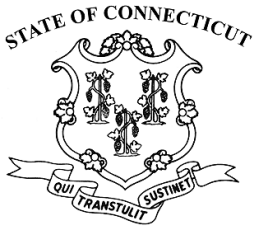

Senate Bill No. 956

Public Act No. 23-39

AN ACT REQUIRING DISCHARGE STANDARDS REGARDING FOLLOW-UP APPOINTMENTS AND PRESCRIPTION MEDICATIONS FOR PATIENTS BEING DISCHARGED FROM A HOSPITAL OR NURSING HOME FACILITY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-504c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) For purposes of this section and section 19a-504e:

(1) "Caregiver" means any individual who a patient designates as a caregiver to provide post-discharge assistance to the patient in the patient's home in the community. The term "caregiver" includes, but is not limited to, a relative, spouse, partner, friend or neighbor who has a significant relationship with the patient. For the purposes of this section and section 19a-504e, the term caregiver shall not include any individual who receives compensation for providing post-discharge assistance to the patient.

(2) "Home" means the dwelling that the patient considers to be the patient's home in the community. The term "home" shall not include, and the provisions of this section and section 19a-504e shall not apply to, a discharge to any rehabilitation facility, hospital, nursing home,

assisted living facility, group home or any other setting that was not the patient's home in the community immediately preceding the patient's inpatient admission.

(3) "Hospital" has the same meaning as provided in section 19a-490.

(4) "Post-discharge assistance" means nonprofessional care provided by a designated caregiver to a patient following the patient's discharge from an inpatient admission to a hospital in accordance with the written discharge plan of care signed by the patient or the patient's representative, including, but not limited to, assisting with basic activities of daily living, instrumental activities of daily living and carrying out support tasks, such as assisting with wound care, administration of medications and use of medical equipment.

(b) The Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to set minimum standards for hospital discharge planning services. Such standards shall include, but **[**not necessarily**]** need not be limited to, requirements for (1) a written discharge plan prepared in consultation with the patient, or the patient's family or representative, and the patient's physician, including, but not limited to, the date and location of each follow-up medical appointment scheduled prior to the patient's discharge and, to the extent known to the hospital, a list of all medications the patient is currently taking and will continue to take after the patient's discharge, and (2) a procedure for advance notice to the patient of the patient's discharge and provision of a copy of the discharge plan to the patient prior to discharge.

(c) Whenever a hospital refers a patient's name to a nursing home as part of the hospital's discharge planning process, or when a hospital patient requests such a referral, the hospital shall make a copy of the patient's hospital record available to the nursing home and shall allow the nursing home access to the patient for purposes of care planning and

consultation.

(d) Whenever a hospital's discharge planning indicates that an inpatient will be discharged to the patient's home, the hospital shall (1) allow the patient to designate a caregiver at, or prior to, the time that a written copy of the discharge plan is provided to the patient, and (2) transmit in an electronic manner to the patient's pharmacy each prescription ordered by a hospital employee for the patient prior to discharge that the patient will need after discharge. A patient is not required to designate any individual as a caregiver and any individual designated as a caregiver under this section is not obligated to perform any post-discharge assistance for the patient.

(e) If an inpatient designates a caregiver pursuant to subsection (d) of this section prior to receiving written discharge instructions, the hospital shall:

(1) 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 discharge plan.

(2) Make reasonable attempts to notify the patient's designated caregiver of the patient's discharge to the patient's home as soon as practicable. In the event the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient.

(3) Prior to discharge, provide caregivers with instructions in all post-discharge assistance tasks described in the discharge plan. Training and instructions for caregivers may be conducted in person or through video technology, as determined by the hospital to effectively provide the necessary instruction. Any training or instructions provided to a caregiver shall be provided in nontechnical language, to the extent

possible. At a minimum, this instruction shall include: (A) A live or recorded demonstration of the tasks performed by an individual designated by the hospital who is authorized to perform the post-discharge assistance task and is able to perform the demonstration in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law; (B) an opportunity for the caregiver to ask questions about the post-discharge assistance tasks; and (C) 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.

(4) Document in the patient's medical record any training for initial implementation of the discharge plan provided to the patient, the patient's representative or the designated caregiver. Any instruction required under subdivision (3) of this subsection shall be documented in the patient's medical record, including, at a minimum, the date, time and contents of the instruction.

