diminish the seriousness of any crime against a person, but I emphasize that if a person has served time in prison, come out of prison, served probation, or is on parole, is registered and reporting his or her whereabouts as required and has not committed any further offenses it is not appropriate to automatically restrict him or her from public facilities, from employment, visiting, or living with or near senior citizens. Some of the people on the registry are in fact senior citizens!

The bill raises important questions: What are the best practices for protecting senior citizens? How to identify individuals who pose a risk to the community? Those questions need to be answered before enacting draconian legislation. The bill also seems to recognize, in the final paragraph, that it is necessary to assess the risk to the community that each offender poses. **We support reforms to our current sex offender**

registry system to create a tiered approach that utilizes the already existing risk assessments done by Dept. of Corrections to determine who is a high, medium or low risk. People deemed to be low risk should not have to be on a public registry at all. There should be a mechanism to petition to be removed from registry and sentencing judges should have discretion not to put an individual on the registry in the first place. CLRP respectfully suggests that there is much research to be done before this bill is drafted or enacted: research regarding best practices, regarding the risks, and regarding the legality and the wisdom of wholesale restrictions on the movements of citizens.

CLRP supports with questions Proposed Bill No. 5455 and Proposed Bill No. 290.

Both bills appear to enact a version of the CARE Act: Caregiver Advise, Record, Enable ACT. CLRP supports the bills because they provide autonomy for patients (of any age) and fill a gap in our current continuum of assistance, so that a person can designate a caregiver who will be involved in care but who is not a substitute decision maker. The carer can be available and must be informed without requiring a finding that the patient is incapable. I have had clients who found that the only way to be sure that their trusted family members were informed of important issues was to make those family members voluntary conservators of the person, which is a more restrictive solution than necessary. These bills may provide a middle ground.

However, there is no text to the proposed bills. We have some concerns about the ACT provided on the AARP website (attached to this testimony):

1. "Caregiver" need not be limited to individuals living in the same residence.
2. Section 2 A (c) (i) (1) states that if the patient or patient's legal guardian declines to consent to the release of medical information to the patient's designated caregiver, the hospital is not required to provide notice of discharge or transfer or to provide information contained in the discharge plan. There is an "all or nothing" quality to the release of information. A person should be able to consent to notice of discharge and/or transfer and release of information contained in the discharge plan without having to give the caregiver access to all of his or her medical records. A caregiver is not a medical decision maker, and only needs to know what he or she needs to know. A patient can make that distinction and should not have to forfeit the protections of an informed caregiver to preserve other aspects of his/her medical privacy.
3. Section 5 (B) states that any health care directive claimed to be in conflict with the Act must be in existence prior to the patient's entry into a hospital. Under CT law, a person can execute an advance directive for health care while in the hospital, and there is no inherent conflict between the designation of a caregiver and the designation of a health care representative. It can be one person, but need not be.

Thank you for your work and for your consideration of these serious concerns.

Caregiver Advise, Record and Enable (CARE) Act

December 2013

(Session No.) Legislative Assembly
of (State)

HOUSE BILL NO. ____

Introduced by (Sponsors)

(Committee Assignment)

A BILL for an Act to require a medical hospital as defined in [STATE STATUTE] to allow a patient an opportunity to designate, upon entry to a hospital, a caregiver in the patient's medical record; to require a hospital to notify and meet with the designated caregiver to discuss the patient's plan of care prior to the patient's discharge or transfer to another facility; to require a hospital to instruct the designated caregiver in certain after-care tasks upon a patient's discharge to his or her current residence; and to provide an effective date.

Statement of Legislative Intent

At any given time, an estimated [##] [STATE RESIDENTS] provide varying degrees of unreimbursed care to adults with limitations in daily activities. The total value of the unpaid care provided to individuals in need of long-term services and supports amounts to an estimated $[##] every year, based on 2009 data. Caregivers are often members of the individual's immediate family, but friends and other community members also serve as caregivers. While most caregivers are asked to assist an individual with basic activities of daily living, such as mobility, eating, and dressing, many are expected to perform complex tasks on a daily basis such as administering multiple medications, providing wound care, and operating medical equipment.

Despite the vast importance of caregivers in the individual's day-to-day care, many caregivers find that they are often left out of discussions involving a patient's care while in the hospital and, upon the patient's discharge, receive little to no instruction on the tasks they are expected to perform. The federal Centers for Medicare & Medicaid Services (CMS) estimates that $17 billion in Medicare funds is spent each year on unnecessary hospital readmissions. Additionally, hospitals desire to avoid the imposition of new readmission penalties under the federal Patient Protection and Affordable Care Act (ACA).

In order to successfully address the challenges of a surging population of older adults and others who have significant needs for long-term services and supports, the state must develop methods to enable caregivers to continue to support their loved ones at home and in the community, and avoid costly hospital readmissions. Therefore, it is the intent of the [STATE] Legislative Assembly that this Act enables caregivers to provide competent post-hospital care to their family and other loved ones, at minimal cost to the taxpayers of this State.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF [STATE]:

Section 1.
Definitions.