(f) If the patient agrees, the written discharge materials referenced in this section may include electronic-only versions, and acknowledgment of any such written discharge materials may be documented through electronic means.

Sec. 2. Section 19a-535c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) For purposes of this section and section 19a-535d:

(1) "Caregiver" means any individual who a resident designates to provide post-discharge assistance to the resident in the resident's home in the community. The term "caregiver" includes, but is not limited to, a relative, spouse, partner, friend or neighbor who has a significant relationship with the resident. For the purposes of this section and

section 19a-535d, the term "caregiver" shall not include any individual who receives compensation for providing post-discharge assistance to the resident.

(2) "Home" means the dwelling that the resident considers to be the resident's home in the community. The term "home" shall not include, and the provisions of this section and section 19a-535d, shall not apply to, a discharge to any rehabilitation facility, hospital, assisted living facility, group home or any other setting that was not the resident's home in the community immediately preceding the resident's admission.

(3) "Resident" means a resident of a nursing home facility or the resident's representative.

(4) "Nursing home facility" has the same meaning as provided in section 19a-521.

(5) "Post-discharge assistance" means nonprofessional tasks provided by a designated caregiver to a resident following the resident's discharge from a nursing home facility in accordance with the written discharge plan of care signed by the resident or the resident's representative, which involves assisting with basic activities of daily living, instrumental activities of daily living and carrying out support tasks, such as assisting with wound care, administration of medications and use of medical equipment.

(b) The Department of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to set minimum standards for nursing home facility discharge planning services. Any such standards shall include, but need not be limited to, requirements for (1) a written discharge plan prepared in consultation with the resident, or the resident's family or representative, and the resident's physician, including, but not limited to, the date and location of each follow-up

medical appointment scheduled prior to the resident's discharge and a list of all medications the resident is currently taking and, to the extent known to the nursing home facility, will continue to take after the resident's discharge, and (2) a procedure for advance notice to the resident of the resident's discharge and provision of a copy of the discharge plan to the resident prior to discharge.

(c) Whenever a discharge plan from a nursing home facility indicates that a resident shall be discharged to the resident's home, the nursing home facility shall (1) allow the resident to designate a caregiver at, or prior to, the time that a written copy of the discharge plan is provided to the resident, and (2) transmit in an electronic manner to the resident's pharmacy each prescription ordered by a nursing home facility employee for the resident prior to discharge that the resident will need after discharge. A resident is not required to designate any individual as a caregiver and any individual designated as a caregiver under this section is not obligated to perform any post-discharge assistance for the resident or agree to receive any instruction required under this section.

(d) If a resident designates a caregiver pursuant to subsection (c) of this section prior to receiving written discharge instructions, the nursing home facility shall:

(1) Record the resident's designation of caregiver, the relationship of the designated caregiver to the resident and, if known, the name, telephone number and address of the resident's designated caregiver in the discharge plan.

(2) Make more than one reasonable attempt to notify the resident's designated caregiver of the resident's discharge to the resident's home as soon as practicable. In the event the nursing home facility is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the resident or an appropriate discharge of the resident.

(3) Prior to discharge, provide caregivers with instructions in all post-discharge assistance tasks described in the discharge plan. Training and instructions for caregivers may be provided in writing or conducted in person or through video technology, as determined by the nursing home facility to effectively provide the necessary instruction. Any training or instructions provided to a caregiver shall be provided in nontechnical language, to the extent possible. At a minimum, this instruction shall include: (A) A written, live or recorded demonstration of the tasks performed by an individual designated by the nursing home facility who is authorized to perform the post-discharge assistance task and is able to perform the demonstration in a culturally competent manner and in accordance with the requirements of the nursing home facility to provide language access services under state and federal law; (B) an opportunity for the caregiver to ask questions about the post-discharge assistance tasks; and (C) answers to the caregiver's questions provided in a culturally competent manner and in accordance with the requirements of the nursing home facility to provide language access services under state and federal law.

(4) Document in the resident's medical record any training for initial implementation of the discharge plan provided to the resident, the resident's representative or the designated caregiver. Any instruction required under subdivision (3) of this subsection shall be documented in the resident's medical record, including, at a minimum, the date, time and subject of the instruction.