A. "Hospital" is defined for the purposes of this Act as a facility licensed under [STATE STATUTE].

B. "After-Care" is defined for the purposes of this Act as any assistance provided by a caregiver to a patient under this Act after the patient's discharge from a hospital. Such assistance may include, but is not limited to, assisting with basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), or carrying out medical/nursing tasks, such as managing wound care, assisting in administering medications, and operating medical equipment.

C. "Caregiver" is defined for the purposes of this Act as any individual duly designated as a caregiver by a patient under this Act who provides after-care assistance to a patient living in his or her residence. A designated caregiver may include, but is not limited to, a relative, partner, friend, or neighbor who has a significant relationship with the patient.

D. "Discharge" is defined for the purposes of this Act as a patient's exit or release from a hospital to the patient's residence following any medical care, treatment, or observation.

E. "Entry" is defined for the purposes of this Act as a patient's entrance into a hospital for the purposes of medical care, treatment, or observation. A patient need not be formally admitted to a hospital for the provisions of this Act to apply.

F. "Residence" is defined for the purposes of this Act as a dwelling that the patient considers to be his or her home. A "residence" for the purposes of this Act shall not include any rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed by the [STATE DEPARTMENT OR LICENSING BODY].

Section 2.
Caregiver—Opportunity to Designate.

A. A hospital shall provide each patient or, if applicable, the patient's legal guardian with at least one opportunity to designate at least one caregiver under this Act no later than twenty-four (24) hours following the patient's entry into a hospital and prior to the patient's discharge or transfer to another facility.

   a. In the event that the patient is unconscious or otherwise incapacitated upon his or her entry into a hospital, the hospital shall provide such patient or his/her legal guardian with an opportunity to designate a caregiver within twenty-four (24) hours following the patient's recovery of his or her consciousness or capacity.

   b. In the event that the patient or the patient's legal guardian declines to designate a caregiver under the Act, the hospital shall promptly document this in the patient's medical record.

c. In the event that the patient or the patient's legal guardian designates an individual as a caregiver under this Act:

i. The hospital shall promptly request the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated caregiver following the hospital's established procedures for releasing personal health information and in compliance with all federal and state laws.

1. If the patient or the patient's legal guardian declines to consent to release medical information to the patient's designated caregiver, the hospital is not required to provide notice to the caregiver under Section 3 of this Act or provide information contained in the patient's discharge plan under Section 4 of this Act.

ii. The hospital shall record the patient's designation of caregiver, the relationship of the designated caregiver to the patient, and the name, telephone number, and address of the patient's designated caregiver in the patient's medical record.

d. A patient may elect to change his or her designated caregiver at any time, and the hospital must record this change in the patient's medical record within twenty-four (24) hours.

B. A designation of a caregiver by a patient or a patient's legal guardian under this Section does not obligate any individual to perform any after-care tasks for any patient.

C. This section shall not be construed to require a patient or a patient's legal guardian to designate any individual as a caregiver as defined by this Act.

Section 3.
Notice to Designated Caregiver.

A. A hospital shall notify the patient's designated caregiver of the patient's discharge or transfer to another hospital or facility licensed by the [STATE DEPARTMENT OR LICENSING BODY] as soon as possible and not later than four (4) hours prior to the patient's actual discharge or transfer to such facility.

Section 4.
Instruction to Designated Caregiver.

A. As soon as possible and not later than twenty-four (24) hours prior to a patient's discharge from a hospital, the hospital shall consult with the designated caregiver regarding the caregiver's capabilities and limitations and issue a discharge plan that describes a patient's after-care needs at his or her residence.

a. At minimum, a discharge plan shall include:

i. The name and contact information of the caregiver designated under this Act;

ii. A description of all after-care tasks necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the caregiver; and

iii. Contact information for any health care, community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan.

B. The hospital issuing the discharge plan must provide caregivers with instruction in all after-care tasks described in the discharge plan.

a. At minimum, such instruction shall include:

i. A live demonstration of the tasks performed by a hospital employee authorized to perform the after-care task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law;

ii. An opportunity for the caregiver to ask questions about the after-care tasks; and

iii. Answers to the caregiver's questions provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law.

b. Any instruction required under this Act shall be documented in the patient's medical record, including, at minimum, the date, time, and contents of the instruction.

C. The [STATE DEPARTMENT OF HEALTH] is authorized to promulgate regulations to implement the provisions of this Act, including, but not limited to, regulations to further define the content and scope of any instruction provided to caregivers under this Act.

Section 5.
Non-Interference with Powers of Existing Health Care Directives.

A. Nothing in this Act shall be construed to interfere with the rights of an agent operating under a valid health care directive under [STATE STATUTE].

B. Any health care directive claimed to be in conflict with this Act must be in existence prior to the patient's entry into a hospital.

Section 6.
Effective Date.